COUNSELLING AS AN INTEGRAL PART OF INTERMEDIATE CARE FOR THE AGED

by

HÉLÈNE MARY GALBRAITH MCLELLAND

B.A., University of Victoria, 1976

A THESIS SUBMITTED IN PARTIAL FULFILLMENT

OF THE REQUIREMENTS FOR THE DEGREE OF

MASTER OF ARTS

in the Faculty of [redacted]

Education

ACCEPTED
FACULTY OF GRADUATE STUDIES
DEAN
DATE 5 Jul 1982

We accept this thesis as conforming
to the required standard

[redacted]

Donald W. Knowles, Ph.D.

[redacted]

David J. Chabassol, Ph.D.

[redacted]

G. Alexander Milton, Ph.D.

© HÉLÈNE MARY GALBRAITH MCLELLAND

University of Victoria

April 1981

All rights reserved. This thesis may not be reproduced in whole or in part, by mimeograph or other means, without the permission of the author.

Supervisor: Professor Donald W. Knowles

ABSTRACT

The literature of aging, institutionalization, counselling and psychotherapy was examined to determine if there was a need for counselling as an integral part of Intermediate Care for the aged. A primary need of the institutionalized old may be psychosocial care, but a view exists that the old cannot profit from psychological intervention because of inability to change.

Research questions were asked as to the characteristics, needs and tasks of old age; and whether there are problems unique to the institutionalized old which justify counselling.

A review of the literature of the decade 1970 - 1980 was conducted. Characteristics, needs and tasks of old age were described, supporting the conclusion that these might indeed be addressed by counselling. Counselling was found to be indicated for supportive and rehabilitative purposes, and in particular for relocation (or the process of institutionalization) and adjustment.

It was concluded that the old, and particularly the institutionalized old, do indeed have problems that are age specific, for which counselling may be required; and that there were a number of functions which a counsellor might perform within the institutional setting.

A need to train more counsellors to work with the aged was found concomitant to the increased number of individuals living into old age, and it was recommended that health and education agencies might examine this problem with a view to providing training opportunities.

Examiners: _____

Donald W. Knowles, Ph.D.

[redacted]

David J. Chabassol, Ph.D.

[redacted]

G. Alexander Milton, Ph.D.

TABLE OF CONTENTS

Chapter Page

LIST OF TABLES

Acknowledgement

I am greatly indebted to Dr. Don Knowles for his time, patience and valuable suggestions as Chairman of my Thesis Committee, and to Dr. David Chabassol and Dr. G. A. Milton for their generous assistance and comments.

Acknowledgement must also be made of assistance from staff of the University of Victoria McPherson Library both in ERIC search and the obtaining of material through Inter-Library Loan.

Thanks are due to Sarah Baylow who typed the final draft.

It would be appropriate at this time to thank a tolerant husband and understanding friends for their forbearance during the preparation of this thesis.

To Maggie Kaplan and Dr. David Jordan I am indebted for inspiration and encouragement, but most of all I thank Miss Florence Robinson, to whom this thesis is dedicated.

CHAPTER I

INTRODUCTION

Despite increasing frailty and chronic disease, the primary needs of the old may be seen as psychosocial, requiring counselling as an integral part of any program of Intermediate Care for the aged.

Old persons entering an Intermediate Care Home do so at a period in life which may be seen as a final stage of growth, for which society provides no adequate socialization (Erikson, 1963; Kubler-Ross, 1975; Marshall, 1978).

Research has shown, however, that the nursing home must provide its residents with a way of life, and that psychosocial services may foster forward motion, forestall decline and also be life-maintaining by giving the individual a reason to live (Gottesman, 1970). Counselling is seen as an essential part of such services, and attention to psychosocial needs as critical to the well-being, or even survival, of the institutionalized old (Brody, 1973; Cape, 2978; Eisdorfer & Stotsky, 1977; Koff & Koff, 1977; Lowenthal & Haven, 1968; Pressey & Pressey, 1972; Robinson, 1973; Solomon, 1968; Weg, 1973; Weiner, Brok & Snadowsky, 1978).

The increased number of individuals living into old age has prompted suggestions that counsellors will be working more extensively with the old by the year 2000 than at the present time (Osipow, 1980; Wrenn, 1980),

although activity in this field is already evidenced by the use of terms such as geropsychology and gerocounsellor (Ganikos, 1979; Gentry, 1977).

Due to negative stereotyping of the old, however, a view has existed that older people are unlikely to profit from psychological intervention. Such a view has been reinforced by a general lack of understanding of the aging process, and society's failure to prepare for the growing numbers of elderly (Butler, 1971, 1979; Ginsburg & Goldstein, 1974; Weiner, Brok & Snadowsky, 1978).

Problems of the old have been viewed as diverse and overwhelming, so that many of the roles the gerocounsellor will need to assume may be at variance with those traditionally characteristic of counsellors (Butler, 1979; Ganikos, 1979). It appears, however, that few theories of counselling have addressed the older person, and that too few counsellor education programs offer courses in gerontology (Ganikos, 1979; Blake, 1975). It has been reported that only about 6% of counsellor training programs in the United States offer even elective courses in counselling the elderly (Ganikos, 1979) and such information does not appear to be available for Canada.

In order to investigate the need for counselling the institutionalized old, therefore, it is necessary to ask the following questions:

- what are the characteristics of the old?
- are there needs and tasks specific to old age?
- are there needs, tasks or problems which are unique to the individual who is institutionalized?
- what are the effects of institutionalization?

If answers to such questions are forthcoming, the counselling needs of the old person in Intermediate Care may be addressed by asking two additional questions: (a) for what purpose, need or problem might counselling be required, and (b) what kind of counselling might be required?

In this manner it may be possible to determine whether there are counselling requirements specific to the old which justify counselling as an integral part of Intermediate Care for the aged. (See Appendix 1 for definition of Intermediate Care.)

Limitations of the Study

Sources were limited primarily to literature of the period 1970 - 1980, and of Canada and the United States. In some cases literature of an earlier date, or from other sources was included as being of particular significance to the present study.

Because of the use of "old, "elderly" and "aged" often without definition in the literature, experimental studies cited in the present paper have, wherever possible, been those relating to the chronologically old (i.e., over 75 years of age). This author does not, however, arbitrarily

accept chronological age as the sole criterion for aging.

For the sake of brevity, some exclusions were made when searching the literature. Three such exclusions were loneliness, depression and sexuality. The first two are regarded as intrinsic to the multiple losses of aging, which are discussed, and the latter as a major component of special needs, which are not (e.g., blindness, lifelong single status, etc.).

CHAPTER II

METHOD

The method followed in this study was a systematic search of the literature of aging, institutionalization, counselling and psychotherapy, from September 1970 to September 1980, with particular focus upon counselling and institutionalization.

The search was limited by the availability of literature, obtained primarily through the University of Victoria McPherson Library.

A search was made of the Psychology Abstracts for the decade September 1970 to September 1980, and a computer search for the same period was made of literature from the Educational Research Information Centre (ERIC). Table 1 shows major areas included in the search, together with descriptors used.

Data from relevant studies were allocated to, and reported under, one of three categories: (a) aging; (b) institutionalization; (c) counselling and psychotherapy; with appropriate sub-categories. Data reported in these categories included both supportive and non-supportive literature so that as comprehensive a range as possible was obtained.

Supplementary data, relevant but not specifically reported in the text were placed in Appendix 2 for

Table 1

Major Areas of Research with Descriptors

Major Area	Descriptors
Counselling	Aged
Geriatrics	Anxiety
Gerontology	Counselling
Nursing	Geriatric patients
Occupational therapy	Geriatric psychotherapy
Psychology	Geriatrics
Social work	Gerontology
	Learned helplessness
	Nursing homes
	Psychosocial rehabilitation
	Psychosocial resocialization
	Psychotherapy
	Residential care institutions

information and for consideration in Chapter VI, Summary and Discussion (p. 65).

Following reports of relevant data, findings in each of the three categories were summarized and discussed and conclusions presented (Chapter VI).

CHAPTER III

THE LITERATURE OF AGING

In order to investigate the need for counselling the old, it was first necessary to identify the needs and tasks of old age by (a) a brief overview of current or significant theories, and (b) an examination of the characteristics of aging.

Three basic emphases were found in theories of aging, (a) biological (including physiological and biobehavioral), (b) psychological (including developmental and personality), and (c) social.

Brief Overview of Current or Significant Theories

Biological, Physiological and Biobehavioral

Aging may be viewed as primary or secondary, as described by Busse (1969). Primary aging consists of time dependent biological processes, rooted in heredity, and independent of stress, trauma and disease, while secondary aging involves disabilities resulting from trauma and loss. Primary aging may be seen as a decline in the efficiency of the various functions of the organism which progressively increases the probability of death.

It was generally accepted that biological aging occurs at different chronological ages in different individuals,

and that demographic, economic and social factors appeared to operate alongside biological ones to produce the bodily changes that occur as age increases (Kart, 1976; Saxon & Etten, 1978).

Physiological changes due to aging may be considered in terms of glucose metabolism, cardiovascular functions, bone changes and body mass. Although the physiology of man is markedly altered during aging, it may be suggested that within this field it is difficult to determine how much deficit in the aged is the result of normal aging, and how much is secondary to stress (Masoro, 1974; Schonfield, 1980; Weg, 1973).

A biobehavioral view was found suggesting that behavior depends upon the limits set by genetic heritage, the modification and reinforcements of physical and social environments, and the self-concept achieved through the integration of past life experiences (Birren, 1980).

It was evident, however, that in some areas it may be difficult to distinguish between biologic and psychologic aspects of aging. Biologic changes may affect an individual's psychologic state, and biologic functioning itself may be affected by psychologic and psychosocial changes (Kart, Metress & Metress, 1978). In addition, physical environment may be a factor in such changes (Cohen, 1976; Cottrell, 1974).

Psychological Theories

A major component of the experimental approach to the psychology of aging has been in the spheres of cognitive and intellectual functioning (Eisdorfer, 1973). Inherent in this approach, however, is the problem that research has tended to derive its assumptions, predictions and interpretations from youth-centred models, using instruments and techniques developed for children and young adults (Labouvie-Vief, 1978; Schaie, 1980). For this reason, it has been shown that stereotypes of aging may be challenged when factors other than measured performance are taken into consideration. For example, Botwinnick's (1973) work on learning.

Developmental theories. It is beyond the scope of this paper to discuss fully life-span and life-stage theories of development. It may be noted, however, that life-span theory emphasizes developmental processes that attain their salience in a life-span, or life-course context (Baltes & Brim, 1979); whereas life-stage theory emphasizes sequences or cycles of development (Erikson, 1963). Many authors referred to developmental, or adaptive, tasks of aging, and these are shown in Table 2.

These developmental tasks of old age may be seen as either regressive or compensatory, depending upon whether they encompass adjustment to declining functions and limited roles, or to the initiation of a new search for status,

Table 2

The Developmental and Adaptive Tasks of Aging

Physical
To adjust to decreasing physical strength and health. To conserve strength and resources when necessary. To retain physical function, specifically physical activity and self-care capacity.
Psychological
To adjust to the changes and losses occuring as a part of the aging process.
To adjust to the death of spouse, peers and relatives.
To clarify, deepen and find a use for a life-time of experience.
To undertake life review and delineate a final identity.
To enjoy the achievement of being a completed human being. To maintain intellectual and emotional stimulation.
Social
To establish an explicit affiliation with one's age group.
To adjust to changes in living arrangements and establish satisfactory physical living arrangements.
To adopt and adapt to social roles in a flexible way to bring recognition and respect.
To transcend previous social roles and limit definition of the self.
To use leisure time in satisfying ways.

Note: Derived from Butler and Lewis (1977); Havighurst (1972); Pfeiffer (1977); Sherron and Lumsden (1978); and Wolff (1970).

modification of self concepts, or other positive forward moving adjustments (Barrett, 1972).

Personality. Personality structure may be more clearly revealed in the old person than in the young, with individuals becoming "increasingly like themselves" as they age (Neugarten, 1964, p. 198). In fact, personality may be regarded as the pivotal dimension in describing aging, as there is no discontinuity of personality with age but, rather, an increasing consistency. Patterns of overt behavior are likely to become increasingly consonant with the individual's personality needs, and his desires (Neugarten, Havighurst & Tobin, 1968; Verwoerdt, 1976). Kimmel (1974) regarded this as being the revelation of internal aspects of personality.

Social Theory

In 1961 Cumming and Henry introduced what became a predominant social theory, that of disengagement. This theory proposed that chronological aging accompanied decline in emotional involvement with the environment, resulting in a mutual disengagement between the old person and society. The theory was later challenged by Maddox (1963, 1966, 1970) and others, who proposed, instead, the notion that continued activity and involvement was integral to successful aging.

Disengagement has been used to support laissez-faire policies and negligent practices in the care of the old--to the deep regret of Cumming (1975).

In commenting on disengagement, Sill (1980) suggested that awareness of finitude was a better predictor of disengagement than chronological age, and that the aging person may perceive himself as near death and thus begin to constrict his life space.

It has been suggested that those who were happy and satisfied with their activity and productivity will continue to be happy and satisfied while maintaining a considerable part of their activity and productiveness. Conversely, those who were happy and satisfied by being relatively passive and dependent will be happy to become even more disengaged in their later years (Wolff, 1970).

Further factors of aging to be considered are behavioral and experiential aging. Experiential aging may be seen as independent of chronological or behavioral aging, and related to the quality of contact between the person and his environment, whereas behavioral aging refers to chronological aging (Sparks, 1973).

The difficulties and conflicts of the old in having to focus not only on "what is supposed to be" but also on "what is" have been described by Morgan (1979, p. 39) who put forward a double bind theory of aging. This theory suggested that aging is the internal experience of the individual, experienced by each individual in a different way.

The Characteristics of Aging

It was found that the characteristics of aging fell into four categories (a) multiple losses, (b) chronic disease, (c) psychopathology, and (d) nearness to death.

In addition, Butler and Lewis (1977) identified seven special characteristics of the old, and these are reported in Table 3.

Multiple Losses

Old age has been characterized by many authors as a period of multiple losses, and a synthesis of these is given in Table 4.

Many of these losses may be regarded as idiosyncratic to aging. For example, loss of physical attractiveness, sexual drive, locomotion and independence are not generally found in early life, nor is impairment of cardiac function and memory (Verwoerdt, 1976).

Coping with such losses poses difficulty for the old person at a time when age implies failing physical and mental health (Burnside, 1973; Butler & Lewis, 1977; Wolff, 1970). There arises a need for the old to replace usual ways of coping by new techniques of adaptation rather than mastery. This may require a process of review, re-evaluation and re-appraisal leading the individual to an internal re-orientation to the world and to self (Verwoerdt, 1976).

Table 3

Special Characteristics of Old People

Characteristic	Definition
The desire to leave a legacy	To provide a sense of continuity (a sense of participation even after death).
The elder function	The sharing of accumulated knowledge and experience.
Attachment to familiar objects	Obtaining a sense of continuity to aid the memory and provide comfort, security and satisfaction. Fear of loss of possessions on death is a frequent preoccupation.
Change in the sense of time	A sense of sensory and emotional enjoyment and awareness. A sense of immediacy or elementality; a sense of living now, in the moment.
Sense of the life cycle	Historical perspective; a capacity to summarize and comment upon one's life as well as one's times.
Creativity, curiosity and surprise	Creativity often begins in old age; curiosity and the ability to be surprised are qualities that have a strikingly adaptive quality.
Sense of consummation or fulfillment in life	The quality of "serenity" or wisdom resulting from resolution of personal conflicts; from reviewing life and finding it acceptable and gratifying; viewing death with equanimity. A feeling of having done one's best; of having met challenge and difficulty, or sometimes simply from having survived against terrible odds.

Note: From Butler and Lewis (1977).

Table 4

The Multiple Losses of Aging

Physical

Loss of body image through physical change. Loss of vitality and energy production with age related changes in organ systems.

Loss of mobility with consequent physical and/or psychological isolation and decreased independent activity.

Psychological

Loss of mental acuity and intellectual capacities.

Loss of effectiveness and speed to take in sense data, to process and evaluate it and carry out motor tasks.

Loss of ability to cope with stress.

Loss of hope for a better future.

Loss of life itself--i.e., the need to come to terms with death and the loss of the body itself--"dissolution".

Affiliative

Loss of spouse, older friends, colleagues and relatives.

Loss of children by virtue of geographical distance.

Loss as loneliness, e.g., the loneliness of impending death of self or other.

Loss of persons prepared to be listeners.

Loss of security in religion (as religious rituals are increasingly questioned and discarded).

Loss of support from loved ones and friends equals stress associated with alienation; concomitant decline in physical and psychological resources.

(continued on page 17)

Table 4 continued -

Social

Loss of usefulness and feeling of participation in society.

Loss of familiar places and things.

Loss of income, status, prestige and self esteem.

Loss of privacy and individuality (for the institutionalized).

Loss of societal support for grief and mourning.

Loss of role peculiar to the individual self (in institutionalized individuals).

Note: Derived from Burnside (1973); Butler and Lewis (1977); Renner and Birren (1980); Rosow (1973); Verwoerdt (1976); Weiner, Brok and Snadowsky (1978); and Wolff (1970).

In addition, the old person may experience a form of loss unique to the institutionalized, namely, loss of roles peculiar to the individual's self. Such a loss involves the inability to play a familiar role (such as parent or grandparent) in the manner in which this role would be played outside the institution (Kart, Metress & Metress, 1978).

Chronic Diseases

It was found that most old people suffer from at least one chronic disease, with many affected by three or four (Woodruff & Birren, 1975). The most common mental disorders of the aged are depression, anxiety or hypochondriasis (Pfeiffer, 1977).

It has already been noted that the old are caught in a vicious circle of experiencing failing physical and mental health at a time when they are required to cope with the stress of multiple losses (Verwoerdt, 1976) so that it may be readily understood that such failure to cope may lead to psychopathology (Butler & Lewis, 1977; Pfeiffer & Busse, 1973; Wolff, 1970), or to somatic illness (Hess, 1977). In this manner, physical ailments may often be presented as mental confusion or disorientation; and symptomatic behaviors such as aggression, incontinence, insomnia and wandering have also been described (Burnside, 1980).

A variety of somatic illnesses were found in the literature as having psychological effects, and vice-versa (See Table 5).

It has been suggested that the mere knowledge of physical sickness can lead to anxiety and tension (Wolff, 1970) and a multiple systems interaction has been described whereby stress on any one system often affects others. For example, pharmaceutical treatment of one condition may trigger another (Hess, 1977).

In addition to such effects, the old expend enormous amounts of physical and emotional energy in grieving, adapting to (and recovery from) stress and change resulting from loss (Butler & Lewis, 1977).

Psychopathology

It was reported to be necessary, when considering the psychopathology of later life, to differentiate organic diseases from functional disease. The former are seen as having a physical cause, while the latter may be regarded as emotional in origin and related to the personality and life experience of the individual (Butler & Lewis, 1977).

