SELECTED PROCEEDINGS

WORKSHOP

on

Social Gerontology for Home Economists

November 1965

Department of Home Economics
and
Institute of Gerontology

THE UNIVERSITY OF IOWA
IOWA CITY, IOWA

WORKSHOP

on

SOCIAL GERONTOLOGY FOR HOME ECONOMISTS

(Selected Proceedings)

June 29 - July 10, 1964

Editor

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and the

Institute of Gerontology

UNIVERSITY OF IOWA,

Iowa City, Iowa.

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FOREWORD

Dr. Adeline Hoffman is to be complimented on the way in which she and her colleagues in Home Economics arranged and carried forward the workshop for which the present publication represents the Proceedings. I believe it is an interesting idea to talk with the home economists about the problems of the aging and aged and we have some evidence to suggest that last year's workshop has already borne worthwhile fruit.

To work with such interested people is a pleasure and also represents the Institute of Gerontology doing the job it was originally charged to do; that is, to stimulate interest and promote activities among already existing University departments and groups.

Home Economists, working as they do in a variety of contacts with people of all types--always with the goal of trying to improve their living conditions in one way or another, are a particularly important group of people with whom gerontologists should have dialogues. Indeed, it is our hope that these proceedings will reach many more of these interested people than were able to attend the workshop during the summer of 1964. We hope they enjoy and profit from what they read here.

W. W. Morris, Ph.D.,
Director,
Institute of Gerontology.

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PROGRAM

Monday, June 29.

10:00 a.m. Registration and coffee. Pentacrest Room, Iowa Memorial Union.

10:30 a.m. "Greetings." Dr. F. Eugenia Whitehead, Chairman, Department of Home Economics, College of Liberal Arts, University of Iowa.

"Orientation to the Workshop." Dr. Adeline M. Hoffman, Professor of Textiles and Clothing, Department of Home Economics, College of Liberal Arts, and Affiliate Staff Member, Institute of Gerontology, University of Iowa.

"Demographic Trends." Dr. W. W. Morris, Director, Institute of Gerontology, and Associate Dean, College of Medicine, University of Iowa.

1:00 p.m. "New Responsibilities, New Alliances and New Satisfactions for Home Economists." Dr. Helen Judy Bond, New Hope, Pennsylvania, Committee on Aging of the American Home Economics Association, Professor Emeritus, Teachers College, Columbia University, New York City.

3:00 p.m. Reception for Dr. Bond. Old Gold Room, Iowa Memorial Union.

Tuesday, June 30.

10:00 a.m. "Employment Problems of the Older Worker." Mr. Edward K. Kelley, State Supervisor of Selective Placement, Iowa Employment Security Commission, Des Moines, Iowa.

1:00 p.m. "Problems of Income Maintenance for Older Workers." Dr. Jack F. Culley, Professor of Labor and Management, and Director, Bureau of Labor and Management, College of Business Administration, University of Iowa.

Wednesday, July 1.

10:00 a.m. "Trends in American Society: Their Implications for Aging and the Aged." Dr. Harold W. Saunders, Professor of Sociology, Department of Sociology & Anthropology, College of Liberal Arts, University of Iowa.

1:00 p.m. "Health and Chronic Diseases in the Aged." Panel Discussion. Room E405, University Hospitals.

Dr. Arthur P. Long, Moderator. Acting Commissioner of Public Health, Iowa State Department of Health, Des Moines, Iowa.

Dr. Robert Hardin, Dean, College of Medicine, University of Iowa.

Dr. A. L. Sahs, Professor and Head, Department of Neurology.

Dr. Robert Gauchat, Associate Professor, Department of Pediatrics.

Dr. W. R. Wilson, Associate Professor, Department of Internal Medicine.

Thursday, July 2.

10:00 a.m. "Understanding the Aging Process: The Psychological Aspects." Dr. W. W. Morris.

1:00 p.m. Morning program continued.

Friday, July 3.

10:00 a.m. "Development of Federal Programs in Gerontology." Miss Amelia Wahl, Regional Representative, Office of Aging, Kansas City Regional Office, Department of Health, Education and Welfare.

1:00 p.m. "Regional Programs in Aging." Miss Amelia Wahl.

Monday, July 6.

10:00 a.m. "The Prevention of Emotional Disturbances in the Later Years." Dr. Ralph H. Ojemann, Professor, Institute of Child Behavior and Development, University of Iowa.

1:00 p.m. "Youth Looks at Aging: An Approach to Content for a Unit of Study on Aging at the Secondary School Level." Dr. H. Lee Jacobs, Assistant Professor, Institute of Gerontology, University of Iowa.

Tuesday, July 7.

10:00 a.m. "Food for the Aging." Dr. Margaret Ohlson, Director, Department of Nutrition, College of Medicine, University of Iowa.

1:00 p.m. "Research in Clothing Problems and Clothing Behavior of Older Women." Dr. Adeline M. Hoffman.

Wednesday, July 8.

10:00 a.m. "Medical Quackery." John G. Thomsen, M.D., Executive Council, Iowa State Medical Society, and member, Iowa Interprofessional Assn., Des Moines, Ia.

1:00 p.m. "Leisure and Aging." Miss Geneva F. Allen, Recreation Director, Iowa Methodist Hospital, Des Moines, Ia.

Thursday, July 9.

10:00 a.m. "Housing Needs of the Aged." Mr. Robert D. Blue, Attorney, Eagle Grove, Ia., and Former Governor of Iowa.

1:00 p.m. Visit to Meth-Wick Manor Retirement Home, Cedar Rapids, Iowa. The Rev. Ralph James Barron, Jr., Executive Director.

"Retirement Living." Panel discussion by residents of Meth-Wick Manor.

Friday, July 10.

10:00 a.m. "The Needs and Interests of Older People." Panel Discussion. Dr. W. W. Morris, Moderator.

M. E. Barnes, M.D., Professor Emeritus, Hygiene and Preventive Medicine.

Mark L. Floyd, M.D., Associate Professor Emeritus, Pediatrics, College of Medicine.

Dr. Walter Daykin, Professor Emeritus, Labor and Management.

Mrs. Edward Mason, Designer Craftsman, Ceramics and Sculpture, Iowa City.

Mrs. E. T. Hubbard, Vice President, Iowa City Retirement Home Association.

Miss Bertha Schlotter, Former Chief of Activity Therapies, Illinois Department of Public Welfare, and Former Director of Aging, Hull House, Chicago.

12:00 noon — Luncheon. Old Gold Room. Iowa Memorial Union.

Guests: Dean Howard Jones, College of Education; Dean Dewey B. Stuit, College of Liberal Arts; Dr. F. Eugenia Whitehead, Chairman, Department of Home Economics; Faculty Members of the Department of Home Economics, and Panel Members.

Adjournment.

NEW RESPONSIBILITIES - NEW ALLIANCES - NEW SATISFACTIONS FOR HOME ECONOMISTS

Helen Judy Bond, Ph.D.*

I. Introduction.

Little did I dream when I left the campus of the University of Iowa as a graduate in the class of 1923 that 41 years later I would again be in these sacred halls facing a group of persons discussing the subject of "Aging." Perhaps my chief qualification for this assignment is as an "exhibit" only.

Youth thinks little of growing old but in 1923 the public had little concern for this segment of society. National growing pains were so much a part of the stream of activities of society that the citizenry was as oblivious to the problems and concerns of the aging as I was on June 9, 1923.

We were still, especially in the Middle West, more agrarian than industrial in our outlook. In fact, 15 years later I sat beside Judge Rutledge at a University of Iowa Dinner in New York. He was then a member of the Supreme Court but before this the Dean of the Law School at Iowa. The title of his address was "Iowa Thomas Jefferson's Concept of a Democracy."

This stirring address was lost to Iowans because of his sudden death. As he described the State of Iowa it was in terms of a state made up of

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*Professor Emeritus, Teachers College, Columbia University, Committee on Aging, American Home Economics Association.

persons chiefly in control of their own destinies based on individual initiative and a willingness to work long hours to achieve the goals which the family members had set up for themselves. These were primarily personal freedom, education for the children, economic independence, a place for themselves in a community, and security in old age within the close ties of the family itself. I was so touched by the picture he painted of life in Iowa for it had been so much a part of my own background that I wrote to Mrs. Rutledge after his death to see if the yellow sheets on which he had made the pencilled notes could be found so it could be published and shared with all Iowans. But alas, she was unable to find them. If it could have been printed I am afraid that it would now be only a historical document.

World War II, industrialization, mobility, population increases, government controls, deflation of the dollar value, improvement (we hope) in education, better use of our products for human welfare, medical and chemical research have all added up to a vastly changed physical society. There are many new problems. Many hidden problems have been brought to light, but we hope that the desire for family betterment has not been lost in the society of today. Many of its problems have certainly been shifted from the four walls of the family home to the larger society.

In this transition many new problems have been created and this workshop is evidence of one of them.

Yes, a new word has been added to our vocabulary although it was found in the original dictionary of Daniel Webster's day. It represents a

phenomenon as old as life itself. To many it is a word which brings fear, rebellion and foolish nonacceptance, instead of pride, serenity, a sense of achievement and graceful acceptance. This simple five letter word is AGING.

At a luncheon of great writers in London many years ago, Margaret Fuller drew herself up with great affectation and said, "I accept the Universe." Thomas Carlyle, who sat across the table, said, "Gad, you'd better." No, this period need not be softened for me by such terms as "senior citizens," "later years," "golden age," "age of maturity," or "autumn of life" as Walter Ruther called it in a television appearance.

We will accept aging or the scientific terms gerontology and geriatrics. But "the aged" is not one I will use. To me that seems to mean a static state and I want to assume there can still be creativeness, growth and interest in this lengthening period of the life span.

Aging is a natural part of any organism whether its span of life is measured by seconds, a season or 3 score years and ten, now rapidly becoming 4 score and ten.

Intelligent human beings should accept each period of life, prepare for it, live with it, and make every effort to enjoy it to the full.

I am in the period under discussion but I am not going to rebel against it but will try to expend my energies making every effort to enjoy it to the full in every way becoming to a woman of my advanced years. It is even a challenge to me and I secretly hope I can help to improve the image many people have of aging.

II. The Problem.

Why has "aging" become a problem of such great concern. There are many reasons but we will only mention a few and your own imagination can easily expand the list.

A. The number is an ever increasing one.

1. In 1960 census it was found that there were 17,000,000 persons in the Nation over 65 years of age--more than 5 times as many as in 1900.
2. In 1900 the figure represented 4% of the total population. Today it is almost 10%.
3. The projected figure for 1980 is 25,000,000.
4. During the first half of the twentieth century the life expectancy at birth for women increased 20.3 years and for men 17.6 years.
5. In 1980 there will be 177 women to 100 men in the age group 85 years and older.

B. Financial Resources have definite limitation.

1. The dollar value has been greatly reduced.
2. Cost of living has greatly increased.
3. Income tax and other taxes have made great inroads on personal savings.
4. Longer life has necessitated larger sums for medical care.
5. Relief loads have been steadily increasing.

C. Family Mobility and Responsibility.

1. Families often cannot assume the care of older persons.

2. Care often cannot be purchased because of unavailibility of help or lack of resources.

3. Institutional care is not available or far too expensive.

D. Lack of Employment.

1. Retirement regulations.

2. Inability to shift to another type of work.

3. Unemployment.

III. What is Being Done About the Problem.

In August, 1950, a National Conference on Aging was held and from time to time legislation introduced. Before 1960 some states had given some recognition to the problem but it was at this time that Senator McNamara from Michigan, who had headed a subcommittee, brought a series of bills before Congress. These proposals covered a wide range of needs.

Health, employment, retirement savings, housing and even a bill to create a Federal Agency for Aging. But it seemed difficult to generate enough interest. Committees continued to meet and finally a subcommittee recommended a bill authorizing funds for a White House Conference on Aging and in preparation for this, that states be given $5,000 to $15,000 in order to collect information, organize conferences, and to formulate recommendations. It was further recommended that the Secretary of Health, Education and Welfare be given the statutory responsibility of carrying out the Act. On September 2, 1958, President Eisenhower signed the bill. A total of $2,156,000 was appropriated for carrying out the provisions of the Act.

A Special Staff on Aging prepared a comprehensive plan covering the use of the State Grants and a total plan for the conference.

By December 12, Secretary Fleming sent a letter to all Governors asking them to designate an official who would receive grants and assume responsibility for the study of the problems within the state and plan for a state conference.

A National Advisory Committee to the White House Conference on Aging, consisting of 147 persons, was formed. The group was composed of professional persons and others representing many organizations and voluntary groups. They were to establish technical advisory committees as needed.

Fortunately, Home Economics was represented on this Committee by an able colleague, Dr. Thelma Porter.

The date set for the White House Conference was January 9-12, 1961. The over-all plan for the preparation for the conference was an excellent one. Technical committees in Washington were hard at work in producing materials and making plans for the conference. States were doing their "homework." Professional groups were made aware of the oncoming conference and invited to become involved in it. Many professional and voluntary groups appointed committees. The theme of the Conference was "Aging With a Future - Every Citizen's Concern."

IV. Home Economics Involvement.

This is where I came in but it was not the first time the A.H.E.A. or I had been involved in concern with respect to aging.

National Welfare Assembly which was started in 1950 had a subcommittee

on aging. In 1958 the American Home Economics Association was invited to send a representative to a meeting in New York City. I was asked to represent the organization. Only eight other professional groups sent one of their members. In 1961, at the annual meeting, 115 professional and work groups were represented. It was at this meeting that the Committee became a separate organization now called The National Council on Aging. I had the privilege, several years ago, to recommend that A.H.E.A. become a sponsoring member of the Council. This was done.

Because of this experience, I imagine, or because in the interim I had retired, Mildred Horton, then Executive Secretary of American Home Economics Association, wrote to me while I was in Colombia, South America, and asked me to take the chairmanship of a Committee on Aging in A.H.E.A.

The Committee went into action immediately on my return with a threefold purpose in mind:

1. To work closely with the Advisory Committee of the White House Conference and particularly with our representative, Dr. Thelma Porter.

2. To help develop an awareness on the part of the members of the Association, not only as to what was being done at the state and national level but to acquaint them through the pages of our journal with facts, problems, and trends in respect to the aging. An attempt was made to alert the membership as to the need for their participation in state and local committees. There was great variation as to our contribution in the activities leading up

to state conferences.

3. To contact Governors, state councils and offer them assistance and to make them aware of the contributions Home Economists could make and to ask them to appoint Home Economists to state committees and as delegates to the White House Conference.

As the time for the White House Conference approached and we were able to secure the names of delegates it was decided we have a pre and post conference at Headquarters. At the final meeting, Louise Rosenfeld suggested that A.H.E.A. sponsor a workshop. This suggestion fell on fertile ground.

The Association approved and the workshop became a reality the week of April 29, 1962, at Purdue University.

The purposes were defined as follows:

1. To clarify the role of Home Economics in regard to aging.
2. To help appropriate groups of the Association develop programs, ideas and resources in regard to aging.
3. To develop a philosophy that determines the Association's course of action in relation to education and service in programs for the aging.

The third of these objectives was written and published in the proceedings of the workshop and in the October, 1962, Journal of Home Economics.

The subject matter and professional sections considered their responsibilities and with the help of state presidents or coordinators and the Washington staff, a "Dear Jane" letter came out with some

recommendations for American Home Economics Association, State Associations, Professional and Subject Matter Sections, You and Me.

In the program of work and the resolutions of the 1962 meeting, directives were given to the state associations and to each member to make every effort to study the proceedings and to formulate a forceful and active program in every state. I hope it will be one of the textbooks of this workshop.

We have attended a number of state meetings this past year and talked at a number of universities. It is most gratifying to see the efforts that are being made to strengthen the contribution of Home Economics through the state association, through programs of education in our colleges, universities and the schools, through participation with other groups and through individual effort. But much more must be done.

Your American Home Economics Association Committee has continued to serve.

1. Last year before the annual meeting in Kansas City a news release was prepared.
2. A booth at this meeting had a display of the activities of a number of states. Much interest was shown in these.
3. A subcommittee has been working on a guide which was available at the annual meeting this year - "Aging - A Phase in the Life Cycle."
4. Our Committee's recommendation to the Executive Board was that a more effective liaison could be established and maintained with state associations and their coordinators and committees on

aging if the A.H.E.A. replaced the committee with a coordinator on aging. The Executive Board accepted this recommendation and the new president will make an appointment as of August 1st.

5. The Journal will continue to report local and state activities, projects and research which may be helpful to others. It is hoped that you will make these known for they may contain just the spark other state associations and individuals will need to undertake projects, services or research.

6. The A.H.E.A. in cooperation with the National Committee on Homemaker Service has published a folder entitled "The Home Economist Looks at Homemaker Service" which shows clearly how important it is for us to not only be alert to this program but to be a part of it.

There is great variation in regard to what states have done. I continue to receive publications from several state councils or commissions and I am a member of the Penn State Commission on Aging.

I have brought one state file and I am sorry it is not one of the states I claim but it is a very close neighbor.

There is no doubt that much is being done one many fronts. Real leadership is being exerted. But in the final analysis if existing problems are solved or distress lessened, if now and constructive programs of a preventive nature are instigated these must be carried on where people live, where our agencies, institutions and professional groups work.

The archives of the nation and of every state in the union are filled with facts and figures in regard to persons over 65 years of age in

this country. We know in general how many are in each group; we know where they live; we know something of how they live; we have some information in regard to their health status; we know something about their wealth or lack of it, but these generalities are of little value unless they are related to people--people who are living in our counties, our home towns, our own families.

That is where services need to be rendered. This is where we come face-to-face with personal needs, personal feelings, personal desires and the innermost problems that need our help.

Problems of the older generation living in our local communities are better known to their neighbors, their doctors, the visiting nurses, their ministers or priests, their grocery man or delivery boy, the postman, the banker or others we could name. Let us be sure that Home Economists have an important place on this list.

It is at the so-called grass roots level we need to work, for it is here where we need to get significant facts and it is here we need to develop our programs for better housing, better nutrition, better clothing, better use of income, better use of leisure time, better services in general.

All aspects of family life form the basis of our professional field. Throughout the years we have been building the program of Home Economics in cooperation with other professional groups, chemistry, physics, sociology, economics, medicine, psychology, more recently--geriatrics, as the needs of individuals and families were revealed by the pressures of society. We have done this by assessing present knowledge and

resources at hand and then by building up new knowledge through research and experimentation. Now the increase in the life span and the impact this has made on society has brought us to the "Age of the Aging." Assistance in the solution of problems is now being asked of every professional group. To no group should this offer more challenge than to those of us in Home Economics.

Education for Family Life includes preparation for this period and if we do what is rightfully expected of us we must recognize this. We need to form new alliances with other professional groups and continue older ones if we are to have the satisfactions which will come to us if we can help make for others as well as for ourselves these the most meaningful years of life.

In closing let me list specifically some concrete things we should consider.

V. Our Responsibilities.

1. If we feel we do not have knowledge and the ability let us see that we achieve them and that every student preparing for work in Home Economics receives in her education a philosophy and educational materials as well as a very real challenge to see that it is her responsibility and opportunity to add this important segment of family life to her program.

Every person in this workshop should be commended, for your presence here shows your concern for better preparation for this important work.

The members of the faculty who have provided this opportunity

show an awareness of today's problems and the leadership role Home Economists should take in it.

You may be sure that in my talks and committee and Commission work this year I will point with pride to what "my Alma Mater is doing."

2. If family education is truly a major responsibility of our profession, old age should be as much a part of our program as infancy, childhood, adolescence, marriage, parenthood and middle age.

3. If we believe that each period of life is based on and affected by the preceding one, education at each level is necessary in order to be prepared for the ones to follow.

It has been said if 10% of an individual's or family's income income could be saved through the years and not frittered away the financial problems of old age would be taken care of.

4. Home Economists have within their grasp more opportunity than any other group to make a preventive approach to problems of old age.

5. Preparation for the portion of life called aging should be every individual's and every family's responsibility.

6. The community, the state and the nation should <u>supplement</u> and not surplant individual and family effort to meet and solve problems.

7. Home Economists should seriously evaluate our present body of knowledge in each of our subject matter areas and

determine its usefulness in meeting the problems of today's older citizens, point out the information needed to fill the gaps, set up the research needed to find solutions and determine the best methods of translating this into the solution of today's and tomorrow's problems.

8. The need for interdepartmental and cooperative professional exploration and research was never more apparent than in the field of gerontology.

9. Every effort should be made on every level--national, state and community--to bring together representatives of all professional groups, institutions and agencies as well as members of the older age groups to jointly consider problems, services, needed research and perhaps laws or changes in laws to help make "aging with a future" a promising reality.

10. Let each of us look well at ourselves and see how we, personally, can relate acceptably to older persons, understand them, bear with them, help them, and then quietly pray that someone will do the same for us.

11. The last point may be a dream or a nightmare; all we know is it is a deep-seated desire. The longer we work in the field of Home Economics, the more we work with other groups, the more closely we become involved in local, state and national government the more we are convinced that what this country needs is a Department of the Family with a Secretary in the President's Cabinet and a like setup in every state.

A Thought for Closing:

"When the heart is set right, the personal life is cultivated,
When the personal life is cultivated, then the family is regulated,
When the family is regulated, then the national life is orderly.
When the national life is orderly, then there is peace in the World."

---Confucius

EMPLOYMENT PROBLEMS OF THE OLDER WORKERS

Edward K. Kelley*

Thomas Carlyle wrote, "Blessed is he who has found his work. Let him ask no other blessedness." And the novelist, Charles Kingsley, put it just as strongly: "Thank God every morning when you get up that you have something to do that day which must be done, whether you like it or not. Being forced to work and forced to do your best will breed in you temperance and self-control, diligence and strength of will cheerfulness and contentment, and a hundred virtues which the idle will never know."

