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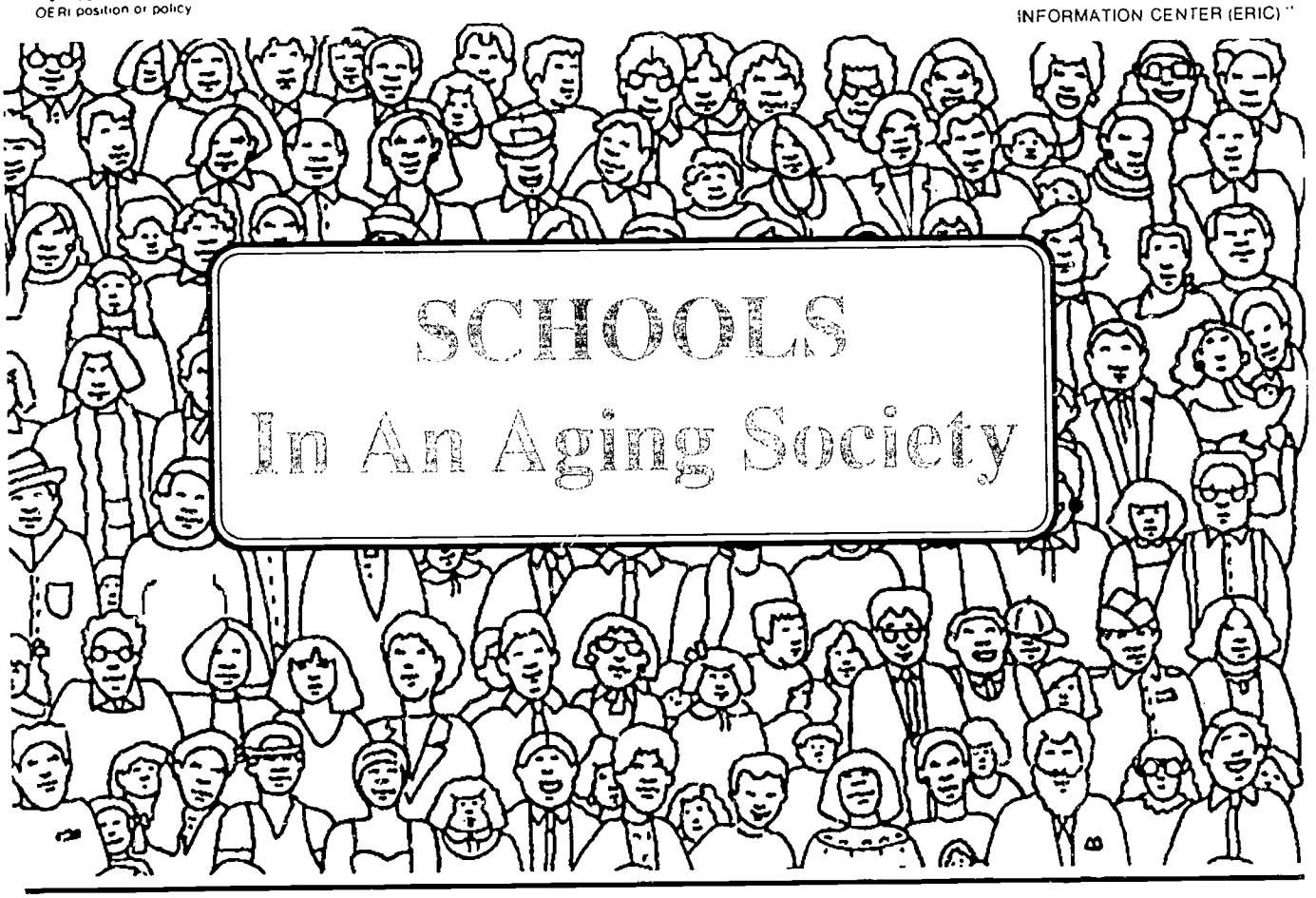
ABSTRACT

As the fastest-growing segment of society, older adults can be valuable resources for schools. The intent of this guide is to promote education for, with, and about older adults; to confront stereotypic images; and to present an accurate and balanced view of aging. The manual consists of 21 lesson plans for secondary teachers of health and home economics. Suggested activities are designed to address existing curricular objectives, promote interdisciplinary instruction, help students develop healthy attitudes toward their own aging, realize the lifelong importance of decisions they make as young adults, and understand the interdependence of all age groups. Lesson plans are divided into five sections. The first section, "Attitudes about Aging," addresses children's attitudes toward old people. The lessons in section 2, "Normal Aging Process," focus on physical and sensory changes in later life, psychological facts on aging, and myths about memory loss. Section 3, "Making Healthy Life Choices," deals with skin care, exercise, nutrition, healthy lifestyles, and alcohol abuse. The fourth section, "Intergenerational Issues," covers similarities between young and old, diversity in families, and stressful life events. The final section, "Home and Community Awareness," provides a home safety checklist and health and social service programs that help older adults in meeting their needs. Each lesson plan includes an introduction, objectives, key terms, materials, procedures, and extension activities. (LL)

HEALTH/HOME ECONOMICS CLASSROOM ACTIVITIES FOR SECONDARY SCHOOLS



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Schools In An Aging Society:

HEALTH/HOME ECONOMICS CLASSROOM ACTIVITIES FOR SECONDARY SCHOOLS

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CONTENTS

PREFACE

Young people need to be aware of the social, political and economic consequences of an aging society. Schools can prepare students with the necessary knowledge, skills and values to participate in this changing world. The intent of the series *Schools in an Aging Society* is to promote education for, with and about older adults. It consists of six interrelated guides.

Strengthening the School-Community Connection shows how schools can be more responsive to the larger community. It is especially beneficial in areas where an increasing proportion of residents are older and have no school-age children. The guide is designed for school administrators, volunteer coordinators, staff developers, and members of local boards of education who seek creative uses of community resources and want to increase intergenerational cooperation. It describes in detail AGES (Advancing Generations' Education through the Schools), a planning model that promotes awareness of older adults through staff development, intergenerational exchange projects, curricular activities, curriculums on aging, and classroom and extracurricular activities. Eight steps are followed in designing an AGES program at either a systemwide or individual school level. Issues such as recruitment, follow-up, and continuity of projects are addressed. The program benefits students, teachers and older residents with minimal resource commitments from any one group.

As the fastest-growing segment of society, older adults can be valuable resources for schools. *Elders as Resources* develops a rationale for intergenerational programs that address the educational and social needs of younger and older persons. Older adults can offer their expertise and experiences to enrich educational programs, as well as satisfy their own needs for meaningful social roles. Younger persons benefit from older persons who serve as positive role models and mentors. *Elders as Resources* suggests seven intergenerational models for classroom teachers. Practical suggestions are given for planning intergenerational programs, facilitating intergenerational discussions and conducting oral history interviews.

The challenges for our society require educators to confront stereotypic images of older adults and to present an accurate and balanced view of aging. Three *Classroom Activities* guides in this series consist of lesson plans for secondary teachers of health and home economics, language arts, and social studies. The suggested activities are designed to address existing curricular objectives and require minimal preparation time. Although learning activities are separated by discipline, teachers are encouraged to use information in other content areas. Since aging is an interdisciplinary subject, many activities would be appropriate in several subjects as well as for promoting interdisciplinary instruction. The activities are intended to help students develop healthy attitudes toward their own aging, realize the lifelong importance of decisions they make as young adults, and understand the interdependence of all age groups.

Finally, a *Guide for Pupil Personnel Specialists* provides age-related information on the changing family and workplace. It is appropriate for school counselors, psychologists and social workers. Changes in family structure, such as fewer children and more older persons, mean that students have different family experiences and needs than young people of past generations. An increasing number of young people are

(continued)

in homes where primary care is provided to their grandparents. Also, a growing number of children are under the primary care of their grandparents. Additionally, career opportunities and the workplace are affected by the aging society. School counselors are in a unique position to help young people by working with students individually, in the classroom, with families, and through school-community programs.

Schools and community organizations can act as catalysts for promoting a supportive social and economic environment for successful aging. The benefits extend to future generations of older people.

ACKNOWLEDGMENTS

The six-part *Schools in an Aging Society* series was developed as part of the Connecticut Aging Awareness Project, a joint effort of the Connecticut State Department of Education and State Department on Aging. The project was funded by the United States Administration on Aging and ITT Hartford Insurance Group.

Laura Donorfio, project assistant, contributed in countless ways to the development of these materials, including researching topics, typing, reviewing, editing and organizing material.

David Shuldiner, humanities program coordinator for the Connecticut State Department on Aging, was the lead author of the guide, *Elders as Resources*. He worked closely with educators and social service agencies to provide intergenerational program recommendations.

Mark A. Edinberg, originator of AGES (Advancing Generations' Education through Schools), was the lead author of *Strengthening the School-Community Connection*. He worked closely with schools that have implemented the AGES planning model.

The ideas found in the discipline guides of *Schools in an Aging Society* come from many individuals whose contributions may not be acknowledged here, but whose efforts are greatly appreciated. Numerous ideas were generated from outstanding educators participating in Connecticut's Institute for Teaching and Learning over the past four years. The following educators served in advisory capacities and provided background information, classroom suggestions and organizational ideas for the *Classroom Activities* guides.

Jean Ann Anliker, University of Connecticut Cooperative Extension System
Diane Arifian, Brookfield High School
Clare Barnett, Danbury public schools
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Rachel Bird, Fairfield High School
Kathy Brophy, State Department of Education
Ronald Burke, Vernon public schools
Jean Burkus, Amity Regional Junior High School, Orange
Marsha Casey, Conard High School, West Hartford
Gina Cristalli, Elmwood Senior Center, West Hartford
Jo Ann Hoff, State Department of Education
Jan Horn, Manchester Board of Education
Jim Horton, Cromwell High School
Patricia Jacqueline, Windsor High School
Michael Krochmalny, State Department of Motor Vehicles
Christine Lewis, Connecticut Department on Aging
Rita Madigan, Bridgeport Central High School
Linda Masterson, Canton High School
Kevin Mahoney, Office of Policy and Management
Debra Neary, Rainbow Family Day Care, Southington
Mary Nietupski, Connecticut Bar Association

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David O'Connor, E.O. Smith High School, Storrs
Frances Pass, Bloomfield public schools
Judith Sellers, Uncas on the Thames
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Helen Silchenko, Bloomfield High School
Selina Strong, Fairfield Parent-Teacher Association
John Sutherland, Manchester Community College
Jean Wells, Glastonbury High School
Bob Wessman, Plainville High School
Peter Wild, Glastonbury public schools
Deb Zak, State Department of Education

Other ideas for classroom activities were developed from efforts of national leaders in the field of aging education, most notably Fran Pratt, director of the Center for Understanding Aging in Southington, Conn. He offered valuable suggestions as an outside reviewer of the materials.

Bruce Craig, aging program specialist for the U.S. Administration on Aging, offered helpful suggestions and encouragement throughout the development of these materials.

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Don Goranson, editor, Division of Teaching and Learning, with the assistance of Janet Montague, made appropriate changes both in style and content and prepared the manuscripts for publication.

Donna P. Couper, Director and Principal Writer
Connecticut Aging Awareness Project

Daniel W. Gregg, Consultant in Social Studies
Connecticut State Department of Education

LESSON 1
How Old Is Old?

Introduction

Aging is a gradual process which begins at birth. While there are several universal aspects of aging (such as physiological changes in skin, hair, senses and internal organs), people age differently. Many factors affect how an individual ages, including gender, heredity, education, occupation, diet, exercise, family life, socioeconomic status and lifestyle choices.

Although age is merely a measure of time, it has significant social meanings and implications. Different cultures and historical periods have different perceptions of age. Perceptions of age also change as individuals themselves age, so that an 8-year-old would have different notions than an 80-year-old of what it means to be old.

This activity is appropriate for units on human development or human relations, or as an introduction to intergenerational activities.

Objectives

Students will:

- examine perceptions of *old*; and
- question popular notions about what it means to be old.

Key Terms

gerontologist, human development, middle aged, young-old, old-old, oldest-old; psychological age, physiological age, chronological age, legal age, social age

Materials

Handout: "How Old Is Old?" (see page 3)

Procedures

1. Introduce this activity by using the *Family Circus* cartoons on the handout. Then ask students to answer the questions. After they have answered the questions by themselves, they may compare answers with groups of students. The teacher then may ask student groups to reach a consensus on the answers.
2. Discuss student responses to the handout. In addition to the information in the introduction (above), emphasize the following points:

    - In earlier history, people thought in terms of two life stages – childhood and adulthood. Now people generally think of several life stages.
    - Childhood often is divided into subgroups such as infant, toddler, preschooler, school aged, preadolescent and adolescent. However, old age can span a period of 40 years – two or even three generations – even though 60-, 80- and 100-year-old persons differ considerably.
    - The period of adolescence begins earlier and ends later than it did even a few decades ago. It may even carry over into adulthood. An example of a characteristic of adolescence which extends into adulthood is financial dependence on parents, including many more young adults moving in with their parents.

- As more people live to be old, the perceptions of age are changing.
- The concept of middle age differs. One gerontologist described middle age as the time when a person stops counting how many years he or she has lived and starts counting how many years he or she has left to live.
- Most people have some sense of how long they think they might live. For persons who think they might live to be around 60 years old, middle age might be around 30. They would tend to have major life events, such as marriage and parenting, at earlier ages, while persons who anticipate longer lives would be more apt to postpone major events.
- Gerontologists now use old age subdivisions of *young-old* and *old-old*. Some add the subgroup *oldest-old*. The differences between a *young-old* person and an *old-old* person can be as great as those between an infant and an adolescent. There is little consensus on when *young-old* and *old-old* begin. Some people would have middle age begin at 50, while others might say *young-old* begins at 50. *Old-old* typically is placed around age 75. Some 75-year-olds, however, would prefer the demarcation to be at least 80.
- Sixty-five often is designated as the age at which people become *old* because this is the present age for collecting full Social Security benefits. This legal age tends to put people who are 65 and older into one category. It is similar to other arbitrary age divisions, such as age 18 for voting and age 12 for setting admission rates for children in museums and amusement parks. While it is convenient to have age divisions for administrative and political purposes, these divisions tend to reinforce stereotypes about age groups.
- The older a person is, the more different from others he or she becomes. Sixteen-year-olds vary among themselves more than 6-year-olds or certainly 6-month-olds. Because of their diverse backgrounds or life paths, older adults vary greatly among themselves.
- What is *old* depends on whether a person is talking about psychological age, physical age, chronological age, legal age or social age.

3. Conclude by asking students how their perceptions of teenagers have changed from when they were young children. In the *Family Circus* cartoons, Dolly will never become old. However, real people get old, and as we age our perceptions about *old* age changes.

Extension Activities

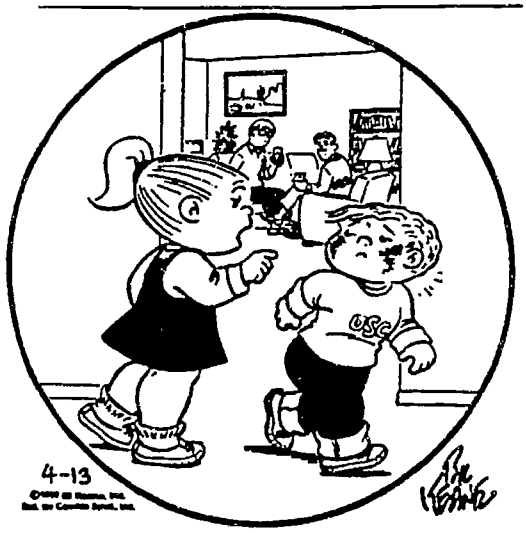
- Students can interview older persons (relatives or nonrelatives) to learn how their views about different ages have changed. For example, what do they think it means to be a teenager? What does it mean to be old? When they were younger, what did they think about being old?
- Discuss the disadvantages of age classifications. Note that they tend to promote stereotypes. They reinforce attitudes and behaviors which do not represent all individuals, thus making it difficult for persons who have the attitudes and behaviors that are expected of younger or older persons. For example, what about an 11-year-old who still likes to play with a toddler's toys? A 15-year-old who is seriously interested in starting her own business? A 65-year-old who wants to go to college?

How Old Is Old?

(For Use With Lesson 1 On Page 1)

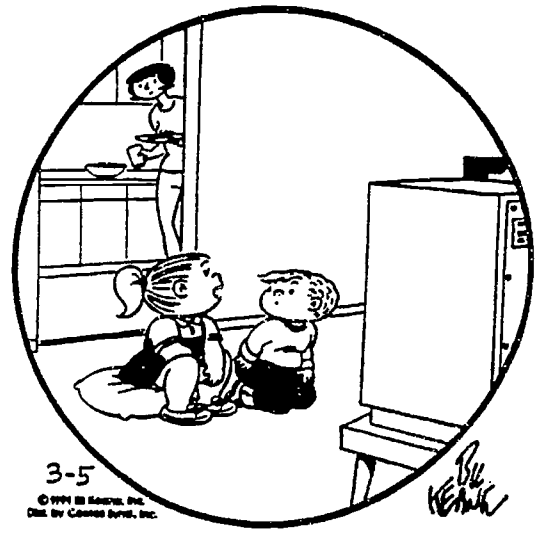
Dolly thinks old age begins at 30. What do you think?

Family Circus / By BIL KEANE



"You better treat Mr. Rice with 'spect. When you get to be 30 YOU'LL know what it's like to be old, too."

Family Circus / By BIL KEANE



"Senior citizens are very OLD people — like Mommy and Daddy."

1. On the line graph below indicate at what age you think a person:
   a. becomes a teenager;
   b. becomes an adult;
   c. becomes middle aged; and
   d. becomes old.

10 20 30 40 50 60 70 80 90 100

1_____1_____1_____1_____1_____1_____1_____1_____1_____1_____1

2. Why did you choose the age(s) you did for when a person becomes:

   a. a teenager?
   b. an adult?
   c. middle aged?
   d. old?

3. Overall, the best age is_____ because_____

_____

4. When does a person begin to age?_____

LESSON 2

Children's Attitudes Toward Old People

Introduction

People generally hold negative perceptions of aging. This activity illustrates that negative attitudes are pervasive among young children and raises questions about how attitudes are formed. It can be used with instructional units on child development, human relations and aging. This activity is appropriate for art, psychology, sociology, health and home economics classes.

Objectives

Students will:

- identify physical attributes associated with aging;
- compare stereotypical portrayals of young and old people; and
- realize that perceptions of older people are formed in the early years.

Key Terms

attitudes, stereotypes

Materials

Handouts: Set A (1 - 16), drawings of old people by young people; and Set B (1 - 12), drawings of young and old people by young people (see pages 6-15)

Procedures

1. Divide students into small groups. Distribute to each group Set A drawings. (To save time, give each group four or five different drawings from the set.) Ask students to list characteristics of old people as portrayed in the drawings. Student observations will include the following:

    - missing body and facial parts (hands, legs, feet, eyes, nose, mouth, ears);
    - distorted or withered body parts;
    - wrinkles;
    - canes, wheelchairs;
    - cigars or pipes;
    - hairstyle;
    - sad or grimacing face;
    - distorted or reduced body size;
    - disproportioned body parts (such as large body with small feet);
    - passive or no obvious activity; and
    - clothes, shoes, hats.

2. Distribute Set B drawings. Ask students to list similarities and differences between the young and old people in the drawings.

3. Based on procedures 1 and 2 above, discuss some perceptions of older and younger people, including personality traits and physical characteristics. Note that many negative portrayals of older persons may reflect attitudes of ambiguity, powerlessness and irrelevance toward aging.

4. Discuss possible sources of negative and positive attitudes, such as experiences with grandparents or viewing television characters. How might these attitudes affect the way children view their parents and themselves as they grow old? How might a person's attitudes about aging and aged persons change over time?

Extension Activities

- Before showing the class the sets of drawings, ask students to draw two pictures, one of a young person and one of an old person. Have the students compare their own drawings with those in Sets A and B (pages 6-15).
- Before using the two sets of drawings, ask students to draw sketches of themselves at different stages in their lives, beginning at birth, followed by 10-year intervals, until their death. If possible, provide students with large sheets of paper which they can divide into approximately eight to 10 sections, one for each life period.
- For additional art, health and psychology projects using drawings as a projective technique, teachers and students may refer to the following resources:

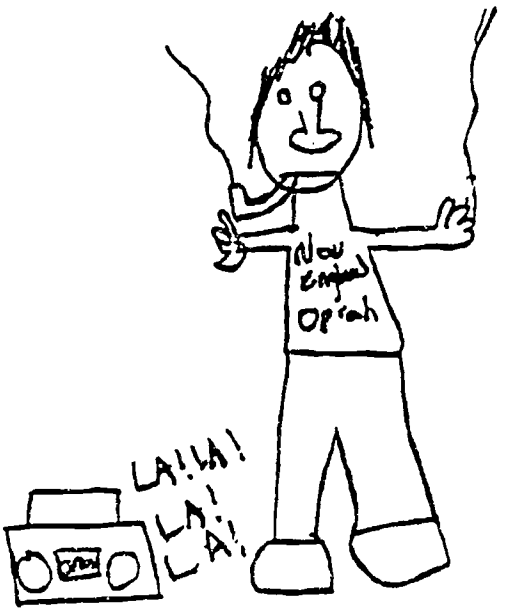
DiLeo, J. H. *Child Development: Analysis & Synthesis.* New York: Brunner/Mazel, 1977.

Koppitz, E. M. *Psychological Evaluation of Children's Human Figure Drawings.* New York: Grune & Stratton, 1968.

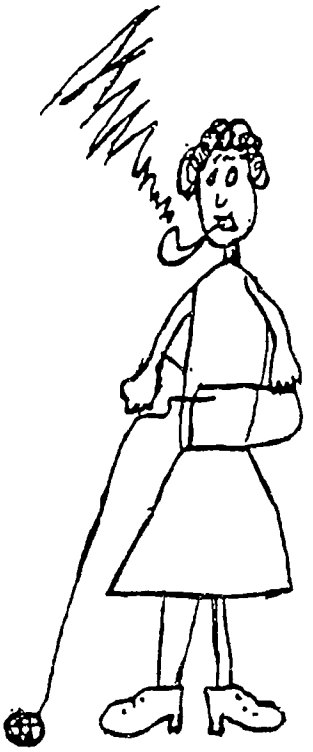
Machover, K. *Personality Projection in the Drawing of the Human Figure: A Method of Personality Investigation.* Springfield, IL: CC Thomas, 1991.

This activity was developed by Laura Donorfio,
project assistant for the Connecticut Aging Awareness Project.
Drawings in the handouts were part of her research at the
University of Connecticut on children's attitudes toward older people.