Organic disorders (also described as organic brain disorder, or organic brain syndrome) have been documented by Busse (1973), Verwoerdt (1976) and Saxon and Etten (1978). The major disorders are summarized in Table 6.

It has been said that one way to ensure "senility" is to misdiagnose a case of reversible cognitive disorder

Table 5

Somatic/Psychological Disorders

Disorder	Description
Diabetes	Boredom often accompanied by depression; often stressful enough to alter the blood glucose value; emotional instability owing to continuous anxiety and fear of dying suddenly.
Hypoglycemia	Mental confusion; permanent cerebral damage.
Digestive disturbances	Moodiness and occasional bad temper.
Cardiac	Restlessnes, demanding behavior, tenseness (hospitalization may lead to depression).
General/cerebral arteriosclerosis	Depression.
Prostate	Feelings of being invalided, rejected.
Pneumonia and myxedema	Confusion as a first sign.
Deafness	Depression, paranoia.
Visual deficiencies	"Senile" behavior.
Back pain	Depression.
Anorexia, insomnia	Depression.
Hypochondriacal/ psychosomatic symptoms	Masked depression.

Also to be considered: The refusal to eat; lack of stimulation as a possible correlate of brain syndrome; depression masked and expressed as "sick" to gain attention.

Note: Derived from Glasscote, Gudeman and Miles (1977); Granick (1971); Hess (1977); Lesse (1979) Nowlin (1973); Parkes (1964); Smith (1972); Verwoerdt (1976); Wolff (1970).

Table 6

Organic Brain Syndrome

Type	Description
Acute, or reversible (also known as delusional state, or senile delirium)	Causal factors: drug intoxication, metabolic disorders, malnutrition, congestive heart failure.
	Other factors which tax the individual's reserve capacity or ability to cope.
Chronic brain syndrome (irreversible; also known as senile brain disease, senile dementia, senility)	
Senile psychosis	Related to diffuse brain cell loss; cause unknown.
Arteriosclerotic psychosis	Loss of brain cells from lack of oxygen and necessary nutrients; difficult to distinguish from senile psychosis.
Presenile dementia	Most commonly Alzheimer's disease and Pick's disease. Symptoms appear in 40's and 50's and decline is rapid with deterioration of intellectual skills and disorganization of personality.

Note: From Saxon and Etten (1978). Classic symptoms are disorientation for time, place and person; memory loss; disturbance in thinking, especially in abstract thinking and reasoning; impairment of judgement; emotional lability, or inappropriate emotional response.

(organic brain disease), and consequently treat the patient as a case of chronic (irreversible) brain syndrome (Libow, 1977). Libow (1977) recommended that the clinical rule must be to seek out and diagnose the pseudosenilities with the expectation that effective therapy will follow.

It may be that so-called chronic brain syndrome is better viewed as a complex of symptoms derived from isolation (Ernst, Beran, Safford & Kleinhauz, 1978), or that the psychopathology of old age centres ultimately on the fear of dying (Roth, 1978).

Nearness to Death

Death may be regarded as the compact expression of all the anxieties of aging and of the troubles that older persons endure. Death was seen as always close at hand to the elderly, and almost palpable at times (Roth, 1978).

Indeed, some people may feel that they have already died when forced by circumstances to enter an institution (Saul & Saul, 1977) or that they are pressured toward death by the nursing home life (Gustafson, 1975).

Distance from death and awareness of finitude may be important factors affecting status and way of living as well as psychological functioning (Granick, 1971; Lieberman, 1966; Lieberman & Coplan, 1969; Marshall, 1976) with impending death a status passage requiring socialization (Marshall, 1976).

Old persons have expressed a variety of views about death and dying, ranging from matter of fact acceptance of the inevitability of dying, to fear (Palmore, 1974; Matthews, 1975; Roberts, Kinsey, Logan & Shaw, 1970; Roth, 1978; Wolman, 1978). Death anxiety appeared to be a function of the individual's living arrangements, in that the presence of other elderly people with common interests served to defuse death through continuing concern for wellbeing, illness and death of others (Nehrke, Bellucci & Gabriel, 1978). Those who find meaning in suffering and death may find the meaning of life to be enhanced (Durlak, 1973; Frankl, 1978). It should be noted that control over one's life is an important part of human existence, of particular importance to the dying person, although not always clearly recognized. This lack of recognition may result from the apparent dependency of the dying person, proximity to death, or the caretaker's lack of appreciation for sustaining control throughout life (Koff, 1979).

CHAPTER IV

THE LITERATURE OF INSTITUTIONALIZATION

In the previous chapter, the process of aging was briefly examined and the characteristics of aging reported. The intention of the present chapter was to examine the impact of institutionalization on the old, and it was possible to categorize this under four headings: (a) effects of institutionalization, (b) effectance, coping skills and locus of control, (c) relocation effects, and (d) staff and environment.

Effects of Institutionalization

Table 7 summarizes the effects of institutionalization on the old as reported throughout the literature. There appeared to have been no complete longitudinal control group studies allowing a critical test of the effects of institutionalization (Kasl & Rosenfield, 1980; Lawton, 1977).

However, it may be suggested that these effects include possible increased mortality, and are dependent upon personality variables and the amount of personal attention received by the individual (Brody, Kleban & Moss, 1974; Kasl & Rosenfield, 1980; Turner, Tobin & Lieberman, 1972; Wigdor, 1980).

It would seem that the common stereotype of the nursing home as a place to die is evident among the old

Table 7

Effects of Institutionalization

Effect	Definition
Isolation	Geographic and social distance from family and friends and cultural milieu.
	Loss of interest in activities or the outside world.
	Lessening of affiliation and withdrawal from social interaction with consequent loneliness and lack of meaningful interpersonal contacts.
Loss of autonomy	Loss of control of positive reinforcement.
	Loss of privacy and freedom.
	Exposure to disrespectful or belittling staff attitudes.
Adoption of patient or "sick" role	Perception of less capacity for self care.
	Increased preoccupation with bodily concerns.
	Physical, psychological and social decline.
	Manifestation of "senile" signs (e.g., incontinence).
	Desexualization and infantilization.
Loss of ego strength	Erosion of personality and loss of purpose or meaning to life.
	Feelings of dependency, depersonalization, low self esteem, apathy, helplessness, resignation, depression, dislocation, devaluation, anxiety, submissiveness, alienation, hopelessness and despair.

Note: Derived from Barnes, Sack and Shore (1973); Baxter (1977); Blackman, Howe and Pinkston (1976); Brody (1973); Butler and Lewis (1977); Felton and Kahana (1974); Fuller (1978); Kraus, Spasoff, Beattie et al. (1976); Queen and Fritag (1978); Tobin (1980); Tobin and Lieberman (1976); Weiner, Brok and Snadowsky (1978); Verwoerdt (1976).

(Lieberman, 1974; Noelker & Harel, 1978) and may even be expressed as a disidentifying process, e.g., "I don't really belong here" (Weiner, Brok & Snadowsky, 1978, p. 57).

With specific reference to Intermediate Care, it may be noted that the Home for the aged is not a hospital, but an extension of the residential community. Individuals seeking admission do so with a residential intent, and in consideration of specific personal needs of a health and social nature which are, typically, ongoing. A function of the Home, therefore, is to assist residents to feel comfortable and at home, through long range planning for comfort, security and contentment (Gaynes, 1973; Stotsky, 1973).

Parenthetically, the U.S. Department of Health, Education and Welfare noted in 1978 that because models for long term care were lacking, it had been found easier and more expedient to adopt a medical model of care even though the patient's primary need was psychosocial and other non-medical care. In this manner, institutional services included limited nursing at the intermediate care level.

Too often the individual may be assigned a patient-status role, with accompanying emphasis on the medical model, when, instead, living patterns of the individual prior to institutionalization should be taken into account (Brody, 1973). The home for the aged of the future has been seen as a complex facility combining both medical care

and the ability to fulfill the elderly person's needs for social, religious, recreational and occupational activities (Wolff, 1970).

Several authors have pointed out the difficulties faced by the individual who is forced to survive in a new setting at a time when he does not adapt readily. Such difficulties may result in frustration and anger leading to antisocial behavior acceptable neither to fellow residents nor to staff, and culminating, perhaps, in transferral from the institution due to unmanageability (Robinson, 1973). This may be seen in terms of elderly persons taking with them characteristic attitudes and ways of relating to others, and transferring emotions, ideas and expectations from a previous setting to the new situation (Verwoerdt, 1976). The suggestion was made that acknowledgement of the resident's feelings and perceptions through therapeutic intervention is an important factor in life satisfaction and morale (Noelker & Harel, 1978).

Referring to the individual who is slightly disoriented on admission, a case was made for institutionalization as leading to increased confusion culminating in non-awareness of time, place and/or person (Weiner, Brok & Snadowsky, 1978). A relationship also was found between coping style and adaptation to institutional living, with a hostile-narcissistic preadmission style adapting best, although limiting of smooth personal and interpersonal relations (Turner, Tobin & Lieberman, 1972).

However, the literature showed that, regardless of age, people relate to their environment only to the degree to which it contains information relevant to them. Enrichment of environmental information will augment messages carried to the aging organism (Weinberg, 1970). It was suggested, also, that the quality of care in institutions for older adults may accelerate rather than reduce the threat of cultural isolation and social rejection (Euster, 1971). Privacy was found to offer opportunity for personal autonomy, emotional release, self evaluation and protected communication. All of these factors were seen as having significance in allowing for self-evaluation, reflection, integration and assimilation which, in turn, enhanced self-understanding, self identity and an increased sense of freedom of choice (Butler & Lewis, 1977).

When the elderly individual enters an institution, he or she may be seen as leaving the community, and the suggestion has been made that there is a need for continued awareness of the outside community as a necessary stimulant for the intellectually impaired (Miller & Barry, 1976).

Birchenall and Streight (1973) saw dependency in the old (as in institutionalization) occuring at a time when the individual's need to be independent is more intense than at any other period except adolescence, and viewed such dependency as having negative effects upon the need to maintain a meaningful life.

This concept of Birchenall and Streight (1973) may be considered in light of Weiner, Brok and Snadowsky's (1978) observation that in the institution everything that occurs is fed back into everything else through a looping process. For example, dress and manners are constantly under the scrutiny of others, as are staff and residents' conversations.

A first month syndrome has been described, during which the individual experiences transient but severe behavioral changes which will show some stabilization by two months after admission, with perhaps some lessened friendliness and more hostility toward others (Tobin, 1980).

Effectance, Coping Skills and Locus of Control

The literature search indicated that effectance and locus of control appeared to be significant factors as related to the social needs of the institutionalized old, and several studies were found.

Residents given responsibility showed higher health, sociability and activity patterns over time than those who were not, and belief in having control over desired outcomes was suggested as being associated with positive self concept. Control over outcomes may indeed be a core concept of the adjustment and wellbeing of the old (Fuller, 1978; Langer & Rodin, 1976; Reid, Haas & Hawkings, 1977; Rodin & Langer, 1977; Wolk, 1977). Conversely, depression, helplessness, and accelerated physical decline were found to be at least partly attributable to loss of control (Schulz, 1976).

Reports showed that control by staff directly maintained dependent behavior, and that residents perceiving staff as the locus of control were better adjusted to institutional life, and had more life satisfaction, than those who did not (Barton, Baltes & Orzech, 1980; Felton & Kahana, 1974). Thomae (1980) suggested that adjustment might be assumed if the individual had survived after one year.

Two views were found relating to the individual's pre-institutionalized repertoire of behavior. These views suggested that (a) because environmental variables controlled behavior, institutionalized behavior might be contrary to that prior to institutionalization; and (b) that the aged found themselves in a double bind involving contrast between long-held beliefs about personal control and the new reality of diminished control (Blackman, Howe & Pinkston, 1976; Bradley & Webb, 1976). There was evidence that residents in the institutional setting felt themselves to be controlled rather than controlling (Queen & Fritag, 1978; Solomon, 1979; Wolk, 1976).

Sensory deprivation and perceived lack of self worth were seen as conducive of the so-called "senile signs" of maladjustment, neuroticism and lack of ego strength (Weiner, Brok & Snadowsky, 1978), which could result in what Barns, Sack and Shore (1973) described as a spiral of senility leading to degeneration and death.

Verwoerdt (1976) claimed that the flow of time is essential to optimal functioning, and that when this ceases, as in institutionalization, a powerful regressive pull is exerted on the individual. Aggression, autistic withdrawal or irreversible senility may result from this "timelessness" or stagnation.

It appeared from the literature that initial adjustment difficulties might be related to a variety of factors ranging from poor capacity for interpersonal relationships to chronic brain syndrome, and including relocation disruption and lack of individualized psychological experience (Kahana, 1973; Kart, Metress & Metress, 1978; Rodstein, Savitsky & Starkman, 1976).

A suggestion was made that provision of on-site geropsychiatric services could have an impact on the prevention and treatment of crippling mental or emotional disability. This would obviate disruption of the lives of residents, and help to preserve the essential value of life both for individual residents and for the Home as a whole (Sherr & Goffi, 1977).

Relocation, or the process of moving from one residential setting to another, was found to be a major factor in the effects of institutionalization and for ongoing debate in the literature.

Reviews have been undertaken by Yawney and Slover (1974) and Schulz and Brenner (1977), and mention must

also be made of the pioneering work of Lieberman in this field (Lieberman, 1965a, 1965b, 1969; Lieberman & Lakin, 1963; Lieberman, Prock & Tobin, 1968).

Significant factors in the process of relocation are shown in Table 8 and studies representative of these factors are shown in Table 9.

Three stages in the relocation process were noted: (a) decision and preparation, (b) impact, and (c) settling in (Lieberman, 1965a, 1965b). These stages may be paralleled by the development of institutionalization which has been described as a progressive loss of identity after the first (readily reversible) stage (Linden, 1967; cited in Yawney & Slover, 1974).

Two factors regarded as predictive of well-being and survival were the applicant's cognitive and emotional states at both application and entry (Noelker & Harel, 1978), and an analogy may be made between relocation and physiological changes. This was done by Verwoerdt (1976), who suggested that while the body may tolerate small doses of an alien substance, large doses may overwhelm the organism's defence mechanisms. In this manner, a "large dose" of relocation may result in behavioral changes, and Verwoerdt (1976) recommended that the individual should have prior knowledge of a move, and give his approval.

From a similar stance, it was also recommended that the psychosocial area was an appropriate intervention point

Table 8

Significant Factors in the Process of Relocation

Researcher	Factor
Lieberman (1974)	The personal characteristics of the individual.
	The relocation process.
	The characteristics and impact of the institutional environment.
Schulz (1977)	Voluntary or involuntary relocation.
	Degree of control over pre-relocation environment.
	Pre-relocation preparation programs.

Table 9

Representative Views on Relocation

Researcher	Finding
Bourestom and Tars (1974) n = 98, median age 76	Preparation should be mandatory in all situations involving radical and involuntary relocation; helps to reduce fatalities and facilitate adjustment.
Lieberman (1974) n = 640	Preparation for a move can and does alleviate the "human misery" inherent in the transition process.
Carman (1977) n = 36	Supportive preadmission therapy resulted in reduction of placement stress and increased adjustment.
Hasselkus (1978) Position paper	The stress of relocation can lead to increased physical and psychological problems, serious illness and even death.
Gutman and Herbert (1976) n = 81, mean age, 77.93 Pastalan and Bourestom (1977)	Careful and systematic procedures using rehabilitation oriented staff resulted in successful relocation of groups of individuals. Relocation need not result in increased mortality.
Wolanin (1978) Review	Important to maintain the status quo of the individual during relocation.
Schulz and Brenner (1977) Review and theoretical analysis	Subjects moved involuntarily had higher mortality rates than non-relocated controls.
Pino, Rosica and Carter (1978) n = 100	Less decline in mental alertness among prepared individuals; pre-relocation counselling essential.
Schwartz (1977) n = 108 and n = 79	The higher the level of care and programs, the lower the mortality rate.

Table 9 continued -

Researcher	Finding
Farquhar (1977) n = 45, mean age 78	Need for preadmission counselling and better understanding of the dynamics of the preadmision period. Discrepancies may be experienced between preadmission outlook and actual living arrangements.
Yawney and Slover (1973) Review of research	When relocation is beneficial, manipulation of the environment will provide support, acceptance and encouragement.
Turner, Tobin and Lieberman (1974) n = 85, mean age 78	Personality traits are powerful predictors of institutional adaptation among the aged.
Rodstein, Savitsky and Starkman (1976)	Initial period stressful; anxiety, aggressiveness and depression are the major patterns. Integrated study of the individual recommended.
Simon (1980)	Referring to personality disorders; involuntary relocation may precipitate a reactive, tense, hypochondriacal depression.
Hutchins, O'Brien and Coleman (1972)	Transplantation shock manifested by confusion, incontinence, belligerency, despondency and depression.
Verwoerdt (1976)	Sudden move may cause transplantation shock.
Borup, Gallego and Hefferman (1979) Review	Relocation does not bring about an increase in mortality. Programs should focus on factors which extend the life of the elderly rather than on the stress of relocation.

for providing interpersonal and environmental buffers to increase the chance that relocation would be a positive experience (Lawton, 1980).

One positive effect of relocation may be the strengthening of family ties, or renewed closeness between family members, following the institutionalization of elderly parents (Smith & Bengsten, 1979).

Staff and Environment

Desirable staff characteristics as found in the literature are shown in Table 10.

There appeared to be little doubt that staff were seen as the critical focus for delivery of service to the institutionalized elderly, with emphasis put upon the need for comprehensive training in psychosocial programs so that the resident might continue to live a full life (Kahana, 1973; Kramer, 1974; Lewis, 1979).

The suggestion was made that the institution be viewed in its total context as a therapeutic community, or "family", with each person in the institution having an effect upon every other "family" member (Kramer, 1974). That such a view has particular importance was emphasized by Birchenall's (1973) claim that for some individuals the institutional staff are the only source of love.

Several authors believed that staff should be aware of the particular lifestyle of the individual, and that the aging individual should be involved in creating the humane

Table 10

Desirable Characteristics for Institutional Staff

Researcher	Findings
Bengston (1973)	Ability to judge the older person in terms of his own frame of reference rather than by the observer's own value system. Ability to define activities and behaviors appropriate for aged individuals.
Birchenall (1973)	Ability to put individualized care before procedures and routines.
Birchenall (1973)	Recognition of the importance of deference in the use of first names.
Brink (1977)	Maintenance of a non-threatening environment in which the patient's desires are respected and his attempts to cope with daily life are permitted, encouraged and reinforced. (Pampering and harsh treatment is regarded as neglect.)
Busse (1967)	Recognition that serious impairment of vision and hearing may manifest themselves in irrational behavior.
Butler and Lewis (1977)	Avoidance of violating individual's privacy by casual intrusion or unwanted help.
Goldfarb (1975)	Ability to communicate that the patient is understood.
Kart, Metress and Metress (1978)	Flexibility, good humour, caring and respect; ability to understand the resident as an individual; avoidance of infantilization, and ability to overcome attitudinal and behavioral barriers.
Wolff (1970)	Ability to put the accent on rehabilitation rather than custodial care. Never punitive, restrictive, or uncompromising.

environment in the institutional setting (Kahana, 1973; Weiner, Brok & Snadowsky, 1978; Wolff, 1970). It should be noted, however, that just as staff may tyrannize patients, so may patients depersonalize and mortify staff (Miller, 1979).

