Counseling the Older Disabled Worker

JOHN E. MUTHARD, PH.D.

WOODROW W. MORRIS, PH.D.

Editors

Proceedings of two conferences
sponsored by:
College of Education
and
Institute of Gerontology
State University of Iowa, Iowa City, Iowa
Vocational Rehabilitation Administration

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Muthard

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FOREWORD

Concern for the older disabled worker and for the extension of vocational rehabilitation services to more adequately meet the needs of this population group has definitely sharpened in recent years. This, of course, results in part from the substantial increase in the number of older persons and an awareness that in the future these persons can be expected to be with us even longer. More important, however, it results from a growing understanding of the particular problems faced by older disabled people and a greater recognition that the positive concepts of modern rehabilitation can contribute materially to their solution.

Rehabilitation personnel in the States of Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota, and South Dakota are mindful of the fact that many sections of their midwestern region have a higher proportion of older citizens than is found in the general population elsewhere. This clearly places upon all rehabilitation agencies and facilities, both public and voluntary, a special responsibility for developing improved and expanded services commensurate with existing need. Consequently, an intensified effort is being made to develop more dynamic and comprehensive programs and facilities that are designed to meet the physical, emotional, social, and vocational needs of the older disabled population.

Numerous pilot programs, research projects, and demonstrations now under way in the region are focusing on the problems of the older disabled worker and are developing new techniques and "know how" that promise to be of substantial aid in bringing the benefits of rehabilitation to older persons. These projects are generally financed in part by grants from the Federal Office of Vocational Rehabilitation. The success of these new ventures is being reflected in the increased number of such persons who are able to return to work each year as personally and vocationally adjusted individuals. Perhaps the most encouraging evidence of accomplishment is in the fact that over one-third of the successful rehabilitation closures of many State vocational rehabilitation programs now come from persons in the older age brackets. This is especially significant and challenging when it is realized that these individuals commonly have multiple disabilities or personality difficulties and lack the motivation essential to maximum restoration and rehabilitation. Many of them have been hospitalized or unemployed for long periods and, before rehabilitation, were dependents upon welfare, their families, or disability insurance benefits.

An essential to any successful program of rehabilitation is a properly trained staff. This was particularly apparent in developing services to the older disabled person. In meetings of the directors of State vocational rehabilitation agencies and State agencies for the blind in this midwest region, the need to explore new approaches to counseling older disabled persons was repeatedly

pointed out. These directors, who constitute the planning committee for the regional program of staff development, were anxious that vocational rehabilitation counselors be kept abreast of new project findings and be given an opportunity to develop greater insight into the problems and needs of older people. It was decided that a one-week training workshop should be held in the region as a means of increasing counselor understanding of the problem and counselor competencies in dealing with older disabled persons. Because of the number of trainees desiring to enroll for the workshop, two identical one-week sessions were scheduled for the spring of 1961. The State University of Iowa applied for and received a grant from the Federal Office of Vocational Rehabilitation to finance the planning and conducting of both workshop sessions.

The initial planning meeting was held on December 2, 1960 with representatives of State vocational rehabilitation programs in four States participating. Also participating were representatives of the Iowa Employment Service, the Counselor Training Program and the Institute of Gerontology at the State University of Iowa, and the regional Office of Vocational Rehabilitation. At the planning session, it was recognized that in most rehabilitation settings all counseling staff work with older disabled clients. Since it was impossible to accommodate all counselors as trainees in the two short courses being planned, it was agreed that those selected by State directors to attend the workshop should be persons who could be utilized in the State's own program of in-service training for all staff. This objective of reaching all counselors in the region was kept in mind in developing both methods and materials for the sessions and in the actual conduct of the workshop.

Several different teaching techniques were used throughout the sessions to make the subject matter most meaningful, including lectures, general discussions, small group discussions, panel discussions, case studies, tape recordings, and films. Each State agency prepared in advance of the workshop at least one case study involving (1) problems related to the total evaluation of an older disabled client, (2) problems related to motivating a counselor to change his negative attitudes toward older clients and involving problems of motivating an older disabled client to accept rehabilitation services, or (3) problems related to developing community resources for the vocational rehabilitation of older disabled persons. These materials were used for discussion sessions and were made available to participating State agencies for follow-up use in their staff development programs.

The publication in this volume of lectures given at the workshop is intended to further aid in the follow-up in-service training of staff. Likewise, it is expected that the extensive bibliographies, references, and film lists will provide rich material for use in continued training. Additional copies of tape recordings of the workshop discussion sessions have also been made available.

Special acknowledgment is given to the lecturers whose papers appear in

this publication and to the State agency directors and staff who participated in the cooperative planning of the workshop. Among those individuals deserving of special mention for the success of the workshop are Dr. John E. Muthard, Coordinator, Rehabilitation Counselor Training, State University of Iowa; Dr. Woodrow W. Morris, Director, Institute of Gerontology, State University of Iowa; Dr. W. D. Coder, Coordinator, Center for Continuation Studies, State University of Iowa; and Dr. Gerald W. Green, Assistant Regional Representative, Office of Vocational Rehabilitation, Department of Health, Education, and Welfare.

Howard L. Benshoof
Regional Representative
Office of Vocational Rehabilitation
Department of Health, Education, and Welfare

Preface

The conference program reported in these proceedings was part of a continuing cooperative effort in Region VI of the Office of Vocational Rehabilitation to develop the competencies and backgrounds of professional workers in the region. Each year the universities in the region which have rehabilitation counselor training programs (Missouri, Minnesota, and Iowa) and other institutions in the region, conduct workshops and conferences based on topics which the state and regional leaders believe are needed for staff development. These training meetings, which are supported by Office of Vocational Rehabilitation training grants, have brought to the staffs of state, and to some degree private agencies, programs which would not be feasible on an individual basis.

Several considerations appear to have suggested a conference on *Counseling the Older Disabled Worker* at Iowa in the Spring of 1961. For some time the state directors had been finding the age level of clients rising each year and the impact of the OASDI program increasing. This and the influence of the White House Conference on Aging prompted them to request the University of Iowa, which has an Institute of Gerontology, to conduct a conference which would contribute to increased understanding and effectiveness of counselors in their work with older clients. This program was presented to rehabilitation counselors on February 27-March 3 and April 25-28, 1961.

To help the university staff plan a supervisors program which would meet the needs of state agency personnel, a planning committee was held in Des Moines, Iowa in December, 1960. In addition to leadership from the Iowa DVR program—Merril E. Hunt, Jerry Starkweather, Mario Barillas, and Lou Ortale—and Kenneth Jernigan, director of the Iowa Commission for the Blind, the committee included Fred Novak, director of the Nebraska DVR program; Charles Hagen, supervisor of placement for the Minnesota VR program; Mrs. Adaline Cross, district supervisor, Kansas City, Missouri VR office; Howard Benshoof and Gerald Green of the OVR Region VI office; H. Lee Jacobs, research associate of the Iowa Institute of Gerontology; and John Muthard. The editors, who also were co-directors of the programs as they were held, wish to acknowledge the valuable contribution made by this group in formulating the basic plan for the conferences and suggesting staff for it.

Whether conferences of this type are successful, and here we are thinking of the ongoing, immediate satisfaction of the participants and not any ultimate criterion, hinges to a significant degree on the foresight and efficiency reflected in a comfortable learning situation, a well-paced and varied program, and opportunities for sharing ideas with colleagues from other states. Since Dr. William Coder and his Center for Continuation Studies staff contributed substantially toward making this a satisfying meeting, we wish to note our deep appreciation of their help.

Many others shared in making these conferences possible. The participants contributed case materials and questions, and the staff of the Iowa Vocational Rehabilitation Training Center in Des Moines made available a tape recording of a staff conference. Substantial roles were played by H. Lee Jacobs, who led the discussion of films and also arranged for all the films presented at the conference. Mrs. Mabel Edwards organized not only extensive bibliographies, but placed many books and pamphlets on display for both groups. We wish to acknowledge the contribution of these people.

W. W. Morris
J. E. Muthard
November, 1961

THE NATURE AND MAGNITUDE OF THE PROBLEM

C. Esco Obermann, Ph.D.*

As we look over the agenda for this Conference, it is clear that the intention is to give considerable emphasis to the psychological and adjustment problems related to growing older in our culture. It might be assumed that we will spend considerable time discussing the psychological and psychiatric characteristics of older persons themselves. It is appropriate that we should do this. However, the psychological make-up of an upper-age citizen is really less significant in his total adjustment than is the social psychology of the population surrounding him. It is almost correct to say that one can be only what those around him will permit him to be or will lead him to be. We might profitably, therefore, spend some time considering the characteristics, the attitudes, the prejudices, and the limitations of ourselves—we, who deal with the problems of aging and those who will relate to aging persons in many, many ways.

The pressing problem of accommodation of the older persons among us has been receiving much high-level attention the past few years, as you well know. There seems to be an increasing recognition of the importance of those issues arising out of the fact that our culture tends to create "disadvantaged" types. Older persons constitute one of these "disadvantaged" types. And, in this role, they experience deprivation and frustration, and the community loses the value of what they might contribute.

Why do we commit ourselves to this interest, to the expenditure of time and energy on this whole topic? Why are we, currently, increasingly concerned about the fate of our fellow men, about their struggles for self-expression? Why, in the last few years, has there been such an outpouring of money, of time, of people meeting in conferences such as this? Humanity has not always been so solicitous of those who are aged or infirmed. There is a kind of a law of the jungle that decrees that every man shall be for himself and the devil may take the hindermost. On the other hand, there is the truth that many less-strong banded together, will be more durable than the individually strong. Are we working towards a brave, new world in which dignity, self-realization and the privilege of being fully a member of society is to be assured to everyone? Are we now beginning to implement in this special way this basic historical statement—"We hold these truths to be self-evident, that all men are created equal, that they are endowed by their Creator with certain inalienable rights, that among these are life, liberty, and the pursuit of happiness."?

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Is this a rebirth of the ancient Mediterranean view of man, of his worthiness, of his entitlement to respect, and of his claim upon all the rest of his fellow men for a chance to achieve self-realization? Perhaps the answer to these questions is "yes."

Man has been a durable animal. Many thousands of years ago he finally established himself among his fellow creatures on this planet in such a way that he could feel sure he would survive and endure. Having acquired this basic security he could then begin to consider the more involved meanings of life and of his own nature. Cooperation and mutual helpfulness could become a practice based on something other than sheer survival requirements. He developed the concept of human rights on an ethical basis. His fellow man could be free as well as useful. His religious and political structures reflected this.

There have been recessions from this high level of life and living. The forces of nature, and especially of his own stupidity, have sometimes reduced man to something less than what the ancient Greeks insisted he was. Around the world, however, there has been a long-term growth of the idea that an individual has a basic right to develop and to be all that he is capable of being; that somehow the interests of all the rest of us would not be threatened if we served the interests and met the needs of the individual and thus permitted him to *be* an individual.

There has been little confusion among the many tribes and races of men as to what should be done, generally, with respect to the training and the development of the healthy and the young. Elaborate ceremonies, routines of indoctrination, schools (both simple and elaborate) have all been devised as social means of preparing the offspring to take their roles effectively in their various cultures. The young have always obviously needed protection, training and conditioning. While the parents have had certain responsibilities for meeting these needs, social economics have dictated that the whole community shall be involved in furnishing such services as education, health protection, recreation and physical conditioning. With today's community services most nondisabled children and adults can move from a status of inadequacy to a status of adequacy, can develop a fullness of living and can make a social-economic contribution.

But it has not been so clear just what should be done about the aged and impaired. Various cultures have dealt with them in various ways. In our own times, age and disability are often made synonymous with "handicap." Our institutions have not been designed efficiently to accommodate older or disabled persons. The attitudes of many people have not been conditioned to accept them. Dependency in an adult is really not very well understood. For the dependent young, we have a comfortable procedure; for the adult not able to establish and maintain himself, the prescription is not so clear. We could have pity; we could have charity. But it has become obvious that these are not enough. It is a requirement for man's individual development that his

fellows accord him a *positive* role in the community. Pity and charity really spell exclusion from full community participation.

Much could be said or written in an attempt to explain the aversion to, the rejection of, the older person and the disabled person. There are deep psychological considerations, related to guilt, or to fear, or to many more-complicated concepts that, as of now, have not even been identified and named.

But, dealing with the problem much more superficially, there are many reasons for isolating and rejecting those whose age has made them infirm and those whose physical or mental limitations prevent their easy absorption into the group. Among us, strength, youth and beauty are still much admired and sought. Weakness, agedness and disability are negative characteristics and, among many, they are *overriding* characteristics. High intelligence is not the most desired trait even at centers of higher learning, such as the great University of Iowa, where the athlete has more facilities afforded to him, is accorded much greater honor, and is better known than the honor student. The headlines of the *Daily Iowan* reflect this.

It is easy to accommodate the young, well-in-body person in the group. We find it makes less demand on us if our associates can see, hear and run. Even those who have lost those capacities would prefer to see and hear and run, and to be able to relate well to others who can see and hear and run. We have tended to isolate ourselves from those who differ from us, and thus require special adjustments from us. We have not given our children the opportunity to learn to accept disability. We have sent the blind child, the deaf child, the mentally retarded child, off to special schools outside the home community. Thus, the opportunity to understand them and to let them fit into our social groups has been denied us and our children. Based on his own childhood experience, the employer among us finds it difficult to believe that disabled persons can fit into the community and into his work force. Disability has been made synonymous with "abnormality"—with unfitness and handicap.

Older persons, too, must be especially accommodated in our day-to-day activities. When the effort demanded gets too great, we send them off to state hospitals or to "nursing homes." Again, we teach each other that the non-young, like the physically or mentally non-strong, really cannot be expected to fit into our community life. We order our community life so that proper provision is not made for them.

So, while it has been quite clear what we should do about the development of the young and the physically and psychologically fit person, it has not been so clear what is to be done about the older and the disabled person to insure that he too should have an adequate opportunity to develop in the role of a person fulfilling our concepts of dignified and self-respecting man.

However, in the last few years there has been this growing concern about the problem. The special procedures required to assist persons with age or physical or psychological handicaps we have referred to as the processes of "rehabilitation." What these processes are able to do for a large and growing segment of our population is attracting increasing attention. Perhaps this growing concern and activity does arise out of a rebirth of the old, highly enlightened view of man; or perhaps it is only coming as the result of the new political forces or the recognition of some basic economic truths.

I would prefer to believe that the rehabilitation movement is largely motivated by the growing belief that every human being must be helped, by his fellows, who *can* help him to a full and satisfying life; that each of us can achieve our own self fulfillment only if our fellow men achieve theirs. I would prefer to believe that we are dealing with a new or renewed revelation of truth or simple basic knowledge, and that this accounts for the current ferment. We do know that ideas that gain momentum, that capture a wide range of human interest, that result in positive action, usually are based on simple basic truth. Those of us who are engaged in the rehabilitation movement perhaps should feel reassured that our work is getting this new impetus because we are dealing with a basically sound concept. What we would do about disability and age is consonant with what will be demanded by the basic laws of survival. Victor Hugo has been quoted: "There is nothing more powerful than an idea whose time has come." And, Kipling's "Law of the Jungle" might well be quoted here:

"Now this is the law of the forest,
As old and as true as the sky;
And the wolf that shall keep it may prosper,
But the wolf that shall break it must die.

As the beetle that girdles the tree trunk,
The law runneth forward and back—
The strength of the pack is the wolf,
And the strength of the wolf is the pack."

Of course, there are ample data to affirm the view that rehabilitating disadvantaged persons could be politically and economically motivated, and is therefore being given increasing support, not for any "high-minded" reasons, but just because more people are coming to believe that "rehabilitation" is good business. Considering aging persons only, the statistics are impressive. It has been told to us over and over that the fastest growing segment of our population is that segment represented by the upper-age group. At the present time, there are 52 million people in the nation who are age 45 or more; nearly 16 million of these are age 65 or more; 3 million are over

80. It is estimated that by 1980 there will be over 68 million in the population who will be age 65 and over. About 5 million will be over age 80. Between 1955 and 1975 our population in the United States will grow by 1,000 persons a day in the over-45 category.

These are large increments, but it should be emphasized that the *ratio* of older people is also increasing. Whereas, only a few short years ago only about 4% of the population was over age 65, currently the ratio is nearly 9%.

Disability tends to increase in the upper-age groups. Disabilities of nearly all types occur with greater frequency among aged persons than among those who are younger. In 1958 it was estimated that more than 5 million people in this country who were age 45 or more had been disabled for more than three months. A large percentage of these were considered to be good rehabilitation candidates. Many of them, of course, did not require special services to make adequate adjustments socially and occupationally. Others were so severely disabled that *vocational* rehabilitation, at least, would not have been a reasonable objective.

It is easy to understand that such large groups of people can constitute an important political force. Even if we did not subscribe to the general proposition that older people have certain rights to *rehabilitation* services, we nevertheless could expect that legislatures would take positive actions to insure that public support for services to these people would be increased. I am sure that we have all been impressed with the solicitude of the Congress with respect to medical care for older persons. Some professional opposition has been expressed, especially by the American Medical Association, against the public financing of medical care. However, the prevailing political sentiment seems to be in favor of providing assistance to older people in getting *medical* services through some group or social approach. *"Rehabilitation"* features in the legislation that has been passed or is now pending have not been included, but this is probably due to our negligence as professionals in bringing to the attention of the lawmakers the importance of this requirement for older persons. "Medical care" has not been interpreted as including many of the services that we refer to as "rehabilitation." The medical discipline of physical medicine is not yet receiving adequate emphasis. Many medical schools are not yet even offering training in the new discipline; and many of those that are, treat it as a minor subject and require a minimum number of hours of instruction to the medical student. However, the concept is growing that the health needs of individuals who have experienced disease or accident will not be fully met unless there is provided to them an opportunity to re-establish themselves socially and economically after the acute stages of their difficulties are passed.

The orientation of medical doctors is extremely important in rehabilitation. The emphasis on the doctor-patient relationship makes it very difficult for

the person recovering from an accident, from a disability or from a disease to receive services beyond those prescribed by the physician. Faster progress will be made when a large majority of medical practitioners are aware of the potential needs of their patients after recovery from the strictly medical aspects of their difficulties that brought them to their doctors' office initially. This problem is recognized by medical men themselves. Let me quote from an article in a recent issue of a nationally distributed magazine. The author was discussing stroke patients.

"The attitude of the medical profession has been one of helplessness," says Dr. Irving S. Wright of Cornell University Medical College. "It was just too bad, but the stroke patient was stuck."

"This attitude must end," says Dr. Rusk. "The doctor who forgets the stroke patient after the acute phase is over is just as negligent as the one who still treats diabetes with diet alone when insulin is available."

The medical profession has indicted itself. A mammoth five-year study of chronic illness, sponsored by the American Medical Association and related groups reports: "It is still commonplace for the hemiplegic (stroke patient) to be discharged without any retraining as soon as the medical crisis is past. He may deteriorate to be a helpless, speechless, bedridden invalid."

Dr. Bonner was shocked to find recently that most medical students get no contact with rehabilitation. "Most stroke patients still continue to be doomed to chronic invalidism," he says.

Not only is there a need for enlightenment in the medical profession concerning the requirements for rehabilitation, but people generally should be led to understand that "disability" does not necessarily indicate "handicap." Probably the most significant concept, and the one that is likely to mean the most to the rehabilitation movement, is the conviction that disability and impairment do not automatically relegate the individual to certain defined limitations with respect to his vocational and social activities. This is a matter of improving our semantics concerning disease, disability, and handicap. Great progress is made in dealing with persons with disability problems when we refrain from categorizing them according to generalized diagnosis. We would do well if we could eliminate from our language such terms as "the epileptic," "the cardiac," "the mentally retarded," "the amputee," etc. There is no such entity as the "epileptic." There are wide variations in their seizures, in their capacities, in their motivations, and in their potentials. One of the most grievous mistakes that can be made when dealing with such individuals is to group them and to assume certain fixed, common characteristics among them.

A few short years ago there was an almost standard outlook presumed for persons who had had heart attacks of one kind or another. They were referred to as "cardiacs" or perhaps as "old cardiacs." Many people were

prematurely relegated to a status of invalidism and idleness because of our inability to differentiate among those who had had some type of cardiac accident. Currently, there are scattered through the country about 50 evaluation centers where persons who have had heart attacks are individually evaluated and receive individual prescriptions as to what kinds of activity they might safely undertake.

The chief medical consultant to the cardiac evaluation center in Minneapolis states that because we are approaching these people as *individuals*, with *individual* characteristics and potentials, medical men are finding that about 78% of persons who had suffered heart attacks can return to work they were doing; and over 90% can return to the work force in some productive capacity. In my opinion, this step forward was made possible by the simple application of intelligent semantic principles.

"The tragedy is that nearly all could be up walking, caring for themselves, looking forward to living. Except that their children don't expect them to, most doctors don't expect them to, and the patients themselves therefore give up hope.

After the stroke, they lie in bed stunned, frightened. In 24 hours the affected arm starts curling and tightening, the leg turns out, the heel tendon shortens, pulling the toes downward. When the patient—out of desperation with bed—tries to get up, his side is so stiff, his leg so painful that even the most determined gives up."[1]

Disability imposed by assumption and language can be eliminated if we can discard such terms as "the epileptic," "the blind," "the deaf," "the handicapped," and the attitudes they promote. Among the more sophisticated workers in rehabilitation, it has long been recognized that the physical impairment is not the most important consideration in effecting a good adjustment to work or to social living. Such factors as the attitudes of the individual towards himself, the attitudes of others around him, and the expectations they have relative to the disability can be much more important than the lack of physical capacity resulting from accident or disease.

"Old age" is another term loaded with negative connotations. There are far too many generalizations about the characteristics of older persons. This is true even among the professionals who apparently find themselves overwhelmed by the popular attitudes concerning "old" people. It would be well if we would understand that the individual's chronological age is not his most important characteristic. Some people are old at age 35, others are still young at age 75. This refers to physical status as well as to psychological status. One of the most important jobs that rehabilitation workers have to do in working with persons in the upper-age brackets is to reaffirm their conviction that the age of the individual does not relegate him to a preassigned role. An individual is still an individual with peculiar characteristics,

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[1] Davies, R. C. We can rescue stroke patients. *Farm Journal* 1961 (Feb.) 38-39.

aptitudes, capacities, motivations, and potentials no matter what his age. It is unfortunate that we persistently use the term, "the older disabled worker."

What kind of a person is the "older disabled person?" At what stage of age or development does he move into that select circle? What can be expected of him? What are his limitations? What are his potentials? What are his needs? If there is such an entity as the "older disabled worker," all of these questions should be answerable, and we should be able to answer them with confidence and with at least as great a degree of readiness as is used in applying the label.

Actually, we all know that these questions cannot be answered with respect to any population. Intellectually, at least, we accept the proposition that every individual has individual characteristics. But in dealing with "the older disabled worker" do we behave as if we believe this? Is it not true that we tend to use stereotyped approaches, stereotyped solutions, and give stereotyped counseling to older persons who come in to us for rehabilitation services? Is it not true that if a prospective employer is informed that you have an "older person" for him to consider, he is likely to present stereotyped objections to hiring such an individual?

One of the basic things that we should undertake to do is to destroy these unrealistic stereotypes. Something rigid and almost magical has been assigned to the age 65 which, it has been pointed out, was foisted upon us as a retirement age by Bismarck 'way back in 1880. Perhaps it is time for a change. In 1880 the life expectancy was 40 years. Now, the life expectancy is 70 years.

Your agenda reveals that you will be spending much time during the next four days on techniques and procedures in helping and counseling older disabled persons. Good leadership has been assembled here to teach you. My role is not to anticipate all that you are to do or discuss here; however, I cannot resist making a suggestion relative to the long-term objectives of counseling and rehabilitation.

In counseling any disadvantaged person, whether his disadvantage arises out of disability or age, it is important that we look beyond the mere requirement that we somehow get him off our hands and into a job or into an acceptable routine of daily living. We should try to work with him in such a way that there will be an increased assurance that he will *stay* rehabilitated and will not again regress to a stage of needing the same services that we have just completed giving him. Most of our clients have discoverable weaknesses that can be identified and observed—weaknesses that will ultimately cause them to have difficulty in employment, in retaining the skills of daily living, or in other types of adjustment required of social beings. These weaknesses should be taken into account and the client should be given help in anticipating their possible ill effects. How many of us are completely

comfortable about the durability of the rehabilitation services we are giving from week to week? If we are not comfortable about it, why not? Is it necessary that our work shall represent a patchwork of emergency actions that will fail the moment that adversities involve our client?

There is one other suggestion I would like to make. We have talked and written so much about the *rights* of disabled persons that we and our clients sometimes forget that *responsibilities* must always be coordinate with rights. Clients have responsibilities, and if they are not accepted, your efforts and mine can no more fill our clients' needs than a faucet can fill a container with no bottom.

Clients have the obligation to prosecute the opportunities available to them; to keep well; to apply the principles that keep any of us on the job and healthy; to refrain from courting pity; to resist dependency; to accept and carry the role of the independent, self-respecting persons that they aspire to be.

I envy you your opportunity here this week. You should go away from here with enhanced abilities to engage in this great movement of rehabilitation; you should have a better understanding of the principles that underly the movement. Recently, the National Rehabilitation Association formulated a statement of those principles. Here they are:

Scope:

Effective rehabilitation is comprehensive. It presupposes all the services necessary to enable impaired persons to function adequately as individuals, as family members, as citizens, and as economic contributors. It should be available to all disabled persons wherever they live and whatever their disability.

Joint Effort:

Effective rehabilitation requires a rehabilitation emphasis in education, health, welfare, employment insurance, and recreation. It necessitates the coordination of the services of many public and voluntary organizations. It presupposes joint planning and action at local, state and national levels.

Professional Coordination:

Effective rehabilitation requires a combination of professional and technical skills. It presupposes conditions that enhance professional coordination, that encourage effective communications among the various professions, foster equality of status among them, and facilitate cooperative effort.

Research:

Effective rehabilitation requires constant self-analysis, stimulation, and evaluation. It uses research and advancing knowledge to evolve more effective methods of achieving rehabilitation goals.

Standards:

Effective rehabilitation requires qualitative and quantitative standards which assure a sufficient number of well-trained persons, facilities adapted to special needs of impaired people, and effective application of services. It presupposes the availability of services when and where needed.

Public Understanding:

Effective rehabilitation requires public understanding. Rehabilitation programming presupposes an understanding of disability, knowledge of rehabilitation objectives, and acceptance of disabled persons by the community.

Voluntary Effort:

Effective rehabilitation requires united community action. The efforts of voluntary organizations and individuals provide needed services and supply vitality and new approaches to the rehabilitation movement.

Governmental Responsibility:

Effective rehabilitation requires the assumption of major fiscal and program responsibilities by the federal government and states. This implies the appropriation of funds based upon needs and the progressive improvement of standards and goals in program development.

Administration:

The satisfactory implementation of this function requires client-centered administrations that encourage the development of effective policy and enable administrators to deal effectively with other governmental and voluntary organizations.[2]

If these National Rehabilitation Association-formulated principles need further definition and development, perhaps you will be able to accomplish that here this week.

This week should be another in the long series of "adventures in development" of the rehabilitation worker. Throughout that series, we work towards:

1. Defining our philosophy in rehabilitation,
2. Defining what shall be our guiding attitudes,
3. Defining our distinctive roles in our work,
4. Defining our terms,
5. Developing greater skill in identifying the needs of our clients and in meeting them,
6. Defining better our obligations as rehabilitation workers and the obligations of our clients,
7. Developing a recognition that we are not alone in our efforts—that we must not try to work alone,

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[2] National Rehabilitation Association Policy Committee. NRA Statement of Principles and program, *Journal of Rehabilitation*. 1961 (Jan.-Feb.), 15.

8. Developing techniques for enlisting the many persons and interests in the community that have a stake and a responsibility in rehabilitation,
9. Insuring that every experience leads to more insight and greater competency.

MEDICAL EVALUATIONS OF OLDER PATIENTS

David M. Paul, M.D.*

I was asked to discuss with you the subject of medical evaluation of the older disabled worker. When we talk about older people, older patients, older workers, and their medical evaluation, we enter a field that I am very much interested in. Yet, I find discussion of medical evaluation of disability in the older patient to be rather difficult because it is so complex. I think two factors help make the medical or disability evaluation of older people complex. The first is germane to the aging process itself; the second has to do with the personal error factor in any evaluation process.

When we deal with aging, we have to deal with arteriosclerosis and degenerative changes, fields that we in medicine still know too little about. It is a well known fact that the disabled older person is hardly disabled by a numerical figure, his age, but is rather disabled by the effects of degenerative and attritional changes within his body, the principal one of which is hardening of the arteries. For example, there is an X-ray man at our hospital who is 69 years of age. He is still as sharp as they come, an accomplished pianist, a mathematician and astrophysicist, all in addition to being a most competent radiologist. He is witty, clever, and he can out-golf me, and I am his junior by many, many years. On the other hand, there are people who at the age of 45 are already showing signs of senescence and are soon to have their lower extremity amputations because of arteriosclerosis obliterans or occlusive peripheral vascular disease of the lower extremities. So, when one considers the older person and the older worker from the medical evaluation standpoint, one has really to consider not a mathematical figure, but rather the impalpable physiological status of the body as a whole, the efficiency of the several body systems, and their competence for sustained and coordinated effort.

Another factor which makes medical evaluation of disability complex, is that it is difficult to get various physicians to agree on disability evaluation. Take any two physicians with exactly the same developmental background, with exactly the same training, with the same standards, and if possible with exactly the same emotional make-up, and you would be amazed, as I have been many times, at the wide differences between their disability evaluations of the same patient. There are many books on disability evaluation, and one may well be impressed by their failure to concur on this particular subject; actually, they may even contradict each other. I brought with me this morning a small text entitled "Disability Evaluation of the Back and Extremities" published by the *Journal of the American Medical Association*. It is about

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112 pages in length and deals only with the evaluation of permanent impairment of the extremities and back. What one is first impressed by is the confusion with regard to terms, such as "permanent disability," "permanent impairment," "partial disability" and "partial impairment," etc. Any disability rating obtained from this guide would have to be predicated first upon competent measurement of joint dysfunction; second, familiarity with relative impairment of function due to restriction of motion, ankylosis, amputation, fracture, and other conditions; and, finally, familiarity with the methods for combining several such individual disabilities, and relating various impairments with each other. Joint measurement, in itself, is subject to tremendous personal error.

In the preface of this disability evaluation outline, one notes: ". . . although a number of valuable contributions have been made . . . the committee found no comprehensive practical system of the type necessary for the evaluation of permanent impairment by individual body systems or of the whole man . . ." As one consults this text, one becomes aware that there could be several different solutions or evaluations to any one disability.

Sometimes the discrepancy in disability estimates is related to the basis or the reason for the evaluation. For example, if the evaluation is for workmen's compensation, one may get one result; if it is for a pension, you may get still another result; if it is for retirement, you may get still another opinion; and, on the very same patient, if the examination is for employment, you may get still an altogether different evaluation. Occasionally, the personal viewpoint or attitude of the individual physician colors an evaluation, despite the fact that his medical evaluation is sound and solid. But no matter what the many reasons, the fact remains that these discrepancies have made for a very difficult situation, and one that has not as yet lent itself to an acceptable solution. We usually have to make allowances for differences of opinion. Even in statistics, which is a most exacting and scientific discipline, differences are permitted to occur and are lumped together. In the biological and behavioral sciences most of our measurement lacks the precision and accuracy which we desire. It used to be the commonly accepted attitude that the physician was faultless, and that he never made a mistake. This is no longer the case. I think we have to settle here and now for the fact that the physician is not infallible and he, too, can and does make mistakes.

It is perhaps a commentary on the whole subject of physical handicap and its evaluation that criteria have not been developed which would facilitate agreement among professional workers, for there are as yet no adequate universal criteria for disability evaluation. On the whole, firm research into the medical evaluation of the physically disabled has been pursued much less vigorously than the needs of the handicapped and the magnitude of the problem would justify. Only within very recent years have concerted efforts been made among physicians towards a proper appreciation and under-

standing of the important relationship that exists between the physical condition of an individual and what we term his psychological status. What I refer to here is our understanding of the "whole person", rather than just his disability.

In this "whole person" or "whole man" concept, we stop thinking of the amputation alone, stop thinking of a paralysis by itself, stop thinking in terms of physical disabilities, and rather begin to think of a person with disabilities . . . a person with feelings, a man with a wife, a man with a home, a man with children, a man with neighbors, a man with a mortgage, a man with car payments, a man with taxes to pay, a man with ideals and hopes, who also happened to have lost a leg or who also happened to have lost the motor function of one of his extremities. In other words, it is only recently, and at that only with some physicians, that they have stopped thinking only of the disability and have begun to think in terms of disabled people. I think it is fortunate that the ancillary disciplines are being well indoctrinated with this "whole man" concept, and it may be that we as physicians will have to learn to appreciate this concept from the success that you in the ancillary disciplines are having with it.