I believe we all agree that perhaps the major satisfactions of our lives are derived from our accomplishments. That we would not be happy unless the inner drive to achieve were given a chance to fulfill itself.

But what of our fellow men who, due to the incidence of age, are no longer given the privilege of holding a job, who are barred by business and industry from working by age discrimination in hiring or in selection for retraining or who are forced to quit work because of compulsory retirement policies?

Employment has different meanings for different older Americans depending upon their individual needs. It means full time remunerative

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work for one; for another, a part-time job to supplement a pension income and, for still another, voluntary work in his home community. To others, it means a place to go every day--the inner drive to achieve that we mentioned.

We all feel the need to be useful--to be independent and to contribute in some way to the welfare of our community. But many of our citizens are finding only rejection and isolation because of their age.

Perhaps some of you may not have heard this poem which, to me, contains some elements of truth:

In savage tribes, where skulls are thick
And primal passions rage,
They have a system, sure and quick
To cure the blight of age
For when a native's youth has fled,
And age has sapped his vim
They simply knock him in the head
And put an end to him.

But we, in our enlightened age,
Are built of nobler stuff,
And so we look with scorn and rage
On deeds so harsh and rough.
And when a man is old and gray
And stooped and short of breath,
We simply take his job away,
And let him starve to death.

That may seem to be a little exaggerated but there are many forms of starvation. To starve, can mean "to destroy or disable by want of any kind." Mature people want to work--want to be useful--want to be independent--want to contribute, and when they are deprived of these things, they will surely starve, mentally and physically.

So far, we have been speaking in generalities. Now, let's scrutinize the situation as it exists right here in our own State of Iowa. As of 1961--12 percent of the total population of this state were 65 years of age or older. 331,000 men and women. By 1970--in less than six years that figure will have increased to 12.3% or 357,000 people. At this time we have the largest population--percentage wise--of "over 65's" of any state in the nation. Most of them are able to work, are seeking jobs and have something to offer in the way of skill, knowledge, ability and experience. But in a state with one of the lowest employment rates in the nation--26.0 of the men and 46.0 of the women 65 and over had incomes of less than $1,500 per year. Of our population of aged "65 and over" citizens only 9.0 of the men and 12.0 of the women had adequate incomes.

Mergers, shutdowns, moves to a new location, cut-backs, automation--these are everyday words in the business vocabulary. Everyday words but with important consequences for the older workers. The result may be a number of unemployed mature workers. Now, let me drop the bomb. We have referred previously to our population of men and women 65 years of age and older, a group in which I have particular interest because I feel that too little is being done to insure their continued activity in community life. Are they our older workers? Only partially--if you are

past 45 years of age, you are today considered an older worker.

If you are past 45 years of age you will find that you are discriminated against when you seek employment. If you are past 50, you will encounter even greater discrimination. Records prove that the ideal hiring age is 21 to 45. Why? Statistics show that 45.3 of the workers, over 45 years old who lose their jobs remain unemployed for from 15 to 30 weeks. Why?

Studies have been made by the United States Department of Labor, by the National Association of Manufacturers and by the United States Chamber of Commerce to try to determine the reasons for employer resistance to hiring the so-called older worker.

The employers--from all sections of the nation--who participated in the survey, listed as basic reasons for not hiring mature workers as:

1. Health. Employers insisted that the onset of the aging process and the attendant decline in the physical well-being of older workers affects their employability.
2. Absenteeism. Which causes interruption of production schedules.
3. Older workers are accident prone.
4. Production rate. Older workers fall behind.
5. Versatility. Older workers are set in their ways. Thus far the tone of these remarks has been a negative one. I hope that I have aroused in you, a feeling of sympathy for the older worker. So--to switch to a more positive approach let me begin by exploding the myths which I have just expressed as employer objections to hiring the older worker.

admirably. They deserve much credit for their contribution to our total war effort.

So what, basically, is our problem. Is it because so many employers think in stereotypes? Because they equate youth--and only youth--with drive, imagination and aggressiveness? Is it because they interpret maturity to mean inflexibility and lack of dynamic energy? Unfortunately--in many instances--this is true. The paradox is, that on the job, the mature worker is well thought of by his employer, who relies heavily on the skills, knowledge and experience of that mature worker. But the plight of the mature job seeker is an entirely different story. Employers too often do an about face and become reluctant when a mature worker knocks on their door.

I'm hoping that at this point you are somewhat knowledgeable of the problem of the mature job seeker, the person over 45 years of age who finds it necessary to again face the discouraging task of looking for work.

I don't care much for people who pose a problem, explain its ramifications and then walk away, leaving the whole matter dangling. So as not to place myself in that category, I'm going to impose upon your time for a few more moments to explain that this problem of the older worker is not unsolvable nor his position untenable. Let me explain.

By 1965, the U. S. Bureau of Labor Statistics estimates, our gross national product will have reach 560 billion dollars and will continue to increase. And what does this mean to our labor force? It means that by 1970, thirteen and a half million more workers will be needed in the labor force to provide the increased goods and services. Some of you

may recall that during the ten year period from 1930 to 1940 there was a decline in the birth rate--which simply means that from 1965 and beyond 1970 there will be no increase in the so-called "prime working group" ages 25 to 44. In fact, the number of available workers in this age group may decrease. Conversely, the 14 to 24 year old age group will increase by 41% but this is the school age group and therefore will be able to provide only a limited number of workers to the labor force. So where must we look for the additional thirteen and a half million workers who will be needed. Our only source will be the "45 and over" age group which will have increased by approximately 31%. Authorities tell us that by 1975, 50% of the labor force in the United States will be over 45 years old. But that is 11 years away.

So, I believe, I have fulfilled my assignment--and a little more. In addition to presenting the employment problem of the older worker as it exists today, I've given you a brief glimpse into the future to reveal that the problem is a temporary one and that there exists, in the future, a solution. This doesn't mean, however, that today's unemployed mature worker derives any consolation from what will happen in the future. Employer discrimination in hiring is still evident and may exists for some time to come. The public employment service has no intention of relaxing its efforts in behalf of the mature worker until we are assured that employment opportunities are present for this group in all areas of business and industry. This is not our problem alone but should be the concern of every professional person in the state. You can help us bring our message to the employers in your community.

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PROBLEMS OF INCOME MAINTENANCE FOR OLDER WORKERS

J. F. Culley, Ph.D.*

The sharp drop in income and standard of living that occurs when a person retires or otherwise loses the income from full time employment constitutes a major problem of economic adjustment for most older workers, relatively few of whom have sufficient savings to see them through their old age. In 1959, for example, the Federal Reserve Board estimated that 29 percent of the older people in this country had no liquid assets, such as bank accounts or savings bonds, and nearly 50 percent had less than $500.[1] The obstacles to successful saving are many in number and include expensive sickness and accidents, the high cost of educating our youngsters, periods of prolonged unemployment, and the seductions of modern high-pressure advertising. When one adds to these factors the eroding effect of inflation, it becomes apparent that one should not expect too much from savings as a form of income maintenance in the future.

In view of the bleakness of the savings picture, it is encouraging to note that older people as a whole have substantially more income today than they had ten to fifteen years ago. In 1950 there were 12 million persons 65 and over and they had a total income of about $15 billion. By 1961 the number of persons 65 and over had risen to 17 million and

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they had a total income of $35 billion. Thus, the number of older persons increased about 40 percent and their total income increased about 130 percent during this period. By contrast, the total personal income for the entire population increased some 80 percent during the same period.[2]

Encouraging as the rise in total personal income has been, it has not altered the fact that for most older Americans income maintenance remains a problem of major proportions. In 1962, for example, 65 percent of all persons 65 and over had money incomes of less than $1,500, and 37 percent had less than $1,000, according to the 1964 report of the President's Council of Economic Advisors. The gravity of the situation is seen in government estimates that it requires an income of approximately $3,000 a year for retired couples to maintain a "modest but adequate" standard of living. Most retired couples do not have that kind of income and many of those who do are beset by health problems that take the money which would normally be available for their support.

Estimates of the amount of poverty in this country vary widely, but there seems to be general agreement that persons 65 and over constitute more than a fourth of the nation's poor. In 1960, for example, there were some 6 million multiple-person families in the United States headed by persons 65 and over, of which nearly two-thirds had money incomes under $4,000; one-third under $2,000 and one-tenth under $1,000.[3] The severity of the picture is relieved somewhat by the knowledge that many of these families include only two persons and that some families own their own homes or have other sources of non-money income, such as home grown food and medical care furnished the family without cost. Non-money

resources enable a family to live better, but they do not release an equivalent number of dollars for purchasing other needed goods and services.

The federal government and 17 of the 35 states that levy personal income taxes recognize the special problems encountered by older citizens and allow them additional deductions. Of course, one must have an income of a certain size before he can take advantage of these favorable rulings, and many older persons do not have such incomes. Just as it is said to take money to make money so, in this case, it takes money to save money. The real problem of taxes and the older person is not one of deductions, however, but rather of state and local taxes on purchases--the familiar sales tax which bears down most heavily on the poor. It is estimated that 28 percent of family incomes under $2,000 a year is paid out in taxes. Thus, the poor pay out more of their incomes in taxes than families earning five to seven times as much.[4]

Statistical data are subject to varying interpretations, so it is often possible for the same data to be used on both sides of an argument. It is doubly important, therefore, that in interpreting statistics on poverty one constantly be reminded that he is dealing with human beings and not cold figures. One should also keep in mind that factors other than statistical data have great bearing on the problems of income maintenance for older workers. For example, age, geography, and marital status can be critical factors in determining poverty levels. Young people, married or single, can get by on low incomes during the years needed to complete college and not be considered economically depressed. Likewise, an older couple without dependent children and owning their own home in a small rural

community may get along reasonably well on an annual money income that would represent bare subsistence to a similar couple in a more expensive city. So, too, the family with dependent children and a father 65 or over may find life bearable on a low cash income in a rural area where everyone has a garden, rents are low, and there are fewer opportunities or temptations to spend money on non-essential purchases.

If the record shows us that most individuals cannot rely on their savings to maintain a decent income during their later years, and it does, then where is the answer to the question of income maintenance to be found? A partial answer for most older workers is found in Old Age and Survivors Insurance (OASI), or Social Security as it is commonly called. In 1961, more than 3 out of 5 older persons were receiving OASI benefits.[5] These payments plus those made under related programs, such as Old Age Assistance (OAA), make it possible for most older workers to have some regular income today, even though relatively few of them work at gainful employment. Social Security has also made it possible for older women who were formerly wholly dependent on others to collect wives' or widows' benefits and thereby assure themselves of a measure of economic independence. This feature of the law is particularly important in a society such as ours where only one-third of the older women, as contrasted with two-thirds of the older men, live with a spouse. Because men tend to marry women younger than themselves and because women live longer than men, the proportion of women with income is actually higher at age 65, than at younger ages.

It is important to understand that Social Security benefits, specifically OASI, are not intended to provide all the income needed to maintain a

reasonably adequate standard of living. They were not so intended when the Social Security Act was passed in 1935 nor are they so intended today. Rather, they are conceived of as minimal protection to be supplemented by individual savings, or by such other resources, private or public, as may be available to the recipient. Unfortunately, a number of recipients have little or no income except OASI benefits, and 750,000 of these supplemented their OASI income with OAA benefits in 1961. It is estimated that 1 in 5 retired couples and nearly 2 in 5 aged widows had either no income in addition to their Social Security payments or less than $75 a person per year.[6]

Social Security, in the form of OASI benefits, provides the bulk of income received by older workers; but OASI benefits, by themselves, are not enough to support a retired couple or even an individual. OAA benefits are a possible source of additional income for those whose OASI benefits are so small as to be negligible. OAA benefits are also available to persons not eligible for OASI payments; in fact, they are intended primarily to provide income for this latter group. For one reason or another, however, many persons fail to qualify for benefits under either program. The situation has led to proposals for the elimination of the present system of Social Security in favor of a flat pension program to be financed out of general revenues. Other proposals would immediately "blanket in" all older persons, regardless of any contributions they may or may not have made to the Social Security Fund during their working years. Such proposals would destroy the insurance basis of the Social Security Program and might well rob the recipients of the dignity now associated with receiving payments from funds to which they contributed over their working years.

Other sources of income for older workers, and ones which will assume much more importance in the next 10 to 20 years, are the various private and public pension programs. Pension programs in business and industry are still relatively new, especially for hourly paid workers, and many retired persons today receive only a token monthly benefit from this source. Even so, the additional money coming in regularly can make the difference between mere existence and a reasonably satisfactory standard of living. Public pension programs for civil servants at the federal, state, and local levels are also making significant contributions to the income needs of retired persons. So, too, are the veterans' pensions available to former service men and women over 65 who have a disability of 10 percent or more, provided their income does not exceed a certain level. The disability need not be service connected and old age itself may be the basis of presumptive disability. This source of retirement income assumes considerable importance when one considers the millions of citizens who have served, or will serve, their country as members of the Armed Forces.

Life insurance could be a valuable asset or saving for older persons, but in too many cases the policies held by the elderly have low face value and no cash surrender value. The proceeds of such policies are more readily available to bury the policy holder than to meet the costs of current medical care. Similarly, savings tied up in a home are not readily available to meet the current costs of daily living. Home equity for all OASI beneficiaries in 1957 averaged about $5,000. It was higher, about $8,100, for the 2 in 3 who owned their homes outright. During the same year, the average holdings of liquid assets, those readily converted into cash, for

all OASI couples surveyed was only $1,300.[7]

A variety of approaches have been proposed for resolving the income maintenance problems of older workers. Some authorities, for example, have emphasized the importance of educational efforts because of the strong correlation between lack of education or adequate skills training and economic dependence among the older population. It is a simple fact of life in our society that those who have the best education and training also have the best jobs and incomes. It is also true that those who earned more while working draw the largest Social Security benefits on retirement, are more likely to have private pension plans, and probably own their homes and have other savings. By the same token, those who have the least education and training are most likely to draw the smallest Social Security checks and to be most dependent upon public and private welfare services for supplemental income.

In the opinion of many authorities the great bugaboo for older workers is unemployment for whatever cause: lack of education, lack of training, lack of work opportunities, or perhaps simply discrimination because of age. Harvard economist, John Kenneth Galbrath, in addressing this year's Annual Meeting of the American Society for the Advancement of Science, questioned the government's efforts to solve the unemployment problem by reducing taxes. He proposed instead an all-out assault on the underlying causes of our current enemployment. "Why not," he said, "instead improve education, improve health, abate slums, develop backward areas, and take more steps to wipe out racial inequality?" We are already chipping away at these barriers to full employment but the

task is formidable and progress may come too slowly to benefit the present generation of workers.

President Johnson's "War on Poverty" program is intended to help all who are unemployed, whether young, middle-aged, or older. Few would argue about its being a step in the right direction, but critics consider it too limited in terms of the vastness of the problem. They point out, for example, that our present efforts to resolve the income maintenance problems of older workers are largely limited to persuading employers that they should hire on ability and not age, and to counseling older workers on how to find jobs. Lack of facilities and funds and a shortage of personnel with training and experience in vocational counseling of older workers severely restrict the effectiveness of these programs. Similar restrictions limit the potential effectiveness of the nation's efforts in the fields of manpower training and retraining. Such programs are of potential value to those in the 65-75 year age group who are employable, but not to those in the equally large group of 75 and over, the majority of whom are not employable.

In conclusion, older workers seem destined to face problems of income maintenance well into the foreseeable future. National programs of vocational counseling, education, training, and retraining can be expected to relieve the situation for those who are employable, but it is doubtful whether they can have more than a palliative effect until the majority of the nation's employers are convinced that workers should be hired on the basis of ability rather than age. It is conceivable that progress can be made on this front in the years that lie immediately

ahead. It is much more difficult to see similar progress being made toward a solution of the problems of income maintenance faced by those who are no longer employable. It seems reasonable to predict, however, that the numbers of economically dependent older persons will eventually constitute such a tax burden for the younger, productive members of society that greater efforts will be expended to remedy the situation than has been the case to date.

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TRENDS IN AMERICAN SOCIETY:

THEIR IMPLICATIONS FOR AGING AND THE AGED

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Introduction

Any attempt to deal effectively with the social problems of a local community, state, region, or nation, requires that the specific problem to be attacked be placed accurately in its demographic and ecological setting or perspective. This is especially true of the problems confronting our senior citizens--or of our society as we face the basic issue of what can and should be done to make possible a happy, dignified, and productive "old age" for those members now in the later years of life.

Unless and until we know how many persons fall into this category, who they are and how they are distributed, how rapidly they are increasing in number, how their characteristics are changing, why these changes are taking place, and what the probable consequences of these changes will be for the functioning of our social institutions, little or no effective action can be taken, particularly at the collective level. Corrective or remedial action may be more or less effective without a basic understanding of the processes at work to produce the problem, but preventive action cannot be very well conceived and executed in the

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absence of fundamental knowledge about the social conditions to be controlled. Moreover, a broader comprehension of the situation, including the long-run trends at work, may result in a conception of the problem which relieves it of some of its more threatening features. This is significantly true of an aging population with advancing levels of social and economic development.

Viewed in its most general and sweeping terms, an aging population is a great social achievement, an indication that some of man's most persistent hopes have at long last been realized. Instead of a situation to be decried or bemoaned, the presence of an increasing number and percentage of persons in the upper age brackets reflects greater economic productivity and security, highly advanced institutions of medical care, sanitation, and public health.

In contrast to the economically and socially underdeveloped countries where birth and death rates are high, most urban-industrial countries have aging populations, resulting mainly from low levels of fertility. The population growth of the western European nations which occurred between 1650 and 1950 A.D. was a manifestation of the modern demographic cycle, a growth process which results from a falling death rate, not a rising birth rate. In fact, the growth results in spite of a falling birth rate, because the death rate falls first and more rapidly during the early stages of the growth cycle. Nevertheless, the later states of the cycle are characterized by a birth rate which declines more rapidly than the death rate and, hence, which overtakes the death rate as the latter tends to level off at or near its lower limit set by the

natural life span. Growth of population ensues as long as the birth rate exceeds the death rate but the decline of the birth rate cancels out the growth which would have taken place had the birth rate remained constant. In the long-run birth and death rates must be in some approximation of equilibrium--seemingly we cannot have death control without birth control, otherwise the extremely rapid population growth counteracts or uses up the increased productivity made possible by technological modernization.

The combination of falling death and birth rates contributes greatly to a shift in the age composition of the population undergoing modernization. The average age of the population rises sharply, while the proportions of persons at the two ends of the age scale alter considerably. A low death rate (and an increased expectation of life at birth) adds to the number of persons surviving to the later ages (60 years of age and over). The lowered birth rate reduces the number or percentage of children (under 15 years of age) in the population. The fact that the birth rate lags in its fall as compared to the death rate, results in transitional populations having abnormally high numbers in the young, vigorous adult ages. Such a bulge of population between 15 and 45 years of age results in a crude birth rate (annual number of live births per thousand members of the population) which is temporarily high; and in a crude death rate (annual number of deaths from all causes per thousand population) which is temporarily low. As the new demographic equilibrium is achieved at the low level of birth and death rates, with expectation of life at birth being 70 years or longer, the crude birth rate falls

and the crude death rate rises somewhat to reflect the basic state of affairs.

Today the United States can be compared to such countries as the United Kingdom, France, Sweden, and Belgium as to percentages of the young and old members of the population, respectively. In the United States in 1950 about 27 percent of the population was under 15 years of age and 12 percent was 60 years of age and over. In the United Kingdom 22 percent are children and 16 percent are oldsters. In Sweden the percentages for the two groups are 23 and 15 respectively. Until recently their fertility patterns were quite similar to ours, but the post-war baby boom tapered off in the United Kingdom and Sweden sooner than it did here. The birth rate of the U.S. is just now (in early 1960) showing some signs of slackening after remaining constant on a plateau of 25 per 1,000 population throughout the 1950's.

In the underdeveloped countries of Africa, Latin America and the Near and Far East, about 40 percent of the population is under 15 years of age, and only 4-6 percent is 60 years of age and over. In general, then, the percentage of oldsters in a society is a very good index of the degree of modernization and industrialization which that country has undergone.

As to the factors which determine the age composition of a population, demographers have reached the following conclusions. The primary factor is fertility; a high birth rate results in a young population with a large proportion of children, with a low birth rate resulting in a high proportion of adults, and subsequently, of aged persons. Mortality and migration are secondary factors. How many of each generation survive

childhood and adulthood to reach old age is determined by the level of mortality. Emigration tends to reduce the proportion of young adults; and, coversely, immigration tends to increase that proportion.

Finally, age structure influences as well as reflects the levels of fertility and mortality in a population. A large concentration of population in the early middle years (the young adult ages when persons are most marriageable and employable, and which are the reproductive ages for females)tends to result in higher birth rates and lower death rates. A high concentration at the opposite ends of the age scale (among the very young and the very old) produces lower birth rates and higher death rates. Likewise, migration rates reflect age structure as well as influence it. Mobility rates are at a maximum in the young adult ages.

Nevertheless, even though advanced civilizations naturally have much higher proportions of older adults in their populations, in contrast to the most primitive societies which never exceed 3 percent 65 years of age and over, an increasing proportion of older persons percipitates new modes of individual and group adjustment. Until new institutional arrangements and new life patterns are constructed and established, personal and social problems exist both among the increasing numbers in the upper age category and among those members of the society responsible for the welfare of the oldsters, or who have social relationships with them.

