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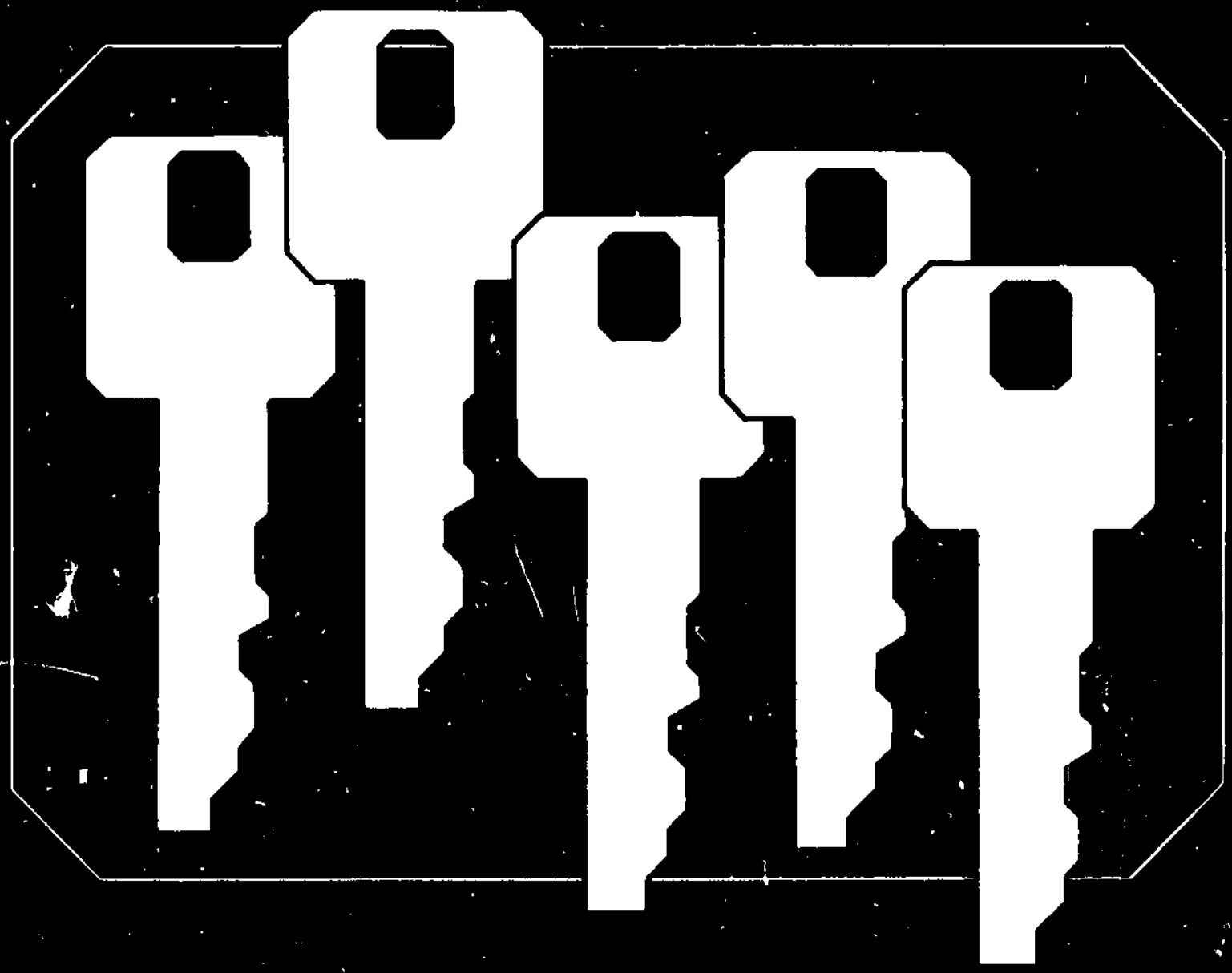
ABSTRACT

This learning module, one in a series of competency-based guidance program training packages focusing upon professional and paraprofessional competencies of guidance personnel, deals with meeting the guidance needs of older adults. Addressed in the module are the following topics: describing a negative and a positive bias, stereotype, or attitude held toward older adults and determining the possible cause and effects of each one; describing examples of older adults' positive and negative accommodation to changes in life roles and factors that explain each type of accommodation; identifying strengths and weaknesses in listening and attending skills; and applying a problem-solving strategy to help older adults solve their career development problems. The module consists of readings and learning experiences covering these four topics. Each learning experience contains some or all of the following: an overview, a competency statement, a learning objective, one or more individual learning activities, an individual feedback exercise, one or more group activities, and a facilitator's outline for use in directing the group activities. Concluding the module are handouts, a participant self-assessment questionnaire, a trainer's assessment questionnaire, a checklist of performance indicators, a list of references, and an annotated list of suggested additional resources. (MN)

Meet Guidance Needs of Older Adults



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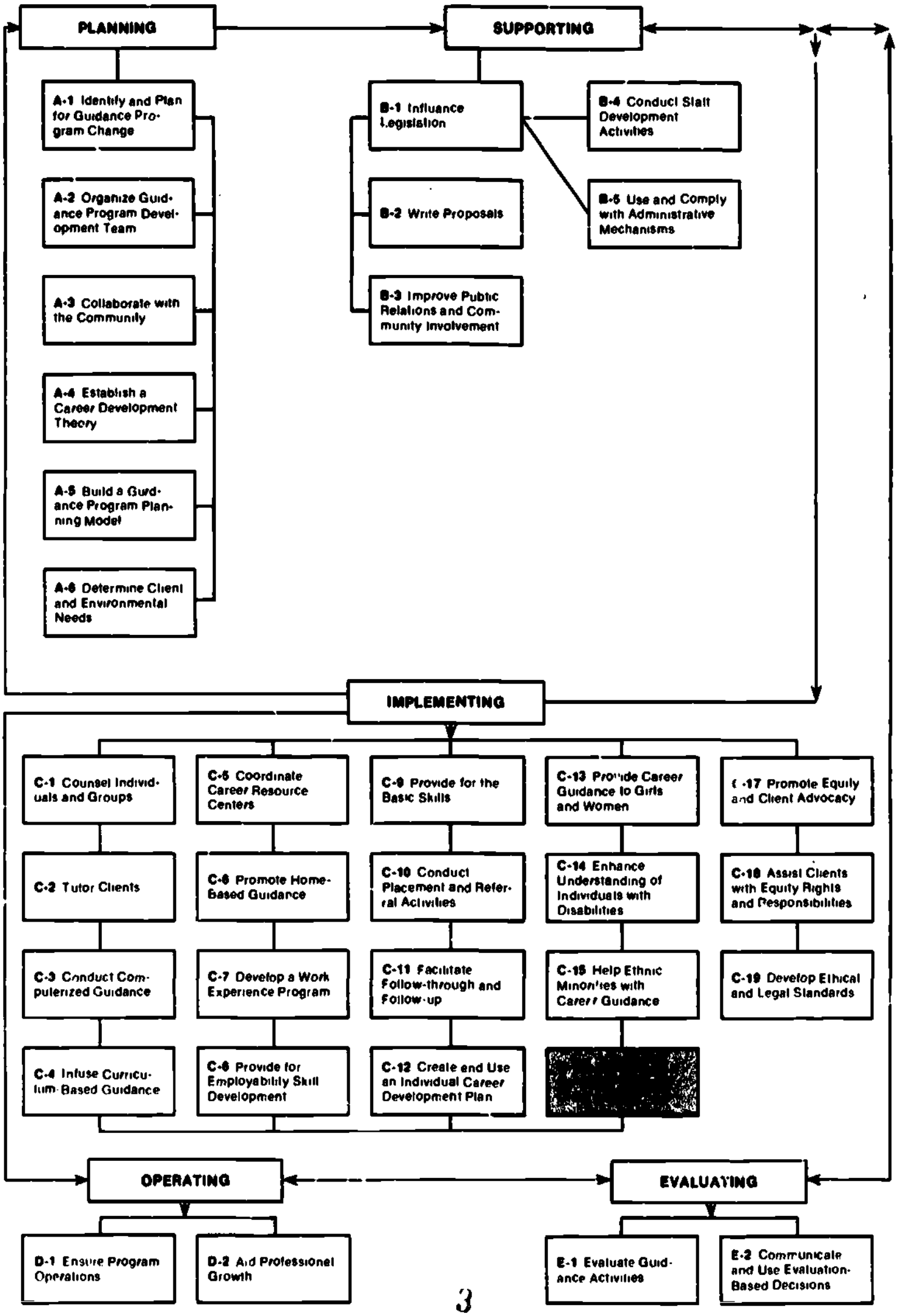

Meet Guidance Needs of Older Adults

MODULE CG C-16

Module CG C-16 of Category C — Implementing
Competency-Based Career Guidance Modules

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FOREWORD

This counseling and guidance program series is patterned after the Performance-Based Teacher Education modules designed and developed at the National Center for Research in Vocational Education under Federal Number NE-C00-3-77 Because this model has been successfully and enthusiastically received nationally and internationally this series of modules follows the same basic format

This module is one of a series of competency-based guidance program training packages focusing upon specific professional and paraprofessional competencies of guidance personnel The competencies upon which these modules are based were identified and verified through a project study as being those of critical importance for the planning supporting implementing operating and evaluating of guidance programs These modules are addressed to professional and paraprofessional guidance program staff in a wide variety of educational and community settings and agencies

Each module provides learning experiences that integrate theory and application each culminates with competency referenced evaluation suggestions The materials are designed for use by individuals or groups of guidance personnel who are involved in training Resource persons should be skilled in the guidance program competency being developed and should be thoroughly oriented to the concepts and procedures used in the total training package

The design of the materials provides considerable flexibility for planning and conducting competency-based preservice and inservice programs to meet a wide variety of individual needs and interests The materials are intended for use by universities state departments of education postsecondary institutions intermediate educational service agencies JTPA agencies employment security agencies and other community agencies that are responsible for the employment and professional development of guidance personnel

The competency-based guidance program training packages are products of a research effort by the National Center's Career Development Program Area Many individuals institutions and agencies participated with the National Center and have made contributions to the systematic development testing and refinement of the materials

National consultants provided substantial writing and review assistance in development of the initial module versions over 1300 guidance personnel used the materials in early stages of their development and provided feedback to the National Center for revision and refinement The materials have been or are being used by 57 pilot community implementation sites across the country

Special recognition for major roles in the direction development coordination of development testing and revision of these materials and the coordination of pilot implementation sites is extended to the following project staff Harry N Drier Consortium Director Robert E Campbell Linda Pfister Directors Robert Bhaerman Research Specialist Karen Kimmel Boyle Fred Williams Program Associates and Janie B Connell Graduate Research Associate

Appreciation also is extended to the subcontractors who assisted the National Center in this effort Drs Brian Jones and Linda Phillips-Jones of the American Institutes for Research developed the competency base for the total package managed project evaluation and developed the modules addressing special needs Gratitude is expressed to Dr Norman Gysbers of the University of Missouri-Columbia for his work on the module on individual career development plans Both of these agencies provided coordination and monitoring assistance for the pilot implementation sites Appreciation is extended to the American Vocational Association and the American Association for Counseling and Development for their leadership in directing extremely important subcontractors associated with the first phase of this effort

The National Center is grateful to the U S Department of Education Office of Vocational and Adult Education (OVAE) for sponsorship of three contracts related to this competency-based guidance program training package In particular we appreciate the leadership and support offered project staff by David H Pritchard who served as the project officer for the contracts We feel the investment of the OVAE in this training package is sound and will have lasting effects in the field of guidance in the years to come

Robert E Taylor
Executive Director
National Center for Research
in Vocational Education

THE NATIONAL CENTER
FOR RESEARCH IN VOCATIONAL EDUCATION
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The National Center for Research in Vocational Education's mission is to increase the ability of diverse agencies, institutions, and organizations to solve educational problems relating to individual career planning, preparation, and progression The National Center fulfills its mission by

- Generating knowledge through research
- Developing educational programs and products
- Evaluating individual program needs and outcomes
- Providing information for national planning and policy
- Installing educational programs and products
- Operating information systems and services
- Conducting leadership development and training programs

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ABOUT THIS MODULE

MEET GUIDANCE NEEDS OF OLDER ADULTS

Goal

After completing this module, career guidance personnel will be better aware of stereotypes and biases inhibiting work with older adults, critical issues facing older adults, strengths and weaknesses in people's abilities to listen and attend to these persons, and a personal problem-solving strategy, for helping them solve their career problems.

ABOUT USING THE CBCG MODULES

CBCG Module Organization

The training modules cover the knowledge, skills, and attitudes needed to plan, support, implement, operate, and evaluate a comprehensive career guidance program. They are designed to provide career guidance program implementers with a systematic means to improve their career guidance programs. They are competency-based and contain specific information that is intended to assist users to develop at least part of the critical competencies necessary for overall program improvement.

These modules provide information and learning activities that are useful for both school-based and nonschool-based career guidance programs.

The modules are divided into five categories.

The GUIDANCE PROGRAM PLANNING category assists guidance personnel in outlining in advance what is to be done.

The SUPPORTING category assists personnel in knowing how to provide resources or means that make it possible for planned program activities to occur.

The IMPLEMENTING category suggests how to conduct, accomplish, or carry out selected career guidance program activities.

The OPERATING category provides information on how to continue the program on a day-to-day basis once it has been initiated.

The EVALUATING category assists guidance personnel in judging the quality and impact of the program and either making appropriate modifications based on findings or making decisions to terminate it.

Module Format

A standard format is used in all of the program's competency-based modules. Each module contains (1) an introduction, (2) a module focus, (3) a reading, (4) learning experiences, (5) evaluation techniques, and (6) resources.

Introduction. The introduction gives you, the module user, an overview of the purpose and content of the module. It provides enough information for you to determine if the module addresses an area in which you need more competence.

About This Module. This section presents the following information:

Module Goal: A statement of what one can accomplish by completing the module.

Competencies: A listing of the competency statements that relate to the module's area of concern. These statements represent the competencies thought to be most critical in terms of difficulty for inexperienced implementers, and they are not an exhaustive list.

This section also serves as the table of contents for the reading and learning experiences.

Reading. Each module contains a section in which cognitive information on each one of the competencies is presented.

1. Use it as a textbook by starting at the first page and reading through until the end. You could then complete the learning experiences that relate to specific competencies. This approach is good if you would like to give an overview of some competencies and a more in-depth study of others.
2. Turn directly to the learning experiences(s) that relate to the needed competency (competencies). Within each learning experience a reading is listed. This approach allows for a more experiential approach prior to the reading activity.

Learning Experiences. The learning experiences are designed to help users in the achievement of specific learning objectives. One learning experience exists for each competency (or a cluster of like competencies), and each learning experience is designed to stand on its own. Each learning experience is preceded by an overview sheet which describes what is to be covered in the learning experience.

Within the body of the learning experience, the following components appear.

Individual Activity: This is an activity which a person can complete without any outside assistance. All of the information needed for its completion is contained in the module.

Individual Feedback: After each individual activity there is a feedback section. This is to provide users with immediate feedback or evaluation regarding their progress before continuing. The concept of feedback is also intended with the group activities, but it is built right into the activity and does not appear as a separate section.

Group Activity: This activity is designed to be facilitated by a trainer, within a group training session.

The group activity is formatted along the lines of a facilitator's outline. The outline details suggested activities and information for you to use. A blend of presentation and "hands-on" participant activities such as games and role playing is included. A Notes column appears on each page of the facilitator's outline. This space is provided so trainers can add their own comments and suggestions to the cues that are provided.

Following the outline is a list of materials that will be needed by workshop facilitator. This section can serve as a duplication master for mimeographed handouts or transparencies you may want to prepare.

Evaluation Techniques. This section of each module contains information and instruments that can be used to measure what workshop participants need prior to training and what they have accomplished as a result of training. Included in this section are a Pre- and Post-Participant Assessment Questionnaire and a Trainer's Assessment Questionnaire. The latter contains a set of performance indicators which are designed to determine the degree of success the participants had with the activity.

References. All major sources that were used to develop the module are listed in this section. Also, major materials resources that relate to the competencies presented in the module are described and characterized.

INTRODUCTION

Effective career guidance is essential for **all** persons! That statement assumes that all of us have career development needs over the **life span** and that we may want assistance with them. It also assumes that no group or individual is without such needs and should not be excluded from receiving guidance assistance if desired. Exclusions based on personal characteristics like sex, ethnic and racial membership, age, educational level, and socioeconomic status are inconsistent with these assumptions.

However, it is all too painfully clear that the above philosophy is violated--far too frequently. One of the groups of people who receive inadequate career development attention is the **older adults**. For the purpose of this module, this group includes people who are **65 years** or older. But since this is an introductory module in the area of improving career guidance for older adults, the concepts, the learning experiences, and the instructional objectives are viewed as appropriate for guidance personnel who are working with persons anticipating or undergoing mid-career change as it is for guidance workers serving adults over 65.

The primary focus of this module is on helping you to explore the possible changes that need to be made in the ways you relate to people in this group. To make some changes--in fact, to recognize that they need to be made--we encourage you to begin by taking a hard look at yourself, not just at your potential clients. Such self-study would entail assessing your perceptions of older adults and the process of aging. In fact, the module begins by encouraging you to project yourself into the life situations faced by many people in this group.

Think about what your life is going to be like when you reach the age of 60. How about 65 when retirement may begin? or 70? or even 80? Think of the older adults whom you know--persons facing mid-career change, perhaps your parents or grandparents, friends, or just someone you happened to notice the other day. How will your life at their age compare?

Pick an age for the first older adult who comes to mind. Now, think of an adjective that best describes the life situation that you project for yourself at that age. You may find it helpful to think of life experiences in the following categories:

- Physical and mental health
- Finances
- Family relationships
- Spiritual and philosophical values
- Interests and social behavior patterns
- Personal and social behavior patterns

If so, conjure up an adjective for each category.

So often the effectiveness of career guidance programs is curtailed by the biases and stereotypes guidance workers have for the target groups they serve. The adjectives you just identified might give you hints about some of the restricting beliefs and attitudes you have regarding older adults.

The Older Adult--Biases and Stereotypes

Competency 1

Describe a negative and a positive bias, stereotype, or attitude you hold regarding older adults and determine the possible cause and effect of each one.

Let's take a closer look at some of the **negative biases** and stereotypes about the elderly. Read over the following paragraph. In it, Robert Butler (1975: 6-7) has embodied a multitude of the myths that surround old age:

> An older person thinks and moves slowly. He does not think as he used to or as creatively. He is bound to himself and to his past and can no longer change or grow. He can learn neither well nor swiftly and, even if he could, he would not wish to. Tied to his personal traditions and growing conservatism, he dislikes innovations and is not disposed to new ideas. Not only can he not move forward, he often moves backward. He enters a second childhood, caught up in increasing egocentricity and demanding more from his environment than he is willing to give to it. Sometimes he becomes an intensification of himself, a caricature of a lifelong personality. He becomes irritable and cantankerous, yet shallow and enfeebled. He lives in the past; he is behind the times. He is aimless and wandering of mind, reminiscing and garrulous. Indeed, he is a study of decline, the picture of mental and physical failure. He has lost and cannot replace friends, spouse, job, status, power, influence, income. He is often stricken by diseases which, in turn, restrict his movement, his enjoyment of food, the pleasures of well-being. His mind does not utilize oxygen and sugar at the same rate as formerly. Feeble, uninteresting, he awaits death, a burden to society, to his family, and to himself.

Talk about stereotypes! Butler's paragraph is overloaded with them. Not only are all older persons males, they fit into a series of boxes. We are going to analyze Butler's paragraph into different categories of stereotypes about older adults.

> **Physical/Mental Health.** "He is often stricken by diseases which, in turn, restrict his movement, his enjoyment of food, the pleasures of well-being. He has lost his desire and capacity for sex. His body shrinks, and so too does the flow of blood to his brain. His mind does not utilize oxygen and sugar at the same rate as formerly."
>
> "An older person thinks and moves slowly. He does not think as he used to, or as creatively.... He can learn neither well nor swiftly and, even if he could, he would not wish to.... He is aimless and wandering of mind. ... Indeed ... the picture of mental and physical failure."
>
> **Finances.** "... demanding more from society than he is willing to give to it.... He has lost and cannot replace ... job, status, power, influence, income."
>
> **Relationships with Family and Friends.** "He has lost and cannot replace friends, spouse... [he is] a burden to society, to his family, and to himself."
>
> **Interests and Activities.** "He is bound to himself and to his past and can no longer change or grow.... Tied to his personal traditions and growing conservatism, he dislikes innovations and is not disposed to new ideas."
>
> **Personality Traits.** "He becomes irritable and cantankerous, yet shallow and enfeebled ..., reminiscing and garrulous."

Generalizations about a particular group of people are not only common, but sometimes helpful and necessary. For example social scientists often group people for studies that result in the development of better services or provide information on living patterns, educational needs, or cultural patterns. The harm comes when we apply these generalizations so stiffly that we fail to take into account individual differences, and the individuals are deprived of their rights, services, or in some cases, self-respect. Generatizations then become stereotypes, such as the words illustrated by Butler's above categories.

Personal biases, like stereotypes, can influence the way we deal with people. While there can be a positive as well as negative side to biases (personal preferences, partialities, or inclinations), the degree to which we let them influence our dealings with others may affect the relationship we establish or the other individuals abilities to sort out solutions to their problems.

Negative stereotypes and biases sometimes can be counteracted by the presentation of facts which challenge the myths on which these generalizations are based. Under the following five topics, recent research materials are quoted and facts that tend to contradict frequently held stereotypes are presented: (1) physical health; (2) mental health; (3) finances; (4) family, finances, and health; and (5) interests and activities. Under each topic, try to pick out facts which challenge at least two or three generalizations you have tended to develop about older people.