I am sure you all know enough about this so that I don't have to go into detail about the immense literature that has come out in recent years concerning the psychology or the psychological adjustment of the disabled. You are all as familiar as I am with the problems of psychological adjustment to physical handicap. It is not within my province or appropriate to my presentation for me to dwell on this at any great length, except perhaps to mention that handicap serves as a never-ending source of limitation and frustration to the patient. His emotional reaction colors the sensory feed-back to us. And it can color our interpretations, evaluations, and our estimates of his disability. I think I should do no more than mention, only so as to recall to you, the typical modes of adjustment these people show, such as withdrawal, substitution, obliteration, and compensation. The physician, too, has to know about these, because they affect the history and color the physical evaluation; and the physician must take these into account if he is going to properly evaluate the "whole person" rather than the disability. Physicians who do disability evaluations have to be familiar with the feelings that handicapped or disabled people have as members of a minority group. We also have to be familiar, as you are, with the tendency of some to refuse our help. In evaluating disability, we must also have a good understanding of how these people react to normal people—how they relate to you, to me, to other people, and what their feelings are about themselves. One of the most important considerations in my own experience has been the disturbances of body image concept which I see frequently in the many amputees I evaluate. Unless the physician understands the emotional background of disability, it could be

difficult for him to evaluate such things as the phantom limb phenomenon, which can get in the way of a good rehabilitation end result.

While it is not my purpose in this essay to talk about the psychology of the disabled, I should not hesitate to emphasize too strongly that in disability evaluation the physician can not think in terms of the disability alone. He has to think of the disabled person in a socio-economic milieu, each and every portion of which affects him, his disability and his reaction to his disability. The first step in all evaluations, whether it be a medical work-up by me or a case evaluation by you, has to be a proper history. A medical work-up is something that cannot be done in a few minutes. This is as true in my medical practice as it is in all other disciplines, including your own. Perhaps the doctors' failures at uniformity in disability evaluation stems from the fact that many physicians may actually lack time to devote about an hour with each patient to obtain a good history, and about another half to one hour for complete examination. A proper disability evaluation may well take this long. There have been suggestions of dissatisfaction because of some of the disability evaluations you have seen from some of your medical colleagues. If so, I think we must keep in mind that a good disability evaluation takes a good deal of time, and many medical men are so pressed for time that complete work-ups may not be done in some cases.

Another factor which may lend itself to difficulty in disability evaluation, particularly in medical evaluation of the older patient, is that much of such disability may be cryptic or hidden. This may be better understood when I tell you that one may readily classify geriatric patients into three principal groups: one, the overtly handicapped patient—this is the patient with obvious hemiplegia, arthritic diseases, fractures, amputations, neuromuscular diseases, etc.; second, the chronically ill patient without any obvious signs of a disability—this is the patient who may have chronic heart disease, chronic pulmonary disease, etc., and who, because of such chronic illness devoid of manifestations, has, none the less, lost stamina and endurance for sustained effort; third, those elderly people who are not obviously ill, who do not have an obvious handicap or disability, who do not have chronic disease but, because of the attritional effects of the aging process itself, have their physical fitness definitely impaired, again with stamina and endurance for sustained effort clearly decreased. What I wish to point out here is that it is difficult, even for the trained disability evaluator, to recognize all the disability in older people because it may well be hidden in the subtle senescent and arteriosclerotic changes which are invariably present. Despite the difficulties in formulating a firm disability evaluation, it is still one of the most important steps in the rehabilitation of the patient. There can be no sensible rehabilitation program without a good evaluation of the medical problem and a setting down of what is actually wrong with the

patient and what remedial steps have to be taken to overcome or minimize the disability. Unfortunately, this is a time-consuming process; unfortunately, there aren't enough physicians who specialize in this kind of work to take care of the steadily increasing patient load.

I have mentioned the making of a rehabilitation estimate. I could not possibly cover but a fraction of this large subject in this brief essay. However, I can touch on it briefly by telling you how we go about making some of the decisions and coming to some of the conclusions that we do. Actually, I was asked to mention something about how we go about making a rehabilitation estimate of persons with hemiplegia. This is one of the most common disability areas in our work. The usual question asked by the relatives, by the rehabilitation counselor, or by the disability rating agency is, "Will the patient walk again?" We feel that we may often be able to predict this. Given the case of a hemiplegic lying supine in bed—if this recumbent patient can lift his heel all by himself off the sheet, keeping his knee stiff, within a few weeks after the stroke, the chances are good that he will ambulate. He may need a short leg brace and a cane, but such a patient should be able to stand and walk again. When I find this sign, I urge whoever is taking care of the patient to get him out of bed, and get him up on his feet, because the longer he stays in bed, the less will be the probability of his walking. But once he is able to effectively contract his quadriceps femoris so that the knee stays extended in the stance phase of the gait pattern, you have come close to solving the walking problem. This is because the big task in walking comes in maintaining the knee fully extended as one bears weight on it. If the patient can perform this straight leg raising with the knee fully extended, he usually should be able to walk again.

Another question that is frequently asked of us is, "Will recovery in the arm of the hemiplegic patient occur?" As you know, motor function in the leg may return while function in the arm does not. Or, if arm function does come back, the return of function in the upper extremity is not as complete as it is in the lower extremity. Also, if function of the arm returns, one can usually predict that the hemiplegic will walk. If arm function comes back, the leg almost invariably will, because in 90% of the cases, the amount of residual paralysis in the arm is far greater than the residual disability in the leg. Paralyses may be divided into two types: the first, *spastic*, is the "tight" type, where there is resistance to any attempts at motion of the extremity on your part; the second is the *flaccid* type, where the arm hangs limp, loose, and flail-like at the side. It is in this flaccid type of upper extremity paralysis where I have seen only very few show return of function, and my experience goes back many years. Once I see this flaccid type of upper extremity, I am inclined to predict that return of function of the arm will not occur.

I should also mention something here about the paraplegic. The question is often asked of me, "In paraplegics, how long should you wait for return

of function?" I feel that whatever function we find present after about five to six months is what the patient is going to have for effective use from then on. (Notice that I have said *effective* use.) I fully realize that after as much as eight months, additional function can and may appear at times. But there is a lot more voluntary muscle function required to ambulate effectively than can be accomplished by a little additional motion in the ankle, or even flickers of motion in the quadriceps. Such flickers or muscle twitches won't hold the patient erect; it takes a lot more muscle function than that. In the paraplegic, I usually settle for what he has at the end of about 6 months. This may be open to controversy without some qualification. What I have just referred to is the spinal cord lesion. As you know, we can also have paraplegia due to poliomyelitis. What we have to be able to do is to differentiate between the upper motor neuron lesion and a lower motor neuron lesion. What we are then dealing with is the site of the lesion—central nervous system lesions (the brain and the cord) as against peripheral nerve lesions. Here is the important thing to remember—brain and cord lesions usually don't regenerate, while peripheral nerve lesions may. Thus, in the case of a peripheral nerve lesion like poliomyelitis, I usually wait between six months and a year. This has to be a generalization, of course. In actual practice much will depend on the actual circumstances.

However, it is important that paraplegics, no matter how disabled they are, get up on their feet and stand every day, even if they don't walk. This actually becomes a form of ambulation. The mere fact that they bear weight is very important to their health. If they don't, they will undergo bone demineralization, they will develop stasis and infection in their urinary tracts, and they will develop urinary stones. They will also develop bed sores with what we call negative nitrogen balance, and they will usually die from these several complications rather than the basic paraplegia. These patients go down hill and die because they often spend all their time in a wheel chair. They then often develop urinary tract infections, cystitis, pyelonephritis, and they may then die a urinary-failure death. So, despite the fact that they cannot walk, paraplegics must be gotten up out of their wheel chairs or out of bed every day, on a tilt table or between parallel bars with braces. This is not so much directed toward return of function and actual ambulation, as it is to prevent the deconditioning, and the disuse effects of inactivity.

Another important area where we make a rehabilitation estimate is in the case of the lower extremity amputee. The question frequently asked is, "Will he walk with a prosthesis?" For obvious reasons, we have to attempt to predict whether the above-knee amputee, or the below-knee amputee for that matter, will or will not ambulate. What we do first is give the patient a trial on a pylon. (We fabricate a soft-socket pylon in our clinic for about $1.00 in less than a half-hour.) If the patient can walk successfully with a pylon, then he should be able to walk on a final-type limb. Another test

we use is the patient's ability to do a *swing-through* gait with crutches. If he can do this, he will probably walk on an above-knee prosthesis. More important, if he can't do a swing-through gait on crutches, he probably will not be able to walk on an above-knee prosthesis, and the determination of this fact has saved us thousands of dollars, not only in the cost of the prosthesis, but also in the cost of unnecessary hospital stay.

Now I would like to illustrate some of the points we have just discussed.[1] If one were to look at a cross section of a brain in which apoplexy or a stroke had occurred, commonly referred to as a cerebral vascular accident, there would be a red area representing the hemorrhage. The blood vessel that bleeds is most often the lenticulostriate artery. If the hemorrhage is within the right side of the brain, the paralysis will be on the left side of the body; if the hemorrhage is on the left, the patient will have right-sided paralysis.

In a schematic representation of a lateral view of the brain one would see the middle cerebral artery which carries blood to the brain from the heart. These arteries go up to the frontal lobe where the motor area which takes care of skilled motor action is located; another branch supplies the parietal lobe where the sensory area of the brain is located, while still another goes forward toward the frontal part of the brain and supplies a region known as Broca's area which is said to be the center for expressive speech. When this area is affected by the apoplectic process, speech is affected and the patient has aphasia or difficulty in speaking. Broca's area is said to be located in the left side of the brain in right-handed people and on the right side in left-handed people, thus aphasia occurs in right-handed people when Broca's area is involved by a left sided brain lesion, the paralysis then involving the right side of the body.

Now I would like to discuss for you what the usual spastic hemiplegic looks like. If we were to see the patient lying in bed we would note that the affected arm is internally rotated and adducted, and the elbow, wrist, and the fingers are flexed. In the lower extremity, the hip and knee are flexed and the thigh is outwardly rotated. The foot is plantar flexed. If you were to see the same patient standing in an erect position you would again see the adducted internally rotated shoulder and flexed elbow, wrist, and fingers. The lower extremities would demonstrate the *pes equinovarus*, or dropped foot with inversion. The foot and toes, in other words, would be pointed downward and the patient would not have the motor power to dorsiflex the foot. This condition can be corrected without too much difficulty by using a drop-foot brace with an anti-inversion "T" strap.

Let us next consider some suggestions for appropriate selection of cases for rehabilitation in hemiplegia. It is important that we select only those patients who are able to respond to treatment. Experience has shown that failure oc-

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[1] In the actual presentation, Dr. Paul presented a series of 10 slides.

curs much more frequenly under the following conditions: when senility and debility are present; when there are medical complications which prohibit activity; psychotic behavior or emotion lability; lack of motivation; long-standing contractures; and loss of learning ability. We have to exclude from our rehabilitation effort those cases in which the rehabilitation process cannot keep up with the degenerative and pathological processes. In order to be realistic about our rehabilitation, we have to be selective and we have to rule out those patients who have irreversible and irremediable lesions. Another important point is that loss of learning ability is a very common cause for treatment failure. There is seldom any brain damage without some loss of learning ability. It is my understanding from my psychology colleagues that the degree of loss of learning ability can be ascertained by appropriate psychological tests. I should stress, however, that one should not confuse aphasia, the difficulty in speaking, with loss of learning ability. It would be a tragic mistake to overlook the rehabilitation of a remediable speech lesion by assuming that the patient's inability to communicate was the result of a learning defect due to cerebral damage.

There has always been some disagreement concerning the indications and contraindications for prescribing prostheses for lower extremity amputees. I will now discuss some of the considerations concerned in the evaluation of the patient for such a prosthesis. The physiologic age of the patient and his ability to relearn and retrain in the use of the prosthesis is very important. Whether or not there are any serious intercurrent or progressive diseases present would also be significant. The condition of the opposite extremity must be evaluated, particularly where occlusive peripheral vascular disease usually involves the contralateral limb as well. Occlusive peripheral vascular disease occurs more frequently in diabetics than in non-diabetics. Experience has indicated that in a significant number of diabetics the well limb may require amputation a few years after the first limb is amputated. Thus, the status of the well limb must be evaluated before a prosthesis is considered. Other considerations are the presence or absence of permanent contractures, the condition of the stump, and the dependability of the patient for following up in a rehabilitation training program. It is worth repeating here that retraining, particularly for the older patient, in prosthesis ambulation is a difficult process requiring full cooperation on the part of a well motivated patient if it is to be successful.

In a series of 100 selected lower amputees that I had an opportunity to observe, we decided that at least 50% would not be able to use a prosthesis adequately because of age, intercurrent disease, contractures, or what we considered unreliability of the patient. From the standpoint of pure disability evaluation, however, we found one test that seemed to relate quite well with the patient's physical ability to perform adequately with an above-knee prosthesis. This was his ability to perform a "swing-through" crutch gait ade-

quately. This "swing-through" gait on crutches is performed as follows: both crutches are lifted by rocking backward, the arms are straightened, crutches placed forward, and the body then raised and swung forward through the crutches. We have noticed that if the patient has the ability to perform this type of gait and the stamina to perform it, and can ambulate sufficiently well so as to make him independent in his daily living activities, climbing stairs and traveling in public transportation, then we feel that he will use the above-knee prosthesis, and we prescribe it. If we find the patient cannot satisfactorily carry on these daily living activities by using a "swing-through" crutch gait, then we hesitate in prescribing a prosthesis because we do not feel he will be able to use it.

While we are on the subject of propriety in the prescription of prostheses for lower extremity amputation, let me mention the partial foot amputation. Except for the Syme type, amputations at this level can be a prosthetist's nightmare. While the Syme is a fine operation resulting in a useful, weight bearing stump, there still are some prosthesis problems which should be mentioned. It is an end-bearing stump and usually there is too little soft tissue left to carry the load of the body weight, and the soft tissue becomes sore in many cases. Also, this is a difficult prosthesis fit since the large bulbus stump necessitates an equally large, heavy, unsightly, cumbersome appliance above the ankle.

In using the prosthetic appliance for the Syme amputation certain problems must be considered. For one thing, the large bulbus deformity will show beneath the stocking on the involved side. In the case of a man wearing long trousers this would be obscured most of the time but most females would object to this as being unsightly and would much prefer the below-knee amputation where the prosthesis can be fabricated so that the ankle matches the well ankle of the patient.

Another important consideration concerns the abnormal gait patterns that occur in patients who are wearing lower extremity prostheses. It is important to consider this in the disability evaluation since an amputee who has been fitted with a prosthesis may remain unable to use the device properly, efficiently or effectively. Whether a patient with a prosthesis can perform his job properly and efficiently utilize the device may rest on the doctor's ability to evaluate and correct these gait defects. Since the cause and correction are purely medical or prosthetic considerations, we will not go into detail concerning these at this time. However, it is important for this group to realize that the well-trained disability evaluator should also be able to undertake gait analysis in the case of a patient who is not utilizing a prosthesis properly. This is called performance evaluation and amounts to the examination of the amputee-prosthesis functional combination. This includes not only the sciences of prosthetic mechanics but also the evaluation of the individual's performance with the prosthesis. Additional considerations here include the am-

putee's verbal reactions to the functions of the prosthesis comfort or discomfort (pain, sores, condition of the other extremity); function (stability, what he can and cannot do with the leg); effort required (is fatigue nominal or excessive); and acceptability (patient's attitude toward the prosthesis).

I would like to mention only briefly another area where there may be cause for confusion in disability evaluation and that has to do with nomenclature. We are all interested in the area of disability resulting from rheumatological conditions, so let me take the field of rheumatism-arthritis as a subject in point. Let me mention first the commonest form of rheumatism which occurs usually in older people. This is known as senescent arthritis, osteoarthritis, hypertrophic arthritis, or more properly, degenerative joint disease. Another less common form of extremely disabling arthritis, occuring usually in younger people, is known as rheumatoid arthritis, or may be referred to as atrophic arthritis, chronic arthritis, infectious arthritis, chronic infectious arthritis, arthritis deformans, and proliferative arthritis. One can readily understand the confusion and misunderstanding that results from the use of these many different terms. By the same token, there are many conditions erroneously called rheumatism which do not involve the joints. It would be impossible to render a proper disability evaluation without an exact diagnosis. The following are not uncommon diagnoses used for patients who have painful stiff joints: nonarticular rheumatism, fibrositis, lumbago, painful stiff neck, bursitis, periarthritis, tendonitis and tenosynivitis, fasciitis, panniculitis, shoulder hand syndrome, and a definite diagnostic entity known as "psychogenic rheumatism." It may be proper to mention at this time, again in connec- with rheumatoid arthritis, that it is common to have atypical cases which, if we would evaluate the disability properly, must be differentiated from the following: periarticular fibrositis, pallinoremic rheumatism, rheumatic fever, postcalatinal arthralgia, gonorrheal arthritis, Reiter's syndrome, gouty arthritis, degenerative joint disease, tuberculous arthritis, focal infection, luetic joint disease, posttraumatic arthritis, lymphogramuloma, dissiminated lupus erythematosus, periarteritis nudosa, and psychogenic rheumatism. By the same token, the stiff and painful shoulder which occurs quite frequently and is quite disabling, can be due to between 27 to 30 causes, depending on what authority you read. I mention all this to point out and to emphasize the great possibility of error that can occur in diagnostic and in nosologic description. We have to accept that proper disability evaluation is predicated on proper diagnostic evaluation and description. If we will be exacting in our disability evaluation, then we must have sharply defined diagnostic terms and diagnostic criteria.

Summary: An effort has been made to indicate to you that disability evaluation is not a simple process. There are still no definite rules or fixed criteria for this and it seems that men who have learned how to evaluate disability have done so from long experience and disciplined judgment. Experience

and judgment are very difficult bits of medical knowledge to dispense to others. However, it is still important in this type of work that physicians become able to agree fairly closely on the amount or degree of disability in an injured or handicapped individual. We are still searching for reliable methods of calculating and translating physical disability. Most disabilities causing loss of function result from loss of motion to a member or part of a member of the body. What we have to keep in mind, however, is not the loss of motion. We should think, rather, in terms of remaining function, and our disability evaluation should be expressed, if possible, in terms of the useful motion or useful function which remains.

PSYCHIATRIC PROBLEMS OF OLDER WORKERS

William Moeller, M.D.*

I. Introduction:

I would like to begin today by referring to a report of the White House Conference on Aging held in January 1961. Let me quote from the policy statement under Section 1 entitled Population Trends: Social and Economic Implications

"The Basic Facts as to population trends have been established by research. We know that today the average man or woman can expect to live longer than ever before—into his 70's and 80's. More people will have longer periods of retirement. At age 60 in 1900, for example, a man could expect less than 3 years in retirement. Today he can expect more than 8 retirement years. We have 16 million people over 65 today. This is five times more than we had in 1900 and the number will double in the next 40 years. The number over 75 will triple. At that time the over-65 group will exceed 10 per cent of our population. Its numbers will not only be growing but its economic power will be increasing. The health of many in the 65-75 group, both mental and physical, will be good, but because there will be more persons of advanced ages in the total group, there will be many whose health is seriously impaired, necessitating nursing or convalescent care. At 65, social competence will still remain high. In the case of women, many will actually be entering the labor market for the first time after 50. Women will increasingly outnumber men at older age levels. Some 50 to 60 percent of those over 65 have incomes of less than $1,000 per year. About half have assets of less than $1,000. The most common asset of greater value is a home. Medical costs for those over 65 will be approximately twice that for the average member of the total population. Persons over 65 spend 2¼ times more time in hospitals than those under 65. As they pass through the 60's, roles will change. Responsibilities of each person as worker, parent, or spouse will lessen, but those of citizen, friend, church or club member, and user of leisure time may be expanded if he has the desire and capacity, and if society expects this to happen and provides opportunities."

While I recognize the general good intent of such a policy statement, I feel that it is commensurate with an attitude that has accounted for much of the difficulty we now face in relationship to the problems of aging. The policy statement does nowhere report the source of the general information given, and the general theme is one of alarm and, I think, generally overstates or overimplies that the problems a minority will face represent a threat to all. Let me point out a few areas where I feel elaboration would be needed. In the first sentence they make reference to research as establishing what is to follow. I feel that the word research is used to imply validity and in itself may be misleading. Whenever research is used, the source and nature of same should be

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explained. Secondly, there is reference to age 60 man in 1900 having three years of retirement ahead, while today we have eight years of retirement ahead. It is vague as to whether they are referring to the fact that individuals are expected to retire now at age 60 and then would have 8 years of retirement, or what. It is established through studies of the Social Security Department that the average retirement age is 67. Then there is pure speculation, perhaps valid, that while we have 16 million people over 65 today it will double in the next forty years and the number over 75 will triple, the implication, I suppose, being that the problems will double and triple. But this, of course, is not a truism. Later on they refer to the health of many in the 65 to 75 group being good, when a recent random sample study by the University of Chicago indicates that only 14% of the people over 65 report significant ill health. I state this to indicate that perhaps the phrasing should be that the health of most will be good. But certainly if this statement is to be challenged, then at least we can agree that there is no consistent attitude about health problems when we are 65 or older. And I later on refer to the fact that some 50 to 60% of those over 65 have incomes of less than $1,000 per year. We must remember that this is crossing the sex line, and certainly most women do not have any income whether they are 65 or not and, then again, what kind of income are they referring to. Later there is speculation that the cost of medical treatment for those 65 or older will be approximately twice that for the average member of the total population. When is this, and what will it be related to? Now I raise these challenges to this general policy statement because I feel there is a lot of misunderstanding implied in this general statement, and this only nurtures the basic problem of fear of growing old.

II. I feel we should be talking about suspected psychiatric problems of some older workers rather than the "Psychiatric Problems of Older Workers." There is little agreement about when a worker is an older worker. For instance:
   A. United States government in 1930s established Social Security and set up age 65 as an expected retirement age and indeed a significant age.
   B. Our Governor last year in preparing for the White House Conference set up study committees for "senior citizens" 45 years and older.
   C. In Colorado, and in a few other states, there are "forty plus" clubs for men and women—the unemployed clubs.
   D. In spite of what we are discussing during these meetings, and what we may feel personally, I have not seen any study calculated to prove when one is to be classified as an "older worker" and, secondly, I have not seen any problem including death which is interpreted to be the prerogative of only the aged. Age in itself, as we view it, is a total relative matter. To the 18-year-old, 35 is ancient. To the person 65,

eighty years is old. To the eighty-year-old, 70 is young. Also, we recognize that even those who are older, who speak of the advantages of youth and the better qualifications of the younger, et cetera, are not willing to relinquish their role to the younger.

III. But then you may ask, don't we see a lot of older people who are depressed, a lot of them who have difficulty remembering things, a lot of them who are sick, who are unable to, or won't work, who are upset, irritable, et cetera—why does this occur? I feel the emotional problems of aging evolve from the processes of disillusionment, isolation, and the fear of aging or death and the subsequent confusion and panic.

A. Disillusionment. When the day comes that we find ourselves fresh out of dreams and hopes for the future and adopt the attitude that we have missed our opportunities, that it is much too late to fulfill our hopes and dreams, dissolutionment has occurred.

B. Isolation, a process starting when we say, "I don't want to be a burden to my children," being nurtured when we feel that it is a danger to go to the football games. The process of aging, generally, in our society dictates a lack of definition of roles and subsequent removal of responsibility in community life or social life and family life. This is not only enforced isolation by our general social standards and attitudes, but is contributed to by the individual himself who retires to the rose garden in the back yard.

C. Fear of the irreversibility of aging. The broken leg to the youngster generally tends to make him a hero, whereas to the oldster it becomes a burden and fearsome prospect. There is no doubt but what two out of three people measure aging by appearance of the body, or in other words, in physical signs and symptoms. By this standard the aging processes related to the skin, hair, et cetera, serve as a constant reminder of approaching death and this, perhaps being the most significant factor in the emotional reactions, we see related to illness, social isolation, financial problems, et cetera.

D. The confusion and panic that occurs at this age, which is related to the sight of the aging body and the realization that we are fresh out of dreams "for the future", finds its expression about the four major concerns of financial security, social status, satisfying activities, and physical health.

IV. Let it be established then, that most of the reactions of old age are based on misconceptions and established, antiquated attitudes, and these reactions are reflections of our society. Indeed, we feel that the best age is in the twenties, whereas in other societies, such as the French, the best age is the one in which you happen to find yourself. The aging processes that take their toll can be overcome by the full realization that flexi-

bility need not be lost with the accumulation of numbers of years and that *the greater determinant of our ability will be our mental attitudes and not our ages.*

A. Show the movie entitled, *Many Lives of John Q. Public*—this movie demonstrates the need for continuous adjustments to our changing body, beginning early in life and not just when we are older. The most significant point in the movie is the establishment that not until about age sixty do we find any decline in our total mental abilities, but that whether we are able to establish this as our individual peak will be based on our continuing to exercise and make use of our mental abilities through the intervening years.

B. Our government is beginning to reverse its attitudes, established in the thirties, and now we find that it is being suggested that retirement ages of a strict rule should be done away with. At the same time, greater protection is being thought of for older individuals. Recently in Des Moines, a Reverend A. W. Mueller was speaking and he suggested the fact that "there is danger if we plan too much for too many people; we could destroy initiative." At the same time, Social Security benefits are expected by our President to begin at age 62 (this is his present recommendation), and we recognize that this will have much to do with now establishing retirement to begin at age 62, or age 60, instead of 65, that many retirement programs will be geared toward this age 62, et cetera. Once again, let me suggest that age is not as great a handicap as society's confused attitudes and mixed motivations.

V. Without detailing it, I would like to further this attitude by referring to a study conducted in Kansas City between the years 1952 and 1956. A study of adult life by the University of Chicago Committee on Human Development surveyed several hundred adults in middle and late life (with reference to their total adjustments) and, without going into the facts that led to this statement, I will repeat these words from an article written by Robert Peck, who took part in this study: "Chronological age per se has little to do with adjustment, happiness or effective living; the individual's attitudes and ways of approaching each day's experience are elements which far outweigh any effect of age itself."

Another study which is more current, and about which I will elaborate a little more in detail, is reported in the *Journal of Geriatrics* in February 1960. It is related to the "psychoneurotic reactions of the aged," and is a study being done at Duke University by Doctors Busse, Dovenmuehle and Brown. All subjects in this study were over the age of sixty and 650 were examined. Only 222 were reported in this study, however, and these were individuals who were volunteers and were maintaining a satisfactory social adjustment in the city. These people had what

one might classify as a thorough study, you know, like even meeting the standards of the most careful eye of the Vocational Rehabilitation counselor.

These people had:

1. Medical history
2. Physical examination
3. Neurological examination
4. Psychiatric evaluation
5. Dermatological examination
6. Ophthalmoscopic examination including fundus, photographs in color and visual acuity.
7. Audiometry
8. Electroencephalogram
9. Electrocardiogram
10. Ballistocardiogram
11. Microscopic vascular structure and hemodynamic bulbarconjunctiva with photography.
12. Laboratory studies including urinalysis, C.B.C., N.P.N., fasting blood sugars, serology tests for syphilis, blood cholesterol.
13. Chest X-ray
14. Psychological test, including Rorschach and intelligence scale and level of aspiration studies.
15. Social history and evaluation including socioeconomic classification.

Need I say more. Let me emphasize that this study is taken from individuals in the community and would differ from studies of people who were in the hospital, institution, nursing homes, et cetera. The reports of these 222 people indicate the 40%, or 89, were considered normal; 25%, or 56, were psychoneurotic, of whom 25 had severe neurotic reactions; 21 demonstrated relatively mild non-psychotic organic changes, 42 had combined psychotic and neurotic symptoms and 14 presented evidence of psychosis. Of these the psychoneurotic subjects were compared to normal individuals in regard to a number of parameters, including physical, psychological and social measurements. Those who were psychoneurotic were decidedly less social than were those of the normal group, and they were apt to be hypochondriacal and depressed. Although their attitude toward friends was distorted, their attitude toward work was not strikingly different from the normal group. *It was felt that this acceptable attitude toward work could be one of the determinants that prevents emotionally disturbed people from becoming patients.* This work presents evidence of the fact that a number of elderly people with psychoneurotic reaction of varying degrees are still able to maintain a reasonably acceptable adjustment in society. A previous finding was also substantiated by this study; they also found an inverse relationship

between age and mental disorders, suggesting the possibility that with advancing years a better adjustment is attained. Even after this study, they say in summary that "to recognize the elements which permit a person to maintain his satisfactory role in the community requires much further investigation." I should say at this time that this sentence should not imply these problems are related simply to age 65 and older. These statements and the above findings could probably be duplicated at any age level.

These two appraisals are the type of thing one finds in the literature and it gives me the impression that we have first been convinced, through some devious process, that there must be a problem associated with aging. Now we are going about trying to prove it and we are having a great deal of difficulty with same.

Not too long ago I talked with the Vocational Rehabilitation counselors of Iowa concerning psychosomatic illnesses, stressing that the patient with these illnesses thinks that these symptoms constitute his illness and does not understand that the essential difficulties are his conflicts and anxieties and his inability to establish order and peace and security in his personal life. Today I would take a look at, in a general way, the converse of this situation. Let us take a glimpse at the situations in which organic physical illness may be provocative of emotions that may greatly complicate the original disability. We have to, for the point of simplification, here agree that the manifestations of a physical illness are frequently much colored by the patient's personality and that many persons who already have a well defined disease of chronic nature experience exacerbations or complications of it in relation to severe life stress. Depending on the personality, a patient suffering from a serious and progressive physical disorder such as multiple sclerosis might be very prone to develop some psychological response to it. This may take the form of depression, and excessive denial of the illness or an exaggeration of symptoms through a desire for pity and attention. However, it is not only illness or disability itself that is of psychiatric importance, but also what a particular disability means to a particular individual, so that the loss of a hand, for example, may have a very different meaning to a surgeon than to a psychiatrist, and the resulting emotional disturbance or disorganization of the personality may be of a different nature. And taking a little different line, we find that certain parts of the body are of more symbolic significance, such as, operations on the reproductive organs frequently cause more emotional disturbance than appendectomies. Other types of illness that allow a crippling in this highly competitive world may produce severe reactions. It is not uncommon for the reactions of the deaf to be paranoid in nature, the paranoid reaction causing much more harm than the deafness itself. Sometimes the disturbances may be related to the sex of the individual, for instance, the appearance of the face being much more important to the fe-

male than the male, so that a scar acquired in the early life of a girl may go on to disturb her whole orientation, whereas the same to a male may become a sign of masculinity.

You will hear often repeated here and elsewhere, that the attitude which the patient takes toward his handicap is extremely important. So that if an individual has had a coronary heart attack, he must not only adjust himself to his physical limitations as related to the heart disease, but he also must adjust to the idea of his disability. Depending on his personality, the coronary patient is capable of responding with complete retreat to the bed and never returning to work, or going to the extreme of the day after the attack denying that this was of nothing but mental origin and returning immediately to his work.

Those of us who have families well recognize the convenience of the husband's illness allowing him more frequently the opportunity to be in bed, whereas "good old mom" works up to the last minute before she is rushed to the hospital for delivery, manages the home by telephone while in the hospital, and will walk the floor for countless hours during the next months, come the flu, a broken arm or increased taxes.

But let me now emphasize that I have not been talking about the age and illness, but pointing out that frequently the manifestations of the patient's illness are determined more by his personality characteristics than by the nature of the etiological agent producing the disease or his age. He experiences his illness in accordance with his personality makeup and established types of reaction to stress.

Once again, in reference to the report of the White House Conference, referring again to the same section, let me repeat to you what they have established as the rights of senior citizens, but more important the "obligations of the aging."

Rights of Senior Citizens: Each of our senior citizens, regardless of race, color, or creed, is entitled to:

1. The right to be useful.
2. The right to obtain employment, based on merit.
3. The right to freedom from want in old age.
4. The right to a fair share of the community's recreational, educational, and medical resources.
5. The right to obtain decent housing suited to needs of later years.
6. The right to the moral and financial support of one's family so far as is consistent with the best interest of the family.
7. The right to live independently, as one chooses.
8. The right to live and die with dignity.
9. The right to access to all knowledge as available on how to improve the later years of life.