If we can pinpoint the areas where older adults are most heavily concentrated or where their numbers are increasing most rapidly, if we can locate and identify variations in the personal characteristics

of these older populations, such as variations by sex, occupation and employment, rural-urban residence, marital status, kinship ties, and group affiliations, then it will be possible to direct our efforts at problem solution toward the most acute problem situations and with some clear realization of the various dimensions of the problems at hand. Such knowledge should make our collective efforts both more effective and more humane.

Population Trends in the United States, 1900-1960

The trends now occurring in the Iowa population, including the position of the state as we enter the fateful decades of the sixties, can best be understood if demographic description (and analysis) is presented against the background of the nation as a whole. The same basic factors are at work in the state and nation, and the State of Iowa is bound up with the processes occurring throughout our land. The fact of inter-dependence between state and nation must be kept in mind constantly in appraising trends in the Iowa population and economy.

Although the composition of the population of the United States has been changing for more than a century most of the changes in age structure have taken place since 1900. In colonial times our population structure by age was similar to that of the underdeveloped countries of today. As late as 1900 only four percent of the nation's people were 65 years of age and over. But by 1950 the total population had doubled, going from about 76 million to 151 million. In that same period, however, the number of persons 65 years of age and over increased from 3.1 million to 12.3 million, or had quadrupled, and composed 8.2 percent of the

total population at mid century. Today there are more people 65 and over than there were in the total population of the United States in 1830.

In 1900, over 34 percent were children under 15 years of age. By 1930 about 29 percent of the population was in this age category. But by 1940 the percentage had fallen to only 25. The baby boom following World War II boosted the proportion of children to 27 percent by 1950 and it has remained at this fugure until 1960.

The median age, or that age which divides the population into two equal parts above and below, has risen from 23 years in 1900 to 30 years in 1950. Since 1950 the median age has declined slightly to 29.2 years.

Spectacular reductions in the death rate accompanied by sizable increases in life expectancy in the United States have been achieved since the beginning of the twentieth century. The crude death rate has been cut almost in half. It declined from 17.2 to 9.4 in 1954. When the death rate is adjusted for age, the reduction is even greater, from 17.8 in 1900 to 7.7 in 1954. In 1900 the average expectancy at birth was 49.0 years. Today, it is 70. Life expectancy in the United States ranks among the highest in the world; it is surpassed only in a few countries such as the Netherlands, New Zealand, and the Scandanavian nations.

Females have participated in these gains in longevity to a greater degree than males. In 1900, girls could expect an average life of 48.3 years; and boys 46.3 years. By 1953 girls could look forward to 72.1 years; boys to 66.1 years. The advantage favoring women has grown from two years in 1900 to six years in 1953. The death rate for women was

reduced more than 50 percent from 1900 to 1954. The death rate for men declined only 41 percent in this same period.

The gains in life expectancy for persons over fifty years of age, however, have been less pronounced. Just a little over three years has been added to their life expectancy since the turn of the century. In 1900 the death rate for persons 45-54 years of age was 15.2. In 1954 the rate was 7.7. This represents a reduction of 48.7 percent in a little over a half century. The infant mortality rate was reduced 81.3 percent in this same period. For persons 65 to 74 years of age the death rate decreased 30.5 percent. For all ages it declined 46.5 percent.

The main causes of death in the early years, the communicable diseases, have been largely brought under control. The degenerative diseases which are the principal causes of death among older persons have yet to be conquered. This basic fact underlies many of the observable differentials in death rates and life expectancies within our population.

Racial minorities represent younger population groupings with higher death rates and shorter life expectations at birth. In 1900 the death rate was 25.0 for non-whites as compared to 17.0 for whites. By 1953 the rates were 10.6 and 9.5 respectively. Consequently, in1953 a non-white baby girl could expect to live, on the average, 64.4 years, compared to 72.9 for a white baby girl. A non-white baby boy could expect to live 59.7 years on the average, compared to 66.8 years for a white male child. The demographic status of non-whites has improved relatively since 1900. Non-white females have gained 30.9 years and

non-white males 27.2 years. White females have gained 24.2 years and white males only 20.2 years.

Social class differences in longevity are less clearly defined than those of sex and race. Death rates are higher for the poorest people until age 55 or so, largely because more of them die from the communicable diseases. After age 55 the differential drops off sharply. The lowest socio-economic groups still show higher death rates from the contagious and infectious diseases, but the chronic disease rates are not very different from the various socio-economic groups. Although differentials still exist in life expectancy for groups classified in terms of occupation, education, and income, there appears to be a definite tendency for the gap in life expectancy between the highest and lowest socio-economic groups to become smaller.

Rural-urban differences in life expectancy have in the past favored the rural areas. But it now appears that the rural-urban differential may continue for only a relatively short time longer. Many urban areas now have superior facilities for the control of the communicable diseases.

Differences in mortality and life expectancy do exist for the various geographic regions of the United States, but crude death rates reflect differences in age, sex, and racial composition of the population. The age-adjusted death rate for the nation in 1950 was 8.4. The West North Central region had a rate of 7.6, the lowest of all regions. The South Atlantic region with a rate of 9.1 was the highest. New England and the Pacific region were tied for second lowest position with a rate of 7.9. The East South Central region was second highest with a rate of 8.9.

The superior position of the West North Central states with respect to longevity is revealed by the following figures: whereas in 1949-51 the life expectancy for white males in the United States was 66.3 years and that for white females was 72.0 years, white males in the West North Central region had a life expectancy of 67.8 years and white females in this region had a life expectancy of 73.3 years, the highest in the nation for both sexes. However, the percentage increases in life expectancy for men and for women in the West North Central states for the decade from 1940 to 1950 were below the national average. The percentage increase for white males in the nation as a whole was 5.6 during this decade, but only 4.0 in the West North Central region. The percentage increase for white females in the nation at large was 7.0, but only 5.9 in the West North Central states. The fact that the bulk of the non-white population resides in the southern states serves to keep the expectation of life at birth below the national average for those regions, but they have been making above average percentage gains since 1940 and the previous differentials are being significantly reduced. However, the Mountain region has had the highest percentage increases, 7.2 percent for white males and 8.9 percent for white females during the decade of the 1940's.

In spite of the spectacular gains in life expectancy and the sharp reductions in the level of mortality during the first six decades of the twentieth century, the falling birth rate has been the principal factor increasing the percentage of older adults in the population of the nation. According to V.G.Valaoras, a member of the United Nations staff,

"If mortality had remained at the level of 1900 while fertility declined as it actually has done, the resulting age structure would be somewhat older than the one that now exists, but the total population would of course be smaller. If, on the other hand, fertility had remained at the level of 1900 while mortality declined as it has done, the age structure would be considerably younger and the total population would be much larger." (Population Bulletin, Vol. XI, No. 3, May, 1955, p.37.) A second factor serving to strengthen the basic process is the sharp reduction of the flow of immigrants following the adoption of our national restrictive immigration policy during the 1920's. No longer does immigration feed a sizable flow of young adults, predominantly males, into our growing population. Consequently the foreign born portion of our population is rapidly shrinking and the bulk of them are in the upper age brackets, residing preponderantly in our large cities. During the decade of the fifties, net civilian immigration to the U. S. averaged about 290,000 persons annually and constituted about 10 percent of our average annual population increment. As a rate, we were adding 1.7 immigrants per thousand population each year from 1950 through 1959. The birth rate averaged 24.8 and the death rate 9.5 making for an annual average rate of natural increase of 15.3 during the decade just passed. Because of our present policy to admit refugees over and above our quota of 154,000 persons per year, current immigrants enter more as family groups, are more evenly balanced between men and women, and are more representative of the entire age spectrum than prior to 1940.

Population Trends in Iowa with Emphasis upon Changing Age Composition: Some Social and Economic Implications

I. Population Profile of Iowa in National Perspective: Iowa population trends can be better understood when compared to those of the nation as a whole.

A. General Characteristics of the Iowa Population. Iowa is a relatively small and stable part of the total American population. It is quite homogenous, racially and ethnically; it is almost evenly balanced in terms of rural-urban distribution, with the scales tilted slightly in the urban direction at the present time (1960); beginning with 1950, it is slightly weighted in the direction of more females than males; and it ranks second in the nation, next to Vermont, with respect to the percentage 65 years of age and over. Iowa is part of the West North Central region, the geographic portion of the United States with the lowest age-adjusted death rate for persons over 60 years of age and the longest expectation of life at birth.

1. In 1950, Iowa had a population of 2,621,000 out of a national total of 151,000,000, or about 1.75 percent of those living in the United States. In 1960, Iowa had 2,736,400 out of 179,500,000, or 1.52 percent of the nation's people. In the last ten years Iowa's population increased 4.4 percent, but the U. S. population grew by 18.8 percent. Iowa's share of the nation's population fell 14 percent in the last decade.

2. The number of senior citizens in Iowa is increasing more rapidly than the total Iowa population. In 1940 there were 228,000 over 65; in 1950 there were 273,000. Between 1940 and 1950 the total Iowa population increased 3.3 percent, but those over 65 years of age increased

19.7 percent. In 1960 there were 327,685 Iowans over 65. This represents an increase in their number of 15.7 percent, while the total population of Iowa rose only 4.4 during the last decade. In 1940, persons 65 and over constituted 8.9 percent of Iowa's total population; in 1950 the percentage was 10.4; by 1960 it had reached 11.9.

3. Iowa has more than its proportionate share of the nation's senior citizens. According to the estimates of the U. S. Census Bureau, in 1955 Iowa had 1.6 percent of the nation's population, but slightly more than 2 percent of the persons 65 years of age and over. In other words, Iowa had 25 percent more than its pro rata share of the nation's elders. However, our share of the nation's elders is declining. In 1930 Iowa exceeded its quota of senior citizens by 41 percent; in 1940 we were 32 percent over our quota; and in 1950 we had 28 percent more than our proportionate share. The situation today (1960) is about as it was in 1950.

4. The main reason for the slow growth of Iowa population, and the high percentage of senior citizens in the state, is the heavy net out-migration of young adults.

a. Birth and death rates in Iowa are close to the national average (Iowa birth rate slightly lower, death rate slightly higher, partly as a result of older population). Rate of natural increase was about 16 percent below national level in 1958.

b. Iowa exports about 70 percent of its natural increase regularly. Between 1950 and 1960 Iowa had an excess of births over deaths of 365,000; but the population increased only 115,000, meaning a

"loss" of 250,000 persons because of migration elsewhere. Between 1940 and 1950 the balance of births over deaths was 281,000 but 198,000 left the state.

c. The highest rates of outmigration are for those between 18 and 34 years of age, with little difference for males as compared to females. The lowest rates are for those 65 and over, with the rate being about three times as high for women.

5. In 1950, for the first time in Iowa history, females outnumbered males very slightly (1,310,790 to 1,310,283); but women 65 years of age and over outnumbered men in this age group 142,232 to 130,706, a ratio of 91.9 index to 100 females over 65. By 1960 females outnumbered males by 39,443 (1,398,490 to 1,359,047); and women 65 years of age and over outnumbered the men in this age group 178,444 to 149,241, with a drop to 83.6 in the ratio of males to 100 females 65 and over.

B. Homogenity by race and nativity--most of Iowa's aged are white, native born citizens. In 1960 less than one percent of the population was non-white; and only 3 percent of the white population were foreign born.

1. Only six-tenths of one percent of the persons 65 and over in 1960 was non-white.

2. Females bulk larger among persons 65 and over for both non-whites and whites.

3. Non-whites, mainly negro, reside almost entirely in cities; and this is true for those 65 and over.

4. Only 14 percent of Iowa's senior citizens are of foreign birth, but over 45 percent of the foreign born population of Iowa (38,000 out of

84,000) are 65 years of age and over.

5. Iowa's foreign born population is largely of Swedish and German extraction; it is also more urban in residence than are native born Iowans, especially the Swedish-Iowans of foreign birth.

C. Distribution of Iowa's Senior Citizens: they are unevenly distributed both geographically and by rural-urban residence.

1. In 1960, about 47 percent of the total Iowa population was rural, as compared to Iowa's senior citizens who were 47.0 percent rural. Percentage over 65 was 10.7 in 1950.

2. The large imbalance by rural-urban residence is within the rural population. The rural nonfarm areas contain only 7.1 percent of the total population, but they had 22.9 percent of Iowa's senior citizens in 1960. On the other hand, the rural farm territory had 39.8 percent of the total population and only 24.0 percent of Iowa's elders. In 1950, only 6 percent of the rural farm population of Iowa were 65 and over, compared to 15.0 percent of the rural nonfarm.

3. The eighteen largest, most urban and wealthiest counties of Iowa have less than their pro rata share of the state's elderly population. In 1960, they contained 54 percent of the total population but only 44 percent of our senior citizens--or they had 12 percent less than their share.

4. In contrast, the twenty most rural, poorer counties contained a little less than 10 percent of Iowa's total population but had nearly 15 percent of the population 65 years of age and over. The ten counties with the heaviest concentrations (with 16.5 percent

or more over 65) had 48 percent more than their proportionate share of the elderly; while the next nine with a heavy concentration of elderly (with 15.7 percent 65 and over) had 32 percent over their pro rata share.

These twenty more "aged" counties are located in southern Iowa, mainly in the two tiers along the Iowa-Missouri line, excluding those on the Mississippi and Missouri rivers.

5. The "bottom" nineteen most rural counties have fewer economic resources for the care of the aged, as compared to the "top" eighteen.

   a. As reported in the 1960 census, the nine largest, urban, and most affluent counties had a median income of $3,011, and only 31 percent of their households had incomes less than $2,000 per year.

   b. In comparison, the ten small, rural counties, with the heaviest concentrations of older people, had a median income of $1,844, and over 53 percent of their households had incomes under $2,000 per year in 1960.

6. In all probability, the relative burden of the dependent aged in Iowa has proved to be still more unequally distributed according to detailed information from the 1960 census.

   a. During the 1950's, all nine of the counties with the highest percentages of Iowa's aged lost population; and the percentage reduction in total population for all Iowa counties ranged from 0.2 (Poweshiek) to 18.6 (Appanoose).

   b. The percentage change resulting from net out migration for

these counties was even higher (9.5 for Lucas, to 18.6 for Appanoose). Each of the counties had a small surplus of births over deaths, but the outmigration far overbalanced it.

c. Only five of the 18 large urban counties had a net population gain during the 1960's resulting from more inmigration than outmigration: Linn (11.2), Pottawattamie (2.1), Scott (1.0), Black Hawk (0.9), and Polk (1.1).

d. The counties with the large concentration of older people are presumably worse off now than in the 1950's; they have a larger percentage of population in top age brackets, and relatively they have a reduced economic base for the support of households with larger proportions of the aged.

D. Income position of Iowa's Senior Citizens--according to the 1960 census the elderly population of the state is in an unfavorable income situation, generally speaking.

1. About 15 percent of the males over 65 and 45 percent of the females in that age category were reported as having no income of their own in 1950. Due to social security benefits, by 1960 these percentages were reduced.

2. The median income for older persons residing in rural farm areas was higher than that for urban areas and rural nonfarm communities; but a higher percentage of those in farm areas lacked independent incomes. Older women living in urban areas are relatively better off, both in terms of median dollar income and in percentage with independent incomes, than their rural peers.

3. Elderly persons without an independent income are much more likely to be living in a household with a relative as the head. This is essentially true for females (one-fifth of females compared to over 10 percent for men), particularly when they live in rural farm areas (three-fifths of the women, only one-fifth of the men). In rural nonfarm places only a tenth of the older men and a fifth of the older women live in a relative's household.

4. Those males living in a household of a relative had a median income of less than $1,000 in 1960; the females in a similar position had a median income of less than $600.

5. In 1956, only 14.5 percent of the men and women in Iowa over 65 were receiving old age assistance, as compared to 17.9 percent for the entire United States: at that time only 34 percent in Iowa were receiving social security payments as compared to 42 percent for the nation as a whole. This reflects the lower degree of urban-industrial development in Iowa. However, the situation was considerably improved by 1960. In 1955 the average old age assistance payment was $60 per month. In 1960 it was much closer to $100.

6. But median income in Iowa is below the national average (in 1959 it was $1,953 for all persons compared to $2,166 for the U.S.); and it is rising less rapidly in Iowa than in the nation as a whole (3 percent as compared to 6 percent in 1959).

E. Employment Status of Iowa's Senior Citizens. Income largely reflects employment status; and labor force participation drops sharply with increasing age, especially for women.

1. Only 32.7 per cent of the men over 65 were still in the labor force in 1960, as compared to over 80.0 for all males in 14 years of age and over. Only 11.5 percent of the women were still employed after age 65, whereas over one-fourth of all women 14 years and over were in the working force.

2. The chances of remaining in the labor force after age 65 are about 66 percent greater for men than for women.

3. But many are still in the labor force after age 75 (20 percent of the men and 3 percent of the women).

4. For older men, labor force participation rates are highest in rural farm areas; for women they are highest in urban areas.

5. Expectations of continuation in the labor force vary considerably with occupational classification. For men, farmers and farm managers have the highest rates of continued employment after 65. Nearly 63 percent of the men still employed after age 65 are found in four occupational categories: farmers and farm managers; craftsmen, foremen, and kindred workers; business managers, officials and proprietors; and service workers. For women, nearly two-thirds of those employed after age 65 were in the following four occupational categories: service workers; private household workers; professional, technical, and kindred workers; and machine operatives and kindred workers.

6. The sub-classification of male workers with the highest expectation of continued employment after age 65 is within the professional category, namely physicians and surgeons, whose chances were 171 percent better than those of the average worker in 1950.

F. Population Projections for Iowa to 1975.

1. The Division of Vital Statistics in the State Department of Health estimated prospective changes in the Iowa population from 1957 to 1972.

a. The total population for Iowa given in the 1960 U. S. Census was 2,575,537 persons. The estimated number of those 65 and over was 327,685, or 11.9 percent of the total. The estimated number of those 18-64 years was 1,260,584, or 52.3 percent. They estimated that there were 1,260,584 children under 18, or 35.8 percent of the population in 1960.

b. The total estimated for 1972 was 2,955,000 (an increase of over 9 percent in 15 years, or 6.1 percent per decade, as compared to the actual 4.4 percent increase from 1950 to 1960). Of this number, 336,000 or 11.4 percent would be 65 years of age and over in 1972.

c. The burden of dependency will rise sharply by 1972, because those between 25 and 44 years of age would decrease from 23.6 to 20.9 percent of the total population. In 1957 there were 92.5 dependent persons for 100 in the economically active ages. By 1972 there will be 114 to 100, or a 23 percent increase in the burden dependency in 15 years.

2. Another projection, made by the writer using a different technique, the ratio method, gave a somewhat different result:

a. A total of 2,910,500 by 1975, or 45,000 less than the first projection in a period of 3 more years. On this basis we would have 355,000 persons over 65 in 1970, or 12.2 percent of the total population; and by 1975 we would have 372,000 or 12.8 percent.

b. Using this type of projection we would have an expected increase of 40 percent in the burden of dependency for Iowa by 1975.

3. At any rate, the burden of dependency is certain to rise considerably by 1975 (more among the dependent youngsters than among the dependent oldsters) unless:

a. The birth rate declines sharply, exchanging young dependents for old dependents;

b. Or, we adopt a more flexible retirement policy after age 65 and encourage the employment of women 45 years of age and over.

4. This could result in the threat of a serious conflict of values and programs.

a. The needs of the young dependents, especially their educational needs might be defined as opposed to the needs of oldsters, with the needs of the latter giving way or being subordinated.

b. However, this tendency may be counteracted by the fact that the senior citizens could become an organized and articulate voting bloc, especially if they conceive of themselves as being an underprivileged minority.

II. Conclusions and Recommendations: On the basis of the preceding analysis, three general recommendations may be offered:

A. In the first place, the state should make greater efforts and explore new ways and means to promote the industrialization of the Iowa economy. For instance, the work of the Iowa Industrial Development Commission should be strengthened.

1. If we wish to reduce the percentage of senior citizens, the major need is to encourage industrial development and increase the number of urban-type jobs, far more rapidly than now, in order to more than offset the shrinkage in agricultural employment.

2. In this way we could probably reduce the rate of outmigration among young adult Iowans and perhaps retain 60 percent rather than 30 percent of our natural increase.

3. Nevertheless, we do have and we shall continue to have a sizable number of older persons, male and female, who need to work, who want to work, and who have valuable skills to offer our economy. Hence, we should also try to attract industries which would and could employ older workers.

4. If we do not elect to pursue a policy as a state of competing vigorously for a larger share of the nation's industrial development and population growth, mainly young adults through reduction of outmigration, then there are two other possible courses of policy determination:

   a. We can specialize permanently in producing "human capital" for national export; and get our compensation, either vicariously through the careers of our children and grandchildren, or by obtaining larger grants and subsidies from the federal government to rear our youngsters and care for their parents and grandparents during old age.

   b. Or, we can encourage a reduction in the Iowa birth rate so as to reduce the burden of the dependent young and reduce the flow of

outmigration, trying to get a rate of natural increase equal to the net increase in employment opportunities--but this policy would mean a still higher proportion (not absolute number) of older people in our population; and it is fraught with the risk that our young people still may choose to locate outside the boundaries of Iowa, especially if we have trouble holding our own as the nation continues its urban-industrial development.

B. We also wish to recommend increased state aid to those localities with higher concentrations of older people.

1. One possibility is to encourage county consolidation for health care and hospitalization, and for the provision of more adequate housing facilities and employment opportunities.