Physical Health

Adapted from *Working with Older People: A Guide to Practice*. Volume II, Biological, Psychological and Sociological Aspects of Aging. Public Health Service, U.S. Department of Health, Education and Welfare (1970).

Increasing elderly population. Half of all people now 65 and older are about 73 or older; 6 percent are 85 or older--more than one million persons. In the years ahead, the increase will be particularly great at the oldest ages. With the population 65 and older projected to **rise 50 percent** between 1960-85, the population 85 and older may double.

Need for increased preventative and therapeutic services. The steady increase in the numbers of old and "older" old persons in the population is particularly significant in view of the fact that chronic disease, long-term illness, and disability comprise the bulk of the health problems of adults in their late maturity. Consequently, the increase in the need for preventive and therapeutic services for this age group will be greater than the increase in numbers suggests. Physical diseases which disable or kill the greatest number of the aged are cardiovascular-renal diseases, cancer, arthritis, tuberculosis, diabetes, and glaucoma.

According to the National Health Survey, during the year ranging from July 1966 to June 1967, about 7 out of 10 persons between the ages of 45 to 64 (71.6 percent) had one or more chronic conditions, as compared with more than 5 out of 6 persons aged 65 and older (86 percent). The findings further reveal that the extent and intensity of physical disabilities associated with chronic disease increase sharply with age.

Variations among the age groups with regard to the **mobility limitations** provide a revealing yardstick. Individuals have a mobility limitation when they have difficulty getting around alone, when then need special aid or help from another person in carrying out the activities of daily living, or when they are confined to the house because of a physical condition. Of the total population, fewer than 1 out of 20 of those 34 to 64 and almost 1 out of 5 of those 65 and older.

Multiplicity of ailments. It is important, too, to keep in mind the fact that the aged more frequently suffer from a multiplicity of ailments.

This is the Nation's chronic disease picture by category:

- 14.6 million adults have definite heart disease, and an additional 13 million have suspected heart disease.
- 2 million are known to be diabetic.
- 13 million report some form of arthritis.
- Upwards of 500,000 new cancer cases are diagnosed each year.
- Heart disease, cancer, and stroke account for more than 70 percent of all deaths in this country.

Illness and poverty. It is an undisputed fact that medical needs and the **cost of meeting these needs rise** with declining health, and that the impact of chronic diseases is greatest among the elderly. Of the total $41.5 billion health care bill for the total population in the fiscal year 1967, more than one-fifth ($9.2 billion) was used by, or in behalf of the aged who comprise approximately one-tenth of the total population. The rise in cases is only partly met by Medicare, which covered 35 percent of the health costs of the aged in 1967. Of expenditures for hospital care, 57 percent was through the Medicare program. For many of the elderly, illness serves as a major cause of poverty by reducing their incomes; conversely, poverty can be a major contributory cause of illness when it serves as a barrier to receiving adequate medical care.

The elderly use more **physician services** than do young persons. The U.S. average for persons below age 45 is 4.0 visits per year, for those 45 to 64 it is 4.7 visits per year, and for those 65 and older it is 6.0 visits per year.

The elderly have more admissions to **hospitals**, and stay longer. For example, persons 65 and older account for 14.5 percent of hospitalizations, even though this age group comprises 9.3 percent of the civilian noninstitutional population. The rate of hospitalization among the elderly has

been increasing. The length of stay for the elderly is 13.8 days (as against 6.5 days for those under 45). Moreover, the elderly are prime users of nursing homes and other long-term care facilities. As home-health agencies develop, the elderly undoubtedly will be prime users of these, too.

The elderly use more **prescribed drugs**. The per capita expenditure for prescription drugs for the elderly was more than three times greater than for those with no disabilities.

Gerontology, health, and aging. Gerontology studies the biological, behavioral, and social manifestations of aging. The gerontologist tries to determine what happens to the organism and groups of organisms as time passes. From the practitioner's point of view, the biggest questions for gerontology are: "Is there a mechanism of aging, as distinct from disease? Can the effects be prevented, modified, and repaired?"

Today, there are no definite answers. There may be one or more mechanisms fundamental to the manifestations of aging, including susceptibility to chronic disease. Gerontologists admit there is a big difference between "**changes with age**" and "**changes due to an aging process.**" One biologist says that there is no single process which is known to determine aging.

Aging has been thought of as **vulnerability to stressas**. These may be disease, accident, or psychosocial events, such as widowhood, economic depri ation, and loss of social status. It may be that our oldest people are extraordinary survivors because of their psychobiological equipment, not only genetic endowment but also acquired abilities to cope with environmental stress.

Aging probably has a basic relationship to **chronic disease**, which is a growing challenge to research and therapy. Since 1940, death rates from heart disease and cancer have each increased by one-fourth. The U.S. rate for heart disease is among the world's highest. Among males in the productive ages of 40 to 54, mortality rates are substantialty higher in this country than in other industrial nations and amost twice the rate of that in Sweden

While chronic diseases have grown, death rates from infectious diseases have declined. Between 1910 and 1940 the death rate from influenza and pneumonia was cut 55 percent; it has since been halved again. But the rate of decline in these and other infectious diseases has slowed or stopped. Possibly, antimicrobial therapy has approached its maximal contribution to mortality reduction for the aged, particularly, the limit of antibiotic protection apparently is being reached. It is likely that antibiotics cannot provide any further extension of protection for the highly vulnerable aged person.

Thus, despite antimicrobial therapy and other contributions to health, a basic death pattern still prevails. The Gompertz plot, a mortality equation formulated in the early nineteenth century, states that the likelihood of death doubles every eight years of adult life. This observation is considered one of the best indications of an underlying aging process, as distinct from disease.

Mental Health

Adapted from: *Why Survive? Being Old in America.* Robert N. Butler (1975). Chapter 8: "They Are Only Senile," pp. 225-231. By permission of Harper and Row, Publishers.

Emotional health. What is good mental health in old age? It means the capacity to **thrive** rather than simply survive. All of us meet older persons who are described as "full of life," "young for their years," "bright-eyed" and "zesty." Some older people appear serene and contented yet actively involved in life. Others delight in struggle of fighting for a cause. One sees in them the ongoing capacity for creativity, curiosity, and surprise as well as a sense of consummation or fulfillment in life. Some may actively seek change and new knowledge while others concentrate on consolidating what they have built up over a lifetime. There are many ways to be emotionally healthy in old age, but several common themes emerge: the desire to be an active participant, to make one's own decisions, and to share mutual love and respect with others. Healthy old people experience many of the same feelings and responses as people of all ages, yet old age has its own unique flavor. The special qualities of late life come from having lived nearly an entire life span with all that this entails, and from facing the issues inherent in old age--time, aging, and eventual death. Ultimately this means facing the meaning of one's own life.

Old age has the potential for being an immensely interesting and emotionally satisfying period of life. But this potential is endangered by many forces. **Change and loss** are predominant themes. Loss of physical health and the death of important persons--spouses, close friends, colleagues, relatives--are occurrences in late life which tend to place enormous stress on human emotions. Crises of all kinds must be met, sometimes one after another, sometimes simultaneously--retirement, widowhood, major and minor illnesses, changes in bodily appearance, sensory losses, a

feeling of decreasing social status, and for many elderly, a drastically lowered standard of living. There is much energy expended as the old go through the process of mourning for their losses, resolving grief, adjusting to the changes involved, and recovering from the stresses. Multiple crises can leave people drained emotionally and weakened physically.

The age-related life crises, together with the stresses of daily living, produce a range of emotional problems from mild to severe, depending on the individual's personality and earlier life experiences, physical health, and social and family supports. Finances, shelter, medical care, and social roles are all intricately connected with emotional responses and capacities. Feelings of grief, guilt, loneliness, depression, despair, anxiety, helplessness, and rage are common and should not in themselves be considered mental disorders. If they remain unresolved, causing problems in necessary functioning or a great deal of emotional pain, outside assistance is advisable.

Emotional problems or mental illness? The point at which problems become severe enough to be called mental illnesses or disorders is difficult to establish. Serious problems in functioning, extraordinary emotional distress, and various observable symptoms of emotional and/or mental impairment are criteria by which behavior can begin to be evaluated. The mental disorders of old age are of two kinds: the **organic disorders** which have a physical cause, and the functional disorders which appear to be related to one's personality and life experiences. Organic disorders, also called organic brain syndromes, can be reversible or chronic. The reversible brain syndromes can often be successfully treated. Chronic brain syndromes, on the other hand, are the result of permanent damage to the brain, as in cerebral arteriosclerosis and senile brain disease. They can be treated symptomatically but not reversed. **Functional disorders** refer to psychotic disorders, neuroses of various kinds, personality disorders, and psycho-physiological disorders.

All too often, mentally confused older people are sent home untreated by doctors and hospitals when they are suffering from reversible confusional states--a surprising number of which are due to malnutrition, anemia, alcohol, and unrecognized physical ailments including congestive heart failure, infections, and even fecal impaction. For example, doctors have created acute brain disorders through the use of tranquilizers. Many workers, such as Cosin in Britain have demonstrated the treatability of confusional states in the elderly.

The extent of mental disorders of all types can only be guessed at since so many of the elderly exist outside the purview of medical, psychiatric, and social programs. A million persons over 65 are in institutions, primarily nursing homes, and well over 50 percent of these have evidence of some psychiatric symptomology and mental impairment. About two million people living in the community have serious chronic disorders. A minority of these are primarily mental disorders, but while the majority are physically based, there are often associated emotional reactions requiring attention. Added to this are the elderly patients in mental hospitals (138,000 in 1968). The poverty conditions under which seven million elderly live are known to contribute to mental breakdown--among them malnutrition, stress, and victimization through crime. And last, one must consider the emotional toll suffered as a result of lowered social status and loss of social roles.

Until recent pressures against admission, Americans 65 and older accounted for about 25 percent of the annual state-mental-hospital admissions. One study by the National Institute of Mental Health (reported by the World Health Organization in 1959), shows the following occurrence of new cases of psychopathology of all types:

- 2.3 cases per 100,000 population--Under age 15
- 76.3 cases per 100,000 population--25-34
- 93.0 cases per 100,000 population--34-54
- 236.1 cases per 100,000 population--Over age 65

Clearly those over age 65 are the most susceptible to mental illness.

Suicides, too, increase with age and it is surprising to learn that the rate of suicide is highest in elderly white men, probably the result of several causes: loss of status (in the largely white male-dominated society), desire to protect finances for a surviving wife, and a decision to avoid otherwise unavoidable physical helplessness and obdurate pain. For nonwhite women and men and for white women the curve of suicide is bell-shaped, with the greatest peak during the earlier adult and middle years. Twenty-five percent of all known suicides take place in the over 65 population (that is, among 10 percent of the nation's population). More than that probably occur since families out of shame or guilt are frequently unwilling to report suicides.

When signs of emotional problems and mental disorders emerge in old age, **immediate diagnosis** and treatment are crucial, particularly in the case of the reversible brain disorders. Prompt care can be preventive in avoiding full-blown functional disorders if, for example, depression

or anxiety can be alleviated. Older persons ordinarily face more stresses than the young and, given their declining reserves of strength, they may require swift attention in order to avoid being overwhelmed emotionally. Ideally, treatment should be a collaborative effort among the patients, their families if they have one, and mental-health personnel, with the patients or family members making the initial request for services.

Providing mental health services for the elderly. Contrary to popular professional opinion, older persons can make effective use of the whole **gamut of mental-health services**, including psychotherapy, psychoanalysis, group psychotherapy, drug therapy, occupational, physical, and recreational therapies, behavioral modification therapies, family and marital counseling, and last, but by all means not least, sex counseling and therapy. Because of the mental-health profession's disinterest in and prejudices against the old, and the overt and covert forms of discrimination on the part of agencies and institutions, most elderly persons never have a chance to obtain mental-health services. As one illustration, nursing homes seldom provide any form of psychiatric care, in spite of the fact that over 50 percent of their residents have been found to have psychiatric problems of sufficient magnitude to warrant professional attention. Other factors enter into the failure to obtain care: lack of the information necessary to recognize important symptoms on the part of the patients and their families; shame or fear of mental illness; lack of knowledge regarding services; guilt in family members, who think they should be able to handle things; improper diagnoses by medical and mental-health personnel; and lack of services designed especially for the old.

One important way in which mental-health professionals can become more effective is to become aware of their own feelings toward the elderly. For example, I have found it extraordinary in my consultative experience with a range of mental-health specialists, from psychiatrists to social workers, that they are so often impatient and irritable with their older patients for not responding swiftly to their ministrations. It would not occur to them to push for such rapid improvement in younger patients. In part, they reflect the notion that old people cannot change. Ironically, part of the reason old people are eminently capable of change is that they stand so near to death. They have things to accomplish before it is too late.

One function of mental-health specialists which has direct application to work with older people is cultivation of the art of listening. The so called garrulousness of old people and their wish to hold on so tenaciously to someone's attention is a social symptom related to their loneliness. Patience, listening, and simply spending meaningful time with them are of great therapeutic value. Older people use reminiscence to review their lives and resolve problems, much as does classical psychoanalysis.

One of the great losses of old age is the loss of choice. Needs, interests, and desires differ greatly. Choice, exercised as freely as possible, supports self-respect; when denied, it promotes helplessness. Symptoms such as anxiety, depression, dependency, and anger rapidly develop when a person--of any age--has few options. Therapists should encourage a great variety of alternatives both in the emotional lives of old people and through changes in the social environment which touches their daily existence.

Irreversibility of emotional and mental disorders must **never be casually assumed**. Many conditions are subject to amelioration. Even people affected by the chronic brain syndromes or chronic physical illnesses have anxiety and depressive symptoms which are responsive to treatment. Depressive, paranoid, and behavioral reactions present in the clinical course of organic brain damage can be helped. Depression may be masked as an organic state showing itself as physical symptoms and if recognized, it can be treated. At the very least, intimate human responses are nearly always helpful.

Research evidence supports clinical impressions that older persons benefit from mental-health care. Studies in private mental hospitals show that as many as 75 percent of patients over 65 are returned improved to their own homes within 2 months. Outpatient work in clinics and private offices also reveals capacities for change and recovery. Even severely brain damaged patients respond in a prosthetic (artificial) milieu with well planned programs for orientation, activities, and socialization. Clearly, if there is a combination of resources and genuinely motivated interest on the part of professionals, older people, like patients of other age groups, respond to treatment.

Finances

Adapted from: *Why Survive? Being Old in America*. Robert N. Butler (1975). Chapter 2: "How to Grow Old and Poor in an Affluent Society," pp. 24-29. By permission of Harper and Row, Publishers.

The Total Income Picture. To understand the poverty of older Americans in an affluent society, we need to see how the old currently are sup-

ported and the difficulties they experience. Those 65 and older as a group receive their aggregate income as described in table 1.

The Old Grow Poor. Two crucial and distressing facts about poverty and old age are clear. First, although the numbers of those in poverty in other age groups are said to be decreasing, there has been an **increase in both the number and proportion of aged poor**. The U.S Senate Special Committee on Aging, using the conservative, government established poverty threshold, reported that in 1969 there were approximately 4.8 million people aged 65 and older who were living in poverty, almost 200,000 more than in 1968. In this same period, said the committee, poverty declined by 1 2 million for all other age groups.

Second, the elderly are the fastest-growing poverty group. This is new poverty, not simply poverty transmitted from generation to generation within the same family Independent of previous means and previous socioeconomic status, one may be thrown into poverty for the first time in old age. Catastrophic diseases, or the sheer cutback of income in retirement, may create instant poverty where none previously existed.

In fact, many--I think most--elderly poor have become poor after becoming old. What does it mean in the lives of retired persons to receive a total pension income from both public and private sources of one-quarter to one-half or less of their average preretirement earnings?

What is poverty? How does one arrive at a realistic idea of what constitutes poverty in old age? The official government estimate of poverty, that is, the amount of income necessary to meet essential needs, is based on the Department of Agriculture's Economy Food Plan for emergency use, designed to keep a healthy person alive and functioning reasonably for 30 days. Since the average family spends approximately one-third of its income on food, government economists multiplied this amount for food by three to obtain the total minimal budget that one could possibly live on; those with less are considered poor. In 1973, for an individual this was an income of $2,100 a year or less. The 1973 weighted average for a two person older family was $2,640.

What if we take a less biological view of poverty and consider more than brute survival by examining the lot of the aged in terms of America's standard of living? The Retired Couple's Budgets of the Department of Labor estimate what a "modest but adequate" standard of living would cost, rather than an emergency budget. These budgets are detailed listings of items and quantities to meet the normal needs of an urban retired couple as judged adequate by the staff of the Bureau of Labor Statistics (BLS), which intermittently revises them.

The "experts"--economists, statisticians, and social-science analysts--develop these hypothetial budgets for a hypothetical standard of living, assuming an existing inventory of clothes, furni-

Table 1

Source of Income

Percentage of Income	Income Source
46	Retirement benefits (Social Security, 34%; public pensions, 7%; private pensions, 5%)
29	Earnings from employment
15	Income from assets
4	Public assistance
3	Veterans' benefits
3	Other (contributions from family, etc.)

ture, appliances, and so on. The retired couple is defined as a husband, age 60 or over, and his wife, who are self-supporting, living independently in their home, in reasonably good health and able to take care of themselves. More recently the Bureau of Labor Statistics has designed two additional Retired Couple Budgets, one at a somewhat lower standard of living and the other at a higher standard. "All three budgets provide for the maintenance of health and allow normal participation in community life, taking into account social and conventional as well as physiological needs." So say the government experts--but is this the case?

Do the Old Need Less? The total Intermediate Budget for the Retired Couple, calculated in 1971, was $4,776. Let us look at what that detailed budget allows. The staff concluded that $24 per week was adequate for groceries. (An elderly couple was allotted a little over $3 per meal plus tip in a restaurant once every week.) Housing averaged $139 per month, including household repairs and furnishings. For example, 1 percent of a sofa could be purchased every year. In the way of clothes, every year 7 percent of topcoat was allowed for a man, one and one-fourth of a street dress for a woman, one house dress, two-thirds of a bra, etc. The husband was allowed 15.3 haircuts a year and his wife 1.7. For each person, one-fifth of an eye examination for glasses was allowed and one-half pair of glasses. Needless to say, it is not possible to live statistically.

American advertises and fantasizes old age as a period of leisure, travels, and hobbies, but the recreation allotment in 1971 was $91 a year for both the husband and wife. No allowance was made for visits with children, travel away from home, or vacation costs. The retired couple was alloted $5.30 a year to provide for a pet animal, which is for many people their major solace in loneliness, and often an aid to safety as well. Traditional American virtues have emphasized providence, but no money was allotted for savings.

The Retired Couple's Budgets in themselves tell us something about popular conceptions about the old "needing less." The Bureau of Labor Statistics has developed a whole set of budgets to describe a modest but adequate income for different family compositons. To compare the itemized accounts of these budgets for retired and younger couples with those for the four person family is informative. One might expect housing, transportation, and certain other costs to be greater for the larger younger family and some personal care costs to be higher for the older family, which is, indeed, reflected in the budgets. But the reasoning behind the appreciably smaller clothes allowances for the adults in the older family, or for home furnishings or gifts and contributions is less understandable. In the intermediate budget, for example, the retired man was allowed $94 for clothing, and the younger wife $211. Should we automatically assume that retired men and women are going to be leading drab and inactive lives. The older family was allotted $231 for gifts and contributions, the younger family $270. Yet the older couple might well have children and grandchildren to make gifts to, as well as churches and special causes to which to contribute.

Retirement budgets are calculated on the assumption that the older couple have already accumulated much of what they will need for the rest of their lives. This is asking a lot of the healthy, potentially active older couple who may have 20 or more years ahead of them--if not the 100 years it would take to save the 1 percent a year allotment toward a new sofa! Are the elderly expected to keep their appliances and furniture in better shape than the rest of the population in our economy of planned obsolescence? Are they expected to care less for the satisfaction of wearing something new on those special occasions when they go out? What do we know about the spending patterns of older people? In studies of consumer expenditures high income families--whether younger or older--tend to show similar expenditure patterns. In other words, if older couples have the money, they are as interested in recreation, clothes, and a pleasant home environment as anyone of any age. The reason old people spend less is that they have less to spend.

To put these two government estimates--the poverty line and the modest but adequate budgets--into perspective, let us note that economist Leon Keyserling considers those who are above the poverty line but below the Bureau of Labor Statistics budget to be living "in deprivation." In terms of elderly couples and individuals, table 2 presents the poverty "definitions" and "guidelines" available at the time of the White House Conference on Aging.

Hobart Jackson, chairman of the National Caucus on the Black Aged, affirms that an adequate income is the chief need of the elderly. He sets a minimum floor of $6,000 for a single old person and $9,000 for an aging couple. Jackson's figures are much more realistic than the official guidelines. They begin to approximate the median income of Americans regardless of age. The National Council of Senior Citizens, however, only supports the recommendation of the 1971 White House Conference on Aging for approximately $4,500 a year per couple, which was less

Table 2

Poverty Levels

Organizations That Have Defined Poverty	Point Below Which Poverty Occurs	
	Couple	Individual
Official poverty level, 1970	$2,328	$1,852
Retired Couple's Budget (Bureau of Labor Statistics, 1971)		
Intermediate Budget "Modest but Adequate"	4,776	2,627
Higher Budget	7,443	4,094
National Welfare Rights Organization, 1971	**	2,250
Chairman, National Caucus on Black Aged, 1971	9,000	6,000

*Estimated at 55 percent of couple.
**No "guideline" available.

than the 1970 Retired Couple's Intermediate Budget. Official 1967 analyses of the Retired Couple's Budgets against actual income levels, completed by the Bureau of Labor Statistics, found that 56 percent of all older couples had less income than even this "modest but adequate" budget!