Obligations of the Aging: The aging, by availing themselves of educational opportunities, should endeavor to assume the following obligations to the best of their ability:

1. The obligation of each citizen to prepare himself to become and resolve to remain active, alert, capable, self-supporting, and useful so so long as health and circumstances permit and to plan for ultimate retirement.
2. The obligation to learn and apply sound principles of physical and mental health.
3. The obligation to seek and develop potential avenues of service in the years after retirement.
4. The obligation to make available the benefits of his experience and knowledge.
5. The obligation to endeavor to make himself adaptable to the changes added years will bring.
6. The obligation to attempt to maintain such relationships with family, neighbors, and friends as will make him a respected and valued counselor throughout his later years.

Now I feel these things to be quite valid and perhaps we can summarize them in another way. The results of studying those individuals who have made successful life adjustments seem to indicate that there are certain personality characteristics that are desirable to facilitate a better acceptance and adjustment to the various ages in inherent situations as we go through life. They are in summary:

1. Show interest in people and new things and tend to look ahead and to be optimistic.
2. Profit from mistakes and be flexible and open-minded.
3. Have several and varied interests and last, and in summary, to have interests outside of ourselves.

INITIAL INTERVIEW AND APPRAISAL OF OLDER CLIENTS

Edwin Cohen, Ph.D.*

Initial Interview and Appraisal of Older Clients? "Sure, I'll be happy to discuss that." At first hearing, it sounded relatively straightforward and so I consented very readily when asked to speak on that topic. Sometime later I realized that in my passive acceptance I had probably bitten off more than could be used as cud for a brief presentation. I made an observation, which is probably not original with me, but which I shall nevertheless transmit. The last two words in my topic, "older clients", sound simple enough, but let's pause for a moment to consider them further. Suppose one of you were asked to talk about counseling amputees or perhaps mental patients. You would immediately be faced with the recognition that although you have been given what appeared to be a definite assignment, it really is not. You might justifiably ask, How can I talk about counseling with the amputee or the mental patient when amputees might have nothing in common with each other, other than that they suffer the same affliction; and likewise with mental patients. Essentially this is my problem: what do older clients have in common with each other, over and above the fact that they have attained a given number of years? Of course, you may see this as over simplification since there are certain problems, attitudes, and feelings which are probably highly correlated with age and should be considered in counseling with older clients. Although I shall direct myself primarily to these factors, it should not be forgotten that individual differences exist by the millions, and attempts to generalize to a specific individual are fraught with chances of unreliability.

Since my entire counseling experience has occurred within the hospital framework, much of what I have to say will be drawn from that environment. In this instance, I believe you may safely generalize to the problems you may face outside the hospital in counseling with the same age group.

If I may digress for a moment, let me say that perhaps even more than other organizations, the Veterans Administration is beginning to realize the tremendous potential impact of the problem of the older client. Hopefully, in the event that no more wars occur in our lifetime, the Veterans Administration can look forward to serving an even older patient population. Even now the great bulk of WW I veterans are over 60 years of age and many

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of the WW II veterans are in their 40's and 50's. The rehabilitation counselor will be asked to play an ever increasing part in the total treatment program. In these days of enforced retirement at a given age and the lack of inclination to hire older men, it is incumbent upon the counselor to play an effective part in helping to maintain the individual's health, granted him in the hospital. Since Dr. Morris will be speaking to you on *The Meaning of Work to the Older Person,* suffice it to say here that in most instances it is extremely important in maintaining the gains made in the hospital.

Since I am concerning myself today with the initial interview, perhaps the logical place to begin is with the approach to the patient or client. As Tyler[1] points out, the beginning interview is an anxious moment for both client and counselor. Neither knows just what to expect or how he will proceed. This is apt to be especially true in the hospital situation, where the patient does not feel well to begin with and may be apprehensive of treatment processes, and where the counselor is being particularly careful to co-ordinate all his activities with those of other teamworkers.

The counselor, having done some research on his patient with the doctor, the nurse, other staff who may be familiar with him and the chart, will have begun, perhaps, to formulate plans on how he will proceed; but it also seems desirable for him to see the patient for the first time on the ward. This allows the counselor to meet his patient with less preliminary build-up and in the ordinary framework of hospital activity. This is not to say that the counselor should engage in the gathering of personal data on the ward where there is little privacy. He will probably wish simply to introduce himself, to describe his services in general terms, and to suggest that he will contact the patient at a later date to see whether or not there is any contribution to his plans that the counselor might make.

Having been seen initially on the ward, the patient should be less anxious when he later arrives at the vocational counselor's office. And, perhaps the patient will be more likely to come to the counseling service as a result of his own motivation. It is easy to forget in the hospital situation that the patients report to many services, more or less on order, for the execution of medical tests, and the experiences they have are not always pleasant. It is often much easier to start a conversation with a patient who has been seen on the ward and who, therefore, is not wondering what lies in store for him on this new service.

This procedure is to be advocated for any client regardless of age, but seems particularly helpful with older clients who find themselves, often uncomfortably, in a world of young staff men who are apparently interested in various parts of them without apparent concern for what these men see as

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[1] Tyler, Leone E., *The Work of the Counselor,* (New York, Appleton-Century-Crofts, 1953.)

the large problem, namely now that I am old and have no job, what happens when they say I am well enough to leave the hospital. By seeing them initially on the ward in an informal manner, it serves to obviate the probability that the trip to the counselor's office will be viewed as just another trip to see someone who is interested in yet another part.

Perhaps before discussing the initial interview in any detail, it is crucial that we consider an important and frequent problem. It has frequently been observed in various agencies that counselors often are not particularly enthusiastic about working with older people. Of course, the reasons for this are not always the same. However, they do include such factors as a futile outlook on the part of the counselor, and the counselor's discomfort in working with an individual perhaps twice his age. In my opinion, it is extremely important that both of these factors be worked through prior to the initial interview, or prior to the counselor working with older people. Should they continue to exist, even in small measure, it will only serve to reinforce the feelings which the client probably brings with him to the counseling process. A futile outlook and discomfort sufficient to provide a barrier to a good social, as well as professional relationship, are rather difficult to conceal from the counselee. I am aware that this is almost self-evident, but I feel it worth mentioning since it does so frequently occur in working with the older age group where the glamour associated with such problems as rehabilitation of amputees is not so easily encountered. It must also be remembered that the counselor will seldom see an older person as a vocational problem per se. In order to qualify for most vocational rehabilitation services, he must also have a significant physical or mental impairment which interferes with his ability to offer himself on the open job market. Thus, there is often some basis for the counselor's feeling of futility, for not only is his client probably to be discriminated against because of his age, but also, perhaps, because he has some added handicap for frosting on the cake. Perhaps I am saying that in such instances the counselor cannot afford to be too objective, lest he destroy even the less than average chance for realizing a successful outcome with his client.

When the client, who happens also to be an older person, arrives for his initial interview, it is crucial that the counselor again review with the client the purpose of his visit and advise him what he can expect in the total process. This I view as essential in order that the client may be helped to look upon the entire process—interviewing, testing, counseling and placement—as purposeful and designed to help him in the end to arrive at a solution to his problems. This will also serve to allay any tendency toward simply passing the time of day or chit-chat on the part of either the counselor or client. This is not to say that rapport should be sacrificed at the expense of gathering information. I am simply saying that an attempt to maintain the interview on a functional level will serve the very useful purpose of conveying

the notion that the counselor views the session in a purposeful manner, thus avoiding any inference of an attempt to cover a futile outlook with social amenities.

Although the gathering of information is extremely important in the initial stages of the counseling process, it should not be placed ahead of the earlier goal of establishing a good counselor-client relationship. Again, this may be viewed as self-evident, but I feel it bears stating in this context since there seems to be a tendency on the part of the less experienced counselors to defend against their feelings of discomfort by proceeding according to a preconceived plan. This may often take the form of rigidly structuring the interview in such a way that it leaves little or no room for free or spontaneous interaction. Although this conveys the notion of a business-like attitude, it does little to provide the client with a feeling of interest in him as a unique individual, capable of talking about himself in his own fashion. Once again he is being examined, without adequate preparation, just as he has experienced on his ward, at X-ray and the lab. Just as there are reported to be various ways to skin a cat, there are also various ways to secure information; some better than others. Allowing the client to tell his own story to an interested and sympathetic friendly listener who may ask various questions –because he is interested–serves the dual purpose of establishing confidence in the counselor as well as providing relevant information.

It has been my experience that severely handicapped younger people may often seem to take a hysteric attitude of not really recognizing the extent of their disability and may even attempt to ignore it. This is seldom true with the older person who is often acutely aware that he is an old man, cast off by society. In my opinion, it is the counselor's task in the initial interview to make known to the client that he is interested primarily in his abilities, and only secondarily in his disabilities. As I indicated earlier, it is most important that the counselor convey an attitude of confidence and primary interest in what the client can do rather than what he cannot do.

I might digress slightly here to note that counselors often largely dispense with the information gathering portion of interviews by requesting that the client fill out a detailed questionnaire. I have no quarrel with this procedure for younger clients who have had enough experience with such a procedure, often recent, to be able to do it rather easily. However, this is often not the case with the older client. He may look upon such a task as too large and complex, particularly if he no longer reads or writes more than he finds absolutely necessary, and as a useless task, particularly in view of the depressed outlook he is apt to have regarding his future.

Although, as I have stated, I do not believe the interview should be structured to gather information in any particular order, the counselor should, by following the lead of the client, attempt to obtain information in the following areas: hobbies and leisure activities, work experience, military

experience, education, family and home information, and at least a general idea of how the client views his own potential. In most instances, many questions will have been left unanswered during the initial interview. It is best that the counselor obtain this information in later interviews and not detract from the purpose of establishing a good relationship by attempting to secure complete information during the first interview. This is usually impossible anyway, since there will always be further questions to which the counselor will be seeking an answer.

At this point I might also mention another caution which to this audience is self-evident; however, it may be noted in younger and relatively inexperienced counselors. This is the tendency to introduce tests too early in the counseling process; perhaps even during the initial interview. I believe this to be particularly relevant in this discussion because it is my opinion that this occurs most often when the counselor is uncomfortable. Finding himself feeling this way in the presence of an older disabled person he is more apt to lean on testing as a crutch and as a means of concealing his anxiety. Tests can serve a very useful purpose, but allaying the counselor's anxiety should not be one of them. However, the time will often legitimately arrive when testing should be incorporated in the counseling process.

The counselor must not suggest testing until he has some assurance that the patient understands the counseling process and has accepted it and the counselor. When tests are discussed the patient certainly should be given some preliminary description of what can and cannot be expected from tests and what they are designed to measure.

There are, of course, patients for whom few tests, or none at all, are indicated. If the counselor has sound reasons for feeling that tests would not give valid results or would not contribute the desired data, he should proceed to furnish the data by some other means.

Tyler's reminders that old tests are better than new ones (since more data are available for use in interpretation) and that, in choosing tests, one should consider non-test information already available, are worth the careful consideration of all counselors. Tests must be carefully prescribed on an individual and selective basis to yield needed specific data. There is no particular virtue in the use of many tests. Wise use of selected tests, to provide specific data to fill gaps in knowledge or to corroborate or deny the implications of other data, should be the rule.

If the procedures leading up to and including test selection have been effectively handled, counselors should not be apologetic or overly concerned about how tests look to the patient. Tyler has made the point that face validity is probably not important if a well-based counseling relationship, with the underlying acceptance and understanding, has been developed.

The lower social, economic, and educational levels of many patients may make it desirable to establish the patient's reading level before too much is

done about test selection, and before test results can be interpreted with confidence. The counselor must know something about the reading levels of the various tests he is using. Counselors cannot assume that if the patient understands the directions for a test, he will necessarily comprehend the test items. In addition to knowing the reading level of the tests available, it is necessary, of course, to make some estimate of the reading level of the individual patient. Some suggested clues to this include vocabulary level, as revealed in the interview, and results of a test of mental ability, if available. Since impaired vision may also be a factor, particularly in the older age group, it is important that the counselor determine that the client is not penaiized unnecessarily. Often such a simple act as reminding the client that he should bring his glasses, if he has them, will serve to obviate such a problem.

I shall go no further into the counseling process with older people since I feel that other speakers will cover other facets. If it has appeared that I have spoken as much about the counseling process in general as about the problems encountered with older people, it is only because I believe that their problems are not entirely unique. As often encountered with the mental patient, I feel that the greatest need in this area is one of counselor as well as public acceptance and a genuine desire to be of help.

REHABILITATION AS IT SEEMS TO BE AND AS IT MIGHT BE

Wendell Johnson, Ph.D.*

During the past year and a half or so I have served as Chairman of the University of Iowa Council on Rehabilitation, and in that capacity I have spent part of my time visiting fifteen rehabilitation centers or programs in various parts of the United States and attending meetings of rehabilitation personnel, reading reports and other relevant materials, listening to lectures and discussions, and thinking more or less continuously about what I have been seeing and hearing in the general field of rehabilitation. For the past four years I have been serving as a member of the National Advisory Council on Vocational Rehabilitation. As the Central Office Consultant in Speech Pathology for the Veterans Administration, I have spent a considerable amount of time during the past two years in the Washington office of the V.A. and in V.A. Hospitals, Outpatient Clinics, and Regional Offices throughout the country. Recently, I assisted in the review and evaluation of data collected in a study of Federal legislation, programs, appropriations and expenditures, problems and unmet needs, and relevant information and opinion in the fields of rehabilitation and special education, conducted by the Committee on Education and Labor of the United States House of Representatives. At the 1960 White House Conference on Children and Youth, I chaired a section concerned with problems of vocational rehabilitation for handicapped youth. It is a pleasure to share with you the main observations I have made of vocational rehabilitation in this country, and my more compelling reflections about what I have observed.

As Dr. Muthard has told you, I have a certain kind of personal background from which I talk to you about these matters. I was a "handicapped child." It always startles me to say that—and I suspect that many other people are startled when they are referred to as "handicapped." It is a word we use rather loosely, I'm afraid, and often in ways that blur our purposes. I stuttered very badly, not only as a child, but even for many years after I received my doctoral degree, and I've improved my speech most in the last five years. The reason for the recency of my major improvement in speech is that only in recent years have we done the research on the problem of stuttering that has enabled us to work out the preventive and remedial methods we now have. When I was a boy about as good a treatment for stuttering as anyone had figured out was three sugar pills after each meal—an actual prescription made by our marvelously wise and kindly old family doctor. Nothing in my life has been more deeply satisfying than the privilege

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of participating in the highly rewarding research effort that has made possible better speech for millions of children and adults. This kind of experience gives one, necessarily, a tendency to focus on certain factors in thinking about rehabilitation.

Differences Among Rehabilitation Programs

The rehabilitation programs I have studied differ along a number of dimensions. They differ, for example, with regard to the degree to which they are research-based or research-oriented. There are some that are mainly research programs. There are others in which there is no research thinking that one can detect. They differ also in the degree to which they are integrated with training programs in universities or with hospital residency programs. They differ with regard to the nature of the services that are rendered and with regard to the pattern of integration of these services—if integration is the word. Sometimes it appears that even when integration of services is attempted, however elaborately, not much integration is achieved. The programs differ, too, with regard to the professional group that exerts the dominant influence. Some of them are directed by physiatrists, others by orthopedic surgeons, or pediatricians, or other kinds of medical specialists, or by nonmedical professional workers. They differ also, of course, with regard to the degree to which they involve prevocational and vocational training.

Similarities Among Rehabilitation Programs

There are also some common denominators in the various rehabilitation programs, as I have observed them. These common factors reflect, in part, the policies of the United States Office of Vocational Rehabilitation and the laws which underpin that Office in its responsibilities with respect to these programs. They also reflect, in part, the influence of the professional organizations in the field.

In general, to me the most conspicuous common denominator that characterizes our rehabilitation programs is the fact that they are money and job oriented. It is almost as though unconsciously we have fallen into the habit of defending what we do in rehabilitation because "it pays." Every year the taxpayers and their representatives are told that so many people have been rehabilitated and that they will pay in income taxes the cost of their rehabilitation, or more, as though it were something that we were really doing for a profit, or as though its major justification is that it reduces our taxes. I think that we are not generally aware, certainly I wasn't and I have talked with many other persons who were not aware, of the degree to which we have taken on the habit of justifying what we do in rehabilitation on this basis. Because this tends to be the justification—the main justification, not the only one, of course—we tend to orient our rehabilitation efforts around

the objective of preparing the client for paid work. And this has some pervasive and very important effects on our programs.

Effects of Money and Job Orientation

The economic orientation of our vocational rehabilitation programs tends, for one thing, to eliminate children from consideration, and so we waste a great deal of our effort because we get there relatively late in most cases. Somehow, we seem to feel that there is something natural about the legal or official distinction that has been made between persons below and above the age of sixteen years or thereabouts. There is nothing natural about this, of course; this is as arbitrary as anything could possibly be. And my own view of it is that it is one of the greatest anchors around our necks. The time to rehabilitate a person, if possible, is when he is very young. Now, while there is, of course, something done by some agency or by somebody for most children who have disabilities, it is not always well integrated with what is done later by some other agency, or some other set of persons.

Our basic orientation also tends to eliminate from major consideration persons who are very old. Anyone too young to work, or too old to work, tends not to be looked upon, in general, as a suitable client for rehabilitation, and we have come to take this pretty generally for granted.

Moreover, we tend to eliminate, in accordance with our established kind of justification and objective, those who are too disabled to be trained for paid employment. I think I detect—these things aren't as obvious after a great many looks at them as they are at first—I think I detect a general assumption on the part of most people that there is in this total picture some sort of a division of labor and responsibility. When we are having to deal with a person too old, too young, or too disabled to be prepared for a paid job, then this, we seem to feel, is the responsibility of somebody else.

"Somebody Else"

This term "somebody else" is very vague. It isn't at all obvious in most cases who this "somebody else" is. And it just about comes down to the fact that, from the point of view of the client as a person who is disabled, if he is too young, too old, or too disabled to work, there frequently isn't anybody else who's doing much of anything to serve his needs as a person. Many nursing homes, for example, don't provide a very satisfactory answer for people who are too old to work. Our society really neglects these people to a great extent.

In this connection, we do a very strange thing with children. You're familiar I assume, with some of the fine children's hospital schools that have been built, like the one in Iowa City. And I assume I can't get a rise out of you by referring to these as being, in part, monuments to our fondness for children. They're not completely utilitarian; they're not entirely functional in the way they are designed and programmed. One of the tremendous problems you have when

you try to do something about children who are disabled arises from the fact that you solicit the help of their parents, and with their help you arouse the legislators, or whoever has to be aroused, and you build the buildings which you have in mind and you open their doors—and by the door of each of these buildings you paste a little set of rules and on it, among other things, you say that in order to be eligible for this program the child must be educable, or trainable, or eligible according to some such word. The basic principle is that the asumption is made that some children are more worth working with than others. And so, very soon you are confronted by a bunch of angry tigers, parents who thought they were helping to build something for their children, and then they find out that their children are not eligible. They're not educable, some of them, according to some criterion or other having to do with I.Q., or something of the sort.

With others, I helped to start a program of hearing clinics a few years ago, bringing together the resources of several departments of the University, the public schools, and the Iowa State School for the Deaf. We hold hearing clinics every so often in which we review cases. It is extremely impressive that a certain proportion of the children who are reviewed turn out to be children for whom the State of Iowa simply has no suitable facilities. It isn't always a good asumption that if you have a program for people with certain needs, other people with other needs are being served by other programs. Very often—very often, indeed—there isn't anybody else doing anything about "the others."

The Need for More Than a Job

In general, then, I think that we have in the over-all rehabilitation program as we know it in this country the inspired and inspiring core of a program for disabled people. I think it should be broadened. I think in a world of urbanization, automation, rising population, shrinking of distances, and general "electronization" we're probably not being very realistic when we take as our over-riding objective of rehabilitation the training of disabled people for jobs in the labor market. I just don't look upon this as being, in many programs and situations, a very well thought-through kind of objective. After all, we have lots of unemployed people who are not disabled at all. We all know the disabled as a group can make good work records, but I think we can hypnotize ourselves to some extent with this kind of talk. Moreover, we do great disservice to thousands of people whom we're supposed to be helping because we decide, after we size them up and do what we call the best we can do, that we shouldn't do any more for them—because we don't think they are employable.

Now, I deeply believe in work. I think work is about the healthiest form of human activity and the most satisfying, and I am convinced that for many persons there are disorienting effects of trying to make a distinction between

work and play, or work and recreation. I think this must have a great deal to do with such problems as delinquency. We teach children that there are two kinds of activity in the world; one we call "work" and one we call "play". The one we do because we have to; the other we do because we like to. The one is fun; the other is drudgery. With the choices put in these terms, only a fool would want to work. And then we wonder what makes many children seem so irresponsible.

I think there is something very wonderful about work, but I don't think the major consideration should be that you get paid for it. I think life might be much more satisfying for almost everybody if that were quite incidental. Work doesn't have to be paid employment. It can simply be useful and creative activity. And more and more, all of us are going to have to learn to enjoy this useful and creative activity whether we get paid for it or not, because we're getting more automation, shorter work weeks, and more workers. It isn't just scare talk that we're getting more automation. You have all seen some automated factories, I'm sure. I recently saw an automated iron ore processing plant on the Mesabi Range. Eight men were running it—and when I was there they were playing cards. This isn't a dream or propaganda, this is real. There are many oil pipelines and refineries these days that can practically be run from a distance by pressing buttons and turning dials. More and more we're all going to have to figure out what to do between three in the afternoon, or earlier, and time to go to bed, and it is to be hoped that we learn to do something better than we're doing now, for the most part.

One of the things about the kind of a rehabilitation program for which the major justification is economic and the major objective is training people for jobs is that we serve only to a partial degree even the people we do accept as clients. We don't, as a rule, train them, for example, for retirement. I may be making some statements to which you would prefer to attach some footnotes and qualifications, but I have the impression that we don't give a lot of thought to training people for retirement. Many of our clients and prospective clients, especially the older ones, are soon going to retire or have already retired, because it's in the later years that they have strokes, or undergo surgery because of cancer, or have other reasons for needing our rehabilitation services. They don't need to be trained for paid jobs. They need to be trained for their actual or imminent retirement.

There are many able-bodied people, in fact, who are retired in the sense that they have lost their jobs because a town has lost its industry, or for some other reason, and although they're only forty years old, perhaps, they do not readily find new jobs. Thousands of men and women in West Virginia and Detroit and various other places are retired in this sense. It is not always realistic to train even such people for new or different jobs unless we're prepared to develop a kind of economy that we now don't have. In order to provide them with jobs, it would in some cases be necessary to move a large part

of an entire town. Doing things like this inches very easily into regimentation and collectivization. We're against these things, we say; we're for individual freedom. We don't readily pick up a town and move it from Massachusetts to Alabama because the industrial conditions are more favorable there. If we're going to do things like that to any considerable extent, then we are going to have to shift our gears politically and philosophically.

Meanwhile, what are we doing about training people for retirement—and for their non-working hours? This is very essential rehabilitation for most people. What are we doing to train them for weekends? Suppose they're lucky enough to work forty hours a week—most weeks—what about the other 128 hours? What are they doing then? What are we doing about that?

The "Tower of Health"

These, then, are some of the thoughts I have had as I've gone around the country looking at rehabilitation programs, trying to ponder as effectively as I could, for example, what the University of Iowa should do about rehabilitation. This is a state institution supported by tax funds and it is properly supposed to serve the public, including the disabled. How can the University of Iowa, or any similar institution, best do this?

I think it becomes pretty obvious that a university supported by tax funds can't do what it might reasonably be asked to do in rehabilitation by limiting its attention to people who can be trained for paid employment. This would seem, necessarily, to involve discrimination. It can hardly fulfill its proper function if it doesn't serve children as well as adults, and if it doesn't somehow serve them in an integrated way, moreover, so that what is done for children actually leads to satisfying the needs they have when they get older. Nor can we serve the public fully by neglecting those who happen to be disabled in certain ways, so that they probably can't be placed in paid jobs. So what are we going to do about it? What kind of program can a state university best justify?

For one thing, I believe that at such an institution as the University of Iowa we're going to have to do more than train people to work, in the usual economic or market sense of that word. One of the most creative ways in which we can come at the problem has been symbolized by Dean Norman B. Nelson of the University of Iowa College of Medicine. He has been talking for many years about a concept which he has attempted to make "graspable" by referring to it as a tower, an actual "tower of health." What he means by this is a tower having several floors, with each floor devoted to some professional or vocational specialization, or some branch of knowledge. If you were to build a tower like this, you would go to the School of Music and ask, "What do you want to put in this tower? This is a tower of health designed to contribute to the well-being of people. What do you have to contribute?" You would go to the Mathematics Department and ask, "What is your contribution to health,

and specifically what good are you to a person who happens to be disabled?" You would ask this question of the Departments of Political Science, History, Chemistry, Art, Philosophy, Physics, Education, Home Economics, and all the others. All around the University you would ask: "What do you have to contribute to make the lives of the disabled richer, not just to make them employable, but to enable them to become, in a broad and comprehensive sense of the word, humanly rehabilitated?" I think we need essentially a tower of health. I think this concept suggests the basic kind of program that would do everyone concerned the most good.

The idea of a tower of health embodies at least two particularly fundamental principles. These principles were championed here at Iowa for almost half a century by a man who left his mark indelibly on the University. His mark isn't always obvious to newcomers, and sometimes it has to be pointed out to them, but the mark is there. His name was Carl Emil Seashore. He was the son of a pioneer. He went to Yale and Germany for his advanced education, and came back to Iowa from Yale in 1897. He soon became Head of a new Department called Psychology, and then he also became Dean of the Graduate College. He was in these two positions for roughly thirty years, and then came the second World War and he was called back to the Graduate College Deanship after retirement. For almost half a century he played a very important role in the development of his institution. The two great principles which he championed, and the effects of which continue to be decidedly evident here at Iowa, are both embodied in Dean Nelson's tower of health concept.

One of these basic principles is that you can't solve any human problem within the confines of a single academic department. Academic departments are institutionalized abstractions or verbal structures. They don't correspond at all precisely to anything outside of themselves. In order to solve any real problem at Iowa, for example, we have to bring to bear upon it all the resources of the University and of the community outside the University. It takes inventiveness to bring all of the available resources to bear upon a problem. In order to do this, we have to knock down departmental barriers within the University—and within the University Hospitals—and sometimes we have to offend departmental prides and prejudices. We have to persuade people to do something that very few of them are well trained to do, and that is to work with others who are not like themselves—to work *with* them, neither to "control" them nor to be "controlled" by them.

Dean Seashore's other great idea was that before we can render a service, before we can have a rehabilitation center or a speech clinic, for example, we have to have a classroom. That is, we have to train students to render the desired service. And before we can do that we have to have a laboratory, because we must have some knowledge to teach the students. It is important to be very clear about where such knowledge comes from. Knowledge comes

only, as far as I know, from laboratories, in a very broad sense of this word—that is, it comes from disciplined observation and creative thinking about what is observed.

Now, if we are going to build a tower of health, before we can figure out what the Department of History, for example, could possibly put in it, we're going to have to do some experiments. Where are you going to find out what good the study of history is to a disabled person? It could be very good for him, no doubt, but we're going to have to do some research in order to determine its distinctive value. This kind of research isn't usually done by historians because it isn't "in their line," and it usually isn't done by the rehabilitation specialists working in their respective academic departments or areas of concentration because of the particular focus of preoccupation by which each one of them is restricted—and that's one of the many things the matter with departments. A lot of fly balls fall between the fielders when the members of the team are departmental minded. This kind of talk is as disturbing as it is challenging, of course. Meantime, what can we do about the problems caused, or complicated, by the departmental form of organization which we seem to take for granted?

The Need for Research-Mindedness

I don't have many suggestions to make about these problems because the necessary research has not been done. I don't know whether the word "research" rings a bell with you, whether you like the sound of it or don't like it. Most of the students I know who say they want to become speech pathologists and audiologists, or clinical psychologists, or physicians, for example, say they don't want to do research, they want to "work with people." Now, I don't know quite how you work with people, in fields such as rehabilitation, except as you are helpful to them in solving problems. And so far as I know the only problem-solving method that the human race has ever developed is the scientific method, the method of research. What's the unscientific method of solving problems, by the way?

The more we realize that in rehabilitation we are necessarily and basically problem-solvers, the more we develop a desire to know how to solve problems, and this must lead us inevitably to the study and application of the scientific method, not only in formal research but in our work generally. Meanwhile, most of the research that needs to be done in the field of rehabilitation hasn't been done yet. I believe the observation I made during the past four years as a member of the National Advisory Council on Vocational Rehabilitation that I would be most likely to write a book about could be summarized in some such words as these. As a Council we had so much money, appropriated by Congress, to spend for research and demonstration projects. For my last year on the Council I believe the amount was about eight million dollars. Anyway, it wasn't much compared to the 500

million or so that the National Institutes of Health had to manage, somehow, to figure out how to spend, or the larger amount we are trying to spend on research concerning "outer space." It isn't easy to spend so much money. It isn't easy even to spend eight million dollars for research in our field—and spend it with assurance that the dividends in data are going to be maximal. Please don't misunderstand—it is easy to find eight million, or eight hundred million, dollars worth of research needs in the field of rehabilitation. The major bottleneck is that from our schools at all levels, including the level of the M.D. and the Ph.D. degrees, and in all relevant fields, there do not come very many graduates oriented to think in the ways research workers must think.

We say we must keep up with the Russians in science. I'd rather say that in science, as in other spheres, we must meet our own expectations of ourselves simply because our sense of well being requires us to do our best to realize our potential for creativity and progress. Meanwhile, how many babies do you suppose there are in this country at this hour being influenced on their mothers' knees to want to become scientists? The number must be extremely small. And so when we try at the level of the graduate school to pump money into the universities to produce research scientists, we find that to a crucial degree we can't buy this kind of product. Scientific research is a way of life that involves a certain way of thinking and a distinctive value system. The research scientist fundamentally prefers to trust his own nervous system rather than to be dependent for his judgments on someone who wears a white robe or coat or a symbolic collar or uniform, or who is invested with a title or some other symbol of authority.

What a scientist does mainly is to ask questions that can be answered by observations that can be made by methods that are available, or that can be devised. He then reports these observations in descriptive language and draws tentative conclusions from his report, not from some book that was written before he made his observations. Then he asks new questions on the basis of his conclusions, and makes further observations to answer these questions. He reports his new observations responsibly, revises his conclusions accordingly, and from these revised or improved conclusions he again draws new questions. Then he makes new observations, which he carefully reports, and on the basis of them he makes still further improvements in his conclusions, or generalizations, and so on he goes in an endless spiral of evaluation and re-evaluation that is called scientific research and thinking, and that can make only for continuing progress.

An exceedingly small number of children in our society manage to get through our schools and colleges and come out thinking and working habitually in accordance with this pattern of scientific behavior. Almost everybody in our culture is trained to deal with problems by trying to find the persons who are supposed to know the answers. We characteristically go to the doc-

tor, or the priest, or the teacher with our questions, or we look up old Judge Thompson, or we write home to mother, or try to buy our way out of perplexity. Our assumption that there are Knowers makes for authoritarian, and so, essentially, infantile relationships. Most patients treat their doctors as though they were magicians, quite as though, indeed, they were primitive medicine men. In the kind of culture that encourages such relationships the scientific approach to problems, especially personal and social problems, is not the rule by any means, and so major research in rehabilitation has been spotty, sporadic, and sparse.

Nor are we likely, I believe, to change very fast our basic culture and the related principles of child rearing and formal education that run counter to a scientific orientation. Most of our school and college teachers, as well as our counselors and physicians, have been trained to act as though they know all the answers, and they do not comfortably say they don't know. They have learned, somehow, to feel that wide-eyed curiosisty is something appropriate only in early childhood. Mostly in the schools we teach "content," or what is known, or believed to be known, as though it were final, instead of methods of investigation and evaluation. Having been made to feel that they should not have to ask any more questions, because they are supposed to know all the answers, most teachers do not train their students in the art of asking questions. There is, meanwhile, no more potent and important art. Certainly it is the art that is basic in the way of life called research. And it is just as basic in the way of life called rehabilitation.

Needed Research in Rehabilitation

If we could get more of the needed research done, here are some of the things that I think we would find it worth trying to do, and when I put it this way I'm talking directly to you, the vocational rehabilitation counselors on the front line. Somewhere, for example, the data have to be collected. Many of the data have to be collected with your help. Somehow you're going to have to adjust your programs to accommodate the research workers—or in some instances you may become research workers yourselves. The attitude, so common in our society, that we don't want to be guinea pigs must be rooted out if we're going to get ahead more rapidly in this field. Everybody's a guinea pig, of course. There is a sense in which everything we do is an experiment—only we don't usually control the conditions very well, or notice what the data are. You were a guinea pig here tonight, eating what you ate, just as I was, eating what I ate. I'm actually a subject in an experiment in nutrition at the University Hospital at the present time. What I'm eating these days, however, is no more of an experimental diet than what I was eating previously. It is not that we are not guinea pigs, it's just that almost all of "us guinea pigs" are usually neglected—or we neglect ourselves.