The necessity for staff awareness of residents' fears must be stressed. Institutionalization may be viewed by the elderly as catastrophic and fraught with impending death. This fear may be superimposed upon already existing fears of illness and the unknown. Many health workers have attributed confused and disoriented behavior resulting from fear to senility rather than to the slow adjustment of older people to institutionalization (Birchenall, 1973).

Separation from persons and things in which one has invested self and energy (termed secondary loneliness) may be reduced by staff directing a reinvestment process into new and more appropriate things and activities (Francis & Odell, 1979). Similarly, if the resident's subjective perceptions of the institutional environment (rather than the objective characteristics of that environment) were the critical factors for personal well being, then a positive perception of the facility, staff and other residents may be positively associated with morale, life satisfaction, and satisfaction with treatment (Noelker & Harel, 1978).

Sick role identification following institutionalization may possibly result from the provision of a protective,

prosthetic environment for the elderly with declining physical capacity (Myles, 1978). Verwoerdt (1976), however, considered the sick role in terms of hypochondriasis.

The search revealed only three follow-up studies: Langer and Rodin (1976) and Rodin and Langer (1977); Schulz (1976) and Schulz and Hanusa (1978); and Arthur (1971) and Arthur, Donnan and Lair (1973).

CHAPTER V

THE LITERATURE OF COUNSELLING AND PSYCHOTHERAPY

The previous two chapters considered the needs, tasks and characteristics of the old, and the impact of institutionalization. The purpose of the present chapter was to examine the literature of counselling and psychotherapy in order to determine how counselling might best help the old individual in the institutional setting.

The literature of counselling and psychotherapy was found to range from true experimental studies to descriptive studies of a general or subjective nature. For convenience, some of this literature has been entabulated in Appendix 2.

Also found in the literature was a differentiation between counselling and psychotherapy, and instances of this are shown in Appendix 3. In the present paper the terms are considered to be synonymous, although it should be pointed out that counselling excludes work more appropriately undertaken by the clinical psychologist or psychiatrist.

It was found that a number of authors criticized the lack of literature in this field (See Table 11), and that Schmidt (1976) called for a thorough review of the literature of aging with implications for counselling.

It may be noted that the literature search revealed only three examples of follow-up to empirical studies

Table 11

Criticism of the Lack of Research in the Field of Counselling the Aged

Researcher	Findings
Birren and Schaie (1977)	Lack of carefully controlled studies.
Burnside (1978)	Scarcity of reports on group work at international gerontology meetings.
Gotestam (1980)	Looked at 27 studies. Research methods open to criticism (with the exception of Butler and Pfeiffer).
Gray and Stevenson (1980)	Scarcity of well designed experimental studies using any of the group therapies.
Sachs (1975)	A "paucity of research" in relation to behavioral techniques with geriatric subjects.
Schaie and Schaie (1977)	Lack of carefully controlled studies determining the efficacy of various approaches. Need for studies of validity in order to predict success in psychotherapy.
Schmidt (1976)	Relatively little published about the counselling of older people.
Sparacino (1979)	Descriptions of individual psychotherapeutic techniques "typically vague and anecdotal and/or general and methodologically deficient" (p. 215).
Storandt (1978) Ronch and Maizler (1977)	Lack of research with respect to the application of psychotherapeutic techniques.
Toepfer, Bicknell and Shaw (1974)	Remotivation remained empirically untested.
Verwoerdt (1976)	Clinical experience with behavioral techniques is still limited.

(Langer & Rodin, 1976, and Rodin & Langer, 1977; Shulz, 1976, and Shulz & Hanusa, 1978; and Arthur, 1971, and Arthur, Donnan & Lair, 1973).

Four basic emphases were found in the literature: (a) need for counselling, (b) types of counselling, (c) desirable counsellor characteristics (including age, sex and training), and (d) contraindications for counselling.

Need for Counselling

Some areas of need for counselling identified in the literature are shown in Table 12. These areas included support for specific needs (e.g., crisis intervention), as well as assistance in adapting to aging, institutionalization and approaching death, and in working with family and institutional staff.

Types of Counselling

The literature search revealed that counselling was used by medical and helping professionals as well as by counsellors *per se*, and that the work may be regarded as either supportive or rehabilitative, with the terms not mutually exclusive.

All therapies may be said to share certain characteristics, namely (a) psychosocial stimulation, (b) opportunities for social interaction, and (c) opportunities for positive reinforcement related to growth and achievement (Weiner, Brok & Snadowsky, 1978).

Table 12

Some Areas of Need for Counselling

as Found in the Literature

Researcher	Need
Barns and Raskind (1980) and Pressey (1973)	To provide supportive services and crisis intervention. To relieve situational anxiety.
Bauer (1977) and Koff (1979)	To provide warmth and human concern for the dying older person.
Birchenall and Streight (1973)	To aid in the process of dying with dignity; to allow the opportunity to express any private anxiety that may be present about death; as liaison with family and institution.
Butler (1963), Butler and Lewis (1977) and Ebersole (1978)	To assist in the coming to terms with the totality of life experience and the attainment of integrity.
Butler and Lewis (1977)	To counter grief reaction of family on admission of parent to institution.
Cape (1978)	To establish independence.
Frankl (1978)	To assist in finding meaning for life.
Gaitz (1980)	To provide support in recent bereavement.
Gottestam (1980)	To foster autonomous social and instrumental goals.
Noelker and Harel (1978) and Pulvino and Colangelo (1980)	To acknowledge the individual's feelings and perceptions regarding fears and negative dispositions towards institutionalization; motivation adjustment.
Pressey (1973)	To help reshape psychological, social, medical and legal attitudes toward death and dying and attend to the welfare of the dying and their families.

Table 12 continued -

Researcher	Need
Pressey and Pressey (1972)	To provide counselling in the institutional setting. A resident counsellor to be of help to both residents and institution.
Yawney and Slover (1973)	To provide psychological support while awaiting admission to an institution.
Various authors	To assist in relocation (see pages 34 and 35).

Supportive therapy, as described in the literature, may be given five classifications, and these are shown in Table 13. Rehabilitative therapy was described in terms of keeping the individual functioning at his optimum level, which may range from rehumanizing and revitalization to, perhaps, assisting the individual to solve a minor problem (Hess, 1977; Verwoerdt, 1976; Weiner, Brok & Snadowsky, 1978).

There were indications in the literature that more patients improve or recover as a result of psychotherapy than fail to react to it (Benitez, 1973; Butler, 1979a, 1979b; Cumming & Cumming, 1975; Koff & Koff, 1977) and that improved functioning is possible in individuals within the age range 80 - 90 years (Cape, 1978; Weiner, Brok & Snadowsky, 1978). Butler (1971) urged that medical and psychiatric efforts must be directed toward making restitution where possible, and promoting realistic acceptance where fundamental change is impossible.

Of particular interest was the view expressed by Pressey and Pressey (1972) who wrote both as experienced counsellors and as residents of an intermediate care facility. They saw a need for a resident counsellor in the institutional setting, and gave a variety of reasons which are shown in Table 14.

Additional counselling needs were to aid residents in time of crisis, and to be a confidante to whom fears may be

Table 13

Indications for Supportive Therapy

1.	Support in functioning: In anticipation of difficulties associated with aging; adapting to physical and environmental changes; losses and stresses; facing own death. Blake (1975); Birren and Schaie (1977); Burnside (1970a, 1970b); Hunt (1980); Lowy, (1980); Rosenow and Long (1972); Schaie and Schaie (1977); Stickle (1977); Verwoerdt (1971).
2.	Support for ego enhancement and performance: Enhancing competence for adequate role performance; encouraging the pursuit of goals; to improve self image, sense of identity, sense of life's worth and of feeling useful; to emphasize strengths. Bengston (1973); Gotestam (1980); Pfeiffer (1977); Wolff (1970).
3.	Support in the expression of feelings: To express and work through feelings related to guilt and restitution; guilt and atonement; awareness of the passage of time; disguised fears of death; autonomy and identity; anger and frustration; sense of separateness, isolation or alienation; loneliness. Buckley (1972); Butler and Lewis (1977); Morrison (1976).
4.	Support for family. Lowy (1980).
5.	Support in relocation and process of institutionalization. Bourestom, Pastelan and Tars (1973); Carman (1977); Farquhar (1977); Lowy (1980).

Table 14

Some Areas in Which Counselling is Needed in the Institutional Setting

To aid in initial and continuing orientations.
To assist in friendship building.
To facilitate utilization of all resources.
To meet crises.
To foster resident-management relations.
To assist "isolates" and problem cases.
To act as ombudsman in dealing with legitimate complaints regarding service; and to clarify with management the problems of residents.

Note: Derived from Pressey and Pressey (1972).

expressed (Solomon, 1973; Weg, 1973). Solomon (1973) believed that certain institutionalized persons needed to have a "non-retaliatory powerful health worker" (p. 40) to whom they could express anger and frustration, and who "has the power within the institutional system to do something remedial" (p. 41).

The counsellor in the institutional setting may also be said to have almost unrecognized research opportunities (Pressey & Pressey, 1972), as well as being of assistance to improve the quality of communication between older persons and those working with them in helping capacities (such as staff in nursing homes) (Blake, 1975). The educational function of the counsellor may also be extended to include changing beliefs, attitudes and feelings which are detrimental to old people, and drawing attention to their needs (Hutchins, O'Brien & Coleman, 1972; Miller, 1979; Pressey, 1973).

Rehabilititave therapy. This involves the three core therapies of sensory training, reality orientation and remotivation, which were reported by many authors. (See Table 15 and Appendix 4.) These therapies may be seen as forming a step-ladder approach to rehabilitation of the institutionalized old, and are geared especially toward the more regressed, less intact individual (Weiner, Brok & Snadowsky, 1978).

Table 15

Sensory Training, Reality Orientation and Remotivation

Sensory training	Goal: to put the individual into touch with his surroundings. Awareness of self and body (e.g., through orientation as to person, time and place; and exercises). Use of all five senses.
Reality orientation	First developed by Folsom (Taulbee & Folsom, 1966) and designed to heighten the individual's awareness of time, place and person through a structured behavioral approach. Use is made of clocks, calendars, bulletin boards and reality orientation board, and a variety of materials to stimulate interest.
Remotivation therapy	Originated by Dorothy Smith and designed for stimulating individuals who are withdrawn (see Robinson, n.d.). Utilizes a five-step approach, and is basically a structured program of discussion utilizing objective materials to which individuals are encouraged to respond (Dennis, 1978).

Note: Derived from Weiner, Brok and Snadowsky (1978).

Emotional problems were seen as the first priority in any rehabilitation program which, in turn, was regarded as an integral part of geriatric medicine and as capitalizing on remaining abilities within realistic goals (Hunt, 1980; Wolff, 1970). Erber (1979) suggested the notion of developmental deprivation in the institutionalized old as correlating with a need for sensory retraining.

Supportive therapy. In discussing supportive therapy, acknowledgement must be made of the work of Alvin Goldfarb who pioneered in the field of "brief psychotherapy" with the aged (Goldfarb, 1953, 1955, 1956, 1969, 1971, etc.).

Increased functioning through individual, group or family therapy on a short-term, goal-directed basis is the general goal for the majority of individuals. Objectives for such therapy were seen as improved adjustment and rehabilitation, delaying of deterioration, assistance with adaptation to present situation, and insight and self-care skills (Butler, 1971; Gotestam, 1980; Pfeiffer, 1971; Wolff, 1970).

It has been pointed out that many of the conditions that cause the elderly unhappiness or anxiety cannot be changed, so that counselling must therefore be supportive (Buckley, 1972).

Failure to attempt therapy with older people who have not maintained physical activities and social contacts may result in their physical limitation and social isolation

(Seymour, 1978). It may be also suggested that the tranquilized or sedated noisy and active patient may have the best chance for physical and mental rehabilitation (Brink, 1977). While institution of therapy may be seen as fostering a sense of being cared about, the importance of attempting psychotherapy even when brain damage has been diagnosed unequivocally cannot be ignored (Butler & Lewis, 1977; Lowy, 1980; Pfeiffer, 1977; Schaie & Schaie, 1977; Wolff, 1970).

Rehabilitation may be regarded as dependent upon the motivation, lifestyle and ability of the individual (Pfeiffer, 1977; Rosenow & Long, 1972) so that even old persons with serious chronic sickness are able to become useful and remain active (Wolff, 1970).

The importance of psychosocial factors in successful management of a wide range of physical disorders such as stroke, diabetes, etc. has been stressed (Birren & Schaie, 1977). (See Table 5, page 20.)

Several modes of therapy found in the literature warranted special mention, and these were (a) attitude therapy, (b) milieu therapy, (c) touch, and (d) special therapeutic indications related to death and dying.

Attitude therapy. This is generally used in conjunction with reality orientation and involves a consistent and appropriate staff style of behavior toward the individual's habitual response to his environment. (See Table 16.) (Taulbee & Folsom, 1966; Verwoerdt, 1976; Weiner, Brok & Snadowsky, 1978)

Table 16

Attitude Therapy

Staff Attitude	Type of Patient Behavior
Active friendliness (constructive statements designed to rebuild confidence)	Apathetic, withdrawn; with little or no confidence; feelings of failure.
Passive friendliness (shows interest and concern; allows the patient to take initiative while indicating support)	Frightened, suspicious. Alienated.
Matter-of-fact (unrewarding to manipulation; open but teaching the patient to accept responsibility for own behavior)	Highly manipulative or shows social maladjustment.
Firm kindness (to help the patient focus away from self; to foster understanding that appropriate expression of strong feeling is acceptable)	Depressed.
No demand (to remove pressure and protect)	Frightened; angry; acting out fears. Aggressive toward self and others. Panic

In the "no demand" situation the patient may not leave the treatment area; will not be allowed to harm himself or others; must take medications.

Note: As described by Weiner, Brok and Snadowsky (1978).

Milieu therapy. This is a total program for working with people in institutional settings. The key to its success lies in the creation of a climate accommodating different lifestyles in which the old person can be influential in his or her own treatment. Milieu therapy recognizes that each of several environmental components has the potential for becoming a therapeutic or nontherapeutic agent in treatment. These components are program of activities, the staff, the physical setting and other residents (Coons, 1978).

Touch therapy. In contrast to therapy with younger adults, physical touch plays an important role in therapeutic communication with older individuals, and may be seen as a "powerful" means of communicating and caring during sensory deprivation, reality orientation, pain, and during the dying process (Burnside, 1979; Verwoerdt, 1976). In addition, touching by the patient as well as the therapist is important, and has been reported to reflect a spontaneous and natural interaction (Butler, 1979; Weiner, Brok & Snadowsky, 1978).

Reminiscence may be described as a means to gain understanding and develop wisdom. This is a developmental phenomenon that becomes increasingly important for adaptation as one ages (Ebersole, 1978).

Life review has to do with the individual coming to terms with the totality of life experience (Butler, 1961, 1963; Butler & Lewis, 1977; Ebersole, 1978).

The function of reminiscence and life review are shown in Table 17.

The significance of reminiscence and life review may be considered in terms of Frankl's (1978) notion that "having been" is still a mode of being, and "perhaps even the safest mode" (p. 105), and that integrating experience is important as an "optimism of the past" (p. 104).

Those persons who are disinclined to consider the past may be viewed as deprived of a valuable coping procedure for dealing with present similar events (Costa & Kastenbaum, 1973; Havighurst & Glasser, 1972; Lewis & Butler, 1974). Furthermore, failure to achieve a sense of life's worth may lead to psychopathology (Pfeiffer, 1977). Sometimes lack of hope for a better future and love and approval from others is lacking, so that life becomes empty. In such an instance the old person who cannot deal effectively with the present and future may tend to overvalue the past (Wolff, 1970).

Death and dying. It was seen as important for staff to be aware when a patient wishes to talk of death, and for opportunities to be made available for serious discussion about death and dying conducted by qualified persons (Birchenall & Streight, 1973; Kubler-Ross, 1975; Wass, 1978). Support for the dying individual to maintain control over death, and in the transition from stage to stage towards death, was seen in the literature as an important counsellor function (Gustafson, 1976; Kart, 1979).

Table 17

The Functions of Reminiscence/Life Review

Researcher	Function
Berland and Poggi (1979)	To confront the great issues of the life stage.
Burnside (1979)	A progressive cognitive and psychological function. Signs of effective life review will include: attitudinal flexibility; strength of purpose; hopefulness; meaningful activity; personal integrity. Ineffective reflection takes the form of rumination, depression and self-rejection.
Butler (1971, 1973) Butler and Lewis (1977) Ebersole (1978) Hess (1977)	A chance to put one's life in order; to come to terms with the totality of life experience; to gain understanding and develop wisdom; to "find oneself". A natural healing process to deal with time left.
Frankl (1978)	To integrate life experience as an "optimism of the past" so that life ends with a sense of meaningfulness.
Pfeiffer (1977)	To delineate an identity which integrates the diverse elements of a lifetime and allows a reasonably positive view of life's worth.
Simon (1978)	To deal with past conflicts. As a preparation for death; a means of achieving Erikson's (1963) ego integrity.
Weiner, Brok and Snadowsky (1978)	Life review may lead to feelings of guilt, anxiety, despair and obsessional ruminations about past mistakes.

In addition, it may be said that there is a need for individuals to deal with the values of limitation, intimacy and self-actualization during the dying process (Hall, 1977).

Apart from providing support for the dying individual, the counsellor may be regarded as an available listener for staff during the incidence of death in the institution (Burnside, 1973), and perhaps as an ombudsman, confidante to, and monitor of, the constellation of professionals having contact with dying persons and their families (Bauer, 1977).

Contraindications for Counselling

Two areas in which particular therapies were contra-indicated were remotivation and reality orientation. While the former was regarded as useful for particular patients with respect to specific dimensions, it should not be seen as a panacea, nor allowed to become a vehicle for infantilism (Hess, 1977; Storandt, 1978). Reality orientation has been described as "futile" for patients with senile dementia, and neither universally effective nor conducive to autonomy or happiness (Hellebrandt, 1978; Schwenk, 1978; Storandt, 1978). A risk also was seen in assigning individuals indiscriminately to reality orientation, and thus causing less demented patients to feel resentful. Such resentment could become generalized to the entire staff and to other forms of therapy (Storandt, 1978).

Care should be taken in therapy to avoid highly intellectual interpretations which may cause old subjects to feel threatened, or to withdraw from therapy (Lawton, 1976).

Caution also should be exercised in group work in order to avoid making the individual compliant or dependent, or to devalue, scapegoat or subject him to group rejection (Lieberman, Yallom & Miles, 1973).

In the case of life review, it may be advisable to use this with caution, so as to avoid feelings of guilt, anxiety, despair and obsessional ruminations about past mistakes (Weiner, Brok & Snadowsky, 1978).

Interventions in old age should not conform merely to standards and values held by the dominant, ruling class of society, but should foster a wide range of opportunities and developmental paths, and lead to acceptance and respect (Looft, 1973).