Estimates of government agencies and private organizations--other than the National Caucus--run low because of conceptions of "political realities." In other words, requests and estimates are determined by what politicians feel have a chance of being approved by Congress, or the President, or an appropriate state official, rather than by what is needed. Government agencies also feel pressures to minimize the estimate of need. Increasingly, mild reform proposals become no more than mere ritual, a tinkering with the lives of the old.

What would it cost to provide a better standard of living? The National Welfare Rights Organization estimated in 1971 that to bring all Americans up to their minimal budget estimates ($6,500 for a family of four, $2,500 for a single person) would cost between $30 and $50 billion. Other agencies and organizations have offered similar estimates. To support all age groups decently, will cost a lot of money. It cannot be done cheaply. As a people we either want to direct our resources in this direction or we do not.

Overview: Family, Finances, Health

Reprinted by permission of *Time: The Weekly News Magazine*. "New Outlook for the Elderly," June 2, 1975, pp. 44-51.

Throughout history the aged have occupied a precarious position in society. Some primitive peoples like the Eskimos and other nomads respected the elderly but left them to die when they could no longer care for themselves. Natives of some South Seas islands paddled away from their families--to death--when age overtook them. Nor is the idea of abandoning the elderly unique to primitive societies. Marya Mannes' 1968 novel *They* postulated a world in which everyone over 50 was herded into public institutions and eventually liquidated. A 1966 Rand Corporation study concluded that if the United States survived a nuclear war it would be "better off without old and feeble" citizens, and suggested that no provisions be made to care for the surviving elderly.

The U.S. has clearly not taken such advice. Most Americans, whether moved by religion or common decency, still try to follow the Fifth Commandment and "honor" their parents. But despite their concern, and frequently the anguish that marks their hard decisions about the elderly, the position of the aged in the U.S. has grow perilous. A couple of decades ago, most Americans who reached 65, the admittedly arbitrary age for

retirement, could look forward to spending their last years in peace and security, respected and cared for by their families and friends. No longer. For an increasing number of Americans, the years after 65 are a time of growing uncertainty and isolation as, cut off from family, beset by illness and impoverished by inflation, they struggle not to enjoy the rest that they have earned but simply to survive.

Their problem is a pervasive, urgent one, both for the old and for their children. America as a society has yet to develop a practical, human policy for dealing with the woes of old age in a modern world. For those elderly Americans who can still manage--both physically and financially--life goes on much as it always has. But for those who cannot manage, the end of life, or at least of life as most people would want to live it, can be an agony. About a million, or 5 percent of the nation's elderly already live in nursing homes, too many of which are grim warrens for the unwanted. Tragically, the population of the nursing homes is growing. But so, too, is the public's concern over the plight of the old. Americans have yet to come up with the answers, but more and more are at least asking themselves the question that most face sooner or later: What do we do with our parents?

There is no easy, single answer. In an earlier time, when most Americans lived in farms, the relatively few who reached old age simply stayed at home, inevitably working less and less but expecting and getting as their rightful due more and more care from their families. Industrialization, urbanization, and the automobile have ended that. Most Americans no longer live on farms or in closely knit family groups. Evermore mobile, Americans by the tens of millions do not stay rooted in one place all their lives but pull up stakes, move and move again. Of those who hold on in the old home town, few live out their lives in one house. Married couples rarely stay with parents any more; even young singles are encouraged to strike out on their own. Those who leave frequently lose contact with their parents because of distance or because they are too busy to bother with the old folks, and may even be embarrassed by them. Says Anthropologist Margaret Mead, 73, and a grandmother: "The modern family, in its present form, is not equipped to care for old persons."

The problem is that there are **more old people** than ever to care for. In 1900 only 3.1 million, or 1 out of every 25 Americans, were over 65. Now 21.8 million, or 1 out of every 10, fall into this category. The reason for the rise is twofold. Modern medicine has cut infant mortality rates and increased the average life expectancy from 47 years in 1900 to 71.3 today. Since 1957 the U.S. birthrate has dropped (*Time*, Sept. 16), increasing the ratio of elderly to young people. If present population trends continue, those over 65 and those under 15 should account for 20 percent of the population by the year 2000.

A significant number of today's elderly are, according to University of Chicago Professor Bernice Neugarten, "**disproportionately disadvantaged**." Many are foreign born, uneducated, and unskilled. Far from all the aged are infirm, but 38 percent do suffer from some kind of chronic condition that limits their activities. Of these, fully half have serious problems and 5 percent, or 1 out of every 20, are homebound. About a third of all aged Americans are also plagued by poverty. Despite pensions, savings, and Society Security, which will disburse $72 billion to 33.5 million recipients this year, fully 4.75 million of the nation's aged exist on less than $2,000 a year--well below the Federal Government's poverty line.

Depending on what they can afford and the extent to which they can take care of themselves or count on their families for help, the aged live in a wide variety of arrangements. For most, the accommodations are reassuringly familiar. More than two-thirds of America's elderly remain in the communities that they have known for most of their lives--and in the same homes. Most like the security of the familiar. For many, however, the decision not to pull up roots is economic as well as emotional: nearly 70 percent of older people own their own homes, humble as they may be. For owners, housing costs--utilities, taxes (often reduced for those over 65) and repairs--have long been relatively low. Now all of those costs are climbing sharply.

For some, old age means giving up solitary independence and moving in with their children. Sometimes that works out well. Edna Segar, 74, who plays the piano in a Culver City, California, senior citizens' dance band, finds the arrangement fine. So do her son Donald, 54, and his wife Frances, 59. Says Donald, "You wouldn't throw your kids out, so you don't throw your parents out when they need you."

For others, caring for parents is a serious problem. Many urban Americans simply do not have the room to house an elderly father or mother, especially in New York and other cities where an extra room means paying an enormous increase in rent or buying a larger home than they can

afford. Others claim that the presence of a parent in the home strains marital relations and puts tremendous pressure on children. Still others just cannot take the tension involved in caring for senile parents.

Many families also cannot handle the physical aspects of aging. The Jury family, of Clarks Summit, Pennsylvania, watched helplessly as "Grandpa" Frank Tugend faded. The Jurys kept the retired coal miner with them bearing with him as he became confused and foregetful, cleaning up after him as he lost control of his bodily functions. In his lucid moments, the proud 81-year-old Tugend knew what was happening to him. One day he took out his false teeth and refused to eat anymore. He had decided to die, and no one--not his doctor, not his family--could do anything to change that. His children and grandchildren cared for him with anguished tenderness until death claimed him 3 weeks later.

Few children have the devoted patience or endurance of Tugend's family. Each year more and more of them face the problem of deciding what to do when aged parents need more care than they can--or are willing to give. In some cases, the answer is obvious: put them in a nursing home. The decision is often devastating for parents and children alike and has ripped many families apart. Whatever happens, guilt hangs in the air like a sulfurous, corrosive fog. Even children who keep their parents at home generally feel remorse about what Paul Kirschner of the University of Southern California calls the "battered senior syndrome," which involves caring for aged parents but excluding them from many family activities. Those who place their parents in nursing homes often feel a still heavier burden of guilt for "abandoning" the old folks.

In many cases, what they have done, for whatever reason, amounts to **abandonment**. Mary Adelaide Mendelson, of Cleveland, a former community planning consultant, has spent 10 years of studying institutions for the aged. In a book titled *Tender Loving Greed*, she concluded that U.S. nursing homes are a national scandal. She writes: "There is a widespread neglect of patients in nursing homes across the country and evidence that owners are making excessive profits at the expense of patients."

The best nursing homes deprive their patients of some independence. The worst deprive them of far more: their resources, rights and, ultimately, their humanity. They are killer institutions. An investigation still under way in New York has dug out evidence of widespread abuse and exploitation of nursing home patients. Inspectors who have made surprise visits to homes have found in the worst of them incontinent patients wallowing in their own filth, patients shot full of tranquilizers to keep them bovinely docile, others whose requests for help went unanswered and still others who were unfed or given the wrong foods and medication. They have also found many patients--unlike those at the now closed Towers Nursing Home in New York City--who were unwilling to complain for fear that they would be punished later by the attendants.

The **crimes** against the weak are not confined to New York. Authorities in Illinois are investigating not only suspected fraud but also the deaths of seven patients in a home in Rockford. California officials have turned up even more disturbing evidence. Los Angeles County investigators reported that a paralyzed woman at the Torrance Medical Convalescent Center, a 212-bed nursing home in Torrance, California, died after a nurse tried to feed her orally rather than through a stomach tube, then dismissed her gasping and flailing as an attempt to burn off "excess energy." The victim was not the only patient to die at Torrance, whose license to operate is being challenged. One patient died when he apparently leaped from a second-story window. "He probably jumped because of the conditions inside," said one angry health official.

Regardless of their condition, the elderly deserve to be treated like human beings. Fortunately, action to guarantee such treatment has already begun. A special commission in New York has submitted an 11-bill package that would include unannounced inspections of nursing homes, establish a stiff schedule of fines for violations of state standards and give the state the right to sue nursing homes that failed to provide proper care. The Minnesota state legislature has tightened up certification procedures and passed laws requiring close monitoring of nursing-home operations. Massachusetts authorities have shut down eight substandard homes and plan to close three more unless they are sold to someone who will run them properly.

Congress is also acting. Senator Frank Moss, chairman of a Senate subcommittee on long-term care, has introduced 48 bills that would, among other things, require 24-hour attendance of a registered nurse, offer financial incentives to nursing home operators by allowing higher payments for better care, and provide for full disclosure of the identities of all individuals involved in a nursing home's operation.

The enactment of pending legislation--indeed, even the enforcement of existing state and federal regulations--would go a long way toward ending the dehumanization and exploitation of those who can no longer care for themselves. But improving nursing homes will not help 95 percent of America's elderly. What will help them and those who will one day join their ranks is a realization that U.S. suffers from what Dr. Robert Butler of Washington, DC, calls "ageism"--or prejudice against the elderly--and a determination to end this cruel form of discrimination. "The tragedy of old age is not that each of us must grow old and die," writes Butler in his book *Why Survive?* (Harper & Row), "but that the process of doing so has been unnecessarily and at times excruciatingly painful, humiliating, debilitating, and isolating through insensitivity, ignorance, and poverty."

But, says Butler, much of this pain and humiliation can be eliminated. He and his fellow gerontologists urge those who want to help their parents--and other elderly--to help overhaul old policies and develop some new ones, particularly with regard to:

Retirement. Most people assume that to be old is to be finished, or "over the hill," and at least half of all American workers are now employed by companies that have institutionalized this assumption by forcing their employees to retire at age 65, if not earlier. The effects of this involuntary idleness can be traumatic. "One day they have life, the next day nothing," says Margaret Mead of unwilling retirees. "One reason women live longer than men is that they can continue to do something they are used to doing, whereas men are abruptly cut off--whether they are admirals or shopkeepers."

Most companies claim that **mandatory retirement** is necessary to maintain efficiency, preserve profits, and clear the way for younger employees. But, gerontologists find the arguments unfair. There is no evidence that an individual's efficiency or creatively declines dramatically once they pass their 65th birthday; indeed, many people--from scientists to craftspersons to musicians--have done their best work during their declining years. Nor can it be assumed that most elderly Americans are too feeble to support themselves. At least half of those now over 65 are physically capable of doing a day's work. Mandatory retirement is, in fact, now under challenge. A former civil servant has filed suit to set aside the Federal Government's retirement policies. The American Medical Association has allied itself with him, insisting in a friend-of-the-court brief that there is no evidence that older workers are any less efficient than younger ones.

Income. It is pure romanticism, say more gerontologists, to assume that prudent people can provide adequately for their old age. Inflation in the 1970s can erode the value of the most liberal of pensions and shrink the worth of even the fattest savings accounts. Nor does Social Security, upon which most elderly Americans depend for at least a third of their income, enable most to live with any measure of financial security or comfort. A 65-year-old couple entering the plan this year and entitled to the maximum benefits, which they have paid for in taxes, draws only $474 a month. That inches them above the poverty line but hardly enables them to live beyond the barebones level. Besides, the average couple received only $310 a month.

To alleviate the financial plight of the elderly, experts recommend placing a reasonable floor, pegged to the actual cost of living, under retirement incomes, either by increasing Social Security benefits or supplementing them from other state or federal funds. They also recommend reforms in both Government and private pension systems, to assure that all workers who contribute to a pension plan will derive at least some benefits from it.

Medical Care. Most medical plans are designed to care of the elderly once they become ill. Gerontologists believe that the emphasis should be on preventing illness and preserving health and keeping the aged in the community.

Attitudes toward Aging. Americans, says Butler, take an unhealthy and often unrealistic attitude toward aging, assuming that old people have no further contributions to make to society and should be excluded from it. Many of the elderly share this view, occasionally attempting to conceal evidence of their advancing years and withdrawing from an active life. Butler and others believe that attitudes must change if the aged are ever to be treated fairly in the U.S. They urge society to recognize the basic rights of old people to independence and security. Gerontologists also urge society to make better use of the elderly, drawing on their experience and talents and giving them a greater voice in matters that concern them. It is ridiculous, they argue, to have panels of 35-year-olds determining the wishes of and setting policy for the aged when the aged are better equipped to do the job.

Improvements in these areas are on the way. Congress has moved--albeit not very far--to tap

the reservoir of talents the elderly have accumulated during their lives. It has approved $45 million for a variety of projects, including the **Foster Grandparent Program**, which pays oldsters for supervising dependent and neglected youngsters; $17.5 million for the **Retired Senior Volunteer Program** (RSVP), which pays out-of-pocket expenses to 100,000 involved in such community activities as entertaining the handicapped and visiting homebound parents; and a skimpy $400,000 for the **Senior Corps of Retired Executives** (SCORE), which reimburses some 4,500 retired exectives for expenses incurred while counseling small businesses and community organizations.

Other programs are under way. One **feeds** the elderly, who often stretch their skintight budgets by subsisting on peanut butter sandwiches or skipping meals entirely. The nutrition section of the 1965 Older Americans Act, funded for $125 million this year, now provides 220,000 seniors with a hot meal a day through local nutrition centers of "Meals on Wheels" vans that deliver hot food right to the doors of the homebound aged.

More encouraging are the programs to keep the elderly in the community and **out of institutions**. Chicago, which set up the nation's first municipal office for the aged in 1956, sponsors some 600 senior citizens' clubs, where they can meet to talk out their problems and organize to get things done. It also operates some 62 nutrition centers, where an estimated 3,800 come for a low cost hot meal and some companionship.

At present, these programs reach and benefit only a handful of the nation's elderly. But the prospects for their expansion and for the development of other new approaches toward aging are brightening. One reason for this improved outlook is the growing recognition by most Americans that the country has a lot of catching up to do in its treatment of the aged and the new desire to change what more and more agree is an intolerable situation.

This urge to change things has been inspired in large part by the realization that other countries have done so much more than the U.S. in caring for the elderly. Sweden, Denmark, and Norway have used part of the mountain of taxes collected from their citizens (as high as 50 percent of most salaries in Sweden) to ease many of the burdens of aging. In Sweden, city governments run housing developments where the aged can live close to transportation and recreational activities. Denmark, with a population of 5 million, houses many of its more than 600,000 elderly in subsidized houses or apartments and helps those who want to remain in their homes by providing them with day helpers and meals. Those who need nursing homes find them a considerable cut above most of their American counterparts: with their excellent design, many look like modern hotels.

Another force behind the new impetus for change is the growing **political power** and militancy of the elderly themselves. Many groups--blacks, young people, women--have realized how much political muscle their numbers provide and organized in recent years to demand and get attention and help from federal, state, and local officials. The aged are following their lead. No longer content to pass their days playing checkers or weaving potholders at senior citizens' centers, a growing number of elderly Americans are banding together to make their wishes known. Several thousand of them have joined a group known informally as the **Gray Panthers**, whose leader, a retired Philadelphia social worker named Maggie Kuhn, 69, is dedicated to altering U.S. attitudes toward the aged. The Panthers have agitated for better housing and medical care and more employment opportunities for the elderly. "Most organizations tried to adjust old people to the system," says Miss Kuhn, "and we want none of that. The system is what needs changing."

The system is changing, and it is likely to change even further. Politicians, aware that the elderly are more likely to register and vote than the young, are listening when senior citizens speak. So are younger people. The new interest is encouraging. Americans have for too long turned their backs on their old people. Now many are seeing them for the first time, recognizing their plight and moving to help them. The interest and action are both humane and pragmatic. Today, millions of Americans are wondering what to do about their parents. Tomorrow, their children will be wondering what to do about them.

Interests and Activities

Reprinted from *The Myth and Reality of Aging in America* · A study for the National Council on Aging, Inc., 1975, pp. 54-61, by permission of Louis Harris and Associates.

A Description of the Sample. Trained Harris interviewers conducted a total of 4,254 in-person household interviews for this study during the late spring and early summer of 1974. The sample included a representative cross-section of the American public 18 years of age and over, selected by random probability sampling techniques. Scien-

tific sampling techniques guaranteed each household in the continental United States an equal chance of being drawn into the sample.

In addition to a cross-section of the public 18 years of age and over, an additional representative sample of the public 65 and over was surveyed in order to provide adequate numbers of older people for detailed analysis of the conditions and attitudes of this group. Similarly, an additional cross-section of people 55 to 64 years of age was drawn into the sample to allow an in-depth analysis of the group that is approaching retirement age. Finally, a cross-section of the public and 65 and over would yield too few older blacks for a detailed look at their conditions and attitudes. For that reason, the sample design included an additional cross-section of blacks 65 and over. While the above mentioned groups were sampled beyond their natural proportions in the U.S. population all subgroups were weighted back to their true proportions for their purposes of analysis.

Activities of Older People. An important ingredient in the overall image of older people is **public perceptions** of how most people over 65 spend their time. To the extent that older people are felt to spend their time engaged in constructive, contributing activities, it is safe to assume, the public views them as active, involved members of the community. To the extent they are felt to spend their time at retiring, sedentary activities, however, the public views them as worn-out, passive members of society.

At the outset, the public 65 and over were asked how in fact they spend their time. The most popular activity among the older public was "socializing with friends" (47 percent of the older public said they spend "a lot of time" at this activity), followed by "gardening or raising plants" (39 percent), "watching television" (36 percent), "sitting and thinking" (31 percent), "caring for younger or older members of the family" (27 percent), "participating in recreational activities and hobbies" (26 percent) and "going for walks" (25 percent). Needless to say, participation in all these activities varies among older people according to age, income, etc.

The interesting finding is, however, that the older public seems no more or less likely to spend "a lot of time" on most of the pastimes tested than those under 65. Comparable numbers of the old and the young, for example, said that they spend a lot of time "sleeping," "reading," "sitting and thinking," participating in fraternal or community organizations," or "going for walks," etc. In three areas, those under 65 are much more likely than the older public to spend a lot of time watching television than is the younger public. But, apart from these four areas, the involvement of the young and the old in the activities mentioned was nearly comparable. (See tables 3, 4, and 5.)

As has been seen throughout this report, public perceptions of the older population are very different from the way older people personally see themselves. In terms of how they spent their time, the public at large are far more likely to credit most people over 65 with spending their time at passive, sedentary activities than the older public say they actually do.

- While 36 percent of the older public say that they spend "a lot of time" watching television, a higher 67 percent of the total public expect that most people over 65 do. The fourth most popular activity mentioned by the older public, it was judged to be their number one pastime.

- While 31 percent of those 65 and over say they spend "a lot of time" sitting and thinking, twice that many (62 percent of the public at large) expect that this is how most people over 65 spend a lot of time. Their fifth most common activity according to older people surveyed, it was considered the second most frequent pastime by the total public.

- Only 16 percent of the older public say they personally spend "a lot of time" sleeping compared with a much higher 39 percent of the public who expect them to. According to the testimony of older people, sleeping is their tenth most time consuming activity, although the public at large expects it to be their fourth.

- Similarly, while only 15 percent of the 65 plus group say they spend "a lot of time" just doing nothing, a higher 35 percent of the public think this is how most people over 65 spend a lot of time.

On most other activities, however, the public at large appear to have a fairly realistic appraisal of the amount of time spent by most people over 65.