2. Another possibility would be the organization of permanent county planning committees, coordinated by a permanent state office or agency, which would keep a running inventory of needs and resources as well as be action-oriented, such as the promotion of cooperative efforts among contiguous counties.

C. Finally, we recommend that steps be taken to provide more complete, reliable, and more basic information concerning Iowa's senior population, on a county by county basis, particularly in the inter-censal years--if not every year, at least in years ending in 5.

1. This could probably be done on a sampling basis, thereby reducing the cost.

2. The Division of Vital Statistics in the State Department of Health is the logical place in which to store, analyse, and interpret the basic demographic data.

3. In order to avoid waste and excessive duplication the state agency should work closely with the U. S. Bureau of Census--perhaps all 50 states might join in a request that this be done on a national basis.

4. In Iowa, which has a research unit like the Institute of Gerontology at Iowa City, the collection of census-type data should be supplemented by regular social surveys in depth on Iowa's senior citizens, their welfare and contributions to our society.

UNDERSTANDING THE AGING PROCESS:

THE PSYCHOLOGICAL ASPECTS

Woodrow W. Morris, Ph.D.*

Introductory Note.

My understanding of a "process" is that it is an ongoing constantly changing--both growing and deteriorating--but always a lawful, consistent and--if all the variables were known and everything could be known about all the variables--quite a predictable set of events. Nothing is true of nature if this basic premise is not true.

And so it is with all of life and so it is with individual human lives in all their many aspects. The significant thing about the process of living probably can be summed up in the single word "integrity." Certainly as one studies biology and its kindred natural sciences and as one studies psychology as it relates to the developing and declining life processes of people, it is striking how well the whole hangs together. In this instance, then, the whole is not equal to the sum of all its parts but is equal to the sum of the parts plus all of the important integrating relationships between and among the parts. And, just as there are no two fingerprints in the universe which are identical, neither are there two human lives, viewed as wholes, which are identical. As

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a matter of fact it is this great diversity among people, this great plethora of individual differences which go to make life among people so exciting, challenging, stimulating, perplexing, and difficult of predictability. This, then, is the nature of the subject with which we are dealing and I shall try to restrict myself to only two or three aspects of human psychology as it pertains to the aging process.

Section I: Concepts of Adjustment.

Here I would like to try my hand at suggesting a frame of reference within which adjustment might be regarded as a dynamic, complex, living, continually changing aspect of human behavior.

Freud has had much to say about this; some of which has been misstated and misunderstood with unhappy consequences. Some of these consequences have become more and more apparent recently through a reappraisal of some of the tenets of the progressive education movement and so-called "modern child psychology." For example, the following paradigm has been attributed to Freud: "Frustration of wishes and needs produces conflict and stress, and conflict and stress are the basic elements of neurosis." This is an entirely sensible, logical statement; certainly one with which one might not want to argue. But let us examine what follows from such a concept. If frustration produces conflict and conflict leads to neurosis, then the most obvious way to handle child behavior in order to produce good adjustment would be to avoid the danger of producing conflicts and stresses by not frustrating the child in his needs and wishes. Too often this is exactly the course which has

been followed--and with dire results.

Note, now, how different the entire frame of reference becomes when the clause which was omitted from what Freud <u>really</u> said is added to the statement: "Frustration of wishes and needs produces conflict and stress, which are the basic elements of neurosis; but <u>the successful resolution of conflict is the basis of growth and development.</u>" With this addition all the sequelae change. Now it not only becomes all right to frustrate the child and to put him in conflict and stress situations, but it would appear that this is the healthy thing to do providing parents, teachers, psychologists, truant officers and other parents-surrogate do everything possible to help the child resolve these conflicts successfully and to master the stress situations as they arise. This, I am sure, is what makes being a parent so trying at times. Mother or Father must on the one hand attempt to assist in the socialization of a child by frustrating him and thus produce conflict and stress and on the other hand they must somehow turn this in a positive direction by the manner in which discipline is administered. I am sure it is this which led to the development of the expression, "As the twig is bent, the parents are bushed."

I am sure the central position of frustration and stress in this system has a lot to do with the fact that in much of the discussion of adjustment one encounters a great deal of emphasis on the importance of being able to handle and master the stresses and strains of living. Such stresses take many forms such as the frustration of personal needs and goals, the presses emanating from the environment, demands put on the individual by

his friends, relatives and co-workers, and changing physiological conditions within the person himself and in relation to previously learned and expected demands. Here stress is conceived as a momentary, acute, emergency situation and also a system which operates through time and rather continuously. We do not know nearly enough about the relationships between the "mastery of stress" and adjustment but some research has been reported and should be underway as time goes on. On the other hand, it seems quite closely related to such factors as available personal resources, previous experiences, and early training and development.

One of the most recent and interesting reports of studies of stress is that of Funkenstein and his colleagues entitled Mastery of Stress.[1] In it, Funkenstein makes a very thorough and ingenious series of controlled laboratory explorations of psychological and physiological correlates of both acute emergency reactions to stress and the ability to master stress as time passed. In the former he posits a parallelism between psychological and physiological mechanisms of behavior, and concludes that the habitual emergency reaction of a man during acute stress is seen as a deeply laid down feature of personality, its roots extending backward into the biological and evolutionary development of men and upward into his childhood experience and form his basic disposition throughout life. The personality correlates of acute emergency reactions to stress included the person's perceptions of his parents, his internal self-concept, his fantasy life, and his social attitudes.

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1. Funkenstein, Daniel H., King, Stanley H., Drolette, Margaret E., Mastery of Stress. Cambridge, Harvard University Press. 1957.

On the other hand, Funkenstein reports that mastery or failure of mastery of stress over time were independent of the emotion reported during acute reactions. Mastery or failure of mastery of stress were related to different aspects of the personality from those personality factors related to reactions dur ing acute stress. The important personality correlates of the ability to handle stress as time passed were: interpersonal relationships, the ability to assess reality, and general personality integration. In other words, this aspect of stress is relative to ego strength especially as seen in its "adaptive" function.

Funkenstein's methods were applied to college age students. The methods would be equally applicable to other age groups and the potentialities for developing important new information along the age continuum are exciting to contemplate. As can be seen from the foregoing, attitudes play an important role and these are especially important in relation to one's own attitude toward aging and those of other people toward the aged.

In the Way of All Flesh, Samuel Butler has stated the problem succinctly and clearly:

"All our lives, every day and every hour, we are engaged in the process of accommodating our changed and unchanged selves to changed and unchanged surroundings; living, in fact, is nothing else than this process of accommodation; when we fail in it a little we are stupid, when we fail flagrantly we are mad, when we suspend it temporarily we sleep, when we give up the attempt altogether we die. In quiet, uneventful lives the changes internal

and external are so small that there is little or no strain in the process of fusion and accommodation; in other lives there is great strain, but there is also great fusing and accommodating power. A life will be successful or not, according as the power of accommodation is equal to or unequal to the strain of fusing and adjusting internal and external change."[2]

Section II: The Growth and Change of Intelligence.

What most of us have been taught about changes in adult intelligence has been pretty consistent from textbook to textbook and coincides rather well with what the man on the street usually believes about what happens to intellectual behavior with increasing age. To illustrate this let me quote from a standard text on the measurement of adult intelligence:

"Senility, or extreme mental deterioration, is merely a terminal state of certain processes which begin relatively early in life and continue progressively with age. The net result of the accompanying changes is to impair all original endowment*."[3]

And again:

"We have put forth the hypothesis that the decline of mental ability with age is part of the general organic process which constitutes the universal phenomenon of senescence, and have insisted upon the fact that the phenomenon begins relatively early in life."[4]

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2. Butler, S., The Way of All Flesh, New York, Dutton, 1916.
*Italics mine.

3. Wechsler, David Measurement of Adult Intelligence, 1944, Baltimore: Williams and Wilkin, page 55.

4. Ibid., page 59.

The growth and changes in intelligence, then, are depicted as showing the well-known rapid growth and development in children; beginning at an age varying from 15 to 22, the curve begins to fall off; and after age 35, it falls off rapidly. This, then, is the common curve of mental growth and decline as described in the quotation above. Well, in science nothing is sacred, and a few psychologists have carried on research with somewhat different (and I am sure you will find them encouraging) results.

The first of these is by Bayley and Oden.[5] This was a study of the adult intelligence of the original subjects of the Terman Study of Gifted Children. In this study over a thousand subjects comprising adults who were formerly subjects in the gifted children studies and their spouses were located and given the difficult Concept Mastery Test. After a twelve year period they were re-examined. At the first testing these subjects averaged 30 years of age; at the second, 42 years of age; the range in age was from about 20 to 50 years. According to the curve of mental decline, a decline would have been predicted during this critical period of life. The results, however, showed the reverse; there was an increase on the retest. This was just as true, furthermore, for the men as for the women subjects. In addition, and suggesting again the selectivity that takes place in marriage choices, there was a similar increase in the instances of spouses of the Gifted Study subjects.

Concerned lest some of this increase might be reflected by the differential ages of the subjects, Bayley and Oden grouped them into 5-year intervals, which showed that the test-retest scores of all age groups increased.

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5. Bayley, Nancy and Oden, M.H., "The maintenance of intellectual ability in gifted adults." J.Gerontology, 1955, vol. 10, p. 91-107.

Now educational attainment and professional and vocational pursuits of these subjects was regarded as of some interest in this connection, since these factors could be related to the changes in scores. The tendency was clear that the scores improved with age, the lower-scoring ones improving most, although this trend may in part be due to ceilings on the second test which limited the gains of those who originally scored very high.

Gains in score occurred at all educational levels; here again there seemed to be the tendency for those scoring low at the first testing to gain the most on retest.

A second study is that reported by Owens at Iowa State.[6] In this instance, Owens located 127 former Iowa State students all of whom had been administered the Army Alpha Test in 1918-19 when they were entering freshmen at the school. His retesting took place some 30 years later in 1949-50. In brief, Owens' findings indicated that there were significant increases on those tests titled "Practical Judgment," "Synonym-Antonym," "Disarranged Sentences," "Information," and probably "Analogies." In addition there was a significant increase on the total Army Alpha Score. In the cases of the other three tests there was no significant decrease in score but a picture of maintenance of an original level of performance over the 30 year period.

This still left many gaps in our knowledge about the nature of the growth and change in intellectual behavior. Since the foregoing reports are concerned solely with originally superior adults, what would be the

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6. Owens, W.A., "Age and mental abilities: A longitudinal study." Genet. Psychol. Monogr., 1953, 48, pp. 3-54.

case with average or slightly above average adults? What happens in the instance of originally dull people? Do these changes reflect continued intellectual activities in an enriched environment? If so, what would be the results with people who had discontinued intellectual pursuits and/or lived in relatively unstimulating and unrewarding environments? These are questions still to be answered but about which hypotheses may be derived. I think the way the questions are posed above, it may be clear what some of the hypotheses might be. For example, one might suspect that originally average adults would tend to maintain abilities but show greater variability than the gifted or that the dull adult would show a decrease in abilities perhaps proportional to or greater than the superior adults. Again, we might expect to find that people in occupations or following avocations which are less and less stimulating of intellectual activity would show less of an increase if not an actual decrease in scores and the same might be true of people according to their environments.

These are studies which we are carrying out at the Institute of Gerontology. The conception, at least in part, attempts to relate life experiences and events at earlier ages to those of later periods of life.

Because of the paucity of information in other studies, we are employing the longitudinal approach in order to determine the direction and magnitude of changes in test scores over time and the factors related to such changes. In a doctoral dissertation[7] completed at the Institute of Gerontology by Dr. Mir F. Zaman (now back home as Professor

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7. Factors Related to Test Performance: A Longitudinal Analysis, by Mir Fakhruz Zaman, a Ph.D. dissertation, University of Iowa. June 1964.

and Head, Department of Psychology, University of Dacca, East Pakistan), three subtests (Ability to Do Quantitative Thinking, Ability to Interpret Materials in Natural Science, and General Vocabulary) of the Iowa Test of Educational Development were readministered to a group of 196 subjects who were high school seniors in 1947-1948 in Cedar Rapids, Iowa, and in Davenport, Iowa, who took these three subtests in 1947-1948. Along with these tests, a specially constructed attitude questionnaire was also administered for assessing the attitudes of the subjects toward intellectual activities. A Personal Data sheet was provided to gather information about the intervening experiences of the individuals between the two test administrations. There were altogether 100 males and 96 females in the sample secured.

The analysis of the data obtained indicated that:

1. Education, high school grade point average, and attitude toward intellectual activity emerged as excellent predictors from a group of eight predictors considered.

2. Occupation turned out to be a good predictor for the 1964 scores of the males.

3. The initial test scores are significant predictors of the future performance along with certain variables reflecting intervening experiences.

4. Attitude toward intellectual activities, itself predicted in part by the 1947 test performance, is also a good predictor of 1964 performance.

Type I analyses, employed for the purpose of determining the differential effects of some of the variables considered, indicate that:

1. There is no decline of the abilities or skills as measured by the tests employed in the present study with advancing age in adulthood,

at least up to 34 years of age; on the contrary, there is a significant increase in such skills as reflected in the test scores.

2. Males and females perform differentially on the kinds of tests re-administered in this study because of differential intervening experiences.

3. Among the females, working females perform better on the tests than do the non-working females.

Results were interpreted as supporting the view that abilities or skills do not decline with advancing age in adulthood, and contradicting the view that abilities or skills decline, at least up to 34 years of age. The 1947 characteristics of the subjects retested along with the 1947 test scores and other intervening experiences between 1947 and 1964 were found to be the best predictors for the increased performance on these tests in 1964. Furthermore, the increases were noted at each of the three ability levels into which the subjects were divided on the basis of their 1947 test results.

Section III: The Concept of Senility.

Now let me turn to another area of interest. This has to do with mental hygiene and with a statement I heard recently to the effect that "due to the nature of senility, older people cannot be helped by psychological or psychiatric treatment." The nature of senility referred to here is well-illustrated in the following gloomy description offered in a standard text-book of clinical psychiatry:

> "The prognosis of the senile psychoses is manifestly hopeless. No well-defined remissions are to be expected.... The course is progressive, the patient gradually becoming demented although life may

continue for ten years or even longer before death supervenes."[8]

In large part this opinion about senility is conditioned by the fact of organic brain changes and their importance in the mental health of the patient. But as Aring has said, "The frequency with which our patients are said to be suffering from chronic brain syndrome these days leads me to wonder whether this rather elegant phrase isn't serving something besides diagnosis. House officers seem to be fond of it. It sounds so final. Chronic brain syndrome when combined with a diagnosis of cerebral arteriosclerosis represents senile dementia in modern dress. The indications usually are that an irrevocable mental state has set in."[9] Again, concerning treatment of these patients, Aring says, "As a young neuropsychiatric house officer I had the usual introduction to the problem of taking care of many patients in a general hospital with what was then termed senile dementia. In the early 1930's, as today, these people were given the minimum of our time and were as rapidly as possible shunted to the state hospitals and sanatoria for boarding the rest of their lives. As I try to recapture our thinking about these patients, we were as much embarrassed by them as any other feeling we may have had, a condition made tolerable for us by reason of the fact that they were soon to be gone. This state of affairs isn't much changed today; witness the frequency with which we move patients with chronic disorders out of the stream of medical consciousness, usually to somewhere in the suburbs or even more distant.

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8. Noyes, A.P.(M.D.), Modern Clinical Psychiatry, 2nd ed., 1939, Philadelphia: W.B.Saunders Co., p. 298.

9. Aring, C.D. (M.D.), "Senility," A.M.A. Archive of Internal Med., Vol. 100, Oct. 1957, p. 520.

"It was only later that I became aware of some of the social and economic factors that brought many of these patients to us. The loosening of family ties with all that it implies, the relaxation of discipline with its depreciation of elders, the critical financial decade and the accompanying unemployment beginning in 1929, the urban shift of population, conscription, even the isolationism rampant after the first world war; these and many other factors played a part. However, a busy young physician earning clinical spurs had little time in those days for such concepts; it was only later that they entered my thinking about senile dementia."[10]

This conception of senility is, as you have already observed, quite at variance with the aforementioned textbook description of the senile psychoses. Furthermore, it suggests environmental causative factors which may be important in the production of or in the hastening of the production of senile changes. These suggestions are, in turn, in keeping with the thinking and research of Maurice Linden who has the following to say concerning the nature of senility: "The author is of the conviction... that senility as an isolable state is not an inevitable biologic stage in the human life cycle, but is rather a cultural artifact, a product of prevalent social attitudes. It is the logical culmination of the combined social rejection of the late mature person and the senescent person's self-rejection."[11]

Linden goes on to describe the onset of the senile state as marked by

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10. Ibid., page 521.

11. Linden, M.E., "Group psychotherapy with institutionalized senile women: study in gerontologic human relations." Int. J. Group Psychotherapy, 3, 1953, 150-170.

a profound feeling of rejection and isolation, accompanied by a sense of insecurity and diminishing self-esteem, followed by a deep feeling of fatigue and melancholy. These beginnings seem to be successively followed by loss of environmental contact and periods of confusion during which memory and orientation are affected. If unchecked this proceeds into the terminal deteriorative state.

Now the emphasis in these viewpoints is upon social and intra-personal stresses which impinge upon older people rather than inevitable, biological decline. If this were so, it should follow that the condition might be alleviated if attention were paid to the posited causative factors. This is the approach Linden took in proposing to do group psychotherapy with female patients of this type.

The patients with whom we are concerned here had a mean age of 70, three were younger than 60 and one was 89. The time spent in the hospital before treatment ranged from 1 to 480 months. The mean was about 58 months. Thirty-one of the total of 51 had been hospitalized for 2 years or less; twelve had been inpatients for 8 years or more.

In addition to their psychiatric diagnoses, a number and variety of other conditions were also present in these patients such as cardiac disease, arterial hypertension, nutritional anemia, diabetes, osteoarthritis, gynecological disorders, and arrested tuberculosis.

Employing criteria of a clinical nature which were more a measure of resocialization than of complete remission of a psychosis, arrived at from physician and nurse observations, patients were classified as much, moderately, or slightly improved, or as showing no change whatever. None became

Of the total group, the results are: 22 patients were much improved; 8 were moderately improved; 11 showed slight improvement and only 10 were unchanged. Twenty-three patients, or 45% of the total, left the hospital for their own homes, county homes, or placements.

A very rough comparison is made of these results with those of the other 279 patients in the same building who did not participate in therapy. Of these, 13% left the hospital as compared with the 45% of the therapy group.

Again there is a theme evident here: There seems to be a relationship between earlier life experiences and environmental stresses and the development of so-called senile psychoses and, perhaps of even greater importance, there seems to be a relationship between the attitudes of responsible health personnel and the "fates" of the aged ill.

Section IV: The Functional Importance of Attitudes.

My final section is concerned with the functional importance of attitudes--attitudes of people toward their own aging and those of others toward the aging.

All of us have some sort of an attitude or set of attitudes toward our own later years. Whether verbalized or not we have had such attitudes since our early years and these turn out to be pretty important. Speaking generally it is probably safe to say that young people usually do not look forward with any particular relish to growing old. Without going into the whole history of the development of such attitudes, suffice it to say that there is this tendency to reject the idea of old age. Part of this may be determined by cultural mores and part, I am sure, arises out of attitudes

developed by children while growing up and passing through the socializing process required of them by their parents, teachers, ministers, truant officers and the other important elders in their lives. Too often during this process negative, antagonistic feelings toward these elders aid in the formation of elder-rejecting attitudes and feelings.

Theoretically, the next step would be that of not only a rejection of the idea of becoming old but in addition the rejection, passive or otherwise, of old people themselves, representing as they do symbols of the state of being which is both feared and rejected. Maurice Linden has described this state of affairs graphically as follows:

"In our society we are more subtle about such matters. We neither revere nor crudely discard the aged. But our passive neglect of them has caused annihilation just as surely as if our mode of action had been more direct. Witness youth who reject the protective caution of their elders as 'conservativism and fuddy duddyism.' Is not the reactive suffering of the older group, thus hastily by-passed in the stream of life, murderous? Witness industry that arbitrarily regards age 65 as the end of usefulness. Is not the mandatory retirement thus achieved a ticket to nowhere? Witness the physician, yes even the psychiatrist, the social worker, the counsellor, who, annoyed with problems difficult of solution, says, 'Well, what do you expect of older people? They're rigid, unyielding, unmodifiable, and cantankerous.' Is not the resultant do-nothingness an invitation to indolence, stagnation

and regression?"[12]

It should not be surprising, then, that when these same people do reach that age at which they overtly or covertly say, "I am old," they must reject themselves. In other words, their feelings previously directed toward elders are now directed toward themselves. This is, almost by definition, depression and melancholy accompanied by all the feelings of uselessness, low self-esteem, loneliness, and reduced self confidence usually associated with melancholia.

The roles of attitudes may be illustrated by two recent experiences. In talking to a group of some 100 or more middle aged and older women, I asked them quite spontaneously for a show of hands on the question, "How many of you are looking forward with positive attitudes (joy, pleasant expectations, enthusiasm) toward your later years?" One woman tentatively raised her hand and then took it down again. Afterwards she told me she would have raised her hand, but she didn't want to be the only one.

The second experience is related to this one. In lecturing to 34 senior nurses, I decided at the beginning of the lecture to use the same question with some elaborations. I asked them also how many were looking forward with these same positive feelings toward their next five years (ages 20-25); then the next 5 years (25-30); then the next 10 years (30-40); then the next 15 years (40-55) and finally to the following 10 years or more (55-65 or more). The results were about what you would expect. Favorable attitudes were expressed by all 34 girls to the periods 20-25

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12. Linden, Maurice E., "Emotional Problems in Aging." In The Jewish Social Service Quarterly. Vol. XXXI, Fall 1954. P.81.

and 25-30. Three girls defected for the period 30-40. Only 15 felt positively about the middle-age period from 40-55. None raised her hand for the 55-65 period!