There would appear to be evidence also that, where individual therapy is concerned, old people as a group do not generally seek this even when it is available (Weiner, Brok & Snadowsky, 1978).

Counsellor Characteristics: Age, Sex, Training

Desirable counsellor characteristics derived from the literature are given in Table 18.

Reference to the early work of Goldfarb showed that this included presentation of the therapist as a parent-

Table 18

Desirable Counsellor Characteristics

Researcher	Characteristics
Goldfarb (1975) Wolff (1970) Gurian (1978)	Dependable, predictable, caring and strong--an "ally".
Karpf (1980)	A "person for all seasons" not "a mere specialist who sees the redwoods but misses the forest". Knowledgeable; pragmatic; able to find personal fulfillment and deep gratification from helping others in the terminal stage of the life cycle.
Burnside (1973)	A good listener.
Wolff (1970)	Empathic, good emotional equilibrium, hopeful life philosophy; ability to face concern for dying with calmness and serenity.
Weiner, Brok and Snadowsky (1978)	An astute observer, tireless collector of data, a curious investigator, a disciplined clinician and an independent thinker (citing Abraham, 1948).
Schmidt (1976)	Understanding of the aging process.
Weiner, Brok and Snadowsky (1978)	Consistency.
Blank (1974) Verwoerdt (1976)	Able to overcome age barrier between therapist and client.
Kozma and Stones (1978)	Awareness of age changes in sensory, cognitive, motor and affective areas.
Verwoerdt (1976)	Ability to observe behavior and draw inferences.
Sinick (1977)	Knowledge of psychology and individual differences; sensitivity to interpersonal relationships.

Table 18 continued -

Researcher	Characteristics
Granick (1971)	Understanding of the individual's psychological make-up and personality; emotional patterns and characteristic way of coping with life patterns, etc.
Hess (1977)	Familiarity with gerontology and communication skills.
Verwoerdt (1976)	Insight first and foremost a requirement regardless of the type of psychotherapy.
Pulvino and Colangelo (1980)	Ability to understand the old person's particular concerns in light of Erikson's integrity and despair; and in terms of patterns of growth and existing developmental issues. Ability to understand the old person's mental set.
Troll and Nowak (1976)	The ability to move towards trying new options.
Verwoerdt (1976)	Consistency of approach; skill in verbal and non-verbal communication; empathy and ability to use physical touch.
Weiner, Brok and Snadowsky (1978) Burnside, Ebersole and Monea (1979)	Should know how to make use of touch.
Buckley (1972)	Ability to share self and personal or social experiences in the counselling relationship.
Lawton and Gottesman (1974)	Knowledge of age related changes in sensory, motor and affective areas, and of how these are modified by health, social and environmental events.
Fuller (1978)	Flexibility in approach.

Table 18 continued -

Researcher	Characteristics
Sinick (1979)	Knowledge of developmental stages and tasks; deviations caused by individual differences and affected by variables such as sex, ethnic and socioeconomic status.
Burnside (1970, 1971)	Flexibility, warmth, perseverance, patience and the ability to learn.
Hess (1971)	Ability to allow for changes in vision, hearing and ability to process information quickly.

surrogate, dependable, predictable, caring and strong, which, while a successful approach, contradicted traditional psychiatric training that the therapist should avoid increasing the dependency of the patient in therapy (Gurian, 1978; Wolff, 1970).

An issue of concern in the literature was that therapists should be able to understand and analyze their own attitudes toward old people, and toward their old parents in particular (Blank, 1974; Burnside, 1970a, 1970b; Grotjahn, 1978; Verwoerdt, 1976; Wolff, 1970).

It may also be that younger therapists experience difficulty relating to older clients, or understanding their experience, through fear of aging, identifying with their own parents, lacking experience of their own aging, or being unable to accept love and hostility from older clients (Blank, 1974; Gotestam, 1980; Grotjahn, 1978; Verwoerdt, 1976; Wolff, 1970).

A further area of difficulty may be that sometimes persons receiving therapy are not only older than the therapist, but have had in addition superior social or professional status. In such an event, the therapist may feel constrained by feelings of awe, and the client hesitant to settle in an appropriately dependent position (Verwoerdt, 1976; Wrenn, 1980).

Where age of counsellor is concerned, various opinions were reported in the literature.

It seemed that older therapists have greater contact with aged patients than younger therapists, and find their work more fulfilling, although it is not clear whether older therapists are generally more (or less) effective with older individuals. It may be that wide personality differences among patients and therapists obfuscate the age factor (Mitchell, 1976; Ryan, 1976; Sparacino, 1979). Facilitative older counsellors of either sex were preferred by older women, while older men preferred male advisors, although males and females all preferred middle-aged advisors (Clayton & Jellison, 1975; Mitchell, 1978). Wolff (1970) simply suggested that the therapist should be neither too young nor too old.

It has been suggested that while a young counsellor can take on the life issues of an aged client as his own, the older counsellor can partake of the client's life situation with greater understanding. Similarly, elderly persons may find it easier to accept help from an older counsellor, one who is middle aged and has been faced with some of the experiences and problems that the old find so overwhelming (Buckley, 1978).

The literature emphasized the importance of the therapist being able to recognize the link between age changes in sensory, cognitive, motor and affective areas, as well as in health, social and environmental events (Kozma & Stones, 1978; Lawton, 1976). In addition, it may be advisable for the therapist to be aware that rehabilitative

goals may not be achieved due to clinical or physiological phenomena associated with old age (such as multiple disease, slower learning, acute brain syndrome, etc.) (Hunt, 1980). The pace of psychotherapy also may be considerably slower than with younger clients for similar reasons, e.g., slower decision making (Lawton, 1976).

Counsellor Training

It has been suggested that many practising counsellors are not available to the aged because the schools that trained them were not concerned that they become involved in this particular area of counselling. It may be further suggested that the motivation for counsellors in training will be provided by the counsellor training they complete, and, more specifically, by the counsellor educator who instructs them. It was pointed out that counsellors working with the aged must at present seek out further training and additional skills on their own initiative (Lawson & Hughes, 1980).

However, it should be noted that few theories of counselling address the older person (Ganikos, 1979) even though a need has been seen for therapeutic programs to be based on a sound theoretical and empirical background (Birren & Renner, 1977). Without such a background, counsellors may have inappropriately high expectations that techniques successful with younger clients may benefit the old (Fogelman, 1978; Lawton, 1979).

The limited number of courses available has been deplored (Blake, 1975; Salisbury, 1965); and special training for counsellors to work with the dying urged (Carey, 1976; Hall, 1977; Koff, 1979; Sinick, 1976).

CHAPTER VI

SUMMARY AND DISCUSSION

Summary

In asking whether counselling should be an integral part of Intermediate Care for the aged, it was first necessary to identify characteristics, needs and tasks specific to aging. Following this it could then be determined whether there were needs, tasks and problems intrinsic to institutionalization and, indeed, what were the effects of institutionalization.

If a need for counselling were found, then it would be possible to ask (a) for what purpose counselling might be required, and (b) what kind of counselling was required.

In addition, further factors such as training requirements for counsellors might be identified, together with empirical studies relating to specific therapies.

Characteristics, Needs, Tasks or Problems of Aging and Institutionalization

For ease of reading, the characteristics, needs and tasks of aging as found in the literature have been summarized in Table 19 (and given in full in Table 2, page 11, and Table 3, page 15). Similarly, the needs, tasks and problems of the institutionalized old individual are summarized in Table 20, page 66 (See also the effects of institutionalization as given in Table 7, page 25.)

Table 19

Characteristics, Needs and Tasks Specific to Aging

Characteristics	Definition
Physiological changes	Decline in efficiency of the various functions of the organism.
Psychological changes	Increased consistency of personality; behavior increasingly consonant with personality needs (see also Table 4, p. 16, Multiple Losses).
Multiple losses	Physical, psychological, affiliative and social (see Table 4, p. 16).
Chronic diseases	Including mental disorders such as depression, anxiety or hypochondriasis.
Psychopathology	Emotional or organic (organic brain syndrome, acute or chronic).
Developmental and adaptive needs and tasks	See Table 2, p. 11.
Physical Psychological Social	Adjustment to changing bodily and mental functions, as well as to social and environmental changes.

Table 20

Needs, Tasks and Problems of the

Institutionalized Old Individual

Need, Task or Problem	Definition
Need to establish effectance and make use of coping skills while adapting to surrender of roles	To maintain self worth, ego strength and autonomy. To develop coping skills congruent with new situation.
To establish locus of control	To be able to identify and adjust to locus of control within the institution, i.e., to be able to give up responsibility and accept control by others.
To cope with relocation	To be able to accept and adjust to the change from one environment to another.
To accept staff and adapt to environment	To be able to accept care from staff, develop relationships with staff and other residents; to accept and adapt to institutional environment.
To accept finitude	To recognize and accept that institutionalization is the penultimate stage before death.

Major areas of need during aging for which counselling was indicated are shown in Table 21.

Factors relating to institutionalization and identified as significant to a need for counselling are shown in Table 22.

It may be seen that the needs and tasks of aging may be grossly compounded by the effects of institutionalization.

Purpose for which Counselling may be Required

The literature of aging and institutionalization indicated needs for counselling during aging and throughout institutionalization.

The literature of counselling indicated a variety of purposes for which counselling in the institutional setting was desirable, either as supportive or rehabilitative therapy.

Kind of Counselling Required

Counselling was seen to range from empathic touching to structured individual therapeutic programs for specific needs such as a behavioral approach to improving eating habits (e.g., Geiger & Johnson, 1974) depending upon whether a supportive or rehabilitative approach was required.

Supportive therapy was recommended for (a) support in functioning, (b) developing ego enhancement and performance, (c) facilitating the expression of feelings, (d) family support, and (e) the process of relocation and

Table 21

Major Areas of Need During Aging

Indicating a Need for Counselling

Finding	Reference
Developmental needs (Psychological support in adjusting to the changes and losses of aging, and in adapting to altered living arrangements and roles)	Blake (1975); Birren & Schaie (1977); Burnside (1970a, 1970b); Butler & Lewis (1977); Havighurst (1972); Hunt (1980); Lowy (1980); Pfeiffer (1977); Rosenow & Long (1972); Sherron & Lumsden (1978); Schaie & Schaie (1977); Stickle (1977); Verwoerdt (1976); Wolff (1970).
Need for ego enhancement, independence and maintenance of performance	Barns, Sack & Shore (1973); Bengston(1973); Birchenall & Streight (1973); Cape (1978); Euster(1971); Fuller (1978); Gotestam (1980); Langer & Rodin (1976); Noelker & Harel (1978); Pfeiffer (1977); Reid, Haas & Hawkings (1977); Robinson (1973); Rodin & Langer (1977); Schulz (1976); Wolff (1970).
Need for support in the expression of feelings	Blake (1972); Barns & Raskind (1980); Buckley (1972); Butler & Lewis (1977); Morrison (1976); Noelker & Harel (1978); Pressey (1973); Pressey & Pressey (1972); Robinson (1973); Weg (1973).
Need to come to terms with the totality of life	Berland & Poggi (1979); Burnside (1979); Butler (1963); Butler & Lewis (1977); Costa & Kastenbaum (1973); Ebersole (1978); Havighurst & Glasser (1972); Hess (1977); Lewis (1971); Lewis & Butler (1974); Pfeiffer (1977); Simon (1978); Wolff (1970).

Table 22

Factors Relating to Institutionalization

Having Significance for Counselling

Factor	Reference
Relocation	Bourestom, Pastelan & Tars (1973); Bourestom & Tars (1974); Carman (1977); Farquhar (1977); Gutman & Herbert (1976); Hasselkus (1978); Hutchins, O'Brien & Coleman (1972); Kart, Metress & Metress (1978); Lawton (1977); Lieberman (1965a, 1965b, 1969, 1974); Lieberman & Lakin (1963); Lieberman, Prock & Tobin (1968); Lowy (1980); Noelker & Harel (1978); Pablo (1977); Pastalan & Bourestom (1977); Pino, Rosica & Carter (1978); Rodstein, Savitsky & Starkman (1976); Schulz & Brenner (1977); Schwartz (1977); Sherwood & Nadelson (1977); Simon (1980); Tobin (1980); Verwoerdt (1976); Wolanin (1978); Yawney & Slover (1973).
Characteristic attitudes and lifestyle of the individual	Blackman, Howe & Pinkston (1976); Bradley & Webb (1976); Kahana (1973); Robinson (1973); Turner, Tobin & Lieberman (1972); Verwoerdt (1976); Weiner, Brok & Snadowsky (1978).
Impact of the institutional environment	Birchenall & Streight (1973); Butler & Lewis (1977); Euster (1971); Miller & Barry (1976); Noelker & Harel (1978); Robinson (1973); Rodstein, Savitsky & Starkman (1976); Tobin & Lieberman (1976); Weinberg (1970); Weiner, Brok & Snadowsky (1978).
Perceived locus of control and life satisfaction	Felton & Kahana (1974); Fuller (1978); Queen & Fritag (1978); Reid, Haas & Hawkings (1977); Schulz (1976); Solomon (1979); Wolk (1976).

Table 22 continued -

Factor	Reference
Staff attitudes	Barton, Baltes & Orzech (1980); Birchenall (1973); Brink (1977); Busse (1967); Butler & Lewis (1977); Francis & Odell (1979); Kramer (1974); Lewis (1979); Myles (1978).
Finitude and dying	Bauer (1977); Birchenall & Streight (1973); Gaitz & Varner (1980); Gustafson (1976); Hall (1977); Kart (1979); Koff (1979); Kubler-Ross (1975); Matthews (1975); Wass (1978).

institutionalization. Such therapy might take the form of one to one intervention.

Particular emphasis was put upon the importance of reminiscence, life review and touch.

Rehabilitative therapy consisted of the core therapies of sensory training, reality orientation and remotivation (see Table 15, page 48) with attitude and milieu therapy as significant adjuncts (see Table 16, page 51, and page 50).

In addition to supportive and rehabilitative therapy, nine additional counsellor functions were identified, and these are shown in Table 23.

Training Requirements for Counsellors

Emphasis was placed upon the need for training in gerontology for counsellors working with the old, and for more counsellors to be trained to work within the fields of aging and institutionalization (see Table 24). Middle aged counsellors seemed to be preferred.

Empirical Studies

Empirical studies related to counselling and the supportive or rehabilitative therapies were few in number, thus endorsing criticism found in the literature (see Table 11, page 41).

It may be that the practice of counselling the old is not yet widely reported, has been reported as informed opinion or, as suggested by Gotesman (1980) is reported

Table 23

Nine Additional Counsellor Functions

in the Institutional Setting

Function	Reference
To act as confidante and ombudsman to those working with dying persons and their families	Bauer (1977)
To improve the quality of communication between the old and persons working with them	Blake (1975)
To provide an alternative to tranquilizers and sedation in the noisy, active individual	Brink (1977)
To act as a listener for staff during periods of stress (e.g., deaths)	Burnside (1973)
To foster forward movement, forestall decline and be life maintaining	Gottesman (1970)
To act as an advocate to change beliefs and attitudes detrimental to the old	Hutchins, O'Brien and Coleman (1972); Miller (1979)
To provide a sense of being cared about	Lowy (1980)
To foster resident-management relations and act as ombudsman regarding legitimate complaints, etc.	Pressey and Pressey (1972)

Table 24

Need for Counsellors to Work with the Old

Need	Reference
Need for more counsellors to work with increasing number of people living into old age	Osipow (1980); Wrenn (1980).
Need for counsellors in the institutional setting	Blake (1975); Hutchins, O'Brien & Coleman (1972); Koff & Koff (1977); Pressey (1972); Pressey & Pressey (1971); Robinson (1973); Solomon (1979); Weg (1973).
Need for training based on gerontological knowledge	Blake (1975); Butler (1979); Fogelman (1979); Ganikos (1979); Lawson & Hughes (1980); Lawton (1979).
Need for trained counsellors to work with the dying	Carey (1976); Hall (1977); Koff (1979); Sinick (1976); Wass (1978).

without a sound research base. This finding upholds the views of Ganikos (1979) and Birren and Renner (1977) that a sound theoretical base is required.

Of the studies listed in Appendix II as experimental, it may be noted that in most cases samples were small, with the exception of McClanahan and Risley (1973 & 1974) who appeared to have used the same sample of 100 subjects for two studies. In addition, findings may reflect the effects of variables other than those controlled for. For example, Berger and Rose (1977) resocialized 25 subjects to increase interpersonal skills, but noted that training did not generalize to a new situation. Kiley (1977) noted inconclusive results following five weeks of endeavoring to stimulate resocialization through refreshments and reminiscence. Salter and Salter (1975) and Schulz (1976) and Schulz and Hanusa (1978) found that individuals who had benefitted from stimulating events regressed or declined when these events were withdrawn. This may imply a need for consistency or sustained therapeutic efforts.

However, studies involving verbal or social reinforcement, choice or a novel event, appeared to show positive results (Arthur & Lair, 1973; Baltes & Zerbe, 1976; Duncan, 1976; Geiger & Johnson, 1974; MacDonald & Butler, 1974; Quilitch, 1974; Sachs, 1975), thus suggesting that a variety of factors may operate in successful therapy with the old, with choice and interpersonal relationships significant.

It is interesting to note that biofeedback and relaxation reduced depression in one sample of 41 individuals (West, 1978) whereas group counselling failed to have the same effect in another sample (Tutaj, 1975). A multiple therapy program increased verbalization and interpersonal interaction (Gray & Stevenson, 1980), whereas a program using crafts with similar intent resulted also in hostility, conflict and mistrust (Jones, 1972).

It would seem that therapy with the old involves not merely a variety of variables, but also a variety of techniques, not the least of which may be flexibility on the part of the therapist. Certainly there is a need for many more studies.

Discussion

The literature leaves no doubt that a great part of the needs of the institutionalized old is psychosocial, and that there are many supportive and rehabilitative areas in which the counsellor may be of service.

The problem may be, rather, to determine if there are areas in which counselling is not required.

For the old person obliged by frailty or incapacity to become institutionalized, the stresses and losses of old age are compounded by the need to adjust to a new, and perhaps frightening, lifestyle, and to possible depersonalization and loss of choice, control, independence and privacy.

The institutionalized old, who have already fulfilled many of the developmental tasks prior to entering the institution, must repeat the tasks once again within a new setting. For those who have been unsuccessful in accomplishing the tasks of aging, the difficulties are now compounded by their being forced to learn survival in a new environment at a time when they do not readily adapt.

Characteristic attitudes and ways of relating to others, together with preinstitutional lifestyle, may not be compatible with the institution. In addition, there is the need to adjust to the physical or mental disability underlying the need for institutionalization. It may be that it is this latter factor which brings the institutionalized old person to the often painful awareness of finitude and nearness to death, or to the brink of psychopathology.

Intervention of a counselling nature would seem to be not merely appropriate, but imperative both to reassure and encourage the old person, and as an integral part of the institutional program.