While the public 65 and over were far less likely than those 18 to 65 to exaggerate the amount of time most people over 65 spend at sitting and thinking, sleeping, and just doing nothing, the older public are still more likely to attribute to most older people sedentary pastimes than they say they personally are involved in themselves. On most other activities, the public 65 and over

Table 3

"A Lot of Time" Personally Spent Doing Various Activities by Public 65 and Over Compared with Public 18 to 64

	18 to 64	65 and Over	Net Difference
	%	%	
Socializing with friends	55	47	- 8
Caring for [illegible] members of household	53	27	- 26
Working around the house	51	10	- 41
Reading	28	26	- 2
Sitting and thinking	27	21	- 6
[illegible]	23	28	+ 5
[illegible]	16	8	- 8
Watching television	16	29	+ 13
Going to church	15	18	+ 3
Participating in [illegible] civic activities	22	3	- 19
Sleeping	12	13	+ 1
Participating in [illegible] or community organizations or clubs	13	17	+ 4
Just doing nothing	12	18	+ 6
Doing volunteer work	8	8	—
Participating in political activities	5	6	+ 1

Table 4

Public 65 and Over Who Spend "A Lot of Time"
Doing Various Activities Compared with Total Public
Who Think "Most People Over 65"
Spend "A Lot of Time" at These Activities

	Public 65 and Over Who Spend "A Lot of Time" Personally		Total Public Who Think "Most People Over 65" Spend "A Lot of Time"		Net Difference
	Rank	%	Rank	%	
Socializing with friends	(1)	47	(3)	52	+ 5
Gardening or raising plants	(2)	39	(5)	45	+ 6
Reading	(3)	38	(6)	43	+ 5
Watching television	(4)	36	(1)	67	+31
Sitting and thinking	(5)	31	(2)	62	+31
Caring for younger or older family members	(6)	27	(11)	23	- 4
Recreational activities and hobbies	(7)	26	(9)	28	+ 2
Going for walks	(8)	25	(8)	34	+ 9
Fraternal or community organizations or clubs	(9)	17	(10)	26	+ 9
Sleeping	(10)	16	(4)	39	+23
Just doing nothing	(11)	15	(7)	35	+20
Working part- or full-time	(12)	10	(14)	5	- 5
Volunteer work	(13)	8	(12)	15	+ 7
Participating in political activities	(14)	6	(13)	9	+ 3
Participating in sports, such as golf, tennis, or swimming	(15)	3	(15)	5	+ 2

Table 5

Public Who Think "Most People Over 65" Spend
"A Lot of Time" Doing Various Activities"
(Public 18 to 64, Compared with Public 65 and Over)

	18-64[1]	65 and[2] Over	Net Difference
	%	%	
Watching television	68	64	- 4
Sitting and thinking	66	42	- 24
Socializing with friends	53	42	- 11
Gardening or raising plants	47	34	- 13
Reading	45	33	- 12
Sleeping	42	25	- 17
Just doing nothing	37	27	- 10
Going for walks	35	24	- 11
Participating in recreational activities and hobbies	28	24	- 4
Participating in fraternal or community organizations or clubs	26	22	- 4
Caring for younger or older members of the family	24	21	- 3
Doing volunteer work	15	10	- 5
Participating in political activities	9	10	+ 1
Working part- or full-time	5	6	+ 1
Participating in sports such as golf, tennis, or swimming	5	5	—

[1] People Who Think "Most People Over 65" Spend "A Lot of Time"
[2] People 65 and over Who Think "Most People Over 65" Spend "A Lot of Time"

tend to feel that most of their contemporaries spend about as much time as they personally do. (See table 5.)

Observation. The above measure of the amount of time spent at various activities must be seen as a subjective and relative measure. To begin with, what may seem like "hardly any time at all" to one person may seem like "a lot of time" to another. Furthermore, "a lot of time" spent gardening may be in no way comparable to "a lot of time" spent watching television. For this reason, the above results should not be interpreted as absolute measures of how much time older people spend at various activities. Instead they are valuable as indications of the kinds of activities that people see themselves involved in, and the degree of involvement. It is a significant finding therefore that large proportions of the public at large (and the young even more than the old) attribute to most older people greater involvement in sedentary, private and isolated activities than the older public attest to personally. It is no wonder that the public at large considered "not enough to do to keep busy" a serious problem of older people, although those 65 and over deny this is a problem.

Concerns of Change of the Older Adult

Competency 2

Describe examples of older adults' positive and negative accommodation to changes in life roles and factors that expain each type of accommodation.

Life satisfaction in the later years results from some interaction among one's earlier ones. Or you could say that your **old age** depends on your **young age**. This could be just another way of stating that people basically age the way they live. If you have been a worrywart as a young person, chances are you will continue to be a worrywart as an older person. If you enjoyed social activities as a young person, then chances are you will be socially inclined in your old age.

Significant changes such as financial, health, family roles, and status can definitely influence the older person's living patterns. It is not unusual for retired people to live on drastically reduced "fixed" incomes. The change in identity from a worker and a provider to a person who is now "underfoot" can cause new stress in the family relationships. For many older people the concern for adequate health maintenance becomes both a personal and financial burden.

The counseling concern that surrounds all these factors mentioned is one of preparing the older adult to **deal with change**. To assist clients through the process of adapting and accommodating new factors into their established daily routines is indeed the challenge inherent in working with the older person--the influence of the present state of life has a great influence on how individuals perceive their total life experience. The later years of life are often viewed as the conflict of gain and loss. For each year gained, the loss of economic and personal comforts becomes greater.

The low income problem of the elderly comes at a time when other resources are diminishing. The possibility of part-time employment or borrowing money against future prospects is limited as well. The most influential factors that contribute to lower income levels among the older adults are education, race, and sex.

Not all issues of the older adult deal with negative concerns. The area of life satisfaction and enjoying the fullness of one's life cycle is also common. Studies have been conducted to investigate high and low sources of morale for the older adult.

Clark and Anderson (1967) collected data from interviews with 65 elderly people in San Francisco, half of whom lived in the community and half in long-term care facilities. This study (table 6) indicated that entertainment and diversions were the most frequently reported sources of high morale.

To understand why some people have difficulties while others have none requires an appreciation of the interplay between biological, social, and personal changes as they come to expression in an individual coping style.

The range of **individual differences** in the biological aging process is great. Studies have indicated that although creativity, motivation, and emotional reactions can be reduced by aging, guidance personnel need to be aware of the impact of restricted social and educational environments

Table 6

Sources of High and Low Morale for
65 Elderly San Francisco Residents

Sources of High Morale	Percentage Reporting This Factor
Entertainment and diversions	69
Socializing	57
Productive activity	56
Physical comfort (other than health)	52
Financial security	46
Mobility and movement	40
Health, stamina, survival	20
Sources of Low Morale	
Dependency (financial and physical)	60
Physical discomfort or sensory loss	57
Loneliness, bereavement, loss of nurturance	50
Mental discomfort or loss	38
Loss of prestige or respect	12
Fear of dying	10

SOURCE: Clark and Anderson (1967)

available to the older adult. Sensory impairments such as sight or hearing loss and the altering of taste and smell can be expected. The majority of older adults have some kind of chronic health problem requiring visits to the doctor, special diets, or rehabilitative therapy.

The **sociological impact** of aging is an important area to consider when examining factors that affect the quality of life of the older adult. Society's perception of aging (value of age) and the development of new roles are common challenges of this special group. Most people over 65 are either living alone or with only their spouses. Another change in family relationships is identified as "role reversal." The elderly mother and/or father are not associated with providing emotional, social, or financial support, rather the children now assume the "parenting" role.

The quote "you married me for dinner, but not for lunch" accents another social factor of aging. Many married relationships are developed around the couple's work identity and schedule. The retirement period can cause readjustment in the husband-wife relationship.

Acknowledging the factors that can be influential to the impact of aging, Kalish (1975) offers four possible definitions of successful aging:

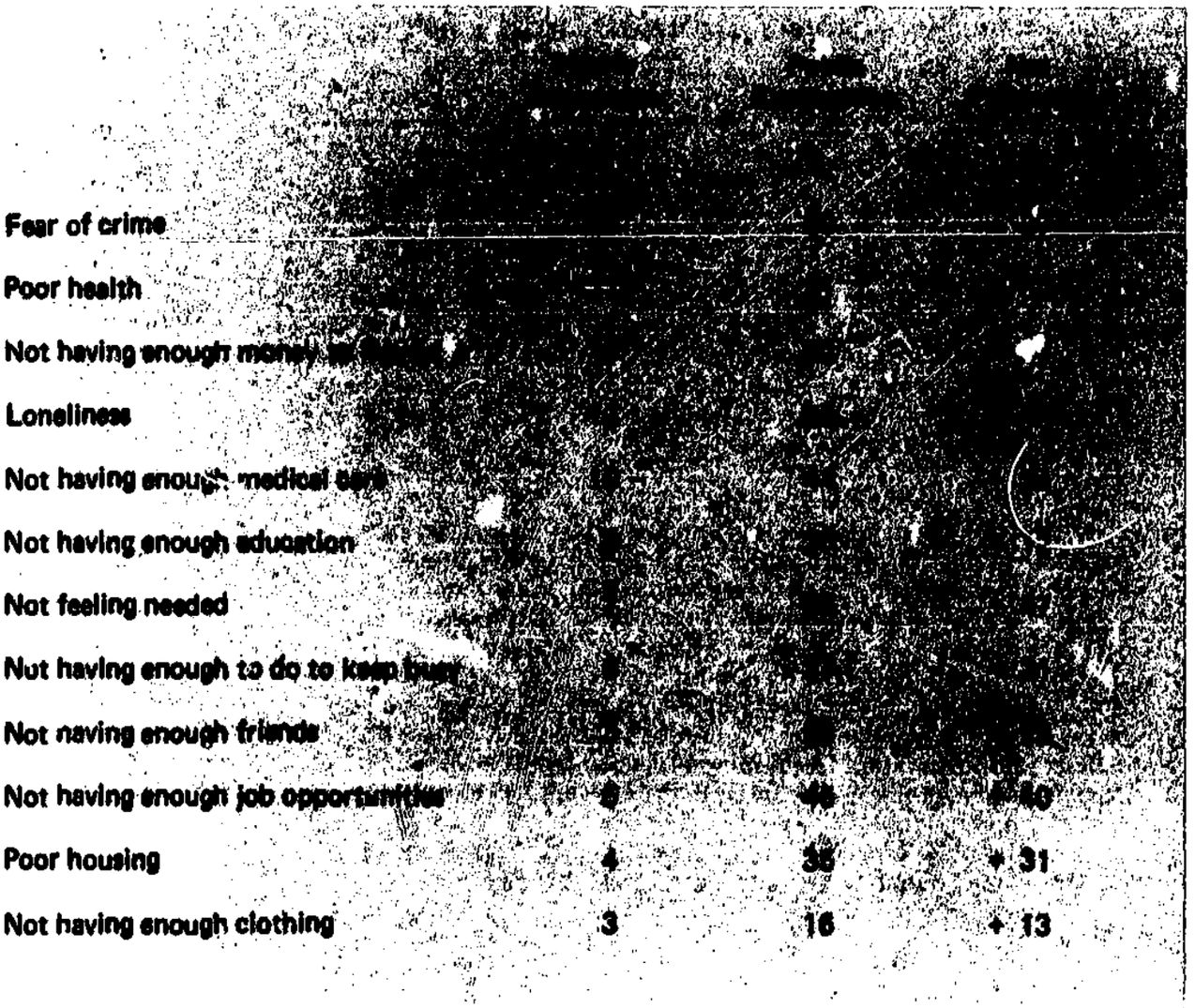
1. A way of life that is socially desirable for this age group
2. Maintenance of middle age activities
3. A feeling of satisfaction with one's present status and activities
4. A feeling of happiness with one's life

To encourage "successful" aging, older adults can benefit from information about what it means to become elderly. Learning effective methods of coping with change and maintaining self-esteem can make the aging process less negative.

To investigate attitudes about aging, the National Council on Aging (Louis Harris and Associates, 1975) conducted a poll representing a cross-section of adults. The survey was designed to measure the gap between the expectations and the actual experience of being old. The problems identified (table 7) were less overwhelming than most of us would expect.

Table 7

Differences Between Personal Expectations of Americans 65 and Over and Expectations Held by Dther Adults About Those Experiences



Most people over 65 regret that they did not plan better for the years ahead. They expressed concern that facts about life in the later years had not been available to them. The aged suffer from the insulation of problems of the later career/life cycle and they become victims of their own stereotypes

Much of the negative age-socialization, or the accepting of the stereotype that old means useless does conspire against the older adult maintaining adequate social status. Yet the desire for positive identity and the need to challenge one's potential remains a concern throughout the career/life cycle.

John Flanagan and Darlene Russ-Eft (1977) conducted a survey to study this very area. This investigation examined the quality of life components important to males and females at ages 35, 50, and 70. As you will note there is very little change in people's response to their quality of life needs at the different age levels. (See table 8.)

The stress and losses that come with increasing age dictate a need to cope and adjust to the new life pattern. It is not unusual for the older adult to maintain the same adjustment pattern that was prevalent in the younger years. The older person's potential for growth and development can be supported by the available information. Yet the strength of socioeconomic factors still influences the perceptions of many people its assume what being old is all about. The danger becomes even greater when the older people themselves are mirroring this negative image and accept the role of being just "old."

Effective Attending and Listening Skills

Competency 3

Identify strengths and weaknesses in your listening and attending skills.

Communication, like other daily life experiences, can be something that people take for granted. We tend to believe that when words are spoken, they also are understood. The continual emphasis on listening with "open minds" as well as "open ears" is worthy of consideration.

Much of the time our listening attention is captured by vivid impulses such as loud noises or dramatic contrasts. These impulses command our attention because they force themselves into our consciousness. When our senses respond to the pressure of **physical impulses**, th **primary** or basic level of attending has been affected.

When w gir to select or sort through all the words a. uli being transmitted and rely on our past experiences to give **meaning** to what is being said, then **secondary** attention level results. It is at this secondary level, the level when we are interpreting through our frame of reference, that the skill of listening attentively and openly becomes complex.

Good listening skills require that we operate at both primary and secondary levels To tune into someone else's perspective and not block the communication with our values or experiences, is the core of effective listening behavior. Accurate listening skills will require that we listen with our eyes as well as our ears. We can be sensitive to body language, such as body movement, facial change, or looking into another persons' eyes comfortably, when talking.

Competent attending and listening behavior is critical when we are involved with older adults. Habits, attitudes, and previous experience with older adults can influence and possibly block new information being shared with us. Kelter (1973) suggests these general considerations for developing our effective listening skills:

1. Develop habits of seeking beyond what we expect a situation to produce.
2. Develop habits of focusing attention on the speech of others.
3. Prepare to listen.
4. Check our role and purpose in any given communication.
5. Examine the role and purpose of the speaker
6. Determine how we wish to relate to the speaker.

Table 8

Education and Quality of Life

A Sample of 1,000 30-Year-Olds, 600 50-Year-Olds, and 600 70-Year-Olds Reporting Each of the 15 Components as Important or Very Important to Their Quality of Life

Component	Percentage of Males			Percentage of Females		
	30	50	70	30	50	70
PHYSICAL AND MATERIAL WELL-BEING						
A. **Material comforts**—things like a desirable home, good food, possessions, conveniences, an increasing income, and security for the future.	80	85	87	75	86	87
B. **Health and personal safety**—to be physically fit and vigorous, to be free from anxiety and distress, and to avoid bodily harm.	98	96	95	98	98	96
RELATIONS WITH OTHER PEOPLE						
C. **Relationships with your parents, brothers, sisters, and other relatives**—things like communicating, visiting, understanding, doing things, and helping and being helped by them.	68	63	60	83	76	78
D. **Having and raising children**—this involves being a parent and helping, teaching, and caring for your children.	84	85	83	93	92	88
E. **Close relationships with a husband/wife/a** person of the opposite sex.	90	88	85	94	83	46
F. **Close friends**—sharing activities, interests, and views: being accepted, visiting, giving and receiving help, love, trust, support, guidance.	71	76	70	79	80	87
SOCIAL, COMMUNITY, AND CIVIC ACTIVITIES						
G. **Helping and encouraging others**—this includes adults or children other than relatives or close friends. These can be your own efforts or efforts as a member of some church, club, or volunteer group.	70	71	64	72	74	78
H. **Participating in activities relating to local and national government and public affairs.**	47	62	64	42	58	58
PERSONAL DEVELOPMENT AND FULFILLMENT						
I. **Learning**, attending school, improving your understanding, or getting additional knowledge.	87	68	50	81	67	60
J. **Understanding yourself** and knowing your assets and liminations, knowing what life is all about and making decisions on major life activities. For some people, this includes religious or spiritual experiences. For others, it is an attitude toward life or a philosophy.	84	84	80	92	90	88
K. **Work** in a job or at home that was interesting, rewarding, worthwhile.	91	90	55	89	85	59
L. **Expressing yourself** in a creative manner in music, art, writing, photography, practical activities, or in leisure time activities.	48	39	36	53	54	58
RECREATION						
M. **Socializing**—meeting other people, doing things with them, and giving or attending parties.	48	47	49	53	49	60
N. **Reading, listening to music, or observing** sporting events or entertainment.	56	45	52	53	56	63
O. **Participation in active recreation**—such as sports, traveling and sightseeing, playing games or cards, singing, dancing, playing an instrument acting, and other such activities.	59	48	47	50	52	52

SOURCE Flanagan and Russ-Eft (1977).

7. Identify the style and language of the speaker.

8. To whatever degree possible, determine how the speaker sees the world and follow the context of that person's world.

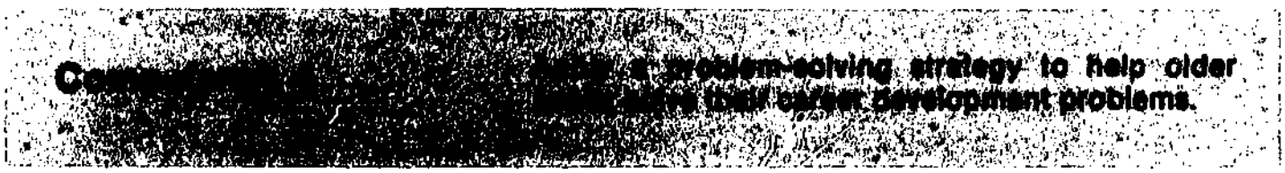
9. Determine the relevancy of bits of information to our own needs and purposes.

10. Test the reliability of the information we get from a speaker.

11. Deliberately attempt to perceive the relevant stimuli of the speaking situation from as many viewpoints as possible.

Listening requires the use of both visual (attending) and auditory (listening/hearing) capabilities. It is not unusual for these skills to be considered an elementary function of communication. Even the familiar saying, "Well I can't do much for you, but I can at least listen," could suggest the priority sometimes given to listening. But it is so often this very assumption, that **anyone** can be a good listener, that can complicate the best intentions of people working with the older adult. To prepare yourself to listen accurately and openly to another speaker requires that you make a conscious effort to seek beyond what you expect to hear.

Problem-Solving Strategies for the Older Adult



The awareness of individual differences (e.g., age, sex, culture) should be a key factor that influences the selection of career guidance strategies. Often times specific training is necessary so that career guidance workers learn the needs of the particular client group and evaluate their own attitudes, values, and biases regarding this target population. To effectively implement a career guidance program for the older population, information about their particular needs warrants investigation. Butler and Lewis (1977) list the following as special characteristics of older people to which career guidance personnel should be sensitive.

1. **Desire to leave a legacy.** Older people have a need to leave something of themselves behind. The need to feel that their life was meaningful gives continuity to their living and dying process. Some will express this need in their family (children); others may leave art, material goods, as a reminder of their participation in life.

2. **The "elder" function.** The older individuals could adopt the role of wisdom and want to share with others the wealth of experience their lives have enjoyed.

3. **Attachment to familiar objects.** Objects such as pets, scrapbooks, and old letters provide comfort and continuity to the older person. These familiar possessions can be a source of security and satisfaction for the aged and fear of loss of these possessions is frequently a fear of the older person.

4. **Change in sense of time.** The awareness of time escaping them or being on the "shadow" of life is a common characteristic of the older person. The focusing on very basic elements of life--children, nature, plants--can assume greater significance as people grow older. Living each day to the fullest, an acute sense of "present" time is a result of the change in the sense of time.

5. **Sense of the life cycle.** We are now using older people for recording "oral" history. To appreciate the fullness of the life span, the beginning and the ending, is a more positive attitude towards the growth of old age. Older people are being asked to verbally record history as they have lived it through their life cycle.

6. **Creativity, curiosity, and surprise.** The ability to be interested, motivated, and a learner does not necessarily diminish with age. The fact that many older workers maintain uninteresting jobs for much of their lifetimes because the work ethic in operation at the time of their youth directed them to early vocational decisions could open possibilities for discovering untapped potential in their elder years. Many older people learn

new skills and establish new interests because of the opportunity of time and support given to them in their older years.

7 **Sense of consummation of fulfillment of life.** The sense of reflection over one's life cycle, to enjoy the experience of living the review of one's years, can be a gratifying one. To have met the challenge of everyday conflict, reflect on the quality of life spent, can be influential on how the older person completes the cycle and ends the circle of life.

When you provide career guidance to the older adult, concerns such as those listed above will arise in your sessions with them. The time element is usually of great concern to the older person. Sometimes you might only see the person for one time. You might be tempted to underestimate the significance of that contact.

The desire for a "**second chance**" or a "new start" is common for many older adults. This could be your cue for their wish for a change and to undo past behaviors.

Grief and restitution are central issues for many older adults dealing with the loss of loved ones and awareness of their own dying process might be important guidance goals for the older adult.

The ability to exercise some **control** in their lives or the right to assert their belief systems is issue for some older adults. A sense of helplessness can diminish their self esteem.

The issues presented here have a common challenge of change and adaptation. Effective career guidance programs that encourage successful accommodation to the aging process are vital techniques to use when working with older people. As a career guidance worker, you should **facilitate growth and change** by modeling behaviors that encourage openness, regard, and empathy. You should be sensitive to the unique issues that older people face.

Problem-solving strategies can serve as a valuable tool for your career guidance efforts. The majority of your contacts will be concerned with the clients sharing problems that need to be discussed. It is vital to the quality of the guidance relationship that you do not solve the problem "for" the client.

There are common elements in the act of listening to guidance problems. They including helping the clients: (1) to go beyond problem awareness by carefully defining the problem; (2) to set their goal of what they want to do about the defined problem; and (3) to deal with the obstacles that may arise in the achieving of that goal. For example:

Problem: (Mrs. Jones speaking) My sister died and left me her share of the furniture that graced the old family home. I want to keep that furniture and be able to display it so people can appreciate fine old antiques.

Goal: I think I'll have to get a larger apartment for me to accommodate both my possessions and those my sister left me.