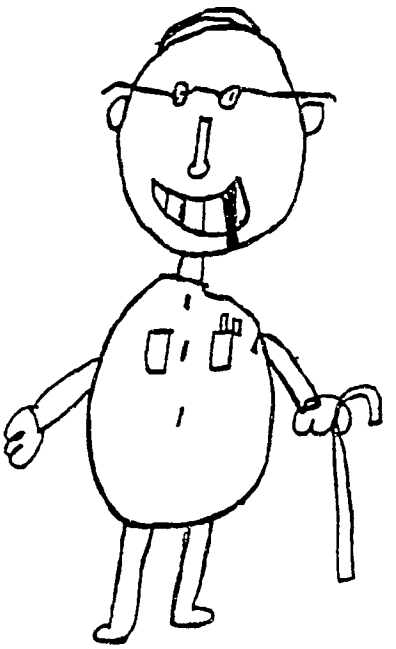
A1 7th Grade Girl



A2 5th Grade Girl

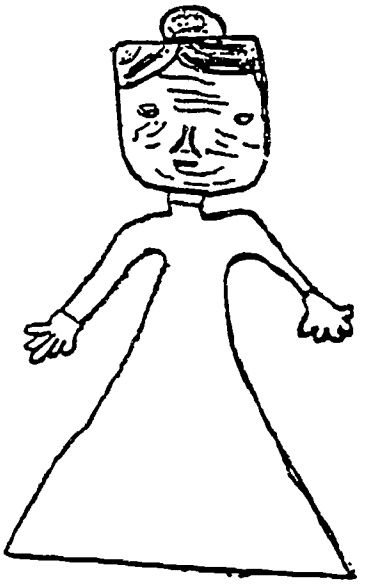


A3 7th Grade Girl

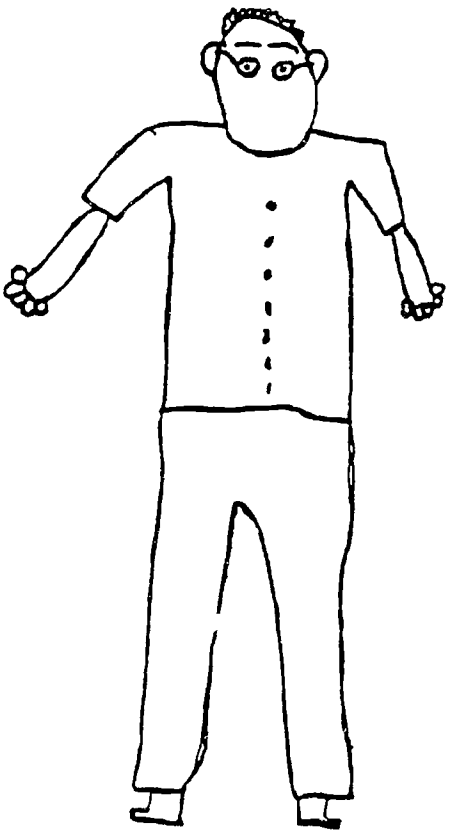


A4 5th Grade Girl

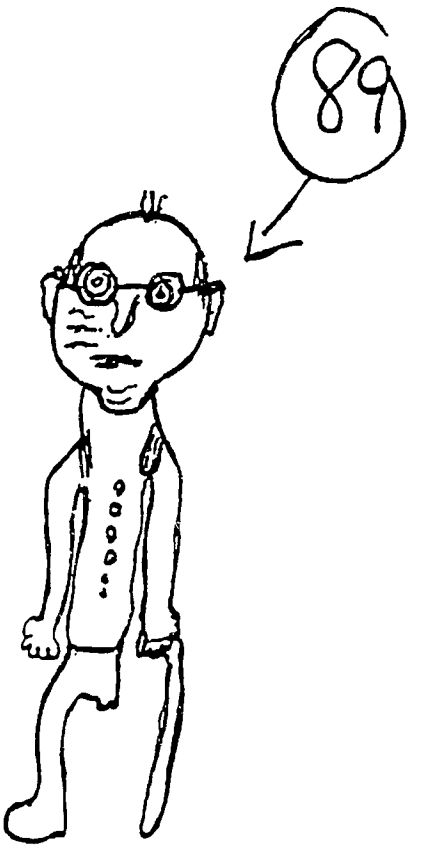
A5 7th Grade Girl



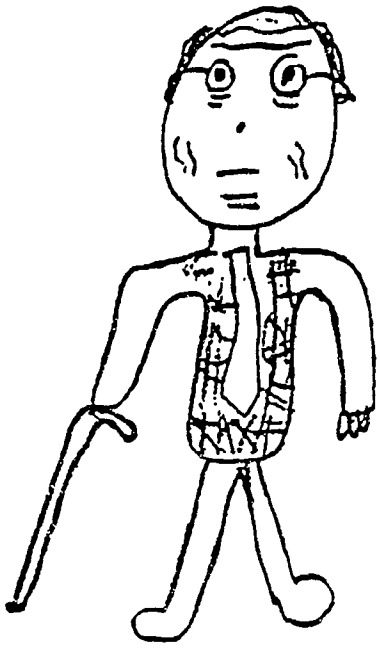
A6 5th Grade Girl



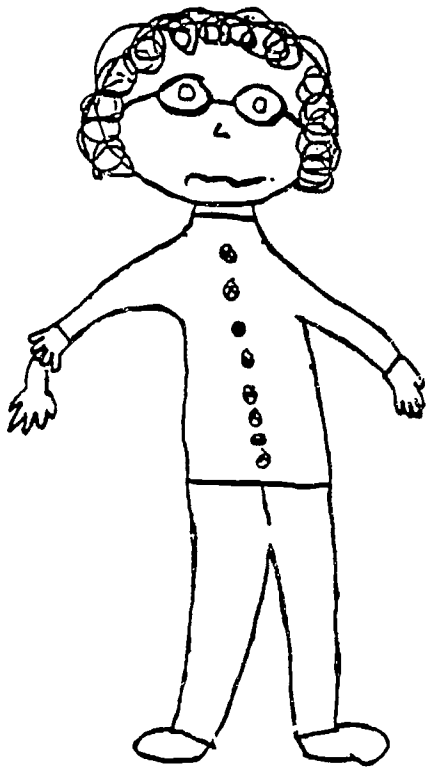
A7 5th Grade Boy



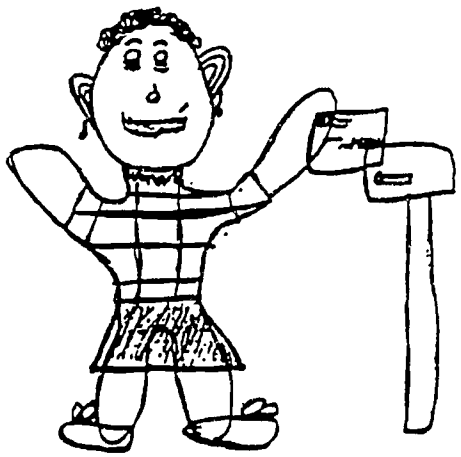
A8 7th Grade Boy



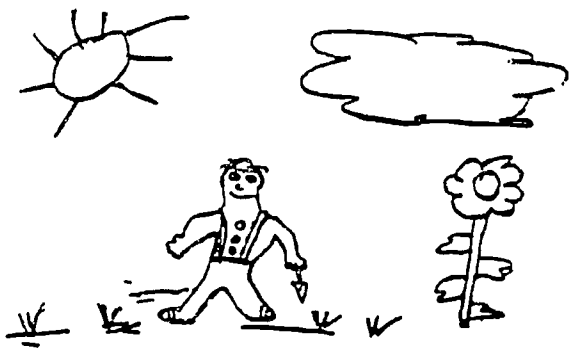
A9 5th Grade Boy



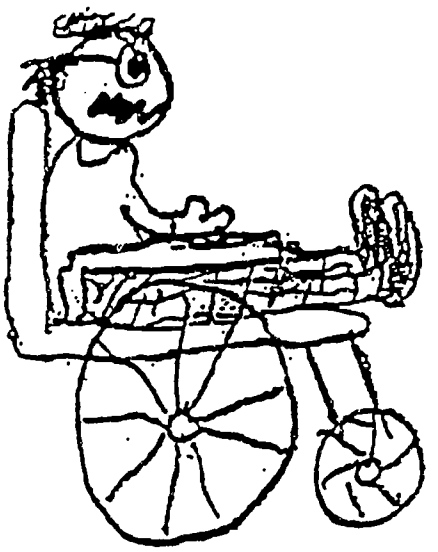
A10 3rd Grade Girl



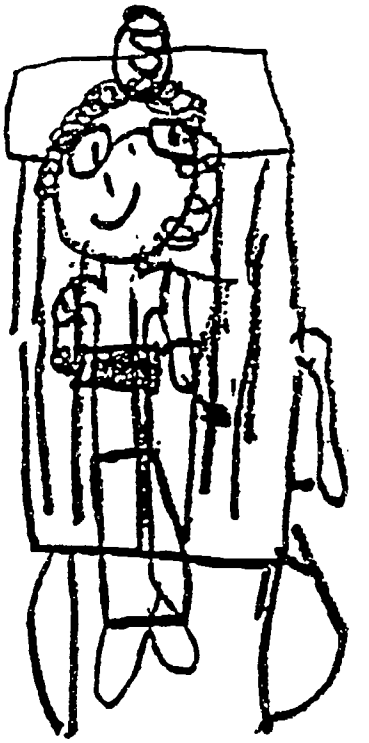
A11 3rd Grade Boy



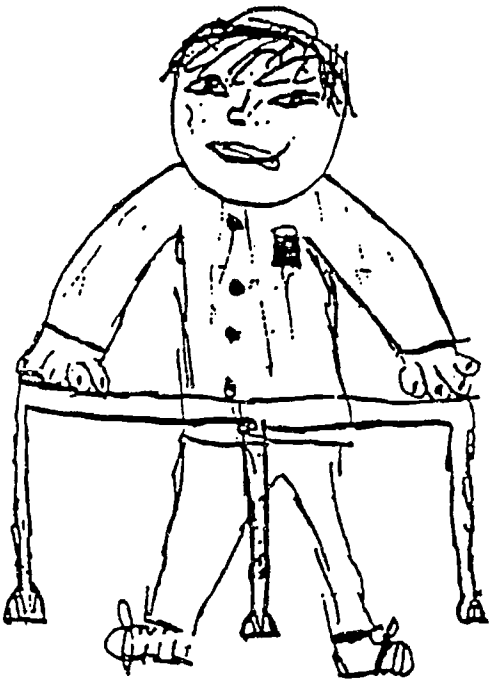
A12 5th Grade Boy



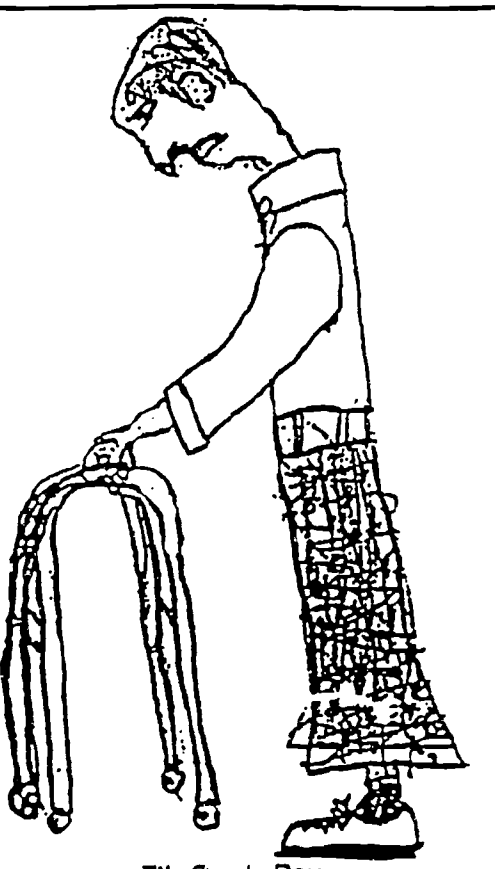
A13 7th Grade Boy



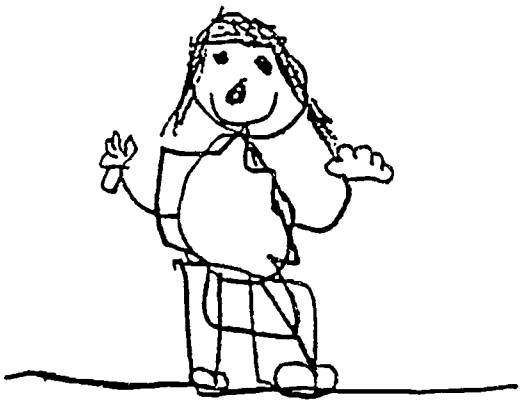
A14 3rd Grade Boy



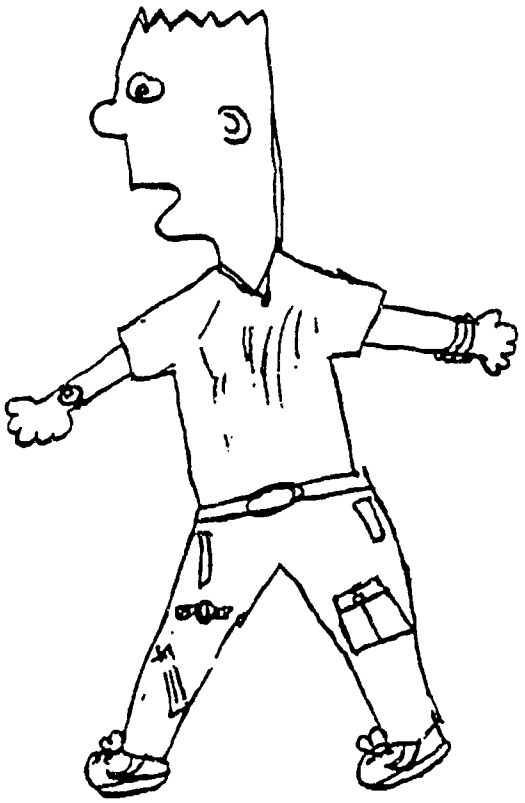
A15 7th Grade Boy



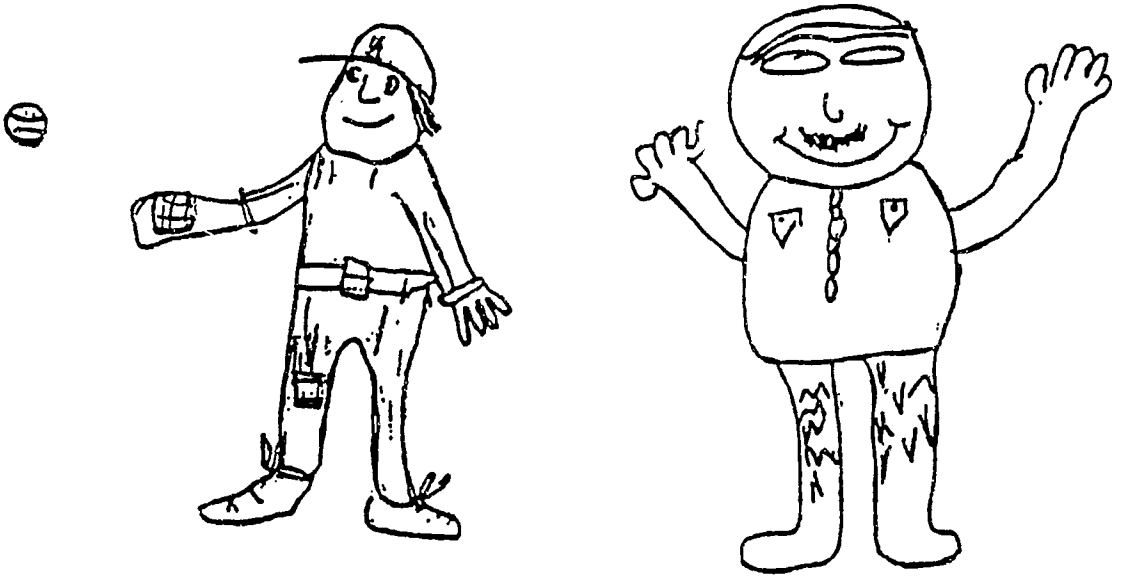
A16 7th Grade Boy



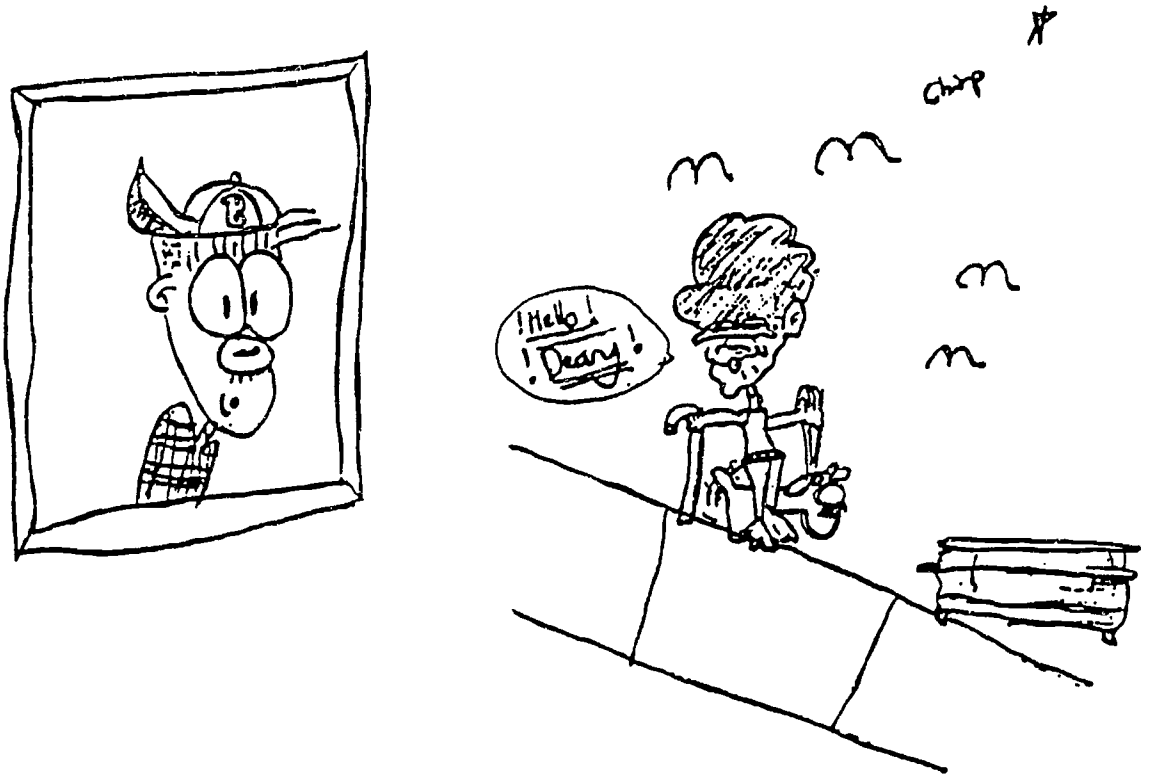
B1 Young 5th Grade Girl Old



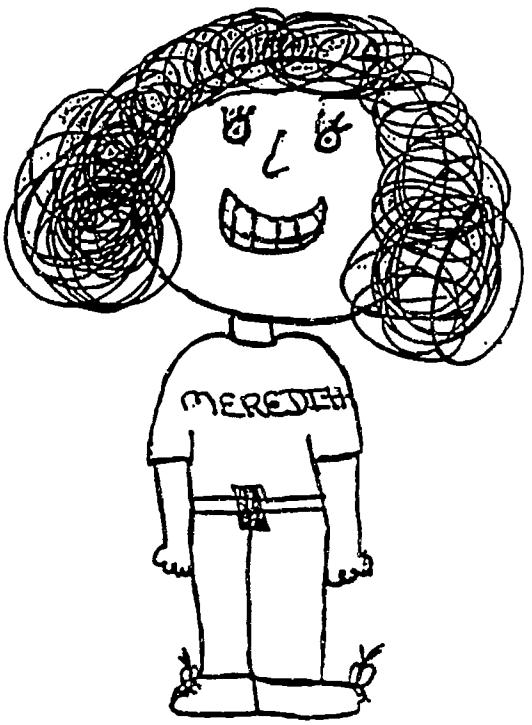
B2 Young 5th Grade Boy Old

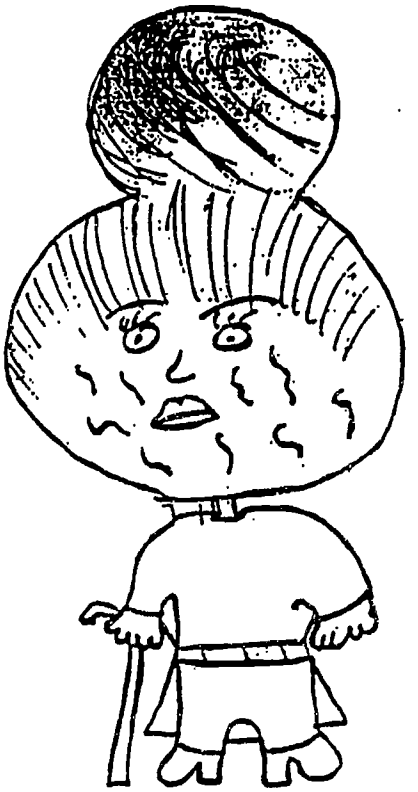


B3 Young 3rd Grade Boy Old

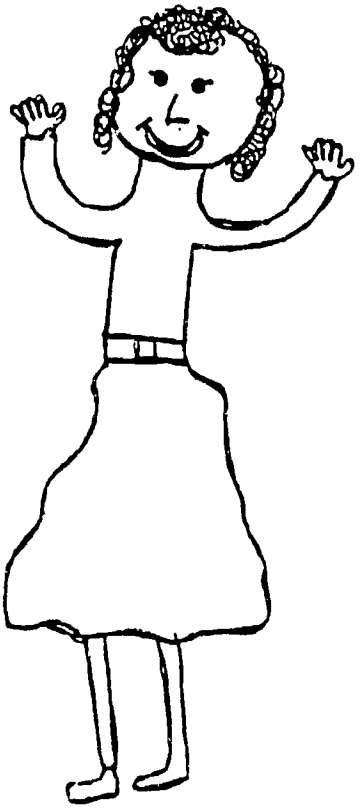


B4 Young 5th Grade Boy Old

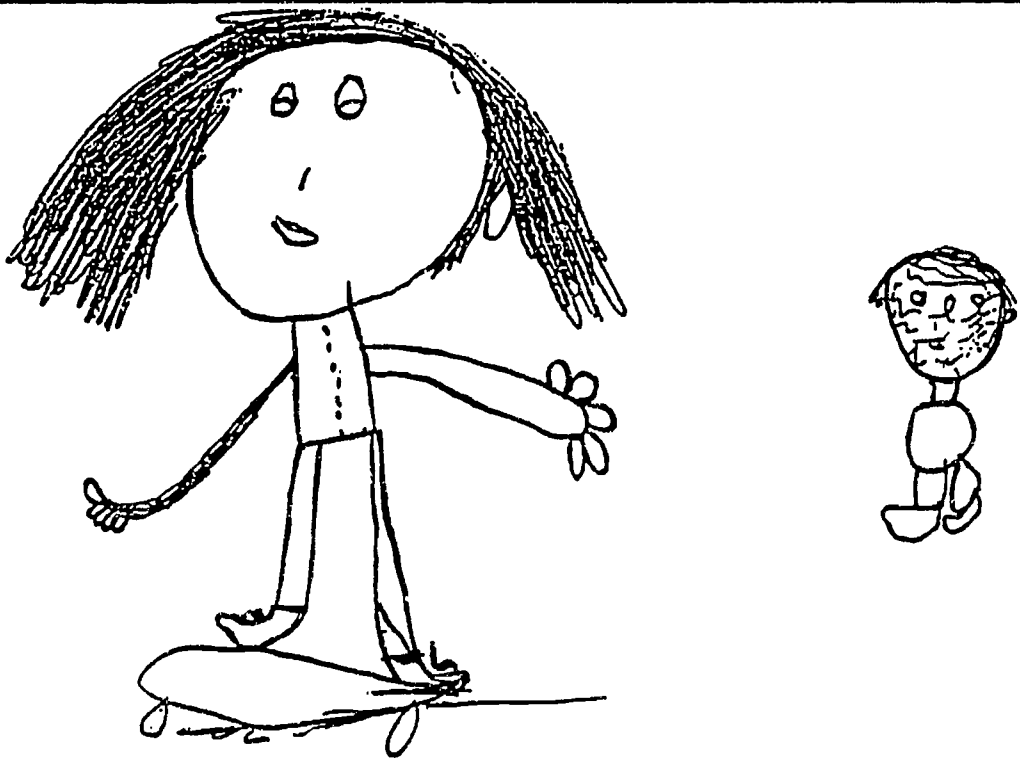




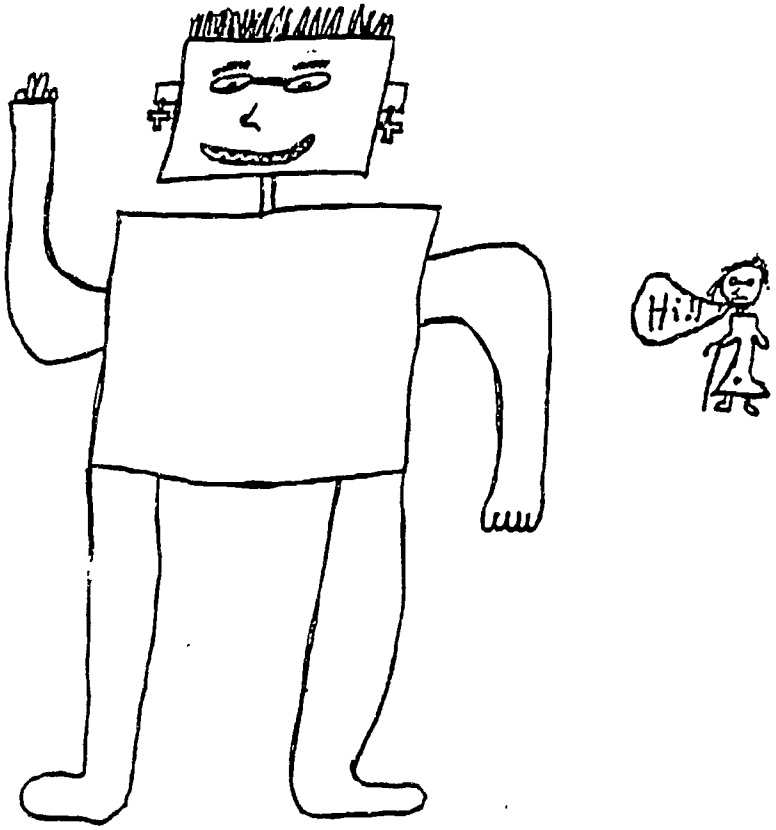
B5 Young 3rd Grade Girl Old



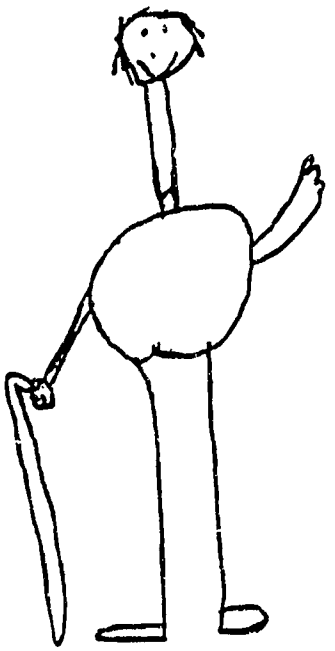
B6 Young 5th Grade Girl Old



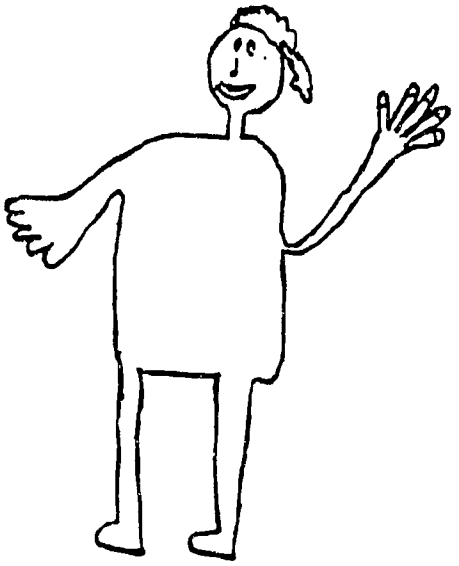
B7 Young 3rd Grade Boy Old



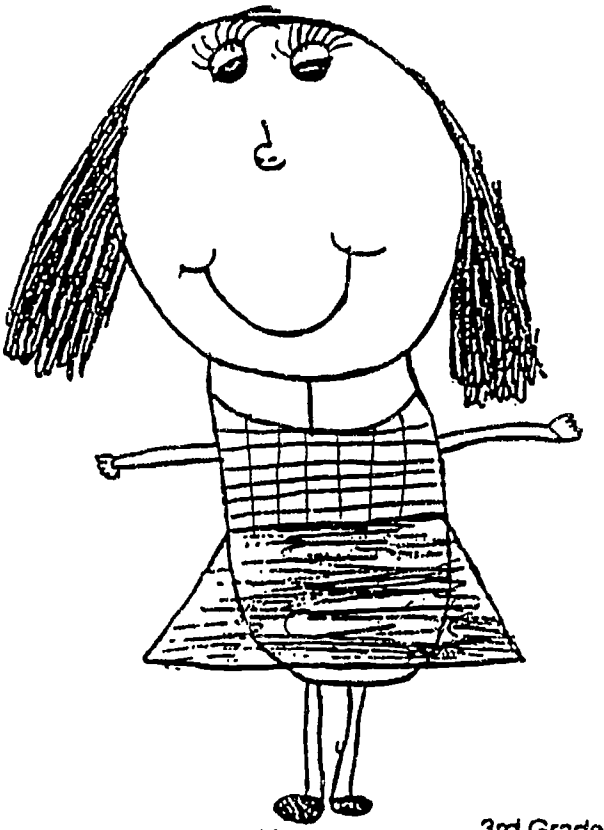
B8 Young 5th Grade Boy Old



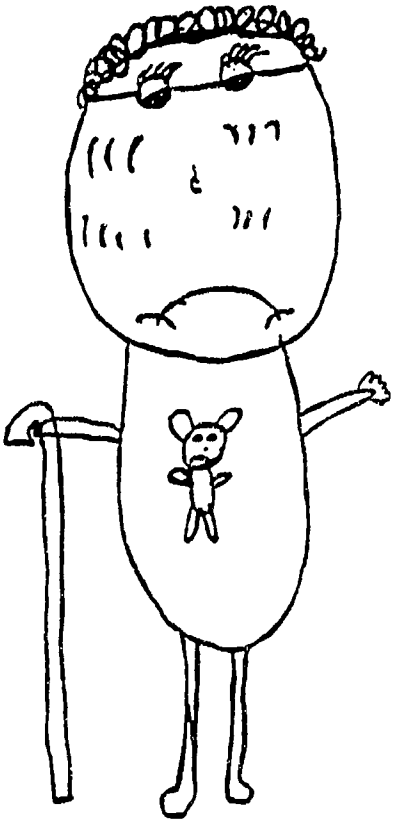
B9 Young 3rd Grade Boy Old

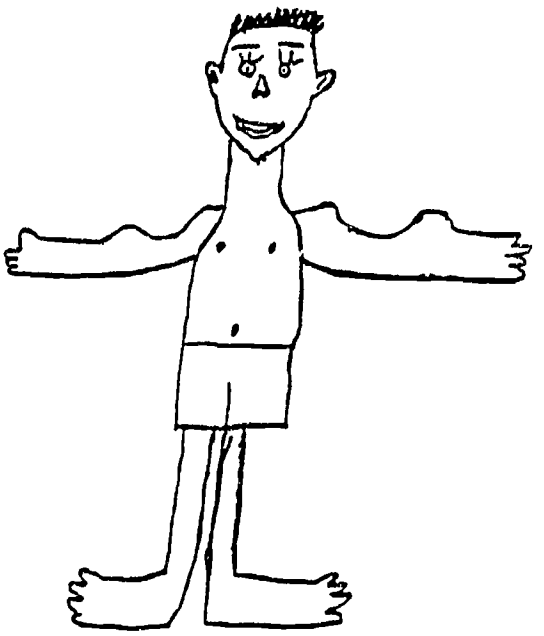


B10 Young 3rd Grade Boy Old



B11 Young 3rd Grade Girl Old





B12 Young 5th Grade Boy Old

LESSON 3

Attitudes About Aging: Using Your Imagination

Introduction

When individuals try to imagine themselves as being old, they usually see themselves as relatively healthy and active. When they imagine others as being old, they tend to see older and more frail persons. This activity illustrates different perceptions of *old* people. It can be used as an introduction to units on aging in health, home economics, psychology or sociology courses.

Objectives

Students will:

- identify common attitudes about older people; and
- recognize differences in perceptions of one's own old age and others' old age.

Key Terms

attitudes, perceptions, stereotypes, young-old, old-old

Procedures

1. Prepare students for a classroom exercise, using the following suggested model.

   The teacher reads the following: "For about five minutes or so you will imagine yourself in two different situations. I will guide you through the two scenes as you imagine them."

   (The teacher may want to dim the lighting in the room, either the overhead or the window light.)

   "You may lean back in your seats, look down, or you may even want to close your eyes."

   (Read the following in a calm, slow, even-pitched manner.)

   "In the first scene, imagine yourself driving in a car or riding in a car, depending on whether you are of driving age. You are riding along, not in a particular hurry, perhaps running an errand, or going to visit someone. And all of a sudden, you start to have car trouble. The car is making troublesome sounds from the engine, so you pull over to the side of the road and stop. You wonder what to do.

   "You get out of the car and walk to the nearest house to see if you can use a phone to call for help. You walk up to the house and knock on the door. No one answers. You knock again. Then an old person answers the door." (Do not exaggerate the word *old* but do read the sentence slowly and clearly, followed by a long pause.)

   "What does the person look like? . . . The face? . . . Expression? . . . Eyes? . . . Nose? . . . Mouth? . . . Hair? . . . Posture?

"What is the person wearing?

"Do you have any idea what the person was doing before you came to the door?

"Is there anyone else in the house? If so, who?

"As you look in the room behind the person, what do you see? . . . The light and darkness of the room? . . . Colors? . . . The furniture? . . . The walls? . . . Any pictures?

"Do you notice any unusual or strong smells or aromas?

"Do you hear any sounds or voices?

"How do you feel as you are about to explain your situation to the person?

"Now, for the next minute or so, imagine yourself in conversation with this old person. Explain your situation, make your request and notice the response."

(Allow at least 30 seconds.)

"Well, eventually you resolve your problem. The car is repaired and you are on your way.

"Clear your mind of this scene, because it is now many, many years later – 40, 50, 60, maybe even 70 years later.

"You are at home. A car drives by your home. It is making troublesome noises. The young driver pulls over, stops the car, walks to your place and knocks on the door a couple of times.

"You are the old person answering the door." (Long pause. Do not exaggerate the word *old* but speak in an even, slow voice.)

"What do you look like? . . . Your face? . . . Expression? . . . Eyes? . . . Nose? . . . Mouth? . . . Hair? . . . Posture?

"What are you wearing?

"What were you doing before answering the door?

"Is there anyone else in the house? If so, who?

"What does the young person at the door see in the room behind you? . . . The light and darkness of the room? . . . Colors? . . . Furniture? . . . Walls? . . . Any pictures?

"Are there any smells or aromas coming from your home which the stranger might notice?

"Any sounds or other voices?

"Now, for the next minute or so, imagine yourself as an old person in conversation with the person at the door. Notice your response and the person's reactions toward you."

(Allow at least 30 seconds.)

"Eventually the car problem is resolved and you now can come back to this time and place."

2. Have students in pairs describe their two old persons. Allow ample time for this, since students generally will have lively conversations.

3. Discuss the exercise with the entire class. The following are some leading questions:

    - Were any of you, for any reason, unable to picture an older person? (This does not occur often, but if so, acknowledge and accept. In some cases, mental distractions make it difficult to participate in this exercise. For some, it is difficult to visualize oneself as being old.)

    - In the first scene, how old would you say the old person was? 60? 70? 80? 90? (The first old person tends to be in the old-old category.)

    - How do you know the age of the old person? (Students usually identify physical characteristics which suggest age.)

    - How many of you saw a male? Female? (Observe any patterns in the class, such as males or females imagining same- or opposite-gender older persons.)

    - Was the person someone you know or like someone you know, such as a grandparent, parent, relative, neighbor or television personality? (Point out that we often base our images of what it is like to be old on experiences with older people we know. These personal role models may or may not be positive or realistic ones.)

    - Of those of you who saw old men, what did they look like? What were they wearing? (For example, some will see flannel shirts, overalls, sweaters or pipes.)

    - What was the person doing? (Note the level of activity or inactivity.)

    - What smells did you notice? (Common responses are mustiness or bread or cookies baking.)

    - How helpful was the old person? (Observe inferred personality attributes of the old person.)

(Repeat questioning for those who saw females. Compare images of old men and old women. Stereotypical images commonly consist either of grandmother or grandfather characters like the "sweet" old lady or man, or the "crabby" or frail older characters.)

(Repeat questioning for images of themselves as old. People are more likely to picture themselves as younger – young-old vs. old-old – and more active.)

- Why do you think we have these stereotypes of older men and women? Where do we get these ideas? Do stereotypes serve any useful purposes? Do you think older people tend to have a more positive view of themselves and their older friends than they do of a vague generalized image of an old person? (Note that older adults tend to have more negative attitudes of old people in general, while having more positive attitudes toward older individuals they know.) Which is a more accurate perception: how we see ourselves or how we see others? (Discuss perceptual subjectivity in both cases.) In what ways are stereotypes of older people like stereotypes of ethnic or other groups?

4. On the chalkboard write down main points which the class learned from the exercise, drawing conclusions from the students.

Extension Activity

- Have students write descriptions of the two older persons they imagined in the class exercise.

LESSON 4
Too Old? Or Something Else?

Introduction

Old age is unduly blamed for behaviors that are more rightly attributed to personality traits, personal preferences, health status or social restrictions. Age – young or old – is not a good explanation for why persons behave the way they do. This activity is appropriate for units on prejudice, human development and health.

Objectives

Students will:

- list behaviors that are considered inappropriate or difficult for older adults;
- identify multiple reasons why persons do or do not behave in certain ways; and
- understand the fallacy of attributing certain behaviors to old age.

Key Terms

attribution, attitudes

Materials

Family Circus cartoon (see page 22)

Procedures

1. Have students consider a list of activities for which they believe people become too old. Give one or two examples, such as too old to ride a motorcycle, too old to wear miniskirts or too old to drive a car. Students may work in small groups or the teacher may engage the entire class in a brainstorming activity.
2. Show the students a transparency of the *Family Circus* cartoon (page 22) which shows little Dolly saying her father is too old to go on a slide. Ask the students if Dolly's statement is accurate. Is her father really too old or are there other reasons why her father is not going on the slide? (Note that the accompanying cartoon includes text for teachers who may want to alter the activity by using printed handouts instead of a transparency.)
3. Allow students time to think about other explanations. Based on student responses, make a list on the chalkboard of other possible reasons why the father does not go on the slide. For example, the father may not be interested in sliding, is too big for the slide, would rather help his children have fun rather than have all the fun himself, thinks others might laugh at him, or does not want to get his shorts dirty like those of his youngest son.

4. Make the distinction between health and old age. In the cartoon, the father is in good health and is physically capable of going down the slide. However, if he were feeling sick or were physically impaired, would the reason for not going down the slide be that he is too old or that he is sick or physically impaired? While there is a correlation between old age and declining health, *old* does not mean *sick*. For example, we hear expressions like, "She does not look her age," or "He looks good for his age." Behind such comments is the implicit belief that when people get older, they become sickly or unhealthy. Much depends on the individual's lifestyle, diet and exercise – not just years of life.
5. Go back to the students' list of behaviors for which a person might be too old. For each behavior, identify other reasons why a person might not engage in the activity, using suggestions from the list of alternative attributions developed in procedure 3. Inquire as to whether students know or have read about older persons who do various activities that might be on their list, such as run marathons.
6. (Optional) Introduce the term *attribution* – the ways in which we understand the causes of our behavior and that of others. In our attempts to know the persons around us, we draw upon several sources of information. We observe people's behavior, then infer certain traits, motives or intentions. How old a person is may partially explain certain behaviors, but it is never the sole explanation. People's behavior usually can be explained through a variety of external causes (situations beyond a person's control) or internal characteristics (personal dispositions).
7. Give other examples of overly simplified attributions, based on stereotypes and prejudices related to gender or socioeconomic status.
8. Conclude with the main point: Old age is used to explain older persons' behaviors, but these are more accurately explained through numerous other external and internal causes. Age – young or old – is not a good explanation for why persons behave the way they do.

Too Old? Or Something Else?

(For Use With Lesson 4 On Page 20)

Family Circus / By BIL KEANE

"Poor Daddy. He's too old for sliding boards."

Dolly thinks her father is too old to go down the slide. But is Dolly's statement accurate? Is her father really too old, or are there other reasons why her father is not going on the slide? For example, the father might not be interested in sliding, is too big for the slide, or would rather help his children have fun rather than have all the fun himself. Perhaps he does not want to get his clothes dirty or thinks others might laugh at him.

Dolly's father is in good health and is physically capable of going down the slide. However, if he were feeling sick or were physically impaired, then would the reason he does not go down the slide be that he is too old or that he is sick or physically impaired? While there is a correlation between old age and declining health, *old* does not mean *sick*.

Old age is used to explain older persons' behaviors, which are more accurately explained through numerous other external and internal causes. Age – young or old – is not a good explanation for why persons behave the way they do.

LESSON 5

Facts On Aging: Physical And Psychological Health

Introduction

People of all ages generally lack accurate information about the physical and mental changes associated with aging. Accurate information can alleviate some of the fears one might have for older persons they know and for their own aging. This activity would be appropriate for units on health and human development.

Objectives

Students will:

- identify misconceptions about the aging process; and
- learn basic facts about physical and mental changes associated with aging.

Key Terms

life expectancy, chronic illness, acute illness, senility, sensory changes

Materials

Handouts: "Facts on Aging Quiz" and "Facts On Aging Answers" (see pages 24-26)

Procedures

1. Give students the "Facts on Aging Quiz," which is used as a teaching technique, not an assessment tool. Allow students to discuss in groups what they think are the correct answers.