When we discussed their reasons for these latter feelings, their general picture of the later years was marked by such words and phrases as the following: gloomy, dependent, poor health, insecure, lower prestige and status, useless, nothing to do, end of the road, burden on others, etc. The rest of my lecture was spent in discussing these attitudes.

Of equal, if not greater, importance are the attitudes of others toward the aging themselves. Not long ago I happened to be going up in an elevator in a large Iowa hospital along with two young residents. I couldn't help hearing and taking note of the following conversation:

Resident No. 1: "Where are you going?"

Resident No. 2: "Oh, I have a real interesting 27 year old patient to see up on 7." (Followed by a brief description of the patient and his problem.)

Resident No. 2: "Where are you going?"

Resident No. 1: "Oh, I have to see an 'old crock' on 5!"

This not uncommon attitude, which I call "old crockism," needs little comment on my part. What disturbs me most is that I find it so frequently among young doctors, psychologists, social workers, and even among teachers and ministers, though less outspokenly to be sure among the latter.

For a long period of years a similar set of attitudes were quite common with reference to psychiatry and psychology. Patients tried to hide the fact of their needing psychological treatment. They would go to appointments as surreptitiously as possible and their behavior was marked by feelings of shame at having what they apparently regarded as defects in character requiring psychological or psychiatric help.

Over the past several years these attitudes have been slowly changing. One feature of the change seems to have been the increase with which people have been able to relax a little and poke fun at psychiatry and psychiatrists. The change is so pronounced that I understand that in some Eastern cities a woman feels somehow left out of things at her afternoon bridge party if she cannot talk about "her psychoanalyst."

Well, for the past several years we have seen many people working on, with, and for the aged and whenever the subject comes up it seems to be accompanied by a clenching of the fists and a setting of the jaw and an expression of the attitude that this business of aging is a grim business and not one to be taken lightly either by the aging or by the gerontological worker. Now I see some hope rising over the horizon--people are beginning to poke a little fun at aging, too. And with it, it might be hoped, there may come some relaxation of feelings about the grimness of it all and a little better acceptance of aging as a normal, developmental phase of life.

Conclusion.

The examples I have presented and many others which time didn't permit even noting, serve to suggest that many of the problems ascribed

to the aging are not novel problems, but have their roots in earlier life experiences. The study and understanding of these earlier life events should be the key to understanding the aging process better; indeed this approach carries with it the hope of prevention rather than merely the detection and handling of already existing problems. What I am suggesting is that we must emphasize the continuity of behavior--continuity from phylum to phylum, continuity from normal to abnormal; and this applies also to personality development and to adjustment.

I have prided myself upon having arrived at this conception, which I consider a dynamic conception of the aging process. This possessiveness on my part, while naïve was not unhealthy. It turned out to be naïve because not long after I had first expressed it to some of my colleagues, one of them pointed out the similarity between it and the following quotation from Leonardo da Vinci: "In youth acquire that which may requite you for the deprivations of old age; and if you are mindful that old age has wisdom for its food, you will so exert yourself in youth, that your old age will not lack sustenance."

Another quotation expresses the same theme; one even older than that of da Vinci. This is from the Dialogues of Plato, Vol. II: "There is nothing which for my part I like better, Cephalus, than conversing with aged men; for I regard them as travellers who have gone a journey which I too may have to go, and of whom I ought to inquire, whether the way is smooth and easy, or rugged and difficult. And this is a question which I should like to ask of you who have arrived at that time which the poets call the 'threshold of old age'--Is life harder towards the end, or what report do you give of it?

"I will tell you, Socrates, he said, what my own feeling is. Men of my age flock together; we are birds of a feather, as the old proverb says; and at our meetings the tale of my acquaintance commonly is--I can not eat; I can not drink; the pleasures of youth and love are fled away; there was a good time once, but now that is gone, and life is no longer life. Some complain of the slights which are put upon them by relations, and they will tell you sadly of how many evils their old age is the cause. But to me, Socrates, these complainers seem to blame that which is not really in fault. For if old age were the cause, I too being old, and every other old man, would have felt as they do. But this is not my own experience, nor that of others whom I have known. How well I remember the aged poet Sophocles, when in answer to the question, 'How does love suit with age, Sophocles, --are you still the man you were?' 'Peace,' he replied; 'most gladly have I escaped the thing of which you speak; I feel as if I had escaped from a mad and furious master.' His words have often occured to my mind since, and they seem as good to me now as at the time when he uttered them. For certainly old age has a great sense of calm and freedom; when the passions relax their hold, then, as Sophocles says, we are freed from the grasp not of one mad master only, but of many. The truth is, Socrates, that these regrets, and also the complaints about relations, are to be attributed to the same cause, which is not old age, but men's characters and tempers; for he who is of a calm and happy nature will hardly feel the pressure of age, but to him who is of opposite disposition youth and age are equally a burden."

Finally, and a final blow to "my new conception" of the process of aging--this from the Book of Ecclesiastes, Chapter 12:

"Remember now thy Creator in the days of thy youth,

While the evil days come not, nor the years draw nigh,

When thou shalt say 'I have no pleasure in them'."

NATIONAL AND REGIONAL PROGRAMS IN GERONTOLOGY

Amelia Wahl*

You have undoubtedly heard from your various lecturers during this workshop that there are some 18,000,000 persons 65 years of age and over in our population. Concern on the part of our Federal government has been expressed through proposed and enacted legislation with regard to this segment of our population and I should like to describe some of these programs.

The one Cabinet level department which covers a broad spectrum of human needs is the Department of Health, Education and Welfare. Some of the other departments touch upon the welfare of many older persons but I think one can safely say that the Department of Health, Education and Welfare has the broadest coverage. Yet, one can carefully study each individual program and find there are gaps in service and limitations in programming.

The Department of Health, Education and Welfare was established in the Eisenhower Administration although most of the programs within it had been in operation a good deal longer. The Department is a Cabinet level office having a Secretary appointed by the President. Within the Secretary's office are a Deputy Secretary and several assistant Secretaries in charge of some program area. Subordinate to the Secretary are the

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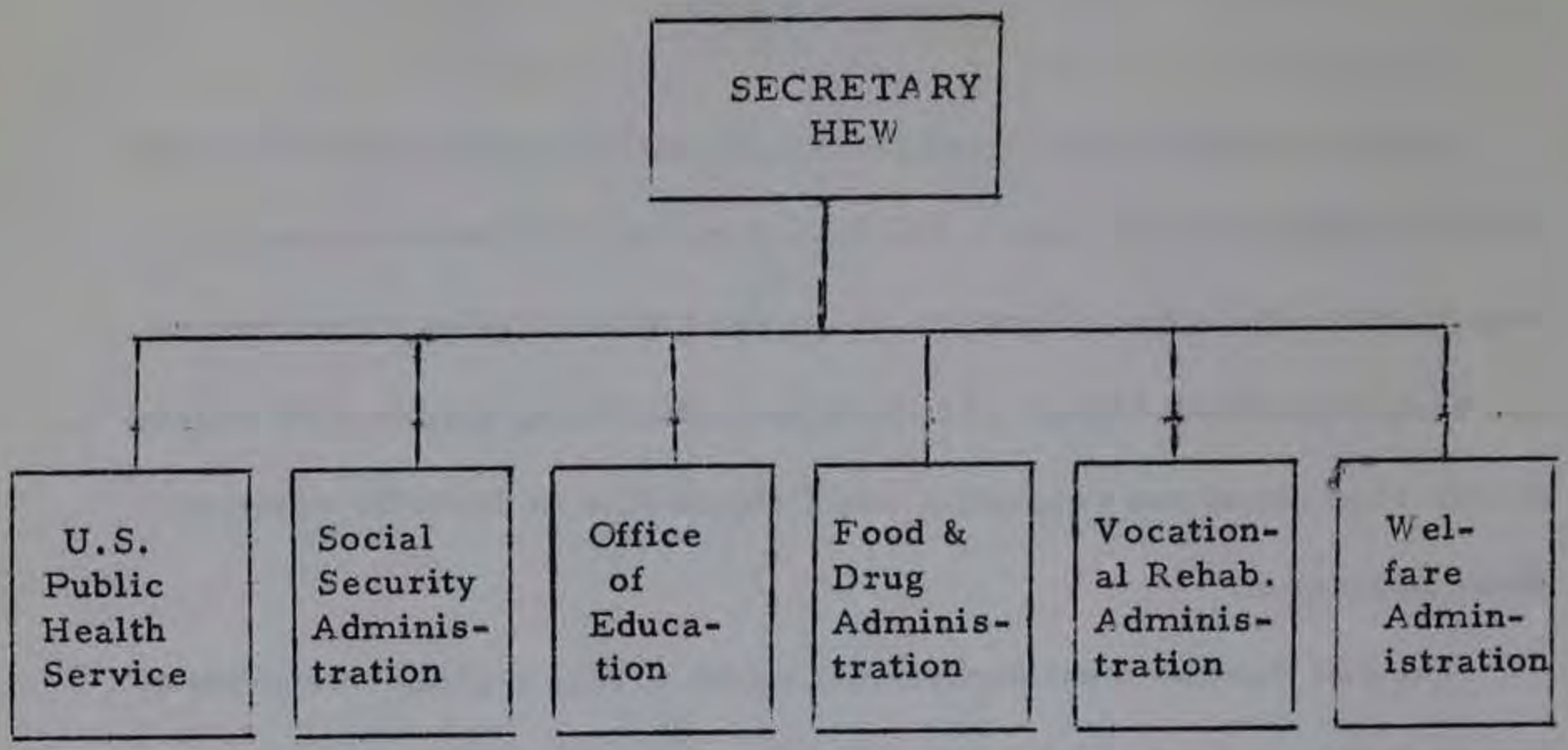
various health, education and welfare programs with an organizational pattern looking something like this:



The Department, in addition to the central office in Washington, has nine regional offices, one of them being located in Kansas City, known as Region VI. The States in this region are Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota and South Dakota.

The U. S. Public Health Service is the oldest of the Department of Health, Education and Welfare programs. To give you some picture of the size of this program, the total expenditures for one year have been $1,545,619,000. Almost 60 percent of this amount was allocated to the National Institutes of Health. A little over 77 percent through NIH went for non-Federal research institutions and individuals for research projects, research training, and construction of research facilities. One of the institutes within NIH is the National Institute of Mental Health which disburses a large share of these funds in the mental health field for research, training and demonstration projects. I imagine there are a number of

departments here at the University of Iowa which have received or are receiving a grant for some kind of research. I can recall one specific research project in the social field which was conducted by your School of Social Work here at the University of Iowa. A report stemming from this study is titled "A Comprehensive Analysis of Health and Welfare Services for Older Persons in One Community." The study was conducted in Cedar Rapids, Iowa, and was part of a larger study receiving a grant from the National Institutes of Mental Health. There are, of course, many other programs in the Public Health Service such as in heart, cancer, diabetes, chronic diseases, accident prevention, communicable diseases, community health services, dental health, occupational health, and hospital and medical facilities. Most of these departments are also available in the regional office. An example of one of these programs and its relationship to aging is the Chronic Diseases Program in the Bureau of State Services which administers through the Regional Office a formula-grant program to State Departments of Health. The formula-grant program is on a 50-50 matching basis for chronic disease projects which vary according to a State Plan submitted by each Department of Health. Examples of two here in Iowa receiving formula-grant funds through the State Department of Health are the Nursing Administrators Training Course which the Institute of Gerontology is conducting and the Earlham Care Program in Earlham, Iowa.

There is also a Gerontology Branch in the U. S. Public Health Service which has funds available for demonstration programs in health as well as in research and training.

The Social Security Administration in the Department of Health, Education and Welfare perhaps touches upon more of the elderly than any other program. More than 90 percent of persons 65 and over are now covered by Social Security benefits. This program was started through the passage of the Social Security Act in 1935 which provided that each employee contribute a certain percent of his salary to the Social Security Trust Fund to provide for insurance protection in the retirement years. An employer matches the amount which the employee contributes. Throughout the years the Social Security program has been liberalized so that more workers are covered and benefits are higher. Persons may now choose to receive Social Security benefits at 62 years of age rather than 65, and the disabled are recipients of Social Security benefits at any age in which it is determined they are totally and permanently disabled. Of course, a recipient of Social Security benefits must have a certain amount of coverage or have paid into the system a certain specific amount of time in order to be eligible. As of one specific month, there were some 321,777 persons 62 years of age and over in Iowa receiving Social Security benefits and some 16,315 receiving disability benefits. As you know, there has been for a number of years a Bill in the Congress providing for benefits to cover costs of hospitalization for the elderly but this Bill has not been passed as yet.[1]

The Office of Education is primarily concerned with impacted school districts and defense education activities. There is a Cooperative Research

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1. Editor's Note: At the time of the publication of this document, the Hospitalization Benefits through Social Security were passed by the Congress in 1965.

program within the Office of Education which has moneys available for research in adult education. These moneys are available to universities and State Departments of Education.

You perhaps are familiar with the Food and Drug Administration in that this program keeps a watchful eye on consumer items in the food and drug field.

The Vocational Rehabilitation Program is administered as a grant-in-aid program through State Divisions of Vocational Rehabilitation for the rehabilitation of the physically and mentally handicapped to gainful employment. You probably have a number of students here at the University of Iowa receiving assistance through this program.

The largest expenditure for program is probably in the Welfare Administration. Total Welfare Administration expenditures in one year were over $3,094,844,000. In the Welfare Administration, there is the Public Assistance program of payments for Old Age Assistance; Aid to the Blind; Aid to the Disabled administered by the Bureau of Family Services through the State Departments of Public Welfare. Through the Bureau of Family Services, efforts are being made to stimulate the provision of Consultants on Aging in the State Departments of Public Welfare. A number of State Departments of Public Welfare do have these positions filled. Other programs of the Welfare Administration are the Children's Bureau, the Juvenile Delinquency Program, Cuban Refugee Program, and the Office of Aging.

The Office of Aging is a small progam in comparison to the others, having a budget a little over $500,000. This office was formerly the Special Staff on Aging in the Secretary's office. It was the Special Staff

on Aging which administered the 1961 White House Conference on Aging. The present role of the Office of Aging is to stimulate programs for older persons in a broad spectrum of health, education, social services, recreation, research, training, pre-retirement counseling, etc. This office acts as a clearinghouse for information with regard to the elderly. Presently, this office does not have a grant program. There are, however, two Bills before the Congress requesting appropriations for demonstration, research and training moneys. One Bill, called the Administration Bill, requests appropriations for grants to the States for demonstration projects, research and training in the field of Aging as well as moneys for the construction of Activity Centers for older persons and moneys for demonstration projects to develop part-time employment for persons 65 years of age and over. Another Bill introduced by Congressman Fogarty and Senator McNamara provides appropriations to States and local communities for demonstration projects as well as for research and training in the field of Aging to nonprofit organizations and institutions.[2]

The Office of Aging, in addition to being a clearinghouse of information, works with the States in the development of programs for older persons. State Commissions on Aging have been adopted through legislative action in over half of the States. In this region, only one of the States, Minnesota, has a Governor's Citizens Council on Aging established by the legislature. Iowa, although ranking first in the nation in percentage of persons 65 years of age and over in its population, does not have such a State body solely

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2. Editor's Note: At the time of this publication, this Bill, The Older Americans Act, was passed and signed by the President in July, 1965. The Office of Aging will become a separate Administration on Aging in the Department of Health, Education and Welfare.

concerned with programs for older persons although the Governor in late 1963 appointed a bi-partisan legislative Governor's Committee on Aging to study the feasibility of such a Bill. Representative Tom Riley of Cedar Rapids is the Committee Chairman. The first meeting was held in January of this year, and further meetings are planned for the fall to determine whether a Bill should be presented to the 1965 Iowa General Assembly.[3] Communities in Iowa are quite active in programs for older persons in spite of the fact there is no coordinating body at the State level. One of these very active programs is the Earlham Care Program of home care services which has received national recognition. A meals-on-wheels program is operating out of a hospital setting in Ottumwa and a very active Homemaker Program exists in Des Moines, to name just a few. The Earlham Program and the Homemaker Program in Des Moines are programs stemming from the State Department of Health.

Regionally, there is one program which was organized as a result of activities for the 1961 White House Conference on Aging which may be of interest to you. As a result of the Five State Surveys of Older Persons, a Midwest Council for Social Research in Aging was organized. Iowa was one of the States conducting these surveys and has been a participating member of the Midwest Council through your Institute of Gerontology. The Midwest Council has a membership of universities and colleges in a nine State area, including Iowa, Illinois, Wisconsin, Missouri, Kansas, North

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3. Editor's Note: At the time of the publication of this document, the Iowa Legislature passed the Iowa Commission on Aging Bill with an annual appropriation of $26,500. Two other States in this Region passed similar legislation. North Dakota passed a Bill creating a Governor's Council on Human Resources and Nebraska passed a Bill creating a Nebraska Advisory Committee on Aging.

Dakota, South Dakota, Minnesota, and Nebraska. This group has been holding research seminars and conducting research in the social aspects of aging. A bcok is being published, "Older Persons and Their Social World," edited by Arnold M. Rose, Ph.D., of the University of Minnesota, and Warren A. Peterson, Ph.D., of Community Studies, Inc. While in the initial stages of development the Midwest Council received funds from two private foundations, the Kansas City Association of Trusts and Foundations and Hill Foundation of St. Paul. Now, the Midwest Council has funds from the Gerontology Branch for support of the research seminars.

Before closing I should like to mention a few programs in other departments of the Federal Government which also have an impact upon the well-being of our older population -- one of these, the low-rent housing program of the Public Housing Administration. Through the Housing Act of 1937 and its later amendments, the Public Housing Administration is providing housing designed specifically for persons 62 years of age and over. The low-rent housing program provides for the construction of individual efficiency or one bedroom units with kitchen facilities. The rentals are at prices which older persons can afford to pay on their reduced incomes. The rentals are established within limits by a Local Housing Authority. Each local authority is governed by local commissioners (usually five) who are appointed by the Mayor or governing body and who usually serve without pay. The Local Housing Authority must be self-supporting obtaining its revenue from the collection of rentals which must pay for the salary of an Executive Director (part-time or full-time depending upon the number of units); utilities and maintenance. The Local Housing

Authority plans, builds, owns and operates public housing and is an autonomous public corporate entity.[4] In addition, while the Local Housing Authority is a tax exempt institution, it is allowed to pay to the local taxing body payments in lieu of taxes up to 10% of the shelter rents. Obviously, the low rentals which may range on an average of $28 - $32.50 per month would not be sufficient to pay off much, if any, of the principal and interest involved in the cost of construction. The construction cost is actually borne through the sale of municipal bonds to private investors which bonds are actually insured by the Federal Government. Each year the Public Housing Administration, in accordance with an Annual Contributions Contract worked out with the Local Housing Authority before construction begins, makes an annual contribution over a 40-year period to retire the bonds. Through this procedure, the low-rent housing program, in any given community, is a 100% federally subsidized program. The only expense which a community incurs for a low-rent housing program is to implement over a period of time the housing code enforcement and community improvement agreed upon at the outset.

In addition to the construction of the low-rent dwelling units, construction of community center space is also allowed. About 25 square feet of space is allowed per unit for an Activity Center which space is used for recreation and social activities for the residents and the community. Although stove and refrigerator are furnished for the Community Center, the community must provide the furnishings and programming of the Center.

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4. Public Housing Fact Sheet, Housing & Home Finance Agency, Public Housing Administration, Washington, D. C. December, 1964.

In addition to the community center space, 5 square feet of space per dwelling unit is allowed for a health clinic. The arrangements for programming of the health facility might be worked out with involvement of County and State Health and Welfare agencies.

The Housing and Home Finance Agency administers the Public Housing Administration program of low-rent housing (PHA); the Community Facilities Administration (CFA) program of Direct Loans at reduced interest rates to nonprofit groups to construct housing for the elderly; and the Federal Housing Administration program (FHA) which is a mortgage insurance loan program to private and nonprofit groups. The Department of Agriculture through the Farmers Home Administration administers a housing construction program for the elderly in communities of 2500 or less population.

I might mention one more department program and that is the Small Business Administration (SBA) in the Department of Commerce. The Small Business Administration has loans available at reduced interest rates for the development of small businesses which retired persons could undertake. Also, the Small Business Administration has organized in its regional offices a retired business executives consulting group known as SCORE or Service Corps of Retired Executives. This group is available to assist small businesses which have management problems or assists new groups in starting out in a new business. Certainly this is one way of utilizing the resources and talents of our retired population.

As you can see, each of these programs can have a full time class discussion and barely scratch the surface in all the ramifications of any one program itself. I do hope this gives you a picture of some of the Federal

programs and I might hasten to add "all of these are only as good as the State and local communities wish to make them." If you have any further questions on any specific program I shall try to answer or get the answer for ycu. In any event, I should like to take this opportunity to express my appreciation to the Department of Home Economics and Institute of Gerontology at the University of Iowa for their interest in aging shown through this workshop.

FOOD FOR THE AGING

Margaret A. Ohlson, Ph.D.*

"Methuselah ate what he found on his plate,
And never, as people do now,
Did he note the amount of the calory count;
He ate it because it was chow.
He wasn't disturbed as at dinner he sat,
Devouring a roast or a pie,
To think it was lacking in granular fat
Or a couple of vitamins shy.
He cheerfully chewed each species of food,
Unmindful of troubles or fears
Lest his health might be hurt
By some fancy dessert;
And he lived over nine hundred years."