Obstacle: In my building I can't afford the two-bedroom apartment it would take to properly display all the furniture.

Helping problem solving here would be giving all three steps attention. However, trying to solve the problem on the client's terms is important, if at all possible. For example, following the stated steps above should come first. If the obstacle seems insurmountable, alternatives could be discussed as in the following questions: Does she want all of the furniture? If not, would taking just certain pieces reduce her need? If she could sell some, would it help her gain more space for the remaining pieces? Are there things of her own she would be willing to part with in order to keep more of the antiques?

If moving still prevails as the solution to the goal stated above, certain considerations should be discussed such as: (1) it must be in her price range, (2) it must meet her space requirements, and (3) it must meet her standards in neighborhood environment, such as transportation, friends, and personal safety.

The problem-solving process can be an effective technique of exploring both personal and group concerns. The process requires that decisions are made throughout the discussion. As people mature and gain life experiences, they become increasingly unique. The above method of problem solving is effective for dealing with this "uniqueness" of each person.

NOTES

Learning Experience 1

The Older Adult--Biases and Stereotypes

OVERVIEW

COMPETENCY	Describe a negative and a positive bias, stereotype, or attitude you hold regarding older adults and determine the possible cause and effects of each one.
READING	Read Competency 1 on page 7.
INDIVIDUAL LEARNING OBJECTIVE	Identify and describe in writing at least one bias, stereotype, or negative attitude and at least one positive [illegible] adults which you personally hold and determine the possible cause and effects of each one on your career [illegible] tacts with them.
INDIVIDUAL ACTIVITY	Take and score a short quiz, review the reading, review your quiz results, and complete a writing assignment.
INDIVIDUAL FEEDBACK	Assess your written product using the listed criteria.
GROUP ACTIVITY	Participate in groups to discuss the documentation for correct answers on the quiz and to share what has been learned in this section.

INDIVIDUAL ACTIVITY

Take and score a quiz, review the reading, review your quiz results, and complete a writing assignment.

The following quiz is intended to help you assess your perceptions of the characteristics and concerns of older adults. Oftentimes people will answer a quiz such as this one, the way they think they "should" or the way they feel things "ought" to be. The emphasis of this activity is on your examining your own biases and assumptions.

The following 25 statements listed by Erdman Palmore in his "Facts on Aging: A Short Quiz" illustrate the varying, and sometimes conflicting, generalizations people have about this group. Do these help you get in touch with more of your personal beliefs?

Circle "T" for True or "F" for False.

T F 1. The majority of old people (past age 65) are senile (i.e., defective memory, disoriented, or demented).

T F 2. All five senses tend to decline in old age.

T F 3. Most old people have no interest in, or capacity for, sexual relations.

T F 4. Lung capacity tends to decline in old age.

T F 5 The majority of old people feel miserable most of the time.

T F 6. Physical strength tends to decline in old age.

T F 7 At least one-tenth of the aged are living in long-stay institutions (i.e., nursing homes, mental hospitals, homes for the aged, etc.).

T F 8. Aged drivers have fewer accidents per person than drivers under age 65.

T F 9 Most older workers cannot work as effectively as younger workers.

T F 10 About 80 percent of the aged are healthy enough to carry out their normal activities.

T F 11 Most old people are set in their ways and unable to change.

T F 12 Old people usually take longer to learn something new.

T F 13 It is almost impossible for most old people to learn new things.

T F 14 The reaction time of most old people tends to be slower than reaction time of younger people

T F 15 In general, most old people are pretty much alike.

T F 16 The majority of old people are seldom bored.

T F 17 The majority of old people are socially isolated and lonely

SOURCE: Palmore, Erdman. "Facts on Aging: A Short Quiz." *The Gerontologist* 17, no. 4 (1977), pp. 315-316. Reprinted with permission of the publisher.

T F 18. Older workers have fewer accidents than younger workers.

T F 19. Over 15 percent of the U.S. population are now age 65 or over.

T F 20. Most medical practitioners tend to give low priority to the aged.

T F 21. The majority of older people have incomes below the poverty level (as defined by the Federal Government).

T F 22. The majority of old people are working or would like to have some kind of work to do (including housework and volunteer work).

T F 23. Older people tend to become more religious as they age.

T F 24. The majority of old people are seldom irritated or angry.

T F 25. The health and socioeconomic status of older people (compared to young people) in the year 2000 will probably be about the same as now.

Take time now to score your quiz. The key to the correct answers is simple: all odd numbered items are false while all even numbered items are true. Remember your score (out of 25 points) and the content of the items you got wrong. You will have an opportunity to discuss these in a group activity later in this section. However, you will not have to share your answers unless you choose to do so. Next, review the reading for Competency 1 on page 7.

An important objective of the preceding activities is to help you to identify your own biases and stereotypes of the older adult as well as to reinforce your positive attitudes. Now you are to write two paragraphs answering the following questions.

Paragraph One

What attitudes do you hold about the older adult that could be particularly beneficial in your role as a career guidance worker? What learning experiences do you think produced that positive attitude? What client benefits could you expect to be derived from the positive attitudes you have indicated?

Paragraph Two

What bias, stereotype, or attitude have you identified within yourself that could adversely affect your career guidance efforts with the older adult? What learning experiences do you think produced that bias or stereotype? How do you think the bias could affect your relationship with the older adult and the outcome of your guidance efforts?

INDIVIDUAL FEEDBACK

Assess your written product using the listed criteria.

If it is acceptable to you, it would be desirable to have your assessment checked (or verified) by a friend or colleague. This person also should use this checklist. Use the following checklist to certify that you have successfully met the requirements of the learning objective for this competency area. Your paragraphs must contain each of the following six ingredients:

1. An example of a personal attitude about the older adult which could be beneficial in your role of career guidance worker.
2. At least one well described incident in your life that helped you learn that attitude.
3. A brief discussion of possible client benefits which could be derived from the positive attitude you indicated.
4. One example of a bias, myth, stereotype, or negative attitude which you hold about the older adult.
5. At least one well described incident in your life that helped you learn that negative attitude.
6. A description of how that bias, myth, stereotype, or attitude might affect your relationship with an older adult.

Revise your paragraphs until they met all of the above six criteria.

GROUP ACTIVITY

Participate in groups to discuss the documentation for correct answers on the quiz and to share what has been learned in this section.

Note: The following outline is to be used by the workshop facilitator.

Facilitator's Outline	Notes
A Starting Point	
1 Divide the participants into groups of at least four persons.	Retaining the same subgroup of four throughout the workshop is advantageous because the members feel more at ease with each other, and the feeling enhances the exchange of remarks needed in the skill activities.
2 Ask participants to complete the Individual Activity if they have not already done so	

Facilitator's Outline	Notes
B. Conduct Activity	
1. Ask group members to review and discuss the adjectives they wrote when they completed the two-page introduction of this module.	Encourage group participation as you circulate around the room.
2. Convene the large group and on a large sheet of paper or chalkboard, use the following outline to get ideas from each small group.	One outline should be created to summarize key ideas across the small group.

	Physical Health	Mental Health	Finances	Family	Values	Interests	Personal and Social Behaviors	Leisure
65 to 70								
70 to 75								
75 to 80								

3. In the large group, examine, with group participation, the differences, if any, in the adjectives selected to describe adults as they grow older.	Discussion could be stimulated by the following questions: What influence did their perception of aging have with their choice of adjectives? Were their responses influenced by the "image" of aging (or the myths and stereotypes about aging)?
4. Ask participants to return to their small groups in order to discuss their results on the 25 quiz. Where anyone of them disagrees with the answers provided, encourage the group to review and discuss the handout "Documentation for Facts on Aging: Short Quiz" on page 37. Work with them until agreement is attained.	The seven-page "Documentation for Facts on Aging: A Short Quiz" is presented at the end of this section.
C. Wrap Up	
1. Ask the small groups to share what they have learned in this learning experience.	
2 Request that the participants once again review the paragraphs they wrote in the individual activity. Encourage participants to make sure they can verify that the learning objective has been achieved.	Work with any participants who cannot verify achievement of this learning objective.

NOTES

Handout

Documentation for Facts on Aging: A Short Quiz

1 The majority of old people are not senile (i.e., defective memory, disoriented, or demented). Only about 2 or 3 percent of persons age 65 or over are institutionalized as a result of psychiatric illness (Busse and Pfeiffer 1977). A series of eight community surveys found the prevalence of psychosis (of all types) to range from 4 to 8 percent (Riley and Foner 1968). Thus, all the evidence indicates that there are less than 10 percent of the aged who are disoriented or demented. It is more difficult to get accurate estimates of the proportion with defective memories, partly because of the different types of memory defects and different methods of measuring it. However, most studies agree that there is little or no decline with age in short-term memory storage capacity (using the digit span test). Four studies did find large age differences in free recall of words, but two of them found no age differences in recognition of words in a list (Woodruff and Birren 1975). As for long-term memory, various community surveys have found less than 20 percent of the aged who cannot remember such things as the past President of the United States, their correct age, birth date, telephone number, mother's maiden name, address, or the alphabet (Botwinick 1976; Pfeiffer 1975). Thus, it is clear that the majority of aged do not have such serious memory defects.

2. All five senses do tend to decline in old age. Most studies agree that various aspects of vision, hearing, and touch tend to decline in old age. Some studies of taste and smell have not found a significant decline, but the best evidence indicates increases in taste and smell thresholds with age (Riley and Foner 1968). Studies of structural atrophy in the tongue and nose with old age support the experimental evidence of decline in taste and smell (Birren 1969).

3. The majority of persons past age 65 continue to have both interest in, and capacity for, sexual relations. Masters and Johnson (1966) found that the capacity for satisfying sexual relations continues into the decades of the 70s and 80s for healthy couples. 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).

4. Lung capacity does tend to decline in old age. Both vital lung capacity (the volume of air that can be forcibly expelled in one breath) and maximum breathing capacity (the volume of air that can be moved in and out of the lungs in 15 seconds) declines on the average from age 30 onward (Shock 1962).

5 The majority of old people do not feel miserable most of the time. Studies of happiness, morale, and life satisfaction either find no significant difference by age groups or find about one-fifth to one-third of the aged score "low" on various happiness or morale scales (Riley and Foner 1968). A recent national survey found that a fourth of persons 65 or over reported that "This is the dreariest time of my life;" while a majority said "I am just as happy as when I was younger" (Harris 1975).

6 Physical strength does tend to decline in old age. Studies of various kinds of muscular strength show declines in old age compared to young adulthood of 15 to 46 percent (Birren 1959).

7 Only 4.8 percent of persons 65 or over were residents of any long stay institutions in 1970 (U.S. Census 1970). Even among those age 75 or over only 9.2 percent were residents in institutions.

8 Drivers over age 65 do have fewer accidents per person than drivers under age 65. Older drivers have about the same accident rate per person as middle-aged drivers, but a much lower rate than drivers under age 30 (National Safety Council 1976). Older drivers tend to drive less miles per year and apparently tend to compensate for any declines in perception and reaction speed by driving more carefully

9 The majority of older workers can work as effectively as younger workers. Despite declines in perception and reaction speed under laboratory conditions among the general aged population, studies of older workers (the 12 percent who are able to continue employment) under actual

working conditions generally show that they perform as well as young workers, if not better than younger workers, on most measures. When speed of reaction is important, older workers sometimes produce at lower rates, but they are at least as accurate and steady in their work as 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, older workers have less job turnover, less accidents, and less absenteeism than younger workers (Riley and Foner 1968).

10. About 80 percent of the aged are healthy enough to engage in their normal activities. About 5 percent of those over age 65 are institutionalized and another 15 percent among the noninstitutionalized say they are unable to engage in their major activity (such as work or housework) because of chronic conditions. This leaves 80 percent who are able to engage in their major activity (National Center for Health Statistics 1974).

11. The majority of old people are not "set in their ways and unable to change." There is some evidence that older people tend to become more stable in their attitudes, but is is clear that most older people do change and adapt to the many major events that occur in old age such as retirement, children leaving home, widowhood, moving to new homes, and serious illness. Their political and social attitudes also tend to shift with those of society, although at a somewhat slower rate than for younger people (Cutler and Kaufman 1975; Glenn and Hefner 1972).

12. Older people usually take longer to learn something new. Experiments have consistently shown that older people take longer than younger people to learn new material (Botwinick 1967). Studies of on-the-job trainees also show that older workers tend to take somewhat longer to learn new jobs (Riley and Foner 1968).

13. But, it is not impossible for most old people to learn new things. The same studies (cited in #12) also show that most older persons can eventually learn new things about as well as younger persons, if given enough time and repetitions of the material to be learned.

14. The reaction time of most old people tends to be slower than that of younger people. This is one of the best documented facts about the aged on record. It appears to be true regardless of the kind of reaction that is measured (Botwinick 1967).

15. Most old people are not pretty much alike. There appears to be at least as much difference between older people as there is at any age level; there are the rich and poor, happy and sad, healthy and sick, high and low intelligence, etc. In fact, some evidence indicates that as people age they tend to become less alike and more heterogeneous on many dimensions (Maddix and Douglas 1974).

16 The majority of old people are seldom bored. Only 17 percent of persons 65 or over say "Not enough to do to keep busy" is a "somewhat serious" or "very serious" problem (Harris 1975). Another survey found that two-thirds of the aged said they were never or hardly ever bored (Dean 1962). The Duke Adaptation Study found that 87 percent of those 65 or over said they were never bored in the past week.

17. The majority of old people are not socially isolated and lonely. About two-thirds of the aged say they are never or hardly ever lonely (Dean 1962), or say that loneliness is not a serious problem (Harris 1975). Most older persons have close relatives within easy visiting distance and contacts between them are relatively frequent (Binstock and Shanas 1976). About half say they "spend a lot of time" socializing with friends (Harris 1975). About three-fourths of the aged are members of a church or synagogue (Erskine 1964), and about half attend services at least three times per month (Catholic Digest 1966). Over half belong to other voluntary organizations (Hausknecht 1962). Thus, between visits with relatives and friends and participation in church and other voluntary organizations, the majority of old people are far from socially isolated.

18 Older workers have fewer accidents than younger workers. Most studies agree this is true For example, a study of 18,000 workers in manufacturing plants found that workers beyond age 65 have about one-half the rate of nondisabling injuries as those under 65, and older workers have substantially lower rates of disabling injuries (Kossoris 1948).

19. Only 10.3 percent of the population were age 65 or over in 1975 and this will probably not increase to more than 12 percent by the year 2000, even if completed fertility drops to zero population growth levels (Current Population Survey 1975).

20. Most medical practitioners tend to give low priority to the aged. A series of 12 empirical studies all found that most medical students and doctors, nursing students and nurses, occupational therapy students, psychiatry clinical personnel, and social workers tend to believe the negative stereotypes about the aged and prefer to work with children or younger adults rather than with the aged. Few specialize, or are interested in specializing, in geriatrics (Brown 1967; Campbell 1971; Coe 1957; Cyrus-Lutz and Gaitz 1972; Delora and Moses 1969; Gale and Livesley 1974; Garfinkel 1979; Gunter 1971; Miller, Lowenstein, and Winston 1976; Mills 1972; Spence and Feigenbaum 1968).

21. The majority of persons 65 or over have incomes well above the poverty level. In 1975 there were only 15.3 percent of the aged below the official poverty level (about $2,400 for an aged individual or $3,000 for an aged couple). Even if the "near poor" are included, the total in or near poverty is only 25.4 percent (Brotman 1976).

22. Over three-fourths of old people are working and would like to have some kind of work to do (including housework and volunteer work). There are about 12 percent of persons 65 or over who are employed, 21 percent who are retired but say they would like to be employed, 17 percent who work as housewives, 19 percent who are not employed but do volunteer work, and another 9 percent who are not employed and not doing volunteer work but would like to do volunteer work (Harris 1975). These percentages total to 78 percent.

23. Older people do not tend to become more religious as they age. While it is true that the present generation of older persons tend to be more religious than the younger generations, this appears to be a generational difference (rather than an aging effect) due to the older persons' more religious upbringing. In other words, the present older generation has been more religious all their lives rather than become more religious as they aged. Longitudinal studies have found no increase in the average religious interest, religious satisfaction, nor religious activities among older people as they age (Blazer and Palmore 1976).

24. The majority of older people are seldom irritated or angry. The Kansas City Study found that over one-half the aged said they are never or hardly ever irritated and this proportion increases to two-thirds at age 80 or over. About three-fourths said they are never or hardly ever angry (Dean 1962). The Duke Adaptation Study found that 90 percent of persons over age 65 said they were never angry during the past week

25 The health and socioeconomic status of older people (compared to younger people) in the year 2000 will probably be much higher than now. Measures of health, income, occupation, and education among older people are rising in comparison to those of younger people. By the year 2000, the gaps between older and younger persons in these dimensions will probably be substantially less (Palmore 1976).

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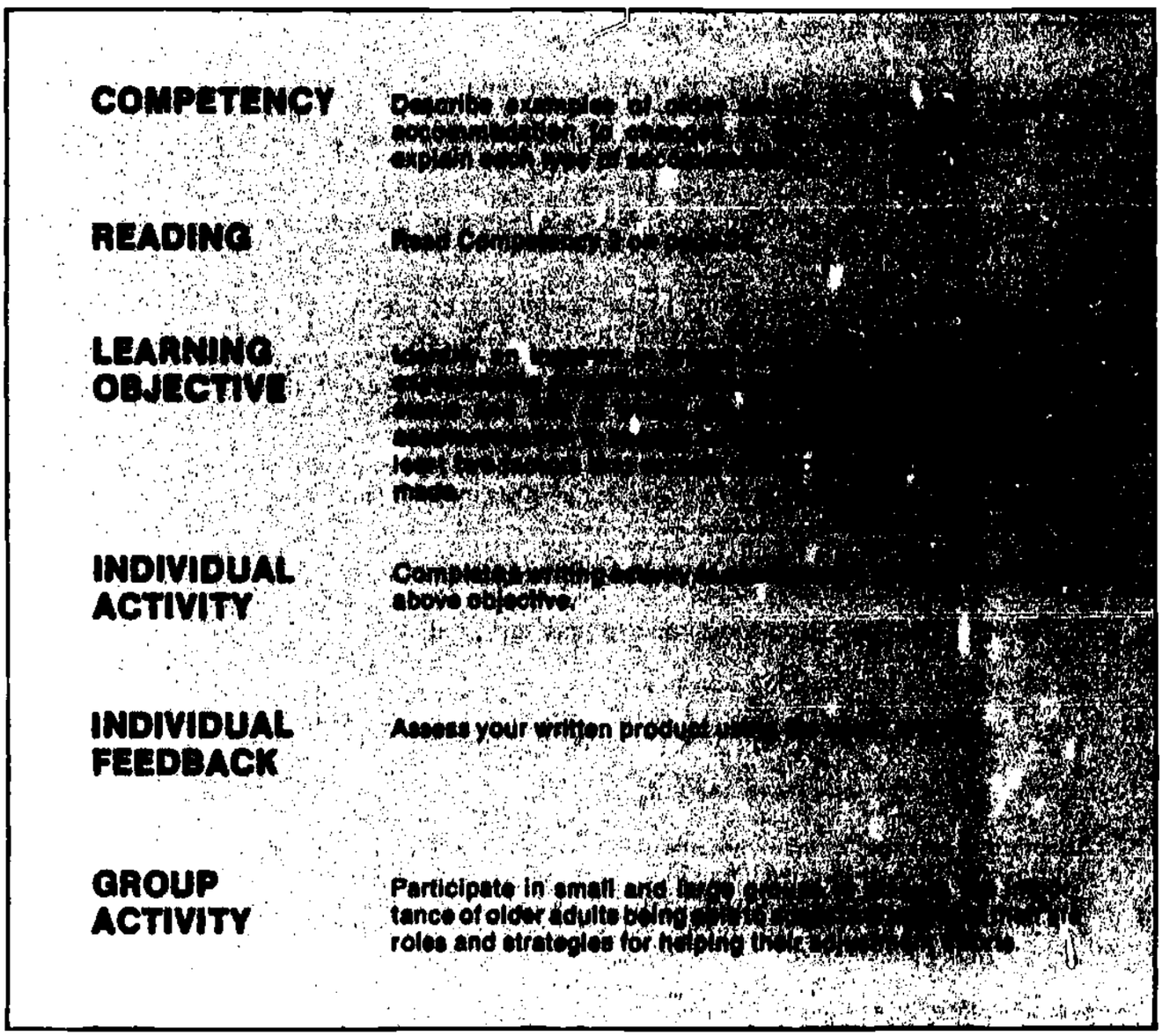
NOTES

Learning Experience 2

Concerns of Change of the Older Adult

OVERVIEW



INDIVIDUAL ACTIVITY

Complete a writing assignment to achieve this section's learning objective.

Read Competency 2 on page 23. To prepare for this reading, remember that the reading for Competency 1 asserted that external factors definitely play a significant role in determining "successful" aging We can perceive life as a circular process. A process where the beginning, as well as the ending, have equal wealth and significance.

When you have completed your reading, use the following three paragraphs as a review to highlight the key points presented in this section.

1 **Financial factors.** In 1971, the White House Conference on Aging conducted a survey of nearly 200,000 persons 65 and older and asked them how they felt about their finances. Over half of these people received and spent less than $200 a month; over one-third had trouble paying their housing costs, over half stated they did not always have money to "make ends meet."

2 **Social-cultural factors.** Factors to highlight could be change in family routine, society's attitude about aging (value of age), and the development of new roles. "You married me for dinner, but not for lunch." This quote focuses on the readjustment of family and marriage roles that are common in the retirement period.