2. With the entire class, go over the "Facts on Aging Answers," comparing students' answers and discussing general misconceptions about aging.

Extension Activity

- Have students give the "Facts on Aging Quiz" to their parents, grandparents or other adults. Discuss in class general attitudes and beliefs which adults have about aging.

Facts On Aging Quiz

(For Use With Lesson 5 On Page 23)

T F 1. A person's height tends to decline in old age.
T F 2. Persons over 65 have more chronic illnesses that limit their activities than younger persons.
T F 3. Older persons have more acute (short-term) illnesses than persons under 65.
T F 4. Older persons have more injuries in the home than persons under 65.
T F 5. Persons 85 and older have fewer car accidents than drivers between the ages of 16-44.
T F 6. The life expectancy of nonwhites at age 65 is about the same as whites.
T F 7. The life expectancy of men at age 65 is about the same as the life expectancy of women at age 65.
T F 8. The majority of older people (over 65) are senile.
T F 9. All five senses tend to decline in old age.
T F 10. Most older people have no interest in, or capacity for, sexual relations.
T F 11. Over 10 percent of the aged are living in long-stay institutions, such as nursing homes.
T F 12. Most families do not care about their older members and often abandon them.
T F 13. Older people take more medications than younger people.
T F 14. If a person has been smoking for 30 or 40 years, it does no good to quit.
T F 15. Older people should stop exercising so they do not wear out their muscle tissues or deplete their energy.
T F 16. Intelligence usually declines with old age.
T F 17. Older people usually take longer to learn something new.
T F 18. The reaction time of most older people tends to be slower than that of younger people.
T F 19. Most medical practitioners tend to give the aged a low priority.
T F 20. In general, most older people are very much alike.
T F 21. Personality tends to change with age, with older people being more easily provoked or agitated.
T F 22. Most older people are set in their ways and are unable to change.
T F 23. People tend to become more religious as they age.
T F 24. Although older people often express awareness of death in conversations, they generally are not fearful of it.
T F 25. Many grandparents take care of their grandchildren full time.

Facts On Aging Answers

(For Use With Lesson 5 On Page 23)

1. *True.* Height does tend to decline with age. Studies of 35 different populations around the world all show that persons in each decade of life over age 50 are shorter than persons in the previous decade. Some of these differences are due to cohort (generational) differences because later cohorts (generations) tend to be taller than earlier cohorts. However, all longitudinal studies (which repeatedly measure the same cohort over many years) show decreases in average height after age 55. This decrease appears to be caused mainly by changes in posture or "slump," and by decreases in the intervertebral discs.
2. *True.* More persons over 65 have chronic illnesses that limit their activity (43 percent) than younger persons (10 percent). Common chronic illnesses among older persons are arthritis (47 percent), hypertension (41 percent), heart disease (30 percent) and hearing impairment (29 percent).
3. *False.* Older persons have fewer acute illnesses than younger persons. There are 102 acute illnesses per 100 persons over age 65 per year, compared to 230 for persons under 65. Thus, the higher rate of chronic illnesses among the aged is partially offset by the lower rate of acute illnesses.
4. *False.* Older persons have fewer injuries in the home than persons under 65: 12 per 100 persons over 65 per year compared with 14 for persons under 65. The injury rate is especially high for children under 6: 26 per 100. This is why home safety features are important for all ages.
5. *True.* Older persons, age 85 and over, have fewer accidents per thousand drivers than persons in the 16-44 age groups. However, when the number of miles driven is taken into account, the National Safety Council reports that in 1985 drivers age 55 and older had more accidents than drivers in their middle years.
6. *True.* According to the U.S. Bureau of the Census, the life expectancy of nonwhites at age 65 is about the same as whites. In 1987 the average life expectancy at age 65 was 14 for white men, 14.1 for nonwhite men, 18.4 for white women, and 18 for nonwhite women. However, the life expectancy of nonwhites at birth is about four years less than that for whites at birth. This reflects a higher death rate among nonwhites during childhood and early adulthood.
7. *False.* Women at age 65 have a life expectancy between four and five years greater than men.
8. *False.* Only about 5 percent of adults over 65 have an incurable form of brain disease or dementia such as Alzheimer's Disease. Even among those who live to be 80 or older, only 20-25 percent have some form of dementia. Confusion and serious forgetfulness in old age can be caused by an organic brain syndrome, but some 100 other problems can cause the same symptoms. A minor head injury, high fever, poor nutrition, adverse reactions to medications and depression all can be treated, and the confusion they cause will be alleviated. Other reasons for memory loss include self-fulfilling prophecy (negative stereotypes) and lower self-esteem. The loss of memory is not part of healthy aging. Senility is an inaccurate term that should be avoided.
9. *True.* All five senses tend to decline in old age. Most studies agree that various aspects of vision, hearing and touch tend to decline in old age. For many, vision acuity begins to decline at age 8, which is why many young people wear corrective lenses. Hearing loss increases for individuals exposed to loud noises, such as loud music or loud concerts. Taste tends to decline in old age, not because of changes in taste buds, but because of a decline in the sense of smell.

(continued)

10. *False.* The majority of persons over 65 continue to have both interest in, and capacity for, sexual relations. Need for touch and intimacy remains. The media emphasize intimate relationships among younger persons, but most older people are portrayed as asexual.
11. *False.* At any one time, only 5 percent of the older population live in nursing homes. However, up to 25 percent of older people will live in a nursing facility at some time in their old age, particularly after age 80.
12. *False.* Most older people live close to their children and see them often. Many live with their spouses. In all, eight out of 10 men and six out of 10 women live in family settings. Approximately 80 percent of the care older adults need is provided by family members.
13. *True.* Older adults consume about 25 percent of all medications and, as a result, have many more problems with adverse drug reactions.
14. *False.* Stopping smoking at any age not only reduces the risk of cancer and heart disease, but also leads to healthier lungs.
15. *False.* Many older people enjoy and benefit from exercise, such as walking, swimming, bicycling and weight lifting. Exercise at any age can help strengthen the heart and lungs, lower blood pressure, and increase muscle and bone mass. People who exercise regularly throughout their lives live longer.
16. *False.* Most older people maintain their intellect. Creativity and judgment improve for many people as they grow older. Increasingly, research is proving the adage, "Use it or lose it."
17. *True.* Older adults can learn as well, but sometimes not as quickly. Learning ability is better for older persons who are intellectually active or who are frequently involved in challenging learning activities.
18. *True.* Reaction time and nerve impulse speed slow in later life. The slowing process begins in the early 20s.
19. *True.* Older people often are seen as hopeless among health practitioners. More doctors are specializing in geriatrics than in previous years, but negative attitudes and stereotypes of older adults affect all persons, including medical doctors. As the cost of health care increases, debates over the distribution of health care according to age also will increase.
20. *False.* With increased life experiences, older people become more diverse in interests, needs, backgrounds and abilities.
21. *False.* Personality does not change as a result of age. Not all older people can be described as rigid or cantankerous. Most older adults report that they are never or hardly ever irritated. People who are easily irritated later in life probably were easily irritated when they were young. Individuals can change personality characteristics, but it does not happen automatically over time.
22. *False.* Most older adults cope with age-associated changes as they have coped with other changes. Coping styles and behaviors tend to remain the same over the life span. Since many of life's changes and losses (health, income, work roles) are anticipated, many older adults plan for and accept these changes – many of which might devastate younger persons who experience similar changes.
23. *False.* It depends on what you measure. Attendance at religious services decreases with age, usually because of physical limitations. Older people reflect higher spirituality and interest in religion on some measures; however, this may be a cohort (generation) factor, not a change occurring in later life. In other words, the current older generation was more religious when its members were younger. People do not suddenly become religious because they are old.
24. *True.* Older adults are more fearful of painful or prolonged dying than of death.
25. *True.* The 1990 U.S. Census discovered that over 3 million children (5 percent) live with their grandparents full time. It is estimated that another 3 million children may have grandparents as their primary caregivers, but who would not be identified on census reports.

LESSON 6
Life Span Versus Life Expectancy

Introduction

The terms *life expectancy* and *life span* sometimes are incorrectly used interchangeably. This activity helps students understand why life expectancy has increased over the past century, but that potential life span has remained constant.

Objectives

Students will:

- consider common misconceptions about life span and life expectancy; and
- review facts about life span and life expectancy.

Key Terms

life expectancy, life span, mortality

Materials

Handout: "Life Span and Life Expectancy Quiz" (see page 29)

Procedures

1. Introduce the true-false quiz. Explain that the quiz will be used only for instructional – not testing – purposes (although students may see the information on future tests). Students may work in pairs or small groups.
2. After students complete the quiz, explain why each of the five statements is *false*. Students can write accurate information under each statement, based on the teacher's explanations. The following information provides background information for each question on page 29.

   (1) Life span is different from life expectancy. Although life expectancy has increased, life span has not. Average *life expectancy* is calculated by adding the total years of life of all persons who die in a given year and dividing the total by the number of persons who died that year. Obviously, some people die younger; others die older. *Life span* is the maximum age that could be attained if an individual were to avoid accidents and be successfully treated for all illnesses. Although there is no agreement among gerontologists, most place the absolute limits of human life at approximately 110.

   (2) The dramatic increase in life expectancy is due primarily to extending the lives of young people, not older people. Over the past century, the rate of infant mortality (first three years of life) has declined. This is due to improved sanitation, nutrition and immunization. The decline in infant and child mortality has increased the life expectancy by decades. Medical technology applied in later life extends life an average of two to five years, but is not responsible for adding decades to average life expectancy.

(3) The overall life expectancy for all Americans, according to the National Center for Health Statistics, dropped from 75 years in 1987 to 74.9 years in 1988. The decline was most noticeable among blacks, falling to 69.2 years in 1988 from 69.4 years in 1987. Life expectancy for whites in 1988 was 75.6 years, unchanged from 1987. The reason given for the decline was an increase in infant mortality among blacks. The United States ranks 22nd in the world in infant mortality, and its ranking has been getting worse.

(4) The average age of death of the current generation of young people remains to be seen. The increase in infant mortality and deaths due to AIDS, drugs and alcohol, and an increase in the homicide rate may contribute to lower life expectancies. Other factors include worsening nutrition and less emphasis on physical exercise. While these factors may contribute to a declining life expectancy for society in general, individuals can make lifestyle choices which promote long and healthy lives.

(5) *Average* life expectancy is different from *remaining* life expectancy. Life expectancy actually increases with every year of life. The longer a person lives, the longer he or she can expect to live. Later life expectancy considers only those who are still alive in later life, and does not average in those who died earlier. The chart below shows the remaining years of life expectancy and total life expectancy for different age groups.

Average Remaining Life Expectancy

Age	Remaining Years of of Life Expectancy	Total Life Expectancy for Age
50	33.1	83.1
60	24.2	84.2
70	17.0	86.0
80	9.5	89.5
90	5.0	95.0
99	2.8	101.8

Chart based on information from Russell, Charles H; Russell, Anthony P.; and Megaard, Inger. *Good News About Aging*, New York: John Wiley & Sons, Inc., 1989.

Life Span And Life Expectancy Quiz

(For Use With Lesson 6 On Page 27)

Directions: Answer the following true/false statements. The space below each statement is for you to take notes as your teacher reviews the correct answers.

T F 1. Since overall life expectancy in the United States has increased from 47 years in 1900 to the current life expectancy of 75 years, we can reasonably assume that life span will increase to about 125 by the end of the 21st century.

T F 2. The increase in life expectancy is due primarily to medical technology used on older people.

T F 3. The projected life expectancy for people born in the United States has continued to rise over the past 10 years.

T F 4. Children born today are certain to live longer than children in their parents' generation.

T F 5. Since average life expectancy is about 75, a person who is 65 can expect to live about 10 more years.