---Unknown.

It would be interesting to know what Methuselah ate but it would be equally interesting to know what he was like during his life span.

One of the real problems in evaluating the food needed in aging is the lack of a standard of what constitutes a well nourished adult at any age. The midwest farmer, feeding cattle for market, has a clear cut picture of a well finished market animal and his feeding plans are structured to create this animal. In feeding man, we obviously are interested in longevity rather than market finish and the required diet undoubtedly is quite different. Experiments with rats have demonstrated that longevity can be achieved by feeding a ration suitable for adult maintenance but at a fraction of the usual amount consumed by the rat allowed to eat ad libitum. These animals do not mature at the usual times and with the

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most restricted diets, do not reproduce.[1, 2] For man, longevity without the ability to compete in an adult world could be burdensome.

There is, at all ages, wide variability in the plane of nutrition within any group of people. Variability increases with age. We express differences by such generalized terms as "well nourished," vigorous, flabby, lacking in vitality, and tend to be baffled by the patient who is chronically tired but has no evidence of disease to explain the symptoms. Many social and emotional factors may have contributed to the general lack of health of this patient but the probabilities are that all of these factors have acted to reduce the intake of nutrients even though the patient may be ingesting enough calories to support unwanted pounds of weight. A prescription for vitamins seldom solves this problem. There is essentially only one measure of nutrition for the adult for which there is general agreement, and that is that he should not continue to gain weight after growth is complete.

Some years ago, a woman was referred to us for instruction in a diet to bring about a 25 pound loss of weight.[3] She was a flabby, white, unthrifty looking woman with obvious lack of energy but was not obviously edematous. She had been treated for more than a year for a persistent normocytic anemia with all of the usual iron and vitamin combinations. There had been some temporary improvement but no prolonged remission. Her diet history suggested erratic eating with emphasis on sugars and sweets but little good quality protein. She was given 90 grams of protein, largely from animal sources, and 1400 colories and complained bitterly that we were forcing her to eat so much that she would not lose weight.

The first six weeks on the diet justified her interpretation as no weight was lost, although her appearance improved and she obviously felt better. At this time she suffered a diuresis lasting about 3 days during which she lost 15 pounds. She also lost much of her appearance of flabbiness and both the red cell count and the hemoglobin increased to within normal values. For the next few weeks she continued to lose slowly and was eventually stabilized on an intake of about 2000 calories and 70 to 80 grams of protein. A year later she had required no further treatment for the anemia, was well and active, and had maintained her weight.

Weight loss in an outpatient is always difficult to achieve but may be particularly discouraging in the older person who may present himself with the results of years of poor eating practices. There is little doubt that the woman described in the case study was building lean tissues at the same time that fat was being burned. The prompt remission of the anemia is a key to this concept as is the fact that this type of response to high protein, calorie restricted diet in a flabby adult is always associated with a reduction in dress size and an appearance of improved muscle tone before weight losses can be measured by the scales. It is easy for both the doctor and the patient to become discouraged before these adjustments are complete and to give up rather than persist in the diet. Diets of 1000 calories per day for an averaged sized adult, may provide calorie to protein ratios too low for retention of protein to occur and replacement of lean tissues does not take place in the flabby patient. Weight is lost with difficulty and without improvement in well being. A more generous intake of calories will mean slower

weight losses but a patient with poor muscle tone and limited vitality who loses weight on a well balanced diet always has an increased sense of well being after several weeks of dieting.

It is generally accepted that total calories must be reduced with increasing age and reduced activity if undesirable weight gains are to be avoided. It is not as well understood that nutrients and calories occur together in foods and a prescription to eat less is apt to be interpreted as less of everything. Diets of one hundred white women, forty years of age and over, were measured over a period of time and the nutrient intakes estimated.[4] With each reduction of calories, an equivalent reduction in protein, the "B" vitamins, iron and calcium was found. When more than 2000 calories were eaten each day, nutrients obtained were within the range of accepted standards. When only 1000 calories were taken, all nutrient intakes were less than two thirds of accepted standards with the exception of ascorbic acid and Vitamin A which reflect the use of fruits and vegetables but not the staples of the diet.

This is not to suggest that sufficient nutrients cannot be crowded into 1000 calories of food but to point out that few people achieve this happy result when they reduce their intakes by "just eating less" although all too often this is the advice which is given the aging man or woman.

A basic diet plan providing 1000 calories is given in Table 1. This diet meets the minimum daily dietary allowances of the Food and Nutrition Board.[5] It does not, however, provide sweets, dressings or gravies,

TABLE 1, continued

ADDITIONS OF FOOD TO PROVIDE 1800 CALORIES

Food Group	Amount used	Calories	Protein GM	Fat GM	Carbo-hydrate GM	Calcium GM	Iron MG	Vit. A I.U.	Thiamin MG	Ribo flavin MG	Ascorbic acid MG
Apple pie	1/7 pie	330	3	13	53	0.09	0.5	220	0.04	0.02	1
Rolls, plain enriched	2 rolls	230	6	4	40	0.06	1.4		0.22	0.14	
Table fat[4]	3 pats	150		18				690			
Salad dressing blue cheese	2 tsp.	60		6		0.08		20			
Sugar and jelly	3 tsp.	50			12						
TOTALS		1854	85	79	217	0.90	11.9	3410[5]	1.62	1.76	104
Dietary allowances for adult man[6]			70			0.80	10.0	5000	1.50	1.80	75

3. No added sugar.

4. Calculated as enriched margarine.

5. Would be increased to meet allowances by use of carrots, sweet potatoes, or a deep green vegetable such as broccoli or greens about twice per week.

6. Food and Nutrition Board, National Research Council.

TABLE 1

NUTRIENT[1] PROVIDED BY A 1000 CALORIE, BASIC DIET AND THE SAME DIET SUPPLEMENTED TO PROVIDE 1800 CALORIES

Food Group	Amount used	Calories	Protein GM	Fat GM	Carbo-hydrate GM	Calcium GM	Iron MG	Vit. A I.U.	Thiamin MG	Ribo flavin MG	Ascorbic Acid MG
Meat, fish	6 oz.	354	48	18		0.02	5.0	500	0.25	0.35	
Milk, nonfat[2]	1 pint	180	18		26	0.40	0.2	20	0.20	0.88	4
Starches	3 serv.	180	6	2	40	0.40	1.0		0.60	0.15	
Vegetables											
root	1 serv.	50	1		15	0.07	1.5	500	0.14	0.06	10
green or yellow	1 serv.	30	1		8	0.08	1.5	500	0.10	0.10	25
Fruit[3]											
High ascor. acid	1 serv.	40	1		8	0.03	0.3	120	0.06	0.03	60
Other	1 serv.	50	1		15	0.03	0.5	150	0.01	0.03	4
Table or cook. fat	3 pats	150		18				690			
TOTALS		1034	76	38	112	0.67	10.0	2480	1.36	1.60	103

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1. Nutrients chosen for this example are those not widely distributed in foods. If these nutrients are present in suitable amounts in the diet, the association of other nutrients in food groups is such that there is a high probability of the whole diet being adequate. If any food group is omitted, the nutrients of that group must be provided elsewhere in the diet.

2. Milk includes not only fluid milk but all canned, dried or processed products as buttermilk, yogurt, cottage cheese, other cheeses but excluding cream and butter. The nutritive contribution is calculated as the non fat solids of 1 pint of fluid, skim milk. Whole milk, cheese and some processed products would include fat, Vit. A and calories in relation to the amount of fat in the products added.

or alcohol and, if any of these are taken and substituted on an equicaloric basis for the food outlined in the table, one or more nutrients will be taken at less than desirable amounts. Calories may be added from almost any source the patient wishes, if the basic food pattern is included first as demonstrated in the lower half of Table 1. Table 2 shows how these menu patterns can be converted into meals.

In the group of aging homemakers studied, the noon meal was the least well planned and consequently the lowest in the contribution of nutrients. The correlation between regular eating practices and adult vitality in the ages between seventy and ninety was high. The hundred women were followed over a period of eight years during which time patterns of eating changed very little.

In contrast, a group of younger women selected because education and social status suggested that they might be able to use such sound nutritional material as they received through public media and from their doctors, adjusted food choices over a 20-year period and actually increased the total amounts as well as the ratios of protein and other nutrients while decreasing intake of calories. Iron was the only nutrient not supplied in desirable amounts largely because these younger women chose to augment their diets with more milk rather than meat and they chose to decrease calories by omitting cereals rather than the dessert.

Throughout adult life, the man has certain advantages over the woman in maintaining good nutrition in that his food requirements are on the average about twenty-five percent more than those of the woman, assuming equal activity. As pointed out above, the more food eaten the

TABLE 2

MENUS BASED ON DIET PLANS IN TABLE 1

Meal	1000 Calories	1800 Calories
Breakfast	Oatmeal with skim milk and fresh strawberries Black coffee or tea	Oatmeal with skim milk and fresh strawberries 1 poached egg on 1 slice toast 1 teaspoon butter Black coffee
Lunch	Casserole of 1/2 c. cooked rice 2 oz meat or fish 1/4 c. tomato puree 1/2 onion precooked with 1 teaspoon oil Top with crumbs from 1 soda cracker Half grapefruit Coffee or tea	Casserole of 1/2 c. cooked rice 2 oz. meat or fish 1/4 c. tomato puree 1/2 onion cooked with 1 teaspoon oil Top with buttered crumbs from 2 soda crackers Half grapefruit 1 teaspoon sugar 4 oz. skim milk Coffee or tea if desired
Dinner	4 oz. minute steak Buttered beets Tossed green salad with lemon juice 1/2 half dinner roll 1 teaspoon butter 4 oz. Junket made with skim milk and artificial sweetener Coffee or tea	3 oz. minute steak Buttered beets Tossed green salad with 2 teaspoons blue cheese dressing 2 dinner rolls 2 teaspoons butter Apple pie, 1/7 of a 9" pie Coffee or tea
Bedtime	6 oz. skim milk	6 oz. skim milk

greater the probability that a complete diet will be obtained. This does not preclude undernutrition in the aging man but when it occurs, it is apt to be related to the loss of the wife who has been responsible for food preparation or the loss of mobility to shop for food whether from the grocery or the restaurant. Ours is a "cash and carry" economy and the "carry" can be difficult with a cane in one hand. Moreover, the sources of food supply are not always centrally located. Thus improving the diet of an aging man usually means tapping community resources to provide food and a simple instruction in the elements of a good diet is not enough. Surveys of adult diets in our population nearly always report a large portion of the sample to be ingesting less calcium than recommended by the Food and Nutrition Board[6] and that intake of calcium tends to decrease with age. Evidence that demineralization of the bone may be fairly common in the aged man as well as the woman, though of lesser degree, also has been reported.[7] It is agreed that many factors contribute to loss of mineral from the bones of the aged but many people prescribing diets seem not to understand the practical point that other nutrients needed for bone formation and maintenance are provided in the diet which will supply 800 to 1000 milligrams of calcium per day because this diet will include generous amounts of fruits and vegetables as well as some non-fat milk solids. Drinking fluid milk is not necessary. The essential non-fat nutrients of milk are found in many products as cheese, buttermilk, dry milk solids, canned and evaporated milks, yogurt and the like, all of which are useful adjuncts to cookery.

Adaptation to low calcium intakes is amazingly effective in many people but during the years from forty to sixty a significant number of women excrete more calcium in the urine than found in healthy younger people at the same levels of intake. Unless the calcium ingested averages about a gram per day under these conditions, calcium is lost from the body.[8] The work of Malm[9] would indicate that the same finding is characteristic of a portion of the male population though it may be at an older age range than found in women.

The capacity of the aged to use food in rebuilding body tissues in the presence of disease has been demonstrated on many occasions. Several years ago, through the courtesy of the physicians in charge of the Saginaw County Hospital at Saginaw, Michigan,[10] we were privileged to study a man of 70 admitted with severe pulmonary tuberculosis of a year's duration. On admission he was too ill to weigh and was assigned to the critical ward. After 6 months of conventional therapy, he was still in a critical state. Whole blood and plasma were given and within six weeks the patient was able to eat a concentrated soft diet of 2200 to 2500 calories and 100 to 125 gm. of protein. At this time he weighed 46 Kg.

Because of the condition of the patient, a complete balance study was considered impractical but food intake was recorded, aliquots provided for the laboratory and complete urine collections were made. If an allowance of two grams of nitrogen per day be made to include stool and other losses, this man retained from 2 to 8 grams of nitrogen per day during 5 months of continuous study. After a rest period of two months, he was again studied during the 16th and 17th months of hospitalization

and retained approximately 4 grams of nitrogen per day. Weight gains were continuous from the beginning of special nutritional measures and totaled twenty-three kilograms. He was discharged as clinically well after sixteen months of special attention to nutrition as well as his disease. It is not to be assumed that diet cured this man's tuberculosis but diet undoubtedly was a factor in making it possible for the drug therapy to be effective.

Many critically ill patients now receive tube feedings until sufficient strength is recovered to allow them to eat. Both the heavily reinforced milk formula and a total blended and homogenized diet are suitable for these feedings.[11] It is our impression, though the data on utilization are limited,[12] that the aged individual does very well on less concentrated formulae than usually recommended and has fewer complications of diarrhea and vomiting. In this respect, the whole blended meal has proved useful as it simulates in composition the food to which the patient's gastro-intestinal tract is accustomed and, due to the tendency of protein food to gel when blended, it is not possible to make a more concentrated mixture than 50 grams of protein per 1000 calories and have free flow through the tube. Rehabilitation with this mixture is rapid in the absence of disease.

The whole, blended meal requires specialized equipment not usually found except in a large general hospital but a mixture of milk and eggs, cooked into a soft or stirred custard, can be sipped or given through an intragastric tube. Sugar or light cream will add extra calories but the calorie needs of the aged are not large and added sugars

and fats sometimes precipitate gastro-intestinal upsets not encountered in the younger patient.

In an aging population many patients present evidence of chronic undernutrition as well as chronic disease. Their eating practices are well established and change requires specific instruction on the selection of suitable food. The new diet should be planned, if possible, on the patient's usual dietary pattern to take advantage of existing habits at the same time that the patient is asked to make certain changes. This approach may be time consuming at first as it supposes exploration of the patient's eating practices but, in the long run, can be rewarding as change is accepted and put into practice.

The capacity of the aged for nutritional rehabilitation is excellent and attention to nutrition may aid in the recovery from disease.

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RESEARCH IN CLOTHING PROBLEMS AND CLOTHING BEHAVIOR OF OLDER WOMEN

Adeline M. Hoffman, Ph.D.*

Introduction.

Clothing is a persistent center of interest in the lives of all people, though it varies greatly in intensity and in manner of expression. From the cradle to the grave, people are eager for the attention and approval of others, and it is in this interpersonal relationship that clothing plays its major role. As an outward expression of personality and social identity, clothing is most important and is often used as a basis of personal appraisal before there is opportunity for acquaintance. In studying the needs and problems of older people and areas of behavior which might be effected by age increments, clothing takes on a special significance. Not only is clothing of great importance in the appearance of individuals, but it is also a major area of expenditure and therefore, poses certain economic problems.

Economic Problems.

Persons aged 65 and over comprise about ten per cent of the total population. Though their clothing needs are much the same as those of younger people, they also have some special needs which may be age

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related. The problem of how to merchandise to this age group is beset with difficulties. If a new category of clothing was developed or a separate department set up labeled for older people, this in itself would pose a problem, since women emphatically do not want to be identified by age. Thus it is difficult to promote to older woemn and tap this increasingly large older market. In our youth oriented society, in which many women very reluctantly admit to advancing years, it is unlikely that they would be willing to shop in a department clearly marked for older women. Yet the potential is there in increasing numbers. However the clothing may be arranged and labeled, manufacturers have not, as yet, taken into consideration the wants and needs of the older market. The focus is there through the sheer weight of numbers and it will probably be only a matter of time till manufacturers recognize the need and provide the merchandise.

Authorities are not in agreement on levels of income for older couples and older individuals and the percentage that fall into specific income brackets. However, they do agree that the percentage of income spent for clothing decreases with increasing age at all income levels. Reasons given for this pattern of expenditure are that the need for clothing decreases with curtailed social activity, resulting in less wear and tear on clothing and less need for replacement. Reluctance to fashion change and the purchase of more conservative clothing is another reason given for reduced expenditures for clothing among older people. How much less older people spend for clothing compared with other age groups depends somewhat on the specific group represented

in the statistics from which generalizations are drawn. It is reported that among the very low income groups, there is almost no expenditure for clothing at all since these people depend largely on used clothing which is given to them by individuals and social service groups.

Among older people with fixed incomes from various sources including retirement plans, social security, insurance and the like, it is pointed out by some market researchers that expenditures for clothing are higher because many of the older people do not need to save money from their current incomes and in addition, their living expenses are easily covered by their incomes.

Changes in Body Proportions.

Some writers have provided detailed information on changes in bodily proportions that occur with time which effect the way clothing fits. There may be a decrease in stature due to changes in the spine, an increase in bulk in the hips, thighs, abdomen and waistline often to the extent that there is little or no waistline, rounded shoulders and sagging bustline. These changes often create fitting problems that necessitate costly alterations. One chain of women's clothing stores which has its clothing manufactured to order, takes this into consideration in terms of size range rather than size designation.

Psychological Aspects of Clothing and Appearance.

If old age is accepted as a natural part of life rather than simply the loss of youth, effective use of clothing will present the same challenge as in the earlier years instead of something very much more

personally. For this reason, compliments should be carefully worded so as to really sound like compliments instead of sheer judgments. If you say "it's the best looking dress I ever saw you wear," you infer that you didn't like the others. If you say "I always liked that coat," you infer that the coat is getting quite old and it may be time to get a new one. In the event that you compliment the hat of one person when one or two others are present and also wearing hats, you might offend those you do not compliment by inferring that they are less worthy of such recognition than the one you do compliment. If you simply say you like the garment in question or it is very beautiful, you can be sure to compliment without offending.

The word suitability in relation to clothing for older women is sometimes mentioned, but suitability of clothing to the age of the wearer is a moot question. No one has ever defined suitability in this regard. General attractiveness is based on harmony in color, design and texture within the total ensemble, good fit and due consideration to personal coloring which might be enhanced through skillful use of cosmetics. Dressing like a museum piece calls attention to age as does dressing like a child or adolescent. Design features which many older women often look for and cannot readily find in clothing are sleeves in three quarter length or just above the elbow, skirts with a slight flare, necklines not extreme in width and depth, and openings not hard to reach and fastenings not hard to manipulate. Beauty shop patronage among older women usually decreases as income and social participation decreases, but it usually increases among older

women who are not limited income-wise and whose social life goes on as usual.

Because there is morale value in new clothing, it is not recommended that old people stockpile clothing for a few years ahead when preparing to move into a retirement home or other housing facility for older people. The fashion element in new clothing is always stimulating and newness is always exciting. From new clothing, one gets the feeling of being in the mainstream of life, the parade of life rather than on the side lines. A woman who moved into a retirement home made some quick observations and said that she told her son-in-law that she would have to have six new dresses if she was to associate with the other women in the home. Another older woman preparing to move into the home of her daughter and son-in-law gave much consideration to her wardrobe in order to make a place for herself socially in the new community rather than just be labeled the old mother who has come to live with her daughter.

Problems in Research with Older People.

There is much to consider in undertaking research with older people. Those who engage in such research need to consider their own attitudes toward older people. If they have negative feelings and think of older people as curiosities or if they identify too closely with them so that they see in them their own parents or themselves some years hence, it may be difficult to be objective and do good research. Research workers must understand that older people are individuals,

they should be respected as individuals and they should not be considered to be of lesser value because they are old. Research workers must also understand that older people of today may have a different standard of values from that of today's young adults. Such standards develop over a period of time beginning with early childhood and do not always change with the times. Thus older people may have different ways of looking at material wealth, its magnitude and its use. Many older people who cooperate in research work and are interviewed may not be college graduates or even high school graduates and the research worker needs to understand that everyday language is preferable to academic jargon and that two syllable words may have greater communicative value than four syllable words.

There are many problems inherent in research dealing with older people and one of the most difficult is that of sampling. There is no easy way to obtain the names and addresses of older people who are in good health, living in their own homes or apartments, ambulatory and representative of normal older people. Older people have to be sought out individually. There are no lists available except of those who are institutionalized, this small proportion would not be representative of the older population as a whole. Church membership cards do not record age and even friends do not know exact ages. Membership lists may be out of date and some people still appearing on the lists may have moved away from the community or may have died. Even if up to date membership lists were available, the use of specific organizational groups would in itself introduce an element of bias in the

sample since it would not represent all older people.

After a list of individuals has been compiled and a sample has been drawn, it is not unusual for people to refuse to cooperate or for younger members of the family to refuse for them. Most frequent among the reasons for refusing are: fear that confidential data may become known to friends or that it may be published; fear that someone is really selling something rather than conducting research; fear of admitting a stranger to one's home because of recent frauds and swindles, and fear of someone checking on them if they are on pension or other such income. One more reason for refusing to participate in any aspect of aging research is that people feel that this identifies them as "old" and they do not consider themselves to be old and do not want to be identified with a group of older people. In addition to refusal to participate, there is another reason why samples do not always remain intact. In the interval of time between drawing the sample and beginning the research, some of the people in the original sample might be lost through death or removal to another community some distance away.

Problems in Interviewing.