There's nothing wrong with experimenting, as such. Indeed, it is the fastest road to a better world and we need to get used to driving on it.

I think that for one thing we have to be—and I think we are—ingenious enough to do some research using what might be called the anthropological approach to rehabilitation. What, for example, are some of the problems we would be likely to clarify if we were to do some anthropological studies of families in which there are handicapped children? What would you find out if you went into the home of such a family and just stayed for several days? I am sure I would never have found out what I have about the stuttering problem if I had stayed in the little magic room I call my office instead of going into homes when I began my research on the onset of stuttering. For one thing, I have become allergic to a neat living room. If a living room is still neat towards the end of the day, there is a question as to whether anybody really lives there or somebody is just bent on keeping a room neat—and if this is the situation it is awfully tough on two-year-olds.

The research that still needs to be done in rehabilitation is overwhelming. We're living in a dream. For the most part, what we have to go on is, to a disturbing degree, a kind of standardized error—congenial preconceptions. Meanwhile, what does it mean to be handicapped?

I'll never forget the evening when Earl Schenck Miers was the banquet speaker at the annual meeting of the Iowa Society for Crippled Children and Adults. He is an author and an editor for a large publishing company. He also has cerebral palsy. As he spoke, he was a man who seemed, for all his incoordinations, to be perfectly in charge of himself. And what he had to say was wonderful, wonderful stuff. His lean rugged face and shaggy hair—and deep wisdom—suggested a sort of cerebral palsied Abraham Lincoln. At the next table there was a lady who had obviously spent the afternoon in a beauty parlor, and every hair on her head was in place and the face she was wearing had been very carefully constructed. By all ordinary standards she "looked better" than he did—and she was "not handicapped." I kept looking at her and then at him. She didn't have much expressiveness in her face; she didn't seem to be very much interested in anything. What is more interesting and attractive about human beings than their reaction to the world and to other persons? A woman, or a man, who is bland and apparently bored, or indifferent to others, can hardly seem attractive. And so the woman at the next table who had paid someone to make her look "nice," and who was listening with such blandness to this perfectly wonderful speech—she, to me, was the one who was handicapped. By comparison, the speaker, who was supposed to be handicapped, was not merely all right, he was magnificent. Our concepts of "disability" and "handicap" are in need of painstaking review.

I want to mention with special emphasis one very important research

need that we have. As I have gone about the country observing rehabilitation programs and hospitals I have been impressed and depressed by the time and energy and thought that seem to be wasted in bickering, in jurisdictional disputes, in one department head fighting with another one, in one doctor resenting the supposed instrusion of another doctor, or of another person who doesn't have an M.D. degree. What is this? Is this always normal human behavior? I don't think so, not always. I think it needs to be examined and diagnosed. I think we need to do research on it. This is a peculiarly significant and common form of human behavior. We haven't observed it nearly enough in systematic fashion. We get so used to it that we mostly, I think, equate it—even in some of its more bizarre forms—with normality. I don't think for a minute that there is anything natural or inevitable about most of our inter-personal and inter-professional bickering and snarling and nonfunctional competing. I think much of it is as pathological as polio. It can be diagnosed and it can be treated. It can be prevented. Normal, healthy people, I think, like to be kind and creative and to work together for constructive purposes. I think that if a child is to grow up to compete in ways that are to the disadvantage of other people, he will have to be trained to do it. It doesn't come naturally.

The commonly observed politics of hospital space, for example, the grabbing and clinging to square footage, is often seen as a form of abnormal behavior, and in some instances a scandalously wasteful and destructive one. This is seldom the way to do a job with professional competence and humanitarian considerateness. It is more often a way to be a nuisance, and nearly everywhere I go I see its ravages. I observe time after time somebody defending his own department, or his own program, or his own floor space in an essentially paranoid fashion against all comers.

We need to do much more research on these and other aspects of the organization of human endeavor. There is nothing natural about departments or divisions as we know them. They represent a style of organization at least as old as Rome. We have come a long way since Rome in most things, but not in this. It's simply startling to go into a large modern industrial corporation way out on the far frontier of physical research, and observe that for all their inventiveness they are operating with the old Roman style of organization! Why are they not more inventive when it comes to the organization of their own inventive endeavors? We may very well have to become much more inventive socially in order to survive. For example, we take nations for granted. Have you ever walked very reflectively across a national boundary? What was it you crossed? Something natural or something contrived? We haven't even begun to ask the basic questions about our accustomed modes of social organization. What is natural about a hospital, or university, or corporation department? When you walk from one depart-

ment to another what do you cross? We create artificial worlds and then we live in them as though they were real.

Research on Communication

The basic fact, I think, about organization is communication. I believe that what matter and energy are to the physical sciences, symbolizing and communicating are to the social sciences. The most important social science of the future will surely be concerned with the basic processes of communication and with problems of communication networks. I think one of the ways we can gather data most effectively in studying communication is to investigate the blockages that occur in it. I think we can identify these in the communication networks of hospitals, corporations, government agencies, and other organizations. I think we can find out who does not talk to whom when or about what, for what reasons or under what conditions. I think we can find out which way messages flow fast and which way they flow like glue.

Connected with this matter is the problem of the attenuation and distortion of messages. Let me tell you about one modest study I directed in this area some years ago. This was the Master's thesis of Caroline Woods Sherif, published in the journal *ETC: A Review of General Semantics* in 1944 under the title, "John Told Jim What Joe Told Him." We made up a neutral 800-word essay about the Negro-white problem. It had fifty statements, or propositional units, some pro-Negro, some anti-Negro, some neutral, and the pro and anti statements were balanced so that the total effect was neutral. Then we tested hundreds of college students and picked out the thirty who were the most pro-Negro and the thirty who were the most anti-Negro. We divided each of these groups of thirty into three subgroups of ten each. We gave the first ten subjects in each of these two major groups the original article to read. When they had read it, we asked them to put it aside for a few minutes and then to write an abstract of it. We had the ten abstracts from each group typed and we passed these abstracts on to the next ten subjects. We asked each of them to read one of the abstracts and then to write an abstract of the abstract. These abstracts we handed on to the next and final subgroup of ten subjects. They read the abstracts of the abstracts and then they wrote abstracts of them.

We analyzed the changes that occurred in the propositional units or statements contained in the original essay as they moved through the three stages of abstracting. We found, first of all, that roughly three-fourths of the original material was lost in the process. We also found that the abstracts written by the subjects who were pro-Negro ended up significantly different from those written by the subjects who were anti-Negro. What impressed me most, however, was that about twenty-five percent of the propositional units

—or, roughly speaking, details—in the abstracts had been added; that is, they were not in the original essay at all. These findings illustrated very well indeed that in dealing with any communicative situation it is essential, if we are not to be misled, that we be sufficiently sensitive to the abstracting patterns and distortion tendencies characteristic of the communicators with whom we are dealing. Above all, it is to our advantage to be aware of our own habitual patterns of abstracting and distortion in order to avoid deceiving ourselves.

We need more research of this general kind. We need some studies in which, for example, we would tape-record what you as a vocational rehabilitation counselor tell a client after you have reviewed his problem, and then we would follow the client home and tape-record his answer when we ask him what you had told him. By analyzing enough tape recordings of such counseling sessions and follow-up interviews concerning them, we should begin to identify the major sorts of discrepancies that occur between what clients are told by counselors and what they say they were told. What do they remember correctly? What do they forget altogether? What do they distort and what are their usual confusions like? I think one of the hypotheses to be tested by such means is this: people bring to the counseling situation their accustomed folk thinking, and it's extremely difficult to alter this by talking to or with them in the ways we usually do. If we follow them home and ask them what the counselor said, they'll probably tell us in many or most cases about what they would have told us before they went to see the counselor in the first place. Now, what can we do about this in order to make our counseling more effective?

It isn't enough to tell people what we think they should be told about their disabilities and their potentials for improvement, for education, and for employment. They need to know, also, something about the patterns of thinking that they share with other folks, and until they understand their folk thinking sufficiently to become free of it and do some new kinds of thinking on their own, there's not as much point in counseling them as we would like to think there is. There is now quite an accumulation of data indicating that much less happens as a result of most psychotherapy than seems to have been commonly assumed. How much happens as the result of your counseling? Do you have the data needed to answer this question? I believe more data of this sort would be greatly worthwhile.

By Way of Summary

These, then, are some of my main observations and reflections. They can be fairly summarized by saying that, in my judgment, we have made inspiring beginnings in rehabilitation and our accomplishments to date promise still more rewarding achievements in the years ahead. At the present time there appears to be considerable variation among rehabilitation programs

in regard to the relative attention given to service, research and professional training. They differ in their institutional settings. They differ in respect to the profession by which they are controlled or mainly influenced and, in general, in administrative structure.

There is a conspicuous common denominator, however, in our existing rehabilitation programs. They are money and job oriented. We justify them largely on the basis of the claim that the earnings of the persons we rehabilitate, and especially the income taxes they eventually pay, more than balance the cost of their rehabilitation. In keeping with this kind of thinking, we tend to gear rehabilitation to the primary objective of training clients for paid employment. In consequence of this basic justification and this fundamental objective of rehabilitation, we tend to exclude from our programs persons who are too young, too old, or too disabled to qualify for paid jobs. In a tax-supported university rehabilitation program, and perhaps in other types of rehabilitation programs as well, these persons are appropriately to be included and adequately served.

There is a need, in my judgment, to broaden our generally accepted concept of rehabilitation. It is desirable to provide needed rehabilitation services for all who are disabled, regardless of age and degree of employability. Moreover, it is desirable to prepare the disabled who are employable to do more than qualify for paid employment. All rehabilitation clients have a basic need to prepare themselves for the wise and constructive use of their non-working as well as their working hours and for their retirement.

In order to develop rehabilitation programs that will serve these broader purposes—or serve even restricted purposes more effectively—we need to expand greatly our present research efforts in the general area of rehabilitation. We need especially to develop more systematic and comprehensive studies of the various types of disabled or handicapped persons on a longitudinal basis, starting in early childhood and continuing throughout life, and in the homes or natural settings of the persons studied rather than, or as well as, in laboratory and clinical situations. We also need much more research on the problems of administrative organization and policy in rehabilitation programs. In this type of research attention is to be fruitfully focussed on the processes and networks of communication, especially the points of blockage in these networks, and on the loss and distortion of communicated information as these influence the effectiveness of rehabilitation and the welfare of the client. There are in addition, of course, a great variety of other research needs to be met if rehabilitation is to become as creative and constructive a force as it can be in our society and throughout the world.

The future of rehabilitation promises to be very bright indeed—provided we appreciate sufficiently how much we have yet to learn, and provided we do everything possible to learn all we can of the very much that we need to know.

THE PSYCHO-SOCIAL EVALUATION OF OLDER CLIENTS

S. J. Williamson, Jr., Ph.D.

As I read some of the pre-conference material in an effort to understand more about your problems, I became confused. All summer long, until November, I read and heard on radio and television that a certain man was "too young" at 43 for a certain job, and yet as I read your material, I find that you would soon consider him an "older client." I wonder if he realized how perilous his position was while job hunting.

In the discussion which follows, I have chosen to emphasize the need to collect as accurate data as possible, rather than to deal extensively with the distinction between the older client and the younger one. I have chosen this emphasis because if a difference in the approach to the older client is needed, this need can only be shown to be a valid one by being based upon data as adequately collected and as accurate as possible. Further, the use of such data requires the same degree of care as its collection if the client is to be given the kind of help your organizations are charged with giving.

I shall also emphasize the need to consider the counselor as a tool of assessment.

The evaluation or assessment of the older, disabled client requires a great deal of skill, knowledge, and understanding of the problems of these individuals. With the addition to the pool of job seekers of those individuals who usually would not be competing for jobs, the task of the counselor becomes more difficult. While you have done an excellent job in the past, it is imperative that the job you now do be the best of which you are capable. The task of evaluating, training (if necessary), and placement of clients has had enough potential pitfalls for even the most cautious counselor. Now the task is intensified by the increased possibility that the client will be rejected, and the resultant frustrations which will follow. Prospective employers are likely to be more resistive, whether because of the states of their businesses or because of the way they perceive your client.

Your task, that of helping each client "make an optimal vocational adjustment in keeping with his interests, talents, aptitudes, physical and mental capacities, place of residence, etc.," requires that you make predictions about your client concerning each of these factors. This is the essential purpose of assessment.

What kinds of predictions are we called on to make? First, it may be necessary to make some prediction about the ability of the client to learn a job. This prediction carries with it the question of the flexibility of the

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client's attitudes, and the degree of flexibility needed depends upon the job being considered.

Second, we must make predictions about the client's physical strength. This prediction carries with it the question of the possible limitation of motion and the ability to perform certain operations. Some of these operations require strength, that is the ability to lift, to pull, to push and so forth. Some other operations require the client to be quick and agile.

Thirdly, we must make predictions about his ability to work with others. How capable is he of entering into a cooperative task with others? How willing is he to take orders from a younger supervisor? The situation in which he may be forced to take orders from a younger supervisor may be complicated by the fact that the client may have had, at one time, if not now, greater skill than the younger supervisor. How aggressive is the client? In what way does he show his aggressiveness? Does he act it out on the job, or does he sublimate it in an intensification of his attack on problems?

Fourthly, we must make some prediction about the skills still available to the client. This requires, among other factors, an analysis of the jobs which the client has performed in the past. We want to know what additional skills he has developed other than those developed as hobbies and those listed in his work history. What skills has he lost as a result of illness and the lack of practice?

We are called upon, fifthly, to make some prediction about possible absenteeism. For this prediction we must rely upon the past record of the client. We must get data from the client, from his family, and from his former employers. We must take into consideration the limitation which his illness may impose on his ability to be on the job. What are the possibilities of recurrences? What will be the possible frequency of illnesses he is known to have, and what will be the duration? What "secondary gains" will this client get from his illnesses?

Sixth, we must make some predictions about his motivation, utilizing such factors as his financial need, the family pressures to return to work, his reaction to forced inactivity, and the status needs of the client.

To insure the accuracy of these predictions we employ the rules, the logic of the scientific method. In utilizing the rules of scientific methodology, we must first make sure that the data we collect about our client is as accurate as possible. You know what questions to ask, what information to gather. With each client you help, your ability to determine what information you need increases. Every time you "hot-foot it" out of the office to obtain some significant bit of information you failed to get, you remember to get it the next time. The danger is, however, that you will be too zealous in collecting amounts of data, and put your client under undue stress. He may not understand your reasons for obtaining certain kinds of information. I remember a client's reaction to the kind of information a neurologist needed about him

as he complained to me about the examination. "I told him (the neurologist) that my head ached, that I had had it for about three weeks, and that it began all of a sudden. He asked me more questions and scratched the bottom of my foot." This client remembered only that part of the neurological examination which distressed him. I know the neurologist, and I know how thoroughly he does his examinations. In getting information about the client's employment record he is likely to understand the questions and the purpose for which asked. But, when we begin to ask questions to try to get at his attitudes, he is less likely to understand. And, if you are over-zealous he is likely to react with stress reactions.

You get to know what information you need to secure, but every time you face a client you have a new problem concerning the reliability of your information. If you could get all of the data or information you could possibly need, you would still have a problem. In determining the reliability of the information obtained, we can use as a model the work that has been done in determining the reliability of tests. The fact that many of the tests you have attempted to use have proved to be of little value does not change the fact that the model is, in general, a good one. From the study of the reliability of tests, you have become acquainted with two general types of reliability. One type is statistical. It is a method of reporting the self consistency of a test by means of a coefficient. Obtaining statistical reliability in the interview situation is usually not practical. The other type is the use of "internal consistency" which is the method of *approximating* reliability in the clinical, on the job situation. The rigor with which we must apply the criterion of internal consistency is a habit which we must carry over from our study and understanding of statistical reliability.

I am using the concept of "internal consistency" to describe what one does when he looks at his data to see if a particular hunch or prediction about a client is borne out by subsequent data. If one sees evidence that the client is impulsive or that he is disoriented, one should be able to find additional evidence of these characteristics in other data which one gathers about one's client. The very fact that one says that a client is impulsive implies that the impulsivity is a characteristic of the client and should be seen again. Too often in actual practice, one is likely, having observed events on which we base this abstraction of the data, to ignore the need, the obligation; to support the statement with data from elsewhere. A further characteristic of this kind of statement is the implication that another observer could note, independently, the same events and data and make the same generalization.

The reliability of these predictions will be based on the accuracy of the information plus one's ability to interpret adequately the information one gets. In order to aid one in organizing, evaluating, and interpreting the data one gathers about one's client, I think it necessary that one organize this process about some systematic position. However, the beginner is likely

to find the greatest degree of comfort in a printed questionnaire. This state of affairs was recognized by the Veterans Administration as it established the Vocational Rehabilitation and Education services immediately after World War II. It had to get a job done, and the manpower pool available was a large number of school administrators and teachers who had been drafted from their jobs into service. They had not, in general, been trained as counselors. The V.A. worked out a step-by-step analysis of the counseling process and incorporated it into a "1902 series." I salute the V.A.! Inadvertently it dealt a "death blow" to formal, outlined, detailed questionnaires. These early V.A. questionnaires were so rigid, so controlling, so lock-step that all but a few people, whose personalities were as rigid as the questionnaires, reacted with complete rebellion. I am happy to say that the V.A., in the meantime, has made it worth while for those individuals who were untrained to get additional training which eventually freed them from watching the questionnaire and allowed them to look at the client, some for the first time. Nevertheless, one needs some organizing frame of reference.

I suggest then, that one adopt a systematic or theoretical point of view to aid in organizing the data one gathers. To explain, I want to paraphrase a point of view expressed by the theorist in psychology. Theory in psychology, and in any science, consists of statements or guesses as to the relationships existing among data. Theory has an additional function. A good theory generates *hypotheses*, that is testable statements which, if supported, lend weight to the theory. The theoretical position one adopts determines what the guesses are, what the hypotheses are that you make and which you test with the data you obtain. It determines what data you obtain. As the experimental scientist uses theory to guide his search for significant relationships, so may you utilize a theoretical position to unify and to give direction to your efforts.

I shall illustrate the use of a theoretical position in directing and unifying the work of the counselor. I am not suggesting it as the best. It is an example of how one man organizes his efforts. The example is taken from Richards, T.W. *Modern Clinical Psychology*, New York: McGraw-Hill, 1946. It gives us a picture of how he frees himself from a rigid questionnaire and from tests. It alows him to make guesses about his client which can be checked for internal consistency. It allows the counselor to function more adequately, as a tool for the evaluation of the client.

The frame of reference I suggest consists of the appraisal of the individual in terms of his *Control*, his *Capacity*, and his *Motivation*, and is, as I said, simply an example of one way of organizing the collection of data.

CONTROL: The "process by which the individual utilizes his capacity and curbs his impulsive motivations into channels of socially acceptable adjustment." We acquire control as the process of socialization goes on, as we acquire experiences which force us to curb our impulsivity. Most of the

time we are aware of the client's attempt to exercise control when we observe in his behavior either too much or too little. We see individuals who exercise very little control, who appear not to be aware of, or care, what the consequences of their behavior will be. In the infant, or in the very young child we see this lack of control and we accept it much more readily. In the adult we label it pathological. In the older client this lack of, or poorly exercised, control, particularly when we have a history of previously adequate exercise of control, suggests the development of a process which may render him less than average for his group in the potential for rehabilitation. We may have to set goals below what we would expect under other conditions. At least a neurological examination would probably give us some light on this. What is commonly found is overcontrol or inhibition, which results in a constriction of the individual's range of interests. His production, verbal and otherwise, is reduced. Physical signs of restlessness, tremulousness, tachycardia, irregular breathing, increased perspiration, particularly of the palms, may appear. You have noticed that what I have described sounds like the description of anxiety. I am saying that in this way of looking at the client, overcontrol is associated with anxiety.

CAPACITY: Capacity is the potential for adjustment to the demands of the environment. Evaluation of capacity from a case history is possible. A well taken case history, not necessarily a voluminous one, may answer the question of whether the individual has the capacity necessary for rehabilitation. In fact, unless the individual's capacity has been masked by emotional factors there should be adequate evidence of its level in the case history. Not only should there be adequate evidence that the client has the potential to become rehabilitated, but there should be enough evidence so that the internal consistency, or reliability of your judgments of his capacity can be estimated. The skills learned by the client can give you a cue as to his capacity, provided he has had the chance to learn. For example, one would expect more opportunity to have learned certain skills in Detroit than in Iowa City; more opportunity to have learned certain skills on Iowa farms than on a share-cropped farm in the hills of Tennessee or Kentucky. One can evaluate the capacity of the individual from observation of him. Does he show, or has he shown common sense and judgment in his behavior? Does he plan ahead, using his past experiences in the process? Does he, or has he, moved steadily toward a goal, or has he shown random trial and error in his attempts to solve problems? Is he alert? Is he responsive? Does he see the implications for himself in situations with which he is faced? Does he appear to understand himself? Is his behavior logical? Does the sequence of behavior observed appear logical to you? One can get an idea of capacity from the interview, or from conversation with the client, for verbal behavior is highly correlated with intelligence. Note his choice of words, sentence structure, the logic of his thought, his reasoning ability, and his

ability to make you understand him. Does he check to see if you have understood? Not only should there be adequate evidence that the client has the capacity or the potential to achieve rehabilitation, but, as I said earlier, there should be evidence in the data to allow one to judge the internal consistency of the material we gather. In checking for internal consistency, the interviewer will use safeguards to insure that one influences as little as possible what the client says. If you doubt the need to exercise care that one does not influence the client's verbalizations, I suggest that you read some of the research literature on "learning without awareness."

MOTIVATION: Motivation, for our purposes, will be defined as the basic need for ego satisfaction, and, in a wider sense, we might add love and acceptance. This need, and the way in which the individual attempts to satisfy it, is the central core of the personality. The task of assessing motivation is not as easy as the definition would seem to indicate. The experimental psychologists have the advantage over us, in the concepts they study, in that they can control the motivation of the subjects they study, or at least some of the sources of motivation. For the most part they deal with physiological forms of motivation, and when there are learned forms of motivation involved, they have usually been learned within the experimental setting. To postulate hunger as a drive, the experimentalist simply withholds food from the organism for certain periods of time. He may get some idea of the strength of motivation by varying the length of time different groups of subjects are deprived of food. On the other hand, we begin to assess motivation at the response end of the behavior sequence which necessitates inferring the motivation from the behavior. In ordinary language, we tend to equate the strength of motivation with the amount of frustration and the number of obstacles the individual tends to overcome in achieving his goal. In the clinical situation, and in the situation in which you and I work daily, we must infer the individual's motivations and the strength of the motivations in terms of the past history. The vocational interest of the individual, as indicated by inventories, and a discussion of his work history give us information about the individual's motivations. At what level of skill has he worked? Does he express satisfaction with having worked at this level? What social needs does he seek to satisfy? Has he moved from neighborhood to neighborhood in an effort to satisfy certain social needs? If he has worked in a large industry, to what incentives offered by the organization has he responded? What rewards has he received as a result?

Our efforts are complicated further by the fact that some of the stronger motivations of the organism are unconscious. This necessitates our remembering what we know about the operation of unconscious motivation. It is possible that in the inconsistencies of the client's verbal behavior, his answers to questions, you may find information about his motivations, and about the strength of these motivations. One may get a clue as to his reactions to

frustrations, for the degree of reaction to frustration is considered to be a clue to the strength of the instigation to action; to the strength of the motivations.

As we get closer to the personality characteristics, we find that the job of gathering reliable information become more difficult. We find that the answers we get to straightforward questions don't fit the circumstances. If the client is as adequate as he says he is, why doesn't he have a job? We come face to face with one of the strongest needs that people have; an acquired need, but nevertheless a strong one—the need to preserve one's self-esteem. We can understand the situation better if we adopt a widely held, and widely utilized, aspect of a certain theoretical point of view. The client's needs are so strong that they may have caused him to repress much of the information we need. How, then, do we get at this information that he has repressed? We get the information from the client, of course. In his very need to preserve his self-esteem he will reveal inconsistencies. If you have been aware of the reliability of your data, these inconsistencies will be apparent to you and will take on meaning. If you are a supervisor, these concepts may be of use to you in helping your counselors to improve their work.

I am less concerned with the techniques of obtaining data than the development of attitudes on the part of the counselor which will cause him to check the data he obtains, to search for supporting data for each and all of the generalizations he makes about the client. In fact, this habit should be so ingrained that the counselor will experience some anxiety if he does not do so.

One word about tests as a source of data. There are no tests which will answer all the questions which you have the need to ask. Your judgment and your experience, including the information you get from the research literature you read, will need to be relied upon for the task of checking the adequacy of the data. When you need information from tests, ask as specific a question as possible. Where tests can give you the answer, you will have a degree of objectivity. I use tests with the older patients no more than is absolutely necessary. I have a training situation in which I want my trainees to learn as much about the behavior of the older patient in a testing situation, and as much about his test performance as possible. We watch to see that the patient is not upset, and we let him know that we are interested in knowing as much about the test performance of his age group as possible. The test results, however, are additional information about the patient. Test results do not relieve one of the obligation to look elsewhere in the data for additional evidence to support any generalizations about the client, based on the test results. My attitude toward tests is best explained by the definition of a test which I find most useful: a test is a standardized observation situation of which scores, sub-scores, etc., are only a part of the data available.

Most reports of the assessment of clients are made up of a series of inferences and abstractions, at various levels, about the client. Most of us

tend to feel that our training and our experience have prepared us adequately for making these inferences. We tend to give too little thought to the fact that the basic data on which these inferences are based may be inadequate. In one widely publicized study of human behavior in which the authors exerted a great deal of effort to insure the adequacy and objectivity of their basic data, this fact was all but ignored by the reading public. I don't know whether you real Volume I of the "Kinsey Reports," if you read it at all. Most people read the magazine articles *about* the report. One of the most important aspects of the "report" was ignored in the smoke screen put up about the so-called moral influence of the report. One of the most important aspects of the report was the method used to collect the basic data, and the efforts made by the Kinsey people to insure the validity and reliability of this data. Recently, I heard Dr. Wardell Pomeroy discuss this data collecting. One thing he reported struck me as being quite different from the usual way in which interview data is considered. He reported that only the top echelon on his staff did the interviewing. This collection of basic data was considered too important to leave to novices. They now have a staff of a large number of people drawn from various disciplines, but the four top people do the interviewing. All of the inferences, conclusions and recommendations depend upon the adequacy of the basic data.

Another point at which error can creep into the assessment of clients is in the process of making the inferences themselves. Each time we make an inference, we lose some of the specificity which marks the client's behavior. When we say that the client is "aggressive" we lose information which is inherent in a more basic statement, such as, "the client took the lead in the interview and attempted to conduct it as he saw fit." If one only says he is "aggressive," one fails to distinguish the client's behavior from that of the client who threatens the counselor with physical violence. Both can be labeled "aggressive" and both forms of behavior are adequately labeled.

Further, to ask the reader to accept your inferences, your generalizations and abstractions without supplying him with some of your basic data is like asking a contractor to bid on a million-dollar construction job without supplying him with all of the specifications. To say that a client shows impulsivity, for example, is asking your reader to accept your judgment without giving him a chance to see on what you base such judgments. Your ability as a counselor is not in question. What is in question is your confidence in your judgment. If you are sure of your judgments, you can do at least what any scientist does in a report—he presents enough of his data to allow the reader to draw his own conclusions. A popular consumer journal, the *Consumers Reports*, presents its evaluations in such a fashion, perhaps because so many scientists are on its board. When *Consumers Reports* publishes its evaluations of groups of products, it tells which products are considered a "best buy." However, it respects my intelligence enough to tell me how the evaluations

were done. They present some of the basic data on which the inference, "best buy" is based. These people are sure of their techniques and their data. I am not suggesting that you report all of your basic data in a report, but, at least record some of it in your working notes and forms in as basic, as "point-at-able" language as possible.

When we begin our assessment of the older client, we usually have certain information about him. We know, by definition, that he is probably within the age range 45-60, and we will have some information on the original application concerning his marital status, his work experience, his place of residence, whether rural or urban, whether he owns his home and so forth. What do we do with this information besides recording it? This information is important to us as a basis for making our initial hypotheses about him. I use the term "hypothesis" in a very general sense to mean guesses about the client concerning his capacity, his control, his motivation, or whatever information we want about him. We use this information to make guesses about what subsequent information will reveal as a way of checking the internal consistency of the data we get. We utilize it, also, as a basis for understanding the client and his problems, and we need it to make predictions concerning what he might do, or how he might be helped. The kind of information which you will gather, as I said earlier, will depend upon the purpose for which you are gathering the information, and the goals you seek to help the client to achieve. I am concerned that we make this information, this basic data, as accurate as possible because all our plans, all our generalizations about the client, and all the predictions we will make will be based upon this basic data. If it is inaccurate, the whole structure of the client's personality and potentialities, as developed by us, will come tumbling down.

THE USE OF REHABILITATION CENTERS FOR THE OLDER WORKER

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Most counselors are accustomed to using four professional services to rehabilitate the disabled. These services are: Physical restoration, Training, Counseling, and Placement. The majority of clients who are successfully rehabilitated tend to make use of one or more of these services. Because of the rapid growth of rehabilitation centers and facilities, the counselor can now add one more service dimension—a referral to a center for a diagnostic and/or treatment program.

A center or facility can offer three things which are uniquely different from services available from a counselor. First, it can offer a multiple disciplinary approach. Simply stated, this means that the center will have a number of professional people with different training and perceptions of clients. Secondly, it can have a pre-vocational or work evaluation unit which attempts to measure work behavior in a more or less direct way. Thirdly, in some highly specialized agencies, it can offer the counselor specific data on one or sometimes two areas of concern to the counselor. This paper hopes to clarify which clients to refer to what centers by discussing the structure of centers and facilities.

Most referrals to centers are made because other services have either failed, or the counselor anticipates failure. The typical services previously listed sometimes offer limited hope for the older worker for a variety of reasons. For example, physical restoration for the older worker does not usually prove to be nearly as rewarding a service as with the young amputee or paraplegic. The older cardiac, the arthritic, the cerebral vascular accident client and other diagnoses occurring with age typically return from medical clinics with massive amounts of diagnostic data, but minimal amounts of improvement. Medical services seem to be more successful in identifying physical capacities rather than substantially improving function. Although medical progress has been substantial, many of the diseases of age are chronic and irreversible and physical restoration services often discover more problems than they solve. Having failed to obtain significant help from medical services, the counselor next begins to think of formal training for the older worker. He first tests and, with some alarm, often notices a considerable lack of achievement in areas such as reading and arithmetic. Discouraged with objective evidence, he presses the training issue in counseling, only to find out that the client just wants a job, he has children, and besides that, his memories of school are faintly negative. The counselor is usually not too disappointed. Most likely,

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the schools wouldn't take him (minimum education, high school diploma) and as he can only read at the sixth grade level it would be just one problem after another until graduation. As is often the case with the older worker the counselor finally sees that the client already has some adequate skills and that perhaps the main service to offer is a counseling relationship, with the goal of increasing the client's motivation. This is not a too uncommon counseling diagnosis with this particular age group. The counselor now prepares to build a counseling relationship with a rather anxious feeling that he is fast running out of services. However, the older worker has other ideas. His objective in coming to vocational rehabilitation was to get a job. Rehabilitation to the client is an outcome rather than a process. The rehabilitation agency is seen as a super employment agency with a surplus of job orders all involving light work. The counselor sees that the client's unemployment is on the basis of a psychological depression, anxiety, and overconcern with physical symptoms. The client counters with statistics on unemployment, employment barriers, and fails to respond to affect searching counseling probes. Laying aside his counseling techniques, the counselor next decides to offer help on a practical level and proceeds to dispense liberal amounts of information about "good places to apply". He is often startled to discover that the older worker has more accurate, first hand information on the labor market than the counselor himself possesses. At this point, the client and the counselor do develop a relationship based on a mutual problem. Both are equally depressed about the reality of the client's situation. Still, one final service remains—job placement. The counselor, with some feeling that perhaps the client has every right to be unemployed, does make a few calls to employers. The results are not encouraging. The counselor, in frustration, turns to a fresh client, hopefully a good training case to rebuild his professional self-concept with the thought that perhaps the client, if he would admit it, doesn't really want to work. The older worker returns home to the morning ritual of checking the want ads but rarely seeks work because as we all know, nobody ever hires people over 45 years of age.