Kalish (t975) offers four possible definitions of successful aging:

a A way of life that is socially desirable for this age group.

b Maintenance of middle life activities.

c A feeling of satisfaction with one's present status and activities.

d A feeling of happiness with one's life.

3 **Adapting to change.** In many situations, the person's mode of adapting to old age is a direct outgrowth of a long-term adjustment pattern. Although the older person may disengage from previous role activities, they are not likely to disengage from the social values they have internalized over the years The continuous adjustment between life roles and values is the pivotal concern of the individual's accommodation to aging

On a separate piece of paper, list a positive and negative incident you can recall that influenced an older person's accommodation to change in life roles In other words, identify and describe in writing the following

1 A recent time you observed an older adult experiencing a **positive** accommodation to change in life role status List at least two factors which influenced the positive change

2 A recent time when you observed an older adult experiencing a **negative** accommodation to change in life roles List at least two factors which influenced the negative change.

INDIVIDUAL FEEDBACK

Assess your written statements using the listed criteria.

Use the following checklist to determine whether or not you have met the learning objective. It would be desirable to have a friend or colleague doublecheck your assessment. Your written responses to the preceding two questions must contain each of the following four ingredients:

____ 1. A complete description of an older adult's **positive** accommodation to a life role change detailing: (a) who was involved, (b) what the conditions demanding change were, (c) what the person did, (d) the effects of that action, and (e) why the accommodation was **positive**.

____ 2 At least two factors that caused or enrolled that person to make the **positive** change.

____ 3 A complete description from older adult's negative accommodation to a life role change, once again, detailing: (a) who was involved, (b) what the conditions demanding change were, (c) what the person did, (d) the effects of that action, and (e) why the accommodation was **negative**.

____ 4 At least two factors that made that person unable to make a more positive accommodation to the required change in life role.

Revise your written statements until they meet all of the above criteria.

GROUP ACTIVITY

Participate in groups to discuss the importance of older adults being able to adapt to changes in their life roles and strategies for helping their adjustment efforts.

Note: The following outline is to be used by the workshop facilitator.

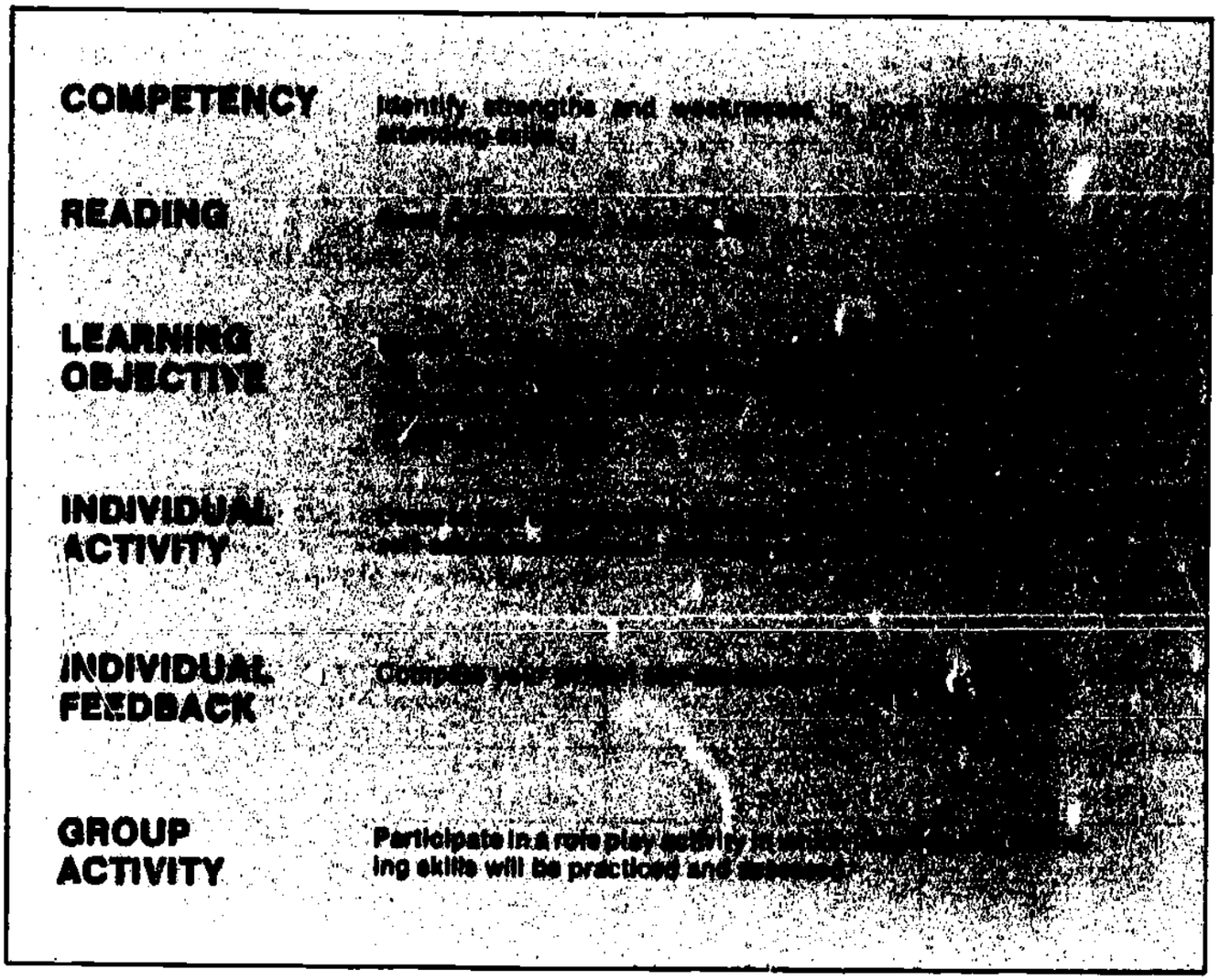
Facilitator's Outline	Notes
A Starting Point	
1 Indicate to participants that they will be identifying strategies for helping older adults to accommodate change.	
2 Ask the participants to complete the Individual Activity if they have not already done so	

Facilitator's Outline	Notes
B Conduct Activity	
1. Ask the participants to assemble in their small groups (i.e., about four persons in each group). Each group should discuss the following two topics and select someone who will report the group's conclusions to the large group, once you reconvene it.	Circulate among the groups to facilitate discussion and progress where necessary.
• The importance of older adults being able to accommodate changes in their life roles.	Encourage groups to identify possible effects that illustrate the importance of constructive adaptation.
• Strategies that can be used by career guidance personnel to increase the skills of older adults or to change environmental conditions so these adults can make more constructive adaptation.	Encourage group members to identify both types of strategies.
2. Convene the large group once again and ask for reports from representatives of each of the small groups. Work toward group consensus on both of the above topics.	Record the group's conclusions on a large sheet of paper or chalkboard.
C. Wrap Up	
1. Elicit participants responses about what they have learned from this learning experience.	
2. Request participants to review their written assignments. Encourage them to make certain they can verify that the objective has been met.	Help any participants who are unsure of their progress on this objective.

Learning Experience 3

Effective Attending and Listening Skills

OVERVIEW



INDIVIDUAL ACTIVITY

Discuss the reading with a colleague or friend and complete a self-assessment on your attending and listening skills.

Read Competency 3 on page 26. It addresses the importance of effective attending and listening skills in your efforts to provide career guidance assistance to the older adult. Once you have completed the reading, pick out the attending and listening skills that are discussed. Also, identify reasons the reading uses as evidence supporting the importance of such skills.

Once you feel comfortable with this reading material, contact a friend who is willing to discuss the content with you. In your discussion, focus on sharing perceptions of your attending and listening skills. Both of you should try to identify skills you frequently use and ones you should use more often. As the final activity, complete the following worksheet.

Worksheet

Attending and Listening Skills

DIRECTIONS: List at least two of your current skills for attending and listening to older adults and two skills (of each type) that you would like to improve for each skill you identify, also briefly describe the effects that you know or expect successful performance of that skill will have on an older person.

Current Attending and Listening Skills		Desired Attending and Listening Skills	
Skills (specify or more)	Current Effects of these Skills	Skills (specify or more)	Current Effects of these Skills

INDIVIDUAL FEEDBACK

Compare your self-assessment with the listed criteria.

Compare your responses on the worksheet to see if they meet the following criteria. It would be helpful if your friend would also review your worksheet. Your responses must meet each of these five criteria.

1 You must describe two skills that clearly indicate how you are currently able to listen to an older adult.

2 Similarly you must describe two listening skills you would like to be able to perform more effectively.

3 You must describe two skills that clearly indicate how you are currently able to attend to an older adult.

4 Similarly you must describe two attending skills you would like to be able to perform more effectively

5 You must name at least eight effects--one for each of the above skills--that describe observable results the performance of those skills are having (current skills) or will have (desired skills) on older adults.

GROUP ACTIVITY

Participate in a role play activity in which listening and attending skills will be practiced and assessed.

Note: The following outline is to be used by the workshop facilitator.

Facilitator's Outline	Notes
A Starting Point	
1 Indicate to participants that they will be involved in a role play activity which will address listening and attending skills	
2 Have participants complete the Individual Activity if they have not already done so	
B Conduct Activity	
1 Convene the full group and demonstrate the role playing activity	The Orientation Sheet is on page 51

Facilitator's Outline	Notes
a. Select three volunteers; b. Explain the roles of the "observers," "listeners," and "speakers;" c. Take the role of the "speaker" in this demonstration; d. Use the following information from the Orientation Sheet to role play the "speaker"--an older adult: When I think of myself as an older adult, I would describe my activities as reasonably active; my personal attitudes to be pretty positive; people in my life to include family and close friends e. Ask the volunteers to "act" their roles as two "observers" rate the interaction using copies of the Role Play Rating Scale and have each person in the audience also rate the demonstration in order to practice the process.	Role Play Rating Scale is on page 53
2. After the role play demonstration, check with the audience so that any questions about this group activity can be resolved.	
3. Give each participant four copies of the Rating Scale.	
4. Direct the participants to their small groups. Each group should repeat the role play activity until each participant has had an opportunity to act the role of the "listener" once and at least two "observer" ratings have been made of the performance. For successful completion of this group activity, each participant must accumulate 12 or more points than two raters.	The need to circulate will be great, because there might be participants who will be having their first experience with this type of activity. Encourage those with more experience to go first, so that the more reluctant ones can see a pattern emerge.
C. Wrap Up	
1. Ask each participant to review responses on the worksheet in the Individual Activity to see if there are any improvements that can be made based on the group experience.	
2. Help any individuals who cannot certify that they have achieved the learning objective for Competency 3	

Handout

Orientation Sheet

Listening is a constantly shifting process. A person's listening aoility is influenced by personal feelings, experiences, and motivations. The following exercise will assist you in developing your listening skills.

Directions

First, complete the following lists in order to have guidelines for the series of role play which follows.

When I think of myself at 70, I would describe:

My Activities as:

1. _____
2. _____
3. _____

My Personal Attitudes to be:

1. _____
2. _____
3. _____

People in my life to include:

1. _____
2. _____
3. _____

After you complete the list, assume your subgroup of four. Each of you will assume a role of: (a) speaker, (b) listener, or (c) observer at different times.

Role of speaker--Discuss with the listener, using your list for discussion suggestions, your activities, friends, etc., as a 70-year-old person (3 minutes).

Role of listener--Listener does not make any verbal responses. At the end of the 3 minutes, listener will paraphrase what has been heard.

Role of observer--Observers use the Rating Scale on the following page to evaluate the listener's attending and listening skills.

NOTES

Handout

Rating Scale for Role Play

Rate the listener's skills using the following scale: 1 = not observable, 2 = moderately observable, and 3 = highly observable.

Attending Skills	1	2	3
1. Attention was on speaker.	____	____	____
2. Established comfortable listening rapport so that self expression was encouraged.	____	____	____
3. Responded to spoken and body language (such as leaned forward when speaker's voice became softer).	____	____	____
Listening Skills	**1**	**2**	**3**
1. Gave accurate interpretations (such as the listener paraphrased at least 80 percent of what was said.)	____	____	____
2. Was sensitive to the speaker's feeling (such as the listener picked up on the joy expressed).	____	____	____
3. Heard the speaker's viewpoint (such as the listener could paraphrase negative comments without injecting personal opinion).	____	____	____
TOTAL POINTS _____ Column Totals			

Evaluation of the Exercise

After each time one member of your subgroup role plays, the observers should share their ratings with the listener and the speaker. Successful completion of this activity for each "listener"/ participant is a rating of twelve or more points from not more than two observers.

NOTES

Learning Experience 4

Problem-Solving Strategies for the Older Adult

OVERVIEW

COMPETENCY	Apply a problem-solving strategy to help older adults solve their career development problems.
READING	Read Competency 4 on page 29.
LEARNING OBJECTIVE	Apply in a role play activity a problem-solving strategy to help older adults solve their career development problems. Your performance as a guidance worker will be observed by 2 observers and you must attain at least 1 agreement from more than 2 observers of role.
INDIVIDUAL ACTIVITY	Discuss the reading with a colleague or friend. Write a self-assessment of your skill in using a problem-solving strategy in career guidance.
INDIVIDUAL FEEDBACK	Compare your written self-assessment to the [illegible]
GROUP ACTIVITY	Participate in a role play activity in which your skill in using a problem-solving strategy in career guidance will be assessed.

INDIVIDUAL ACTIVITY

Discuss the reading with a colleague or friend and complete a self-assessment of your skill in using a problem-solving strategy in career guidance.

Read Competency 4 on page 28. It discusses the importance of helping older adults learn problem-solving skills they can use as they change and adopt during the career/life development process. Concentrate on the three problem-solving skills that are discussed there. The reading does not suggest that guidance workers provide answers for their clients, but rather it encourages guidance personnel to help older adults learn the skills necessary for them to work out their own career concerns. The problem-solving strategy recommended here entails skills you use "with" not "for" someone else.

Discuss the reading's content with a friend. Ask the friend to help you recall and assess instances when you have used the recommended problem-solving strategy in your: (1) own career development and (2) career guidance efforts with clients (especially older adults, if you have worked with them in the past). Both of you should try to identify specific incidents from your past experiences and to judge the appropriateness of these incidents.

Complete the following worksheet.

DIRECTIONS: Briefly describe at least one incident in which you have used each of the three problem-solving skills in your: (1) career development and (2) career guidance efforts with clients. For each application of a skill, identify one effect or result (positive or negative) that occurred.

Skills	Application: Your Own Career Development		Application: Career Guidance with Clients	
	Incidents	Effects	Incidents	Effects
1. Problem defined				
2. Goal defined				
3. Alterna tives discussed				

INDIVIDUAL FEEDBACK

Compare your written self-assessment with the listed criteria.

Compare your responses on the worksheet with the criteria listed here. Your product must meet each of these four criteria. If your friend is still available, ask that person to review your written statements to see if he/she agrees with your decisions about whether or not they meet these criteria.

1. You must provide brief but understandable descriptions of three incidents related to your own career development and three incidents related to your provision of career guidance to others.

2. You must provide brief but understandable descriptions of at least one effect of each of those six incidents of application of a skill.

3. Each incident must describe exactly what you or your client did in applying a problem-solving skill.

4. Each effect must describe an observable result that either you or your client experience in the career development area.

GROUP ACTIVITY

Participate in a role play activity in which your skill in using a problem-solving strategy in career guidance will be assessed.

Note: The following outline is to be used by the workshop facilitator.

Facilitator's Outline	Notes
A Starting Point	
1 Indicate to participants that they will be involved in a role play situation related to problem-solving strategies.	
2 Ask participants to complete the Individual Activity if they have not already done so	
B Conduct Activity	
1 Role play the following case study as a demonstration prior to the small group participation. You need to demonstrate very clearly how each group will interact and what the role of client and guidance workers are	Before the role play demonstration commences, discuss the relevance of this group activity to the preceding (a) activities in this section, and (b) sections in this module.

Facilitator's Outline	Notes
In the demonstration, you should role play the guidance worker; ask for a volunteer to be the client--Marion. **Demonstration Case Study--Merion** Marion is a retired electrician. She was always active in her local union and has been known as one of the forerunners in establishing good labor relations laws. She still goes to the union hall to visit and contributes her time freely to the organization. Marion has many legal documents, momentoes, awards and pictures of the history and growth of the local union. She began to think about leaving them in a special spot in the union hall for all to remember. The electricians' union has a special committee that reviews the documents that can be put on display in the hall. Marion feels a little nervous about offering her personal papers and awards, but feels that the history repesented through them is too valuable to lose. Her family members have expressed an interest in keeping these awards "in the family." But Marion feels they would be safer in the union hall. Marion has made an appointment to talk to the coordinator of the committee to present her gift.	
2. Discuss and highlight the skills and what special characteristics of the older adult as discussed in the reading are being demonstrated here.	
3. Give each participant three copies of the Role Play Rating Scale to rate each of three members of the subgroup of four.	Provide extra copies of the Role Play Rating Scale that is found on page 61.
4 Ask the groups of four to meet. In each role play, one person plays the guidance worker, one plays the client, and the remaining two function as observers Four additional case studies are provided in the handout "Case Studies" on page 63. Each	Circulate among the small groups. It is vital that the participants associate the skills necessary to assist in problem-solving situations. Sometimes the "skills" are lost in the "drama" of the role play. Allow for quick discussion of the activity after all participants have been through the roles and the rating scale copies have been completed.

Facilitator's Outline	Notes
pair of guidance workers and clients should use a different case as their role play situation. The participants should keep switching roles until all of them have been involved as a guidance worker and client for at least 10 minutes.	
5. Before they get started on their role play activities, help them to remember that the four problem-solving skills they are supposed to demonstrate as guidance workers require that they (and their "clients") be able to answer these fair types of questions: a. Is the problem actually clear to the client? Is it part of a larger problem? Can it be brought down to size? If so, what is the agreed definition fit? b. What does the client really want to happen once the problem has been "solved"? c. Have all the obstacles been considered? Which ones seem to be bothering the client most? d. What alternatives need to be considered to reach the desired goal?	
6. Remind the groups that successful achievement of the learning objective means that each "guidance worker" must attain at least 12 points from not more than 2 "observers."	
C. Wrap Up	
1. Ask participants to review their responses on the worksheet in the Individual Activity to see if there are any improvements that can be made based on the group experiments they just had.	This is an important "progress check" since this is the final activity of this module.
2 Help any individuals who cannot indicate that they have achieved the learning objective for Competency 4	You might want to consider scheduling some additional role play activities. Make this the capstone activity of the module.

Facilitator's Outline	Notes
3. Ask participants to review their earlier results on the "Facts of Aging: A Short Quiz" that they completed in Learning Experience 1. See if they can determine any additional attitude changes they have made since taking and scoring that quiz. 4. Have an open discussion of any remaining questions or concerns.	

Handout

Role Play Rating Scale

Problem-Solving Skills	Clear 4	Moderately Clear 3	Slightly Clear 2	Not Clear 1
1. Problem defined				
2. Goal defined				
3. Obstacles considered				
4. Alternatives discussed				
Column Totals				

Total Points

Evaluation of the Exercise

After each member role plays the "guidance worker," the two "observers" should share their ratings with him/her and the "client." Successful completion of this activity for each participating "guidance worker" is a rating of 12 or more points from the 2 "observers." For each role play, use a different one of the four case studies provided on the following pages.

NOTES

Handout

Case Studies

Case Study Number One--Mr. D

Mr. D had enjoyed a very successful career in the music business. He considered himself to be a "self-taught" person and earned a comfortable income, without the benefit of a college education.

Mr. D is 62 and enjoying retirement with his wife. Recently his wife registered for classes at a local community college. Mr. D became interested in the classes and experiences she was having. He thought that returning to school after all these years might seem foolish for him. He had no goals or need to seek employment, but considered taking classes "just for fun."

His wife noticed a senior center on campus. She encouraged her husband to make an appointment with a counselor to discuss his concerns about reentering school.

Case Study Number Two--Mr. B

Mr. B was a 66-year-old retired plumber. He has always worked part-time, even as a retired person because he liked to be busy. Although he enjoyed the plumbing business, he had always dreamed of being an artist. Because he had been so involved with his business, he never felt he had time to take an art class.

Mr. B found himself thinking more and more about painting. He felt that if he were going to do anything about it, he'd better make a decision because time was moving very fast. He was also feeling maybe it was too late to start anything new. Mr. B thought an art teacher wouldn't want to waste time teaching an old man.

One of his neighbors told him about a special Saturday class in beginning painting that was offered very close to his home. He called and made an appointment to talk to the program coordinator.

Case Study Number Three--Mrs. R

Mrs. R is a 64-year-old widow. She had lived on the east coast for 30 years with her husband. Most of her children encouraged her to move closer to them.

Mrs. R. sold the house and all her belongings and decided to make a "fresh start" in California. The children were kind and supportive and she settled in an apartment close to them. Although she enjoyed the climate and her family, Mrs. R found herself feeling very lonely and out of place in her new surroundings. She felt her new widowhood role was very isolated, and she missed her friends back east. She was very shy about making new contacts or engaging in social activities.

She read about a Widow-to-Widow guidance group available at the Senior Center in her community. She didn't know if this would really help her, but she felt so helpless coping with the stresses of widowhood she decided to call for an appointment with the counselor to get more guidance about this program

Case Study Number Four--John and Marion

Marion, who had been single all her life, had been retired for three years and was enjoying her free time. During one holiday in Florida she met a very nice man. John had been a widower for four years and had three married children. Marion and John decided they would like to share their life and had a quiet wedding in Florida before returning to John's home in Boston.