In interviewing older people, there are several problems not inherent in interviewing younger people. Those older people who have a degree of deafness are difficult to interview since questions need to be repeated which takes time and patience. They may be too embarrassed to continually ask to have questions repeated and simply answer "yes" or "no" questions without really understanding the questions adequately.

Loss of memory is also a limiting factor since so much data in behavioral research depends on what the person can report from earlier stages of life. Length of interviews must be limited in accordance with the short attention span of many older people. It is not unusual for some to fall asleep during the course of the interview. Conditions of health may also pose a problem. Even though people have agreed to be interviewed, and dates have been set for the interviews, they may be ill at the time or not well enough to be interviewed. However, at the other extreme, some older people like to be interviewed and have an opportunity to talk about themselves and are likely to provide much extraneous information in addition to answering the questions. This requires tact and patience on the part of the interviewer. Then there may be some older people who have a very active social life and may be too busy entertaining or being entertained, and people who are free to travel may be far off at the time of the scheduled interviews.

Research Objectives and Current Research in Iowa.

The broad objective in research in clothing problems and clothing behavior of older women is to finally identify problems and behavioral characteristics which may be age related. In conducting such research, considerable effort is directed toward a study of social, cultural and economic background factors and their relationship to clothing problems and clothing behavior in order to get a measure of the significance of these relationships compared with age as a main variable. The first piece of research in this field was done by a graduate student at the

University of Iowa, using a sample of women age 65 and over in Iowa City. This work was completed in 1963 and the student was awarded a Master's degree. A later study undertaken by a graduate student, in this same area, was based on a sample of rural women in Johnson County. This study, now in progress, will parallel, to a certain extend, the earlier study in which a sample of Iowa City women was used. A third study, also in progress at this time, on clothing problems and clothing behavior of older women, is based on a more precisely defined sample of older women in Iowa City. Rather than seeking women age 65 and over, the sample consists of the wives of retired University faculty members. Wives of the retired faculty members, especially those recently retired, may be considerably younger than 65, yet the sample as a whole is appropriate for research in this field. More research of this kind needs to be done using many different kinds of groups of women before any generalizations can be made for older women as a whole. This research and the two studies already cited should add to the sum total of information in clothing problems and clothing behavior of older women and should also suggest further studies in this area.

FRAUDS, FAKES AND QUACKERY DIRECTED TOWARD OLDER PEOPLE

John G. Thomsen, M.D.*

Charlatanism in health care is by no means new, and both the physicians and the government have fought it for decades.

Quackery is neither so general nor so varied as it was fifty or one hundred years ago, during the era of "medicine shows," but it is still an important problem, and there still are numerous ways in which the public is being misled. Principal among these are:

1. "Cures" for diseases that are still medically incurable.
2. Machines that do nothing more than dazzle the patient.
3. Palliatives that lead patients to postpone seeing a doctor.
4. Food fads.
5. Dental plates, eyeglasses, and other appliances that are attractively inexpensive because those who supply them can't diagnose the abnormalities that are to be corrected and/or fit the devices properly.

Abuses of the first of these sorts aren't so numerous as they used to be, for there are fewer invariably fatal diseases nowadays, and fully-qualified physicians are meriting greater and greater degrees of confidence. If detected early enough, many cancers can now be eradicated by either surgery or X-ray. Much the same can be said about diabetes,

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the venereal diseases, and many other ailments. But there still are no cures for fully-developed cancers, for arthritis, or for some of the even commoner ailments such as baldness and the common cold. Thus it still is possible for unprincipled people to take advantage of unfortunates for whom no more than relief from pain is possible. It is reported that Americans waste $250,000,000 annually on useless "cures" for arthritis and rheumatism, as one patient out of every two hunts in vain for a miracle, and cancer patients--most of whom have waited too long before seeking medical attention--spend $50,000,000 each year for the charlatan's treatments.

With each new scientific discovery, charlatans are provided an opportunity for hoodwinking the unsophisticated. Following the first development of atomic energy, exhausted uranium mines were touted as health centers. Currently, digital computers are popularly thought capable of answering all problems, and it should surprise no one that formidable-looking machines with impressive panels of blinking lights are claimed to be capable of diagnosing or even curing various ailments. Since nuclear radiation and digital computers have some real uses in medicine, the general public, and even most health workers and civic leaders, can profit from frequent briefings on what is and what is not quackery in this area.

Food fads usually are no more than economic foolishness. If one buys seaweed, "organically fertilized" vegetables, or other esoteric foods, rather than the ones which crowd the shelves of every supermarket, he is wasting his money, but that's about all. If, however,

he eats those products in the expectation that they will relieve him of pain or of some other symptom of disease, he is making a mistake similar to the one committed by the people who rely on patent medicines. Furthermore, it is possible that an unbalanced diet of "health foods" can, paradoxically, create a nutritional deficiency!

Perhaps the worst aspect of medical quackery is that it leads patients to postpone seeking expert help. In their advertisements, many manufacturers of patent medicines list symptoms that might fit any of dozens of conditions, then they dutifully admonish those who suffer from those symptoms to consult a doctor, and finally they sing the praises of their products, all of which are available over-the-counter without a prescription. By implying that their nostrums are precisely what the doctor will prescribe, they invite the patient to skip seeing a physician, to take a patent medicine, and to hope for the best. While the patient is taking the pills or syrups, and quite possibly enjoying relief from pain or some other discomfort, the time may elapse when a physician or surgeon could cure him.

Quackery is a very real evil.

1. It preys on fears of the unknown and the incomprehensible.
2. It holds out false hope to those suffering from incurable disease.
3. It milks precious food money from hungry families in return for unnecessary food supplements, nutritional fads, worthless diets, and reducing schemes.

The worst harm caused by quackery, however, is when it keeps sick people from getting competent medical attention for serious disorders which--if left to the ministrations and phony remedies of the quack--can be fatal.

LEISURE AND AGING

Geneva F. Allen*

Recently at the Rehabilitation Center where I am employed, we had a charming elderly lady in her 80's who was senile. One morning she appeared at the breakfast table with two stockings on one foot. When the nurse spoke to her about it, she said, with all the reasonableness of the senile, "Young lady, any fool knows you can't put two feet in one stocking!"

Putting two feet in one stocking is a difficult job, but I think perhaps I do come to you today in that fashion. The one foot might be labeled, "Leisure in the 20th Century," a primary concern to everyone in our culture; and the other, "The Aging in the 20th Century," also of great concern to each of us who live and feel the pulse of our times. Together the two feet make our subject, "Leisure and Aging." For almost two weeks you have heard discussed the physiological, psychological, sociological, medical and anthropological aspects of aging and their implications for you in your world. In one way or another most of you must be concerned with the vast amount of leisure time available to the aging. Perhaps you work with them professionally; hopefully many of you are involved in volunteer activities in Golden Age Clubs, nursing homes, hospitals, and homes for the aged; or perhaps you have aging

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parents who are restless and unsettled now that children are grown and family responsibilities are less. Some of you, like I, may be at the age where we think about retirement, even though it is some years away, and we like to think about what we will do with much more leisure time available to us.

Because we hear the term leisure so frequently today, we are apt to think of it as a twentieth century phenomenon, but this is not true. Listen to what poets, philosophers and historians down through the ages have said about leisure.

The Psalms: "Have leisure and know that I am God."

Socrates: "Leisure is the best of all possessions."

Disraeli: "Increased means and increased leisure are the two civilizers of man."

Bertram Russell: "To be able to fill leisure intelligently is the last product of civilization."

Modern studies on the subject of leisure have become a favorite of sociologists, psychologists, medical men, economists, etc., as well as recreators. One of the most widely circulated is that of Sebastian de Grazia, a political scientist and philosopher, who did a voluminous work for Twentieth Century Fund called, "Of Time, Work, and Leisure." As an opening to his study he says, "The classical Greek wanted to be wise--and to be wise, one had to have leisure. Not everyone could have leisure as the Greeks knew it, but some men at least could be freed that they might soar to remarkable heights and at the same time lift up to a higher level even those whose workaday life kept them pinned to the ground where leisure is limited."

He theorizes that neither time nor events have destroyed the basic Greek ideal of leisure and this has aroused considerable controversy among his fellow scholars. Comments range from that of the economist who calls Mr. de Grazia a middle class imperialist who wants to remake the world in his own image of nostalgia to the recreator who says that leisure of necessity must be linked to time and work, so that it is not primarily leisure we seek but satisfactory fulfillment of the leisure we have.

Automation moves us all into an era of more leisure time. In order to provide the present work force with jobs, labor unions are suggesting shorter work weeks, longer coffee breaks, earlier retirement, and even longer vacations similar to the sabbatical leaves of the academic world. Automation has really meant in simple terms more work accomplished by machines with the resultant need for fewer men--and more leisure for the labor force. Out of this problem of our century has arisen a new science called cybernetics which is defined as the comparative study of the automatic control system formed by the nervous system and brain and by mechanical-electrical communications systems.

The Center for the Study of Democratic Institutions has published a fascinating and sometimes terrifying pamphlet called "Cybernation: The Silent Conquest." In it Donald Michaels, the author, theorizes about what can happen to society in an automated world if we do not handle the problem of the extra leisure time available to man because work will be done by machines. He divides society into four leisure classes as follows:

Leisure Class I--This would include the unemployed who have too much undesired leisure time. This particular group should be of very real concern to all of us, for if they cannot find ways to successfully and adequately fill their enforced leisure time, anarchy can result.

Leisure Class II--Included in this class would be the blue collar workers who are moving into a shorter and shorter work week. They are on the borderline economically and may moonlight upon other jobs in part of their leisure time, thus eliminating the chance of moving some of the unemployed in Class I into the Class II group. This group, too, are a big challenge, for we have always thought of the so-called laboring class as the ones with the least time for the pursuit of leisure activities and now more leisure time is available than they can adequately handle.

Leisure Class III--Mr. Michaels places the "Service" people in this group. Included might be social workers, teachers, recreators, nurses, doctors, beauty operators, barbers, T-V repairmen, plumbers--all people who have high degrees of educational, technical, and/or creative training and whose skills cannot be replaced by machines because they work directly with others, giving them services that, at the moment at least, no machine can possibly give. This group will have less leisure time than in former eras because there are not enough of them to do the service jobs available.

Leisure Class IV--The men who invent and manage the machines would be in this group. They will have less leisure time than any of us for they will be the "elite" of scientific and social society and upon them will depend how we progress in an automated world. They can be

a force for good or evil according to how well they handle the problem of automation as versus man and his role in it.

How do we then define leisure in an age of automation? According to Mr. de Grazia leisure time is not necessarily free time and what man does for recreation is not leisure. He further states that free time is set off, yet mesmerized by work; it is limited to the clock and only available in small segments; at times busily active, at others passive and uncritical; but in most cases it is uniform or collective.

I cannot reconcile his statements with my own philosophy of what leisure and recreation can mean to man. The primary job of the re-creator ought to be one of leading those around him to the awareness that having fun, playing, using leisure time creatively is a primary source of healthy joyful living, regardless of age, disability, socio or economic factors--really, as one writer puts it, recreation can be a blue print for health and happiness.

Leisure is often pictured as an unoccupied block of free time--that time which is available after necessary work to earn a living, to feed a family, to further education, to take care of the basic needs of survival today. Leisure is that time when we can devote ourselves to the things that we want to do for the pure joy of doing.

It follows that recreation may be those things we choose to do in our leisure time. It is activity as opposed to idleness or doing nothing. When I say activity, however, I do not mean that it will of necessity be physical--it may be and often is purely mental activity. What can be more active than the joy of listening to a beautiful symphony or of sitting

in front of a painting looking at another man's creative impulses expressed in oils, or reading a fascinating book? This may be pure recreation to some of us. To others, composing the music or painting the picture or writing the book is recreation.

Going even farther, what may be recreation to you may be poison or work to others. The gourmet cook who spends hours creating a magnificent meal finds it recreation, but to the mother who has four children and a tired husband to feed, cooking may be work and a bore. The postman doesn't hike for recreation, but the nature lover spends hours in the woods and on the nature trails, never worrying about walking. I sew for recreation and take great pleasure in designing a dress, but to the woman who teaches sewing day in and day out, it is work.

However, no matter what things we do in our leisure time for recreation, they will all have certain characteristics in common. Some of those characteristics might include besides the fact that it is activity and that it occurs in leisure time, the following:

1. The choice of what you do is voluntary.
   a. Reason for not prescribing in recreation therapy.
2. It provides enjoyment and a change of pace from the workaday world.
3. There are satisfactions that are immediate and inherent in the activity. Pleasurable experience at the moment is important though this is not saying that memories won't be an integral part of the value.
4. It is socially acceptable.

For our purposes in discussing leisure in relation to the aging, my definition of recreation will be those things we do in our leisure time for the pure joy and gratification of the doing so long as they are socially acceptable.

When Donald Michaels divided his automated world into four leisure classes, he ignored two distinct groups of people who, I believe, should be in Leisure Class I. The first segment of our population which he seems to have by-passed are the chronically ill and handicapped, be they old or young; and the second group are the rapidly expanding aging population who are able-bodied, capable of playing much more important roles in our society than we seem inclined to permit, and who are not unemployed in the same sense as those who are disadvantaged and really want to work full time but are not equipped with the skills for the jobs available. For this latter group enforced leisure can be a source of dissatisfaction and emotional upset if we do not help them solve the problem of making leisure exciting and pleasureable.

George Bernard Shaw once observed, "A perpetual holiday is a good working definition of hell." How true this can be for our aging population who have retired from jobs of all kinds and often times find themselves retired from life too. After being work-oriented for nearly half a century, men of ability in a variety of areas find themselves looking for a place in the spectrum of community living. They may end up, as do many, staring at that greatest of all tranquillizers, T-V, for hours on end--and what an unsatisfactory experience this must be for active men and women. Studies have shown that when this does

happen, older persons who watch television constantly do not want serious dramas, mysteries, or newscasts. Instead they indicate a preference for programs such as "This is Your Life," "Queen for a Day," quizz shows; in fact, all those programs in which people like themselves play an important role and where they can personally relate to what is happening on the screen.

This fact alone gives us a clue to what the older person wants and needs in leisure time. He does not want to be isolated from those around him, and he resents being made to feel unimportant, so he finds his satisfactions in "people-and-activity-oriented" programs. We hear the word "disengagement" frequently in connection with the aging. Many of us believe that older persons do not disengage themselves from society, but on the contrary our mobile society of today has a tendency to disengage the older person.

Recreation and creative use of leisure time is no panacea for the aging anymore than it is for the juvenile delinquent, but it can help to meet some of the needs which anyone has, be he old or young. Dr. William C. Menninger, the eminent psychiatrist, has this to say, "Recreation is an extremely important aid to growing old gracefully. People who stay young despite their years do so because of an active interest that provides satisfaction through participation."

What are the needs that recreation can help to satisfy. There are many ways of expressing these needs, but I have chosen four rather arbitrary categories for the purpose of our discussion today. First is the need for recognition and security; second, the need for belonging to a

group; third, a need for creativeness and self-expression; and fourth a need for adventure, combat, and competition.

1. Need for recognition and security.

   a. Each of us wants to be loved for self alone, regardless of achievements, looks, financial and social status.

   b. To be thought worthy and useful is essential to good mental and physical health. When aging people stop work and when family responsibilities are lessened, unless these people find other things to do, they become listless, ill--in fact, the expression "fade away" can sometimes picture accurately what happens.

      (1) Use of older person for volunteers--Recreation for the Homebound.

   c. Regardless of age, an assured social roll and reliable interpersonal relationships are a necessity to all of us--and any deprivation of these necessities are accentuated in the aging.

      (1) Opportunities for patients to play role of host and hostess in Center.

      (2) Chance to plan activities.

2. Need for belonging to a group.

   a. This is inculcated in us from early childhood--home, school church.

   b. When ties of yesteryear are broken, companionship and new friends can be a very real and urgent need of the aging.

c. This need is intensified when customary sources of satisfaction are threatened. Aging will turn to many areas to be a part of a group.

(1) Example: Strike Back at Stroke, U.S. Government Printing Office, Washington, D. C. 40¢.

d. By the very act of belonging to a group, the aging feel they are contributing to the well-being of others.

3. The need for creativeness and self-expression.

a. To be allowed to talk and visit is sometimes denied the aging because those around them are younger and forget that the aging are fascinating people.

b. Introduce them to new skills and encourage them to renew old skills, for psychological studies have shown that our skills are the last thing we lose in the aging process.

c. Older persons need to be stimulated beyond their environment.

(1) Play and Puritanism were at odds, and we must help the aging to overcome the idea that play is sinful.

d. Introducing the aged to creative use of leisure time can be stimulating for them.

(1) Creativeness doesn't mean busy work, however.

4. The need for adventure, combat and competition.

a. This will no longer mean an African safari, mountain-climbing, etc., but stimulating activity.

b. Combat and competition may be on an intellectual basis rather

than a physical basis.

c. We often misjudge the interests of the aging and relegate them to what we consider a "dead" era.

(1) Music chosen by older people at cabaret parties.

(2) Costume parties.

Leisure programs for the aging are to be found all over the country and are sponsored by a variety of agencies, both public and private, by churches, schools, especially in the area of Adult Education, by fraternal groups, clubs, etc. The commonest trends have been toward clubs with names ranging from Friendly Seniors, Past Fifty to Young Old Timers, etc., but the commonest has been Golden Age. Obviously to form such a group and to make it a successful one, the program must be based on the needs and interests of the group. Too many programs are of the "do gooder" type and too many do not use the skilled leadership available in the club membership. A basic program should offer opportunities for creativeness and self-expression, service to others and just plain fun, for most of them are social in nature. Principles suggested for such programs are varied, but Valerie Hunt states them most effectively in the book, "Recreation for the Handicapped." She lists the principles as follows:

1. Present and expressed interest should be the basis for the first program.

2. Opportunities should be provided for learning new games and skills starting at a fairly simple level.

3. Participation must be divorced from perfection. Individuals

should progress at their own rate.

4. There should be no sudden changes in the program unless such changes are desired by the group.

5. More women's programs should be planned because there are more women than men in the aging population.

6. Tangible, purposeful recreation should be interspersed with unplanned social hours.

7. V arm beverages add to the pleasure of a period and cut fatigue.

8. Meetings should be held at least once a week to maintain interest. If there is some reason for the group's meeting more often than once a week, the frequency of meetings should be determined by the group according to the requirements of the project. Morning and afternoon hours when facilities are available are best for a continuing program, but some events should be scheduled in the evenings.

Leadership in such a program is best when skilled professionals work with well-trained volunteers. The Governor's Conference on the Problems of the Aging of California put it very well when they stated, in their summary, "Older people need recreational leadership, and this leadership should consist of employed, professionally trained leaders, volunteer leaders within the group being served, and volunteer leaders from otuside the gro ups. The professional leaders should organize programs where a need exists, further organize and give leadership to ongoing programs, stimulate older people to use other recreational resources within the community, and establish good

public relations as a means of creating wide interest in the program. Volunteer leaders within the group should share in the planning and the conduct of the recreation activities and assist in stimulating interest and understanding of the program within the community. Volunteer leaders from outside the group should supplement leadership within the group."

The qualities of the leaders in leisure time programs for aging are much the same as those of any recreation leader, except that he is working with a group who have been successful in many areas and he must be very careful to let them use the skills they have effectively. In no other groups is it so easy to literally get off on the wrong foot by assuming too much too soon. Some of the qualities of a good leader might include:

1. He is warm, friendly, relaxed, and accepting of others.
2. He respects and likes older persons and is not condescending to them--none of the coy "you young boys and girls" approach.
3. He is patient and never hurried with older people, especially with those who may be senile, confused and/or handicapped.
4. He understands the physical and emotional problems of the aging and takes these into consideration, but does not call attention to them.
5. He is not afraid to try new ideas with the aging. Many of them do not really know what they want to do and they have never had time to play and have fun.
6. He lets group leadership take over when it is ready and remains

in the background, but can step in tactfully if things do not move smoothly.

7. He tries to give all in the group a chance to achieve some degree of success. With the timid this may be difficult just as it may be difficult to handle the over-aggressive.

8. He is tactful in handling those who are older, trying to make them feel independent rather than dependent.

Psychologists tell us that there seems to be a very definite relationship between leadership competence and the ability to promote group morale. How much individuals take part and develop satisfactory relationships with others, and the happiness and pleasure which they receive in a group is often the real mark of leadership. The leader's function is that of creating a climate free of internal strife and of making the members of the group feel that they are part of a greater entity. In the aging group, the leader's ability to give support and encouragement to each individual and the help he gives them to assume their responsibilities as participants in a social structure may mean the difference between success or failure.

Older people tend to enjoy those activities that they did when they were young, and in planning programs, this fact should be uppermost in the mind of the leader. Most often by starting with the familiar and having the group attain pleasurable experience in known activities, the way will be made easier for introduction of new ideas and programs. Use of the familiar is, then, a valuable aid in establishing group rapport.

A study done by one researcher showed that the principle leisure time activities and interests of a group of retired workers were square dancing, gardening, movies, picnics and barbecues, bingo, photography, hobby-shop activities, painting or ceramics, shuffleboard or pitching horseshoes, gossip, discussion or conversation, card playing. From this list, a very good and varied program could be planned.

A truly successful program of leisure time activities for the aging must be as diversified as those planned for younger people, but the knowledgeable leader will appropriately modify the activities to meet the physical and emotional capacities and interest of the aging. Again being somewhat arbitrary, I have divided the suggested program activities into four groupings, including (1) Social Activities, (2) Arts, crafts, and hobbies, (3) Music, drama and creative writing, (4) Service and educational. All of them overlap and can be used in a "mix and match" fashion in programming. For example, participation in social activities may uncover interests and talents in other areas, so that the older person who makes decorations and favors for a party may become interested in crafts; taking part in a party stunt may show dramatic ability; or community singing may disclose undiscovered ability in the musical careas.