Those of us who work in rehabilitation centers and facilities do feel that centers have something to offer clients like this. The counselor did make a good diagnosis. The client did have skills, he did know what work was like, and he did have sufficient physical capacities. His main problem was that he would not look for work, or if he did, would not present himself effectively. Our counselor failed in programming. Having exhausted the usual vocational services, he should have considered a referral to another resource to, first, better understand why the client fails to move toward employment and, secondly, to help the client move more effectively.

The selection of the client and the appropriate center depends upon two things. One, a thorough understanding of the rehabilitation center, and, secondly, a good grasp of the client's problem. In short, the referral should be

based on a careful consideration of a variety of issues, one of which is not sheer desperation.

Evaluating the Center:

The problem for the counselor is that he must try to make a determination of both the type and the quality of services which are available from the center or facility and match this with the client's needs. The Conference of Rehabilitation Centers and Facilities, a group composed of member centers and facilities, has taken the leadership in this problem by obtaining a grant to improve the quality of services through the development of standards. Unfortunately, the counselor must wait several years for these guide lines and, since client programming cannot wait, some understanding of rehabilitation centers and facilities needs to be offered.

Centers and facilities carry names which have more utility for fund raising than for understanding of program. In evaluating centers, the following cautions should be kept in mind.

1. The name of the center or facility offers little in determining the center's program.
2. To admit to not being "total" or "comprehensive" requires more courage than most administrators possess.
3. Finding out what services a center really offers is, at this point, an art, rather than a science.

Rehabilitation centers and facilities can provide up to, and including, four basic services. These are: medical, social, psychological, and vocational. In general, the most important consideration is not what services the centers say they can offer, but what kind of a person within the center actually offers them. For example, it is a rare agency who will admit to not offering casework services. You may be surprised, however, to find out that the casework is being done by volunteers, vocational counselors, and Red Cross personnel. Secondly, it is important to note the general availability of such services. Psychological services, for example, are often available on a need or consultant basis. In other words, the services are not routinely available. This limited availability can be, but is not always, to the disadvantage of the client.

The suggestions contained in the following paragraphs offer a limited guide in evaluating the medical, social, psychological, and vocational areas within rehabilitation centers and facilities. It hopes to discuss some of the more essential factors within centers, but it is in no sense complete.

Medical Services

Medical services are typically broken down into screening, diagnostic, and treatment services. Screening services usually mean that medical data is evaluated by a physician within the center, using medical data that is sent in by the referring agency. The evaluation by the center physician is limited by the

adequacy of the material that has been sent in. Under this system it is difficult to consistently arrive at accurate decisions involving the consideration that further physical restoration services might be helpful. Diagnostic and treatment services are self-explanatory. Typical service units under medicine are physical therapy, occupational therapy, and speech therapy. Many small centers have inadequate medical supervision and para-medical personnel such as physical therapists, occupational therapists, and even vocational counselors, sometimes operate on a treatment basis with their clients without a good understanding of the client's total medical problem. This seems to be especially true in sheltered workshops where it is not altogether uncommon that the staff has very limited understanding of the physical capacities of the client, even though a medical report is required at the time of referral. Some centers tend to specialize in certain disability groups such as cardiacs, epileptics, or spinal cord injuries. Such information is most helpful to know and should always be recorded.

Social Service

Casework and group work are the two most common services found under social service departments. Perhaps the most outstanding quality feature which should be noted in any evaluation of a center, is the involvement of casework with the clients' families. It is difficult to imagine rehabilitation being consistently successful with multiple handicapped clients if the family does not become involved in the treatment program. As indicated previously, casework is sometimes done not by a caseworker but is an added responsibility of some other profession. Group work as practiced by a trained group worker is a real rarity in a center. However, it is often listed as a service. In most cases this service tends to be recreational and fails to have explicit professional goals.

Psychology

The two main services are the diagnosis and treatment of personality problems and the evaluation of intellectual functioning, which includes intelligence testing and organic brain damage testing. Small centers will often use an inventory questionnaire type of personality test as a "psychological" service. Frequently a diagnostic interview is not even routinely given. This is surely a questionable process and raises serious doubts regarding the qualities of assessment procedures. At any rate, a question regarding how personality is assessed, and who does the assessment, is in order.

An adequate treatment service for personality problems is always hard to determine because of the semantic game that professionals tend to play. Perhaps the best approach is to ask a center what the average number of interviews per client are, excluding diagnostic testing. This answer should prove to be quite revealing in deciding whether or not therapy is really offered. Psy-

chological services are often available on a consulting basis. That is, every client does not routinely receive services and some staff member decides which clients should receive a psychological evaluation. When used in this manner, problems can arise because the staff sometimes fails to recognize when such consultation is necessary. Also, clinical psychology frequently is a diagnostic, rather than a treatment service in most centers and facilities; such a distinction should be part of the counselor's evaluation.

Vocational Services

These services cover a rather wide range of duties, some of which are often duplicated by the referring agency, such as testing and counseling. In addition, though, there are usually pre-vocational or work evaluation and placement. Pre-vocational or work evaluation units deserve special attention because of the uniqueness and importance of such a service in any vocational unit. There are two dimensions of a work evaluation unit which bear investigation. The first is the distinction between a diagnostic or treatment unit. This is perhaps a question of emphasis rather than a mutually exclusive category. Diagnostic units see as their primary function furnishing the referring agency with data regarding the client's ability to work. In general, such units should be able to comment on the client's general level of employability, some specific occupations which might be feasible, and a description of the client's work habits. Any positive change of the client's behavior is not necessarily a planned result, but will occur. Treatment units usually have fewer machines, or work tryout areas. They commonly use paid work and will sometimes use psychologically sophisticated staff as foremen. The programs are somewhat longer and range in length from about six weeks to one or even two years. The implications should be clear for the referring agency. If a client is obviously a good candidate in terms of motivation, work habits, and interests, but the counselor feels lost in establishing a specific training or employment objective, then a program with a diagnostic emphasis should be considered Those clients who have poor work habits and lack motivation may obtain more benefits from a treatment oriented program. The second dimension of a work evaluation unit is the broad versus limited spectrum of work. Broad spectrum programs tend to offer a diagnostic program covering a substantial number of occupations. As a minimum, perhaps twenty-five different work units representing as many as one hundred or more occupations. Limited spectrum work evaluation units have only a few work areas and offer the referring agency only minimal amounts of data regarding tryouts on specific occupations. The structure of the work evaluation unit is one of the most important determinants of the selection of an appropriate center. A thorough understanding of the treatment versus diagnostic dimension and broad versus limited spectrum tryout is essential in selecting the right center.

Knowledge of placement services will also be a factor in referral to a re-

habilitation center or facility. Job placement is almost always done by centers. The reason for this is a simple one. Vocational agencies are typically pragmatic and will pay money for a placement service because they tend to lead to a closure more expeditiously than do diagnostic and treatment services. Placement can be done by center personnel themselves, or can be accomplished through a referral. Centers assuming the responsibility for placement usually will have their own placement person. Some centers assume a responsibility only for a referral to other community placement resources. Referring counselors should recognize their own placement limitation in terms of skills, attitudes, and available time, and if they find placement to be a chore, then selection of a center offering placement services should be considered.

There are, of course, other issues of concern to the referring agency. Of paramount importance are results. Anyone should be quite cautious in evaluating a center's outcome from data contained in an annual report. Two problems appear which create difficulty in evaluating reports of this type. First, the selection of clients for a program affects results considerably. Easier clients, of course, raises one's batting average. Secondly, the assignment of "success" to a case depends upon how you define success. This is a definition which is made with simplicity by administrators, but argued heatedly by professionals. The problem of definition of success should not confuse the counselor to the point where he feels he has no right to expect results from a center or facility. Every referring agency has the right to expect at least one of two things from a center or facility.

1. An understanding of the client's capacities to engage in an employment activity.
2. A change in the client's attitude or behavior in a positive direction.

If either of these results are not consistently obtained, the counselor should look elsewhere for assistance.

Determining Client Needs

The question that should be answered before a center can be selected is "why is my client unemployed?" If you are able to answer this question, you should be able to select an appropriate center. If you cannot answer this with some feeling of confidence, then you are probably not in a position to refer.

There are two general answers that you will receive from such a question. One answer commonly obtained is that the counselor is not sure what kinds of work that the client is able to do which is related to the practicalities and realities of the labor market. Such clients generally impress the counselor as perhaps being good night-watchmen, or elevator operators, but because of the lack of places to watch and elevators to run, these solutions have only limited application. This type of client generally needs a rather broad spectrum type of work evaluation program where he can try out a number of work tasks. This type of problem in a broad spectrum work evaluation is usually solved within

two weeks. This does not mean, of course, that the client is ready for placement at the end of this time. However, a generalization that might be made is that most older workers who cannot list a suitable occupation that both the counselor and client feel is appropriate, are not going to be ready for a job simply on the basis of receiving factual information about their skills. If a client with forty years of industrial experience is at a loss to select an occupation, a diagnostic program will be of limited value in promoting work readiness. Generally speaking, you can assume that he does possess some personal problem which is interfering with his obtaining employment.

The second reason, and perhaps the main one in sending a client to a rehabilitation center, is that the counselor feels that the client needs intensive help in adjusting to the idea of employment. Clients like this tend to be described by the counselor as having poor work habits, unrealistic, poorly motivated, etc. Many of these clients tend to be motivational problems, even though they do not have a psychiatric label. A rehabilitation center and facilities program should be selected which contains enough therapeutic elements which can assist the client in mobilizing himself toward employment.

Preparation of the Client

Preparing the client for the referral to the center will often make the difference between success and failure in the client's program. Usually the counselor tells the client a reason for the referral which facilitates physical, rather than psychological, acceptance of the referral. The object in preparing the client for a referral should be to develop within the client a readiness to become involved in the center's program in a realistic way. If the client maintains that the reason for his unemployment is his age and employer resistance, a good program result is unlikely. Centers cannot lower a client's age, nor consistently lower employment barriers. They can, however, help the client see that he is able to compete in the labor market regardless of age and employer resistance. Clients who project reasons for unemployment on problems such as these are not prepared to face up to their own deficiencies, and subsequently lack personal involvement in a rehabilitation program. The most common reason given at the time of referral is job placement. Acceptance by the client of this reason for the referral is a poor procedure for a number of reasons. First, it emphasizes the end result and helps the client see his problem as a result rather than a process. A client is so enamored with the idea of getting a job, he fails to become involved in preparing himself for employment. Secondly, it removes the responsibility from the client and places it on the center or facility. Clients like this tend to become impatient with therapies, avoid facing their own problems, and simply coast through the program until, like a diploma, the long awaited job is granted. The counseling relationship should establish a psychological contract with the client and the counselor regarding the reason for the referral. If a counselor is referring the client to

the center because he questions his ability to hold a job, then the client should be made aware of this, as well as some of the reasons for this. If you cannot establish a "treatable" problem with the client, as well as his seeing the center as a helping situation, it is unlikely that the center will be successful.

Summary

Rehabilitation centers and facilities can add to the usual services offered by rehabilitation counselors. They can be especially valuable for the older worker. The effective use of centers depends on a thorough understanding of client needs and the function of the center or facility. Preparation of the client for a center program should be the focus of the interview prior to the actual referral. Preparation involves the client's acceptance that he has an appropriate problem, and his acceptance of the center as a resource which will be of assistance in coping with that problem.

THE MEANING OF WORK TO THE OLDER PERSON

Woodrow W. Morris, Ph.D.*

By way of introduction, there seems to me to be no need to re-emphasize the whole story of our ever-increasing population in the later years. The fact of the higher proportions of older citizens has been repeatedly noted and the impact of this socio-economic-cultural-health phenomenon on the lives of people, as well as on our social institutions, has been described—more thoroughly in some respects than in others. One of the areas of impact which has been relatively neglected is that having to do with retirement and its meaning and significance to the individual person.

One approach to a better understanding of retirement is through a better understanding of the psychology of occupations and the meaning of work in the lives of people. The meaning of work has different connotations to different people. Originally, as implied in the Bible, human beings looked upon work as a punishment imposed upon them for disobedience. The ideal, it would appear, from the Garden of Eden story, was a life free from work—a life where all was provided and nothing demanded—except conformity and obedience. But God had specifically forbidden man to eat of the fruit of certain trees in the Garden of Eden. But, seemingly, even our Heavenly Father had underestimated the power of woman. As you all know, Eve, tempted by the snake, in turn tempted Adam and they ate of the tree of knowledge of good and evil. The results were disastrous. They were ordered out of the Garden of Eden, and further punishment was inflicted by God:

> "And unto Adam He said, Because
> thou hast hearkened unto the voice of
> thy wife, and hast eaten of the tree,
> of which I commanded thee, saying
> Thou shalt not eat of it: cursed is the
> ground for thy sake: in sorrow shalt
> thou eat of it all the days of thy life;
>
> "Thorns also and thistles shall it
> bring forth to thee; and thou shalt
> eat the herb of the field;
>
> In the sweat of thy face shalt

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> thou eat bread, till thou return unto
> the ground; for out of it wast thou
> taken: for dust thou art, and unto
> dust shalt thou return."
>
> —Genesis 3:17, 18, 19

Work, then, is to be regarded as a punishment—an ever-present reminder of man's guilt for his disobedience. Yet with characteristic ingenuity, man seems to have transformed this curse into a blessing, for in present-day terms, the real curse is the loss of work, and blessed is the man who is engaged in full and gainful employment. Yet, despite this reverential attitude toward work, man seems to do all he can to avoid it. Not only does he attempt to shorten his working day and week as much as possible, but he makes every effort to avoid it altogether by achieving retirement as early as possible in his lifetime.

Positive Attitudes Toward Work

Directly opposed to these elements are the positive attitudes which are fostered by our culture toward work. I am, of course, not considering the manifest and compelling reason for working, and that is the obvious economic one. Recognizing that the economic motivation may not in itself be sufficiently strong to keep man at his job, he has had to invest work with other determining meanings. For one, a job or work constitutes further data by which one *identifies* a man. Once the name of any person is elicited, the next obvious question is: "What does he do?" It puts the individual into a certain category and furnishes a frame of reference for further contacts with him. When forced to be unemployed, an individual feels debased, degraded, worthless, and without an identity. To ask a person who is not working "What do you do?" is often tantamount to striking him, for to answer, "I do nothing," means to admit a failure which strikes at the roots of the man's feelings of worthiness, self-esteem, and masculinity.

"Thus the job may often lend the man an *identity* without which life may be intolerable. Recently, I have seen a man who for more than a decade held the dual position of a directorship of a board of education and the presidency of a college. When circumstances compelled him to give up the directorship of the board, he went into a depression. 'How can I face my colleagues and community who have for so long identified me with the board?' was his crying complaint, as if the loss of the identification meant a disgrace and the end of his existence in the eyes of his community. . . .

"Furthermore, work may also supply man with *a reason for existence*. Since man is constantly in search for a meaning to life, being on a job, being useful to his family, community, and society, being a productive member of a group, may furnish the answer to his question. Work also provides status not only because it helps to give one an identity, but also because it enhances one's

interpersonal values. When one is young, appearance may be sufficient to make one attractive and sought after. Once the aging process alters our appearance, the graying, balding, and wrinkled facade must be augmented by other meaningful factors to help keep us in the eyes of other human beings and to avoid isolation. The mere fact that a man works, makes the community of people about him regard him as still being youthful, still capable and virile. Indeed, it puts him on a better competitive level with those who are younger. For it is the fruits of one's labor, one's usefulness, and one's contribution to other people which make the man's value to society. His value determines his desirability to others, and that will, in the final analysis, determine whether he will or will not live a life of isolation.

"Then there are people to whom work has the meaning of a *social interchange*. They can only relate themselves to others through their work; work becomes their medium of communication and once removed from its milieu they are lost. Obviously, for these people to be removed from a job may mean total social isolation and thereby deterioration. This was graphically illustrated to me by a patient who was admitted to the hospital with a marked depression. He was a policeman who did an excellent job in a very quiet efficient manner. While totally adequate in his interpersonal relationship on his job, he was described as a quiet, moody, introverted person away from it. Soon after his retirement he became depressed with many somatic complaints. Despite all heroic efforts on the part of his physician, he went into a quick decline and died despite the lack of demonstrable pathology. Though many factors were undoubtedly responsible for this severe reaction, the outstanding feature was the meaning of his job to him. As the patient's son, a physician, stated: 'It seems as if his life ended when his job ended. He was a different person when he worked. He was able to relate himself to people and to be adequate. It was his job and his social life, and his retirement was his undoing.'"

Work as a Time-Killer (or Time Filler)

Work takes up *time*. Psychologist Anne Roe defines an occupation as whatever an adult spends most of his time doing. Work is a way of filling the day and of passing time.

"Work enables some individuals to avoid boredom and introspection. Most of us have trouble facing ourselves or bearing our own company. This is an ever-increasing problem; for, as Dr. Havighurst and his group of investigators point out, we are moving from a work-centered to a leisure-centered society. We are given to a frantic search of having something to do. Not too infrequently we find ourselves in the pursuit of a method to 'kill time'—as though if we fail to kill time, it will kill us. Time on one's hands is evidently a very threatening element; one must either 'kill' it or utilize it in a non-threatening fashion. Work obviously solves this problem. Many times all of us have heard

this typical comment made to me by one of my patients: 'I just don't know what to do with myself since I've lost my job. I am so restless and nervous, if only I had something to do.' "

Work as Enjoyment

"Work may of course be a source of *intrinsic enjoyment,* that is, enjoyment of the act itself. This would be particularly true of those who take pride in that which they produce. One may identify with the end product, or have the product be identified with oneself, and thus have a great deal of gratification out of the creation of it. Those who render service to others find particular gratification in their work and find it very difficult to give up their jobs.

"Thus, from the above, one can readily see that the unconscious motivation for continued employment in any given individual may be weighed in either direction. On the whole, the need to go on working heavily outweighs the regressive pull toward a dependent, passive existence. Therefore, without extensive investigation, we may generalize that it is usually more desirable for the individual to go on working. It will readily fit into the motivational patterns of most people. Nevertheless, it is by far more desirable that each person's needs be understood and evaluated before any final decision be made as to whether one can bear a life without work. One man's meat is another man's poison. In my experience, it is the rare individual, indeed, who is so prepared emotionally as to be able to enjoy a life of leisure. It requires a certain amount of inner, as well as economic, security to accomplish the above successfully."[1]

Retirement

Retirement, then, while it earlier appeared to be a sought after status, is also fraught with peril and the possible source of much maladjustment. Gone are many of the pleasant associations with fellow workers; gone is the regular time-filling schedule of orderly existence; gone may be many of the enjoyments of work noted above; all these in addition to what are, to many, the important problems centering around financial security.

What Do Iowans Say About Retirement?

In the 1960 survey entitled "Life After Sixty in Iowa"[2] a series of questions was asked concerning the attitudes of men toward work and retirement. From answers received, the very clear finding emerges that most of the men valued their work very highly, and actually seemed to enjoy it. For example, the employed men were asked the question, "In your own case, do you think

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[1] Weinberg, Jack. Motivation of the Aging Worker. Chapter X in Donahue, Wilma (Ed.) *Earning Opportunities for Older Workers.* University of Michigan Press, Ann Arbor, 1955.

[2] Iowa Commission for Senior Citizens. *Life After Sixty in Iowa: The Report of a Survey.* 1961, The Institute of Gerontology, State University of Iowa, Iowa City, Iowa.

continuing work has been good or bad?" More than 75 percent answered "good" without any qualifications, and another 10 percent said continuing work had been "part good, part bad." Less than 1 per cent said that continuing work had been "bad" for them. The positive attitudes of the employed men toward their work are further expressed in their responses to the following question: "How much do you like your work at present? Would you say you like it?:

	% responding
Very much	68%
Fairly much	28%
Not so much	3%
Not at all	1%
Number of respondents	(267)

More than two-thirds of the respondents said they liked their work "very much," and only one man in the entire sample responded "not at all." A further indication that most of the employed men derived a good deal of satisfaction from their work is given by answers to a survey question on leisure time activities, asked in another part of the interviews. Interviewees were given a list of twenty-four activities and were asked to check those which they "like to do" at the time. In this context, more than 60 percent of the employed cited "my work" as a preferred leisure-time activity.

Still another indication of the favorable work-attitudes held by the employed men is provided by their answers to a question concerning prospects of retirement. The question asked: "Do you look forward to the time when you will stop working and retire, or do you dislike the idea?" *Only 22 percent of the respondents said they looked forward to retirement. More than half said they clearly disliked the idea, and another 25 percent expressed at least partial dislike.* Moreover, among those persons who said that they *did* look forward to retirement, many said that they wanted to retire because they could no longer keep up with their work, suggesting that if their physical condition had been more favorable, they might have preferred to continue to work. Among those men wanting to continue working, nearly half of the men mentioned financial considerations as main factors involved. A still larger number (56%), however, said that they wanted to continue working because of their "enjoyment of work," or words to that effect.

Continuing attachments to work also were expressed by the *retired men,* although this attitude was by no means unanimous, nor without mixed feelings. The retired were asked whether "stopping work had been good or bad." Their responses were distributed as follows: 35% responded "good;" 35% responded "part good, part bad;" 23% responded "mostly bad," and 7% responded "don't know." Responses indicate that a majority of the retirees had made at least a fairly satisfactory adjustment to their retirement, as indi-

cated by the fact that they said stopping work had been at least "partly good" for them. At the same time, *nearly 25 per cent complained that stopping work had not been beneficial,* and many indicated ambivalent attitudes. The prevalence of difficulties in adjusting to retirement is further suggested by the fact that two out of five said they had wanted to return to work since they had stopped.

In order to clarify what some of the positive and negative aspects of retirement had been for the retired men, several questions were addressed to them concerning their retirement adjustments. One question asked: "What were the hardest things you had to get used to after you stopped work?" Overwhelmingly, the respondents emphasized the *problem of finding satisfactory activities with which to occupy their time.* "Finding something to do with my time;" "Time on my hands;" "Sitting around;" "Keeping busy;" "How to use my leisure;" and "Lack of activities" were some of the comments made. Quite a number of the retirees used the word "idleness" in describing their adjustment problem, apparently expressing a negative value placed on time that was not being put to some constructive use. Other difficulties mentioned *included the loss of associations on the job and the problem of getting accustomed to a change in a familiar routine.* Some of the responses were: "Miss people;" "Loneliness;" "Lack of meeting customers and friends;" "Not teaching children;" "Not keeping regular hours;" "Not rushing to meet a time schedule;" and "Getting adjusted to staying home." Some of the retirees emphasized that their adjustments had not been hard to make, but it is clear that for many who had spent a lifetime at work there were serious problems created by no longer having occupational responsibilities. Approximately 25 per cent of the retired complained that there were times when they "don't know what to do to keep occupied," and one in ten said that he often had this problem. These complaints were more frequent among the older retirees than the younger ones.

Apart from the problem of finding activity, the next most frequent difficulty mentioned in connection with retirement was the problem of income. By far the largest number of retired men had suffered a lowering of income after they stopped work. Fully 80 percent said that their income had dropped since their retirement, and 61 percent said that their current income was much lower than it had been before. *Particularly among those in the lowest income brackets, the economic hardships of retirement were most likely to receive mention as the "hardest things they had to get used to."* Responses included: "Lack of finances;" "Lower income;" "Miss your own income;" "Not having my own money;" "Have to be more careful spending money." While most of the retired men said they had a sufficient income on which to live, more than 10 percent said they did not have enough money to meet their needs.

Retirement also has its compensations for many, as is seen in answers to

the question, "Personally, what do you find best about not working anymore?" Two main themes stand out among the responses. Many retirees mentioned the physical strains of their work when they were still employed, and expressed relief now that their burdens were ended and they could obtain more rest. Some of the answers given were: "Don't get so tired;" "More time to rest;" "I can rest when necessary;" "Couldn't work;" "Because of my health the work was too hard;" "I couldn't work if I wanted to now;" "I had to quit because of pain;" and "Grew too old to do as I did."

Others emphasized the advantages of being freed from the responsibilities and time-restrictions of work. To some, the advantages mentioned seemed to be primarily negative, involving the release from demanding commitments. "Don't need to get up as early;" "Not having to work when I don't feel like it;" "Not being compelled to work;" "Don't have to watch the clock;" "Lack of pressure;" "No pressure of responsibility;" and "No worry," were some of the responses expressing this theme. Others placed more emphasis on the increased opportunities retirement permitted for choice in spending one's time and the greater chances to engage in recreation activities, or simply to indulge in loafing. Comments included: "Choice of doing what I want;" "Doing what I enjoy doing;" "More leisure, freedom;" "Being independent;" "Not having anything to do;" "Enjoying hobbies;" "Time to read;" "Getting to travel around;" "Laying around;" "Just sitting around;" and "Loafing."

Some of the retired men seemed to relish their retirement, taking full advantage of their greater opportunities for relaxation and the enjoyment of hobbies. However, it appears that this attitude was limited to a minority, and in most cases the persons who found retirement most appealing were those *with adequate health and income who had cultivated many interests before stopping their work.* The main impression gained from the findings is that, while most retirees accepted the necessity of retirement after their health no longer permitted them to work, the majority were left with a feeling of loss more than one of gain. Many found the "free time" that retirement brings to have been a mixed blessing, and felt a lack of sufficiently satisfying activities.

The frustrations of retirement are further suggested by the answers given to a survey question which asked what advice retirees would give to "someone like yourself who intends to retire in a year or so." The most frequent answer given was to keep working as long as possible. "Work as long as health permits;" "Keep working as long as you are able;" "Don't retire until you have to;" "Don't retire until you are physically unable to work;" "Keep working if possible;" "Keep at it as long as you can;" "Get a lighter job;" "Find work your health permits;" "Retire gradually." One retired man said simply, "Don't." Some of the retirees emphasized the financial problems of retirement, giving such advice as "Save money;" "Be sure your income will keep you;" "Put away as much money as you can;" and "Don't retire unless you

have money." Only a small number of the retirees voiced the attitude that a person should retire while he still has the strength and health to enjoy it fully. "Retire and enjoy it;" "Retire early while you still feel good;" "Retire before you get too old," were some of the few comments made along this line.

A good many, in giving their advice, mentioned the problem of finding sufficient activity and the importance of remaining active. "Keep busy;" "Find something to do;" "Keep active;" "Better have a hobby;" "Go fishing and visiting;" "Keep busy at something," and "Do things for others," were some of the statements made. Others said. "Find something to do to keep your mind occupied," "Find something to interest you," and "Have something to do to keep occupied."

While most of the answers given expressed negative attitudes toward retirement, many of the retirees emphasized that once retirement becomes inevitable, one should accept it as a matter of necessity and make the best of it. "Make up your mind and adjust;" "Retire and get used to it;" and "Accept what you can't change" were a few of the comments given, expressing a widely held attitude among persons in the sample.

Finally, what can be done about making retirement years better, happier, more satisfying, and with more of the positive values of work? In the Institute of Gerontology, I have been evolving a theoretical framework within which I hope to be able to view most, if not all, of the major problems and aspects of adult life. Let me attempt to restate this conception and place work and retirement in their proper perspectives within this framework.

The framework is a developmental one; all of life is a developmental process with very few, if any, sudden starts or stops. Thus, "old age" is simply a relative phase along the continuum of this process. Our proper area of concern, then, should be with the whole process of adult development, rather than with the aging per se. Seen from this vantage point, then, the best possible case can be made for what we call the "preventive approach" by way of anticipation and preparation.

I have tried this notion out on a variety of features of adult life and in each case the ideas hang together very well indeed. Thus, economic security is, in large part, a matter of earlier savings, investments, and other forms of financial planning; health, at any age, is, in the main, also a matter of earlier health education, health practices and good hygiene which will help to insure healthy later years; intellectual fitness at 70 or 80 is quite probably directly related to the extent to which one has kept fit at earlier stages of life; finally, then, retirement adjustments would appear to be related to the early anticipation of retirement and thoughtful planning for the sought after years of retirement.

Yet little is done by the individual person to anticipate and prepare; and little is being done by the agencies of social concern—the employer, unions, educational and social institutions, etc.—to help the worker make this impor-

tant transition to a new way of living. The need for extensive, carefully designed pre-retirement counseling programs is obvious. The equally important need to somehow motivate people through educational efforts to *want* to thus anticipate and prepare is equally obvious. That this kind of program is worthwhile; that our adult citizens can be helped to achieve their own private Gardens of Eden through professional help, is an inescapable conclusion. You owe it to yourselves!

COUNSELING THE OLDER WORKER

Leonard D. Goodstein, Ph.D.*

With our rapidly aging population, there has been an increasing interest throughout the country with the aged person and his medical, social, economic, and psychological problems. As one index of this concern, professional workers throughout the country have become interested in counseling and psychotherapy with older people. This counseling is being attempted today in a very wide variety of institutional settings, in hospitals and clinics that deal with all kinds of problem cases, in community agencies that see older persons as part of their general work load, such as the state rehabilitation agencies, and in counseling centers that are now being especially developed to work with older persons like the Old Age Counseling Service of Montreal and the San Francisco Old Age Counseling Center.

The focus of this paper is on some of the special problems of psychological counseling with older persons. These are problems which apparently may go unrecognized and which may, if they are unrecognized, interfere with the proper handling of such older persons and may curtail or prevent any positive personality change from occurring. The thesis advanced here is that there are special problems in counseling older and disabled persons. There are, however, special problems in counseling virtually all identifiable groups. Certainly those who work primarily with the physically disabled recognize that they, as a group, hold some very special problems. Each special group that can be defined poses such a special problem. In fact, the problems that they pose, usually, are related to the identifying operation. Physically handicapped persons pose a problem because they are physically handicapped and counseling typically involves helping the physically handicapped person accept his handicap on a psychological level. Similarly, there are special problems of counseling women, special problems in counseling members of religious and racial minority groups. These are special problems that occur and must be dealt with because individuals of these various groups have idiosyncratic problems that are associated with their membership in this group, and this is true of the older and disabled worker as well.

These are problems that must be faced up to and explored, not covered up or ignored, if counseling is to be effective. The wish that society would not have prejudices against hiring older people may be a very laudable one, but it does not change the hard fact that there is a tremendous amount of prejudice about hiring older people, particularly if they are disabled. The counselor who does not prepare his client to meet this anticipated social and economic rejection is not doing an adequate job of counseling.

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This approach should be seen as a realistically positive one, not a pessimistic one. It recognizes the reality of the situation, the reality of the world to which the older person must adjust.

The problems in counseling that the older person poses, stem from a variety of general factors. First, their age and the associated problems of the aged—economic, social, medical, and psychological—present the counselor with so many real problems, so many difficult and complicated problems, that the counselor, initially, may decide the situation is hopeless. Certainly there are cases that defy any easy solutions. It should be noted that the counselor's attitudes are important here, the counselor's feelings may be very much in the way of seeing effective solutions. Any realistic approach should involve looking at the counselor's feelings and attitude toward this person.

Another general problem having to do with counseling older and disabled persons is that in our culture today the older person does not have a clear cut role. We now are in a time of societal flux about the role and function of the older person, both socially and economically. One of the reasons that there is so much interest in the older person is that we recognize we are going to have more of them around and they are going to be around for longer periods of time. There is going to be a larger segment of our population in the 55 and older age bracket. When you have a change like this occurring, society does not have any easy, built-in solutions. There now has to be a restructuring of society, both socially and economically, to accommodate this particular segment of the population. Therefore, the counselor, when he works with the older worker, does not have any ready-made solutions that the culture provides for him. He now has to develop original and unique solutions; he has to be ingenious. And counselors sometimes are hard-pressed to be ingenious.

Third, one of the important factors creating problems in dealing with older workers is that they present to the counselor a very negative self concept, a bleak outlook. They themselves do not look forward to the future with any degree of anticipation or positive feeling for what they can do. They, themselves, feel that they are the debris of society. These are very difficult people to work with. They say there is no solution, society says there is no solution, and the counselor himself is overwhelmed by the complexity and difficulty of the problems they pose. On the basis of these considerations, there would seem to be some very important problems in working with the older and disabled worker, and these are problems which infiltrate every aspect of professional and rehabilitative work with older and disabled people. This is not only true of rehabilitation counselors and psychotherapists, but these also are problems which interfere with medical care for the aged, social work treatment for the aged, and so on.

In addition to these general problems of the aged, there are the special problems that evolve in counseling or psychotherapeutic work with older

workers. These are problems which develop because of the close interpersonal relationship that occurs in counseling or psychotherapy. Since the counselor typically operates in relatively unstructured interview situations, certain relationship problems emerge rather clearly in counseling the older person. These problems are more obvious and definable in counseling, precisely because of the lack of structure in the counseling interview. The client, in this case an older and disabled person, comes for counseling or psychotherapy with attitudes and expectations about the counselor and about the counseling process. This is true of the client who comes for counseling, rehabilitation, or professional help of any type. When the client is an older worker there are some very special problems. These special attitudinal problems on the part of the client, particularly the unrealistic and unconscious expectations about the counselor and the counseling process, are typically called *transference* attitudes.