The couple were very happy and were well received by all the family except John's youngest daughter. The couple felt the daughter was disturbed by the fact her father remarried and was disloyal to the memory of her mother. Marion wanted to communicate her feelings to the daughter, but was at a loss for a way to begin.

The couple noticed a church bulletin that advertised career/life guidance sessions for families. John and Marion were both feeling a need to talk with someone about their dilemma. They decided to make an appointment with the guidance worker.

EVALUATION

PARTICIPANT SELF-ASSESSMENT QUESTIONNAIRE

1 Name (Optional) _____ 3. Date _____

2 Position Title _____ 4. Module Number _____

Agency Setting (Circle the appropriate number)

6 Elementary School	10 JTPA	14 Youth Services	18 Municipal Office.
7 Secondary School	11 Veterans	15 Business/Industry Management.	19. Service Organization.
8 Postsecondary School	12 Church	16. Business/Industry Labor.	20. State Government.
9 College/University	13 Corrections.	17. Parent Group.	21. Other

Workshop Topics	PREWORKSHOP NEED FOR TRAINING *Degree of Need* (circle one for each workshop topic).	POSTWORKSHOP MASTERY OF TOPICS *Degree of Mastery* (circle one for each workshop topic).
1. Physical health biases and stereotypes about the older adult.	0 1 2 3 4	0 1 2 3 4
2. Mental health biases and stereotypes about the older adult.	0 1 2 3 4	0 1 2 3 4
3. Fina..cial biases and stereotypes about the older adult.	0 1 2 3 4	0 1 2 3 4
4. Family biases and stereotypes about the older adult.	0 1 2 3 4	0 1 2 3 4
5. Interest and activity biases and stereotypes about the older adult.	0 1 2 3 4	0 1 2 3 4
6. Concerns of change and adjustment of the older adult.	0 1 2 3 4	0 1 2 3 4
7. Effective attending and listening skills for providing career guidance to the older adult.	0 1 2 3 4	0 1 2 3 4
8. Problem-solving strategies for the older adult in career guidance.	0 1 2 3 4	0 1 2 3 4

Overall Assessment on Topic of Older Adults

Comments:

_____

_____

_____

_____

_____

Trainer's Assessment Questionnaire

Trainer: _____ Date: _____ Module Number: _____

Title of Module: _____

Training Time to Complete Workshop: _____ hrs. _____ min.

Participant Characteristics

Number in Group _____ Number of Males _____ Number of Females _____

Distribution by Position

_____ Elementary School	_____ Youth Services
_____ Secondary School	_____ Business/Industry Management
_____ Postsecondary School	_____ Business/Industry Labor
_____ College/University	_____ Parent Group
_____ JTPA	_____ Municipal Office
_____ Veterans	_____ Service Organization
_____ Church	_____ State Government
_____ Corrections	_____ Other

PART I

WORKSHOP CHARACTERISTICS—Instructions: Please provide any comments on the methods and materials used, both those contained in the module and others that are not listed. Also provide any comments concerning your overall reaction to the materials, learners' participations or any other positive or negative factors that could have affected the achievement of the module's purpose.

1. *Methods:* (Compare to those suggested in Facilitator's Outline)

2. *Materials:* (Compare to those suggested in Facilitator's Outline)

3 *Reaction:* (Participant reaction to content and activities)

PART II

WORKSHOP IMPACT—Instructions: Use Performance Indicators to judge degree of mastery. (Complete responses for all activities. Those that you did not teach would receive 0.)

	Group's Degree of Mastery				
	Not Taught	Little (25% or less)	Some (26%-50%)	Good (51%-75%)	Outstanding (over 75%)
	Note: Circle the number that best reflects your opinion of group mastery.				
Learning Experience 1					
Group	0	1	2	3	4
Individual	0	1	2	3	4
Learning Experience 2					
Group	0	1	2	3	4
Individual	0	1	2	3	4
Learning Experience 3					
Group	0	1	2	3	4
Individual	0	1	2	3	4
Learning Experience 4					
Group	0	1	2	3	4
Individual	0	1	2	3	4

Code:

Little: With no concern for time or circumstances within training setting if it appears that less than 25% of the learners achieved what was intended to be achieved

Some: With no concern for time or circumstances within the training setting if it appears that less than close to half of the learners achieved the learning experience

Good: With no concern for time or circumstances within the training setting if it appears that 50%-75% have achieved as expected

Outstanding: If more than 75% of learners mastered the content as expected

PART III

SUMMARY DATA SHEET—Instructions: In order to gain an overall idea as to mastery impact achieved across the Learning Experiences taught, complete the following tabulation. Transfer the number for the degree of mastery on each Learning Experience (i.e., group and individual) from the Workshop Impact form to the columns below. Add the subtotals to obtain your total module score.

GROUP		INDIVIDUAL	
Learning Experience		Learning Experience	
1 = score (1-4)	_____	1 = score (1-4)	_____
2 = score (1-4)	_____	2 = score (1-4)	_____
3 = score (1-4)	_____	3 = score (1-4)	_____
4 = score (1-4)	_____	4 = score (1-4)	_____
Total (add up)	_____	Total (add up)	_____

Total of the GROUP learning experience scores and INDIVIDUAL learning experience scores = _____. Actual Total Score _____ Compared to Maximum Total* _____.

*Maximum total is the number of learning experiences taught times four (4).

Performance Indicators

As you conduct the workshop component of this training module, the facilitator's outline will suggest individual or group activities which require written or oral responses. The following list of **performance indicators** will assist you in assessing the quality of the participants' work:

Module Title: *Meet Guidance Needs of Older Adults*

Module Number: CG C-16

Group Learning Activity	Performance Indicators to Be Used for Learner Assessment
Group Activity Number 1: Discuss the documentation for correct answers on the brief quiz and share what was learned in this section.	1. Did the group exercise cause participants to revise their written examples of their positive and negative attitudes about the older adult, the learning experiences that produced these attitudes? 2. Did the group resolve any final concerns participants had with this action.
Group Activity Number 2: Discuss the importance of older adults being able to adapt to change in their life roles. Review strategies for helping the older adult in the adjustment process.	1. Did the group experience influence participants to revise their written descriptions of recent incidents and the influencing factors in which they observed an older adult experiencing a **positive** accommodation (then a **negative** one) to changes in his/her role status? 2. Were participants able to produce logical examples of the importance of older adults' being able to accommodate to changes in their life roles? 3. Did they produce logical strategies for helping the accommodation of older adults?
Group Activity Number 3: Role play listening and attending skills with an older adult.	1. Did each participant accumulate **12 or more points** from not more than **2** raters ("observers") when s/he acted the role of listener? 2 Did the group activity cause participants to modify their assessments of their own listening and attending skills.
Group Activity Number 4: Role play using a problem-solving strategy in career guidance work.	1. Did each participant accumulate **12 or more points** from not more than **2** raters ("observers") when s/he acted the role guidance worker? 2. Did the group experience produce changes in participants' ratings of their skills in using the problem-solving strategy? 3. Did participants resolve all final concerns of this module?

NOTES

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ADDITIONAL RESOURCES

Adult Career Education as an Intervention Strategy in Mid-Career Crisis. Valerie I. Nelson, et al. University Consultants, Inc., Cambridge, MA, 1975

Based on a review of the literature of mid-career crises and various intervention strategies and on collection of a representative inventory of services currently available, a strategy and role for adult career education was developed and priorities and highlights of a research and development strategy were suggested for the National Institute of Education (NIE). Conclusions which emerged are these: (1) A mid-career crisis can be defined as a crisis of re-employment and possible forced mid-life change of career. This crisis can be precipitated by an unexpected loss of work and a shortage of jobs in the local area which utilize the skills of the individual. (2) The literature and data on mid-career crises are inadequate in several key respects. In particular, minimal data exist on the affected population or its numbers, or on the long-term effects of the crisis. (3) A mid-career crisis for most workers entails short-term economic and associated psychological disruption, unless we commit ourselves to a European solution of substantial income support and long term education for the worker. (4) Current programs of assistance are piecemeal and uncoordinated. The experience of programs to date shows, as expected minimal success at averting short-term losses to those individuals who are minimally qualified by objective standards to re-enter the labor force at previous levels of status and earnings. (5) A successful program of adult career education must take into account the labor market and psychological factors in the crises and therefore must include a combination of the following: Counseling, assurance of jobs following training, and involvement of employers in the area.

Career Development Needs of Adults: How to Improve Career Development Programs. Bert W. Westbrook Prepared for the National Advisory Council for Career Education. North Carolina State University Raleigh, NC, 1977.

This document belongs to a series of papers which were commissioned in 1976 to close various knowledge gaps in career education. After a list of tables, an overview of the rational assessment of career and occupational development is given. Another section discusses implications of career development needs of adults for a program while the closing part summarizes selected career and occupational development assessment data for adults. The implication statements are intended to highlight problems and to stimulate thinking about possible career development program activities.

Career Education of Adults. John B. Valley. National Advisory Council for Career Education, Office of Education (DHEW), Washington, DC 1977.

Prepared for the National Advisory Council for Career Education, this paper offers a broad view of the current practice of career education of adults, drawing on statistical information that indicates millions of adults are engaged in diverse kinds of educational activity. The paper defines the terms adult and career education and discusses a structure for the domain of career education of adults drawing on statistical information that indicates millions of adults are engaged in diverse kinds of educational activity. The paper defines the terms adult and career education and discusses a structure for the domain of career education of adults. Information about aspects of career education of adults other than instructional, such as counseling, career development, and job placement, is reported. The point is made that career education for adults depends not only on activities based in educational institutions but also on a wide variety of services by agencies outside colleges, universities, and other postsecondary teaching institutions. (Three examples of such services used to illustrate this point are educational brokering, educational assessment and credentialing, and experiential learning.) Three categories of career education of adults are posited: preparatory, primary, and adaptive, each of which address different goals or purposes of career education of adults. Brief recommendations are made and a list of references is included.

Comprehensive Career Guidance Program Review and Model: Post-Secondary and Adult. Earl J. Moore and Thomas B. Miller, Georgia Department of Education, Atlanta, GA, 1977.

Two chapters of this document are concerned with career guidance programs for adults at the postsecondary level. The fourth introduces a comprehensive career guidance program model. The appendix "Needs Assessment" and "Program Functions" can be used as supplements for needs assessment surveys for different ages. This clearly structured publication allows easy access to various topics and gives an extensive overview on career guidance.

The Conceptualization of a Diagnostic Taxonomy of Adult Career Problems. Robert E. Campbell, et al The National Center for Research in Vocational Education, Columbus, OH, 1979.

This report was prepared to assist practitioners, counselor educators, and program administrators in dealing with adult career development problems. The intent of this report is to propose a diagnostic taxonomy, describe its development and the results of a pilot test using a preliminary design to validate the taxonomy in one problem domain. The taxonomy will prove useful to practitioners in upgrading their counseling skills, serve as a source for the preservice training of career counselors, and provide information for the design of adult counseling programs.

Continuing Education for the Elderly: A Report. Loretta C. Buffer, and Richard R. Teaff. Ohio Dominican College and Ohio Board of Regents, Columbus, 1976.

These proceedings summarize the content and activities of a conference attended by continuing education deans and directors in Ohio's public and private 2- and 4-year institutions of higher education, administrators of nursing homes, and community mental health personnel. Focus is on the major goal of the conference: To examine, with respect to both rationale and means, the extension of educational opportunities to those elderly who congregate in the community, e.g., in recreational centers, retirement housing, and nursing homes. Major sections include a review of conference philosophy, a review of the literature on the conference theme, synopsis of conference proceedings, recommendations and feedback, and a four-page bibliography. An appendix presents guidelines on program planning and proposal writing.

Counseling Needs of Adult Students. Philip Perrone. Wisconsin University, Madison, WI.

The purpose of the study was to identify the counseling needs of the adult student enrolled in vocational-technical schools, and specifically to identify the vocational, financial, educational, personal, and social concerns reported by students. A paper-and-pencil questionnaire was administered to a total of 1,817 subjects--1,514 full- or part-time students attending 1 of 3 area vocational-technical schools in Wisconsin during 1975-75, and 303 from the same 3 communities who were considering returning to school but were not enrolled at the time of the study. The particular schools were elected to ensure representative sampling across size of institution, rural vs. urban setting, and area of the state. Results showed that sex, age, and full-time/part-time status all appear to be related to the type of concerns reported by students attending postsecondary vocational schools and that academic and vocational concerns appear to be predominant among students and nonstudents. Implications resulting from the findings were (1) the need for trial learning experiences (probably minilabs) wherein the adult has an opportunity to perform the "typical" student behavior in a relatively low-risk supportive environment, (2) the need to provide vocational information in a manner more geared to adults rather than adolescents, and (3) the need to recognize and attend to the unique needs of full-time and part-time, male and female students of varying ages.

Middle-Aged Job-Losers: Employment and Training Administration (DOL). Herbert S. Parnes and Randy King, Washington, DC 1977.

A study involving 99 men who had been involuntarily separated from their jobs was done to analyze (1) what happens to a man over 45 years old when he loses a job after having served with his current employer for at least 5 years; (2) what are the probabilities of his finding work within a reasonable period of time; (3) how likely is he to become discouraged and retire; (4) if he does find work, how does it compare with the previous job; and (5) what impact does the total experience have on his economic position and physical and mental wellbeing. Longitudinal data from the 1966 to 1973 National Longitudinal Surveys (NLS) of middle-aged men were used which provided the opportunity to observe men prior to and 2 years after the job separation and compare them to a matched control group of employees. The present study suggests that while job displacements during middle-age are not common, they occur frequently enough to constitute a social problem.

No occupational or educational category of men is immune to this kind of career disruption. The major long-term impact of displacement appears to have a substantial deterioration in occupational status. In addition to economic losses, the displaced workers suffered from deteriorating health and some sense of alienation.

Why Adults Participate in Education: Some Implications for Program Development of Research on Motivational Orientations. Gordon G. Darkenwald. Speech presented to the faculty of the University Extension Division, Rutgers University, January 26, 1977.

While recent research on why adults participate in continuing education programs does not provide educational planners with any easy prescriptions for programming success, it does suggest some broad directions for more effective program development, particularly in relation to needs assessment, the promotional aspect of marketing, and the design and management of learning activities. The most extensive recent studies of motivational orientation (factor analytic studies using Roger Boshier's Education Participation Scale) yielded a striking degree of similarity in findings. Six factors were identified: Social relationship, external expectation, social welfare, professional advancement, escape/stimulation, and cognitive interest. Further study of relationships between the motivational factors and participant and program characteristics revealed little correlation. It can be concluded (1) that Cyril Houle's three-factor typology of the adult learner (goal oriented, activity oriented, and learning oriented) can no longer be considered an adequate representation of reality, (2) that major orientation factors appear to be valid only for participants generally, and (3) that most people appear to participate in adult education for mixed reasons, some of which are unrelated to learning per se or to course content. The research should sensitize planners to the variety and complexity of the motives that underline participation in continuing education. (Implications for program development broad-scale needs assessment, marketing, and management of learning environments are discussed.)

ANNOTATED BIBLIOGRAPHY

Note: This annotated bibliography is reprinted from Counseling the Aged, a 1979 Publication of the American Personnel and Guidance Association, Washington, DC. It is used with the permission of the American Personnel and Guidance Association.

The compilation of the bibliography is an ongoing process. The materials provided here illustrate the content classifications and the proposed format which will be followed. Some completed entries are provided under each major heading for format evaluation. Please allow for missing prices, zip codes, page listing, and minor format inconsistencies while critiquing for **general** content, subject-categories, and format. If specific resources come to mind that you feel should be included, please note them as completely as you can immediately recall.

General Resources

Center for the Study of Aging and Human Development. Duke University. *Training Resources in Aging 5th Edition*. A microfiche bibliography of films, training manuals, audiovisual resources, course outlines, seminar materials, teacher guides for disciplines such as exercise, nutrition, funding, safety, sanitation, and includes information and referral services. Available from the Center, Duke University, Box 3003, Durham, NC 27710. $1.00.

Clearinghouse on Employment for the Aging. *Employment Resources for the Middle-Aged and Retired: A National Directory*. Information on federal programs and legislation related to employment of older workers, listing of public and private agencies by state, suggested readings, and regional addresses for ACTION (volunteer programs for senior citizens) offices. $3.00.

Institute of Gerontology, The University of Michigan--Wayne State. *A Set of Two Selected Annotated Bibliographies*. By Shirley Harrison, 1976. WORKING WITH THE AGED includes materials relevant to milieu therapy concepts as developed at the Institute and DAY CARE FOR THE ELDERLY includes unpublished and published articles on a variety of day services to the elderly. 520 E. Liberty, Ann Arbor, MI 48109. $1.00.

Institute of Gerontology, The University of Michigan *Humanistic Perspectives on Aging*. Walter Moss, Principal Editor. An annotated listing of novels, short stories, dramas, essays and films speaking to human aging and society's attitudes toward it. Resources in Aging Series. 76 pages. 520 East Liberty, Ann Arbor, MI 48109 $3.50

Institute of Gerontology, The University of Michigan. *Past Sixty: The Older Woman in Print and Film*. By Carol Hollenshead. An annotated bibliography including both scholarly and popular materials. It reflects the social-psychological as well as legal issues and economic issues facing the older woman. Other subjects included are marriage and the extended family, ethnic background, widowhood, health, and sexuality. Resources in Aging Series. 52 pages. 520 East Liberty, Ann Arbor, MI 48109. $3.00.

Institute of Gerontology, The University of Michigan--Wayne State. *Resources in Aging: To Live with Dignity*. Marie-France Boudreault, Vivien Larue, and Lena Metzelaar. A paper describing a Milieu Therapy project planned to meet the needs of the ill and frail elderly. The project offers guidelines for others who work with elderly persons who are often considered untreatable. 60 pages. 520 East Liberty, Ann Arbor, MI 48109.

Institute of Gerontology, The University of Michigan--Wayne State. *Staff Development in Geriatric Institutions*. Mark B. Kinney. A "how-to" manual for individuals who are training staff of agencies providing care for elderly persons. The focus is on the processes used in fabricating learning experiences, rather than on a collection of exercises to be used in training. 72 pages. 520 East Liberty, Ann Arbor, MI 48109.

Institute of Gerontology, The University of Michigan--Wayne State University. *Day Care for the Elderly: A Selected Annotated Bibliography*, Shirley Harrison, 520 East Liberty, Ann Arbor, MI 48109.

Institute of Gerontology, The University of Michigan--Wayne State University. *Sexuality in the Later Years of Life*. Alida G. Silverman. Annotated Bibliography. 520 E. Liberty, Ann Arbor, MI 48109.

National Council on Aging. *NCOA Publications List.* An annotated bibliography of new aging materials Published biannually. Available from NCOA. 1828 L St., N.W., Washington, DC 20036 Free

National Council on Aging *The Aged in Minority Groups.* 19 pages. Annotated. 1973. NCOA, 1828 L St , N.W , Washington, DC 20036. $2.00. #7315.

National Council on Aging. *Housing and Living Arrangements for Older People.* Annotated bibliography 14 pages. 1972. NCOA, 1828 L St., N.W. Washington, DC 20036. $2.00. #7214.

National Council on Aging. *Retirement Income.* Annotated bibliography. 1972. 10 pages. NCOA, 1828 L St., N.W., Washington, DC 20036. $2.00. #7217

National Institute of Mental Health. *Depression, Grief and Suicide in the Aged. Aging and Mental Health. Sex and Marriage in the Aging. Recreation for the Aging, and Other Bibliographies.* By Edith Sutherland. 1976. National Clearinghouse for Mental Health Information, 5600 Fishers Lane, Rockville, MD 20852. Free.

New England Gerontology Center. *Publications and Periodicals.* An annotated list of aging related bibliographies, audiovisual productions, books, and periodicals. New England Gerontology Center, 15 Garrison Avenue, Durham, NH 03824. Free.

New England Gerontology Center. *Psychology of Aging.* A general bibliography on such topics as sexuality, death, age-related changes, maladjustment and general psychology theory related to aging. Entries include books, journal articles, periodicals and papers, some of which are annotated 5 pages. 1977. NEGC, 15 Garrison Ave , Durham, NH 03824. $1 50. #033.

New England Gerontology Center. *Gerontological Resource Directory of Services and Education Programs in New England.* The directory lists gerontological resources in educational institutions and service programs for older people Its purpose is to locate resources for service providers, students, and others interested either in the study of aging or the delivery of services to elders 40 pages. 1977. NEGC, 15 Garison Ave , Durham, NH 03824. $3.50. #026.

New England Gerontology Center. *Literature and Aging.* A bibliography which focuses on aspects of aging in fiction, non-fiction, drama, and poetry. Recommended for the elderly themselves, educators, trainers, program and project staff for elderly services. 20 pages. 1977. NEGC, 15 Garrison Avenue, Durham, NH 03824. $2.00. #038.

New England Gerontology Center. *Retirement Bibliography. A Compilation of Resources on the Subjects of RETIREMENT AND PRE-RETIREMENT PLANNING.* Resources include books, pamphlets, periodicals, and government publications on a range of topics related to retirement such as preretirement programs, career changes, retirement experiences, retirement income and alternatives. 15 pages. 1976. NEGC, 15 Garrison Avenue, Durham, NH 03824. $1.50. #029.

U.S. Department of HEW. *More Words on Aging.* Supplement to the earlier publication *Words on Aging.* An annotated bibliography of selected references compiled for the Administration on Aging by the Department Library. For sale by the Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402. $0.75. Stock No. 1762-0040.

U.S. Department of HEW. *Older Americans Act of 1965 As Amended.* March 1976. DHEW Publication No. (OHD) 76-20170, Dept. of HEW, Office of Human Development, Administration on Aging. For sale by the Superintendent of Documents, USGPO, Washington, DC 20402. $1.45.