Attention to psychosocial needs underlying overt behavior, or presenting illness, seems to be of utmost importance if the individual is to function to optimum ability in what is, supposedly, a residential rather than a hospital setting.

The skilled counsellor, trained also in gerontology, will be aware of the unique needs of the old, and able to

institute therapy for remotivation, resocialization, support or crisis intervention appropriate to the condition and needs of the individual. Similarly, the individual already functioning to optimum level may be helped to face declining functions through appropriate and timely counselling.

A major area of importance for counselling is relocation, and the process of institutionalization. Adequate counsellor intervention before, during and following relocation may well be crucial to preventing disoriented or hostile behavior, as well as mediating a comfortable adjustment to institutionalization.

There would appear, also, to be many functions for the counsellor working with family members of the institutionalized old. For example, with support groups; serving as an intermediary between family and resident (or vice versa); for relationship enhancement; in dealing with individual resident concerns, and in undertaking the counselling of family members when this may be supportive.

Because of the nature of the work, the counsellor is in a unique position to act as advocate on behalf of residents, and as ombudsman between residents and administration (or family). It is important to the resident that his perceptions are understood by those caring for him, and the empathic listening function of the counsellor will facilitate this process.

In view of the increasing numbers of individuals living into old age, it is not unreasonable to suppose that the population of long-term care homes will increase proportionately.

The growing emphasis on counselling the old, and the need to provide a psychosocial approach to care, presupposes a growing need for counsellors in the care setting.

It would seem, however, that at present neither health nor educational agencies are prepared to meet these growing needs. Much emphasis within the health field is placed upon the medical model of care--perhaps at the expense of the psychosocial needs of the individual--and little attention is given in counselling programs to providing student counsellors with the courses necessary for a career in counselling the aged.

Such a state of affairs seems incongruent with the findings of the present study which demonstrate a clear need for counselling as an integral part of Intermediate Care for the aged.

It is recommended, therefore, that health agencies consider including counsellors in Intermediate Care teams, and that counsellor training programs expand to make appropriate gerontology courses available to student counsellors.

REFERENCES

Abraham, K. Selected papers. London: Hogarth Press, 1948.

Altholz, J.A.S. Group psychotherapy with the elderly. In I.M. Burnside (Ed.), Working with the elderly: Group processes and techniques. North Scituate, Mass.: Duxbury Press, 1978.

Arthur, G.L. Companionship therapy with the aged in a nursing home. (Doctoral dissertation, Auburn University). Dissertation Abstracts International, 1971, 32, 3614B.

Arthur, G.L., Donnan, H.H., & Lair, C.V. Companionship therapy with the nursing home aged. Gerontologist, 1973, 13, 167-170.

Baltes, P.B. & Brim, O.G., Jr. Life-span development and behavior (Vol. 2). New York: Academic Press, 1979.

Baltes, M., & Zerbe, M.B. Independence training in nursing home residents. Gerontologist, 1976, 16, 428-432.

Barns, E.K., Sack, A., & Shore, H. Guidelines to treatment approaches. Gerontologist, 1973, 13, 513-527.

Barnes, J.A. Effects of reality orientation classroom on memory loss, confusion and disorientation in geriatric patients. Gerontologist, 1974, 14, 138-142.

Barnes, R., & Raskind, M. Strategies for diagnosing and treating agitation in the aging. Geriatrics, 1980, 35 (3), 111-119.

Barrett, J.H. Gerontological psychology. Springfield, Ill.: Charles C. Thomas, 1972.

Barton, E.M., Baltes, M.M., & Orzech, M.J. Etiology of dependence in older nursing home residents during morning care: The role of staff behavior. Journal of Personality and Social Psychology, 1980, 38, 423-430.

Bauer, D.H. Aging and dying: Implications for community mental health. Journal of Community Psychology, 1977, 5, 28-36.

Baxter, R.J. Effects of institutionalization on social-psychological well-being of the aged. (Doctoral dissertation, Princeton University). Dissertation Abstracts International, 1977, 37, 6100A.

Bell, J.Z. Disengagement versus engagement: A need for greater expectations. Journal of the American Geriatrics Society, 226 (2), 89-95.

Bengston, V.I. The institutionalized aged and their social needs. In R.H. Davis (Ed.), The psychosocial needs of the aged. The Ethel Percy Andrus Gerontology Center, University of California, 1973.

Benitez, R. Some further aspects on aging in relation to social policy and ethnicity. Cited in B. Berkman, Mental health and aging: A review of the literature for clinical social workers. Clinical Social Work Journal, 1976, 6, 230-245.

Bennett, R. Social isolation and isolation reducing programs. Bulletin of the New York Academy of Medicine, 1973, 2nd series, 49.

Berger, L.F. Activating a psychogeriatric group. Psychiatric Quarterly, 1978, 50 (1), 63-66.

Berger, R.M., & Rose, S.D. Interpersonal skill training with institutionalized patients. Journal of Gerontology, 1977, 32, 346-353.

Berland, D.I., & Poggi, R. Expressive group psychotherapy with the aging. International Journal of Group Psychotherapy, 1979, 23, 87-108.

Birchenall, J., & Streight, M.E. Care of the older adult. Philadelphia: J.B. Lippincott, 1973.

Birkett, D., & Boltuch, B. Remotivation therapy. Journal of the American Geriatrics Society, 1973, 21, 368-371.

Birren, J.E. Progress in research on aging in the behavioral and social sciences. Human Development, 1980, 23, 33-45.

Birren, J.E., Butler, R.N., Greenhouse, S.W., Sokoloff, L., & Yarrow, M.R. (Eds.). Human aging: A biological and behavioral study. Washington, D.C.: U.S. Government Printing Office, 1963. Publication No. 986 (reprinted 1971, 1974).

Birren, J.E., & Clayton, V. History of gerontology. In D.S. Woodruff & J.E. Birren (Eds.), Aging: Scientific perspectives and social issues. New York: van Nostrant, 1975.

Birren, J.E., & Renner, V.J. Research on the psychology of aging: Principles and experimentation. In J.E. Birren & K.W. Schaie (Eds.), Handbook of the psychology of aging. New York: Van Nostrand Reinhold, 1977.

Birren, J.E., & Schaie, K.W. Handbook of the psychology of aging. New York: Van Nostrand Reinhold, 1977.

Blackman, D.K., Howe, M., & Pinkston, E.M. Increasing participation in social interaction of the institutionalized elderly. Gerontologist, 1976, 16, 69-76.

Blake, D.R. Group work with the institutionalized elderly. In I.M. Burnside, Psychosocial nursing care of the aged. New York: McGraw-Hill, 1973, pp. 153-160.

Blake, R. Counseling in gerontology. Personnel and Guidance Journal, 1975, 53, 733-737.

Blake, R. Counseling the elderly: An emerging area for counselor education. Counselor Education and Supervision, 1975 (b), 15, 156-157.

Blank, M.L. Raising the age barrier to psychotherapy. Geriatrics, 1974, 29 (11), 141-148.

Blazer, D. Techniques for communicating with your elderly patient. Geriatrics, 1979, 33 (11), 79-84.

Blenkner, M. The place of the nursing home among community resources. Journal of Geriatric Psychiatry, 1968, 1, 135-150.

Bloom, S. A study of the impact of sensitivity training on the elderly. Interpersonal Development, 1975-1976, 6, 150-152.

Blumenthal, M.D. Depressive illness in old age: Getting behind the mask. Geriatrics, 1980, 35 (4), 34-43.

Borup, J.H., Gallego, D.T., & Heffernan, P.C. Relocation and its effect on mortality. Gerontologist, 1979, 19, 135-140.

Botwinnick, J. Behavior and aging. New York: Springer, 1973.

Bourestom, N., & Tars, S. Alterations in life patterns following nursing home relocation. Gerontologist, 1974, 14, 505-510.

Bourestom, N., Pastelan, L., & Tars, S. Forced relocation: Setting, staff, and patient effects - preparation for relocation. Report #3, Institute of Gerontology, University of Michigan, Ann Arbor, 1973.

Boylin, W., Gordon, S.K., & Nehrke, M.F. Reminiscing and ego integrity in institutionalized elderly males. Gerontologist, 1976, 16, 113-124.

Bradley, R.H., & Webb, R. Age-related differences in locus of control orientation in three behavior domains. Human Development, 1976, 19, 49-55.

Brink, T.L. Geriatric counseling: A practical guide. Family Therapy, 1976, 3, 163-168.

Brink, T.L. Tender loving care: Is TLC contraindicated for geriatric patients? Perspectives in Psychiatric Care, 1977, 15 (3), 129-131.

Brink, T.L. Geriatric rigidity and its psychotherapeutic implications. Journal of the American Geriatrics Society, 1978, 26 (6), 274-277.

Brody, E.M. A million Procrustean beds. The Gerontologist, 13, 430-435.

Brody, E.M. Long-term care of older people. New York: Human Sciences Press, 1977.

Brody, E.M., Kleban, M.H., & Moss, M. Measuring the impact of change. Gerontologist, 1974, 14, 299-305.

Brown, M. (Ed.). Readings in gerontology. Saint Louis: The C.V. Mosby Co., 1978.

Buckley, M. Counseling the aging. Personnel and Guidance Journal, 1972, 15, 755-758.

Burnside, I.M. Group work with the aged: Selected literature. Gerontologist, 1970a, 10 (3), 241-246.

Burnside, I.M. Loss: A constant theme in group work with the aged. Hospital and Community Psychiatry, 1970b, 21 (6), 173-177.

Burnside, I.M. Long-term group work with hospitalized aged. Gerontologist, 1971, 11, 213-218.

Burnside, I.M. Multiple losses in the aged: Implications for nursing care. Gerontologist, 1973, 13, 157-162.

Burnside, I.M. Psycho-social nursing of the aged. Workbook. Ethel Percy Andrus Gerontology Center. University of Southern California, Summer Institute for Study in Gerontology, 1974.

Burnside, I.M. History and overview of group work with the elderly. In I.M. Burnside (Ed.), Working with the elderly: Group process and techniques. North Scituate, Mass.: Duxbury Press, 1978a.

Burnside, I.M. Group work with the mentally impaired elderly. In I.M. Burnside (Ed.), Working with the elderly: Group processes and techniques. North Scituate, Mass.: Duxbury Press, 1978b.

Burnside, I.M. Psychosocial caring: Touch, sexuality and cultural aspects. In I.M. Burnside, P. Ebersole, & H.E. Monea (Eds.), Psychosocial caring throughout the life span. New York: McGraw-Hill, 1979.

Burnside, I.M. In J.E. Birren & R.B. Sloane (Eds.), Handbook of mental health and aging. Englewood Cliffs, N.J.: Prentice-Hall, 1980.

Busse, E.W. Therapeutic implications of basic research with the aged. Strecker monograph series No. IV. University of Pennsylvania Hospital, Philadelphia, 1967.

Busse, E.W. Theories of aging. In E.W. Busse & E. Pfeiffer (Eds.), Behavior and adaptation in late life. Boston: Little Brown, 1969.

Busse, E.W. Mental disorders in later life: Organic brain syndromes. In E.W. Busse & E. Pfeiffer (Eds.), Mental illness in later life. Washington: American Psychiatric Association, 1973.

Butler, R.N. Reawakening interest. Nursing Homes, 1961, 10, 8-19.

Butler, R.N. The life review: An interpretation of reminiscence in the aged. Psychiatry 1963, 26, 65-76.

Butler, R.N. Clinical psychiatry in late life. In I. Rossman (Ed.), Clinical geriatrics. Philadelphia: J.B. Lippincott, 1971.

Butler, R.N. Successful aging and the role of the life review. Journal of the American Geriatrics Society, 1974a, 22, 529-535.

Butler, R.N. Successful aging. MH, 1974b, 58 (3), 6-12.

Butler, R.N. Counseling the aging. Falls Church, VA.: American Personnel and Guidance Association, 1979.

Butler, R.N. In A. Monk (Ed.), The age of aging. Buffalo: Prometheus Books, 1979.

Butler, R.N., & Lewis, M.I. Life-review therapy: Putting memories to work in individual and group psychotherapy. Geriatrics, 1974, 29 (11), 165-173.

Butler, R.N., & Lewis, M.I. Aging and mental health: Positive psychosocial approaches. St. Louis: Mosby, 1977.

Butler, R.N. Forward. Counseling the aged: A training syllabus for educators. Falls Church, Va.: American Personnel and Guidance Association, 1979.

Cape, R. Aging: Its complex management. Hagerstown, Md.: Harper & Row, 1978.

Caranasos, G.J. Medical theories of aging. In J.W. Brookbank (Ed.), Improving the quality of health care for the elderly. Gainesville: Center for Gerontological Studies and Programs, 1978.

Carey, R.G. Counseling the terminally ill. Personnel and Guidance Journal, 1976, 55, 124-126.

Carman, M.B. Effects of emotional inoculation and supportive therapy on stress incurred from nursing home placement. (Doctoral Dissertation, University of North Dakota.) Dissertation Abstracts International, 1977, 37, 4132B.

Citrin, R.S., & Dixon, D.N. Reality orientation: A milieu therapy used in an institution for the aged. Gerontologist, 1977, 17, 39-43.

Clayton, V., and Jellison, J.M. Preferences for the age and sex of advisors: A life span approach. Developmental Psychology, 1975, 11, 861-862.

Cohen, G.D. Mental health services and the elderly: Needs and options. American Journal of Psychiatry, 1976, 133, (1), 65-68.

Conner, K., Powers, E.A., & Bultena, G.L. Social interaction and life satisfaction: An empirical assessment of late life patterns. Journal of Gerontology, 1979, 34 (1), 116-121.

Coons, D.H. Milieu therapy (The socio-psychological aspects of treatment). In W. Reichel (Ed.), Clinical aspects of aging. Baltimore: Williams & Wilkins, 1978.

Corby, N. Assertion training with aged populations. Counseling Psychologist, 1975, 5 (4), 69-73.

Corey, M.S. Groups for the elderly. In G.C. Corey & M.S. Corey (Eds.), Groups: Process and practice. Monterey, Calif.: Brooks/Cole, 1977.

Costa, P., & Kastenbaum, R. Some aspects of memories and ambitions in centenarians. In D. Charles & W. Looft (Eds.), Readings in psychological development through life. New York: Holt Reinhardt & Winston, 1973.

Cottrell, F. Aging and the aged. Dubuque, Iowa: William C. Brown, 1974.

Covert, A.B., Rodrigues, T., & Solomon, K. The use of mechanical and chemical restraints in nursing homes. Journal of the American Geriatrics Society, 1977, 25 (2), 85-89.

Cumming, E. Engagement with an old theory. International Journal of Aging and Human Development, 1975, 6 (3), 187-191.

Cumming, E., & Henry, W.E. Growing old: The process of disengagement. New York: Basic Books, 1961.

Cumming, J., & Cumming, E. Care in the community. In J.G. Howells (Ed.), Modern perspectives in the psychiatry of old age. New York: Brunner/Mazel, 1975.

Curry, T.J., & Bascom, W.R. The effects of nursing home size on resident isolation and life satisfaction. Gerontologist, 1973, 13 (3), 295-298.

Curtin, S. Nobody ever died of old age. Boston: Little Brown, 1972.

Dennis, H. Remotivation therapy groups. In I.M. Burnside (Ed.), Working with the elderly: Group process and techniques. North Scituate, Mass.: Duxbury Press, 1978.

De Wever, M.K. Nursing home patients perceptions of nurses' affective touching. Journal of Psychology, 1977, 96, 163-171.

Drummond, L., Kirchhoff, L., & Scarbrough, D.R. A practical guide to reality orientation: A treatment approach for confusion and disorientation. Gerontologist, 1978, 18, 568-573.

Duncan, C. The development and maintenance of attendance and participation in recreational activities in geriatric residents. (Doctoral Dissertation, Washington State University) Dissertation Abstracts International, 1976, 36, 3643B.

Durlak, J.A. Relationship between attitudes towards life and death among elderly women. Developmental Psychology, 1973, 8 (1), 146.

Ebersole, P. Reminiscing and group psychotherapy with the aged. In I.M. Burnside (Ed.), Nursing and the aged. New York: McGraw-Hill, 1975.

Ebersole, P. Reminiscing. American Journal of Nursing, 1976, 1304-1306.

Ebersole, P.P. Establishing reminiscing groups. In E.M. Burnside (Ed.), Working with the elderly: Group processes and techniques. North Scituate, Mass.: Duxbury Press, 1978.

Ebersole, P.P. A theoretical approach to the use of reminiscence. In I.M. Burnside (Ed.), Working with the elderly: Group processes and techniques. North Scituate, Mass.: Duxbury Press, 1978.

Eisdorfer, C., & Lawton, M.P. Experimental studies. In C. Eisdorfer & R.O. Friedel (Eds.), The psychology of adult development and aging. Washington: American Psychological Association, 1973.

Eisdorfer, C., & Stotsky, B.A. Intervention, treatment and rehabilitation of psychiatric disorders. In J.E. Birren & K.W. Schaie (Eds.), Handbook of the psychology of aging. New York: Van Nostrand Reinhold, 1977.

Elder-Jucker, P.L. The effects of group therapy on self esteem and social interaction and depression of female residents in a home for the aged. (Doctoral Dissertation, Temple University) Dissertation Abstracts International, 1979, 39 (11-B), 5514.

Epstein, L.J. Clinical geropsychiatry. In W. Reichel (Ed.), Clinical aspects of aging. Baltimore: Williams & Wilkins, 1978.

Erber, J.T. The institutionalized geriatric patient considered in a framework of developmental deprivation. Human Development, 1979, 22 (3), 165-179.

Erikson, E.H. Identity and the life cycle. In Psychological Issues, International Universities Press, New York, 1959.

Erikson, E.H. Childhood and society. New York: Norton & Co., 1963.

Ernst, P., Beran, B., Safford, F., & Kleinhauz, M. Isolation and the symptoms of chronic brain syndrome. Gerontologist, 1978, 18, 468-473.

Farquhar, M. Applicant expectations of homes for the aged and the need for preadmission counselling. Essence, 1977, 2, 33-40.

Felton, B., & Kahana, E. Adjustment and situationallly bound locus of control among institutionalized aged. Journal of Gerontology, 1974, 29, 295-301.

Finch, C.E., & Hayflick, L. Handbook of the biology of aging (Vol. 1 in the Handbooks of Aging). New York: Van Nostrand & Reinhold, 1977.

Fisher, J. Competence, effectiveness, intellectual functioning and aging. Gerontologist, 1973, 13, 62-68.

Fogelman, C.G. Practica and internships for student counselors of the aging. In M.L. Ganikos (Ed.), Counseling the aged: A training syllabus for educators. Falls Church, Va.: American Personnel and Guidance Association, 1979.

Francis, G., & Odell, S.H. Long-term residence and loneliness: Myth or reality. Journal of Gerontological Nursing, 1979, 5, 9-11.

Frankl, V.E. The unheard cry for meaning. New York: Simon & Schuster, 1978.

Fuller, S.S. Inhibiting helplessness in elderly people. Journal of Gerontological Nursing, 1978, 4 (4), 18-21.