1. SOCIAL ACTIVITIES.

   a. Parties are the common denominator for large group participation.

      (1) They should be leisurely and have frequent change of pace.

      (2) Directions should be simple and easy to understand.

(3) Example--"World Cruise Party" (name tags for grouping).

(a) Opener--"Where Shall I Go"--map

(b) Transportation race--active

(c) Gourmets tour--quiz

(d) Chopsticks relay

(e) Geographical charades

(f) Where am I quizz

(g) Sing a song of countries.

b. Dancing.

(1) Square dancing

(2) Mixers and formal dances--Varsivienne; Mexican hat dance; Put your little foot; reels

(3) Waltzes, schottishe, two-step

(4) Round dances

c. Games and sports.

(1) Card games--cribbage, whist, pinochle, bridge, canasta pitch, flint, rook

(2) Table games--chess, checkers, parchesi, monopoly, clue, etc.

(3) Sports--softball, bicycling, horseshoes, billiards, ground bowling, curling, golf, swimming, fishing, shuffle-board, deck tennis

d. Outings and trips.

(1) Picnics

(2) Art galleries, historical places, gardens, fairs, concerts, plays, movies

2. ARTS, CRAFTS, AND HOBBIES

a. Arts and crafts are best when they allow some degree of creativity to the participant. In this area, too much emphasis has been put on "junk" rather than beautiful and useful items.

b. Some interesting arts and crafts: rug making (weaving) braid knotting, etc.; doll clothes; needlepoint; knitting; quilting; leather and woodwork; ceramics; painting--all media--oils tempera, water color, etching, pen, charcoal, etc.; jewelry; textile painting; printing; sewing and needlework; model construction--boats, planes, trains, cars.

c. Dr. William Menninger has described a hobby as an activity in which the participants find more enjoyment and satisfaction in the activity itself than in any other activity. He can have joy in his hobby whether he is alone or in a group. Obviously the arts and crafts are a part of hobbies but there are many others than can be included in this classification: ham radio; photography; gardening (window boxes, large gardens, flower arranging); nature (fish aquariums, bird raising, animal breeding); collections (coins, stamps, ceramic miniatures, dolls, match books, buttons, postcards, programs, guns, heirlooms, antiques); and scrapbooks which have meaning to the older person containing letters and autograph books.

3. MUSIC, DRAMA, CREATIVE WRITING

a. Music is perhaps the most universal language we know.

(1) Community sings, choruses

(2) Bands and orchestras, "kitchen" bands, rhythm bands

(3) Listening group

(4) The types of music most appealing: old familiar music, light opera and operetta, musical comedy, religious music, folk music, semi-classical and classical

b. Drama

(1) Let the group be a source for creating their own material.

(2) Drama should be fun and relaxing.

(a) Beware of long formal plays with many lines to be learned.

(3) Use talents of all in group thru mediums of acting, scenery, props, costumes, make-up, lighting, writing, publicity.

(4) Formal drama: community theater and theater workshops; pageants (historical); revues; puppets and marionette shows; and radio and T-V.

(5) Informal drama: choral reading ("Daffodils," "The Congo," "General William Booth Enters into Heaven"); Bible reading (Psalms); blackouts, skits and stunts; creative dramatics may include improvisations, impersonations, dramatizing, stories, and ballads (Poe) charades, pantomime, original plays and skits; play readings (Shakespeare, O'Neill, Shaw, Ibsen, modern comedies); dramatic readings (old fashioned elocution); story telling; talent and variety shows; and quiz shows ("What's My Line?", Password, Two for the Money, Categories).

(3) Creating your own show: sit in group and discuss ideas; plan for use of local situation and humor; someone must coordinate the writing of show; use simple scenery.

(a) Example: "Have Chair- Must Travel"
Age 16 - 71 years.

c. CREATIVE WRITING

(1) A small group works best in this area.

(2) Newspapers, bulletins, magazines--all mediums for publishing creative material.

(3) Can write the dramas, skits, stunts for drama group.

(4) Poetry is an area where you'll find many writers--it may be the Edgar Guest type, but it is creative work of one individual.

4. SERVICE AND EDUCATIONAL

(1) Service may be in any area where volunteers are used in the community.

(2) Educational

(a) Adult education

(b)University night classes

(c) Subjects are many --historical, music or art appreciation, astronomy, diet and nutrition, management of personal affairs, income planning, city, state, federal, and international affairs, geneology, etc.

No matter what type of leisure activities the aged choose, it should be something they can enjoy. Perhaps the most difficult group to work with are the chronically ill aged, and the recreator who works with them

must certainly respect them and their problems. The recreator must understand the temporary isolation that trauma may have produced. To become suddenly ill, to lose control over body functions; to give up your basic daily life and to become dependent on strangers; to feel rejection of loved ones; to feel bereavement--all these are terrifying experiences to the aged. Those of us who work with these people day in and day out must recognize the proper time to make contact with the individual and to establish a bond with them.

Dr. Lawrence Podell has written a very intuitive article called "Worlds to Study in Motivating the Institutionalized Aged for Recreation." He says that the recreation worker today must combine the skills of activity leadership with the art of social diagnosis. He further points out that we love a baby and feel no revulsion at his crying, soiling himself, etc., but that it is not so easy to love the aged who are wrinkled, ill and smelly. The aged, too, are the products of broken homes just as are some children, and all of this must be taken into consideration in working with older persons in the institutionalized setting. The person who works with this group must be aware of how to motivate them to some kind of activity. Methods used will vary with each individual, but many times it is intuitive knowledge as well as factual knowledge that helps us to do our job.

Hints for working with aging who are ill and/or handicapped:

1. Speak clearly--if group is large try to place hard of hearing ones where they can see you and read lips.

2. Do not give long instructions--rather illustrate by demonstrating an activity.

3. Fine hand coordination is often difficult for aging--substitute gross objects when possible. (Puzzles--using tongue depressors rather than matches.)

4. Be sure wheel chairs are locked when you leave a patient--or when he is doing something active, such as bowling.

5. Provide aids such as cardholders, numbered chess and checker boards, etc., to make activities easier for him. If he has tremors, try to arrange special devices such as magnetized card boards, scrabble boards in special insets for tiles, etc.

6. Stroke patients may need an extra amount of help because of expressive and receptive aphasia, eye problems, poor balance, etc.

7. Never seem hurried--listen, look, and learn!

HOUSING NEEDS OF THE AGED

Robert D. Blue*

There are many facets to the problem of caring for our senior citizens. Most of the problems are of a nature that overlap. This is particularly true of the question of housing for senior citizens.

At the present time, government is concerned with the housing of the elderly at practically every level. Federal government, state government, county government, and city government all are concerned and active in this field.

The Federal Housing Administration will now make loans for housing for the elderly and also loans for nursing homes. These loans can be made to either private or non-profit corporations.

The Housing and Home Finance Administration deals solely with housing for the elderly in urban areas and will make a 100% loan on housing approved by it.

The Farmers Home Administration is concerned with housing for the elderly in rural areas and will make loans to non-profit associations up to 100% of the cost of the structure. The Small Business Administration will make housing or nursing home loans to either private or non-profit corporations to approximately 75% to 90% of the cost of the building.

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The United States Public Health Department under the law commonly referred to as the Hill-Burton Act makes outright grants for nursing homes up to one-third of the cost of the project. In addition to these loans and grant programs by federal agencies, the Federal Government is concerned with housing for senior citizens because a high percentage of the patients in Veterans Administration hospitals fall into the senior citizen category, and the same is true of the residents of veterans domiciliary facilities.

At the county level in Iowa, counties are concerned with housing for the elderly under the authority granted to counties to operate county homes and also under the authority granted to them to build nursing homes in connection with county hospitals.

Cities are concerned with housing for the elderly because of the power granted to them to build nursing homes in conjunction with municipally operated hospitals.

At the state level, Iowa is concerned with this matter through several different agencies. The State Board of Control operates the four mental hospitals in the state and at one time a survey revealed that approximately one-third of all of the residents of state mental hospitals were persons over 65 years of age. With the advent of tranquilizers and a change in the policy of the Board of Control, the percentage of senior citizens residing in state institutions has probably been reduced. Iowa also operates two state homes for the retarded and in these homes there is a substantial number of persons who are over 65 years of age. Here, too, the changed policies of the State Board of Control are such that the

numbers residing in these state facilities have been reduced.

The state also operates a soldiers' home where elderly citizens who have served in the military forces or their spouses may be cared for.

In addition to the different governmental agencies that are active in the problem of housing the aged, are the several non-profit homes in the state which are sponsored primarily by churches, fraternal organizations and union groups.

There is also one other state agency which has a great deal to do with housing for the aged although its contact is in an indirect manner. This agency is the State Board of Social Welfare that has jurisdiction over old age assistance cases. This is true because old age assistance grants normally contain a sum representing the amount allowed the pensioner for rental of housing or an allowance for maintaining the present housing owned by the old age assistance recipient. The last information coming to my attention was that the old age assistance allowance for rentals for a single person was $24.00 a month and for two persons, $33.00 per month. In the event that the individual owns his own home, the housing allowance made was 8% of the assessed valuation of the property of the recipient. It is at this point that there is a certain conflict between the housing allowances granted by the Social Welfare Department and the housing standards established by the Division of Hospitals and Homes of the Health Department. Testimony before one of the governor's committees to study the problem on aging was to the effect that the minimum cost of building modern housing for

a senior citizen was in the neighborhood of $5,000 to $6,000 per bed. At 6% interest, the annual interest rate upon the facility costing $6,000 would be $360 per year or $30 per month for interest alone, whereas the old age assistance allowance is $24 a month. It is apparent that an allowance of $24 per month is insufficient to pay the cost of interest, amortiziation and depreciation for building modern housing for elderly citizens.

As one looks at the over-all picture of aging in Iowa, one is impressed with the fact that there is little or no coordination between federal, state, county and city units of government which are operating in this field and that the channels of communication between the state agencies and non-profit and profit making nursing homes is not as good as it ought to be.

Recently in western Iowa a federal agency made a large loan to a group in a small community to build a new housing facility only 15 miles away from another larger community where a new project was currently in the process of construction. It was my understanding that this loan was made without prior approval of any agency at the state level.

If Iowa or any other state is to have a soundly conceived and operated program of housing for the aged, it would seem that there should be some common coordinating agency, together with an over-all program for meeting the housing needs of senior citizens.

Another question of major importance is what type of housing to build for senior citizens. During the last year, I have talked with groups around the State of Iowa and from outside the state who are

interested in building projects. In nearly every instance, their original vision has been to build housing for ambulatory, self-sufficient persons. Experience has shown that older people entering a retirement home may be well upon their entry, but sooner or later they are going to have to receive nursing care. Some of them will find this care in hospitals and others, because of the chronic nature of their ailment, will have to receive long nursing care in a nursing home.

Across the nation, studies have revealed that approximately one-third of all the beds in retirement homes are used as nursing home beds for people who are chronically ill and the other two-thirds are used for ambulatory residents. Other studies have shown that a high percentage of senior citizens contemplating moving to a retirement home prefer one which provides both residential and nursing facilities. As one writer put it, "they want a package deal," in which they can have all of the services which they believe they might need at some future date.

It is a matter of common knowledge that the cost of hospitalization has been rising very rapidly in recent years and that in many communities there is a shortage of hospital beds. Other studies also show that it costs approximately twice as much to build the facilities for a hospital bed as it does to build the facilities necessary for a good nursing home bed. Still other studies indicate that on the average, adequate nursing care in an approved nursing home can be provided at approximately one-third of the cost of similar nursing care at a hospital.

Iowa is most fortunate in having a good nursing home law and some of the best nursing home regulations to be found anywhere in the nation. The Division of Hospitals and Homes of the State of Iowa has wisely recognized that it is difficult, if not impossible, to gaze into a crystal ball and tell whether a building that is being erected today will be used for ambulatory, self-sufficient residents or for persons who need nursing care. Therefore, they have provided under their rules that all new facilities built in the state shall have hospital-width corridors, hospital-width doors and that each room shall be equipped with an electric call button or other satisfactory system of communication. This makes for a multi-purpose building that can be used for more than one purpose and insures against unnecessary obsolescence of the facility because of changed needs.

Because of increased costs and shortage of beds, many hospitals over the state have become increasingly aware of the problems arising in connection with furnishing beds for the chronically ill at a price that they can afford to pay. As a result of this realization, the Iowa Legislature has enacted legislation permitting county and city hospitals to build nursing homes in conjunction with county or city hospitals financed at public expense. There are certain advantages as well as disadvantages in this concept of providing housing for the aged chronically ill. One kitchen may serve both facilities. The administration costs may be lessened by having one administrator cover both facilities and so on down through the list of possible savings. From the viewpoint of the patient, however, there can be some definite disadvantages. The

psychology, the tempo and the atmosphere of a hospital and a home are, or should be, quite different. A hospital is geared for intensive diagnosis and treatment and the early return of the patient to his home environment. The nursing home is geared at a lower tempo for long term care, perhaps and probably, permanent care of the individual where the relationship of the nurse and the patient will extend into months or years as compared with days or weeks in a hospital. Because of the shorter stay in the hospital, little or no attention need be given to the social needs of the resident, whereas in the case of a long-term resident in a nursing home, a good social program can contribute a great deal, not only to the health and welfare of the patient, but to his general enjoyment of life.

A word about the part that home economists can play in the field of aging. One of the greatest needs today in this whole field is the education not only of older people, but the middle age group who so often must help do the planning for their parents during the later years. Many middle-aged adults are totally unprepared to deal with the problems that confront them when their parents or other aged relatives come to the place where they are no longer self-sufficient. Home economists are teaching at many different levels and are leaders in their respective groups.

I am particularly impressed by the fact that the training of home economists is a good background training for people who might want to become supervisors or superintendents of homes for the aging. Food is always a major problem so far as older people are concerned

and in some ways I feel that the training of home economists in many instances is superior to that of a dietitian, so far as meeting the needs of the average retirement home. I certainly would recommend that departments of home economics give increasing attention to the possibility of training their students for activity in this field.

Perhaps I can help you have a clearer understanding of some of the problems involved in housing for the aged by pointing out a commonly overlooked fact. A great deal is said today about a population explosion. Most of the discussions have to do with the necessity of providing classrooms and teachers, both at the common school and collegiate and university levels to take care of our rapidly increasing population of youngsters. The truth of the matter is that this generation is being confronted with two population explosions. One population explosion is among our junior citizens, the children, who are looking to government for facilities to provide them with an adequate education. The second population explosion is occurring among our senior citizens who in ever increasing numbers are looking to government for help in solving their health and welfare problems.

Throughout the years we have worked out the system to provide teachers and classrooms for education of our young people. We have the leadership and basically we have laws with which to deal with this problem. When we look at our senior citizens we see a different picture. First of all, we have not developed a group of men and women with know-how who can provide leadership community by community, state by state, to help solve the problems which early retirement,

added years and medical techniques which have increased the numbers of senior citizens from about three and a half to four million at the turn of the century to sixteen or seventeen million today.

For many, the word "nursing home" is a dirty word, and yet new, modern nursing homes are being built all over the country in response to need and many of them are doing excellent jobs. The place of the nursing home and the retirement home, however, is a new one in our society and is a developing factor and no one can tell at the moment just what position it will occupy in our social structure twenty-five or fifty years from now, but if it is to do the job needed to be done, the time to start planning and giving direction to the place to be occupied by these new social institutions in our society is now.

When considering the building of a retirement home for a large number of people, a substantial number of different problems ought to be considered. A master TV aerial is necessary in order to provide adequate service for TV's in each individual residence room.

Air conditioning is a matter of choice. Some people like it and some don't. It is my own personal opinion that it is better to build in such a way that each resident can provide an individual unit for air conditioning if he so desires.

Another problem to be considered is permanent awnings. Where a large expanse of glass is included in the architectural plan, this will result in good lighting, but during the hot days will produce an uncomfortably high temperature in the rooms and therefore it is desirable to provide permanent awnings on many of these buildings.

If permanent awnings are not included when the building is erected, then a provision should be made that individual residents can install awnings of their own which should be of uniform design and color. In this connection, it is important to consider that chronically ill people cannot change their environment and that if they are compelled to stay in bed in a room where the temperature is excessively high, this will not only be uncomfortable, but will be injurious to their general welfare.

Another major problem to be considered in building a retirement facility, particularly if it is one that includes nursing care, is the separation of the nursing facilities from those of the ambulatory and self-sufficient. It is undesirable and depressing to have the aged sick confined in areas where the ambulatory, self-sufficient residents are cared for. If at all possible, a further division should be made. Those who become senile should be separated and housed in a wing of their own so as to not disturb the ambulatory, well persons.

Because of the program of moving the aged senile out of state institutions, anybody considering the building of nursing facilities to care for a substantial number of people, should consider the building of separate nursing facilities for the senile.

Of prime importance are public facilities for the ambulatory residents. Provisions should be made for crafts and for social activities and certainly long range planning should include facilities where chapel services may be held.

Taking a long view of the problem of housing of our senior citizens, one must conclude that whether the housing provided is done by individuals

or by non-profit corporations, one of the keys to better housing is an increase in the housing allowance under the old age assistance program in the State of Iowa and if this is not forthcoming, then the only other hopeful alternative is to provide legislation so that the local taxing bodies may provide these facilities through general taxation.

Since a high percentage of all elderly people reside in their own homes, we should turn our attention to this type of housing for a moment. A high percentage of all falls and accidents occur in the home.

There are a number of things that senior citizens can do to make their own homes safer. Grab bars by the bathtub and stool will help the arthritic and the persons who are unsteady on their feet. All throw rugs should be removed and if wax is used at all, it should be non-slip type.

In the kitchen, the gas stove presents some hazard for the older people. The hazards from the gas stove are twofold, failure to completely shut off the gas jet at the time the cooking is ended and the chance that the person at the stove will have on loose, flimsy clothing and the gas when turned on, may flame out and ignite the clothing. For this reason, electric stoves are safer for senior citizens.

Night lights so that one may go to the bathroom without having to get up and fumble around in the dark for a switch, will avoid some accidents. Rails on steps and stairs are aids to persons who are crippled or unsure of their footing.

The medicine cabinet can be as dangerous for the senior citizen as for the child. Unused and old medicines should be disposed of and

not kept around and no person should ever take medicine without looking at the label and knowing that he is taking the medicine that is intended for him.

In Iowa, the sidewalk and the lawn present particular hazards for many senior citizens. As years advance, the elderly citizen finds his heart just not up to battling the cold air and shoveling the sidewalk and these are chores that can best be cared for by someone else.

If one is considering moving to another community, one of the first considerations should be of the location of the home or apartment with reference to church, lodge and shopping facilities.

In conclusion, let me say that the housing facilities which the senior citizens occupy will have a substantial bearing upon the health, happiness and general well-being of every senior citizen and more thought is going to have to be given to this question of housing for our senior citizens in the future than has been devoted to this important subject matter in the past.

HIGH SCHOOL UNIT ON EDUCATION FOR AGING NOW AVAILABLE*

A much needed emphasis in education for aging is expressed in a recent publication, Youth Looks at Aging: A Unit of Study on Aging at the Secondary Level (University of Iowa Extension Bulletin, No. 819) by H. Lee Jacobs, Ph.D., assistant professor in the Institute of Gerontology, University of Iowa.

Designed as a teacher's guide for a unit of three or four weeks, it is built around eighteen major questions which both youth and adults have asked concerning various aspects of aging.

Views of the author, along with extensive resource material, are treated under four main divisions:

1. Typical questions and interests of students
2. Background information for the teacher
3. Suggested methods and techniques
4. Recommended references and aids

It is believed that this bulletin, which comprises a curriculum development for the study of aging at the secondary level, is here presented for the first time. Prior to its publication, however, a rough draft of this material was used experimentally, with good success, in high schools in several states, particularly in North Dakota, over a period of two years.

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*See program outline for exact title of paper presented during "Workshop on Social Gerontology for Home Economists."

A revised outline of the unit was also presented at the Social Gerontology Workshop for Home Economics Teachers, held at the University of Iowa, June 20 - July 10, 1964.

This unit of study, or an adaptation thereof, is appropriate for use in such courses as Family Living, Homemakers, Home Economics, and American Social Problems. It may also be adapted for use in Church, Youth Groups, Parent-Teachers Association, Service Clubs, Women's Clubs, and in regular adult education courses.

Prefatory statements, interpreting the significance of the unit for education today, are written by Dr. W. W. Morris, director of the Institute of Gerontology, and Robert F. Ray, dean of the Division of Extension and University Services, University of Iowa. An instrument for a Community Survey on Aging is also included at the close of the publication.

The purpose of this unit is to investigate aging in the human area, in relation to its nature, personal implications, and human relationship problems involved, and the challenges for life enrichment which it presents. Because of the rapidly changing society in which we live, however, it is not realistic for us to anticipate the discovery of "permanent" solutions to so-called "problems of aging" in family settings or elsewhere. The most we can hope for is to ascertain the ways in which, in the face of change, aging can become synonymous with the "good life," rather than the punitive visitation of fate.

This Extension Bulletin is a joint publication of the Institute of Gerontology and the Division of Extension and University Services, University of Iowa, Iowa City, Iowa, and may be ordered from either source at $1.00 per copy. One free copy will be sent, on request, to school and community libraries.