Similarly, the counselor comes to counseling with expectations about the client and expectations about the process of counseling. He now expects certain things to happen as a function of his experience with other clients like this, or as a function of what he knows about the client from other workers in the agency, or from what he has read in the case history. These attitudes of the counselor, particularly the unrealistic and unconscious ones, are called *counter-transference* attitudes.

Thus, the client comes to counseling and to a counselor with certain problems that arise from these unrealistic, unconscious attitudes or transference attitudes. The typical transference attitude is based mainly on observations and empirical studies of work with younger persons, adolescents and young adults on whom counseling procedures were initially developed. The younger person comes to counseling expecting to find an expert, an older, wiser, more mature and experienced person who will provide counseling and advice based on his professional and personal experience. This person who calls himself a counselor will understand the problems that he, the client, will discuss because of the wisdom, maturity, and insight of the counselor. The counselor will use his experience and knowledge in providing the help that is necessary.

The correctness of this analysis of the counseling process is immaterial; this is the prevalent attitude that the client typically carries into counseling. And, at least in terms of the age-experience ratio between counselor and client, expectation is realized. Most counselor relationships in high school and college certainly fit this model; the counselor is older and wiser, better educated and more experienced than the average client. In working with the older client, however, the age, maturity, and experience balance typically found in professional relationships is reversed, and this reversal poses some very real problems. The older and more experienced client, if one simply counts years of living as a measure of experience, is now placed in the posi-

tion of asking a younger and less experienced person for advice and counsel. This is a difficult step for the older client to undertake and leads to a reluctance to enter in the counseling relationship.

This problem may be intensified by the counselor's own attitudes—the counselor's own feelings of uncertainty and inexperience. If a counselor has some doubts about his own competence and the resistance of the older worker to being counseled by a younger person now interacts with the counselor's sensitivity about his own inadequacies, no effective counseling can occur. This interaction of transference and counter-transference attitudes results in an impasse and a failure of counseling to operate effectively.

There are other transference factors operating with older persons as well. If there are age-role relationships in our culture, that is, if one is expected to behave in a certain way in our culture because of his age, the role expectation of the older person is that he should be respected, obeyed, and revered. As a consequence of such an age-defined role, the client expects the counselor to be respectful, deferent, and to place a great deal of weight upon the client's attitudes about the state of the world. Professional people, however, tend not to behave this way. Professional people have quite a different understanding of what the role of the client is: it is the client who is to be deferent, obedient, and respectful. Here again are contradictory client-counselor attitudes which may interfere with the counseling process.

Generally speaking, the client comes from a different background than the counselor. If in no other way, the client comes from a different generational background and he, the client, is typically quite convinced that most, if not all, of his problems stem from this changing world. The counselor, as a representative of this changing world, may be seen as in some way responsible for his, the client's, problems. The client is hostile to the counselor because the counselor represents youth and change, the things that have put him in this very plight. These generational and background differences are, of course, intensified by the intellectual changes associated with aging. Some unconscious hostility to the younger professional worker may be generated because he represents all of the things that the client is no longer—a gainfully employed, high prestige, successful person.

All these attitudes that the client brings with him to the counselor pose difficulties for the counseling relationships. These are the transference attitudes, and there are some others that were not included in this brief summary. But these are some of the important ones and they are very potent influences, affecting the development and outcome of many counseling relationships.

There are also problems which are posed by the unrealistic and unconscious counselor attitudes toward the older client—the so-called counter-transference attitudes. The first of these involve counselor identification with the client. The counselor in working with an older person, may, without really

being aware of it, develop the feeling that the client represents what he, the counselor, is going to be like in 20 years or 30 years. The fear of being old and sick and unloved is an anxiety-producing one for the counselor. The failure of the counselor to be able to fully recognize and handle such feelings poses very important problems in working with older persons.

Almost all persons have some anxiety over serious illness and imminent death. When counselors deal with older and disabled persons, where serious illness and the imminence of death are very real problems, these client anxieties impinge on the counselor's own anxieties and touch off very strong avoidance tendencies. Such counter-transference attitudes interfere with working effectively with older people in counseling and most other professional situations.

A second set of counter-transference problems involves the counselor and his unresolved personal problems in child-parent relationships. The older client is typically older than the counselor. Many personal attitudes towards older people come from one's personal dealings with one's own parents. One problem posed by counseling relationships with older persons stems from the fact that the counselor may generalize his own personal parental problem (his own child-parent relationships) to this older client who is now unconsciously seen as an aged parent. The counselor may not be able to free himself from dependency feelings because this person is too much like his mother or father, or the counselor may not ask questions which upset this individual because this makes the counselor feel guilty because he is hurting someone like his parents. These concerns, stemming from viewing the aged person as a parent figure, can very easily interfere with the counseling process.

A third set of counter-transference attitudes which pose very real problems involve the frustrations in working with older clients. Older persons, especially when they are physically disabled, have very real limitations, and very limited resources. Most counselors want success and the kind of success which one can achieve in working with older disabled workers is rather limited, especially if one measures success in terms of dramatic changes. The gains will be small, particularly if one contrasts the gains observed in working with older and disabled workers with those which might be noted in working with younger and non-disabled persons. Greater and more dramatic shifts in personal adjustment can almost certainly be noted in a young, growing organism than in an old and deteriorating organism. To the extent to which counselors want to do the impossible, want to change the face of the world, they are frustrated and disappointed in working with these older and disabled workers because they are limited in what they can do because of these very real and obvious limitations such persons have. But it should be noted that this is a measure of the counselor's notions of success and has very little, if anything, to do with the real problems that these older clients

face. Counselors have to face up to the necessity of limited and different goals in working with older and disabled persons, and this places some limitations on their "magical" powers which makes them somewhat resentful. Such a discussion inevitably raises the question of what are legitimate goals for working with older and disabled workers.

There is one last counter-transference problem, which is really a technique problem. Most counselors approach counseling with a genetic or developmental approach. Counselors feel that they must search the life history of the organism and discover how he, the client, got to be that way. This is the longitudinal approach that is the basis for most, if not all, counseling. This rather long historical perspective, including a review of the entire educational and work history of a 60 or 65 year old person, seems completely inappropriate. The goals and techniques in working with older individuals must be more specific to this type of case, and there should be some very serious thinking about such goals and techniques. When a counselor approaches the older worker with this longitudinal approach he may simply be staggered by the enormity of the job. What is needed are some new and fresh approaches in understanding and working with the older and disabled person.

The foregoing discussion raises some serious questions about our current approaches to counseling older persons and suggests that some changes in approach are now required, one of which is in our goals in working with older workers. Different and more appropriate goals must be set. Each stage of life poses very special counseling problems. The adolescent who is vocationally immature and who has not yet really made a vocational decision requires a quite different counseling approach than the older worker who must now be rehabilitated after a lifetime of successful work.

What are legitimate goals for counseling the older and disabled person? To integrate and accept his life as it has been lived—not as he wished he could have lived it—and to plan effectively for the immediate future. These are not less important or inferior goals for working with older, disabled workers; they are just different. Tranquillity is a proper goal for counseling the older individual. Not insight, not regret, but acceptance and a positive attitude toward the immediate future.

Secondly, counseling the older person can be effective if there is a recognition by both counselors and counselor supervisors of transference and counter-transference attitudes, of the powerful, emotional forces that may enter into professional relationships with older workers. If one can carry with him some recognition of these unconscious distortions and how these distortions can interfere with working with older people, they are much less likely to interfere to the same degree that they otherwise might. The counselor can be accepting, warm, and positive in his relationship with an older client but not identify with the client. The counselor must explore his own attitudes toward illness and death and he cannot be an effective worker with older

persons until he does this. Counselors need to be more concerned and more aware of their relationships with their own parents, particularly in their declining years. Counselors need an acceptance of the fact that working with the aged poses many special problems, that counselors must redefine their goals and reanalyze their techniques. Counseling supervisors must not regard every counselor who has worked with either adolescents or adults as immediately qualified to work with aged persons because counseling and therapy with older persons does present different problems. Effective counseling cannot be conducted unless there is recognition and handling of these special problems by every counselor and supervisor who works with the aged.

COMMUNITY RESOURCES FOR THE REHABILITATION OF THE OLDER CLIENT

By Leonard Z. Breen, Ph.D.*

In this paper I would like to discuss the way in which a community approaches problems of rehabilitation, develops programs, and mobilizes its resources to carry out such programs. I would like to cast this in a fairly general framework and then abstract, from some of the studies that we have done, certain principles of the mobilization of the resources of the community. To do this I would begin with certain conceptions of the nature of rehabilitation. You understand, of course, that I approach this topic as a sociologist. I am not myself involved in the practice of rehabilitation, and never have been. This makes it very easy for me to talk about rehabilitation. However, a great many studies have been carried out in communities in which we have examined programs of rehabilitation, and the ways in which people thought of rehabilitation and used it. We recognize that rehabilitation itself has changed historically, just as it has as a profession and as an enterprise. I would like to indicate the way in which we see the changes taking place, and the practice of rehabilitation becoming more clearly defined.

Historically, rehabilitation had as its definition something quite different from that which it has now. I refer to the very meaning of rehabilitation which had its origin in the canons of the feudal laws and feudal societies of the Middle Ages. At that time it meant the restoration to rank of a baron or other nobles who had been demoted, deposed, or who had forfeited this rank. Thus, it was a return to a former rank that was meant when they spoke of rehabilitation. Then the concept began to change and broaden, and came to mean the restoration to good repute of an individual. For instance, Joan of Arc went through a process of "formal rehabilitation" in the middle of the fifteenth century. Rehabilitation has changed, obviously, from this meaning to the kind of community meaning that we now give it. Doctor Leonard Mayo points out that rehabilitation is first of all a philosophy, second an objective, and third a method. He analyzes the nature and function of rehabilitation on these three levels, and finds three different levels of meaning. The National Council of Rehabilitation, in 1942, defined rehabilitation as the restoration of the handicapped to the fullest physical, mental, social, vocational, and economic usefulness to which they are capable. This is the way we now think about the meaning of rehabilitation.

We may wonder what has brought about the change in the concept and how it now fits into a community context. At one time, people thought about

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the handicapped as those who were the weak and therefore ought to be killed off. There were programs of actual removal by which these people were eliminated. This is still true today in many societies but in perhaps a somewhat more gentle sense; here in the United States we still do this to a certain extent. However, we do away with our people in a socially approved manner by taking older persons out into the country and abandoning them in county homes and similar institutions. In such places, people are permitted to deteriorate with no attempt to rehabilitate them in any sense. We remove them from the eyes of society; this is complete social and physical rejection.

The changes in the concept and utilization of rehabilitation mentioned above probably began to occur at least a thousand years ago. As the economic structure of our society changed it became possible to allocate more of the resources of society to those who were dependent upon the rest of the society, and what we call the *dependency ratio* began to increase. Resources were used in such a way as to care for those who couldn't provide for themselves as well as they would have liked to. Rehabilitation has now gotten to the point where we think of it in quite different terms. We don't become concerned only about older persons, but the older part of the population tends to be a focus for much of the rehabilitative effort that takes place in our society. This is so simply because older people represent that part of the population in which the incidence of chronic disease and disability is greatest. About forty percent of chronic disability today is accounted for by people sixty-five years of age and over. Many studies demonstrate that the proportion of the population that is disabled runs between one and three percent, but over sixty-five, this goes up very sharply. Between sixty-five and seventy, it goes up to about six percent. Over seventy-five it increases to about fifteen percent. There is some question about how many of these people can and ought to be rehabilitated and the way in which society ought to approach them. The disability rates for those over sixty-five are at least four times greater for the population in general, yet the proportion is very small and we ought never to forget that over ninety percent of the older population is able to carry on a full, complete, non-disabled life.

The fact of disability is not easily ascertainable at any one time because disability means different things to different people. We have all seen the kind of person, who one would argue, is totally physically disabled and yet is able to carry on a full and complete life. If you ask him if he is disabled, he will deny it. Such a person may not really think of himself as disabled as long as he can carry on the kind of life that satisfies him sufficiently. It is the way in which an individual views his disability, then, that is important since the way in which he views it will be a function of the society in which he operates, his cultural background, and the values he holds as well as the nature of the physical disability with which he is faced. We are

always affected by our attitudes, our superstitions, and our values and illness. These affect not only the day-to-day patterns of living but the individual's feeling about himself and the way in which he views his illness.

A study was carried out at Purdue University this last year which we called "Aging, Illness and Dependency: The Convergence of Attitudes." What we discovered was that many people tend to see aging, illness and dependency as being the same. That is, if a person was old he was thereby seen as dependent, and if he was dependent he was thought of as somehow ill. The interesting thing is that the older one gets, the more likely it is that one will accept this notion of convergence of these attitudes. Younger persons are not nearly so likely to think of it this way. We place a very high value on independence, of course, but because of this, the way in which we react to dependency, we develop an extremely serious problem for ourselves as a society.

There are many things we need to know about rehabilitation. Who should be rehabilitated? By whom should the rehabilitation take place? Toward what level of restoration should we strive? These are not simple questions to answer, as you undoubtedly know. In your own programs you are undoubtedly faced with these kinds of questions on the day-to-day level; questions that you aren't always able to answer readily. It is easy to say that what we need is rehabilitation in the physical, mental, social and economic sense. But these things are so interrelated that one cannot establish programs for physical rehabilitation alone; it just is not possible. I suppose that in some sense it is possible to set up a separate program of physical rehabilitation, but certainly we are not going to get very satisfactory results from this kind of program unless it is coordinated with other approaches to rehabilitation.

We also ought to think about the differences between the various sizes and kinds of communities in terms of the way in which rehabilitation is approached. In the larger communities (by this I mean what most of us would think of as a "big city" and "urban" place) we tend to have coordinating agencies that are in existence, having grown up normally, as a result of some felt need on the part of the society; a need which develops in virtually every large urban area. Because of the size of such an area, the large number of people coming together in a small place, and the consequent high density of population and heterogeneity thus created, people begin to get lost. Sometimes they get lost because they want to be lost; at other times it happens as a result of their living in an urban area. They seek out some sense of security in the relationships between groups of people.

In an urban area, people look for this security in bureaucratic structures. They look for the kind of security that will come to them by way of the large agency that coordinates the activities and makes the proper referrals. It is much more likely that we get this kind of coordinating referral agency in the large city as a function of the bureaucratic structure of the city. What

happens then, is that the people who live in the city act towards each other in a very special way which compounds the problem of rehabilitation. In an urban area, people act toward each other not in terms of themselves as whole people but in terms of the things they do for each other. In sociology we say that they react toward each other as functionaries or instrumentalities. That is, they think of each other as instruments for getting things done. They don't think of each other as personalities. The individual becomes a means toward an end; he is not an end in himself. He is not a whole personality. He counts for relatively little and people react toward him in terms of what he can do for them rather than for what he is. The kinds of relationships that are structured between people in a city become established on the basis of a bureaucratic kind of arrangement. These relationships are what we call secondary relationships; that is, they are not the face-to-face primary relationships that most of us know in the family.

In the small community we find almost the opposite. Here you find people who do react toward each other in terms of the whole person, in terms of the total personality of the individual. The agencies that are established in such smaller communities often become developed on a more informal basis. Often, many agencies are uncoordinated in the small community. Frequently, township trustees make decisions as to who shall receive welfare and in what way; who shall go to the county home; who shall be sent to the county nursing facility; who ought to go to nursing homes. When this happens, these elected officials carrying out the welfare and social agency programs do so without any necessary professional approach to their problems or to the goals the community holds. Each individual has his own conception of the function of welfare programs, which is often that of making a person a "good" person by dealing with him on a welfare basis. The problems, then, of disability become moral problems, and the person who is disabled is looked upon as somehow having been an immoral person and is now being punished. The community is going to help him restore himself by making him a good person through the function of the community approach to welfare and welfare services. What happens then is that the smaller community tries to deal with people in terms of individual problems and often compounds the problems thereby.

There has been a movement toward professionalizing the function of these agencies in the smaller communities. There has been an attempt made to coordinate services so that all of the individuals who are in need of services can call upon them, know of their existence, and be properly referred. The Hill-Burton Act provides for the construction of rehabilitation facilities; although, as you know, the Hill-Burton Act never used the phrase "rehabilitation centers." But the facility defined by the Hill-Burton Act gave impetus to the change toward such facilities in the smaller community. Many of the smaller communities have tried to professionalize and reorganize their pro-

grams to take advantage of this. This has been an attempt to maximize the equipment, the funds, the knowledge, and the know-how available in the smaller community, and establish the rehabilitation agency through the development of a diagnostic center. It seems to me this is the way the smaller community will eventually have to deal with its problems if it is going to do so within the limits of the tax dollars they have available.

Several years ago, two colleagues and myself studied one smaller community in southern Indiana on the Ohio River. It is a middle sized industrial community of about 120,000 persons. This city grew up very slowly by spreading out in several directions; as it spread it never developed any kind of cohesiveness that would permit it to act directly by the mobilization of its resources. Thus, it had agencies spread all over the place. It had a council of welfare agencies which was so inoperative with only two people in it, that they weren't even able to coordinate the homemaker services and the visiting nurse's services. They had a county home there to which they would take people who needed rehabilitation desperately, and forget about them. This was a convenient way to handle it; there was virtually no rehabilitation going on in that community at the time. Then the question was raised: How long can we go on paying for this kind of neglect? Costs were going up as a result of the long-term care being provided with no effort being made to get any of the county home residents back into the community. It was decided that something ought to be done about this, and the concept of the diagnostic center was developed. The county home was able to house about eighty people. During the winter months the population rose and during the summer months it went down. The notion of a diagnostic center evolved as a facility to which people would come who were in need of care of some kind, but usually didn't know what kind was indicated. They would be examined by a diagnostic team and judgments made about their needs. Then referral to the appropriate agency or the appropriate individual who would deal with this particular problem was made. The "center" was thought of as a short term institution and no one was expected to come there for more than a week or ten days during which time the diagnosis and referral was to take place. They might have continued to maintain the county home, but with the implementation of this plan, it was expected that the county home was no longer necessary in the same size that it had been; that they could cut down the county home population very greatly. A feeling developed on the part of the people who were in political power that they were losing power. They, therefore, began to cut back on the plans for the diagnostic center in such a way that, for all practical purposes, it was abandoned. In the long run this kind of diagnostic center has to be developed in the small community to maximize the amount of potential that is there. I don't mean potential of individuals themselves but potential of the community, and the kinds of things that it can provide.

A second thing that needs to be done, which is very important in the mobilization of the resources of the community, is the development of citizen boards on the facilities that continue to operate independently in the community. Here I mean private nursing homes as well as county homes and public homes. Most of the county homes in the midwest have no citizens boards. Often, the appointment of a person to head it is handled as a political appointment. It means that the person who operates the institution has little responsibility to the people of the community except to account financially. In Indiana we hope to soon have a law which will require all of the larger counties to establish citizen boards. We also have another act before our legislature to make it necessary that *all* counties operating public facilities of any kind have citizen boards. We hope to get many of the private institutions in the state to set these up also. Even though they are private businesses, they see the value of a citizen board and have begun to appoint them. These citizen groups provide "sounding boards" for the institution. They provide a way of interpreting their actions to the rest of the community. They provide a source of expert knowledge in their day-to-day operations. There are a great many things that such boards can do that the individual operator himself cannot do.

The third thing developing now in this whole field, is the notion of home care. In one county in Indiana, they are starting a home care program operated out of and by the County Hospital. This will be a broadly based, broadly conceived home care program. It will have homemaker service, nursing services, psychiatric services and general social services. It will all be coordinated through a single administrator who will operate out of the County Hospital and be responsible to the Board of the County Hospital. This person will be a psychiatric social worker; presumably he will have some broad knowledge of the way in which these activities can be well coordinated. Of course, this is the way home care programs have been developing elsewhere in the country, and have carried on by themselves very important rehabilitative efforts. The Montefiore Hospital program, the New York Home for Aged, and Infirm Hebrews, and the Catholic Mary Manning Walsh Home are some of the institutions that have gone out into and related themselves to the community in terms of developing a rehabilitation service appropriate to the problems, needs, and functions of the individuals that they take into the service. This is done on an everyday, out-patient basis, bringing the people in for the kind of services necessary.

There are geriatric centers in relatively small towns like Saskatoon and Moosejaw; and other places in the province of Saskatchewan, Canada have developed out-patient rehabilitation centers operating through a geriatric clinic. These are related in one way or another to the provincial health department in Regina, and to the provincial university at Saskatoon in the northern end of the province. They have a fleet of helicopters and when persons

get to the point where they can benefit from very specialized sort of services, they are picked up by helicopter and taken to Saskatoon, services given, and then returned home.

It has gotten to the point where people who come into what were once long term institutions are now ordinarily discharged within a relatively short time because they have built up rehabilitation services in the communities to the point where they can take these people, do the kind of work necessary, and then return them to the community to permit local community resources to take over. These are the institutions that have developed the true notion of the "swinging door," the door that goes both ways. In most of our long term care institutions the door only goes one way. The people go in and seldom walk out. In many places in Canada this has been changed, and this has been happening in the United States, too.

These kinds of programs are obviously in the process of early development. Each institutional development requires certain kinds of things in order to marshal community services. Publicity programs are necessary to let people know what is going on. They require the kind of professional staff necessary to carry on the program, although this professional staff needs to serve dual functions. That is, they need to provide not only the services but must also act as interpreters to the rest of the community letting people know what is possible. These professionals must make explicit the values of the community, and to make known how these values affect what the community does every day. In a word, they must become the educators of the community since the function of education is probably the most important function in rehabilitation today. People need to be told what is possible, something they do not necessarily understand. Most people, for instance, think that when a person turns sixty-five it is just a matter of a very short time until he will become senile, and that as he turns senile, the physical changes are going to appear and suddenly he will be a lost person; he will no longer be able to function adequately in any sense. Furthermore, this isn't a belief that is held only by lay people. Recently, the director of one of our largest nonproprietary homes in Indiana, said publicly that if we all live long enough we will all become senile. Yet, we know that senility is diagnosable and even treatable. Yet these kinds of ideas get passed on and people believe them; this serves as a real impediment to the development of any kind of rehabilitation services.

We need to coordinate activities much more than we ever have before. We need to be able to work out various kinds of activities together. The function of the rehabilitation counselor, it seems to me, represents a problem of deciding something that is very basic to the whole notion of rehabilitation. That is, should the disabled person be counseled to accept and live with his limitation, or should counseling be designed to induce change in attitude, or in one's physical state? Should it be designed to improve functioning in whatever state the individual finds himself? Counseling can approach this in a variety

of ways, and it seems to me, whatever position the counselor takes, what he must recognize is that he cannot work by himself. The counselor must work within the context of a total community effort. While the counselor is with an individual, he may be carrying on a very important function, but the minute that individual leaves his office, he is then in and part of an on-going, functioning community. Maxwell Jones, when he argues for the development of the therapeutic community, the organization of all of the services into a coordinated approach, he is talking essentially about a closed environment. He wants to bring people into a hospital for a period of time where everybody in the hospital has been trained to approach rehabilitation as a therapeutic community. Even the people who wash the floors are sensitive to the emotional problems of the people who are in the hospital. But this concept of the therapeutic community needs to go much further. You need to have the concept of the therapeutic community function in the community in which the people live. We know we cannot remove *all* the people who need help from the community, and we know it is in fact undesirable to do it very often. As they live in the community, that community itself must be sensitive as to the way it works upon the individual and the way in which the individual in turn works upon the community to change its attitudes. This notion of the total therapeutic community is probably, in the long run, the most important concept we have in this whole field and it is the one toward which we must all direct our attention and our efforts. Most of us are doing this unconsciously as we work in community programs, but this is something about which we ought to become much more conscious. The assembly of those skills that are available must be carried on for purposes of education of all people who are to come in contact with disabled persons and thus lead them to understand that the community itself is, in fact, a therapeutic agency.

Now let me close with a remark concerning problems of aging—"Well, if you don't like getting older, consider the alternative."

COMMUNITY SERVICES FOR AGING CITIZENS

Mark Hale, Ph.D.*

Twenty-five years ago the attention of our country, as far as social welfare was concerned, was focussed on unemployment and its attendant problems for families. Unemployment then, as now, fell more heavily on some workers than others. The unskilled, women, and the aged felt the impact first and had less chance of reemployment. For the latter group—the aged—unemployment in 1935 meant the end of the line for many in terms of further work. Also, for these people the end of the line seemed to have been reached in all walks of life. Bank closings had wiped out savings. Retirement schemes were too few and offered too little. Sons and daughters were often without jobs and without prospects. The aged in 1935 were thus a particularly disadvantaged group in the labor market and in society generally.

For the aged in 1935, the big social welfare imperative was to provide for them some measure of retirement income. Money aid on a continuing, permanent, dignified basis was considered the solution to the problems of the aged. The drive was to get them out of soup lines and off the front porches of "county homes." To do this we established the Social Security system of old age assistance and retirement insurance benefits. The fact that employment was not considered seriously as a possible resource for this group was emphasized in the requirement that any regular earnings—this was in 1935—would disqualify the individual for retirement insurance benefits. This retirement enforcing clause still remains in the OASDI system for people under age 72 but, of course, the earnings limit has been greatly increased.

Now as we look at the circumstances of the aged we see them in an entirely different light. We are beginning to realize that the money aid of the social security system although still needed, is not enough for society to provide these people. Although more than three-fourths of all people over 65 receive social security benefits of some form, this figure is not the panacea to the problem of the aged we once assumed. In the first place, the amount of money paid out to these people under this system is too little for many and downright penurious for some. The average January, 1961, insurance retirement benefit was $74.12 and the average old age assistant payment for the same month was $68.58.

To evaluate the economic situation of all aged is difficult since many live with their family and relatives. However, of all the aged over 65, one-half had less than $870 in 1958. The median was $1440 for men and $560 for women. At the other extreme, 8% of the men and 1% of the women had as much as $5,000 or more. In general, however, nearly everyone studying the question

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agrees that the aged have insufficient income to meet current needs and that, relatively, their economic situation is deteriorating in relation to the cost of living. Also our ideas of what an adequate retirement living standard should be are changing. A rocking chair on the front porch of a cottage does not meet the expectations of many of the aged, or those facing retirement in a decade or so.

In terms of social services for older citizens, inadequate money resources is not our only cause for concern today. As I noted above, we agree that money aid alone, even if adequate, which it is not, is not enough. Why is this so? Our declining years confront us with a number of crises which must be handled effectively if our retirement is to be reasonably satisfactory. These crises, in a sense, form a cycle which generates problems of increasing intensity and which become insurmountable obstacles for the aged person to handle alone. This cycle runs as follows for many older people:

> They lose their spouse somewhere around their 65th year. Within two more years they retire on inadequate funds and must reorder their lives drastically in terms of housing, social activity, and economic affairs. They suffer increasing illness and disability which turns their focus inward and forces a withdrawal from normal activity. The loneliness of social isolation follows with the loss of more and more of their contemporaries. Finally, their inadequate resources make them less and less able to cope with these problems and their situation steadily worsens.

Faced with this cycle, what resources are available to people to enable them to help themselves solve their retirement problems? More specifically, what welfare programs and agencies exist in our communities to serve the aging population? Are they adequate to the job?

Looking at our social services in relation to these questions and the problems of the aged, certain general conditions can be stated. In the first place, the greatest imperative for social welfare for the aged is the provision of services which will enable older people to live as independently as possible, as long as possible. This is in accord with their expressed desires. Most prefer to live in their own homes, for example, rather than with relatives or in institutions. Thus, economic assistance and "home aids" which will maintain independence must have high priority. Secondly, a wide variety of social services are needed in most communities to carry out the above objective. Thirdly, health services and social services must go hand in hand if the lot of the aged is to be good. Fourthly, circumstances which erode independence, such as deteriorating health, can often be prevented or contained if early attention is paid to them. Early referral of clients to the various services can be a most important procedure which rehabilitation counselors working with older people are in a particularly strategic position to offer, and thus head off future need. And finally, ways of promoting, stimulating, and channeling community action

to build sound services for the aged must be developed. With this set of conditions before us, let us look at the present scene and evaluate it quickly.

Financial aids. The only social services specifically designed for the aged which are nationwide in availability are the money aid programs. These are the bases upon which all other services must be fashioned. Certainly, an adequate income to provide life's necessities must be available in our older years. There are three sources of help in this area for the aged: 1) old age assistance through public welfare offices, 2) public retirement benefits through the federal Old Age, Survivors, and Disability Insurance system, and 3) private pension plans and other voluntary arrangements. As noted above the first two of these provide the major financial source for about 80% of the older citizens. Also, public welfare personnel frequently serve as counselors to older people in helping them manage their economic affairs. Such financial counseling service is also available through private social agencies, where they exist, and such agencies may supplement with private funds inadequate budgets of elderly clients.

Although we have made great strides since 1935 in developing these money aids, the system is still dogged by certain persistent problems. In the first place, the amount of help extended the 2½ million recipients of old age assistance varies widely across the country and is inadequate for many people. In the last nationwide survey of assistance standards, about one-third of the recipients lived below "subsistence levels" because of inadequate grants. A second continuing problem which limits the programs is the residence requirement imposed by many of the state public assistance schemes. Not infrequently, older people may move to be near their relatives only to find they do not meet eligibility conditions because of non-residence in the new location, but at the same time they lose aid because they moved from their former residence. A third problem is the fact that not all welfare agencies are staffed adequately to do a good job of financial counseling for recipients. A fifth problem concerns administration of clauses in some public assistance laws which enforce the responsibility of relatives to care for older people by withholding or adjusting money grants. These effect not only the economic situation of older people, but also their family relationships. They sometimes result in denying aid to needy people. Not infrequently they lead to ruptured family ties. Inept administration of such provisions may destroy rather than strengthen resources of the client. Studies of these provisions indicate that legal requirements alone do not lead to family help of older people, but that good casework counseling is the best way to develop family support for older people when the relatives are financially able to offer such assistance.

In summary, we should note that financial aid programs are the only ones which are nationwide as specific services for older people. Other specific social services for older people are available only in some parts of the country

or in isolated cities as demonstrations only. In this sense we seem to be trying to meet the needs of older people on a one-shot basis only and that a rather weak shot in some areas. We can't solve problems calling for personal service by money aid alone. If an adequate assistance approach to the problems of the aged is not enough, what more is needed? This is our next question.

Home aids. Accepting the objective of meeting the problems of the aged in their own homes, a variety of services which have this goal must be given high priority. These may be grouped together under the title of "home aids." They include social services which provide homemakers, housekeepers, home nurses, home delivery of hot meals, home repairs and cleaning, and instruction in home care of disabled and sick people. Although these are important programs to aged couples or older people living alone in their own homes, they are limited in their availability. "Homemaker services" and "Meals on Wheels" have recently had much publicity, but the response is still limited. A few institutions for the aged have provided the equivalent of some of the "home aids", particularly hot food, by establishing out-resident programs. In these, people who live at home come to the institution for meals, social activities and health care. These too, are limited in number, unfortunately.

Casework counseling. A third important kind of service which helps older people maintain independence is casework counseling. Although most older people can manage their own affairs, there are occasions, particularly at times of crisis noted above, when the counsel of some person outside the family may be useful. Also, the caseworker's knowledge of the community and its social services offers the older person referral to agencies as well as help in making the best use of whatever social service may be needed. Private family service agencies and county public welfare agencies offer this service in some places. Unfortunately, however, adequate service of this kind is all too limited in many parts of the country. The Iowa School of Social Work has only recently been awarded a grant from the National Institute of Mental Health to develop a casework counseling and referral service for older people in Cedar Rapids in cooperation with the social agencies of that community. This service will also enable us to train social workers specifically for service to the aged, and to evaluate existing needs and services in that community. More such developments are needed across the country.

Group work services. To keep older people in their own homes, when this is their desire and the best plan, we need adequate money aid, home helps, nutritional services, casework counseling, and information and referral services. Another big problem, which these services alone will not solve, is the isolation and loneliness which frequently accompany our advancing years. To help meet this problem, communities have developed a variety of group activity programs for older people. Among these are Golden Age Clubs, recreation programs, day centers, adult education classes, discussion groups, and hobby and craft classes and activities. These are planned and managed by

churches, settlement houses, welfare departments, private family agencies and such organizations as YM and YWCA's and community centers. Here again, the number of such special programs of this kind for older people is too limited to meet the needs of all across the country. Thus, too many of the aged are confined to their rooms and the isolation of the TV set and the rocking chair.

Friendly visiting. Another program meriting special mention, which also attacks the problem of loneliness, is the "friendly visiting" service which volunteers have developed in some social agencies. These are aimed specifically at the disabled, home-bound, aged in many of the communities where they have been developed. In these programs volunteers visit the older person in his home. Again, they have been developed by churches, social agencies, community councils, lodge groups, and a variety of clubs. As yet they are primarily an urban activity.