Gaitz, C.M., & Varner, R.V. Preventive aspects of mental illness in late life. In J.E. Birren & R.B. Sloane (Eds.), Handbook of mental health and aging. Englewood Cliffs, N.J.: Prentice-Hall, 1980.

Ganikos, M.L. Introduction. Counseling the aged: A training syllabus for educators. Falls Church, Va.: American Personnel and Guidance Association, 1979.

Garrison, J.E. Stress management training for the elderly: A psychoeducational approach. Journal of the American Geriatrics Society, 1978, 26, 397-403.

Gasek, G. How to handle the crotchety elderly patient. Nursing, 1980, March, 47-48.

Geiger, O.G., & Johnson, L.A. Positive education for elderly persons: Correct eating through reinforcement. Gerontologist, 1974, 14 (5), 432-436.

Gentry, W.D. Geropsychology: A model of training and clinical service. Cambridge, Mass.: Ballinger, 1977.

Gibbons, A.C. Popular music preferences of elderly people. Journal of Music Therapy, 1977, 14, 180-189.

Ginsberg, A.B., & Goldstein, S.G. Age bias in referral for psychological consultation. Journal of Gerontology, 1974, 29, 410-415.

Glasscote, R.M., Gudeman, J.E., & Miles, D.G. Creative mental health services for the elderly. Washington: American Psychiatric Association, 1977.

Godbole, A., & Verinis, J.S. Brief psychotherapy in the treatment of the emotional disorders in physically ill geriatric patients. Gerontologist, 1974, 14, 143-148.

Goldfarb, A.I. Psychotherapy of aged persons: I. The orientation of staff in a home for the aged. Mental Hygiene, 1953, 37, 76-83.

Goldfarb, A.I., & Sheps, J. Psychotherapy of the aged: III. Brief therapy of interrelated psychological and somatic disorders. Psychosomatic Medicine, 1954, 16, 209-219.

Goldfarb, A.I. Psychotherapy of aged persons: IV. One aspect of the psychodynamics of the therapeutic situation with aged patients. Psychoanalytic Review, 1955, 180-187.

Goldfarb, A.I. The rationale for psychotherapy with older persons. American Journal of Mental Science, 1956, 232, 181-185.

Goldfarb, A.I. Predicting mortality in the institutionalized aged. Archives of General Psychiatry, 1969, 21, 172-176.

Goldfarb, A.I. Group therapy with the old and aged. In H.I. Kaplan & B. Sadock (Eds.), Comprehensive group psychotherapy. Baltimore: Williams & Wilkins, 1971.

Goldfarb, A.I. Integrated services. In J.G. Howells (Ed.), Modern perspectives in the psychiatry of old age. New York: Brunner/Mazel, 1975.

Goldfarb, A.I., & Turner, H. Psychotherapy of aged persons: II. Utilization and effectiveness of "brief" therapy. American Journal of Psychiatry, 1953, 109, 916-921.

Goldstein, S.E. Social issues in geriatric psychiatry. Journal of the American Geriatrics Society, 1980, 28 (9), 415-417.

Gotestam, K.G. Behavioral and dynamic psychotherapy with the elderly. In J.E. Birren & R.B. Sloane (Eds.), Handbook of mental health and aging. Englewood Cliffs, N.J.: Prentice-Hall, 1980.

Gottesman, L.E. Organizing rehabilitation services for the elderly. Gerontologist, 1970, 10, 287-293.

Granick, S. Psychological study in the management of the geriatric patient. In A.B. Chinn (Ed.), Working with older people (Vol. 4), Clinical aspects of aging. Washington, D.C.: U.S. Department of Health, Education and Welfare, PHS Publication 1459, U.S. Government Printing Office, 1971.

Granick, S., & Paterson, R.D. (Eds.). Human aging II: An eleven-year follow up biomedical and behavioral study. Washington, D.C.: Publication (HSM) 71-9037, U.S. Government Printing Office, 1971.

Gray, P., & Stevenson, J.S. Changes in verbal interaction among members of resocialization groups. Journal of Gerontological Nursing, 1980, 6, 86-90.

Gurian, B.S. Mental health and the aging. In J.W. Brookbank (Ed.), Improving the quality of health care for the elderly. Gainesville: Center of Gerontological Studies and Programs. University Presses of Florida, 1978.

Grotjahn, M. Group communication and group therapy with the aged. In L. Jarvik (Ed.), Aging into the 21st century: Middle agers today. New York: Gardner Press, 1978.

Gurian, B.S. Mental health and the aging. In M. Brown (Ed.), Readings in gerontology. St. Louis: C.V. Mosby, 1978.

Gustafson, E. Dying: The career of the nursing home patient. In C.S. Kart & B.B. Manard (Eds.), Aging in America. Alfred Publishing Co., 1976.

Gutman, G.M., & Herbert, C.P. Mortality rates among relocated extended care patients. Journal of Gerontology, 1976, 31, 352-357.

Hahn, J. Mrs. Richards, a rabbit and remotivation. American Journal of Nursing, 1973, 73, 302-305.

Hall, B. The developing consciousness of dying. Counseling and Values, 1977, 21 (3), 146-159.

Hartford, M.E. The use of group methods for work with the aged. In J.E. Birren & R.B. Sloane (Eds.), Handbook of mental health and aging. Englewood Cliffs: Prentice-Hall, 1980.

Hasselkus, B.R. Relocation stress and the elderly. American Journal of Occupational Therapy, 1978, 32, 631-636.

Hausman, C.P. Short-term counselling groups for people with elderly parents. Gerontologist, 1979, 19, 102-107.

Havighurst, R.J. Developmental tasks of aging. New York: David McKay, 1972.

Havighurst, R.J. History of developmental psychology: Socialization and personality development through the life span. In P.B. Baltes & K.W. Schaie (Eds.), Life-span developmental psychology: Personality and socialization. New York: Academic Press, 1973.

Havighurst, R.J., & Glasser, R. An exploratory study of reminiscence. Journal of Gerontology, 1972, 27, 235-253.

Hellebrandt, F.A. A look at the other side of the coin. Gerontologist, 1978, 18, 67-68.

Hennessey, M.J. Music and music therapy groups. In I.M. Burnside (Ed.), Working with the elderly: Group process and techniques. North Scituate, Mass.: Duxbury Press, 1978.

Herr, J.H., & Weakland, J.H. The family as a group. In I.M. Burnside (Ed.), Working with the elderly: Group process and techniques. North Scituate, Mass.: Duxbury Press, 1978, 320-343.

Hess, P., & Day, C. Understanding the aging patient. Bowie, Md.: Robert J. Brady, 1977.

Hickey, T. Training for a supportive geriatric environment: A preliminary report. Journal of Community Psychology, 1976, 4, 261-268.

Hunt, T.E. Practical considerations in the rehabilitation of the aged. Journal of the American Geriatrics Society, 1980, 28 (2), 59-64.

Hutchins, B.E., O'Brien, D., & Coleman, C. The health care setting and the rehabilitative management of the elderly. In J.M. Long (Ed.), Caring for and caring about elderly people. Rochester, N.Y.: Rochester Regional Medical Program, 1972.

Jenkins, J., Felce, D., Lund, B., & Powell, L. Increasing engagement in activity of residents in old people's homes by providing recreational materials. Behavior Research and Therapy, 1977, 15, 429-434.

Jessum, K.L. The effects of group counseling on geriatric patients institutionalized in long term care facilities. (Doctoral Dissertation, University of Southern California) Dissertation Abstracts International, 1978, 39 (2-A), 677.

Johnson, R.E. The effects of encounter group on selected age related variables in a volunteer geriatric population. (Doctoral Dissertation, University of Miami) Dissertation Abstracts International, 1971, 32, (2-a), 739.

Jones, D.G. Social isolation, interactions and conflict in two nursing homes. Gerontologist, 1972, 12, 230-234.

Jones, M. Maturation of the therapeutic community. New York: The Tiresias Press, 1979.

Kahana, E. The humane treatment of old people in institutions. Gerontologist, 1973, 13 (3), 282-288.

Kahn, R.A. Aging and social support. In M.W. Riley (Ed.), Aging from birth to death: Interdisciplinary perspectives. Boulder, Colo.: AAAS Selected Symposium 30, Westview Press, 1979.

Kalish, R.A. & Knudtson, F.W. Attachment vs. disengagement: A life span conceptualization. Human Development, 1976, 19, 171-181.

Karpf, R.J. Modalities of psychotherapy with the elderly. Journal of the American Geriatrics Society, 1980, 28, 367-371.

Kart, C.S. Some biological aspects of aging. In C.S. Kart & B.B. Manard (Eds.), Aging in America. Alfred Publishing, 1976.

Kart, C.S., Metress, E.S., & Metress, J. Aging and Health: Biologic and social perspectives. Menlo Park, Calif.: Addison-Wesley Publishing, 1978.

Kasl, V. & Rosenfield, S. The residential environment and its impact on the mental health of the aged. In J.E. Birren & R.B. Sloane (Eds.), Handbook of mental health and aging. Englewood Cliffs, N.J.: Prentice-Hall, 1980.

Kiley, R.H. A study of group psychotherapy using resocialization counseling with socially withdrawn institutionalized geriatric patients. (Doctoral Dissertation, University of Southern Mississippi) Dissertation Abstracts International, 1977, 37, 5703A.

Kimmel, D.C. Adulthood and aging: An interdisciplinary developmental view. New York: John Wiley & Sons, 1974.

Kloberdanz, M.A. A study of the effects of gerontological counseling as measured by the Tennessee Self concept scale. (Doctoral Dissertation, University of South Dakota) Dissertation Abstracts International, 1977, 37, 6369-6370A.

Kobrynski, B. Innovations in programs of care for the elderly. Gerontologist, 1973, 13, 50-53.

Koff, T.H., & Koff, B. New horizons in working with the elderly. In C. Hatcher, B.Brooks & Associates, Innovations in counseling. San Francisco: Jossey-Bass, 1977.

Kozma, A., & Stones, M.J. Some research issues and findings in the study of well being in the aged. Canadian Psychological Review, 1978, 19, 241-249.

Kral, V.A. Psychosocial problems of the aged: A shared medical responsibility. Journal of the American Geriatrics Society, 1980, 28 (2), 68-70.

Kramer, J.R. What is a nice girl like you doing here? In E. Pfeiffer (Ed.), Successful aging: A conference report. Durham, N.C.: Center for the Study of Aging and Human Development, 1974.

Kraus, A.S., Spasoff, R.S., Beattie, E.J., Holden, D.E.W., Lawson, J.S., Rodenburg, M., & Woodcock, G.M. Elderly applicants to long term care institutions: Their problems and state of mind. Journal of the American Geriatrics Society, 1976, 24 (3), 117-125.

Kubler-Ross, E. Death: The final stage of growth. Englewood Cliffs, N.J.: Prentice-Hall, 1975.

Labouvie-Vief, G. Models of cognitive functioning in the older adult: Research needs in educational gerontology. In R.H. Sherron & D.B. Lumsden (Eds.), Introduction to educational gerontology. Washington: Hemisphere Publishing, 1978.

Langer, E.J., & Rodin, J. The effects of choice and enhanced personal responsibility for the aged: A field experiment in an institutional setting. Journal of Personality and Social Psychology, 1976, 34 191-198.

Lawson, G., & Hughes, B. Some considerations for the training of counselors who work with the elderly. Counseling and Values, 1980, 24, 204-208.

Lawton, M.P. Geropsychological knowledge as a background for psychotherapy with older people. Journal of Geriatric Psychiatry, 1976, 9, 221-233.

Lawton, M.P. The impact of the environment on aging and behavior. In J.E. Birren & K.W. Schaie (Eds.), Handbook of the psychology of aging. New York: Van Nostrand Rheinhold, 1977.

Lawton, M.P. Environmental change: The older person as initiator and responder. In N. Datan & N. Lohmann (Eds.), Transitions of aging. New York: Academic Press, 1980.

Lawton, M.O. & Gottesman, L.E. Psychological services to the elderly. American Psychologist, 1974, 29, 689.

Lesse, S. Behavioral problems masking depression--Cultural and clinical survey. American Journal of Psychotherapy, 1979, 33, 41-53.

Lewis, K. Practical illustrations of nurse-social worker collaboration and teamwork in a long-term health care facility. Journal of Gerontological Nursing, 1979, 5 (3).

Libow, L.S. Senile dementia and "pseudosenility": Clinical diagnosis. In C. Eisdorfer & R.O. Friedel (Eds.), Cognitive and emotional disturbance in the elderly. Year Book Medical Publishers, 1977.

Lieberman, M.A. Depressive affect and vulnerability to environmental change in the aged. Proceedings of seminars. Duke University, Council on Gerontology, April 1965a.

Lieberman, M.A. Factors in environmental change. Paper presented at the Conference on Patterns of Living and Housing for the middle aged and aged. Washington, D.C.: March 1965.

Lieberman, MA. Observations on death and dying. Gerontologist, 1966, 6, 70-73.

Lieberman, M.A. Relocation research and social policy. Gerontologist, 1974, 14, 494-501.

Lieberman, M.A. & Coplan, A.S. Distance from death as a variable in the study of aging. Developmental Psychology, 1969, 2, 71-84.

Lieberman, M.A., & Lakin, M. On becoming an institutionalized aged person. In R.H. Williams, C. Tibbits, & W. Donahue (Eds.), Processes of aging (Vol. 1). New York: Atherton Press, 1963.

Lieberman, M.A., Prock, V.N., & Tobin, S.S. Psychological effects of institutionalization. Journal of Gerontology, July 1968, p. 343.

Linden, M.E. You won't believe it. Paper presented at State of Delaware Governor's Conference on Aging, 1967. In B.A. Yawney & D.L. Slover (Eds.), Relocation of the elderly. Social Work, 1973, 18 (3), 86-95.

Linsk, N., Howe, M.W., & Pinkston, E.M. Behavioral group work in a home for the aged. Social Work, 1975, 20, 454-463.

Looft, W.R. Reflections on intervention in old age: Motives, goals and assumptions. Gerontologist, 1973, 13, 6-9.

Lowenthal, M.F., & Haven, C. Interaction and adaptation: Intimacy as a critical variable. American Sociological Review, 1968, 33, 20-30.

Lowy, L. Mental health services in the community. In J.E. Birren & R.B. Sloane (Eds.), Handbook of mental health and aging. Englewood Cliffs: Prentice-Hall, 1980.

Lubinski, R.B. Why so little interest in whether or not old people talk: A review of recent research on verbal communication among the elderly. International Journal of Aging and Human Development, 1978-1979, 9, 237-245.

Lyon, G.G. Stimulation through remotivation. American Journal of Nursing, 1971, 71, 982-986.

MacDonald, M.L. & Butler, A.K. Reversal of helplessness: Producing walking behavior in nursing home wheelchair residents using behavior modification procedures. Journal of Gerontology, 1974, 29, 97-101.

McCarthy, K.R. Microcounselling: Its use with an older adult population and its relationship to internal control. (Doctoral Dissertation, St. Louis University) Dissertation Abstracts International, 1978, 39, 1346A.

McClanahan, L.E., & Risley, T.R. A store for nursing home residents. Nursing Homes, 1973, 22, 10-11.

McClanahan, L.E., & Risley, T.R. Design of living environment for nursing home residents: Recruiting attendance at activities. Gerontologist, 1974, 14, 236-240.

Maddox, G.L. Activity and morale: A longitudinal study of selected elderly subjects. Social Forces, 1963, 42, 195-204.

Maddox, G.L. Persistence of life style among the elderly: A longitudinal study of patterns of social activity in relation to life satisfaction. Proceedings of the 7th International Congress of Gerontology, Vienna, 1966, 6, 309-311.

Maddox, G.L. Themes and issues in sociological theories of human aging. Human Development, 1970, 13, 17-27.

Maizler, J.S., & Solomon, J.R. Therapeutic group process with the institutional elderly. Journal of the American Geriatrics Society, 1976, 24, 542-546.

Manaster, A. Therapy with the "senile" geriatric patient. International Journal of Group Psychotherapy, 1972, 22, 250-257.

Marshall, V.W. Socialization for impending death in a retirement village. In C.S. Kart & B.B. Manard (Eds.), Aging in America. Alfred Publishing, 1976.

Marshall, V.W. No exit: A symbolic interactionist perspective on aging. International Journal of Aging and Human Development, 1978-1979, 9, 345-358.

Matthews, S. Old women and identity maintenance: Outwitting the grim reaper. Urban Life, 1975, 4 (3), 339-348.

Masoro, E. Other physiologic changes with age. In A.V. Ostfeld, D.C. Gibson, & C.P. Donnelly (Eds.), Epidemiology of aging. Bethesda, Md.: U.S. Department of Health, Education and Welfare (DHEW Publication No. NIH 77-711), 1977.

Marx, J. Aging research (II): Pacemakers for aging? Science, 186, 1196-1197.

Meichenbaum, D. Self-instructional strategy training: A cognitive prothesis for the aged. Human Development, 1974, 17, 273-280.

Mensh, I.N. Acute, reversible, psychotic reactions in geriatric patients. In O.J. Kaplan (Ed.), Psychopathology of aging. New York: Academic Press, 1979.

Miller, D., & Barry, J.T. The relationship of off premises activities to the quality of life of nursing home patients. Gerontologist, 1976, 16, 61-64.

Mitchell, H.D. Preferences for younger versus older counselors among elderly persons under certain interviewing conditions. (Doctoral Dissertation, Auburn University) Dissertation Abstracts International, 1978, 39, 3379A.

Miller, M.B. Current issues in clinical geriatrics. New York: Tiresias Press, 1979.

Moody, H.R. Education and the life cycle: A philosophy of aging. In R.H. Sherron & D.B. Lumsden (Eds.), Introduction to educational gerontology. Washington: Hemisphere Publishing, 1978.

Moody, L., Baron, V., & Monk, G. Moving the past into the present. American Journal of Nursing, 1970, 70, 2353-2356.

Mooney, C.M. Psychologic problems of the aged. Journal of the American Geriatrics Society, 1978, 26, 268-273.

Moore, E.D. Using music with groups of geriatric patients. In I.M. Burnside (Ed.), Working with the elderly: Group processes and techniques. North Scituate, Mass.: Duxbury Press, 1978.

Morgan, J.C. Becoming old. New York: Springer Publishing, 1979.

Morrison, M.H. A human relations approach to problem solving. Gerontologist, 1976, 16, 185-186.

Myles, J.F. Institutionalization and sick role identification among the elderly. American Sociological Review, 1978, 43, 308-521.

Nehrke, M.F., Bellucci, G., & Gabriel, S.J. Death anxiety, locus of control and life satisfaction in the elderly: Toward a definition of ego-integrity. Omega, 1977-1978, 8, 359-368.

Neri, J.L. Milieu rehabilitation in a long term care facility. Journal of the American Association for Rehabilitation, 1977, 25 (4), 15-17.

Neugarten, B.L. Personality in middle and late life. New York: Atherton Press, 1964.

Neugarten, B.L. Age groups in American society and the rise of the young old: Annals of American Academy of Political and Social Sciences, 1974, 415, 187-198.