Information Pamphlets

"Are You Planning on Living . . . the rest of your life?" Superintendent of Documents, USGPO, Washington, DC 20402. Stock No. 017-026-0038-7.

Based on the premise that good retirement requires good planning, this booklet is a "do-it-yourself" planner that can be used at home and is designed to be used with one other person, e.g., spouse, friend or counselor. The booklet covers financial, leisure, and housing planning and includes a form for contacting the Social Security Administration.

"The Fitness Challenge . . . in the later years: An Exercise Program for Older Americans." Superintendent of Documents, USGPO, Washington, DC 20402. Stock No. 017-026-00009-3.

Prepared by the President's Council on Physical Fitness and Sports and the Administration, this pamphlet outlines three exercise programs graded according to difficulty and designed to help the elderly take advantage of their later years as active years. Simple tests to access one's present level of exercise tolerance and supplementary notes on adults' physical fitness are included.

"Facts and Myths About Aging"

"Fact Book on Aging"

"Your Retirement Consumer Guide"

"Your Retirement Legal G ide"

"Your Retirement Psychology Guide"

"Your Retirement Health Guide"

"Your Retirement Money Guide"

"Your Retirement Income Tax"

"Your Retirement Anti-Crime Guide"

"Your Retirement Hobby Guide"

"Your Retirement Widowhood Guide"

"Your Retirement Home Repair Guide"

"Your Retirement Safety Guide"

"Your Retirement Housing Guide"

"Your Retirement Information Guide"

"Senior Citizens Book of Good Health"

"Save Energy: Save Money"

"The Consumer Information Catalog"

"A List of Guidebooks for Handicapped Travelers"

"Handle Yourself with Care: Accident Prevention for Older Amricans"

"On Being Afone"

"Advocacy in the Field of Aging"

"Legal Services for the Elderly"

"Cases and Materials on Medicare"

"Materials on the Rights of the Elderly"

"Tax Benefits for Older Americans"

"Your Medicare Handbook"

"Medicaid, Medicare Which is Which?"

"Facts about Hearing and H. aring Aids"

"Grief Intervention and the Helping Professional"

"Independent Living for the Handicapped and the Elderly"

"Senior Power: A Political Action Handbook for Senior Citizens"

"Pointers for the Veterans with Military Service before February 1, 1955, and Their Dependents"

"Cooking for Two"

"Food Guide for Older Adults"

"The Food Stamp Program"

"Tax Facts, 1977, for Older Americans"

"The Law and Aging Manual"

"You, the Law, and Retirement"

"Let's End Isolation"

"Your Rig' t to Question the Decision on Your Hospital Insurance Claim"

"Your Right to Question Your Medical Insurance Payment"

"How to Complete the Request for Medicare Payment"

"Home Health Care under Medicare"

"Medicare Coverage in a Skilled Nursing Facility"

"If You Become Disabled"

"How to Choose a Nursing Home"

"Nursing Home Care"

"You Can Work and Still Get Social Security Checks"

"A Woman's Guide to Social Security"

"How SSI Can Help"

"Estimating your Social Security Check"

"Social Security Benefits - Including MEDICARE"

"Social Service Definitions for Title VII of the Older Americans Act"

"Guidelines for a Telephone Reassurance Service"

Sources of Funding Information

A National Guide to Government and Foundation Funding Sources in the Field of Aging. Lilly Cohen and Marie Opedisan-Reich, Eds. The Adelphi University Press, Adelphi University, Garden City, NY 11540.

A 175-page reference for planners and fund seekers in aging. Comprehensive information on over 85 federal fundings programs by category; federal, regional, and local contacts are included. A description of 125 national, regional and local foundations and a record of 500 grants awarded in aging from 1972 to 1976 is presented.

Catalog of Federal Domestic Assistance. Superintendent of Documents, U.S. Government Printing Office. Washington, DC 20402. $17.00

The CFDA is the basic tool for researching sources of federal grant assistance. This 1,000-page plus document provides a complete listing of government programs and is cross-referenced in a number of ways. Includes information on who is eligible, how to apply, and application deadlines.

The Federal Register. Superintendent of Documents, U.S. Government Printing Office. Washington, DC 20402. $50 a year.

The Register tells what research is being funded this year. All proposed rules, regulations and advisory meetings must appear in the Register. It is published daily and indexed monthly. A subscription includes Code of Federal Regulations.

United States Government Manual.

The Foundation Directory

The Foundation News.

The Grantsmanship Center News.

The Foundation Grants Index.

Preparing Instructional Objectives.

Fund Development and Technical Assistance Biweekly Newsletter.

Periodicals Pertinent to Older Persons

Active Times Published by the Society for Pre-retirement Program Planners. Quarterly. Year subscription $7.50 Society for Pre-retirement Program Planners. 2040 North 50th Ave., Omaha, NE 68104

The publication is directed toward program planners, counselors, directors of programs and students in the field of preretirement planning and aging. Pertinent articles, model counseling programs and resource leads are included.

Current Literature on Aging. National Council on Aging. Quarterly. Subscription with NCOA membership or $5.00 for one year, $9.00 for two years, single copy $2.00. NCOA, 1828 L St., N.W., Washington, DC 20036.

Prepared by the NCOA library staff, this publications lists selected recent books and articles under subject headings (aged and aging, community organizations, education, employment, health, housing, institutional care, legislation, nursing homes, retirement, social welfare, etc.).

Adult Leadership

Aging

Aging and Human Development

American Journal of Sociology

American Sociolngical Review

Community Mental Health Journal

Counseling Psychology

Dynamic Maturity

Geriatrics

Gerontologist

Harvest Years

Human Development

Impact

Industrial Gerontology

Journal of American Geriatrics Society

Journal of Counseling Psychologist

Journal of Gerontology

Journal of Health and Human Behavior

Journal of Human Relations

Journal of Marriage and the Family

Journal of Personality and Social Psychology

Journal of Rehabilitation

Journal of Social Isues

Journal of Thanatology

MEMO Newsletter

Mental Hygiene

Modern Maturity

Omega

Personnel and Guidance Journal

Perspective on Aging

Rehabilitation Counseling Bulletin

Rehabilitation Literature

Retired Officer

Retirement Life

Social and Rehabilitation Record

Social Casework

Social Forces

Social Work

Suicide

Vocational Guidance Quarterly

Audiovisual Resources

Media on Aging: Bibliography. Pam Tilton-Alberts. Ed. A bibliography of over 850 titles of films, slides, tapes, filmstrips, video tapes, and plays dealing with gerontology. Nursing homes, retirement, transportation, health, services, and programs are included in the topics covered. The catalog annotates the entries and gives technical information about the film and how it can be obtained. New England Gerontology Center, 15 Garrison Avenue, Durham, NY 03824. #042. $6.50.

KWIC's Film Forum Series. Quarterly updated evaluations of films on aging. KWIC Project, Center for the Study of Aging, Box 3003, Duke Medical Center, Durham, NC 27710. $1.50 per issue.

Print and Audiovisual Resources. Institute of Gerontology, The University of Michigan--Wayne State. Annotated pamphlet of resources. 520 E. Liberty St., Ann Arbor, MI 48109.

Media Resources in Gerontology. Institute of Gerontology, The University of Michigan. Penelope Sahara. A complete manual of annotated listings of films, slides, videotapes and audiotapes. Addresses of distributors included. 520 E Liberty, Ann Arbor, MI 48109. 144 pages.

Sources of Information and Help--Some Useful Addresses

The following national organizations provide technical assistance, information and referral, policy advocacy, conduct research, and in some cases provide training in their area of concern.

AMERICAN ASSOCIATION OF HOMES FOR THE AGING. 1050 17th Street, N.W., Washington, DC 20036. The professional association organization of non-profit community-sponsored housing projects, homes for the aging and health-related facilities serving the elderly throughout the United States working to promote the professional skills and sensitivities of its members and offer interaction with congressional and federal agencies in developing policies conducive to the total welfare of older Americans.

NATIONAL ASSOCIATION FOR SPANISH-SPEAKING ELDERLY. 1801 K Street, N.W., Suite 1021, Washington, DC 20006 or 3875 Wilshire Blvd., Suite 401, Los Angeles, CA 90005. Older persons mass membership and professional association dedicated to articulating the social service needs of the Hispanic Senior Citizens.

NATIONAL ASSOCIATION OF COUNTIES AND NATIONAL ASSOCIATION OF COUNTIES RESEARCH FOUNDATION. 1735 New York Ave., N.W., Washington, DC 20006. An affiliate of local government representing the interests of county government at the national level, a top priority being a strong commitment in federal dollars to assure availability of services to older citizens.

NATIONAL ASSOCIATION OF HOME HEALTH AGENCIES. 8230 Forsyth, St. Louis, MO 63105. Represents home health and related agencies at the national level on home health care issues.

NATIONAL ASSOCIATION OF RETIRED FEDERAL EMPLOYEES. 1533 New Hampshire Ave., N.W., Washington, DC 20036. Older persons mass membership organization, restricted to those covered by Federal Civil Service, their spouses and survivors, representing the legislative interests of retirees from the federal government.

NATIONAL ASSOCIATION OF STATE UNITS ON AGING 1828 L Street, N.W., Suite 505, Washington, DC 20036. The professional association of State Units on Aging allowing them to act collectively and permitting informed and considered action between the States as a positive force to improve the status of older persons.

NATIONAL CENTER ON BLACK AGED, 1730 M Street, N.W., Washington, DC 20036. Offers consultation services to local and national aging organizations, is dedicated to developing a cadre of Black professionals in the field of gerontology, and encourages the development of leadership roles on the part of Blacks, low-income, and other minorities in planning and delivery of social services.

NATIONAL COUNCIL ON AGING 1828 L Street, N.W., Washington, DC 20036. Professional association and affiliation of organizations and individuals concerned about aging providing leadership and guidance in the development of services for the elderly and improving the quality of life for older persons.

NATIONAL COUNCIL OF SENIOR CITIZENS, 1511 K Street, N.W., Washington, DC 20005. Older persons' mass membership organization which promotes the interests of senior citizens by engaging in fact-finding analyses of issues, and by providing a responsive and articulate voice for the senior citizens to promote their general welfare.

NATIONAL INDIAN COUNCIL ON AGING, INC P O Box 2088, Albuquerque, NM 87103. An organization providing advocacy for the Indian and Alaska Native elderly, specifically to bring about the remedial action recommended at the National Indian Conference on Aging.

NATIONAL SENIOR CITIZENS LAW CENTER, 1709 West 8th Street, Los Angeles, CA 90017. A legal services support center providing assistance to legal service attorneys in local programs offering legal assistance to the elderly poor. Assists 29 states in developing legal services for the elderly under Title III of the Older Americans Act.

NATIONAL RETIRED TEACHERS ASSOCIATION/ AMERICAN ASSOCIATION OF RETIRED PERSONS, 1909 K Street, N.W., Washington, DC 20049. Older persons' mass membership organizations providing services and information to enhance enjoyment of life for retired persons and to benefit the community.

URBAN ELDERLY COALITION 1828 L Street, N.W., Washington, DC 20036. Affiliation of public agencies/officials or private agencies which represent a city to be an advocate in behalf of the urban elderly. The Coalition provides ongoing education of leaders and staff of urban area offices on aging.

ADMINISTRTION ON AGING, U.S. Department of Health, Education and Welfare, Office of Human Development, North Building, Washington, DC 20201. Clearinghouse on Aging provides information on services for the elderly in specific areas.

AREA AGENCIES ON AGING.

STATE AGENCIES ON AGING.

CENTER FOR STUDIES OF THE MENTAL HEALTH OF THE AGING, Division of Special Mental Health Programs, National Institute of Mental Health, 5600 Fishers Lane-Room 18-95, Rockville, MD 20852. Centralizes NIMH's efforts on behalf of the mental health of the aging by coordinating NIMH Divisions with support programs for research, training, and services, analyzing NIMH research, training, and service programs and recommending the extent to which such mechanisms should be developed.

ASSOCIATION FOR GERONTOLOGY IN HIGHER EDUCATION, One Dupont Circle, Suite 520, Washington, DC 20036. A professional organization of educational institutions which provide research, professional and other related training and education for gerontology, and to provide a network of communication among such institutions.

GERONTOLOGICAL SOCIETY, One Dupont Circle, Suite 520, Washington, DC 20036. Professional association dedicated to promoting the scientific study of aging in the biological and social sciences, stimulating communication between researchers, teachers, professional and others and to broadening education in aging.

INTERNATIONAL CENTER FOR SOCIAL GERONTOLOGY, 426 13th St., N.W., Suite 350, Washington, DC 20004. A nonprofit research center to advance the social welfare of older people by encouraging and conducting research in various aspects of social gerontology; disseminating information on an international basis, and stimulating the development of training programs to prepare professional workers in the field of aging.

NATIONAL CONFERENCE OF STATE LEGISLATURES. 444 North Capitol St., N.W., Washington, DC 20001. Affiliation of public agencies and officials to improve the effectiveness and quality of state legislatures and to assure states a strong, cohesive voice in the federal decision-making process.

NATIONAL GOVERNORS' CONFERENCE. 444 North Capitol Street, Washington DC 20001. Affiliation of public agencies and officials to represent the interests of state government at the national level.

U.S. CONFERENCE OF MAYORS. 1620 Eye Street, N.W., Washington, DC 20006. Affiliation of public officials to promote the interests of big cities; to enhance municipal program development; and to disseminate information

WESTERN GERONTOLOGICAL SOCIETY. 785 Market Street, Rm. 616, San Francisco, CA 94103. Regional organization on aging dedicated to improving the quality of life of older persons through training, education, communication, and advocacy with older persons themselves and those serving older persons.

SELECT COMMITTEE ON AGING, U.S. HOUSE OF REPRESENTATIVES. Claude Pepper, Chairman, Room 712, HOB Annex 1, 300 New Jersey Ave., S.E., Washington, DC 20515. Subcommittees: Retirement Income and Employment, Health and Long-Term Care, Housing and Consumer Interests, Federal, State, and Community Services.

SELECT COMMITTEE ON AGING, U.S. SENATE. Frank Church, Chairman.

NATIONAL INSTITUTE ON AGING. National Institutes of Health.

Books

Aging and the Aged. Fred Cotrell. Wm. C. Brown Co., Iowa, 1974.

This short book was intended for persons wanting to learn about aging from a sociological point of view. It succinctly covers the processes of aging: health, income, employment, retirement, social, political, friends, family, neighbors, and religion

Aging and Mental Health: Positive Psychosocial Approaches. Robert N Butler and Myrna I. Lewis. St Louis, MO Mosby, 1973.

This text is written about the struggle for quality mental health care of the elderly. Of particular interest to counselors are chapters 9, 10, and 12 dealing with evaluation, keeping the individual at home, and psychotherapy respectively.

Sexuality and Aging. Irene Burnside.

Mental Illness in Later Life. Ewald Busse and Eric Pfeiffer.

Why Survive? Being Older in America. Robert N. Butler.

Sex After Sixty. Robert N. Butler and Myrna I. Lewis.

The Coming of Age. Simone de Beauvoir.

The Psychology of Adult Development and Aging. Carl Eisdorfer and M. Powell Lawton.

Sex in Later Life. Ivor Felstein.

The Psychological Aspects of the Aging Process: With Sociological Implications. Warren H. Green.

The Later Years: Social Applications of Gerontology. Richard A. Kalish.

Middle Age and Aging: A Reader in Social Psychology. Bernice L. Neugarten.

Model Programs

Two Years with Eight Patients: The Evolution of a Therapeutic Environment. Vivien LaRue. Institute of Gerontology, University of Michigan, 520 E. Liberty St., Ann Arbor, MI 48109. 1973, 39 pages. $1.95.

The author describes a 24-month transformation of a therapeutic program involving older patients in a goal-oriented activity milieu.

"On Widowhood: A Discussion," David Blau, *Journal of Geriatric Psychiatry*, 8(1): 29-440, 1975.

A mutual help program for elderly widows is described in which widow helpers who had adapted well to their own bereavement were utilized.

Social Interaction Groups in a Therapeutic Community.

Programs for the Elderly.

Mental Hospital Programs.

Research and Demonstration Projects in Medical Care Facilities.

Challenging Residents to Assure Maximal Responsibilities in Homes for the Aged.

Treatment of Depression in Persons Residing in Homes for the Aged

The Development of a Community-Based Program for Evaluating the Impaired Older Adult

Protecting the Vulnerable Adult.

Effective Social Services for Older Americans.

Catawba Hospital Handbook for Facilitators.

A Therapeutic Milieu for Geriatric Patients.

A Way of Examining Practices in a Treatment Setting.

Activities in a Treatment Setting.

NOTES

KEY PROJECT STAFF

The Competency-Based Career Guidance Module Series was developed by a consortium of agencies. The following list represents key staff in each agency that worked on the project over a five-year period.

The National Center for Research in Vocational Education

Harry N Drier ..... Consortium Director
Robert E Campbell ..... Project Director
Linda A Pfister ..... Former Project Director
Robert Bhaerman ..... Research Specialist
Karen Kimmel Boyle ..... Program Associate
Fred Williams ..... Program Associate

American Institutes for Research

G Brian Jones ..... Project Director
Linda Phillips-Jones ..... Associate Project Director
Jack Hamilton ..... Associate Project Director

University of Missouri-Columbia

Norman C Gysbers ..... Project Director

American Association for Counseling and Development

Jane Howard Jasper ..... Former Project Director

American Vocational Association

Wayne LeRoy ..... Former Project Director
Roni Posner ..... Former Project Director

U.S. Department of Education, Office of Adult and Vocational Education

David Pritchard ..... Project Officer
Holli Condon ..... Project Officer

A number of national leaders representing a variety of agencies and organizations added their expertise to the project as members of national panels of experts. These leaders were--

Ms Grace Basinger
Past President
National Parent-Teacher Association

Dr Frank Bowe
Former Executive Director

Ms Jane Hazeghi
Educetion Coordinator
American Coalition of Citizens with Disabilities

Mr Robert L Craig
Vice President
Government and Public Affairs
American Society for Training and Development

Dr Walter Davis
Director of Education
AFL-CIO

Dr Richard DiEugenio
Senior Legislative Associate
(representing Congressman Bill Goodling)
House Education and Labor Committee

Mr Oscar Giernes
Administrator (Retired)
U S Department of Labor
Division of Employment and Training

Dr Robert W Glover
Director and Chairperson
Federal Committee on Apprenticeship
The University of Texas at Austin

Dr Jo Hayslip
Director of Planning and Development in Vocational Rehabilitation
New Hampshire State Department of Education

Mrs Madeleine Hemmings
National Alliance for Business

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Pennsylvania State University

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Professor Emeritus
Rutgers University

Dr David Lacey
Vice President
Personnel Planning and Business Integration
CIGNA Corporation

Dr Howard A Matthews
Assistant Staff Director
Education (representing Senator Orin G Hatch)
Committee on Labor and Human Resources

Dr Lee McMurrin
Superintendent
Milwaukee Public Schools

Ms Nanine Meiklejohn
Assistant Director of Legislation
American Federation of State County and Municipal Employees

Dr Joseph D Mills
State Director of Vocational Education
Florida Department of Education

Dr Jack Myers
Director of Health Policy Study and Private Sector Initiative Study
American Enterprise Institute

Mr Reid Rundell
Director of Personnel Development
General Motors Corporation

Mrs Dorothy Shields
Education
American Federation of Labor/ Congress of Industrial Organizations

Dr Barbara Thompson
Former State Superintendent
Wisconsin Department of Public Instruction

Ms Joan Wills
Director
Employment and Training Division
National Governors' Association

Honoreble Chalmers P Wylie
Congressman/Ohio
U S Congress

Developed By

Competency-Based Career Guidance Modules

CATEGORY A: GUIDANCE PROGRAM PLANNING
- A-1 Identify and Plan for Guidance Program Change
- A-2 Organize Guidance Program Committee/Team
- A-3 Collaborate with the Community
- A-4 Establish a Career Development Theory
- A-5 Build a Guidance Program Planning Model
- A-6 Determine Client and Environmental Needs

CATEGORY B: SUPPORTING
- B-1 Influence Legislation
- B-2 Write Proposals
- B-3 Improve Public Relations and Community Involvement
- B-4 Conduct Staff Development Activities
- B-5 Use and Comply with Administrative Mechanisms

CATEGORY C: IMPLEMENTING
- C-1 Counsel Individuals and Groups
- C-2 Tutor Clients
- C-3 Conduct Computerized Guidance
- C-4 Infuse Curriculum-Based Guidance
- C-5 Coordinate Career Resource Centers
- C-6 Promote Home-Based Guidance
- C-7 Develop a Work Experience Program
- C-8 Provide for Employability Skill Development
- C-9 Provide for the Basic Skills
- C-10 Conduct Placement and Referral Activities
- C-11 Facilitate Follow-through and Follow-up
- C-12 Create and Use an Individual Career Development Plan
- C-13 Provide Career Guidance to Girls and Women
- C-14 Enhance Understanding of Individuals with Disabilities
- C-15 Help Ethnic Minorities with Career Guidance
- C-16 Meet Initial Guidance Needs of Older Adults
- C-17 Promote Equity and Client Advocacy
- C-18 Assist Clients with Equity Rights and Responsibilities
- C- Develop Ethical and Legal Standards

CATEGORY D: OPERATING
- D-1 Ensure Program Operations
- D-2 Aid Professional Growth

CATEGORY E: EVALUATING
- E-1 Evaluate Guidance Activities
- E-2 Communicate and Use Evaluation-Based Decisions

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