LESSON 7
Aging In The News: Health Issues

Introduction

Contemporary issues related to later life can be found in almost any daily newspaper or weekly tabloid. Health care professionals face various complex issues as a result of the "graying" of society. The fears, concerns and changing attitudes about aging are suggested in the collage of headlines used in this activity. This activity illustrates the magnitude of health-related issues which are increasing as the number and proportion of older adults increases. It is appropriate for instructional units on health or human development.

Objectives

Students will:

- list common health concerns related to aging; and
- relate contemporary aging issues to their own lives.

Materials

Handouts: "Aging in the News: Health Issues" (see page 31)

Procedures

1. Ask the class to think of some health concerns of older adults. The number and kinds of ideas the class identifies probably will depend on previous topics covered in the class as well as the ethnic and racial backgrounds of the students. It may help if students think specifically about the concerns of older people they know.
2. Divide the class into small groups. Give each group a copy of the "Aging in the News: Health Issues" handout.
3. Ask each group to make two columns on notebook paper. In the first column they are to develop generalized statements about people's attitudes and concerns based on the news headlines in the handout.
4. After sufficient time, ask students to review their lists and write in the second column how the issues they named affect young and middle-aged people today, or may affect them when they become old.
5. Process group findings with the entire class, briefly discussing issues surrounding the various topics raised in the headlines. Emphasize in the discussion how aging issues affect younger people now, as they interact with older people, and also when they become older and face similar concerns.
6. Have students collect advertisements and news articles related to aging for at least a week and make an "Aging in the News" bulletin board. This can make a visually powerful statement about the relevance of aging as a topic of national importance.

Extension Activities

- Invite a local health care professional to discuss one or two issues related to aging.
- Invite an official from a local chapter of the American Association of Retired Persons (AARP) to discuss current health issues, such as the cost of health care. (Ask the local chapter if it has audiovisual or print materials on current topics.)

Aging In The News: Health Issues

(For Use With Lesson 7 On Page 30)

Crusade against wrinkles in Europe
The New York Times, 11/5/91

Caring for Aging Parents
Know How, Winter/91

Drugs that fight effects of aging no longer mere fantasy
The Hartford Courant, 12/30/91

'You're 50?' It's time to get some Rollerblades.
The New York Times, 5/29/91

Advice on sexual relationships also applicable to older women
The Hartford Courant, 9/25/91

Quest for youth gains new life
The Hartford Courant, 10/23/91

Whether 17 or 70, life changes are momentous.
The New York Times, 12/3/89

A matchmaker sets up a computer dating service for elderly people.
The New York Times, 2/2/92

Life still zesty for 104-year-old
The Hartford Courant, 11/30/91

Dutch seniors urged to use condoms
The Hartford Courant, 10/24/89

DEPRESSION NOT APT TO GROW WITH AGE
Aging Today, 10/11/91

For Couples, Retirement Brings Joy And Stress
The New York Times, 9/29/88

Strain of Type A especially hard on elderly people
The Hartford Courant, 1/12/92

Adult day care can help elders
The Hartford Courant, 1/11/90

RATIONING HEALTHCARE
Aging Today, 12/90-1/91

Fresh insights guide scientists' research on ways to slow aging
The Hartford Courant, 12/29/91

The Aging Brain: The Mind Is Resilient, It's the Body That Fails
The New York Times, 4/16/91

Volunteer work after retirement can have psychological benefits
The Hartford Courant, 11/1/89

In Women's Tennis, She's Over the Hill at 21
The New York Times, 9/1/91

Fighting Wrinkles With Fat
The New York Times, 7/24/91

At 102, He's Back in School, With Many Like Him
The New York Times, 12/6/90

The elderly are taking their own lives and little is being done to stop them
The Daily News, 7/26/89

Study Suggests Menopause Doesn't Affect Mental Health
The New York Times, 7/26/90

Doctor's evaluation needed to establish cause of memory loss
The Hartford Courant

Health insurance plan would protect assets of elderly
The Hartford Courant, 9/29/89

Can Electrical Charges Really Stop Wrinkles?
The New York Times, 9/9/91

Fountain of Youth in a Jar
Time, 10/14/91

Elderly Become Addicts To Drug-Induced Sleep
The New York Times, 2/2/92

Elderly Explosion To Impact Health Care
National Underwriter, 11/21/88

Widespread Drug Lapses Found Among Elderly
The New York Times, 2/15/89

When Health Care Comes to the Home
The New York Times, 1/28/89

It Isn't Always Alzheimer's Disease
Independence News, Vol.5, No. 3

WHAT IT'S LIKE TO BE 100
Parade Magazine, 10/16/88

LESSON 8

Common Physical And Sensory Changes In Later Life

Introduction

The decline in our senses appears to be a normal part of aging. Most people reach their optimum capacities in their 20s, maintain a peak for a few years, and gradually decline until ages 45 to 55 when the decline becomes more rapid. However, individuals vary greatly in the rate and severity of sensory decline. Some older persons may have better visual acuity than younger persons. Some also may hear better than younger persons.

This lesson examines changes that occur with aging due to vision impairments and hearing loss. Arthritis is added to this section since it represents the most common reason for changes in mobility and sense of touch. The material in this lesson may be used separately in conjunction with specific health issues or may be combined as a unit on health issues in later life. It can be used along with the sensory impairment simulation activity in Lesson 9 of this guide.

Objectives

Students will:

- identify different causes of sensory and physical changes that occur in later life; and
- recognize the special needs of older persons who have sensory and physical impairments.

Key Terms

- Vision: presbyopia, cataracts, glaucoma, retina
- Hearing: auditory, presbycusis, tinnitus
- Arthritis: osteoarthritis, rheumatoid arthritis

Materials

Handouts: "Aging and Your Eyes," "Hearing and Older People," "Arthritis Advice," and Crossword Puzzle "Health and Aging" with key (see pages 34-45)

Procedures

1. Ask students to read the handouts and complete the crossword puzzle. Students may work alone or in small groups.

2. Discuss the readings and crossword puzzle. Address questions or concerns which students raise.

3. The following are additional points to share with students.

    - We all have some level of impairment. No one is equipped with perfect vision, hearing or physical agility.

(continued)

- The Greek word *presbis* refers to old age. From this word comes *presbyters*, meaning elders, and the terms used in the readings: *presbyopia* and *presbycusis*. In the Greek, the term also was associated with reverence or prestige.
- People are most fearful of losing their eyesight. Hearing loss, however, is more socially isolating.
- Over 25 percent of older persons experience significant hearing impairment.
- Some people may not be aware of a hearing impairment, since it is usually a gradual decline.
- Some people who are aware of their hearing impairments may feel insecure or embarrassed about admitting they have difficulty hearing.
- In normal circumstances, the mind screens out background noises and allows a person to concentrate on sounds important to the hearer. Hearing aids do not screen out noises and amplify all sounds, such as traffic, air conditioners and background music. For this reason, hearing aids can be frustrating, especially in crowded or noisy facilities.
- Older eyes receive only one-third the amount of light which reaches the younger eye. (Illustrate by imagining the room's light were reduced by one-third.) The solution is to increase the amount of lighting. However, unless the lighting is diffused, it can create more glare. Older persons with visual impairments experience an exaggerated amount of glare.
- More than 80 percent of all older people have at least one chronic illness, such as hypertension, hearing impairment and heart disease.
- Arthritis is the most frequently reported chronic condition causing limitation of activity in older persons. Almost half (47 percent) of persons over age 65 have arthritis.

Extension Activities

- Ask students to discuss the handouts with older friends or family members. Some may be able to talk with people who have vision, hearing and physical impairments, and about what it is like and how they manage.
- Students can be assigned to write to any of the organizations listed at the end of the handouts to request information which might benefit an older friend or relative.
- Invite an optometrist, an audiologist, and/or a rheumatologist to class to discuss their health specialities and what preventive measures young people can take.

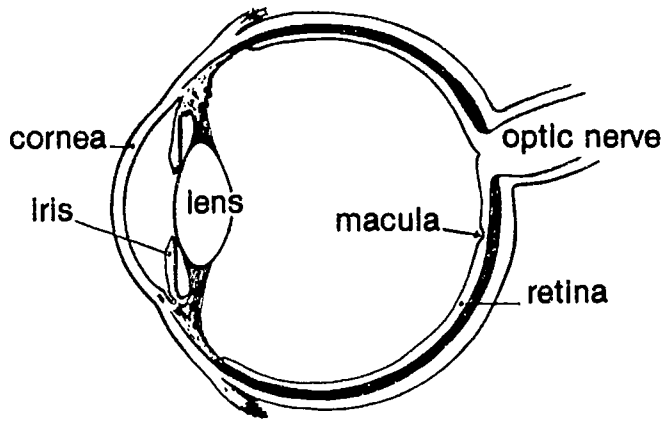
Aging And Your Eyes

(For Use With Lesson 8 On Page 32)

Poor eyesight is not inevitable with age. Some physical changes occur during the normal aging process that can cause a gradual decline in vision, but most older people maintain good eyesight into their 80s and beyond. Older people generally need brighter light for such tasks as reading, cooking or driving a car. In addition, incandescent light bulbs (regular household bulbs) are better than fluorescent (tubular overhead) lighting for older eyes.

Certain eye disorders and diseases occur more frequently in old age, but a great deal can be done to prevent or correct these conditions. Here are some suggestions to help protect your eyes.

- Have regular health checkups to detect such treatable diseases as high blood pressure and diabetes, both of which may cause eye problems.
- Have a complete eye examination every two or three years, since many eye diseases have no early noticeable symptoms. This should include a vision (and glasses) evaluation, eye muscle check, check for glaucoma, and thorough internal and external eye health exams.
- Seek more frequent eye health care if you have diabetes or a family history of eye disease. Make arrangements for immediate care if you experience loss or dimness of vision, eye pain, excessive discharge from the eye, double vision, or redness or swelling of the eye or eyelid.



Common Eye Complaints

Presbyopia (prez-bee-oh'pe-uh) – a gradual decline in the ability to focus on close objects or to see small print – is common after age 40. People with this condition often hold reading materials at arm's length, and may have headaches or "tired eyes" while reading or doing other close work. There is no known prevention for presbyopia, but the focusing problem can be easily compensated for with glasses or contact lenses.

Floaters are tiny spots or specks that float across the field of vision. Most people notice them in well-lighted rooms or outdoors on bright days. Although floaters are normal and usually are harmless, they may be a warning of certain eye problems, especially if associated with light flashes. Persons who notice sudden changes in the type or number of spots or flashes should call their doctor.

Adapted and used with permission from National Institute on Aging. "Aging and Your Eyes." *Age Page.* Washington, DC: U.S. Department of Health and Human Services, 1991.

Dry eyes occur when the tear glands produce too few tears. The result is itching, burning, or even reduced vision. An eye specialist can prescribe special eyedrop solutions ("artificial tears") to correct the problem.

Excessive tears may be a sign of increased sensitivity to light, wind or temperature changes. In these cases, protective measures (such as sunglasses) may solve the problem. Tearing also may indicate more serious problems, such as an eye infection or a blocked tear duct, both of which can be treated and corrected.

Common Eye Diseases of Older People

Cataracts are cloudy or opaque areas in part or all of the transparent lens located inside the eye. Normally, the lens is clear and allows light to pass through. When a cataract forms, light cannot easily pass through the lens and this affects vision. Cataracts usually develop gradually, without pain, redness or tearing in the eye. Some remain small and do not seriously affect vision. If a cataract becomes larger or denser, however, it can be surgically removed. Cataract surgery (in which the clouded lens is removed) is a safe procedure that is almost always successful. Cataract patients should discuss with their doctors the risks and benefits of this elective procedure. After surgery, vision is restored by using special eyeglasses or contact lenses, or by having an intraocular lens implant (a plastic lens that is implanted in the eye during surgery).

Glaucoma occurs when there is too much fluid pressure in the eye, causing internal eye damage and gradually destroying vision. The underlying cause of glaucoma often is not known, but with early diagnosis and treatment it usually can be controlled and blindness prevented. Treatment consists of special eyedrops, oral medications, laser treatments or, in some cases, surgery. Glaucoma seldom produces early symptoms, and usually there is no pain from increased pressure. For these reasons, it is important for eye specialists to test for the disease during routine eye examinations in those over 35.

Retinal disorders are leading causes of blindness in the United States. The retina is a thin lining on the back of the eye made up of nerves that receive visual images and pass them on to the brain. Retinal disorders include age-related *macular degeneration, diabetic retinopathy* and *retinal detachment.*

- Age-related *macular degeneration* is a condition in which the macula (a specialized part of the retina responsible for sharp central and reading vision) loses its ability to function efficiently. The first signs may include blurring of reading matter, distortion or loss of central vision (for example, a dark spot in the center of the field of vision), and distortion in vertical lines. Early detection of macular degeneration is important, since some cases may be corrected successfully with laser treatments.
- *Diabetic retinopathy*, one of the possible complications of diabetes, occurs when small blood vessels that nourish the retina fail to do so properly. In the early stages of the condition, the blood vessels may leak fluid, which distorts vision. In the later stages, new vessels may grow and release blood into the center of the eye, resulting in serious loss of vision.
- *Retinal detachment* is a separation between the inner and outer layers of the retina. Detached retinas usually can be surgically reattached with good or partial restoration of vision. New surgical and laser treatments are being used today with increasing success.

Low-Vision Aids

Many people with visual impairments can be helped by using low-vision aids. These are special devices that provide more power than regular eyeglasses. Low-vision aids include telescopic glasses, light-filtering lenses and magnifying glasses, along with a variety of electronic devices. Some are designed to be hand held; others rest directly on reading material. Partially sighted individuals often notice surprising improvements with the use of these aids.

Resources

Your Area Agency on Aging (also called Office on Aging) can refer you to organizations that provide services for the visually impaired. Most libraries have books with large print. In may areas, libraries for those with special needs are equipped with magnifying lamps, machines that enlarge the print of books, and "talking" books on cassettes, records and computer disks.

The following organizations can send you more detailed information on eye care and eye disorders.

- Office of Scientific Reporting, National Eye Institute, Bethesda, MD 20892. This institute, part of the federal government's National Institutes of Health, conducts and supports research on eye disease and the visual system. A list of free brochures on eye disorders is available.
- National Society to Prevent Blindness, 500 East Remington Road, Schaumburg, IL 60173. The society has several free pamphlets on specific diseases affecting the eyes. *A Home Eye Test for Adults* is available for $1.25.
- American Foundation for the Blind, 15 West 16th Street, New York, NY 10011. This organization can send you a list of its free publications on vision.
- National Association for Visually Handicapped, 22 West 21st Street, New York, NY 10011. This is a private health agency that works with the partially seeing.
- Vision Foundation, 818 Mt. Auburn Street, Watertown, MA 02172. The foundation has published a *Vision Resource List*, which includes information on special products and services for visually impaired people. There is no charge for the list.
- American Optometric Association, Communications Division, 43 North Lindbergh Boulevard, St. Louis, MO 63141, and American Academy of Ophthalmology, P.O. Box 7424, San Francisco, CA 94120-7424. These professional societies gather, study and publish eye-care information. Write to them for free publications.
- National Eye Care Project, American Academy of Ophthalmology, P.O. Box 6988, San Francisco, CA 94120-6988, 1-800-222-EYES. By calling this toll-free help line, eligible callers will receive a referral to a local eye physician and surgeon (ophthalmologist) who has volunteered to provide needed medical care through the National Eye Care Project. This ongoing public service program is designed to bring medical eye care and information to the nation's disadvantaged older people.

Publications

"Keeping an Eye on Glaucoma" is a reprint from the June 1980 issue of the *FDA Consumer*. It is available free from the Food and Drug Administration, 5600 Fishers Lane, Rockville, MD 20857. Please send requests on postcards.

Cataracts: A Consumer's Guide to Choosing the Best Treatment is a large-print book available for $3.50 from the Public Citizen's Health Research Group, 2000 P St. NW., Suite 708, Washington, DC 20036.

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Hearing And Older People

(For Use With Lesson 8 On Page 32)

It is easy to take good hearing for granted. For people with hearing impairments, words in a conversation may be misunderstood, musical notes might be missed and a ringing doorbell may go unanswered. Hearing impairments range from having difficulty understanding words or hearing certain sounds to total deafness.

Because of fear, misinformation, or vanity, some people will not admit to themselves or anyone else that they have a hearing problem. It has been estimated, however, that about 30 percent of adults ages 65 through 74 and about 50 percent of those 75 through 79 suffer some degree of hearing loss. In the United States alone, more than 10 million older people are hearing impaired.

If ignored and untreated, hearing problems can grow worse, hindering communication with others, limiting social activities, and reducing the choices of leisure time activities. People with hearing impairments often withdraw socially to avoid the frustration and embarrassment of not being able to understand what is being said. In addition, hearing-impaired people may become suspicious of relatives and friends who mumble or don't speak up.

Hearing loss may cause an older person to be wrongly labeled as confused, unresponsive, or uncooperative. At times, a person's feelings of powerlessness and frustration in trying to communicate with others results in depression and withdrawal.

Older people today demand greater satisfaction from life, but those with hearing impairments can find the quality of their lives reduced. Fortunately, help is available in the form of treatment with medicines, special training, a hearing aid or alternate listening device, and surgery.

Some common signs of hearing impairment include the following.

- Words are difficult to understand.
- Another person's speech sounds slurred or mumbled, worsening when there is background noise.
- Speech can be hard or impossible to understand, depending on the kind of hearing impairment.
- Certain sounds are overly loud or annoying.
- A hissing or ringing background noise may be heard constantly or the sound may be interrupted.
- TV shows, concerts or social gatherings are less enjoyable because much goes unheard.

Diagnosis of Hearing Problems

Persons with trouble hearing should consult a doctor for treatment or referral to an ear specialist. By ignoring the problem, a serious medical condition may be overlooked. Hearing impairments may be caused by exposure to very loud noises over a long period of time, viral infections, vascular disorders (such as heart conditions or stroke), head injuries, tumors, heredity, certain medications, or age-related changes in the ear.

In some cases, the diagnosis and treatment of a hearing problem may take place in the family doctor's office. More complicated cases may require the help of specialists known as otologists, otolaryngologists or otorhinolaryngologists – all of whom are trained to perform surgery on the head and neck. These

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specialists are doctors of medicine or doctors of osteopathy with extensive training in ear problems. They will take a medical history, ask about problems affecting family members, conduct a thorough exam and order any needed tests.

An audiologist is another health professional who is trained to identify and measure hearing loss and to help with rehabilitation. However, audiologists do not prescribe drugs or perform surgery. To measure hearing they use a device that produces sounds of different pitches and loudness (an audiometer), as well as other electronic devices. These hearing measurements test a person's ability to understand speech. The tests are painless and can, in a short time, locate a hearing problem, allowing the doctor to recommend a course of treatment.

Types of Hearing Loss

Conductive hearing loss occurs in some older people. It involves the blocking of sounds that are carried from the ear drums (tympanic membrane) to the inner ear. This may be caused by ear wax in the ear canal, fluid in the middle ear, or abnormal bone growth or infection in the middle ear.

Sensorineural hearing loss involves damage to parts of the inner ear or auditory nerve. When sensorineural hearing loss occurs in older people, it is called *presbycusis* (pronounced prez-bee-KU-sis). Changes in the delicate workings of the inner ear lead to difficulties understanding speech and possibly an intolerance for loud sounds, but not total deafness. Thus, "Don't shout, I'm not deaf!" often is said by older people with this type of hearing impairment.

Every year after age 50 we are likely to lose some of our hearing ability. The decline is so gradual that by age 60 or 70 as many as 25 percent of older people are noticeably hearing impaired. Just as the graying of hair occurs at different rates, presbycusis may develop differently from person to person. Although presbycusis is usually attributed to aging, it does not affect everyone. In fact, some researchers view it as a disease. Environmental noise, certain medicines, improper diet and genetic makeup may contribute to this disorder. The condition is permanent, but there is much a person can do to function well.

Central auditory dysfunction is a third type of hearing loss that occurs in older people, although it is quite rare even in this age group. It is caused by damage to the nerve centers within the brain. Sound levels are not affected, but understanding language usually is. The causes include extended illness with a high fever, head injuries, vascular problems or tumors. A central auditory dysfunction cannot be treated medically or surgically; but for some, special training by an audiologist or speech pathologist can help.

Treatment

Examination and test results from the family doctor, ear specialist and audiologist will determine the best treatment for a specific hearing problem. In some cases surgery or medical treatment, such as cleansing the ear canal to remove ear wax, may restore some or all hearing ability.

At other times a hearing aid may be recommended. A hearing aid is a small device designed to make sounds louder. Before a person can buy a hearing aid, he or she must either obtain a written statement from a doctor saying that hearing impairment has been medically evaluated and that the individual might benefit from a hearing aid, or sign a waiver stating that he or she does not desire medical evaluation.

Many hearing aids are on the market, each offering different kinds of help for different problems. Professional advice is needed regarding the design, model and brand of the hearing aid that is best. This advice, which is part of the hearing aid evaluation, is given by the audiologist who considers your hearing level, understanding of speech in each ear, ability to handle the aid and its controls, and concern about appearance and comfort.

Persons should remember that they are buying a product and specific services, including any necessary adjustments, counseling in the use of the aid, maintenance, and repairs throughout the warranty period. Before deciding where to buy the aid, it is important to consider the quality of service as well as the quality of the product.

Buy an aid only with those features that are needed. The most costly hearing aid may not be the best, while the one selling for less may offer more satisfaction. Also, be aware that the controls for many of the special features are tiny and may be difficult to adjust. Practice will make operating the aid easier. Hearing aid dealers (usually called "dispensers") should have the patience and skill to help during the adjustment period. It is a good idea to take advantage of the dealer's help, since it often takes at least a month to become comfortable with a new hearing aid.

People with certain types of hearing impairments may need special help. Speech reading allows people to receive visual cues from lip movements, as well as facial expressions, body posture and gestures, and the environment. Auditory training may include hearing aid orientation, but it is also designed to help hearing-impaired persons identify and better handle their specific communication problems. Both speech reading and auditory training can reduce the handicapping effects of the hearing loss. If needed, counseling also is available so that people with hearing impairments can understand their communication abilities and limitations while maintaining a positive image.

If You Have Problems Hearing

If you suspect there may be a problem with your hearing, visit your doctor as soon as possible. Medicare will pay for the doctor's exam and hearing tests that are ordered. Medicare will not pay for the hearing aid.

- Ask your doctor to explain the cause of your hearing problem and if you should see a specialist.
- Don't hesitate to ask people to repeat what they have just said.
- Try to reduce background noise (stereo, television or radio).
- Tell people you have a hearing problem and what they can do to make communication easier.

If You Know Someone With a Hearing Problem

- Speak at your normal rate, but not too rapidly. Do not over articulate. This distorts the sounds of speech and makes visual clues more difficult. Shouting will not make the message any clearer and may distort it.
- Speak to the person at a distance of three to six feet. Position your self near good light so that your lip movements, facial expressions and gestures may be seen clearly. Wait until you are visible to the hearing-impaired person before speaking. Avoid chewing, eating or covering your mouth while speaking.
- Never speak directly into the person's ear. This prevents the listener from making use of visual cues.

- If the listener does not understand what was said, rephrase the idea in short, simple sentences.
- Arrange living rooms or meeting rooms so that no one is more than six feet apart and all are completely visible. In meetings or group activities where there is a speaker presenting information, ask the speaker to use the public address system.
- Treat the hearing-impaired person with respect. Include the person in all discussions. This helps relieve the feelings of isolation that are common in hearing-impaired people.

For More Information

If you would like further information about hearing problems, contact the organizations listed below. Please be sure to state clearly what type of information you would like to receive.

The American Academy of Otolaryngology, Head and Neck Surgery, Inc., is a professional society of medical doctors specializing in diseases of the ear, nose and throat. Information can be provided on hearing, balance and other disorders affecting the ear, nose and throat. Write to One Prince St., Alexandria, VA 22314.

The American Speech-Language-Hearing Association and the National Association of Hearing and Speech Action both can answer questions or mail information on hearing aids or hearing loss and communication problems in older people. They also can provide a list of certified audiologists and speech language pathologists. Write to the American Speech-Language-Hearing Association at 10801 Rockville Pike, Dept. AP, Rockville, MD 20852; or call the National Association of Hearing and Speech Action at (800) 638-8255.

Self-Help for Hard of Hearing People, Inc. is a national self-help organization for those who are hard of hearing. SHHH can help with information on coping with a hearing loss and new hearing aids and technology, and publishes the *SHHH Journal* bimonthly. Write to SHHH, 7800 Wisconsin Ave., Bethesda, MD 20892.

The National Information Center on Deafness at Gallaudet University provides information on all areas related to deafness and hearing loss, including educational programs, vocational training, sign language programs, law, technology and barrier-free design. Write to the NICD, 800 Florida Ave., NE., Washington, DC 20002.

The National Institute on Deafness and Other Communication Disorders at the National Institutes of Health provides information on hearing, balance, smell, taste, voice, speech and language. Write to the NIDCD, Building 31, Room 1B62, Bethesda, MD 20892. NIDCD's National Information Clearinghouse also provides information to health professionals, patients, industry and the public. Write to the NIDCD Clearinghouse, P.O. Box 37777, Washington, DC 20013-7777.

The National Institute on Aging offers information on a range of health issues that concern older people. Write to the NIA Information Center, P.O. Box 8057, Gaithersburg, MD 20898-8057.