Neugarten, B.L., & Datan, N. Sociological perspectives on the life cycle. In P.B. Baltes & K.W. Schaie (Eds.), Life-span developmental psychology: Personality and socialization. New York: Academic Press, 1973.

Neugarten, B.L., Havighurst, R.J., & Tobin, S.S. Personality and patterns of aging. In B.L. Neugarten (Ed.), Middle age and aging. Chicago: University of Chicago Press, 1968.

Noelker, L., & Harel, Z. Predictors of well-being and survival among institutionalized aged. Gerontologist, 1978, 18, 562-567.

Nolter, M. Drama for the elderly: They can do it. Gerontologist, 1973, 13, 153-156.

Nordstrom, M.J. Criteria leading to quality control in rehabilitation: The elderly patient--a team member. Journal of Gerontological Nursing, 1980, 6, 456-462.

Nowlin, J.B. Physical changes in later life and their relationship to mental functioning. In E.W. Busse & E. Pfeiffer (Eds.), Mental illness in later life. Washington: American Psychiatric Association, 1973.

Osipow, S.H. Toward counseling psychology in the year 2000. Counseling psychologist, 1980, 8 (4), 18-19.

Pablo, R.Y. Intra institutional relocation: Its impact on long-term care patients. Gerontologist, 1977, 17, 426-435.

Palmer, M.D. Music therapy in a comprehensive program of treatment and rehabilitation for the elderly. Journal of Music Therapy, 1977, 14, 190-197.

Palmore, E. Questions and responses. In E.W. Busse, & E. Pfeiffer (Eds.), Mental illness in late life. Washington: American Psychological Association, 1973.

Palmore, E. Normal aging II. Durham, N.C.: Duke University Press, 1974.

Palmore, E.B. The effects of aging on activities and attitudes. In M. Brown (Ed.), Readings in gerontology. St. Louis: C.V. Mosby, 1978.

Parkes, C.M. Effects of bereavement on physical and mental health: A study of the medical records of widows. British Medical Journal, 1964, 2, 274.

Patton, F.W. The administrator as group leader: A current events discussion group. In I.M. Burnside (Ed.), Working with the elderly: Group processes and techniques. North Scituate, Mass.: Duxbury Press, 1978.

Pastalan, I., & Bourestan, N. "Newsline", Psychology Today, 1977, 10 (9), 32.

Pearlin, L.I. Life strains and psychological distress among adults. In N.J. Smelser & E.H. Erikson (Eds.), Themes of love and work in adulthood. Cambridge, Mass.: Harvard Press, 1980.

Peterson, R.F., Knapp, T.J., Rosen, J.C., & Pether, B.F. The effects of furniture arrangement on the behavior of geriatric patients. Behavior Therapy, 1977, 8, 464-467.

Pfeiffer, E. Psychotherapy with elder patients. Postgraduate Medicine, 1971, 50, 254-258.

Pfeiffer, E. Successful aging: A conference report. Durham, N.C. Center for the study of aging and human development, 1974.

Pfeiffer, E. Psychopathology and social pathology. In J.E. Birren & K.W. Schaie (Eds.), Handbook of the Psychology of Aging. New York: Van Nostrand Reinhold, 1977.

Pfeiffer, E. Handling the distressed older patient. Geriatrics, 1979, 34 (2), 24-29.

Pfeiffer, E.W., & Busse, E.W. Mental disorders in later life: Affective disorders, paranoid, neurotic and situational reactions. In E.W. Busse & E. Pfeiffer (Eds.), Mental illness in later life. Washington, D.C.: American Psychiatric Association, 1973.

Pino, C.J., Rosica, L.M., & Carter, T. The differential effects of relocation on nursing home patients. Gerontologist, 1978, 13, 167-172.

Powell, L.S. Time limited counseling and the adjustment of new admissions to nursing homes. (Doctoral Dissertation, Columbia University) Dissertation Abstracts International, 1978, 39 (1-B), 394-395.

Pressey, S. Age counseling: Crises, services, potentials. Journal of Counseling Psychology, 1973, 20, 356-360.

Pressey, S.L., & Pressey, A.D. Major neglected opportunity: Old-age counseling. Journal of Counseling Psychology, 1972, 19, 362-365.

Pulvino, C.J., & Colangelo, N. Counseling the elderly: A developmental perspective. Counseling and Values, 1980, 24, 139-147.

Queen, L., & Fritag, C.N. A comparison of externality, anxiety and life satisfaction in two aged populations. Journal of Psychology, 1978, 98, 71-74.

Quilitch, H.R. Purposeful activity increased in a geriatric ward through programmed recreation. Journal of the American Geriatrics Society, 1974, 22 226-229.

Ronch, J.L., & Maizler, J.S. Individual psychotherapy with the institutionalized aged. American Journal of Orthopsychiatry, 1977, 47, 275-283.

Reid, D.W., Haas, G., & Hawkings, D. Locus of desired control and positive self concept of the elderly. Journal of Gerontology, 1977, 32, 441-450.

Remnet, V.L. The eclectic approach to group work. In I.M. Burnside (Ed.), Working with the elderly: Group process and techniques. North Scituate, Mass.: Duxbury Press, 1978.

Renner, V.J., & Birren, J.E. Stress: Physiological and psychological mechanisms. In J.E. Birren & R.B. Sloane (Eds.), Handbook of mental health and aging. Englewood Cliffs, N.J.: Prentice-Hall, 1980.

Roberts, J.L., Kimsey, L.R., Logan, D.L., & Shaw, G. How aged in nursing homes view dying and death. Geriatrics, 1970, 25 (4), 115-119.

Robinson, A.M. Philadelphia: APA/Smith, Kline & French Laboratories, no date.

Robinson, L.D. "You don't seem to want to understand": A case history. In I.M. Burnside (Ed.), Psychological nursing care of the aged. New York: McGraw-Hill, 1973.

Rodin, J., & Langer, E.J. Long-term effects of a control-relevant intervention with the institutionalized aged. Journal of Personality and Social Psychology, 1977, 35, 897-902.

Rodstein, M., Savitsky, E., & Starkman, R. Initial adjustment to a long-term care institution: Medical and behavioral aspects. Journal of the American Geriatrics Society, 1976, 24 (2), 65-71.

Rosenow, A., & Long, J.M. (Eds.), Caring for and about elderly people. Philadelphia: J.B. Lippincott, 1972.

Rosow, I. The social context of the aging self. Gerontologist, 1973, 13, 82-87.

Roth, N. Fear of death in the aging. American Journal of Psychotherapy, 1978, 32, 552-560.

Ryan, T.F. Perceived counselor attractiveness, expertness and trustworthiness as a function of counselor and observer age and sex. (Doctoral Dissertation, Ohio State University) Dissertation Abstracts International, 1976, 37 (5-B), 2526-2527.

Sacher, G.A. Relation of lifespan to brain weight and body weight in mammals. In G.E. Wolstenholme & M. O'Connor (Eds.), The lifespan of animals, Ciba Foundation Colloquia on aging (Vol, 5). Boston: Little, Brown & Co., 1959.

Sachs, D.A. Behavioral techniques in a residential nursing home facility. Journal of Behavior Therapy and Experimental Psychiatry, 1975, 6, 123-127.

Saferstein, S.L. Psychotherapy for geriatric patients. New York State Journal of Medicine, 1972, 72, 2743-2748.

Salisbury, H. Counseling the elderly: A neglected area in counselor education. Counselor Education and Supervision, 1975, 14, 237-238.

Salter, C.D., & Salter, C.A. Regression among elderly patients following interruption of a therapeutic program. Gerontologist, 1975, 15 (5), 404-406.

Saul, S., & Saul, S. Group psychotherapy in a proprietary nursing home. Gerontologist, 1974, 15 (1), 446-450.

Saul, S., & Saul, S.R. Old people talk about--the right to die. Omega, 1977-1978, 8 (2), 129-139.

Saxon, S.V., & Etten, M.J. Physical change and aging. New York: The Tiresias Press, 1978.

Schaie, J.P., & Schaie, K.W. Psychological evaluation of the cognitively impaired elderly. In C. Eisdorfer & R.O. Friedel (Eds.), Cognitive and emotional disturbance in the elderly. Chicago: Year Book Medical Publishers, 1977.

Schaie, K.W. Intelligence and problem solving. In J.E. Birren & R.B. Sloane (Eds.), Handbook of mental health and aging. Englewood Cliffs, N.J.: Prentice-Hall, 1980.

Schmidt, L.D. Issues in counseling older people. Educational Gerontology: An International Quarterly, 1976, 1, 187-192.

Schonfield, A.E.D. Learning memory and aging. In J.E. Birren & R.B. Sloane (Eds.), Handbook of mental health and aging. Englewood Cliffs, N.J.: Prentice-Hall, 1980.

Schulz, R. Effects of control and predictability on the physical and psychological wellbeing of the institutionalized aged. Journal of Personality and Social Psychology, 1976, 33, 563-573.

Schulz, R. Long-term effects of control and predictability-enhancing interventions: Findings and ethical issues. Journal of Personality and Social Psychology, 1978, 36, 1194-1201.

Schulz, R., & Brenner, G. Relocation of the aged: A review and theoretical analysis. Journal of Gerontology, 1977, 32, 323-333.

Schulz, R., & Hanusa, B.H. Effects of control and predictability on the physical and psychological wellbeing of the institutionalized aged. Journal of Personality and Social Psychology, 1977, 33, 563-573.

Schwartz, J., Jr. Status passage stress: A comparative study of nursing home environments, relocation and mortality. (Doctoral Dissertation, University of Texas) Dissertation Abstracts International, 1977, 37 (8-A), 5357.

Schwenk, M.A. Reality orientation for the institutionalized aged: Does it help? Gerontologist, 1979, 19.

Segal, H.A. Initial psychiatric findings of recently repatriated prisoners of war. The American Journal of Psychiatry, 1954, 3, 358.

Seligman, M.E.P. Helplessness. San Francisco: Freeman, 1975.

Seymour, E. Psychosocial needs of the aged (revised). The Ethel Percy Andrus Gerontology Center. University of Southern California, 1978.

Shapiro, E. The residents: A study in motivation and productivity among institutionalized octogenarians. Gerontologist, 1973, 12, 119-124.

Sherr, V.T., & Goffi, M.T. On-site geropsychiatric services to guests of residential homes. Journal of the American Geriatric Society, 1977, 25, 269-272.

Sherron, R.H., & Lumsden, D.B. Introduction to educational gerontology. Washington: Hemisphere Publishing, 1978.

Sherwood, S., & Nadelson, T. Alternate predictions concerning despair in old age. In D.P. Kent, R. Kastenbaum & S. Sherwood (Eds.), Research, planning and action for the elderly. New York: Behavioral Publications, 1972.

Shore, H. Designing a training program for understanding sensory losses in aging. Gerontologist, 1976, 16, 157-165.

Shore, H. Group programs in long-term care facilities. In I.M. Burnside (Ed.), Working with the elderly: Group process and techniques. North Scituate: Duxbury Press, 1978.

Sill, J.S. Disengagement reconsidered: Awareness of finitude. Gerontologist, 1980, 20, 457-462.

Simon, A. Psychological changes that influence patient care. In E. Seymour (Ed.), Psychosocial needs of the aged (Revised). The Ethel Percy Andrus Gerontology Center: University of Southern California, 1981.

Simon, A. The neuroses, personality disorders, alcoholism, drug use and misuse and crime in the aged. In J.E. Birren & R.B. Sloane (Eds.), Handbook of mental health and aging. Englewood Cliffs, N.J.: Prentice-Hall, 1980.

Sinick, D. Must dying be deadly? Personnel and Guidance Journal, 1976, 55, 97-147.

Sinick, D. Counseling older persons: Careers, retirement, death. New York: Human Sciences Press, 1977.

Sinick, D. Adult development changes and counseling challenges. In M. Ganikos (Ed.), Counseling the aged: A training syllabus for educators. Falls Church: American Personnel and Guidance Association, 1979.

Smith, M.E. The elderly person with diabetes mellitus. In J.M. Long (Ed.), Caring for and caring about elderly people. Rochester, N.Y.: Rochester Regional Medical Plan, 1972.

Smith, B.J., & Barker, H.J. Influence of a reality orientation training program on the attitudes of trainees toward the elderly. Gerontologist, 1972, 12, 262-264.

Smith, K.F. & Bengston, V.L. Positive consequences of institutionalization: Solidarity between elderly parents and their middle-aged children. Gerontologist, 1979, 19, 438-447.

Sparacino, J. An attributional approach to psychotherapy with the aged. Journal of the American Geriatrics Society, 1978, 26, 414-417.

Sparacino, J. Individual psychotherpay with the aged: A selective review. International Journal of Aging and Human Development, 1979, 9 (3), 197-220.

Sparks, P.M. Behavioral versus experiential aging: Implications for intervention. Gerontologist, 1973, 13, 15-18.

Solomon, I.H. Psychological characteristics of aged persons residing in a nursing home versus residing in the community. (Doctoral Dissertation, University of Southern Mississippi) Dissertation Abstracts International, 1979, 39 (9-B), 4599.

Stickle, F.E. Satisfying the emotional needs of the elderly: A call for counselors. Counseling and Values, 1977, 21 (3), 180-184.

Storandt, M. Other approaches to therapy. In M. Storandt, I.E. Siegler, & M.E. Elias (Eds.), The clinical psychology of aging. New York: Plenum Press, 1978.

Stotsky, B.A. Extended care and institutional care: Current trends, methods and experience. In E.W. Busse & E. Pfeiffer (Eds.), Mental illness in later life. Washington, D.C.: American Psychiatric Association, 1973.

Taulbee, L.R. Reality orientation: A therapeutic group activity for elderly persons. In I.M. Burnside (Ed.), Working with the elderly: Group processes and techniques. North Scituate, Mass.: Duxbury Press, 1978.

Taulbee, L., & Folsom, J. Reality orientation for geriatric patients. Hospital and Community Psychiatry, 1966, 17, 133-135.

Thomae, H. Personality and adjustment to aging. In J.E. Birren & R.B. Sloane (Eds.), Handbook of mental health and aging. Englewood Cliffs, N.J.: Prentice-Hall, 1980.

Thralow, J.U., & Watson, C.G. Remotivation for geriatric patients using elementary school students. American Journal of Occupational Therapy, 1974, 28, 469-473.

Tobin, S. Institutionalization of the aged. In N. Datan & N. Lohmann (Eds.), Transitions of aging. New York: Academic Press, 1980.

Tobin, S.S., & Lieberman, M.A. Last home for the aged. San Francisco: Jossey-Bass, 1976.

Toepfer, C.T., Bicknell, A.T., & Shaw, D.O. Remotivation as behavior therapy. Gerontologist, 1974, 14 (5), 451-453.

Troll, L.E., & Nowak, C. How old are you? The question of age bias in counseling of adults. Counseling Psychologist, 1976, 6, 41-44.

Turner, B.F., Tobin, S.S., & Lieberman, M.A. Personality traits as predictors of institutional adaptation among the aged. Journal of Gerontology, 1972, 27, 61-68.

Tutaj, G.A. The effectiveness of group counseling in alleviating depression among the aged. (Doctoral Dissertation, George Washington University) Dissertation Abstracts International, 1975, 36 (5-A), 2653. (University Microfilms No. 75-28,417.)

U.S. Department of Health, Education and Welfare, Health Standards and Quality Bureau. Working with older people: A guide to practice (Vol. 2). Human Services. Rockville, Md.: 1978.

Voelkel, D. A study of reality orientation and resocialization groups with confused elderly. Journal of Gerontological Nursing, 1978, 4 (3), 13-18.

Verwoerdt, A. Clinical geropsychiatry. In A.B. Chinn (Ed.), Working with older people. Washington, D.C.: U.S. Department of Health Education and Welfare, U.S. Publication No. 1459, part 4, 1971.

Verwoerdt, A. Clinical geropsychiatry. Baltimore: Williams & Wilkins, 1976.

Vickery, F.E. Old and growing. Springfield, Ill.: Charles C. Thomas, 1978.

Ward, R.A. The aging experience: An introduction to social gerontology. New York: J.B. Lippincott, 1979.

Wass, H. Dying as the final stage of growth: Issues and challenges. In R.H. Sherron & D.B. Lumsden (Eds.), An introduction to educational gerontology. Washington: Hemisphere Publishing, 1978.

Weg, R.B. Physiological changes that influence patient care. In I.M. Burnside & R.H. Davis (Eds.), Monograph: Ethel Percy Andrus Gerontology Center. University of Southern California, 1973.

Weg, R.B. Changing physiology of aging: Normal and pathological. In D.S. Woodruff & J.E. Birren (Eds.), Aging: Scientific perspectives and social issues. New York: Van Nostrand, 1976.

Weinberg, J. Environment, its language and aging. Journal of the American Geriatrics Society, 1970, 18, 681-686.

Weiner, M.B., Brok, A.M., & Snadowsky, A.M. Working with the aged: Practical approaches in the institution and community. Englewood Cliffs, N.J.: Prentice-Hall, 1978.

West, H.L. The differential effects of biofeedback/ relaxation training on elderly people. (Doctoral Dissertation, North Texas State University) Dissertation Abstracts International, 1978, 39, 1523-5124B.

Wolanin, M.O. Relocation of the elderly. Journal of Gerontological Nursing, 1978, 14 (3), 47-50.

Wolberg, L. The techniques of psychotherapy. New York: Grune & Stratton, 1954.

Wolcott, A.B. Art therapy: An experimental group. In I.M. Burnside (Ed.), Working with the elderly: Group process and techniques. North Scituate, Mass.: Duxbury Press, 1978, 292-310.

Wolff, K. The emotional rehabilitation of the geriatric patient. Springfield, Ill.: Charles C. Thomas, 1970.

Wolk, S. Situational constraint as a moderator of the locus of control-adjustment relationship. Journal of Counsulting and Clinical Psychology, 1976, 44, 420-427.

Wolman, B.J. The crisis of identity purpose. The Clinical Psychologist, 1978, 32, 5-7.

Woodruff, D.S., & Birren, J.E. (Eds.), Aging: Scientific perspectives and social issues. New York: Van Nostrand, 1975.

Wigdor, B.T. The drives and motivations with aging. In J.E. Birren & R.B. Sloane (Eds.), Handbook of mental health and aging. Englewood Cliffs, N.J.: Prentice-Hall, 1980.

Wrenn, C.G. Observations on what counseling psychologists will be doing during the next 80 years. Counseling Psychologist, 1980, 8 (4), 32-35.

Yawney, B.A., & Slover, D.L. Relocation of the elderly. Social Work, 1973, 18 (3), 86-95.

APPENDIX I

DEFINITION OF INTERMEDIATE CARE

INTERMEDIATE CARE

- Daily Professional Supervision
- Assistance with Activities of Daily Living
- Protective Atmosphere
- Planned Social Stimulation
- Independently Mobile
- Independently Transfers with or without Special Aids

INTERMEDIATE ONE

A. Communication

- May have difficulty expressing needs, e.g., aphasia dysphasia.
- Unable to adapt to sensory loss, e.g., vision, hearing. Needs directional assistance.