Foster care. For some older people remaining in their own home is not a good solution to their living arrangement needs. Either because their homes are not adequate, or because they cannot remain in them for health reasons or other personal reasons, a substitute home must be found for some. In such cases the solution may be a foster home. Social agencies are thus beginning to develop foster home programs for older people. In these programs the agency builds a list of suitable homes, helps bring the older person and the foster family together, helps both the client and family during the period of adjustment to each other, and may continue regular contact with them to help them resolve any problems which may develop later. In such homes the client usually lives as a member of the family, enjoying the full privileges of the home and participating in the group's active family life. Although such foster care programs for older people are much more limited than those for children, for example, they are beginning to be used for a greater variety of situations. For example, mental hospitals are beginning to use them in their after-care programs for discharged patients who have no home of their own to which to return.

Institutional and nursing homes. Other sources for care outside the home are institutions for the aged and nursing homes. These meet special needs for some older people. Where there are such needs they are useful; however, there is increasing awareness that some residents in such institutions are there by default rather than by plan. Sometimes it is the absence of "home aids" and casework counseling which leads people to leave their own homes against their desire in order to escape loneliness and get the service they need, such as hot meals, health care, and social activity. Where entry to an institution results from inability to stay at home, although this is the preferred plan, instead of a desire for group living, the institution can become an unhappy place in which to spend ones last years. Also, some of them do not offer adequate care. Many are overcrowded. An inadequate staff is not atypi-

cal. Absence of planned and directed group activity may result in group loneliness and isolation and individual boredom and unhappiness. Thus, although institutions and nursing homes are being built extensively across the country, they are not the solution to every older person's situation. There are still too few completely adequate institutions in all aspects of needed service in such agencies. In some places we seem to have traded the "poor house" for a poor nursing home for many aged.

Health and protective services. In addition to the social services which have been described briefly above, many aged need health care and protective services to meet all their needs fully. Consideration of how best to provide good health care for the aged has been a topic of active public debate during the past several years. Complete consideration of this problem, however, is beyond the scope of this review. Development of legal aid and protective services is, likewise, outside this assignment. Inadequate provision in these two important areas, however, can mean that we do not get the full benefits of social services for older people. For example, adequate money aid can be drained away through the exploitation of an older person by some unscrupulous individual with whom he may be doing business. Neglected health may lead to early disability and dependency which denies the older person the opportunity to stay in his own home.

Conclusions. Considering the social service, health, and legal aid problems of older people, we can quickly estimate a need for a score or more different programs. Many are needed by most older people and some of the aged may need several different services at one time. The big question is how to get these services available in the local communities where the mass of the older people live? It is locally based, home centered services that the retired citizen needs. Whose job it is to develop these where they are lacking? Who should take the initiative? Can we wait for spontaneous response to this need? Will they ever develop without some organization, planning, and direction? And without some agency being given responsibility to stimulate community action? Answers for such questions as these must be found if we are to ready ourselves to meet more adequately our social responsibility to older people. As rehabilitation counselors to older people, the state vocational rehabilitation services can help in this job of building better social services for the aged. We will get these only if we get all concerned agencies working together in the interest of the older client.

EMPLOYMENT PROBLEMS OF OLDER DISABLED WORKERS

Bertram Brant*

This paper will discuss the problems of older disabled workers who need jobs. First, I will talk briefly about a few studies which have been made. Then I will go into some of our experiences at the Jewish Vocational Service of Kansas City, where for the past year we have been conducting a demonstration program on the vocational rehabilitation of the older disabled worker.

A good many older disabled workers whom we see or hear about, were long-time employees of large companies, and when they became disabled, and as they grew older, they were shifted to lighter duties which were within their capacities. In some cases, companies have personnel policies under which the company feels a responsibility to look for a suitable job for someone with long and, presumably, faithful service. In other cases, labor-management contracts contain provisions under which transfer to a suitable job is made. A common provision is one which permits a worker to "bid" for a job which is vacant, the first right to bid going to the man with most seniority. Such contract provisions work out so that the newest worker gets the most arduous and heaviest job, and he can progress to easier work as he grows older. Such provisions, incidentally, make it difficult for management to hire an older worker or a disabled worker.

In addition, one comes upon instances where labor and management have agreed to waive seniority rules to permit the continued employment of an employee who has become handicapped.

Finding a job for a worker who is older and handicapped, and who can not return to a former employment, is quite a different proposition. Acceptance by industry of a new employee who is older and handicapped is one of our difficult problems.

There has been, to my knowledge, no attempt to survey employer attitudes toward hiring older *and* handicapped workers, but surveys of attitudes toward hiring older people have been made, and I can report on one survey of employer attitudes toward hiring disabled workers.

In 1956 a survey of employer practices and policies in the hiring of physically impaired workers was made by the Federation Employment and Guidance Service[1] in New York City, under a grant from the U.S. Office of Vocational Rehabilitation. A great deal of information was obtained by interview from a representative sample of employers in seven industry groups

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[1] Federation Employment and Guidance Services, *Survey of Employer's Practices and Policies in the Hiring of Physically Impaired Workers*, Author, New York, N.Y.

—light manufacturing, apparel, printing and publishing, wholesale trade, retail trade, finance and insurance, hotel and amusement. Out of this survey I have drawn some findings which may be of help to counselors. They are as follows:

1) It was found that only 37% of firms hiring 500 or more employees, had knowingly hired a handicapped person. Twenty-two percent of firms with 200 to 499 employees had knowingly hired a handicapped person. This means that the counselor approaching an employer must figure that he probably has never deliberately hired a handicapped worker. The burden is on the counselor to show the employer why he should change his practice.
2) When the labor market is tight, employers tend to be less selective. One employer said: "Under these labor market conditions we are like the army—we take any body as long as it is warm." These remarks were pertinent in 1956 when there was a labor shortage, and will be pertinent at times and in places where workers are in demand.
3) Only in very small firms does the employer seem to be the *sole* person who hires. In larger firms, even those with as few as 25 employees, hiring is a process which takes place in several steps. The personnel man may interview and *screen out* some applicants. Those he finds satisfactory may be sent to the supervisor of the department who may or may not accept the applicant. On occasion, there may be a third person with the authority to screen out applicants, such as an immediate foreman. In six out of the seven industries this decentralization was customary. Only in retail trade did the personnel department usually have authority to hire.

   What does this mean to the rehabilitation counselor who is trying to make a placement? It may mean that he has to sell his client not only to personnel departments and top management, but also to department supervisors. Reaching department supervisors is usually not too difficult. One way is to ask to visit the plant and try to meet and talk to the foreman, at least a little bit. Another way to meet foremen is in the process of obtaining employment references. Immediate supervisors frequently know former employees much better than personnel men. While obtaining valuable information about one client, it is sometimes possible to pave the way for placing another.
4) According to the survey, the employer's past experience plays an important part in his willingness to hire an impaired person. The employer is more likely to hire a handicapped person if:
   a) he had previously hired a person who was disabled, and
   b) the disabled employee had performed well on the job.

   The fact that the employer had *retained* one of his employees who be-

came disabled, did not usually make him more favorably inclined toward *hiring* a handicapped person.

The lesson which counselors can learn from this is to be careful, and even conservative, in placing the first handicapped person with a given firm. If the first handicapped person works out, the possibility of taking a second is much improved. I believe very firmly that the professional vocational counselor has a responsibility *not* to oversell. Employers must learn by experience to have confidence in the professional judgment of the vocational counselor. If we say:—this handicapped person can do this job—, we want the employer to feel that we make such a statement on the basis of knowledge.

5) Firms which require physical examinations hire the same proportions of handicapped people as firms which do not. I think we have a tendency to assume that our handicapped clients will fail pre-employment physicals. This finding suggests that an employer who wants to hire a handicaped person will do so anyway.
6) The survey attempted to find out which type of handicap was most acceptable—or least unacceptable—to employers. They found that workers with orthopedic handicaps were most acceptable, and cardiacs came next. Over one half of the firms surveyed rejected epileptics, cerebral palsied, and people with severe visual defects as a matter of policy. This finding defines our problem, but does not suggest what to do about it.

From examining attitudes toward the handicapped, I now turn to a survey of employer policies regarding hiring of the *older* worker. This is a survey called "Counseling and Placement Services for Older Workers,"[2] which was made by the Bureau of Employment Security, also in 1956. Job orders in the public employment services in seven cities were studied. The cities were: Worcester, Massachusetts; Seattle, Washington; Philadelphia, Pennsylvania; St. Paul-Minneapolis; Miami, Florida; Los Angeles, California; and Detroit, Michigan. There was considerable variation among the cities. In particular, the situation was somewhat different in Worcester, since Massachusetts has a law prohibiting discrimination in employment against age. As far as I can make out from the data, this law resulted in less *stated* discrimination against age, but I do not know whether it resulted in a decrease in discrimination in actual hiring of older workers. The employment service in Massachusetts takes job orders stating a *preferred* age, since it can not accept job orders with *age limitations*. Some of the findings are these:

1) More than half of all job orders specified age limitations of 55 or under: 41% of all job orders specified maximum age under 45.

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[2] U.S. Dept. of Labor, Bureau of Employment Security, Washington, D.C. *Counseling and Placement Services for Older Workers,* BES Publ. #E152, 1956 88 pp. Processed.

2) For males, clerical occupations were the most restrictive in age limits, followed by sales, unskilled, semi-skilled, professional, service, and skilled. For females the order was a little different: Clerical occupations were still the most restrictive, followed by unskilled, professional, managerial, service, sales, semi-skilled, with skilled occupations still least discriminatory.
3) The larger industrial establishments specified age limitations more frequently than the smaller establishments. Age restrictions were found in 52% of job openings from firms with 7 or less employees,
53% from firms with 8 to 19 employees,
56% from firms with 20 to 99 employees,
68% from firms with 100 to 400 employees,
74% from firms with 500 to 999 employees,
and the high proportion of 78% of job orders from firms with 1,000 or more employees contained age restrictions.

Jewish Vocational Services in large cities throughout the United States maintain employment services specializing in job placement of marginal workers. In November and December, 1957, the author directed a survey of 2,500 job orders received by 16 agencies. The pattern of age discrimination was very similar to that in the State employment services.

We also traced the method by which 588 older clients were placed. Only 15% of these placements were within the age range set by the employer when he gave the job order. Twenty percent of the workers were older than the age the employer had specified. Forty-four percent were placed on jobs where the employer had not specified an age, and 21% of the placements resulted from a counselor's phone call or visit in behalf of a particular older worker.

The lesson to be learned from this survey is simple: If you get a job lead, go after it. No matter what age the employer says he wants, sell him on the basis of your client's qualifications for the job.

These studies illustrate two things: (1) that industry accepts the older handicapped individual only to a limited degree; and (2) that an individual approach to employers can bring significant results in placing older and handicapped people on jobs.

Sometimes we assume that, if only employers would be more sympathetic toward hiring handicapped and older individuals, their employment problems would be solved. My opinion is there are other equally important factors. One of them is the unique characteristics of our older clients.

Today a rapidly increasing proportion of young people is graduating from high school. Employers assume that the young man or woman who does not graduate either is not bright enough, or he has some defect of character which would be reflected in his attitude toward work.

Things were quite different 40 to 50 years ago, especially in our Midwest. The majority of our 50 to 60 year old clients grew up in a rural area or small

town. The number of years of schooling they report is not related to their practical intelligence, their ability to figure, or even their ability to read and write. Many of our clients have demonstrated the ability to work with their hands, to adapt to different types of jobs, and frequently to pick up a good deal of mechanical knowledge, without formal training.

Individuals with this kind of background can learn on the job, but may not fit into the methods of learning prevalent in schools. It appears, then, that we need to seek on-the-job training opportunities more frequently than we do. Some employers may need interpretation so that they may modify their ideas of what constitutes a training program in order to utilize a man who learns by doing, rather than by reading and listening.

I believe that there are not many examples of training projects for older workers. I would like to cite two which were reported by the Women's Bureau in 1953, in a pamphlet entitled "'Older Women as Office Workers.'"[3]

In New York City a private organization conducted a retraining course in typing and shorthand for older women. Training in typing was offered for two hours a day, five days a week during a three-month period. It was found that women with no initial skill usually did not learn enough to qualify for employment. Those who at one time had been fairly capable, profited a good deal.

The experience of a bank in Milwaukee seems to me to be of special significance. Several hundred women, many of them over 50 years of age, were trained for part time jobs involving business machine operations. Among the machines used were bookkeeping, key punch and adding machines. Though the older women took considerably longer time to learn—as much as two to three weeks—and although they worked more slowly, they made up for this by being steadier, more careful, and more accurate.

In our day-by-day work we can profit from the findings and predictions of economists, by concentrating on placing our clients in industries where there is growth; where jobs are more likely to be available, both now and in the future.

It is not an accident that we find more jobs in retail and wholesale establishments than in manufacturing plants, that we place handicapped people in hotels and restaurants, hospitals and schools, dry cleaning establishments and laundries, appliance repair shops and gasoline stations.

According to a new report entitled "Manpower—Challenge of the 1960's," just issued by the U.S. Department of Labor,[4] the next ten years will show the biggest growth in employment opportunities in construction, finance, insurance, real estate, trade, government service, and other service indus-

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[3] Women's Bureau, U.S. Department of Labor, Washington, D.C. *Older Women as Office Workers,* Bull. #248, 1953.

[4] U.S. Department of Labor, *Manpower: Challenge of the 1960's,* Feb., 1959, 24 pp.

tries. In the next ten years the greatest increase will be in professional, office, sales, and service occupations. Of these groups, the sales and service occupations seem to offer the most opportunities for older handicapped workers. In part this is because of the prevalence of low wages in a number of these industrial areas. This is a fact which we, as counselors, also have to accept.

Studies of economic change also point up the problems being created by automation. As rehabilitation counselors, we can not solve these nation-wide problems—the rapid changes in the nature of jobs—the extensive dislocations caused by moving plants from one part of the country to another—the rapid obsolescence of products which may be replaced by new products coming from different industries and produced in an entirely different way. However, I believe that we, from the vantage point of seeing constantly the problem of the handicapped and older worker, have the responsibility to focus attention on the effects of these rapid movements in the economy.

At this point I would like to talk about our demonstration project which is entitled "Work Evaluation, Training, and Placement Project for Older Disabled Workers." As you know, its principal support is received from the United States Office Of Vocational Rehabilitation. Most of our clients are referred by counselors in the Missouri and Kansas Vocational Rehabilitation Division. Others are referred by us to the State counselors. Many of these older disabled clients have applied for retirement under the disability provisions of the Social Security law. This means that they presumed that they would not be able to work again in industry. Most of these clients have not worked for more than a year, and some of them have not worked for much longer periods.

For these reasons it is most important to assess their current work attitudes. Even more important is to provide an optimistic atmosphere in which they can make the best use of their remaining capabilities. In the screening interview, in the sheltered workshop, and especially in counseling, the objective of employment in industry is constantly re-inforced. Counseling begins immediately, along with evalutaion, so that our client can begin to look upon himself as a worker; to enter into joint vocational planning with the counselor; to examine his employment history; to see what in his experience may be applicable in spite of disability and age; to look into his own resources—former employers, friends, relatives—for leads to possible jobs.

At the same time we are delving into medical reports. Most of our clients have multiple disabilities, and their thorough examination and assessment is frequently complicated. Our medical consultant can give us very valuable information, especially on prognosis, but he can only do so when we have succeeded in acquiring full medical reports, usually from the several doctors and hospitals who know the client from one angle or another.

Our approach to learning about the client's work attitude, habits, and his

ability to follow instructions, is very similar to that presented by Robert Walker's paper. However, we operate a subcontract shop and feel that the fact that we are doing real work and have real pressures in terms of quality standards and dead-lines tends toward an atmosphere which is more like that of industry.

We use psychological tests where they provide answers to questions of employee-ability. We may need information such as ability to read and write and do arithmetic, ability to pass a civil service examination, clerical skill, and potentiality for training. Occasionally we use clinical tests where we need to find out more about the client's emotional stability.

After the completion of the evaluation, which takes three to six weeks, we plan with the State Rehabilitation counselor as to further steps. The client may need additional training in work habits and attitudes through the workshop, or he may not. Sometimes referral to casework agencies or psychiatric agencies is indicated, or sometimes additional medical diagnosis or treatment turns out to be required. When the client is ready, job counseling and job placement are, of course, essential parts of our rehabilitation project.

I would like to spend a little time discussing our methods and approach toward job placement, since this is somewhat different from what Louis Ortale describes in his presentation in this volume.

Job placement in our agency is part of the work of all our counselors, and is not a specialized function. We tend to look on the employer as a special kind of client who needs to be understood, evaluated, and counseled so that he will accept reality—the reality of our disabled clients who can do his job adequately under favorable circumstances. The counselor must gain the employer's confidence as a friendly, helpful, competent professional who is aware of the employer's problems as well as the client's.

We have tried to create procedures which will help our counselors have the advantage of being representatives of the agency, not individuals doing job placement on their own. We keep a permanent file on each employer. Every time a counselor contacts an employer, whether by visit or by phone, he writes down briefly not only when, but why, a contact was made, with some indications of employer reactions. Thus, after eleven years in Kansas City, our files contain names of employers who are deaf and accept (or reject) hard of hearing workers; employers who like older workers if they are energetic, even if neurotic; employers who are sympathetic to foreigners from certain countries; employers who will accept epileptics—and so on. Job orders with notation as to who was referred or placed, are filed in the firm's folder. We make very many telephone calls to employers, since this is faster, though less thorough, than visiting.

Every month or two we send out mailings with brief descriptions of five or six of our employers. Our mailing list contains over 2,500 names, and

keeping it up to date is a time consuming but necessary job. Mailings not only result in job leads and placements, but also are a means of reminding employers of our existence and the work we do.

Most of these technics are borrowed from the State Employment Services. Personalized and individualized to serve the handicapped client, we find that they are effective in helping the average counselor to place clients with disabilities. From my experience, I would say that most vocational counselors come to an agency with the desire to counsel rather than to place people on jobs. But seeing a disabled client again working, earning, and being independent brings a thrill to the heart of every counselor.

Through research in many fields, the vocational rehabilitation counselor now has an increased amount of information available to him. Studies regarding the employment problems of older workers and disabled workers point up the problem of obtaining acceptance by employers, and give some suggestions for attacking it. Demonstration projects provide ways of testing out new approaches to rehabilitation. Economic surveys indicate the occupations and industries where new jobs are likely to be created. Such studies also suggest that the problem of finding employment for all older workers who need it may be beyond the techniques of vocational rehabilitation.

If this is so, the task of the professional vocational counselor will be to rehabilitate and find work for as many disabled workers as possible, and then tell the public about the number for whom a place must be made in our economy.

EFFECTIVE PLACEMENT PROCEDURES WITH OLDER CLIENTS

Lou Ortale*

It is difficult to apply placement techniques to one group, because basically they apply to all age groups and disabilities. However, there are specific procedures and approaches which are more applicable to specific disability groups and I will try to be as specific as possible. However, in talking to you about three aspects of placement, namely "Finding Job Opportunities," "The Employer Interview," and "Selling the Client," I would like very much to have you keep in mind that the older client usually has a good employment history, and usually can be counseled to accept realistic job objectives. The older client is usually accepted by his co-workers, does not resent younger supervisors (group), is usually well motivated after counseling, compares favorably in self-placement with younger clients, retains or returns to his former employment as often as other disabled clients, is equally or more productive, responsible, reliable, less prone to absenteeism, etc. What is needed is an attitudinal change by counselors to a more positive approach to the older client, buttressed by a confidence in the vocational potential of the older client. The older client is often long on pessimism. Who wouldn't be if his years of experience in acquiring skills came to naught because of the age factor? He needs to be heard, and intensive counseling with this group as with the other disabilities, is of utmost importance and will result in many rehabilitations by dedicated counselors. The older client wants help, but sometimes, in the initial stages, is unresponsive because of the situation in which he finds himself. However, once his situation is clarified, the client usually moves quite rapidly through the rehabilitation process. It is my feeling that if a client has marketable skills, and the mental and physical capacities to perform them, he can be vocationally placed. Employers inform me that they are interested in production and acceptable job behavior and that the age factor has been exaggerated.

A—*Finding Job Opportunities*

It is very important in the area of employer contacts that we always investigate this and not assume that employers are reluctant to employ the older client. In discussing finding job opportunities, I am assuming that you understand that I am talking about the job-ready older client. Probably the best way to begin is to make a negative statement and that is, too often in placement we return to firms where we have had success and have not given enough emphasis to enlarging employer contacts. Another counselor

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practice that has not been beneficial is our failure to make further contacts where unsuccessful contacts have been made; experience has proven that such periodical contacts will bring results. It cannot be over-emphasized that employers must be contacted if we are to know the employers and the employers are to know us.

Placement is not pleasant until made so by the counselor, and this stage is not achieved until the counselor has felt the thrill of successful placement often enough that he approaches placement with confidence. Successful placement is the most rewarding experience that counselors can feel, and this experience is making more counselors placement conscious. Counselors who make structured and informal placement contacts cannot help but be rewarded by success in this area.

Some progress is being made in utilizing the services of agencies and cooperative working agreements. The success in this area is largely dependent on the efforts the counselor makes and the people he tries to involve in the placement of the older client.

It is very important that we keep in constant contact with specific areas in which job opportunities exist for the older client. One practice which I think useful is regular visits by counselors with employers, relative to openings they have, or that they anticipate in the near future. It has been my experience that if you contact them regularly, they will contact you in the event that employment vacancies occur. This continuous and closer relationship makes it possible for us to provide better medical, diagnostic, and other information than if the contact is only set up when an employment possibility is indicated.

One of the better sources of finding job opportunities is former clients. They know the community well and, in many instances, have made many applications and are familiar with job opportunities and where they exist. It has been my experience that this source has resulted in many placements of older clients. Another good source of placement is the client himself. More than half of our placements are brought about by the client himself. The client who placed himself should be of tremendous assistance in locating job opportunities. He has been through the mill and can talk from experience and be exceedingly helpful.

The State Employment Service has been one of our outstanding sources of finding job opportunities. However, the approach to the employment service must be accompanied by adherence to our agreement on referrals, namely that the counselor refer clients while they are within 30 days of completion of training and those who are job-ready. The approach to the employment service worker should be structured. You cannot, under any circumstances, unload a lot of non-feasible cases on them and expect cooperation. The approach to the employment service worker must be "grooved." You should talk to him about one client thoroughly and realisti-

cally, especially after testing and other material has been acquired and you can present the whole picture. Talk in terms of job development and having him keep his eyes on possible job openings. This cooperation can be developed to the point, through good public relations, that the employment counselor examines all job orders that cross his desk as to whether or not one of your older clients could meet the requirements. Too often the counselor, in not developing a good relationship between himself and the employment counselor, will only get those cases where an employer has designated an older client. It is our feeling that the older client should be considered for every job order in which he meets the job skill requirements. In each employment service office there is a counselor assigned to the older clients. Every effort must be made to refer to him the older clients in our caseload. This can best be done by making the employment service your reception center when you are out in the field, so that when an interview with a client is arranged, the services of the employment service interviewer can be utilized. It is hoped that the employment service will provide more counselors to assist in the placement of the older client. Our experience has been that approximately 10% of our older clients are assisted in placement by the employment service.

Another area for locating job opportunities is to utilize former employers, not only for the possibility of hiring a specific client, but for the purpose of possible job opportunities. The former client can be helpful in locating firms that have job operations similar to theirs and listing the firms from which they purchase materials and products.

We try, as far as possible, to encourage the establishment of on-the-job training programs in every counselor's district. He might have a motor rewinding trainer in one part of the district, a wood-working trainer in another, shoe repair in another, and so forth. We utilize these trainers not only in the area of possible job opportunities, but for the information they can give us for possible job opportunities in the same or similar areas.

We also work with the Chamber of Commerce and service clubs, to learn of new industries that are contemplated in the community. These contacts can be very beneficial because we can help new employers with information about the type of older client we have and the areas in which they function. In working with the older client, we must not under-estimate the value of talks to service clubs and asking their assistance in locating job openings.

Another area in which strides are being made, is in the exchange of employment information by professional personnel, which in a sense makes the state the unit being served. This sharing of information is a rewarding experience because it develops close cooperation between the State staff and the district personnel. The district personnel are sharing their employment information, and in many cases assist other professional personnel in job placement. Every client is entitled to the best job we can secure for him,

and nothing should be left undone to insure this end. It is this kind of working agreement that will not only increase our placements, but will increase the quality of same. Vocational rehabilitation counselors are more and more thinking in terms of the total effort and not only of their individual quotas. There have been many placements made because of this unselfish attitude. We must share our knowledge of job openings if rehabilitation is to result. It is satisfying to participate in the placement of a client of another counselor. This experience must be felt to be appreciated.

In working with the older client we need to work closely with unions, definitely clarifying our services. The initial union contact should always be made at the top and we should not by-pass anyone. Most union officials are cooperative if they are aware of our service and know that our people have marketable skills and have been trained in specific areas.

There are many other areas of job opportunities, but one of the most important is to motivate the client, if possible, in self-placement. The procedure that I like to use is, after the job objective is definite, we agree on how we will proceed with finding the job opportunity. One of the devices that has been quite successful is for the counselor and the older client to go over the job possibilities in the community, requesting that the client make specific contacts and report back to the counselor telling who he has seen, his reaction to the employer, and what his possibilities of employment were. The client is assured by the counselor that he will follow-up on any situations in which the older client felt a possibility for employment existed. It is my feeling that if this procedure is to be meaningful, the counselor must also make one or two employment contacts in behalf of the client and inform the client as to the results of his efforts. It is well to remember that in the area of placement the client will be more concerned about what you do than what you say.

B—*Preparing for the Employer Interview*

A great deal needs to be done prior to the actual interview. The most important need is that we know the answers employers are seeking. In all surveys known to me, the chief problem has been the attitude of the employer. The thought prevalent in the minds of most counselors is that resistance to the employment of older persons is there and they anticipate it; consequently, they approach the employer in a negative state of mind. Therefor, they have two strikes against them. We must meet the barriers presented by employers head on, positively, by presenting older clients with real marketable skills. We know the older person is not difficult to place because of the age factor alone. In this order, other factors are: lack of job opportunity, motivation, and lack of skills. We must stress the client's skills and his job adjustment potential in our employer interviews. If employer resistance to hiring older clients is our problem, then employer attitude should be the focus of our approach. Our take-off then is to structure our interviews. We

must know all the information concerning our clients; we must have it at our finger tips. Employers are impressed by counselors who know the answers. It is my feeling that as we prepare for the interview, we must familiarize ourselves with responses that will clarify and deal with employer concerns. For example, we should be ready to explain that workman's compensation rates are determined by two factors—specifically the hazards of the company's operation and its accident experience. This formula does not consider the types of personnel or their disabilities. We must be able to show that our clients are less prone to accidents and that this is borne out by studies of the American Association of Casualty Underwriters. They also state that the handicapped older persons ,when properly placed, have as good a work record as the non-disabled and often better. We must also come armed with a good background of available information concerning unions, second injury fund, and so forth.

We must make certain that management knows the part D.V.R. plays in providing of trained personnel—on-the-job training programs, etc., to older clients. Too much time cannot be spent clarifying our services and especially stressing skills of the older client. We must be able to meet arguments concerning the lack of flexibility, inability to adapt to new machines, etc. We must use a constructive approach to meeting these objections. One of the best techniques is to present the specific client in relation to the objections raised. It is always a good policy to use the client's marketable skills, employment record, and ability to adjust himself, when presenting the situation to the employer.

It cannot be over-emphasized that preparing for the employer interview involves a lot of structured thinking on the part of the counselor. Placement is not an individual effort, but a collective endeavor in which individuals and agencies dove-tail their contributions. It is true that agencies make a tremendous contribution in our placement effort, but the greatest strides are in the area of counselor utilization of individuals in the community in a team effort. It is individuals representing the organizations and agencies, plus those spurred by a desire to help, that are making the real contributions. It is hard to measure the results of four or five individuals who are dedicated in the placement effort. There are the workers at the grass-roots level that really get the job done. The grass-roots job of removing barriers to the employment of the older clients is the responsibility of the community where they live and where their employment must be achieved, because most barriers to employment of the handicapped are community-made and it is the community that must help remove them.

This objective can be expedited by agencies whose policies provide a real environment of selective placement. It cannot be over-emphasized that placement will start with people who are concerned to the point that the effort becomes unified and an organized team effort. This effort makes the counselor

a coordinator in bringing the concerned individuals together and keeping it working collectively and individually until placement is achieved. It is my feeling that this collective effort is a time-saving technique which makes it possible for a great deal to be done in the absence of the counselor. It is always well for the counselor to have those concerned with the placement of the older client, concentrate in the area where they are both knowledgeable and known. It must be a "pressure-on" type of action, keeping them constantly aware of their responsibility in the placement of the older client. It would seem to me that a dedicated counselor should have, in every community in his area, from three to five persons who could be classified as placement assistants.

In setting up any procedure in the placement of the older clients, it must be kept in mind that individual situations warrant specific procedures. However, there are some general steps to follow. These are given only in the form of suggestions and have proven useful in general placement. Therefore, keep in mind that this is not a step-by-step procedure, but merely a general plan.

1. We must always keep in mind that we must know the entire, overall situation, especially the abilities and skills of the client and the part that he can play in whatever contacts are made. With this in mind, the first contact in developing the team effort is to start with the referral source, whether it is an individual or an agency. If it is an individual, you should talk to him about the client's skills, some possible community job opportunities, and how the client and counselor and the referring individual can work together in finding job opportunities. We should also try to find out from the referring individual other persons who might be helpful in this collective effort. If an agency is involved, we should impress upon its members that finding job opportunities and placement is a collective effort; that we would appreciate their assistance in this area. Under no circumstances should we fail to convey to the agency that we will follow-up on any leads it might have and, if any are given, follow-up should be initiated immediately.
2. The next contact should be made with the Employment Service, telling them that you have already talked with the referral source and others on behalf of the client's placement. A specific approach is to explain that you are soliciting his assistance in the placement of this client. The fact that you have mentioned to him that you have contacted the referral source and other people concerned with the placement of this individual, will in itself engender greater interest because he will know that this is not just another referral but one in which the community has indicated an interest. It is also a good procedure at this time, in discussing the client's skills and diagnostic information, to emphasize

medical information which indicates the areas in which this client can function.

3. It is not necessary to bring these interested parties together if the job can be done working with individuals. The important thing is that the situation should be structured, utilizing everyone that can be of assistance. It is surprising how contagious the enthusiasm of a counselor can be when his efforts are active in the community. It is always good policy to interest employers because employers who become concerned, in many instances, will provide jobs for older clients or make employer referrals that often lead to placement. Although it is impossible for any step-by-step procedure to be listed in any sequence, a dedicated counselor will develop the structured approach by just getting under way, motivated by his desire to help the client.

It must be borne in mind that placement involves leg work and foresight and leads to contact with many people. It is my feeling that most contacts on behalf of a client are helpful. Maybe not in this specific placement, but in others who will need placement assistance. It is not the method that you use, because methods will vary. The important aspect is to develop a plan and follow it through. What I have said all occurs prior to the employer interview and this indicates a great deal that needs to be done prior to that time.

C–*Selling the Client*

It is my feeling that, in selling the client to the employer, more emphasis must be given to the original employer contact field. This is the informal contact where you break the ice, tell the employer who you are, why you are here, and what you can do for him. The placement problems of the counselors would diminish if several of these contacts were made weekly, because they would result in a reservoir of employers where specific placement contacts can be utilized. It cannot be overemphasized that the counselor who makes the most placements is the one who knows the most employers, and, in turn, the employers know him. This environment just doesn't happen–it must be structured. We must make the calls and make the most of every employer visit.

Every counselor will utilize placement techniques that he feels will sell the employer on his clients. This endeavor is too important to be left to chance. We must follow general rules that will eliminate as much trial and error as possible. Consequently, some rules are applicable to all counselors regardless of difference in approach or selling points.

There are questions in the minds of employers that must be answered whether or not the questions are asked. We must constantly be aware that every employer is realistic–that he is running a business as efficiently as he knows how and that we must deal with him with this in mind. The first ques-

tion of interest to him is, "Who are you?" This simple question is not always answered so that it is meaningful. I think it is important that we make clear that we represent the Division of Vocational Rehabilitation. It is also necessary that we convey what district office we represent and as much other information as necessary to place us, as counselors, in the proper perspective. This means that we must tell him the type of contacts we make and, generally speaking, how we function as counselors. This means that we should convey to him the importance of selective placement; that every client that is submitted is one who fits into a specific job pattern. It is also necessary that the employer understand that each placement is suitable and within the physical and mental abilities of the client. We must also impress upon the employer that we are utilizing all the diagnostic information that is available so that the employer will have a comprehensive picture of the client. This means that we are trying to provide the highest type individuals with marketable skills. It will also help to get across the relationships between us, as counselors, and the client. The above should pretty well depict our functions as counselors and should provide the answers for "Who are you?"