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Arthritis Advice

(For Use With Lesson 8 On Page 32)

Half of all people 65 or older have arthritis. There are over 100 different forms of arthritis, according to the Arthritis Foundation. They vary in symptoms and treatment methods. Although some forms of arthritis are better understood than others, the causes of most are unknown. Arthritis causes pain and loss of movement. It can affect joints in any part of the body. Arthritis is usually chronic, meaning it can last for years. The more serious forms generally involve inflammation, with swelling, warmth, redness and pain. In older people, the three most common types of arthritis are osteoarthritis, rheumatoid arthritis and gout.

Common Forms of Arthritis

Osteoarthritis (OA), sometimes called degenerative joint disease, is the most common type of arthritis in older people. It can range from a mild problem with only occasional stiffness and joint pain to a serious condition with much pain and disability. OA almost always affects the hands and the large weight-bearing joints of the body: the knees, ankles and hips. Early in the disease, pain occurs after activity and rest brings relief. Later on, pain can occur with even minimal movement or while at rest.

Scientists think that several factors may produce OA in different joints. For example, OA in the hands or hips may run in families. Being overweight has been linked to OA in the knees. Injuries or overuse may relate to OA in joints such as knees, hips and elbows.

Rheumatoid arthritis (RA) can be one of the more disabling forms of arthritis, but varies in severity. Signs of RA often include morning stiffness, swelling in three or more joints, swelling of the hands and wrists, swelling of the same joints on both sides of the body (for instance, both feet), and bumps (or nodules) under the skin. RA can occur at any age and affects women about three times more often than men.

While the cause of RA is unknown, scientists believe it may result from a breakdown in the immune system, which is the body's defense against disease. It is also likely that people who get RA have certain inherited traits (genes) that cause this process to go awry.

Gout occurs most often in older men. It affects the toes, ankles, knees, elbows, wrists and hands. An acute attack of gout is very painful. Swelling may cause the skin to pull tightly around the joint and make the area red or purple and very tender. Medicines can now can stop gout attacks, as well as prevent future attacks and damage to the joints. Although these medicines allow people with gout to eat normal diets, alcoholic drinks should be limited.

Treatments

Treatments for arthritis work to reduce pain and inflammation, keep joints moving safely and avoid further damage to joints. Treatments may include medicines, special exercises, use of heat or cold, weight control, or surgery. Medicines help to relieve pain and reduce inflammation. The medications used most often are aspirin and nonsteriodal anti-inflammatory drugs, such as ibuprofen.

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Exercise also is basic to treatment. Certain activities, such as a daily walk or swim, help to keep joints moving and reduce pain. They also strengthen muscles around the joints. But rest also is important. Rest is good for the whole body and for the joints affected by arthritis. The advice of a physical therapist also can be helpful in developing a personal program that balances exercise and rest.

Many people find that heat or cold helps to temporarily relieve pain. For example, soaking in a warm bath, swimming in a heated pool, or applying heat or ice packs can be helpful. Weight control helps to keep unnecessary stress off joints so that they don't become further damaged.

Surgery sometimes is helpful in OA or RA. It is used when joints are so badly damaged that activity is severely limited and other treatments fail to reduce pain. Surgery may involve repairing or replacing damaged joints with artificial ones. Hip and knee joints are replaced most often.

Unproven Remedies

Arthritis symptoms may go away by themselves but then come back weeks, months or years later. This may be one reason why many people with arthritis try "quack" cures or unproven remedies. Some of these remedies – such as snake venom – are harmful, while others – such as copper bracelets – are not. Still, the safety of many is unknown.

Look for tip-offs that point to which remedies are unproven. For example, claims that a lotion works for all types of arthritis and other diseases, too; scientific support coming from only one research study; or labels that have no directions for use or warnings about side effects.

Arthritis Warning Signs

There are a number of common warning signs to look for. These include:

- swelling in one or more joints;
- early morning stiffness;
- recurring pain or tenderness in any joint;
- inability to move a joint normally;
- obvious redness or warmth in a joint; and
- unexplained weight loss, fever or weakness combined with joint pain.

If any of these symptoms lasts longer than two weeks, see your regular doctor or one who specializes in arthritis (a rheumatologist). He or she will ask questions about the history of the symptoms, do a physical exam, may take x-rays or do lab tests, and can develop a plan for your treatment.

Resources

For more information on arthritis, write to the Arthritis Foundation, P.O. Box 19000, Atlanta, GA 30325; or call (800) 283-7800. Also write to the National Institute of Arthritis and Musculoskeletal and Skin Diseases, Building 31, Room 4C05, Bethesda, MD 20892.

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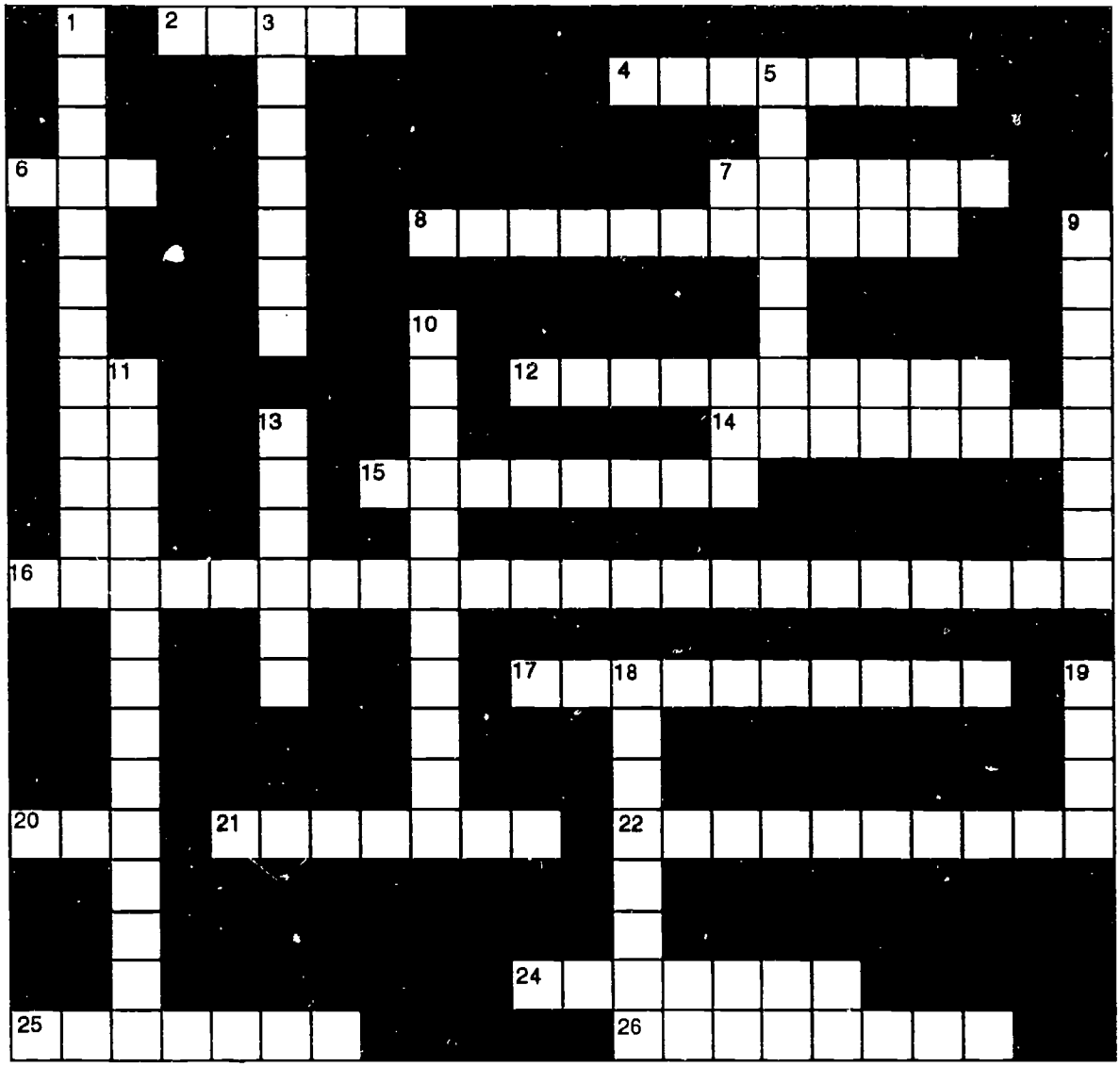
Puzzle: Health and Aging

(For Use With Lesson 8 On Page 32)



ACROSS

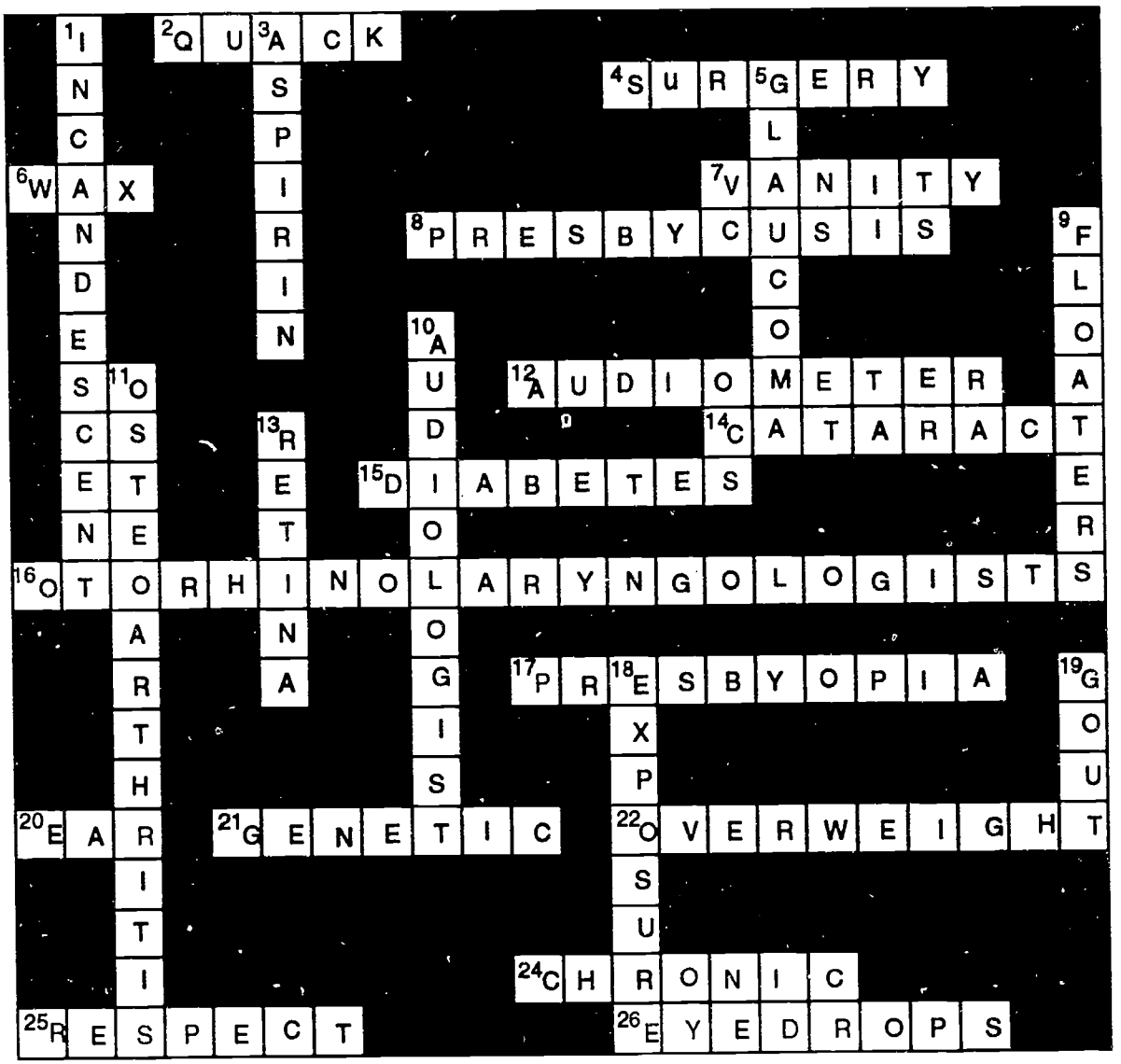
2. unproven remedies; _____ cures
4. a procedure to replace or repair damaged joints
6. buildup in the ear canal which may impair hearing
7. why some do not admit they have hearing problems
8. sensorineural hearing loss
12. electronic device which produces different pitches and loudness to measure hearing loss
14. cloudy area in lens
15. diabetic retinopathy is a complication of this disease
16. specialists trained to perform surgery on the ears, nose and throat
17. declining ability to focus on close objects
20. avoid speaking directly into a person's_____
21. inherited traits
22. a cause of osteoarthritis in the knees
24. diseases which last for years
25. people with sensory impairments should be treated with _____
26. "artificial tears"

DOWN

1. kind of light bulb better for older people
3. medicine often used to reduce inflammation
5. caused by fluid pressure on the eye
9. spots that float across field of vision
10. one who analyzes and works to rehabilitate hearing defects
11. degenerative joint disease
13. thin lining in back of eye
18. a cause of hearing loss: _____ to loud noise
19. arthritis common among older men

Puzzle Key: Health and Aging

(For Use With Lesson 8 On Page 32)



LESSON 9
Physical And Sensory Impairment Simulation

Introduction

This activity sensitizes students to the needs and feelings of persons with physical and sensory impairments. It should not be associated just with old age. Such an inference would only increase fear of aging and the aged, and would not reflect the range of age groups who experience physical and sensory limitations or the range of abilities among older people. This activity should be presented as changes that persons of any age may experience, but which are more common among older adults. The activity should follow learning activities that emphasize the positive aspects of aging in order to balance student perspectives.

Objectives

Students will:

- experience what it is like to be impaired in various physical and sensory modalities; and
- show more understanding toward persons with physical and sensory limitations.

Key Terms

sensory changes, environmental obstacles and supports, person-environment fit

Materials

All of the materials needed for the simulation can be purchased inexpensively. A chair with wheels can be substituted for the wheelchair.

petroleum jelly	cotton balls	button, sweater or coat
eye or safety glasses	baby food	wheelchair
blindfold	plastic spoons	Ace bandages
pen	soda	gloves
paper	cups	telephone book
tape recorder	round hard candy	

Handouts: "Impairment Simulation: Learning Stations" and "Impairment Simulation: Reaction Statements" (see pages 48-51)

Procedures

1. Pairs of students go in any order to 10 stations involving changes in vision, hearing, speech, movement, taste and smell. Each station has a set of directions and materials. After experiencing each physical or sensory loss with a partner, students write their reactions. Reaction statements might include how they felt, what bothered them most, and their interactions with others.

2. After the simulation, discuss student reactions. (Discussion may need to be held the following day.) Some questions to help facilitate discussion are: Which physical or sensory change was worst for you? In feeding, did you feel infantilized? How can persons be fed in such a way that they maintain their dignity and sense of control? How do others react to someone else's loss (such as treating the person as less than a person or being overly solicitous)? Do you appreciate persons with impairments who live productive lives and/or maintain high self-esteem? What helps us to live with our impairments? Emphasize that we all face physical and sensory limitations in varying degrees.
3. Emphasize that sensory changes are common, but are not experienced by all older people in the same ways. Additional points are that the class simulations are for a short time, while real disabilities are present all of the time. Explain the importance of *"person-environment fit,"* making the environment fit the needs of individuals rather than leaving the person to adjust or live with inadequate physical circumstances. Give examples of gadgets or technology that allow people to function more competently.

Extension Activities

- After finishing all stations, students can experience "double indemnity," or the impairment of any two senses.
- Ask for two volunteers to be isolated in the back of the room with simulated visual, hearing and physical impairments. Discuss with them the feelings they had as the class participated in other activities while they were present but isolated.
- Ask that 10-12 students volunteer for another simulation, "Musical Chairs." Volunteer students assume different impairments. They may choose their own or randomly be assigned roles. At least two volunteers should have no assigned impairments. Students not participating observe the behaviors of their classmates as they play "Musical Chairs." For example, some students may take on helping roles. Some may take advantage of the limitations of others. Handicapped persons may be determined to participate; others may give up. Discuss feelings from the volunteers and observations from the class. (This activity was developed by Diane Arifian, home economics teacher at Brookfield (Conn.) High School, and is used with permission.)
- Have students identify environmental barriers in the school or other buildings that hinder access, mobility and interaction. Students can observe sources of glare, amounts of light, levels of noise, and locations of restrooms, drinking fountains, elevators and directional signs.
- Students might interview someone who has a physical or sensory loss to investigate how physical losses affect the individual, friends and family members, day-to-day management, and ways of adapting to changes. Interviews can be conducted with persons of different ages, backgrounds and physical limitations.
- Have students work in teams to design an environment which is handicap friendly. What environmental changes would they recommend to improve the quality of life for impaired persons?
- Have students participate in a handicap-sensitivity day in which they live with one handicap during a full day. They can write a short reaction paper about their experiences.

Impairment Simulation: Learning Stations

(For Use With Lesson 9 On Page 46)

Station A: Vision

Materials

1. eyeglasses or safety glasses covered with petroleum jelly
2. telephone book

Directions

1. Both you and your partner put on glasses which have petroleum jelly on the outside.
2. Look up the telephone number of your school or partner and write it down.
3. Look at your partner and have a short conversation.
4. Write down your reactions to vision impairment.

Station B: Vision

Materials

1. blindfold or scarf
2. paper and pencil

Directions

1. Blindfold yourself.
2. Write your signature on a piece of paper.
3. While blindfolded, have your partner come up to you and start a conversation.
4. Switch roles with your partner.
5. Write down your reactions to blindness.

Station C: Taste and Smell

Materials

1. baby food (without labels)
2. spoons (plastic)

Directions

1. Hold your nose shut and eat the food; all types.
2. Hold your nose; let your partner feed you.
3. Throw your plastic spoon in the trash can.
4. Switch roles; feed your partner.
5. Write down your reactions.

Station D: Taste and Smell

Materials

1. juice or soda (preferably without labels)
2. small paper cups

Directions

1. Hold your nose and drink the soda.
2. Hold your nose; let your partner give you a drink.
3. Throw your cup in the trash can.
4. Switch roles with your partner.
5. Write down your reactions.

Station E: Hearing

Materials

1. cotton balls or swimmer's wax
2. tape recorder and tape-recorded message

Directions

1. Put cotton balls or wax in one ear; cover ears with hands and talk with partner.
2. Put cotton balls or wax in both ears; cover ears with hands and talk with partner.
3. With cotton balls or wax in both ears have partner approach from rear and start a conversation.
4. With cotton balls or wax in both ears, listen to tape-recorded message.
5. Remove cotton or wax and deposit in the trash can.
6. Write down your reactions.

Station F: Speech

Materials

1. pen
2. paper
3. round hard candy balls

Directions

1. Be mute. Write out everything in conversation with your partner.
2. Put a round hard candy in your mouth. Talk to your partner, slurring your words with the candy in your mouth.
3. Switch with your partner.
4. Write down your reactions.

Station G: Tactile and Movement

Materials

1. wheelchair or secretary's chair on rollers

Directions

1. Sit in the wheelchair.
2. Have partner wheel you around at a normal walking pace.
3. Switch with your partner.
4. Write down your reactions.

Station H: Tactile and Movement

Materials

1. Ace bandage

Directions

1. Tie both knees together with an Ace bandage.
2. Have partner help you stand.
3. Have partner ambulate you and climb stairs.
4. Switch with your partner.
5. Write down your reactions.

Station I: Tactile and Movement

Materials

1. Ace bandage
2. button-down sweater or coat

Directions

1. Wrap arm with Ace bandage.
2. Have partner help you put coat or sweater on.
3. Switch with your partner.
4. Write down your reactions.

Station J: Tactile and Movement

Materials

1. gloves
2. child-proof pill bottle
3. manual can opener
4. empty tin can
5. scissors
6. paper

Directions

1. Put on gloves.
2. Put on sweater or coat and button it.
3. Try opening pill bottle.
4. Try opening tin can.
5. Try cutting paper.
6. Write your name on paper with your opposite hand
7. Switch with your partner.
8. Write down your reactions.

Impairment Simulation: Reaction Statements

(For Use With Lesson 9 On Page 46)

Directions: Write your reactions to each simulated impairment. You may use any of the following sentence openers: I feel . . .; I wish . . .; This was . . .; I thought about . .; I liked . . .; I did not like . . . .

Station A. Vision: _____

_____

Station B. Vision: _____

_____

Station C: Taste and Smell: _____

_____

Station D: Taste and Smell: _____

_____

Station E: Hearing: _____

_____

Station F: Speech: _____

_____

Station G: Tactile and Movement: _____

_____

Station H: Tactile and Movement: _____

_____

Station I: Tactile and Movement: _____

_____

Station J: Tactile and Movement: _____

_____

LESSON 10
Myths About Memory Loss

Introduction

Many people believe incorrectly that memory loss is a normal part of aging. Most older adults *do not* have serious memory problems unless they suffer from a disease or injury. This activity explains reasons for memory loss other than dementia and considers what to do in circumstances where dementia may be the cause of memory failure. It provides an opportunity to provide additional information and guidance to students who may have older relatives with dementia. This activity can be included in health units on the mind or human development.

Objectives

Students will:

- identify at least three causes of memory loss other than Alzheimer's disease;
- know that memory loss is not a normal part of aging; and
- discuss ways in which individuals might be affected by family members who have dementia.

Key Terms

Alzheimer's disease, dementia, memory loss, senility

Materials

Transparency of *Beetle Bailey* cartoon and handout: "Confusion and Memory Loss in Old Age: It's Not What You Think" (see pages 54-56)

Procedures

1. To introduce this activity, ask for responses to the following illustration and questions.

   "How many of you have trouble remembering names? Dates? How many of you ever forget where you put things, such as keys? We all forget things at times. When we are young, we do not think anything of it. When we become middle aged, we laugh that we must be 'getting old.' When we become older, we no longer laugh. In fact our friends and family do not laugh either. They are certain it is because we now are 'old.' These are the same experiences – forgetting names or dates – yet we attribute one to simple forgetfulness, the other to old age."

2. Show a transparency of the *Beetle Bailey* cartoon (page 54). Emphasize that becoming senile is a common fear among older adults. The word *senility* is a catchall term used to describe a large number of conditions and causes. Because there is so much confusion and misinformation about the word *senility,* its use should be avoided.

3. Introduce the handout, "Confusion and Memory Loss in Old Age: It's Not What You Think." Have students read the handout and consider the following questions.
    - What is dementia?
    - What are some reasons for memory loss other than dementia? (For example, how well do students do on tests when they are depressed? Tired? In a hurry? On medication? Overloaded with other information or concerns? Have not thought about the matter for a long time, like over summer vacation? Are not interested in the information, like what is on the next science test? Have not had enough sleep?)
    - Why should serious memory loss not be ignored by medical professionals?
    - What are ways in which younger and older people can improve their memories? (Memory aids include concentrating, avoiding distractions, using mnemonics techniques, picturing what you want to remember, taking notes or repeating the information.)

4. Discuss what it might be like for persons who have close relatives with Alzheimer's disease. This is an opportunity for students to address personal concerns, if they wish. Some students may need to be directed to more information or given some guidance. Encourage students to pass the handout on to family members who might benefit from the information.

Extension Activities

- Invite to class a professional who is knowledgeable in the field of dementia.

- Contact the organizations named in the handout for additional information. Ask for videotapes on Alzheimer's disease.

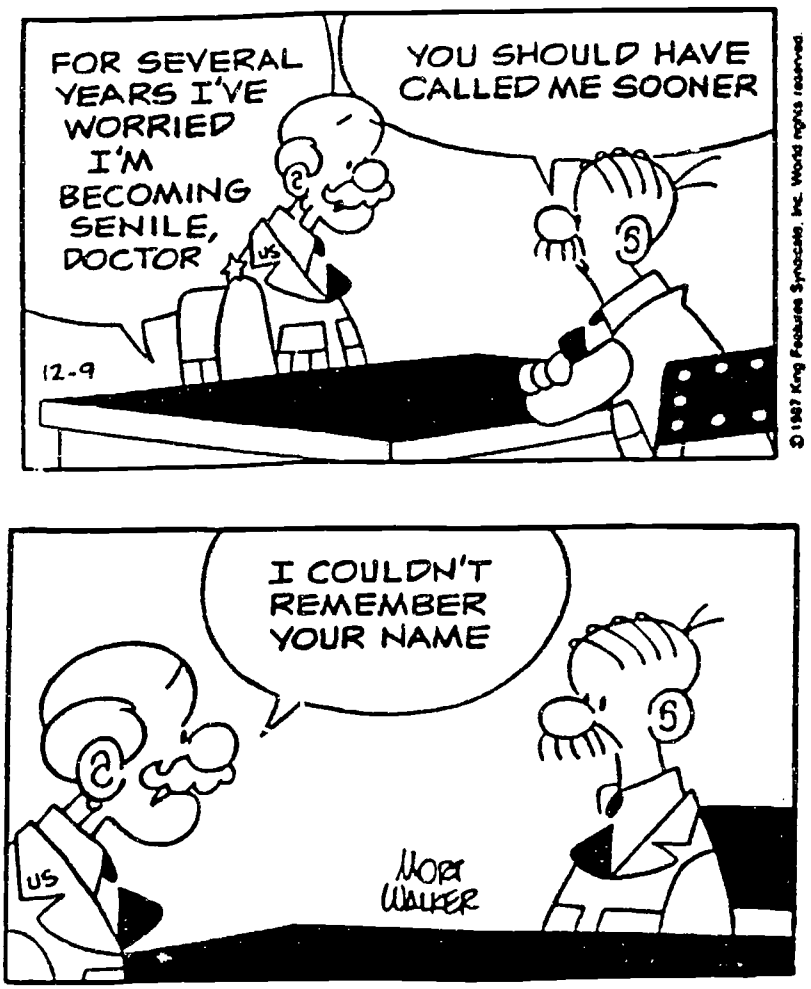
- Request the videotape *Just for the Summer* from Churchill Films, 12210 Nebraska Ave., Los Angeles, CA 90025 (800/334-7830). This video depicts a teenage boy who must come to terms with Alzheimer's disease when his grandmother comes to live with his family. In an eloquent oral report in class, he finally talks about his grandmother and the compassion and understanding he has discovered.