B. Personal Functions

- Independently mobile with or without mechanical aids. May need specialized aids for independently transferring.
- May need a great deal of assistance with bathing, dressing, and grooming.
- May require routine toileting to avoid frequent incontinence.
- May require assistance with toileting to maintain cleanliness.
- May require enemas.
- May need some supervision of feeding.

C. Mental Functions

- May be mildly depressed or agitated.
- May have moderately impaired comprehension--ability to understand simple instructions, simple number and time concepts, etc.

- May be unable to express needs.
- May demonstrate difficulty in orientation as to day, time, place.
- May have varying degrees of mental defect and deterioration.

D. Medical Problems

- Requires daily professional supervision of medications, eye drops, application of special appliances, etc.
- Requires supervision for visits to doctor, dentist, eye specialist, etc.
- Requires therapeutic dietary support; e.g., unstable Diabetic, special therapeutic diets, etc.
- May require the regular services of a physician.
- May require specialist services from time to time; e.g., physiotherapist, occupational therapist, speech therapist, etc.
- May require therapeutic services for a psychiatric problem on a continuing basis.

E. Social Functions

- Requires protective atmosphere to maximize potential in the activities of daily living.
- Requires programs for social and recreational activities.

INTERMEDIATE II

As Intermediate I plus:

a) Is mobile but functioning is impaired significantly due to mental retardation.
b) Needs considerable directional assistance, supervision of activities, etc.
c) Frequently wanders away.
d) Has severely impaired comprehension.
e) Misappropriates others property.
f) May have multiple disabilities/medical problems.
g) May have severe disability/medical problems.
h) May have need of more variety and/or extensive professional services.
i) May be incontinent of bladder and/or bowel.
j) May have an indwelling catheter.
k) May need assistance with feeding.
l) Requires daily professional supervision of catheters, surgical dressings, colostomy, oxygen therapy, etc.

INTERMEDIATE III

As in Intermediate I and II plus:

a) Disturbs others with: anti-social habits such as spitting, voiding and defecating in public, indecent exposures, etc.
b) Has destructive, aggressive, violent behavior; shouting, screaming.
c) Continually wanders away; may endanger own life.

Note: As defined by the Province of British Columbia.

APPENDIX II

EXPERIMENTAL

Reality orientation

To orient to reality. Desirable improvements as program progressed. n = 6: mean age 81 years	Barnes (1974)
Orientation to reality increased. n = 25: mean age 83.5	Citrin and Dixon (1977)
To compare reality orientation and resocialization techniques. Resocialization more effective. n = 20	Voelkel (1978)

Remotivation

Improved self-feeding. Praise and touch as powerful reinforcers. n = 1: aged 79	Baltes and Zerbe (1976)
Remotivation vs. psychoanalytically oriented group. No significant difference. Remotivation showed more interest. n = 39	Birkett and Boltuch (1973)
Increased attendance at activities. Participation was a factor of the activity itself. "Geriatric"	Duncan (1976)
Improved eating habits. Choice of reward a powerful reinforcer. n = 6: 65-91 years	Geiger and Johnson (1974)
Improved walking. "Sick role" may result in loss of function. Verbal reinforcement. n = 2, Mean age 80.8	MacDonald and Butler (1974)

Remotivation

Predictable or controllable events positively affect physical and psychological status. Those who benefit may decline when events are withdrawn. n = 42: mean age 81.5	Schulz (1976) Schulz and Hanusa (1978)

Resocialization

To improve morale and adjustment. Companionship: sustained or rotating. Rotating companions approached significance. n = 30: mean age 77	Arthur (1971) Arthur and Lair (1973)
To increase interpersonal skills. Did not generalize to new situations. n = 25: mean age 77	Berger and Rose (1977)
To increase prosocial interaction: optional activity during inactive part of the day increased interaction. n = 30, 68-96.	Blackman, Howe and Pinkston (1976)
To improve self-esteem: increase interaction; decrease depression. Changes observed but not significant. n = 36, 71-88	Elder-Jucker (1979)
To increase activity in 2 groups (mean age 82). Recreation and interaction stimulated activity. Age range 71-100, mean age 85.	Jenkins, Felce, Lund and Powell (1977)
Group counselling "elderly" significantly improved self concept.	Jessum (1978)

Resocialization

To decrease social isolation. Crafts stimulated interaction also revealed hostility, conflict and mistrust. n = 33, mean age 72.9 " " 74.5	Jones (1972)
Group: Refreshments and reminiscence encouraged. Inconclusive results after 5 weeks. N = 36	Kiley (1977)
To improve self-concept. Individual and/or group counselling. No significant improvement after 3 months. n = 20 "elderly"	Kloberdanz (1977)
Opening a store in activity area increased activity. n = 100, range 76-80	McClanahan and Risley (1973)
Cash a more powerful reinforcer than announcements for improving attendance at activities. n = 100, 76-80	McClanahan and Risley (1974)
Chronic brain syndrome. Refreshments as a reinforcer became secondary to fellowship. n = 20, 75-80	Manaster (1972)
To increase purposeful activity (Bingo). Did not persist when Bingo withdrawn. "Geriatric"	Quilitch (1974)
To decrease (1) isolation, increase (2) walking and (3) oral hygiene. Social reinforcement and token economy. n = 3, mean age 83. (Oral hygiene did not improve)	Sachs (1975)

Sensitivity training

To test feasibility. Some success. n = 23, mean age 79.11 — Bloom (1976)

Biofeedback and Relaxation

Reduced depression, anger and confusion. n = 41, mean age 80.6 — West (1978)

Encounter group

No effect on attitudes to death or physical complaints. Improvement in intellectual functioning and patterns of relationships. n = 12, mean age 78.9 — Johnson (1971)

Group counselling for depression

Did not reduce depression in 62 "aged" subjects. — Tutaj (1975)

Microcounselling

Has potential as a personal growth vehicle. n = 12 — McCarthy (1978)

Multiple approaches

Multiple therapy program. Regression when program withdrawn. Rapid return to previous level of functioning when program reinstituted. n = 18, 60-86 — Salter and Salter (1975)

Multiple therapy program increased verbalization, interpersonal interaction. n = 17 — Gray and Stevenson (1980)

DESCRIPTIVE

Art Therapy

To encourage creativity. Wolcott (1978)

This therapist started her work at age 79 and wrote the article at age 85.

Assertion Training

To assist the institutionalized to become more assertive. Corby (1975)

Attributional approach

A potentially useful approach for disorientation. Sparacino (1978)

Behavioral

To reduce geriatric rigidity: therapist in role of authority. Brink (1978)

To handle the distressed older patient. Group and individual psychotherapy: Relaxation, environmental change; biofeedback, transcendental meditation. Pfeiffer (1979)

Communication

Review of verbal communication among elderly. Lubinski (1978)

For physician: how to handle "crotchety" patient. Blazer (1979)

Expressive psychotherapy

Group cohesiveness in expression of feelings. n = 10, 79-99 years Berland and Poggi (1979)

Family therapy

Group counselling.	Herr and Weakland (1978)
To share feelings.	Corey (1977)

Group psychotherapy

Organic syndrome or senile psychosis. Improvement noted. n = 12	Saul and Saul (1974)
A noticeable behavior was regression following the author's absence.	Burnside (1971)

Group work

To increase interaction: participants became more independent.	Blake (1973)
To enjoy the "here and now": a multifaceted approach; increased interest and animation.	Berger (1978)
For organic brain syndrome: aroused from lethargy; continuity seemed important.	Corey (1977)
To optimize mental performance: miniscule, sudden or dramatic improvement.	Burnside (1978)
To increase personal satisfaction.	Euster (1971)

Individual Psychotherapy

Case examples.	Ronch and Maizler (1977)
Selective review.	Sparacino (1979)
54 "chronic" and "hopeless" geriatric subjects. Improvement after 12 sessions.	Wolff (1970)

Milieu therapy	
Supportive therapy.	Hickey (1976)
To assist the individual become meaningful to self.	Neri (1977)
Multiple therapy approach	
To implement restorative therapy.	Kobrynski (1973)
To break the "spiral of senility".	Barns, Sack and Shore (1973)
Normative life crises: supportive, family, group and behavioral.	Karpf (1980)
Isolation; chronic brain syndrome. Position paper.	Ernst, Beran, Safford and Kleinhauz (1978)
Music therapy	
Rehabilitation.	Hennessey (1977)
To increase social skills (e.g., to affect mood)	Moore (1978)
To achieve highest functioning.	Palmer (1977)
Problem solving	
Expression of feelings: a neglected field.	Morrison (1976)
Medical/psychiatric supportive psychotherapy	
For relocation stress. Psychotherapy seen as the medical prerogative.	Kral (1980)

Reality orientation	
To replace mechanical or chemical restraints.	Covert, Rodrigues and Solomon (1977)
Memory loss: for maintenance or beginning of remotivation.	Drummond, Kirchhoff and Scarbrough (1978)
Social deprivation: to rehabilitate to optimum level of functioning.	Hunt (1980)
Team approach to maximize independence.	Nordstrom (1980)
Not universally effective. Little effect on autonomy or happiness.	Schwenk (1979)
Improved mental status noticed in confused patients. 24-hour continuity essential.	Taulbee (1977)
Reminiscence therapy	
Groups: to produce/enhance cohort effort.	Ebersole (1978)
To reach maximum independence.	Nordstrom (1980)
Remotivation	
Improved interaction: drama.	Nolter (1973)
Resocialization	
To increase interaction: participants became more independent.	Blake (1973)
Sensory awareness	
Exercise and art therapy resulted in improved memory and interpersonal awareness.	Storandt (1978)

Other

To inhibit learned helplessness. Encouragement of independence and control. Continuity of approach required. Fuller (1978)

APPENDIX III

DIFFERENTIATION OF COUNSELLING AND PSYCHOTHERAPY

The terms counselling and psychotherapy as found in the literature may very in definition according to the profession or therapeutic orientation of the particular author.

Verwoerdt (1976)--writing from a medical stance--differentiated insight-oriented psychotherapy (the use of free association and the analysis of transference) from supportive therapy (the components of which he termed counselling and guidance).

He further described supportive therapy in terms of remotivation, resocialization, recreation and reality orientation as carrried out in a variety of group situations.

Counselling, according to Verwoerdt (1976), refers to problem-solving with the counsellor functioning actively as a teacher. He defined guidance as the process of freeing resources restricted by intrapsychic or situational impediments, with the therapist supporting the patient in developing a new emotional perspective.

Brody (1977) referred to counselling in terms of both psychological and practical support.

Burnside (1978) and Lowy (1980) distinguished group work (which may be conducted by non-professionals) from group psychotherapy which is professionally led and directed towards older people who have psychiatric problems.

Butler and Lewis (1977) took exception to differentiating geriatric psychiatry, geriatric psychology and geriatric social work. They maintained that, instead, the significance of the emotional aspects of old age should be part of a core therapy of the life cycle of human beings rather than a separate entity.

Ronch and Maizler (1977) use Wolberg's (1954) definition of psychotherapy:

> ... a form of treatment for problems of an emotional nature in which a trained person deliberately establishes a professional relationship with a patient, with the object of removing, modifying or retarding existing symptoms or mediating disturbed patterns of behavior and promoting positive personality growth and development.

APPENDIX IV

SUPPORTIVE AND REHABILITATIVE THERAPY IN ALPHABETICAL ORDER AS TO TYPE AND AUTHOR

Art therapy

Storandt (1978); Wolcott (1978).

Assertion training

Corby (1975).

Attitude therapy

Barns, Sack & Shore (1974); Covert, Rodrigues & Solomon (1977); Verwoerdt (1976); Weiner, Brok & Snadowsky (1978).

Attributional approach to therapy

Sparacino (1978).

Behavioral

Baltes & Zerbe (1976); Barns, Sack & Shore (1974); Berger & Rose (1977); Brink (1978); Geiger (1974); Hess (1977); Jones (1976); Karpf (1980); Langer & Rodin (1976); MacDonald & Butler (1974); McClanahan & Risley (1974); Rodin & Langer (1977); Sachs (1975); Toepfer, Bickness & Shaw (1974); Wolff (1970).

Biofeedback

Butler & Lewis (1977); Pfeiffer (1979).

Communication

Lubinski (1978).

Companionship therapy

Arthur (1971); Arthur, Donnan & Lair (1973).

Creative writing

Shapiro (1973).

Death and Dying

Birchenall & Streight (1973); Durlak (1973); Gustafson (1976); Kahn (1978); Koff (1979); Kubler-Ross (1975); Sinick (1977); Wass (1978).

Discussion groups

Verwoerdt (1976).

Dream therapy

Gray (1973); Nolter (1973).

Educational therapy

Wolff (1970).

Environmental therapy or restructuring of environment

Arthur (1973); Blackman, Howe & Pinkston (1976); Butler & Lewis (1977); Duncan (1976); Gray & Stevenson (1980); Jenkins, Felce, Lund & Powell (1977); Jones (1972); McClanahan & Risley (1973); Peterson, Knapp, Rosen & Pether (1977); Pfeiffer (1970); Quilitch (1974).

Entertainment therapy

Wolff (1970).

Exercise therapy

Butler & Lewis (1977); Covert, Rodrigues & Solomon (1977); Hess (1977); Storandt (1978).

Family therapy

Birren (1971); Burnside (1977); Butler (1971); Butler & Lewis (1977); Euster (1971); Hartford (1980); Karpf (1980); Miller (1979); Ragan (1979); Storandt (1978); Verwoerdt (1976); Weiner, Brok & Snadowsky (1978).

Group therapy

Altholz (1978); Berger (1978); Berland & Poggi (1979); Blake (1973); Burnside (1970a, 1970b); Burnside (1978); Corey (1977); Euster (1971); Gottesman (1970); Grotjahn (1978); Hartford (1980); Herr & Weakland (1978); Karpf (1980); Pfeiffer (1979); Ragan (1979); Remnet (1978); Saul & Saul (1974); Shore (1978); Verwoerdt (1976); Weiner, Brok & Snadowsky (1978); Wolff, (1970).

Individual psychotherapy

Butler & Lewis (1977); Hess (1977); Kloberdanz (1977); Pfeiffer (1979); Ronch & Maizler (1977); Saul & Saul (1974); Sparacino (1979); Wolff (1970).

Industrial/occupational/sheltered workshops

Gottesman (1970); Linsk, Howe & Pinkston (1975); Verwoerdt (1976); Wolff (1970).

Life review

Butler (1963); Butler (1974); Butler & Lewis (1977); Havighurst & Glasser (1972); Lewis & Butler (1974); Weiner, Brok & Snadowsky (1978); Verwoerdt (1976).

Milieu therapy (therapeutic community)

Barns, Sack & Shore (1974); Coons (1978); Hickey (1976); Kobrinski (1973); Neri (1977); Storandt (1978); Verwoerdt (1976); Wolff (1970).

Music therapy

Hennessey (1977); Moore (1978); Palmer (1977); Wolff (1970).

Psychoanalytic (insight oriented) psychotherapy

Butler & Lewis (1980); Karpf (1980); Verwoerdt (1976).

Rational emotive therapy

Storandt (1978).

Reality orientation

Barnes (1974); Barnes, Sack & Shore (1973); Birchenall & Streight (1973); Citrin & Dixon (1977); Covert, Rodrigues & Solomon (1977); Grummond, Kirchhoff & Scarbrough (1978); Gurian (1978); Hess (1977); Kobrinski (1973); Linsk, Howe & Pinkston (1975); MacDonald & Settin (1978); Schwenk (1979); Storandt (1978); Taulbee (1978); Voelkel (1978); Verwoerdt (1976); Weiner, Brok & Snadowsky (1978).

Religious services in therapy

Gottesman (1970); Linsk, Howe & Pinkston (1975); Weiner, Brok & Snadowsky (1978).

Reminiscence

Ebersole (1975, 1976, 1978a, 1978b); Hess (1977).

Remotivation

Barns, Sack & Shore (1974); Birchenall & Streight (1973); Birkett & Boltuch (1973); Butler & Lewis (1977); Covert, Rodrigues & Solomon (1977); Duncan (1976); Geiger & Johnson (1974); Gurian (1978); Hahn (1973); Hess (1977); Kobrinski (1973); Langer & Rodin (1976); Linsk, Howe & Pinkston (1975); Lyon (1971); MacDonald & Butler (1974); Moody, Baron & Monk (1970); Rodin & Langer (1977); Schulz (1976); Schulz & Hanusa (1978); Thralow & Watson (1974); Toepfer, Bicknell & Shaw (1970); Verwoerdt (1976); Weiner, Brok & Snadowsky (1978).

Resocialization

Barns, Sack & Shore (1974); Berger & Rose (1977); Hess (1977); Jenkins, Felce, Lund & Powell (1977); Jones (1972); Kiley (1977); Quilitch (1974); Sachs (1975); Voelkel (1978); Verwoerdt (1976).

Self image therapy

Barns, Sack & Shore (1974).

Sensory training/retraining/stimulation/awareness

Barnes, Sack & Shore (1974); Covert, Rodrigues & Solomon (1977); Ernst, Beran, Safford & Kleinhauz (1978); Gurian 1978); Kobrinski (1973); Weiner, Brok & Snadowsky (1978).

Sociotherapy

Gurian (1978); Verwoerdt (1976).

Supportive therapy

Carman (1977); Karpf (1980); Ragan (1979); Weiner, Brok & Snadowsky (1978).

Touch

Burnside (1979); De Wever (1977); Hess (1977); Weiner, Brok & Snadowsky (1978); Verwoerdt (1976).

Transcendental meditation

Pfeiffer (1979).

Short-term, goal directed therapy

Brink (1976); Butler (1971); Godbole & Verinis (1974); Gotestam (1980); Pfeiffer (1971); Saferstein (1972); Wolff (1970).

VITA

Surname: McLELLAND Given Names: HÉLÈNE MARY GALBRAITH

Place of Birth: IPSWICH, ENGLAND. Date of Birth: June 29, 1925

Educational Institutions Attended, with Dates of Entering and Leaving:

CAMOSUN COLLEGE, VICTORIA, B.C.	1972 to 1974
UNIVERSITY OF VICTORIA, B.C.	1974 to 1976
UNIVERSITY OF VICTORIA, B.C.	1979 to 1981

Degrees, Diplomas, Etc., Awarded, with Dates and Names of Institutions:

B.A. (First Class) 1976 University of Victoria, B.C.

Honors and Awards:

University of Victoria Fellowship 1980/81

Publications:

PARTIAL COPYRIGHT LICENSE

I hereby grant the right to lend my thesis (the title of which is shown below) to users of the University of Victoria Library, and to make *single copies only* for such users or in response to a request from the library of any other university, or similar institution, on its behalf or for one of its users. I further agree that permission for extensive copying of this thesis for scholarly purposes may be granted by me or a member of the University designated by me. It is understood that copying or publication of this thesis for financial gain shall not be allowed without my written permission.

Title of Thesis:

COUNSELLING AS AN INTEGRAL PART OF INTERMEDIATE CARE FOR THE AGED

Author: 

Signature

Hélène Mary Galbraith McLelland

April 15, 1981