The second question that the employer might have in mind is "Why are you here?" Probably the most important reason is because legislation and increased appropriations have brought about an expansion of our services to employers. We are now able to provide more services of value to employers than in the past. These services include assistance with personnel problems by providing employers with individuals with marketable skills. Our clients have capabilities equivalent to or better than the non-disabled if suitably employed. We have found that where clients have been placed in positions by the efforts of counselors, that job tenure has usually been of longer duration. This means that if we have the opportunity to discuss our clients and see the actual job patterns, we can become better members of the team in an effort to place clients. We are here because, in many instances, the information that the employer can convey to us will assist us in the preparation of our clients for openings in his organization. We are here because our services are available to all employers and we are anxious that he be familiar with them. This should pretty well answer, "Why are you here?"

What can we do for the employer? We can provide him with trainees and pay him for their planned, supervised training. We can make available skilled, trained personnel for regular employment. Make certain when you are making client work comparisons that they are in similar fields, preferably with written information to support your statements. We can also stress that the handicapped are punctual, loyal, good producers, and insurance carriers attest to the fact that they are not as accident prone as the average employee. We can give assurance that previous experience has born out the favorable acceptance of clients by their co-workers and supervisory personnel. We can show an enthusiastic interest in his firm and be ever ready to convey informa-

tion on wage and hour laws, workmen's compensation, etc. We can impress the employer if we know the answers. Another important service is that we can assure him that our interest will be continuous and our cooperation will be wholehearted. It is also necessary that we inform him that, if any of our clients are not performing satisfactorily, we will handle the situation in a manner that will be satisfactory to him. We can help the employer by giving him up-to-date medical and psychological reports, evidence of training, vocational diagnosis, and an over-all picture of the client that can come only from close contact. One of the most important things about our clients is that we know them and their problems. We are anxious to work with employers, and would appreciate knowing possible openings so that we can initiate projects that will fit his job patterns. By all means capitalize on it. See the plant operations in terms of possible employment for your clients. If you are visiting a photo printing plant make a list of the particular jobs where clients with the capabilities of ours might fit in. For example:

Receptionist (telephone work, meeting the public, general clerical)
Printing (contact printer—seat work, can be wheelchair)
Spotting (seat work—light touch—good eyesight—can be wheelchair)
Oiling (seat work—eye and hand coordination—can be wheelchair)
Retouching (seat work—can be wheelchair—good eyesight—light touch and some degree of sense of balance and line)
Mail Clerk (out-going—sitting or standing—no meeting of public—typing, stuffing or advertising circulars, packaging prints)

A job worksheet filled out after the trip through the plant, would provide a permanent record and help in the placement of future clients.

When a specific placement contact is anticipated, it is necessary that you go with all the diagnostic and other pertinent information about your client that is available. It is well to remember that you are using a grooved approach, geared to the selling of a particular client who fits a specific job pattern. The best approach to an employer in a specific placement contact is where an interview has been arranged, preferably prior to an interview where the client is included. Primarily, these interviews should give the employer a comprehensive picture of the client and should include visiting the area in which he will work to make certain that he can physically meet the needs of the job. A check should be made also to see that restroom and other personal need facilities meet the needs of the client. This trip into the job environment probably will open up other possible job opportunities and employers usually are eager to tell you about them. It is well to keep in mind that this counselor-employer interview is very important because you are conveying to the employer a specific client and how you feel he will react to the job opportunity. This should be followed by a presentation of how our clients have fared in comparable vocational pursuits elsewhere, preferably in written form if such is available. It seems "off the cuff" information has no great effect on most

employers. Most business men want written or printed information attesting to the quality of workmanship done by handicapped individuals in similar lines of work.

This initial interview should be followed by a client-employer interview, and if possible, the counselor should also attend. Again I want to stress an earlier point in general placement, that the greater the participation of the counselor in placement effort, usually the more lasting the employment. The client should be instructed prior to the interview in the areas in which he needs assistance. Probably the best method to convey this information to the client is to give him statements. For example: "I have had so much training at such and such trade school, etc. The training consisted of these courses . . . . . ." He should be instructed as to how he should state his disability if the employer asks the question in relation to the position. If he has a visual defect, probably he should say, "I wear glasses and have the same discomfort and inconvenience that other individuals have, but it has in no way hindered my performance during my training period." He should be instructed to emphasize the success he has achieved on the job and to utilize any opportunity to present any evidence of achievements, such as grades, etc. It is necessary that these conferences be brief, but of sufficient duration to give the client an opportunity to state what he can do and his eagerness to get the opportunity to display his skill.

In the above arrangement, the client has had the advantage of a preliminary counselor interview and also the advantage of having the counselor attend the second interview. This will not always be necessary because many of our clients can and should make the initial contact, because without question, self-placement is best if it is a placement commensurate with the client's capabilities. It is well to keep in mind that even the aggressive and capable client needs the assistance of a counselor, and you should make certain that you provide any client who anticipates an employer contact with information that will be helpful. It is a good policy to dramatize an actual interview, with the counselor taking the part of the employer and using the techniques that experience has shown employers use. Sometimes very capable clients have lost jobs because the techniques used did not impress the employer. This is a selling situation that counselors can use, and should use, at every opportunity.

We must study job objectives in the hope of finding clients that have capacities that match job patterns. The information call readies you for the real call which is grooved to a specific client. It is much easier to make a placement where a prior informal contact has been made. It is also good policy, after informal contacts have been established, to mention one or two of your clients whose capacities for specific job patterns might be of interest to the employer.

In presenting this information, it is not necessary to use pressure, merely summarize the capacities of your clients. It might be good procedure to leave

a summary of their capacities for future reference. In all employer contacts, make certain that they are purposeful and that you are armed with the knowledge that is necessary, because employers are impressed by counselors who know the answers and who can make available to them information that they are seeking.

The client must have confidence in his job plans and this can only result from real counseling with the client and his family. Real counseling can ready some clients for self-placement in a position commensurate with their abilities. This is the best type of placement. Whenever necessary, counseling should precede every client placement effort. The family and community resources must be utilized to a greater degree in the placement of the severely disabled, and the trend is to place more emphasis in this area.

Counselors are participating more and more in the development of job patterns and making certain that the client's ability will enable him to function in the job patterns. Job development is being increased by enlarging the number of employer contacts. This is a tremendous responsibility and one that must be accepted by the counselor. This area has just been scratched and the counselor must become the coordinator in the structured approach. This necessitates observation of job operations and suggesting jobs which combine activities that fall within the capacities of his client. Evidence increasingly shows that counselors have made recommendations in job patterns that have led to increased output and employer friends. Job development and engineering must be part of the counselor's thinking at all times. He must always bring the community resources into the picture and utilize every available publicity channel. These contacts are necessary for the placement of the severely disabled. Communities are becoming better acquainted with what we are trying to do through the best means known, and that is successfully rehabilitate clients. This is making our placement job easier. A very rewarding experience to a counselor is one in which he participates in a job development program.

In the event that an on-the-job training program is indicated, we must realize the most important benefits are as follows: 1) the inclusion of the employer into the team effort, not just as a participant but as an expert in conveying the necessary skills to the client and 2) it brings the client and the counselor into an environment where all can function in different ways. The employer as the teacher, the counselor as the adviser and the trouble shooter, and the client as a motivated worker, knowing that he has a job to do and others are standing ready to assist him in any way possible. Every on-the-job training program must be tailored to meet the needs of the client, and there is not any best type of program because the important requisite is the selling of the employer. Because each employer differs in his thinking, we must present to him the plan that is to his liking.

This area is one where some real mutual thought must occur between the client, the counselor, and the potential employer. Prior to the establishment

of on-the-job training, much legwork must be done in the community to insure a job environment that will be successful for the client. This means that a selling job must be done to everyone who in any way can assist the employer, the counselor, or the client in making the adjustment necessary for successful job performance.

For one type of on-the-job training the employer, *only*, is paid for planned and supervised training–this should be in purposeful sequence so it can be evaluated as to training progress. All participants should know the meaning of satisfactory progress and what it entails. The counselor and the client then will know what to expect and periodically can discuss the situation realistically. The above type of on-the-job training is preferred for clients who have specific aptitude for the training but the formal training is not possible because the client is severely disabled. This means the on-the-job training will be tailored to suit the capacity of the client and a job developed to meet the pattern. Others who fall into this category are the employers who want people trained especially for the available jobs, and don't feel that they can afford the cost involved in the breaking-in period. It is well to keep in mind that in this type of training the clients make little or no contribution to the output of the plant during the training period.

In the second type of on-the-job training program, the client and the employer make contributions for which they are both re-imbursed by standards set forth in the original plan; that is, the client is paid wages and the employer, tuition. The agreement could be as follows: that the Division would pay the employer for supervising client training in washing cars at $15.00 a week. Prior to this agreement, the counselor and employer would determine the possible contribution in work effort the client would make in dollars and cents. The amount agreed upon was $15.00. The total wage would be $30.00 a week which is to be paid to the client by the employer. This training will be for a fixed period with no change in client wages or Division tuition paid to the employer. These jobs are largely in areas where skills will be simple and easily imparted to clients. However, it must be emphasized that no matter how simple the skills, they must be taught in a methodical manner so that the counselor and the client will be able to ascertain at any period whether the progress is satisfactory.

For the third type of on-the-job training, the amount paid by the Division decreases as the client acquires skills or abilities that increase his worth to the employer. Many of these jobs are in the trade areas, such as a program where a client is an appliance repair trainee whose tuition up to, and including, the fourth week would be $20.00, from the fourth week to the sixth week, $15.00 and from the seventh through the twelfth week, $10.00. The wages to be paid by the employers increases as the amount paid by the Division decreases.

To establish the fourth type of on-the-job training, the employer, the counselor, and the client discuss a proposed program. It is agreed that the impor-

tant objective is an opportunity for the client to display his skills. The salary worth of the employee in his present state is discussed and set, the trial period decided, and the employer pays him a realistic wage. The Division makes no financial contribution other than counseling as a member of the team. Periodically the team will discuss progress on problems arising; the outcome is highly dependent on the dovetailing of team effort.

The above four types of on-the-job training programs are familiar to all our professional people. However, it is our feeling that all types have not been utilized. Consequently, an explanation of the types might stimulate the use of different methods by counselors. It might counteract a tendency by counselors to overwork one particular type plan and overlook the others. It would seem that before coming to any conclusions as to types of training, that all methods should be discussed and a decision made that fits the specific situation. The important requisite is selecting the type that is most beneficial to the trainer and the trainee.

Placement of the older person, when approached realistically using a structured approach, results in many rehabilitated clients. This is the course we must pursue.

Appendix A

CONFERENCE PROGRAM
ON
COUNSELING THE OLDER DISABLED WORKER

Monday, April 24

7:30 - 9:00 Registration: Continuation Center Office

Tuesday, April 25

8:30 Greetings and arrangements
Dr. W. D. Coder, Coordinator, Center for Continuation Studies
Dr. Woodrow W. Morris, Director, Institute of Gerontology
Dr. John E. Muthard, Coordinator, Rehabilitation Counselor Training
Dr. Gerald Green, Assistant Regional Representative, OVR

9:00 Keynote Speaker
Dr. C. Esco Oberman, Executive Director, St. Paul Rehabilitation Center and President, NRA

10:45 Medical Evaluation of Older Patients
Dr. David M. Paul, Chief, Physical Medicine and Rehabilitation, VA Hospital, Iowa City, and Asst. Professor, College of Medicine, State University of Iowa

1:30 Psychiatric Problems of Older Workers
Dr. William Moeller, Chief, Out-Patient Clinic, Psychopathic Hospital, Iowa City, Iowa

3:30 Initial Interview and Appraisal of Older Clients
Dr. Edwin Cohen, Chief, Psychology Service, VA Hospital, Iowa City, Iowa

6:30 Dinner
Speaker: Dr. Wendell Johnson, Professor of Speech Pathology and Psychology, State University of Iowa

Wednesday, April 26

8:30 Initial Counseling Interview
Demonstration and Discussion of Tape Recording

Recorders	*Consultants*
Piltingsrud	Cohen
Palmer	Green
Aman	Muthard

10:30 Psycho-social Evaluation of Older Clients
Dr. S. J. Williamson, Chief, Psychology Service, VA Hospital, Des Moines, Iowa

1:15 Vocational and Pre-vocational Evaluation of Older Clients
Mr. Robert Walker, Minneapolis Rehabilitation Center, Minneapolis, Minnesota

3:30 Iowa Vocational Rehabilitation Training Center Client
Small group discussions with case materials and tape recording of staffing discussions

	Leader	*Recorder*
Group 1	Hartley	Benedict
Group 2	Otterness	Donohue
Group 3	Starkweather	Hage

6:30 Workshop Library Display: Butler Hall at Continuation Center
Miss Mabel Edwards, Research Associate, Institute of Gerontology, SUI

7:30 Films: Continuation Center
Discussion leader: H. Lee Jacobs, Research Associate, Institute of Gerontology, SUI

8:30 Workshop Library Display available

Thursday, April 27

8:30 The Meaning of Work to the Older Person
Dr. Woodrow Morris, Director, Institute of Gerontology, SUI

10:15 The Treatment and Physical Restoration of Older Disabled Workers
Dr. Carrol Larson, Head of Rehabilitation and Orthopedic Surgery Departments, SUI

1:15 Counseling the Older Person
Dr. Leonard Goodstein, Director, University Counseling Service

3:15 Counseling Interview Demonstration and Discussion
Tape recorded interviews in small groups

	Leader	*Recorder*	*Consultant*
Group 1	Barnhart	Christensen	Green
Group 2	Armstrong	Masson	Goodstein
Group 3	Elliott	Rickert	Muthard

Friday, April 28

8:00 Community Resources for the Rehabilitation of the Older Client
Dr. Mark Hale, Director of School of Social Work, SUI

9:00 Case Discussions
Small groups

	Leader	*Recorder*
Group 1	True	Palmer
Group 2	Cox	Anonsen
Group 3	Schultz	Lord

11:00 Employment Problems of Older Disabled Workers
Mr. Bertram Brant, Director, Jewish Vocational Service, Kansas City, Missouri

1:00	Effective Placement Procedures with Older Clients Mr. Lou Ortale, Placement Specialist, Iowa Division of Vocational Rehabilitation
2:15	Final Session

Appendix B

ROSTER OF PARTICIPANTS

Ahles, Robert J.
1204 Sixth Avenue, S.W.
Minot, North Dakota

Aman, Walter
Cowan Building
Bismarck, North Dakota

Amen, Delbert
St. Charles Hotel
Pierre, South Dakota

Anonsen, Stanley H.
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Minneapolis, Minnesota

Armstrong, Dow
Medical Arts Building
Ottumwa, Iowa

Auch, Arnold
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Sioux Falls, South Dakota

Ballinger, Leonard D., Jr.
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Girardeau, Missouri

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Mankato, Minnesota

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Des Moines 9, Iowa

Otterness, William
Centennial Building
St. Paul, Minnesota

Palmer, Kenneth
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Rapid City, South Dakota

Palmer, Robert
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Paul, John L.
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Wichita, Kansas

Piltingsrud, Kermit
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Fargo, North Dakota

Ravensborg, Milton R.
1821 University Place
St. Paul, Minnesota

Rickert, C. Hobart
Community Service Building
Waterloo, Iowa

Schultz, Vernon A.
Centennial Building
St. Paul, Minnesota

Shimko, Martin A.
630 Service Life Building
Omaha, Nebraska

Sieber, Mrs. Dolores
319 Eagle Street
St. Paul 2, Minnesota

Starkweather, Jerry
415 Bankers Trust Building
Des Moines 9, Iowa

Thomas, George A.
1259 Indian Trail Court
Topeka, Kansas

Thomsen, Edward
1629 - 48th Street
Des Moines, Iowa

Thompson, Lorene
833 Oakley
Topeka, Kansas

True, Thomas A.
State Capitol Building
Lincoln 9, Nebraska

Vogt, Lawrence M.
4238 Valley Road
Minneapolis, Minnesota

Zobel, Walter H.
4321 Beard Avenue North
Minneapolis, Minnesota

Appendix C

ANNOTATED BIBLIOGRAPHY

Compiled by Mrs. Mabel I. Edwards*

General References: Books

The five books listed below are standard references for this field. A more complete annotated bibliography was prepared by Mabel I. Edwards for the conference, and is available upon request from the Institute of Gerontology, State University of Iowa, Iowa City, Iowa.

Birren, James E., (ed.) *Handbook on Aging and the Individual, Psychological and Biological Aspects*. Chicago, University of Chicago Press, 1959. 939 pp. $12.50.

The first of the three volumes is divided into four major subdivisions: (1) Foundations of Research on Aging, (2) Biological Bases of Aging, (3) Aging in Environmental Settings, and (4) Psychological Characteristics of Aging. Prof. Birren says of this monumental work, that it is "intended for use by graduate students, professional and scientific specialists as a reference work". A careful reading of this volume would bring the reader up to date on the psychological aspects of aging, for it is doubtful if any other single volume contains even a small part of the information given here.

Burgess, E.W., (ed.) *Aging in Western Societies*. Chicago, University of Chicago Press, 1960. 492 pp. $7.50.

The third major publication in the series describes the contributions to the U.S. made by Western European countries, with their longer experience in aging. The major part of the book has 11 chapters dealing with aging as a general phenomenon—population, employment and retirement, income maintenance and health insurance, housing and community services, health, mental health, family relationships, life beyond family and work, and research. Each chapter was prepared by a noted American gerontologist using up-to-date information. Comparisons are made among European countries and implications are drawn for the U.S. About one-fourth of the book is devoted to case studies of programs and institutional patterns. Excellent book for students as well as anyone dealing with problems of the aged, especially those looking for ideas on aging.

Donahue, Wilma, James Rae, Jr., and Roger B. Berry, (eds.) *Rehabilitation of the Older Worker*. Ann Arbor, University of Michigan Press, 1953. 200 pp. $3.25.

Basic theme: "All That is Needed". Papers presented at University of Michigan's fourth annual conference on aging: Medical, psychosocial and economic aspects and programs for rehabilitation, employment, and placement. Emphasis is placed upon rehabilitation of handicapped workers over 40, and need to develop technique and programs to rehabilitate older persons who would otherwise remain unproductive, inactive, and dissatisfied with old age.

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*Research Associate, Institute of Gerontology, SUI.

Hurlock, Elizabeth B., *Developmental Psychology,* 2nd edition, New York, McGraw-Hill Book Company, 1959. 645 pp. $6.75.

The purpose of this useful book is "to give as complete a picture of the developmental changes of the total life span of the normal human being as is possible" in one book. Two major themes run through the book: (1) childhood is the foundation age of life; what the person is and does for his remaining years depends largely on what form these foundations have taken; (2) while physical and psychological foundations are biologically determined (heredity) how the person develops these endowments will be influenced by the social and cultural patterns of the group with which he is identified at different stages of life. Two chapters each on middle age and old age. Good bibliographies. Well indexed.

Tibbitts, Clark, (ed.) *Handbook of Social Gerontology,* Chicago, University of Chicago Press, 1960. 750 pp. $10.00.

A comprehensive survey of the field of social gerontology. Nineteen chapters outline, discuss, and summarize present knowledge concerning the social aspects of aging and the aging individual. An extensive bibliography of existing scientific knowledge follows each chapter. This volume is divided into 3 sections and explores the basis and theory of societal aging.

Government Publications

BIBLIOGRAPHIES

Employment of the Physically Handicapped. The President's Committee on Employment of the Physically Handicapped, Washington, D.C. Compiled by Joan A. Donnelly, Reference Dept., the Library of Congress. Publications listed deal with medical aspects of rehabilitation, psychology of disability, mental handicaps, aging, disabled children, disability insurance as distinguished from OASI, list of agencies, directories, films, etc. 93 pp. 1957. Processed.*

Selected References on Aging: An Annotated Bibliography. U.S. Dept. of HEW. Committee on Aging, Washington, D.C., 1955. 61 pp. Processed*, 30¢

Selected References on Aging: An Annotated Bibliography. 1961 White House Conference Edition, U.S. Dept. of HEW, Special Staff on Aging. 1959. 110 pp. 50¢. References included give a broad perspective of the field of aging. Classified to represent major foci of interest and activity. Compiled by subject matter specialists within the various government departments.

OTHER PUBLICATIONS

FEDERAL COUNCIL ON AGING, Washington 25, D.C.

Aiding Older People: Programs and Resources in the Federal Government. 1958. 24 pp. Processed*. Describes the status and progress of programs provided by the different departments of government.

Mobilizing Resources for Older People. 1957. 120 pp. paper bound. Processed*. Proceedings of the Federal-State Conference on Aging, June 5-7, 1956, Washing-

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*Processed means for sale by the Government Printing Office, Washington, D.C. However, single copies may be obtained by writing directly to the agency in most instances.

ton, D.C., attended by official state delegates and for the purpose of clarifying the roles of Federal and State Governments. Divisions included dealt with: (1) income maintenance and welfare; (2) employment rehabilitation and retirement; (3) physical and mental health; (4) education and recreation; (5) housing and living arrangements; (6) State Organization and Function.

U.S. CIVIL SERVICE COMMISSION, Washington, D.C.

U.S. DEPARTMENT OF HEALTH, EDUCATION AND WELFARE, OFFICE OF VOCATIONAL REHABILITATION, Washington 25, D.C.

Placement Process in Vocational Rehabilitation Counseling. Sept. 1960. 104 pp. Processed°. 35¢. (Rehab. Service Series No. 531.) (With list of sources—compiled from proceedings of guidance, training and placement workshops. Edited by Bruce Thomason and Albert M. Barrett.)

Psychological Services in Vocational Rehabilitation by Salvatore G. DiMichael. 1959. Processed°. 53 pp. Designed to be of assistance to rehabilitation agencies in providing high quality psychological services for the disabled.

Small Business Enterprises for the Severely Handicapped. (Rehab. Service Series No. 320.) 152 pp. Processed°. 45¢.

Workshops for the Disabled. A Vocational Rehabilitation Resource by Edward L. Chouinard and James F. Garrett (eds.) (Rehab. Series No. 371.) 1956. 167 pp. Processed°. Presents the origin and nature of the services afforded by the various types of workshops in the U.S. and some of the problems they face.

U.S. DEPARTMENT OF HEALTH, EDUCATION AND WELFARE, PUBLIC HEALTH SERVICE, Washington 25, D.C.

Availability for Work: Chronic Disease and Limitation of Activity. PHS Monograph No. 51. 1958. 46 pp. Processed°. Report of a trial survey in Hagerstown, Maryland among persons 45 and over.

Living Longer: Questions and Answers on the Health of Older Citizens. PHS Publication No. 733. 1960. Processed°. 25¢. Facts about the scope and nature of the health problems of older people. Graphically illustrated.

Strike Back at Strokes. PHS Publication No. 596. 37 pp. 1958. 40¢. Processed°. Detailed information is given on how to care for a stroke patient at home. It has been reviewed by the Committee on Aging, the Committee on Rehabilitation, and the Council on Medical Service of the A.M.A.

U.S. DEPARTMENT OF LABOR, Washington, D.C.

The American Workers' Fact Book. Rev. 1959. 395 pp. Processed°. $1.50. Brings up-to-date American workers economic progress over the past geenration. Considered the prime source of information on workers and working conditions in the U.S.

Manpower: Challenge of the 1960's. Feb. 1959. 24 pp. Processed°. 25¢. A comprehensive study of manpower facts and figures for the 1960 decade. Striking implications for the planning and administration of public employment. Secy. Mitchell states: "These changes will require a major overhaul in the employment policies of many businesses. Employees who do not abandon policies against

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°See footnote on page 127.

hiring workers because of the age, sex, race, religion or nationality, or because they may be handicapped in some way may have real trouble finding enough workers in the decade ahead."

U.S. DEPARTMENT OF LABOR, BUREAU OF EMPLOYMENT SECURITY, Washington, D.C.

Counseling and Placement Services for Older Workers. (BES Publication No. E152.) 1956. 88 pp. Processed*. Study designed to develop and test the most effective methods of providing improved and expanded services for older workers. (Data from 7 state employment security agencies of 7,361 applicants 45 years of age and over.) Discussion of study results indicates that the group receiving intensive services were given four and one-half times the number of placements of those in the control group.

Employment Security Review. Entire issue for April-May 1957 devoted to "Age as a Factor in the Employment Process." Processed*. 20¢ per copy. $2.00 yearly subscription.

Older Worker Adjustment to Labor Market Practices. (BES Publication No. R-151.) September 1956. 269 pp. Processed*. Study of a sample of 160,000 job seekers in seven labor markets in Jan.-Feb. 1956. *Part I:* Nature of the problem and description of survey procedures. *Part II:* Characteristics of older workers and comparisons with younger workers. *Part III:* Detailed treatment of the age factors involved in labor turnover.

Pension Costs . . . . in Relation to the Hiring of Older Workers. Sept. 1956. (BES Publication No. E-150.) 26 pp. Processed*. Article concludes that the cost of private pension provisions need no longer be a real obstacle to employing older workers. The real or ultimate costs of the pensions may or may not be much greater for the newly hired older worker; it depends on the pension plan. In some cases, it may be possible to permit older workers to waive pension rights and rely on OASI benefits.

Services to Older Workers by the Public Employment Service. 1957. 126 pp. Processed*. (BES E-169) (Available for study in local offices of State Employment Service.) Handbook describing in detail the procedures and techniques applied in serving middle-aged and older job seekers.

U.S. DEPARTMENT OF LABOR, BUREAU OF LABOR STATISTICS, Washington 25, D.C.

Comparative Job Performance by Age; Office Workers. Feb. 1960. 36 pp. Processed*. 30¢. Publication No. 768. Also issued as House Doc. 341, 86th Congress, 2nd session. Includes a list of Department of Labor Publications on Older Workers.

Comparative Job Performance by Age: Large Plants in the Men's Footwear and Household Furniture Industries. Bulletin No. 1223, Nov. 1957. 60 pp. Processed*. A study made in order to develop objective measures which would be useful for comparing the performance of production workers in different age groups.

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*See footnote on page 127.

Employment and Economic Status of Older Men and Women. Bull. No. 1213. (Revision of Bull. No. 1092.) 1956. 41 pp. Processed*. Current and historical information on population, employment and economic statistics of older men and women based on published and unpublished material from numerous and varied sources.

Findings: (1) The duration of employment on current jobs tends to vary directly with age. The longer job duration of both men and women over 45 reflects both the greater length of their work histories and their greater employment stability. (2) The decrease in farm work and the increase in semiskilled, clerical, and sales work have tended to restrict employment for older workers.

Job Performance and Age: A Study in Measurement. Bulletin No. 1203. September 1956. 72 pp. Processed*. A pilot study to develop objective methods for determining the effect of age on work performance conducted by the Bureau of Labor Statistics in 4 shoe factories and 4 men's clothing plants (2,217 workers). Employee performance was analyzed in terms of output per man-hour, attendance, work injuries and plant separation.

From findings it was possible to draw some tentative conclusions re: nature of the relationship between age and job performance: (1) Data on output per man-hour indicated that worker productivity was fairly stable until age 54, and then declined slightly (10%). However, women aged 55 to 64 performed as well as younger women; (2) Attendance showed little variation with age; (3) Separations seemed high for workers under 25 and low for the 45-64 age groups. Workers 65 and over had high separation rates due to retirement.

Conclusion: "Insofar as practical implications are concerned, these data emphasize the fact that an employer in considering an applicant for employment should evaluate the potentialities of the individual rather than immediately drawing conclusions from his chronological age."

Older Workers Under Collective Bargaining. Part I: Hiring, Retention and Job Termination. Bulletin No. 1199-1. Sept. 1956. 30 pp. Processed*. Report of a survey of 1,687 agreements covering approximately 7⅛ million workers during 1955 and 1956. Findings indicate: (1) Older job applicant, unionist and nonunionist alike, receives no preferential treatment and little protection against discrimination on the basis of age; (2) Worker growing old on the job is assured a greater degree of protection and more liberal benefit than younger workers. Findings emphasize the change in status of a worker who loses his job after attaining considerable seniority. In general, it was found that labor agreements do not contain provisions which restrict the hiring of workers beyond a certain age. However, only 76 contained any provisions which encouraged the hiring of older workers. A few specified age limits for entering an apprenticeship.

Older Worker Adjustment to Labor Market Practices—An Analysis of Experience in Seven Major Labor Markets. Sept. 1956. 269 pp. Processed*. $1.25. Report of findings of a comprehensive survey of the labor market experience and problems

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*See footnote on page 127.

of older workers conducted by the BES and 7 affiliated State Employment Security Agencies—with cooperation of universities in 4 states.

U.S. DEPARTMENT OF LABOR, WOMEN'S BUREAU

Older Women as Office Workers. Bulletin No. 248. Women's Bureau, U.S. Department of Labor. 1953. Part I: Describes the training programs used in Cleveland, Denver, New York and Milwaukee to train older women and discusses "facts" on older women office workers. Part II: Emphasizes the potential value of such programs—extent of the employment problem is described, statistics are given on age trends in the population, age distribution of women in the labor force, and extent of part-time employment opportunities are given. The importance of overcoming psychological barriers on part of older job seeker is stressed, especially "the trainee's own attitude toward age and its supposed handicaps."

Training Mature Women for Employment. Bull. 258. Processed•. 1955. 46 pp. Describes 23 training programs operated by community organizations that have been used successfully to train mature women for jobs. These projects are described; conclusions presented as reached from the survey findings. The description includes: why and how it was established, who were the sponsors, type of training offered, and length of training time and cost. (Located in Denver, New York City, Washington, Chicago, East St. Louis, Scranton and Hazleton, Pa., and in N.Y. State.) Conclusion: "That women who have never worked before or have not worked for many years can—with proper counseling, training, and placement—become productive and satisfactory employees."

WHITE HOUSE CONFERENCE ON AGING PUBLICATIONS

Background Paper on Rehabilitation of Disabled Middle-Aged and Older Workers. (Included in kit of materials distributed to conference members. For additional copies, write Special Staff on Aging, WHCA.)

Chart Book, 1961, White House Conference on Aging. 65 charts. Processed•. 30¢. (Write Federal Council on Aging, U.S. Dept. of HEW, Washington, D.C. for single copy.) Highly useful, handy sized booklet of charts with commentaries presenting dimensions and trends in major aspects of aging. Excel. source of graphic presentation with projections to 1980 in many areas.

•See footnote on page 127.

Appendix D

ANNOTATED LIST OF FILMS

Compiled by H. Lee Jacobs, Ph.D.*

FILMS SHOWN AT CONFERENCE (available on rental basis from Bureau of Visual Education, State University of Iowa, Iowa City, Iowa).

THE COLD SPRING IDEA, 16 mm, b & w, sound, 12½ min. Documentary demonstrating how retired persons explore and develop potentials for awakening the interests, desires, and capabilities of older persons during a nine-month's course at the Cold Springs Institute.

PROUD YEARS, 16 mm, b & w, sound, 28 min. (recommended for lay audiences). Shows in detail the practical steps that can be taken to aid people to live active, useful lives by overcoming handicaps (strokes, fractures, other disabilities). (This film is lay version of *STILL GOING PLACES*.) Produced by Columbia University Mass Communications Center in collaboration with Medical Directors, Home for Aged and Infirm Hebrews of New York. Grant from Chas. Pfizer and Co., 1956. Distributor: Columbia University Mass Communications Center, 1125 Amsterdam Avenue, New York 25, N.Y., Rental $7–Sale $125. Cleared for local TV use.

RETIRE TO LIFE, produced by Oklahoma State Dept. of Health. 16mm, b & w, sound, 23 minutes. Film showing the disillusionment which often follows retirement from active occupational life. Emphasizes a positive approach to retirement.

FILM LISTS

FILMS ON THE HANDICAPPED, list compiled by Jerome H. Rothstein and Thomas O'Connor. 1955. 56 pp. Council for Exceptional Children, 1201 Sixteenth St., N.W., Washington 6, D.C. $1.00 (annual supplements 20¢ each with 3 annual supplements, $1.50.)

Catalogue of Films and Recordings–*MOTION PICTURES AND RECORDINGS ON AGING*. Department of Health, Education and Welfare, Special Staff on Aging, Washington 25, D.C.

FILMS AND FILM STRIPS ON AGED AND AGING. 16mm, available from Jewish Federation Film Library, 101 North 20th Street, Omaha 2, Nebraska.

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