The Senility Myth

(For Use With Lesson 10 On Page 52)

Like many older people, the colonel in this cartoon is concerned about becoming senile. While cartoons like this may make us chuckle, they also promote myths about memory failure in old age. Memory loss is *not* a normal part of aging.

Beetle Bailey / By MORT WALKER



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Confusion And Memory Loss In Old Age: It's Not What You Think

(For Use With Lesson 10 On Page 52)

Many people are afraid that growing old means losing one's ability to think, reason or remember. They worry when they feel confused or forgetful that these feelings are the first signs of senility. They remember that, in the past, doctors dismissed memory loss, confusion or similar behaviors as a normal part of aging. However, scientists have now have found that most old people live to an old age both alert and capable. They know that people who experience changes in their personalities, behaviors or skills may be suffering from a form of brain disease called *dementia.*

The term *dementia* is used to describe a group of symptoms that usually are caused by changes in the normal activity of very sensitive brain cells. Dementia seriously interferes with a person's ability to carry out his or her daily activities. Dementia is irreversible – it cannot be cured. However, there are many conditions with symptoms that look like but are not dementia. These reversible conditions can be caused by problems such as a high fever, poor nutrition, a bad reaction to a medicine or a minor head injury. Medical problems like these can be serious and should be treated by a doctor as soon as possible.

Sometimes older people have emotional problems that are mistaken for dementia. Feeling sad, lonely, anxious or bored may be more common for older people facing retirement or handling the death of a relative or friend. Adapting to these changes can leave some people feeling confused or forgetful. Persons with emotional problems can be helped by supportive friends and family, or professionally by a counselor.

Diagnosis

People who think they might have a form of dementia should have a thorough physical and neurological and psychiatric evaluations. This includes a complete medical exam, as well as tests of the person's mental abilities. Some tests, such as a brain scan, can help a doctor rule out a curable disorder. Such a scan also may show signs of normal age-related changes in the brain. It may be necessary to repeat the scan at a later date to pin down whether or not changes are taking place at a faster rate than normal.

A complete medical exam also includes getting information about the person's medical history, use of prescription and over-the-counter drugs, diet and general health. Because a correct diagnosis depends upon recalling these details accurately, the doctor also may ask a close relative for information.

The two most common forms of dementia are *vascular dementia* (sometimes called multi-infarct dementia) and *Alzheimer's disease* (pronounced ALTZ-hi-merz). In vascular dementia, changes in the brain's blood vessels result in widespread death of brain tissue. Symptoms that begin suddenly may be a sign of this kind of dementia. Telltale signs of vascular dementia include vision or speech problems and/or numbness or weakness on one side of the body. People with vascular dementia are likely to show signs of improvement or remain stable for long periods of time, then quickly develop new symptoms. Vascular dementia once was thought to be the cause of many cases of irreversible mental impairment. Doctors now believe that most older people with serious mental problems are suffering from Alzheimer's disease. In Alzheimer's disease, nerve cell changes in certain regions of the brain result in the death of a large number of cells. Symptoms begin slowly and become steadily worse. Both forms of dementia can exist together, making it hard for doctors to diagnose either.

Adapted and used with permission from National Institute on Aging, "Confusion and Memory Loss in Old Age: It's Not What You Think." *Age Page,* Washington, DC: U.S. Department of Health and Human Services, 1991.

Treatment

When a doctor diagnoses an irreversible disorder there still is much that can be done to treat the patient and help the family cope.

Family members and friends can help people with dementia maintain their daily routines, physical activities and social contacts. People with dementia should be kept informed about the details of their lives – the time of day, where they live and what is happening at home or in the world. This may help stop brain activity from failing at a more rapid pace. Memory aids can help in day-to-day living. Some families find that a big calendar, a list of daily plans, notes about simple safety measures, and written directions describing how to use common household items can be very helpful.

Proper diet is very important, although special diets or supplements usually are not necessary. Medications often are not needed, but in some people the careful use of drugs can reduce agitation, anxiety and depression, and can help the person sleep.

Although family and friends can help, persons with vascular dementia or Alzheimer's disease should be under the care of a physician. Often a neurologist, psychiatrist, family doctor, internist or geriatrician is the primary care doctor. She or he will closely watch the patient, treat the patient's physical and emotional problems, and answer the many questions the person or family may ask.

Dementia patients lose their abilities at different rates. Even so, there is enough in common in the experiences of patients and their families – the loneliness, the frustrations, the lack of information and resources – to have led to the development of family support groups around the country. One of the largest organizations is the Alzheimer's Association (70 East Lake Street, Chicago, IL 60601-5997; phone 800-621-0379). The association has more than 200 chapters across the country. It encourages research, education and family services on all forms of dementia. The Alzheimer's Disease Education and Referral Center (ADEAR) is a clearinghouse supported by the National Institute on Aging. It also provides information about vascular dementia and Alzheimer's disease (write to P.O. Box 8250, Silver Spring, MD 20907-8250).

Hope for Tomorrow

Diet, the development of new medications, and lifestyle someday may help to prevent or reverse the damage caused by vascular dementia or Alzheimer's disease. Some doctors believe it is very important for people suffering vascular dementia to try to prevent further damage by controlling high blood pressure, monitoring and treating high blood cholesterol, and not smoking.

Developing interests or hobbies and staying involved in activities that keep the mind and body active are among the best ways that older people can remain sharp and keep their mental abilities. Careful attention to physical fitness, including a balanced diet, also may go a long way to help people keep a healthy state of mind. Some physical and mental changes occur with age even in healthy persons, but much pain and suffering can be avoided if older persons, their families and their doctors realize that dementia is a disease, *not* a part of normal aging.

Adapted and used with permission from National Institute on Aging, "Confusion and Memory Loss in Old Age: It's Not What You Think." *Age Page*, Washington, DC: U.S. Department of Health and Human Services, 1991.

LESSON 11

An Active Life: Now And In The Future

Introduction

Young people generally hold two common misconceptions about aging: (1) most old people are not capable of living active lives and (2) young people will never get old. This activity emphasizes the importance of developing interests and in being active throughout life. The alternative is not only a less interesting life, but possibly a shorter life. If students see the value of developing lifelong healthy interests, they may make better lifestyle choices throughout their lives. This activity encourages students to think of creative ways through which they might be able to continue enjoying life despite possible physical limitations. It would be appropriate for instructional units on health promotion, human development and physical education. It also can be used in subjects related to technology and environmental design.

Objectives

Students will:

- examine personal beliefs and stereotypes about what people are capable of doing in later life; and
- consider the relationship between the level of activity during youth and in later life.

Key Term

health promotion

Materials

Handout: "An Active Life: Now and in the Future" (see page 58)

Procedures

1. Follow the directions on the handout. Have students compare their responses in small groups.
2. Make a list on the chalkboard of activities students named. Discuss at what age they think they will not be able to enjoy the activity. Be prepared to counter negative stereotypes of passivity and frailty in old age.
3. Discuss the questions at the end of the handout. Emphasize the importance of lifelong activity.

Extension Activities

- Invite to class an older person from a senior organization who excels in art, music or physical activity. Students can develop interview questions to ask the guest speaker in advance.
- Arrange for a group of students to assist in a local senior marathon or elderhostel program.
- Plan an intergenerational day with persons of all ages, demonstrating or participating in activities related to art, music, dance and sports.
- Have students research areas of interest in which older persons have excelled.

An Active Life: Now And In The Future

(For Use With Lesson 11 On Page 57)

Directions

a. In the first column, list seven activities that you enjoy doing now. Then list three activities you do not do now, but would like to do in the future.
b. In the second, third and fourth columns, check the activities you plan to be doing at age 40, 60 and 80.
c. If you think you will not enjoy an activity when you are older, explain why not in the last column. (Examples: can't afford it, not physically able, no longer interested, no time)

	Activities I Now Enjoy	Age 40	Age 60	Age 80	Why Not?
1.	_____	____	____	____	_____
2.	_____	____	____	____	_____
3.	_____	____	____	____	_____
4.	_____	____	____	____	_____
5.	_____	____	____	____	_____
6.	_____	____	____	____	_____
7.	_____	____	____	____	_____
	Activities I Plan to Enjoy				
8.	_____	____	____	____	_____
9.	_____	____	____	____	_____
10.	_____	____	____	____	_____

For Discussion

- Are there any activities you do not think you will physically be able to do as an older adult, but know there are some older people who do enjoy? (Example: Although there are 80-year-old marathon runners, you may think you will not be running when you are 80.)
- Give examples of two activities you might not be doing at age 80, but could continue doing if you altered the activity in some way. (Example: If vision acuity declines, a person could use large print books, a magnifying glass or listen to books on cassette tape.)
- It is easier for older adults to continue activities than it is to increase activity suddenly. What could you do now and in your adult years to increase the chances of enjoying more activities when you get older?

LESSON 12

An Ounce Of Prevention . . .

Introduction

A person can lower his or her functional age through proper diet, exercise and health maintenance efforts. The readings in this activity look at three health care issues which are best addressed in youth. The material in this lesson may be incorporated into instructional units on exercise, nutrition and skin care.

Objectives

Students will:

- identify ways to promote good health in later life; and
- recognize that good health in later life depends in part on healthy choices made during youth.

Key Terms

- Skin Care: ultraviolet light, carcinoma, melanoma, dermatologist
- Nutrition: protein, carbohydrates, fats, fiber
- Exercise: aerobic, calisthenics, flexibility exercise

Materials

Handouts: "Skin Care and Aging," *Funky Winkerbean* cartoon, "Nutrition: A Lifelong Concern," "Don't Take It Easy – Exercise," "Healthy Lifestyle Checkup" (see pages 60-68)

Procedures

1. The following are suggestions for introducing each of the readings in the handouts.
   - Introduce the reading on skin care (page 60) with a transparency of the *Funky Winkerbean* cartoon (page 63). Invite comments on the attitudes and behaviors suggested in the cartoon.
   - Introduce the reading on nutrition (page 64) by asking students how important they would rate diet for older adults compared to younger adults.
   - Introduce the reading on exercise (page 66) with the question, "What would you think if you saw a 70-year-old woman lifting weights?" Invite discussion.
2. In discussing each reading, make connections with information students have about health promotion for younger people.
3. Use the "Healthy Lifestyle Checkup" (page 68) as a concluding exercise for students.

Extension Activities

- Have students research athletes who are considered *old* for their sport. For example, they may find articles on 90-year-old marathon runners and 40-year-old tennis champions. The *Guinness Book of World Records* documents the oldest champions in various categories.
- Ask students to discuss the handouts with older friends or family members.
- Ask the local senior center director to identify exemplary older adults who maintain active and healthy lives. The older persons could be guest speakers for the class, or could be interviewed by students for extra credit reports.

Skin Care And Aging

(For Use With Lesson 12 On Page 59)

Americans spend millions of dollars each year on "wrinkle" creams, bleaching products to fade spots, and dry-skin lotions to keep the skin looking smooth and healthy. Yet a consumer survey shows one-third of all adults work on developing a tan, even though most know that exposure to the sun damages the skin. In fact, exposure to sunlight is the single most important cause of those skin changes we usually call aging: wrinkling, looseness, leathery dryness, blotches, growths, yellowing and pebbly texture.

In protected areas of the body, the skin does not deteriorate greatly, even in old age. Although some changes occur over the years – for example, sweating decreases and injuries take longer to heal – the skin remains capable of carrying out its main protective roles.

Sun Damage

Long-term exposure to ultraviolet (UV) light from the sun weakens the elastic fibers of the skin, causing a loss of collagen. The breakdown of this fibrous network results in skin that is looser, stretches easily, and loses its ability to snap back after stretching. So, while sun damage goes unnoticed in younger years, it eventually will show decades later.

Some people are at greater risk for sun damage than others. White people – particularly those with fair skin, light hair color, and who sunburn easily – are more vulnerable than blacks. Orientals are at less risk than whites, but at more risk than blacks.

Nothing can completely reverse sun damage after it has occured. However, skin collagen has some ability to repair itself. Avoiding sun exposure over a period of years will allow some new collagen to be laid down. This means you are never too old to begin protecting yourself from sun damage.

Skin Cancer

Sun damage causes not only premature aging but skin cancer as well. The chance of developing skin cancer increases with advancing age, especially among persons living in sunny regions of the country.

Common skin cancers are *basal cell carcinoma, squamous cell carcinoma* and *malignant melanoma.* Basal cell carcinomas are the most common and the mildest. While they almost never spread to vital organs, these types of cancer should be removed because they destroy surrounding skin. Squamous cell carcinomas are less common but are considered more harmful because they can grow quickly and can spread to other organs. Malignant melanomas often look like moles and are dark and irregular in outline. They can spread and kill. Thus, any sudden change in the appearance of a mole requires a visit to a doctor.

Malignant melanoma has become much more common during the past 50 years. In 1930, one person in 1,500 developed the malignancy. By the year 2000, melanomas are expected to affect one person in 90. More leisure time spent under the sun is partly responsible for the increase in cases of malignant melanoma.

When detected early and treated promptly, most cases of skin cancer can be cured. Thus, the best defense against cancer is learning to notice its warning signs. These include the growth of a new spot or changes in a mole, such as a difference in color, size, shape or surface quality (scaliness, oozing, crusting or bleeding).

Adapted and used with permission from National Institute on Aging.
"Skin Care and Aging." *Age Page*. Washington, DC:
U.S. Department of Health and Human Services, 1991.

Dry Skin and Itching

Dry skin is common in later life. In fact, an estimated 85 percent of older people develop "winter itch," caused by overheated indoor air that lacks moisture. Another cause of dry skin is the loss with age of sweat and oil glands. Anything that drys the skin further (such as overuse of soaps, antiperspirants, perfumes or hot baths) will worsen the condition.

Dry skin often causes itching, because it becomes irritated easily. Itching may be worsened by drinking coffee or alcohol, eating spicy foods or exercising strenuously. Itchy skin also deserves serious attention since it can interfere with sleep and cause irritability. People with severe dry skin and itching should be examined by a doctor, since this condition may be a symptom of disease. For example, diabetes and kidney disease can produce itching. Certain medicines also may worsen this condition (diuretics taken for high blood pressure can increase dry skin). Severe itching often leads to scratching, which can cause long-term skin irritation or infection. Wearing a rough fabric next to the skin can start a cycle of itching and scratching.

Many skin moisturizers are available in stores at prices that vary widely, but expensive lotions are not necessarily better. The simplest lotions and creams, such as unmedicated creams and those containing lanolin, are the best. It is good to avoid products with exotic or unknown ingredients.

Tips for Maintaining Healthy Skin

The best protection for skin is to begin limiting sun exposure early in life. Contrary to popular thought, tanned skin is not a sign of good health but indicates the skin has been injured. The following are additional suggestions for skin care:

- Avoid sunbathing or visiting tanning parlors. Try to limit sun exposure between the hours of 10 a.m. and 3 p.m.
- When you do go into the sun, wear protective clothing such as a hat, long-sleeved shirt and sunglasses.
- Sunscreen lotions are an important protection against sun exposure, since they greatly reduce the amount of UV light penetrating the skin. Sunscreens should be put on at least an hour before going outside and should be reapplied after swimming or sweating. Sunscreens offering the best protection are those with the highest SPF (sun protection factor) number on the label, such as numbers 15 and higher. While most sunscreens contain PABA (para-amino-benzoic acid), which mainly blocks short UV rays, some newer brands (called broad-spectrum sunscreens) contain the ingredient oxybenzone, which blocks the longer wavelengths as well.
- Examine your skin regularly for warning signs of skin cancer. If there are changes in your skin that make you suspicious, call your doctor right away. In addition, the American Academy of Dermatology recommends that everyone have their skin examined once a year by a physician as part of a regular physical.
- Dry skin problems can be relieved by using a good moisturizing lotion, bathing with soap less often, and raising the humidity in your home. It is also good to protect your hands by wearing gloves for dishwashing, gardening or other chores. If self-treatment for dryness and itching is not effective, a doctor should be consulted.

Resources

For further information about the skin, contact the American Academy of Dermatology, a national organization representing dermatologists. The AAD is located at 1567 Maple Avenue, Evanston, IL 60201.

The National Cancer Institute has information on all forms of cancer. Write to the NCI at 9000 Rockville Pike, Building 31, Room 10A24, Bethesda, MD 20892; or call (800) 4-CANCER.

The Skin Cancer Foundation promotes public awareness of skin cancer and offers health education materials on both the detection and treatment of skin cancer. Write to the foundation at 245 Fifth Avenue, Suite 2402, New York, NY 10016.

The National Institute of Arthritis and Musculoskeletal and Skin Diseases, part of the National Institutes of Health, supports clinical research on skin diseases. Write to the NIAMS Clearinghouse, Box AMS, Bethesda, MD 20892.

The National Institute on Aging offers information on health and aging. Write to the NIA Information Center at P.O. Box 8057, Gaithersburg, MD 20898-8057.

Adapted and used with permission from National Institute on Aging. "Skin Care and Aging." *Age Page*. Washington, DC: U.S. Department of Health and Human Services, 1991.

Nutrition: A Lifelong Concern

(For Use With Lesson 12 On Page 59)

The basic guidelines for a nutritious diet are the same for most healthy adults. Older people, however, need to pay special attention to the quality of the foods they eat.

An older person's requirement for nutrients – such as proteins, carbohydrates, vitamins and minerals – is not very different from that of younger adults. But because of changes in the body and decreasing physical activity, older people usually need fewer calories. This also is why many people gain weight more easily as they age.

A nutritious (well-balanced) diet provides vitamins, minerals and calories from protein, carbohydrate, and some fat. Such a diet must include a variety of foods from each of the major food groups: fruits and vegetables; whole grain and enriched breads, cereals, and grain products such as rice and pasta; fish, poultry, meat, eggs, and dry peas and beans; and milk, cheese, and other dairy products.

Limiting the amount of fat in the diet may help to prevent weight gain. Excess weight is a factor in some disorders that occur in older people, such as diabetes, heart disease and high blood pressure. Limiting fat in the diet also may help protect against some cancers. Decreasing excessive salt intake is another good health measure.

Some older people do not eat enough food to supply the necessary nutrients. As a result, they may not get the vitamins, minerals and calories they need to stay healthy and active.

Following a doctor's advice about eating is best, especially if an illness requires changes in what or how much is eaten or if an individual is taking medicines. Some drugs interact with certain foods; others can affect appetite or change the body's nutritional requirements.

The Major Nutrients

Protein is the basic material in all body cells, including those that make up muscles, organs, skin, bones, blood, hormones and hair. It enables growth and repair of body cells and helps the body resist disease by forming antibodies.

During ingestion, food proteins are broken down into simple nutrients called amino acids, which are the basic building blocks of body tissue. The body then can reassemble these amino acids into other required proteins.

Many foods contain protein. The proteins in meat, fish, dairy products and eggs contain the eight essential amino acids in proper amounts for adults. These foods are called complete protein foods. The easiest way to get all of the essential amino acids is to eat some of these foods every day. (People who have high blood cholesterol levels should limit their use of eggs and organ meats such as liver.) Plant foods such as dry peas and beans, grain, nuts and seeds contain incomplete proteins because not all of the essential amino acids are present. However, when one of these foods is combined with an animal protein (milk and cereal, for example) or when certain plant proteins are combined (such as rice with beans), they form complete proteins. Foods high in protein usually provide essential vitamins and minerals.

Carbohydrates come in two forms. Starches are present in grains, cereals, legumes, potatoes and other vegetables, and sugars which are found mainly in fruits and milk. These foods are good sources of vitamins, minerals, fiber and calories. Sweet desserts, candy, honey, syrup and other sugary foods should be limited since they provide calories but few other nutrients.

Breads and cereals are more nutritious when they are made from whole grains. Whole grain products include whole wheat and rye breads and crackers, whole wheat cereals, bran, oatmeal, barley, brown rice and cornmeal. However, white breads made with enriched flour supply extra amounts of some nutrients such as iron, thiamin and niacin and can be eaten on occasion to increase variety in the diet.

Fats are concentrated sources of calories. Some fat is needed in the diet because it provides essential fatty acids and gives flavor to foods. However, many American diets are probably too high in fat. Low-fat foods include fish, poultry, lean meat, dry beans and peas, skim milk, yogurt, buttermilk, fruit, vegetables and grains. Eggs and organ meat should be limited, as well as butter, cream, mayonnaise, margarine, oils, lard, salad dressings, gravies, sauces, certain prepared foods, and snack foods such as potato chips.

Vitamins and minerals are needed by the body in relatively small amounts. The fat-soluble vitamins A, D, E and K are absorbed from various food and are stored in the body. The water-soluble vitamins, B and C, generally are not stored. Minerals such as calcium, phosphorus, iron, iodine, magnesium and zinc also are required for building body tissues and regulating their functions. Vitamins and minerals are abundant in fruits, vegetables, meat, dairy products, and whole grain or enriched breads and cereals.

Older people should pay particular attention to their need for calcium. Women past menopause may develop osteoporosis, which thins out the bones and often leads to painful and disabling fractures. Including foods in the daily diet that are high in calcium helps to make sure the body has enough calcium to build and maintain bones. Primary sources of calcium include milk, yogurt, cheese and other dairy products. The low-fat forms of these foods contain as much calcium as those with fat. Legumes – such as beans and peas – are also a good source of calcium.

Fiber

Another important part of the diet is fiber, which is present in foods that come from plants. The role of fiber is not fully known, but it can help prevent constipation. It also may help protect against certain intestinal disorders, and possibly some cancers and chronic diseases. The best way to include fiber in the diet is to eat whole grain breads and cereals with oats and plenty of vegetables and fruits.

The keys to a good diet are variety and moderation. The greater the variety, the less likely you are to develop either a deficiency or an excess of any single nutrient and the more likely you are to stay healthy or even improve your health.

For More Information

The National Institute on Aging has available a variety of information on health and aging. Write to the NIA Information Center, P.O. Box 8057, Gaithersburg, MD 20898-8057.

Adapted and used with permission from
National Institute on Aging. "Nutrition: A
Lifelong Concern" *Age Page*. Washington, DC:
U.S. Department of Health and Human Services, 1991.

Don't Take It Easy – Exercise!

(For Use With Lesson 12 On Page 59)

Each year, more and more scientific evidence points to the benefits of exercise. Regular physical activity can help the human body maintain, repair and improve itself to an amazing degree. And most older people – even those over 85 and those with illnesses or disabilities – can take part in moderate exercise programs.

Anyone planning to start a fitness program should first see a doctor. Those with medical problems may have to avoid some kinds of exercise or adjust their levels of activity. But even people who use wheelchairs can do some exercises to improve their strength and sense of well-being.

Many older people enjoy exercises such as walking, swimming and bicycle riding. But there are other possibilities too, such as modified aerobic dancing, calisthenics and flexibility exercises. People who have stayed in good condition may be able to participate in a wider range of activities.

It is important to tailor your program to fit your own level of ability and special needs. For example, jogging is not for everyone and may be dangerous for those who have heart disease.

The Benefits of Exercise

There is evidence that exercise may strengthen your heart and lungs, lower your blood pressure, and protect against the start of non-insulin-dependent diabetes. Exercise can strengthen your bones, slowing down the progress of osteoporosis, a bone-thinning disorder common in older women. It can strengthen and tone your muscles and help you move about more easily by keeping joints, tendons and ligaments more flexible.

When combined with good eating habits, exercise can help you lose weight or maintain your ideal weight by burning excess calories and helping to control your appetite. Exercise also may give you more energy, help you sleep better and feel less tense, improve your appearance and self-confidence, and contribute to good mental health by keeping you socially active.

Designing an Exercise Program

Anyone who has been inactive for many years never should try to do too much too soon. Start by seeing a doctor, especially if you are over 60, if you have a disease or disability, or if you are taking medication. Your doctor can evaluate your physical condition, help you decide which activity will suit you best, and check your progress after the exercise program is underway.

Choose an activity you like. Decide whether you want to join a group, exercise with a friend, or exercise alone. If you exercise alone, tell someone of your plans in case you need help. See if you prefer an outdoor or indoor activity, and decide what time of day is best for you. You may have to try different activities and times before you set an exercise schedule.

Begin by exercising slowly, especially if you have been inactive. Start with short periods of about 5 to 10 minutes twice a week. Then build up slowly, adding no more than a few minutes each week. If all goes well, increase your exercise periods to 15 to 30 minutes, three or four times a week. Your doctor may advise stretching as well as warmup and cool-down periods of 5 to 15 minutes to tune up your body before exercise and to help you wind down afterward.

Adapted and used with permission from
National Institute on Aging. "Don't Take It Easy – Exercise!"
Age Page. Washington, DC:
U.S. Department of Health and Human Services, 1991.

Always pay attention to what your body tells you. If you feel much discomfort, you are trying to do too much. Ease up a bit or take a break and start again at another time. Although most people will have no problem starting an exercise program slowly, be alert to unusual symptoms, such as chest pain, breathlessness, joint discomfort or muscle cramps. Call your doctor if any of these occur.

Finding an Exercise Program

Most communities have centers where older people can join exercise classes and other recreational programs. Find out about fitness programs at a local church or synagogue, civic center, community college, park or recreation association, senior citizens' center, or service organization (such as an area agency on aging). The YMCA and YWCA usually offer a variety of programs. Organized activities designed for older adults provide many benefits to people who have been inactive or who have health problems.

Ask about programs where you work. Companies know fitness improves performance on the job, so many provide the chance for employees to workout regularly.

If you are convinced that a formal exercise program is not for you, try to stay active in other ways. Activities – such as bowling, square dancing, fishing, nature walks, arts and crafts, card and table games, gardening, and community projects – all offer benefits.

For more information on exercise programs, write to the NIA Information Center/Exercise, P.O. Box 8057, Gaithersburg, MD 20898-8057.

Adapted and used with permission from
National Institute on Aging. "Don't Take it
Easy – Exercise!" *Age Page*. Washington, DC:
U.S. Department of Health and Human Services, 1991.

Healthy Lifestyle Check-Up

(For Use With Lesson 12 On Page 59)

Physical Wellness

_____ 1. Do you exercise every day within your physical limitations?
_____ 2. Do you allow time every day for relaxation?
_____ 3. Do you smoke?
_____ 4. Are you 10 pounds overweight? underweight?
_____ 5. Do you eat a balanced diet?
_____ 6. Do you watch your intake of caffeine, sugar, salt and fats?
_____ 7. Do you have regular physical exams, including dental care, breast exams, pap smears and eye examinations?
_____ 8. Do you fasten your seat belt when you drive?

Psychological Wellness

_____ 1. Do you feel guilty when you say no?
_____ 2. Do you have a friend you can confide in?
_____ 3. Do you rely on pills or alcohol for depression or anxiety?
_____ 4. Are you currently worried about something in the future?
_____ 5. Are you currently feeling guilty about something in the past?
_____ 6. Do you constantly seek the approval of others?
_____ 7. Do you have an activity each day that has meaning for you?
_____ 8. Can you laugh at your mistakes?

Resolution

For a healthier Me, I will _____

_____

_____

_____

_____

_____

LESSON 13
AIDS And Aging

Introduction

AIDS is not limited to young people. The case studies in this activity remind us that AIDS is a life-span disease. Students consider problems and support for older AIDS patients and discuss similarities and differences in the experiences of young and older persons with AIDS. This activity should be included in health units on infectious diseases.

Objectives

Students will:

- learn that AIDS is not limited to young people;
- identify ways in which older adults are more vulnerable to AIDS; and
- consider ways in which the spread of AIDS can be curtailed among younger and older people.

Key Terms

acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV)

Materials

Handouts: "AIDS and Older Adults" and "HIV-Infected Elders: Case Studies" (see pages 71-74)

Procedures

1. Introduce the topic "AIDS and Older Adults," using the first handout. (Note: while information from the National Institute on Aging emphasizes infection from blood transfusions, older adults also contract the HIV virus through homosexual contact.)

2. Divide the class into four small groups. Ask each group to read *one* of the case studies in the second handout (page 72). Ask each group to develop a short role play or dramatic skit using the information given in its case study. For example, a doctor, friend, family member and older person with AIDS might present different facts found in the first case study and give personal perspectives. (Teachers may choose to present the case studies as readings rather than as role plays.)

3. Ask students to consider the following questions as they listen to the presentations.

    - How did the person develop AIDS?
    - How has AIDS affected the older person's life and personal relationships?
    - What sources of support helped the AIDS patient?
    - What are some problems older AIDS patients face?

4. Discuss the questions in procedure 3. Encourage comments that consider the similarities and differences between younger and older AIDS patients. The following examples of common experiences of AIDS patients may be emphasized:

    - deterioration of relationships with friends and neighbors;
    - hostility from people who were fearful of them;
    - depression;
    - financial problems;
    - negative experiences with health care personnel; and
    - difficulty talking about AIDS

5. Summarize students' concerns from the activities.

Extension Activity

Contact a local hospital or Visiting Nurse Association for more information regarding the treatment of older AIDS patients. For additional information, contact the following references.

- There are agencies or centers in most cities that offer testing, counseling and other services for persons concemed about AIDS. In addition, many local and national organizations offer information.

- The National AIDS Hotline operates 24 hours a day, seven days a week. It offers information on transmission, prevention, testing and local referrals. Call (800) 342-AIDS or (800) 344-SIDA for Spanish and (800) AIDS-889 for hearing-impaired persons.

- The American Red Cross offers a variety of written materials. Contact your local chapter of the Red Cross or write to the Office of HIV – AIDS Education, 1709 New York Ave., NW., Washington, DC 20006.

- The National AIDS Information Clearinghouse has free government publications and resource information. Contact the clearinghouse at P.O. Box 6003, Rockville, MD 20850; or call (800) 458-5231.

- The National Institute of Allergy and Infectious Diseases, part of the National Institutes of Health, will respond to written requests for information on AIDS research and clinical trials of promising therapies. Write to the NIAID Office of Communications, Building 31, Room 7A32, Bethesda, MD 20892.

- The National Institute on Aging has information available on a range of health topics concerning older people. Contact the NIA Information Center, P.O. Box 8057, Gaithersburg, MD 20898-8057.

AIDS And Older Adults

(For Use With Lesson 13 On Page 69)

Everyone is talking about AIDS (acquired immunodeficiency syndrome), but few mention how this disease affects older people. No wonder so many older adults believe they are not likely to become infected.

The fact is that as many as 10 percent of all reported AIDS cases have involved people 50 and over. And many more older people are believed to be infected, although not yet experiencing symptoms.

What is AIDS?

The AIDS virus (also called the human immunodeficiency virus or HIV) travels in the bloodstream and affects the immune system. It prevents the body from effectively fighting infectious diseases so that HIV-infected persons can easily become ill with serious infections or cancers. When death occurs, it usually results from one of these diseases.

People with AIDS often appear healthy for a long time after becoming infected. Nearly 10 years is the average length of time after a person becomes infected before disease symptoms begin to appear.

AIDS is spread from person to person through the exchange of body fluids, such as semen and blood. For the most part, the virus is spread by sexual contact or by sharing drug needles and syringes with an infected person. Otherwise, AIDS is not easy to catch. Despite what many believe, AIDS is not spread by mosquito bites, using a public telephone or restroom, being coughed or sneezed on by an infected person, or by touching someone with the disease.

Older People May Be Especially Vulnerable

With increased age there tends to be a decline in immune system functions, making older people more prone to a variety of illnesses, such as infections and cancers. Because of these changes in immune functions, AIDS may affect older people differently than it does the young. Data from the Centers for Disease Control suggest that most older persons infected with the AIDS virus have developed disease symptoms more quickly than younger patients.

The older population also receives the highest rate of blood transfusions during routine medical care. As a result, the second most common cause of AIDS in people over 50 (after homosexual and bisexual activity) has been exposure to contaminated blood transfusions received before 1985, when the public blood supply was not being screened for the virus. Blood banks now offer cleaner blood products; however, the number of older persons who received contaminated blood and who may now be unintentionally infecting spouses or other sexual partners remains unknown. A further problem is that older AIDS patients who have early symptoms are likely to go undiagnosed. Because early symptoms of AIDS (such as fatigue, loss of appetite and swollen glands) are similar to other more common illnesses, many people – including health professionals – may dismiss these as symptoms of minor ailments.

Adapted and used with permission from National Institute on Aging. "AIDS and Older Adults," *Age Page*. Washington, DC: U.S. Department of Health and Human Services, 1991.

HIV-Infected Elders: Case Studies

(For Use With Lesson 13 On Page 69)

The four case studies below were developed as part of a study on AIDS and the aging community conducted for the Philadelphia Commission on AIDS. As you read the case studies, consider the following questions: How did the person develop AIDS? How has AIDS affected the older person's life and personal relationships? What sources of support helped the AIDS patient? What are some problems older AIDS patients face?

MR. A

White, divorced, Mr. A is 54 years old. In 1980, Mr. A had blood transfusions to treat a stomach condition. In early 1987 he fell on the floor at home and was hospitalized. During his three-month hospitalization, he was diagnosed with AIDS. In the interim year, Mr. A says, he has had all regular AIDS symptoms except for Kaposi's sarcoma. These include thrush, pneumocystis carinii pneumonia, fungus in lungs, circulation and vision problems, and mild dementia (occasional immediate memory loss), otherwise he is very articulate and fully oriented.

Up from 97 to 138 pounds, Mr. A is now doing well. Medications fight off most symptoms. His greatest fear is dementia; his debilitation – fear and depression – is "more mental than physical." The illness is a "roller coaster," unpredictable in timing and extent of symptoms. Weakness and unpredictability usually keep him at home lying on the sofa. Mr. A felt tired from the three-block walk from the subway to the interview.

Relationships changed after his diagnosis. A close friend, with whom he would go out to meet women and to drink, has spoken to him once. He fears the reaction of people in his blue-collar neighborhood; perhaps his safety would be at risk if more people knew. He will not visit people's homes, concerned he would be unwanted. But he welcomes visitors. His 80-year-old mother will not admit or accept her son's diagnosis. Two of his daughters are accepting and supportive; his third daughter is less so. His greatest sources of support are people in the AIDS network, especially a volunteer "buddy." A black Muslim woman from an AIDS organization was the first person to hug him after he was diagnosed. His exposure to the black and gay communities is new. It has been "an education and a half;" he finds himself fearful of his peers and getting support from the least-expected places.

Mr. A was a factory worker until 1985, when his plant closed and he was laid off. His previous monthly income was $2,800; severance pay and unemployment covered him until March 1987, around the time of diagnosis. His current monthly income is $732 from SSI and disability. Initially, his maximum Medicaid benefits included prescription coverage. When his income increased to $732, his Medicaid was downgraded. His $900 per month prescription for azidothymidine (AZT) is now not covered. His public welfare worker, who had the state AZT grant program notice for several months, may have missed the application deadline.

(continued)

Mr. A is angry at his government. A veteran of Vietnam and Korea, he protected his country and expected to be protected in return. In addition to his bad experience with the welfare system and his inability to qualify for Medicare until he has been sick for more than two years, he is most angry about the lack of aggressive prevention efforts.

He is very concerned about transfusion recipients. After his 1980 transfusion, Mr. A proudly formed a blood-donor group at work. He personally donated 40 pints of blood.

Mrs. B:

Widowed, black and Catholic, Mrs. B turned 61 the week after her interview. In 1985 she got "bad blood" during surgery. HIV-related symptoms first appeared in August 1987, when she lost her appetite. She then lost 50 pounds, temporarily lost her vision, became shaky and could not walk. Mrs. B does not know her exact diagnosis, but she is aware that it is HIV related. Her physician reports that her diagnosis is AIDS-related complex (ARC).

Mrs. B has painful arthritis for which she might have surgery. Considering the consequences of her 1985 surgery, she feels that she cannot go through that again. Mrs. B is weak. She can do light housework and maintains all of her own personal care. She stays at home most of the time. Keeping walks short, she doesn't visit people. Most upsetting is the change in her appearance. Hair loss and sores on her face and neck cause friends and neighbors to be frightened and uncomfortable with her. They do not want her around their kids. Her family, four children and seven grandchildren, are very supportive. One daughter left her job to care for Mrs. B full time. Her volunteer AIDS "buddy" is also a strong source of support. She wishes community people were better educated about AIDS so they would not be afraid of her.

Financially, things are very stressed. Illness forced her to take early retirement and a lower pension than she had planned. Private insurance covers a small portion of her health care costs, such as weekly blood tests. Weekly doctor visits, $30 each, are not covered. Too weak to take public transit and too young for state-subsidized shared rides, she pays a $20 round-trip cab fare to visit the doctor. She has no prescription coverage. Her savings preclude her from qualifying for Medicaid, and she is also too young for the state senior prescription program. Her doctor took her off of expensive AZT. Unaware that Mrs. B qualified for senior case management services, the physician was looking for a social worker who could fill out Mrs. B's Pennsylvania AZT grant paperwork.

Her family doctor, whom she had seen for 12 years, withheld his suspicion of HIV infection when Mrs. B first began to show symptoms. When he was on vacation, his associate alerted Mrs. B to her HIV infection and referred her to the AIDS specialist, with whom she is very pleased. Of the original physician, she says that he was weighing her and knew what was going on but "did nothing." He has since written to her, apologizing for his inaction and saying that he would have made the referral later on.

MR. C

In bed at the county nursing home, 54-year-old, black Mr. C was weak but fully coherent for the interview. Diagnosed with AIDS-wasting syndrome and pneumocystis carinii pneumonia, he appeared emaciated. He had stomach pain, vomiting and depression. At times he would find himself on the floor, unaware of how he got there. It was difficult to sit up in bed. He was experiencing urinary incontinence and needed assistance with most activities of daily living.

According to the nursing home social worker, Mr. C's HIV infection source was unknown. During the interview, Mr. C said, "It's my fault . . . [for] fooling around." He had been in a week-long relationship with a man several months before becoming ill.

A divorced father of three, Mr. C says he feels all alone. Relationships changed with his illness. His friends were OK when they thought he had cancer, but "they turned on me" when they learned it was AIDS. Mr. C says that his family was unsupportive. Upon an earlier hospital discharge, a home-care agency reported him to adult protective services. They felt that his weight loss and dehydration were due as much to his son's neglect as to AIDS. The referral led to his nursing home placement.

MR. D

Sixty-three-year-old, white, married Mr. D was in his nursing home bed for the interview. Extremely weak and somewhat confused, he was barely able to whisper responses to a few questions. His wife was interviewed in depth.

Mr. D received blood transfusions during 1983 bypass surgery. For a few months following a 1985 flu shot, he experienced unrelenting colds and fevers. After almost a year, more serious symptoms recurred. He was diagnosed with AIDS in early 1987. From then on he became "next to bedridden." Mrs. D provided all personal care. He went from 200 to 106 pounds in a year. During a hospitalization, he became incontinent, developed a chronic high fever, and was fully bed bound. His wife would have been unable to manage him at home, and he was discharged to the county nursing home.

Immediately preceding the interview with Mr. D, Mrs. D was winding down her visit when a staff physician came to meet with her. Mr. D had been receiving IV-tube nutrition and hydration. He was refusing to eat. The doctor said that he was not getting adequate calories through the IV and they would have to feed him through a nasal-gastric tube. Mrs. D said that she had understood that this would not happen. The physician said she would need a court order to stop the tube feeding. Mrs. D heard from her husband's roommate that Mr. D refused the tube the next day.

Mr. D's illness has been very hard for 64-year-old Mrs. D. She has received a lot of support from her children and from her husband's volunteer "buddy."

LESSON 14
Aging And Alcohol Abuse

Introduction

Young people need to know that alcohol abuse is a problem among all generations. Alcohol abuse among older adults is a problem largely ignored or minimized. For older persons, alcoholism can remain well concealed. Some older alcoholics begin drinking early in life, while others do not drink heavily until old age.

Objectives

Students will:

- understand that alcohol abuse crosses all generations;
- know the problems older adults have with mixing medications and alcohol;
- identify two types of older drinkers;
- list several potential signs of drinking problems; and
- have referral sources for additional information and assistance.

Materials

Handout: "Aging and Alcohol Abuse" (see pages 76 and 77)

Procedures

1. Introduce the handout after previous lessons on alcohol use and abuse. Students may read the handout independently or it may be read aloud to the class.

2. Invite discussion and comments about the problems of older alcoholics. (Emphasize that students should not reveal names or identities if they share personal experiences.)

3. Conclude with a summary of key points which students can list in their notebooks.

Extension Activity

- Invite representatives from local alcohol awareness organizations to speak to the class. Encourage speakers to address issues that involve younger and older persons.

Aging And Alcohol Abuse

(For Use With Lesson 14 On Page 75)

Alcohol abuse among older men and women is a more serious problem than people realize. Until recently, older problem drinkers tended to be ignored by both health professionals and the general public. The neglect occurred for several reasons: few of our older population were identified as alcoholics; chronic problem drinkers (those who abused alcohol off and on for most of their lives) often died before old age; and because they often are retired or have fewer social contacts, older people often are able to hide drinking problems. More people are learning that alcohol problems can be successfully treated at any age, and more are willing to seek help to stop their drinking.

Physical Effects of Alcohol

Alcohol slows down brain activity. It impairs mental alertness, judgment, physical coordination, and reaction time – increasing the risk of falls and accidents. Over time, heavy drinking can cause permanent damage to the brain and central nervous system, as well as to the liver, heart, kidneys and stomach. Alcohol can affect the body in unusual ways, making some medical problems difficult to diagnose. For example, the effect of alcohol on the cardiovascular system (the heart and blood vessels) includes masking pain that otherwise might serve as a warning sign of heart attack. Alcoholism also can produce symptoms similar to those of dementia: forgetfulness, reduced attention and confusion.

Mixing Drugs

Alcohol, itself a drug, often is harmful if mixed with other drugs, including those sold by prescription and those bought over-the-counter. People over 65 run the greatest risk of a bad drug interaction since they make up 12 percent of the population and take 25 percent of all medications. Also, older Americans are heavy users of over-the-counter drugs. Mixing drugs – such as alcohol, tranquilizers, sleeping pills, pain killers and antihistamines – can be very dangerous. For example, aspirin in some people causes bleeding in the stomach and intestines. Alcohol also irritates the stomach and, when combined with aspirin, may increase the risk of bleeding. With advancing age, major changes occur in the body's ability to absorb and dispose of drugs and alcohol. Anyone who drinks should check with a doctor or pharmacist about possible drug interactions.

Who Becomes a Problem Drinker?

In old age, problem drinkers seem to be one of two types. The first are chronic abusers, those who have used alcohol heavily for many years. Although most chronic abusers die by middle age, some survive into old age. Approximately two-thirds of older alcoholics are in this group. The second type begins excessive drinking late in life, often in response to situational factors: retirement, lowered income, declining health, loneliness, or the deaths of friends and loved ones. In these cases, alcohol is first used for temporary relief but later becomes a problem.

Adapted and used with permission from National Institute on Aging. "Aging and Alcohol Abuse." *Age Page*. Washington, DC: U.S. Department of Health and Human Services, 1991.

Detecting Drinking Problems

Not everyone who drinks regularly is an alcohol abuser, but the following actions indicate a problem:

- drinking to calm nerves, forget worries or reduce depression;
- losing interest in food;
- gulping drinks and drinking too fast;
- lying about drinking habits;
- drinking alone with increased frequency;
- injuring oneself, or someone else, while intoxicated;
- getting drunk often (more than three or four times in the past year);
- needing to drink increasing amounts of alcohol to get the desired effect;
- frequently acting irritable, resentful or unreasonable during nondrinking periods; and
- experiencing medical, social or financial problems that are caused by drinking.

Getting Help

Older problem drinkers have a good chance for recovery because they tend to stay with treatment programs. Getting help can begin with a family doctor or member of the clergy, through a local health department or social services agency, or with one of the following organizations:

Alcoholics Anonymous (AA) is a voluntary fellowship of alcoholics whose purpose is to help themselves and each other get – and stay – sober. For information, call your local chapter or write to the national office at P.O. Box 459, Grand Central Station, New York, NY 10163. The AA also can send you its free pamphlet, *Time to Start Living*.

The **National Clearinghouse for Alcohol and Drug Abuse Information** is a federal information service that answers public inquiries, distributes written materials and conducts literature searches. Write the clearinghouse at P.O. Box 2345, Rockville, MD 20852.

The **National Council on Alcoholism and Drug Dependence, Inc.** can refer you to treatment services in your area. Write to the national headquarters at 12 West 21st Street, New York, NY 10010; or call (800) NCA-CALL.

The **National Institute on Aging** offers a variety of resources on aging. Write to the NIA Information Center, P.O. Box 8057, Gaithersburg, MD 20898-8057.

Adapted and used with permission from National Institute on Aging. "Aging and Alcohol Abuse." *Age Page*. Washington, DC: U.S. Department of Health and Human Services, 1991.

LESSON 15

Aging In The News: Intergenerational Issues

Introduction

A number of social and demographic trends are affecting intergenerational relationships. Families are becoming more vertical, meaning there are more living generations in families; and less horizontal, meaning there are fewer people in each generation. At one time, for example, large families of five, six or a dozen children were the norm. Today, one, two or three children in a family is more likely. Although families used to consist of two or three generations, four and even five generations are common today.

As more people live to an old age, the number of older family members is increasing compared the number of younger relatives. This results in fewer adult children to support a growing older population. Another trend is that young adults are economically dependent upon their parents for longer periods. Thus the current "sandwiched generation" of middle-aged adults is responsible for caring both for their parents and children longer. Intergenerational strain increases when compounded by other social trends, such as divorce, reconstituted families, a higher proportion of women in the workforce, and increased mobility, creating geographic distance among family members. Despite the physical, financial and emotional costs, most families are willing to assume eldercare responsibilities.

Another trend is the increase in grandparents providing primary care to their grandchildren. According to the 1990 census data, five percent of young people are being cared for solely by their grandparents. Another five percent are estimated to have primarily grandparent care, but are not identified as such on the self-report census forms.

New norms are being established for each generation as society determines the responsibiiities of different generations to others. What are grandparents to do when their grandchildren are neglected? What are the legal and moral responsibilities of adult children to their parents, or even the role of graying grandchildren to their grandparents? When financial, emotional and time resources are limited, who is the first priority of care – a parent or a child?

These are some of the issues facing individuals, families, communities and nations. This activity uses news headlines to heighten student awareness of the increasing number of intergenerational issues. It is appropriate for instructional units on health, home economics or human development in later life.

Objectives

Students will:

- list common intergenerational issues facing individuals, families and society; and
- relate contemporary intergenerational issues to their own lives.

Key Terms

caregiving, intergenerational relationships, multigenerational families, "sandwiched generation"

Materials

Handout: "Aging in the News: Intergenerational Issues," see page 80

Procedures

1. Divide the class into small groups. Give each group a copy of the collage, "Aging in the News: Intergenerational Issues." Ask each group to make a list of as many issues as they can that are represented in the news headlines.

2. With the full class, make a composite list, discussing each point as it is presented. Encourage expressions of opinions from students.

3. Present the information in the introduction and list the social and demographic trends that are affecting intergenerational relations. Students may add other political and economic forces affecting relationships across generations.

Extension Activities

- Invite a guidance counselor or social worker to class to discuss how young people might be affected and how they might help when their grandparents need care.

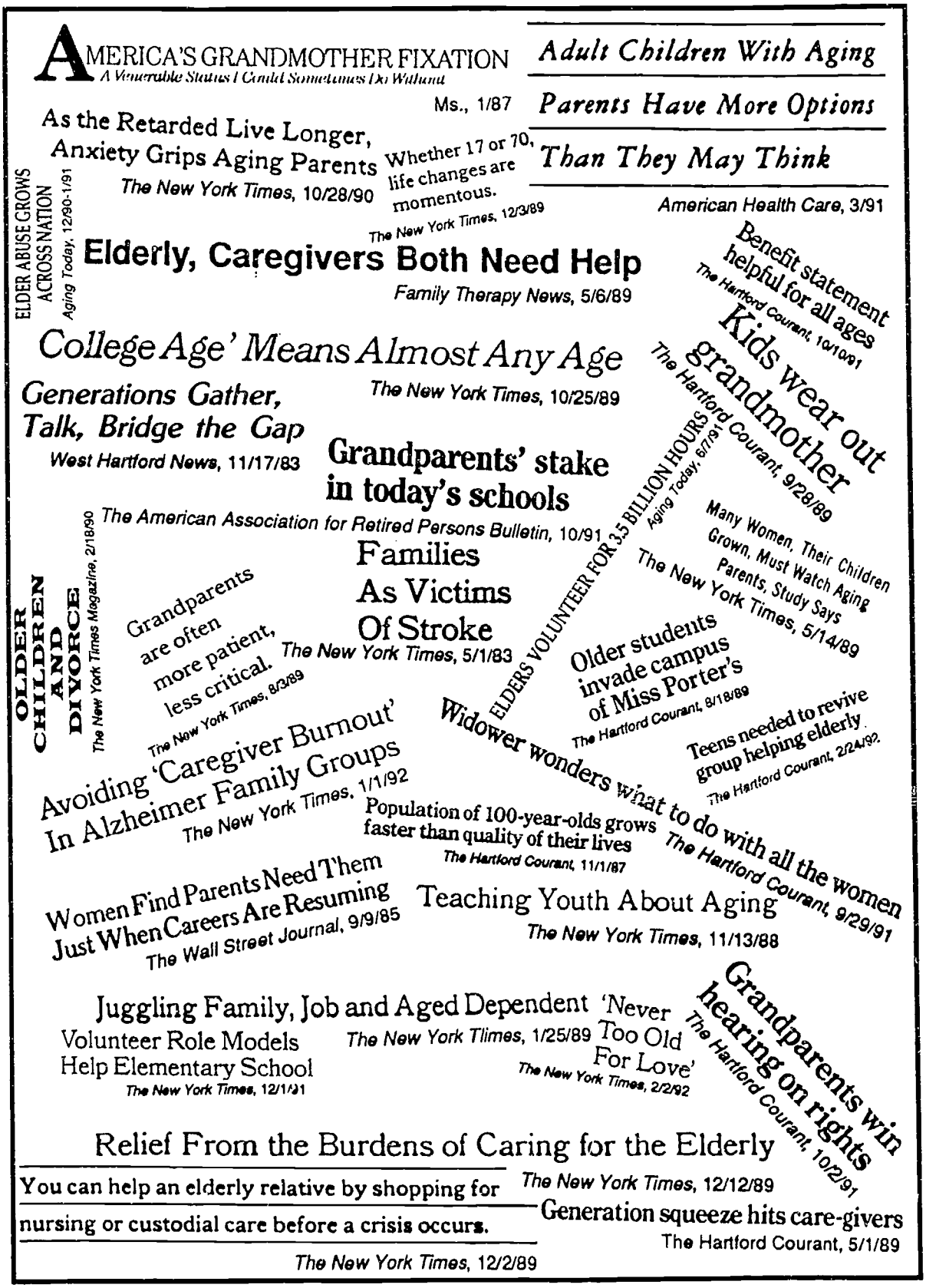
- Request the following films:

  Because Somebody Cares. Terra Nova Films, 9848 S. Winchester Avenue, Chicago, IL 60643 (312/881-8491). This film (27 minutes) shows several real-life vignettes of volunteers, young and old, as they visit older persons who are homebound or in nursing homes. The film shows the friendships that grow when people of all ages reach out to each other.

  My Mother, My Father. Terra Nova Films, 9848 S. Winchester Avenue, Chicago, IL 60643 (312/881-8491). This award-winning documentary (33 minutes) takes a candid look at four families and their deep and often conflicting feelings as they deal with the stresses and changes involved in caring for an aging parent. It elicits a better understanding of and support for individuals and families involved in caregiving.

Aging In The News: Intergenerational Issues

(For Use With Lesson 15 On Page 78)



LESSON 16

Intergenerational Relations: "Dear Blabby"

Introduction

One of the many changes in family structure is seen in the number of three-, four- and even five-generation families. The challenges of each generation affect all members in the family in some way. This activity can be used as a writing exercise in language arts or as a discussion tool in classes on families, human relations or decision making.

Objectives

Students will:

- understand some of the issues of multigenerational families;
- identify ways in which issues of one generation may affect other generations;
- practice problem-solving skills; and
- practice writing skills.

Key Terms

multigenerational families, problem solving

Materials

Handout: "Dear Blabby," see page 83

Procedures

1. Divide students in groups to write responses to letters to "Dear Blabby."

2. Distribute the "Dear Blabby" handout to small groups and discuss possible responses to the letters. In the discussions, students are to consider the consequences of different responses to the problems. For example, if the correspondent followed the advice, would the situation likely improve or worsen? In each situation, would they recommend the correspondent change his or her own attitude, change the environment in some way (such as moving), or try changing other people (usually more difficult)? If the correspondent followed the advice, how might other family members be affected? Are the suggestions easy to implement?

3. Each group writes a reply to one or more of the letters. (Teachers may select specific letters depending on time limitations and course objectives.)

4. Groups share replies, observing similarities and differences. The class can address questions similar to those listed in procedure 2. Points to emphasize follow.

    - **Letter 1.** How can the grandmother get support from her daughter? From her grandchildren? If reasoning does not work, what kinds of discipline could she use? How could the grandmother get her daughter and grandchildren to help her so that she does not feel like she is giving more than she is receiving? (Note that, according to the 1990 U.S. census report, 3.2 million children are being cared for primarily by their grandparents. Many more grandparents are secondary caregivers.)
    - **Letter 2.** How does the mother's need for independence conflict with her children's need to be helpful? How can the mother show her children that she is responsible and capable? How can her children be helpful without making their mother feel like a child? Do you think the adult children in the family are aware of their mother's feelings and needs?
    - **Letter 3.** How are the parents' desires to help the grandfather in conflict with their desires to help their children? Should parents' first responsibilities be to their parents or to their children? What is the role of grandchildren in caring for their grandparents? If all generations openly discussed the situation, do you think conditions could be adjusted so the needs of all family members could be met? Should the young person share this information with a teacher or guidance counselor? How might the family circumstances begin to affect the school lives of young persons?
    - **Letter 4.** Why would grown children object to the remarriage of their mother or father? (Note that, since women usually live longer and tend to marry men who are older, they are more likely than men to be widowed.) How common a problem do you think this is?
    - **Letter 5.** Is the request of the parents reasonable? How do you think the grandfather would respond to the grandson's question? What compromises or creative solutions might address everyone's need? If you were in a similar situation, what would you do?

Extension Activities

- Have students share letters with their parents and/or grandparents. Are there different ways of looking at the problem situations? Students might write a brief comparison, explaining possible reasons for different viewpoints.
- Ask students to write their own "Dear Blabby" letters, posing other problems faced by multigenerational families. Examples might include grandparents who want to divorce, visiting grandparents or stepparents during holidays, living with grandparents, the death of a grandparent, fear of never again seeing grandparents who are moving to Florida, and whether to give a pet as a present to a widowed grandmother.
- While there may be additional stresses, multigenerational families offer additional sources of support and pleasure. Ask students to write about the advantages and disadvantages of living near or with grandparents.
- Bring to class recent newspaper articles and cartoons dealing with multigenerational family issues.

"Dear Blabby"

(For Use With Lesson 16 On Page 81)

Letter 1

Dear Blabby: I agreed to take my daughter's three children while she worked. My daughter is recently divorced and is barely making ends meet. I want to help as much as I can but my grandchildren are hellions. At ages 7, 11 and 15, they are constantly fighting with each other, their grades are declining, and they are starting to talk back to me. How is a grandmother to discipline her grandchildren?

Fit to Be Tied

Letter 2

Dear Blabby: My husband died recently at age 72. I am 66 and still have my health and a modest retirement income from my husband's savings. Since my husband died, my three children – all in their 40s – think I am helpless. My daughter insists that I move in with her, her husband and teenagers. That would be the death of me. I never see my oldest son, but he sends me money occasionally, which I don't need or want. My youngest floods me with articles and books about old people and their problems. Her intentions are good, but I really don't need her advice. I feel like a 17-year-old whose parents are smothering her. Why are they acting this way? What can I do without offending them?

Smothered in Ohio

Letter 3

Dear Blabby: My grandfather moved into our house when my grandmother died three months ago. Don't get me wrong. I like my grandfather. But he had to move into my room and I had to move in with my younger brother. As if that wasn't bad enough, we can't do anything now because "it might upset Grandpa." I can't play my music or have friends over. Sometimes I have to stay home and watch him when my parents are away. I tried to talk to my parents, but all they say is that I have to respect my elders. I hate myself for even thinking it, but I wish the old man would just die. What can I do?

A Desperate Kid

Letter 4

Dear Blabby: My husband died three years ago and I have been dating a nice man for eight months. I am 72 and Stanley is 62. We want to get married but my children are afraid I am making a mistake. They think I am too old and think Stanley is too young for me. We will get a prenuptial agreement so they do not have to worry about their inheritance. I don't want to hurt my children, but I feel I have a lot of good years left and do not want to live alone. How can I get my children to accept our decision?

Afraid to Be Lonely

Letter 5

Dear Blabby: My mom insists I visit my grandfather in the nursing home every weekend, which means I miss football practice. I don't see the point in going so often when all we do is sit around and stare at concrete walls. I feel like I am letting my team down, but my mom says the family comes first. My dad says I am being selfish, since Grandpa won't be around much longer. What do you think?

Born to Lose No Matter What

LESSON 17

Life's Changes: Similarities Between Young And Old

Introduction

Young and old people share similarities in the kinds of problems they face. Young people can put their own experiences in perspective and gain insight as to how to deal with the changes in their lives by considering the circumstances of older persons. This activity would be appropriate for instructional units on decision making, changes during adolescence and coping strategies.

Objectives

Students will:

- take the perspective of others who share similar life challenges;
- identify ways in which their lives are similar to those of older people;
- consider how older people manage changes in their lives; and
- apply coping skills used by older people to the lives of younger people.

Key Terms

coping strategies, problem solving

Materials

Handout: "Life's Changes: Similarities Between Young And Old," see page 85

Procedures

1. Divide the class into two groups. Have one group brainstorm potential problems or obstacles they think are common among young people. Have the second group brainstorm problems or obstacles they think are common among older people. (The second group may need assistance relating to the situations of older people.)

2. After about five to seven minutes, ask each group to report on their lists, writing them on the chalkboard.

3. Introduce the handout. Discuss similarities and differences in the kinds of obstacles the two groups face.

4. The assignment at the top of the handout can be done as a homework writing exercise or used in small-group classroom discussion.

Life's Changes: Similarities Between Young And Old

(For Use With Lesson 17 On Page 84)

Directions: Choose three of the categories listed below. For each category think of coping or problem-solving strategies younger and older persons might use to help with the different problems.

Categories	Young Adults	Older Adults
Transportation	Getting permission to drive Higher insurance rates	Told they should not drive Higher insurance rates
Work	Told they are too young/ inexperienced	Told they are too old/too experienced or unfamiliar with new technology
	Low seniority	Forced or suggested retirement
Companionship	Single/dating issues	Single/dating issues
Income	Low-paying jobs	Fixed incomes consumed by inflation
Sex	Told they are too young	Told they are too old
Drugs	Use of "recreational" drugs	Misuse of prescription or over-the-counter drugs
	Told not to drink alcohol	Told not to drink alcohol
Housing	Moving away from home Have to live with parents for economic reasons	Moving to a smaller dwelling Have to live with adult children for economic or health reasons
Friends	Friends are moving away	Friends are moving away or dying
Dependency	Parents tell them what to do	Adult children tell them what to do
Aging	Physical changes related to age	Physical changes related to age
Emotions	Occasional depression; feelings of hopelessness; sometimes leading to suicide	Occasional depression; feelings of hopelessness; sometimes leading to suicide
Time	Try to find meaningful ways to use time during school years	Try to find meaningful ways to use time during retirement years

LESSON 18

Diversity In Families: Then And Now

Introduction

We have a tendency to glorify family life from the past, but overlook the factors which influence our families. One reason for the diversity among older adults today is the diversity in their family backgrounds. This activity is designed to help students appreciate the diversity of individual family experiences in different historical periods.

Objectives

Students will:

- understand the diversity of family experiences now and in the past; and
- identify ways in which individual circumstances of different time periods influence one's life.

Key Terms

diversity, family life, multigenerational families

Materials

Handout: "Diversity in Families: Then and Now," (see page 88)

Procedures

1. Introduce the handout which shows three-generation family photographs taken in the 1880s.

2. Choose appropriate writing assignments or class discussions, using the list below for ideas.
   - Write a poem or story about the family, one of the persons, or about the times in which those photographed lived.
   - Write about what the family was like 30 years before and after these pictures were taken. What time period would that be? How would the family have changed?
   - Use a photograph from your own family's past. Write about the people in your family photo.
   - If possible, interview a person born prior to 1920. See if your ideas about the past fit with the older person's experiences. Call the person first and let him or her know you want to understand the past better. Ask general, open-ended questions to encourage conversation. Write about your reactions to the interview.
   - Write a skit or play, using the people in the photographs as your main characters. Write a play presenting similar problems but in a modern setting. (You may want to do this with a group of students.)

3. The following points can be discussed.
   - The family background in the Afro-American family portrait (see handout) is unknown. Students may question the absence of male members in the picture. It is possible the photograph was intended to be a three-generation, female-only portrait, similar to what some families do today. The white family in the second picture has only one male pictured.

- Family photographs were not as common years ago as they are today. When they were taken, they were formal shots of individuals or families. Most photographs were of persons with higher incomes who could afford it. As a result, historical archives have limited numbers of pictures of working class, minority persons.

- Generally speaking, families in the past were more "horizontal," meaning they had more children and fewer generations. Families had more siblings and fewer grandparents. Families today are more "vertical," meaning they have fewer children but more living generations. Four, even five generations are common today. Prior to the 20th century, two and three generations were the norm. As a result, issues around parent care in later life are more important today than in the past. Ask how many living generations are in students' families, and how many families look after or take care of older grandparents and great-grandparents.

- An Afro-American girl born in the United States 20 or 30 years after the Civil War with only one sibling most likely would have a different perspective from a white girl born into a wealthy family with several siblings. Discuss how the two females might differ in their outlooks now, as persons who are about 100 years old.

Extension Activities

- Discuss contemporary strains on family life, including divorce, teenage parents, drug and alcohol abuse, and domestic violence.

- Invite one or two older persons to class to explain specific aspects of their family lives.

- Examine the role of structure (age and gender composition) in families.

- Invite a representative from the local historical society to display and explain local historical photographs of individuals and families. (Be sure to include groups from different ethnic backgrounds.)

- Ask students to read historical fiction about families in different historical times and geographical locations.

- Students can do a family history project showing diversity among subsystems of groupings in their family trees.

Diversity In Families: Then And Now

(For Use With Lesson 18 On Page 86)

We all have images of what families were like in the "good ole days." However, family experiences were as varied 100 years ago as they are today. Much depended on the number of children, how long family members lived, how many males and females were in the family, where they lived, the kinds of jobs and education they had, and the personality characteristics of individuals in the family.

These family portraits were taken in the late 1880s. What do you think family life was like then? What historical events might have affected their lives in different ways? Would experiences be the same for all families? In what ways do you think family life was similar to conditions today? Different? In what ways is your family unique?

Photographs courtesy of The Connecticut Historical Society, Hartford, Conn.

LESSON 19
Stressful Life Events

Introduction

Two persons may experience similar life events but perceive them differently. What may be difficult for one person is not a problem for another. Several factors influence how individuals perceive life events. These include temperment, past experiences and social expectations. Events which are anticipated or "on-time" typically are not as stressful as events which are unanticipated or "off-time." This activity is appropriate for instructional units on stress and human development. Students need prior background information on stages of human development.

Objectives

Students will:

- understand how identical events may be perceived differently;
- appreciate the different levels of stress; and
- compare their responses to life events with those of their peers and older persons.

Key Terms

on-time/off-time events, anticipated/unanticipated events, perceived stress

Materials

Handout: "Life Events Cards" (see page 90)

Procedures

1. Divide the class into small groups of four to six students. Have each group represent a different age group: age 16, 26, 36, 56 and 76.
2. Ask students to talk for about five minutes within their groups as they assume the roles of their assigned age group. They can decide among themselves what their respective family circumstances, interests, hobbies and concerns are. The teacher may need to help groups identify common issues for different ages.
3. Distribute life events cards (see handout) to each group. Have each group rank order the 10 most-stressful events and 10 least-stressful events for their respective age groups. Assign group reporters to write their two lists on the board for the class to see. (A variation on this is to have groups assign a stress-point value on a scale of one to 10 for each of the events.)
4. Compare and discuss the results of the five groups. Discussion questions might include:
    - Why might an event be more stressful for one age group than for another?
    - Were there any events which seemed less likely for a particular age group? For example, could a 76-year-old person have living parents or attend college?
    - How might the resources and sources of support differ for people of different ages?

Extension Activities

- Ask students to give the life events cards to an older adult. After the older person has ranked the most- and least-stressful events, students can compare their lists with the older adult's lists.
- Invite guests who have successfully managed difficult life events. Students may ask the guests both prepared and spontaneous questions. Conclude with an open discussion.

Life Events Cards

(For Use With Lesson 19 On Page 89)

Directions: Duplicate, cut and distribute sets of cards to student groups.

Death of a Parent	Death of a Close Friend	Breaking up with Boy/Girl Friend or Divorcing a Spouse	Marriage
Money Problems	Inherit Money	Gain 10 Pounds	Lose 10 Pounds
Personal Injury (6 months in hospital)	Personal Illness (one week in bed)	Mother Becomes Seriously Ill	Sibling Becomes Seriously Ill
Please a Boss/Teacher	Job Interview	Fired from Job	Trouble with Boss/Teacher
Outstanding Personal Achievement	Meeting Deadlines	Change in School/ Work Schedule	Change in Recreation Activity
Vacation	Celebrating Holiday	Observing Birthday	Buying New Clothes
Leaving Home; Moving away from immediate family	Automobile Accident	Acceptance to College	Giving a Speech to Audience of 50
Birth of New Family Member	Wedding of Family Member	Divorce of Close Family Member	Peer Pressure
Parking Ticket	Speeding Ticket	Getting Arrested	Jail Term

LESSON 20
Home Safety Checklist

Introduction

Accidents in the home are serious problems for persons of all ages, especially for the very young and very old. This activity promotes an appreciation for life and safe living conditions. For students in substandard living circumstances, it may increase awareness of the need for building codes, public inspections of apartment buildings and political attention to housing issues. This activity can be used in units on safety or home design.

Objectives

Students will:

- identify and recognize the seriousness of common household hazards;
- suggest changes in their own homes for safer environments; and
- realize that they can make a difference in home safety.

Key Terms

environmental design, home safety, household hazards

Materials

Handout: "Home Safety Checklist" (see pages 92-95)

Procedures

1. Invite student responses from any who know of incidents where accidents in the home could have been avoided if preventive measures had been taken, such as slipping in the bathtub or tripping over a loose rug. Ask students why they think household hazards are a growing concern for persons of all ages, but especially for the very young and very old. Emphasize that serious accidents may be prevented simply by looking for ways to reduce household hazards.
2. Ask students to complete the Home Safety Checklist for their own homes and to give the checklist to at least one older relative or neighbor.
3. Discuss student findings with the class. Identify the most common safety problem that class members found. Students can report on any positive safety actions they or others will take as a result of completing the safety checklist.

Extension Activities

- Invite to class a town building inspector or insurance company loss control representative to discuss his or her job.
- Invite to class a local architect or building contractor to discuss changes in housing design that are intended to allow older persons to live in their homes longer.
- Bring in catalogs of household gadgets that help persons with physical impairments maintain a level of independence. Some students might be interested in designing their own household gadgets that might benefit persons with limited vision, hearing or mobility.

Home Safety Checklist

(For Use With Lesson 20 On Page 91)

Introduction: Accidents in the home are serious problems, especially for the very young and very old. The U.S. Consumer Product Safety Commission (CPSC) estimated that, in 1981, more than 622,000 people over 65 were treated in hospital emergency rooms for injuries associated with products they live with and use every day. Many of these injuries result from hazards that are easy to overlook, but also easy to fix. By spotting these hazards and taking some simple steps to correct them, many injuries might be prevented. As the average life expectancy increases and more people are staying in their homes longer, environmental design and home safety will be more important.

Directions: Use this checklist to spot safety problems that may be present in your home or that of a family member or friend. Circle *YES* or *NO* to answer each question. Then discuss the list with someone who can help in correcting those items which may need attention.

Check All Electrical Cords

Yes No Cords stretched across walkways may cause someone to trip. Are lamp, extension and telephone cords placed out of the flow of traffic?

Yes No Electrical cords that run under carpeting and furniture may cause fire and shock hazards. Are cords out from beneath furniture and rugs or carpeting?

Yes No Nails or staples can damage cords, presenting fire and shock hazards. Are cords attached to the walls or baseboards with nails or staples?

Yes No Damaged cords may cause a shock or fire. Are electrical cords in good condition, not frayed or cracked?

Check All Rugs, Runners and Mats

Yes No Falls are the most common cause of fatal injuries for older people. Are all small rugs and runners slip resistant?

Check the Telephone Area

Yes No Telephone numbers for the police, fire department and poison control center, along with a neighbor's number, should be readily available. Are emergency numbers posted on or near the telephone?

Yes No Is there access to a telephone which prevents a person from having to stand and reach a wall phone in case of an emergency?

Adapted from *Safety for Older Consumers: Home Safety Checklist*, Washington, DC: U.S. Consumer Product Safety Commission, 1986.

Check Smoke Detectors

Yes No At least one smoke detector should be placed on every floor of your home. Are smoke detectors properly located?

Yes No Many home fire injuries and deaths are caused by smoke and toxic gases, rather than the fire itself. Do you have properly working smoke detectors?

Check Electrical Outlets and Switches

Yes No Unusually warm or hot outlets or switches may indicate that an unsafe wiring condition exists. Are any outlets or switches unusually warm or hot to the touch?

Yes No Exposed wiring presents a shock hazard. Do all outlets and switches have cover plates so that no wiring is exposed?

Check the Emergency Exit Plan

Yes No Do you have an emergency exit plan and an alternate plan in case of a fire?

Check the Kitchen Range Area

Yes No Are towels, curtains and other things that might catch fire located away from the range?

Yes No The Consumer Product Safety Commission estimates that 70 percent of all people who die from clothing fires are over 65. Long sleeves are more likely to catch fire than short sleeves. Do you wear clothing with long or loose sleeves while cooking?

Check Lighting

Yes No Low lighting and glare can contribute to burns or cuts. Does good, even lighting exist over the stove, sink and countertop work areas, especially where food is sliced or cut?

Yes No Power tools were involved in over 5,200 injuries to people 65 and over who were treated in hospital emergency rooms in 1982. Good lighting can reduce the chance that you will accidentally be hurt. Are work areas, especially areas where power tools are used, well lit?

Check Step Stool

Yes No Standing on chairs, boxes or other makeshift items to reach high shelves can result in falls. Do you have a step stool that is stable and in good repair?

Check Bathtub and Shower Areas

Yes No Wet, soapy tile or porcelain surfaces are especially slippery and may contribute to falls. Are bathtubs and showers equipped with nonskid mats, abrasive strips or slip-free surfaces?

Yes No Grab bars can help you get into and out of your tub or shower and can help prevent falls. Do bathtubs and showers have at least one (preferably two) grab bars?

Check the Water Temperature

Yes No Water temperatures above 120 degrees can cause tap water scalds. Is the water temperature 120 degrees or lower? (If the water heater does not have a temperature setting, you can use a candy thermometer to check water at the tap.)

Check Medications

Yes No Medications that are not clearly and accurately labeled can be easily mixed up. Taking the wrong medicine or missing a dosage can be dangerous. Are all medicines stored in the containers they came in and are they clearly marked?

Yes No Many poisonings occur when children visiting grandparents go through a medicine cabinet or purse. In homes where children are frequent visitors, do medicines have containers with child-resistant caps?

Check Areas Around Beds

Yes No Lamps or switches located close to each bed will enable people getting up at night to see where they are going. Are lamps or switches within reach of beds, or are night lights installed?

Yes No Burns are a leading cause of accidental death among older adults. Smoking in bed is a major contributor to this problem. Are ash trays, smoking materials or other fire sources (such as heaters, hot plates, teapots) located away from beds or bedding?

Yes No Tucking in electric blankets, or placing coverings on top of them, causes excessive heat buildup which can start a fire. Is anything covering your electric blanket when it is in use?

Check Stairs

Yes No The handrail should provide a comfortable grip for climbing up or going down steps. Are sturdy handrails fastened securely on both sides of the stairway?

Yes No Worn treads or loose carpeting can lead to insecure footing, resulting in slips or falls. Do the steps allow secure footing?

Check Fireplace and Chimney

Yes No A clogged chimney can cause a poorly burning fire and result in poisonous fumes and smoke coming back into the house. Are chimneys clear from accumulations of debris?

Yes No Burning wood can cause a buildup of creosote inside the chimney. This material can ignite and result in a serious chimney fire. Has the chimney been cleaned within the past year?

Check Space Heaters

Yes No Heaters can cause fires or serious burns if they are knocked over. Are small stoves and heaters placed where they can not be knocked over, and away from furnishings and flammable materials such as curtains or rugs?

Yes No Improper venting can cause carbon monoxide poisoning. If your home has space-heating equipment, such as a kerosene, gas or LP gas heater, is it properly vented?

Check Wood-Burning Heating Equipment

Yes No Any wood-burning stove should be on a fire resistant floor and three feet from walls. Is wood-burning equipment installed properly?

Check the Fuse Box or Circuit Breakers

Yes No Replacing a correct-size fuse with a larger-size fuse can present a serious fire hazard because excessive current would be allowed to flow and possibly overload the outlet and house wiring to the point that a fire could begin. If fuses are used, are they the correct size for the circuit?

Check Flammable and Volatile Liquids

Yes No If containers are not tightly closed, vapors that may be toxic when inhaled may escape. Consumer Product Safety Commission reports indicate gasoline stored as much as 10 feet from a gas water heater has exploded. Are containers of volatile liquids tightly capped?

Yes No When spilled, gasoline vapors can settle at ground level and travel long distances. They can ignite from open flames, such as gas water heate r oil-fired furnaces. Are gasoline, paints, solvents or other products that give off vapors o. umes stored away from ignition sources?

Remember to recheck your home periodically. This list is intended to be a guideline and is not all-inclusive. It does not guarantee an accident-free home. Be on the alert for other potential dangers in the home.

Adapted from *Safety for Older Consumers: Home Safety Checklist*, Washington, DC: U.S. Consumer Product Safety Commission, 1986.

LESSON 21
Community Services Scavenger Hunt

Introduction

Local, state and federal governments support several health and social service programs that help older adults in meeting their social, psychological and physical needs. This activity can be included in instructional units on career education, health promotion and community involvement.

Objectives

Students will:

- identify resources for older adults in their local communities; and
- analyze the effectiveness and adequacy of local programs serving older adults.

Key Terms

social services, health care, housing alternatives, nutrition sites

Procedures

1. Ask students to think of federal, state or local programs which are intended to improve the general welfare of young people. Students might think of school lunch programs, drug prevention programs, teen drop-in centers, recreational programs, and various child welfare or educational programs. Make a list on the board.
2. Ask students to think of federal, state or local programs which are intended to improve the general welfare of older people. Make a list on the board. Compare the types of programs students name and the number of programs they can identify for both young and old. The following are examples of senior services: transportation, recreation, visitation, Meals-on-Wheels, nutrition and housing programs.
3. Divide students into small groups. For home work students are to conduct a scavenger hunt for community services for older adults. Students should find out where the services or programs are located, who uses the services, how the services work, and how much they cost. Students can identify services using the following sources of information: (1) pamphlets from community organizations; (2) telephone or personal conversatons with employees of local and state organizations serving older adults; (3) interviews with older neighbors about their needs and how they use services; and (4) library print materials.
4. Students report their findings to the class in oral and/or written reports. List the various programs students have found. Discuss which programs and services they plan on using when they are older and what kinds of programs they would like to have available 50 years from now.

Extension Activities

- Invite to class as guest speakers persons involved with organizations serving older adults. Students can prepare questions in advance which consider the needs of older residents.
- Invite the town manager, mayor or council members to discuss the types and costs of services offered to people under 18, over 60, and those benefiting mixed age groups. Class discussion can include creative ways of meeting the needs of all ages.

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