THE DEVELOPMENT OF

A SELF-DIRECTED ADVOCACY PROGRAM FOR THE OLDER ADULT AND THE EFFECT OF THE PROGRAM ON INTERNAL LOCUS OF CONTROL

bу

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ABSTRACT

The purpose of this thesis is to show that older adults can develop initiative through participation in a program that teaches the component skills of self-directed learning. The basic premise of the study was that older adults want and need to be in control of their lives, but that many are unable to identify their needs, access information or engage the supports they require. A review of the literature failed to uncover a program that systematically applied the principles of self-directed learning to encourage autonomy and personal advocacy in older adults. Therefore, a self-directed advocacy program was developed, field tested, and evaluated.

The thesis begins with the conceptual development of a program designed to promote self-directed advocacy. Discussion then moves to a description of how the program was implemented in cooperation with the Vancouver Health Department and developed formatively with a group of 10 seniors at a local seniors' network. The field development of the program is recorded in case study narrative derived from a continuous participant observation record. The narrative provides a history of individual progress and of the development of group process, and it is used to formulate improvements to the program.

Finally, the summative evaluation focused on internal locus of control assessed by a personal interview procedure and case study analysis. A quasi-control group was compared on three measures of control from Reid & Ziegler's Desired Control Scale (short form) administered by personal interview. The case study analysis describes

how 9 of the 10 seniors identified a goal and successfully completed a personal change contract.

Although the experimental data failed to show a significant difference in locus of control, the case study data suggest that seniors can develop self-directedness and motivation to pursue personal goals through participation in a self-directed group program. Further refinement of the model and directions for future research are suggested.

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CHAPTER 1

<u>Introduction</u>

The Need for Self-directed Learning Programs for Older Adults

John Naisbitt (1982) tells us we are in the information age. He also identifies a trend away from institutional care to self-reliance in every aspect of our lives. Individuals are expected to access the information and services required to maintain control of their lives.

While older adults need to be autonomous, many have been socialized to be passive and dependent and may have neither the skill nor the motivation to be active in creating their own future. In response to the pervasive need for autonomy, educational opportunities are needed to facilitate older adults taking control of their learning and their lives (Wilson, 1980); adults must be encouraged to be self-directed in learning (Fellenz, 1982).

Furthermore, autonomous, self-directed learners need learning resources and community supports (Cross, 1978). Seniors have an active role to play in defining the nature of those support systems (Barnes, 1980; Begin, 1984; John, 1981; Leclerc, 1982; Peterson, 1976; Redford, 1981). It is, therefore, necessary that seniors be able to act as advocates on their own behalf. This means identifying personal rights and needs and speaking up for services to assist them in addressing those needs. For, unless they can speak up, persuade and convince; unless they have a say in what goes on, they are not in control of their lives (Stone & Bachner, 1977). Opportunities are needed that facilitate the development of personal advocacy.

The Solution: A Program in Self-directed Advocacy

To address the need for autonomy and personal advocacy, a program in self-directed advocacy was developed. The purpose of the program was to give older adults the skills and the opportunity to be involved in the planning of programs to meet their needs. The basic assumption of the program was that if seniors are taught how to speak up for what they need and if they are given the opportunity to create their own resources and define the social support systems that serve them, they will feel a greater sense of personal power and control over their lives. If this assumption is valid, a self-directed advocacy program would be expected to increase internal locus of control.

Self-directed advocacy and health promotion. An area in which the program was conceived to be of particular relevance was that of health promotion for seniors. The goal of health promotion is to promote personal responsibility for wellbeing. The program would provide educational opportunities for older adults to identify their needs and take personal responsibility for achieving a sense of wellbeing.

The development of a support group, which the model includes, incorporates the benefits of self-care and self-help networks.

Professionals acting as facilitators and developers could respond with program development appropriate to the unique needs of individuals in each group, thus giving seniors direct input into program planning. The involvement of seniors in planning and implementing programs that address their needs and interests would enhance feelings of competence and control.

Whatever the incentives, the participation of elderly people in the planning and implementation of health services not only makes use of human resources, but is also therapeutic. It allows older people to demonstrate to themselves and others that they can influence the course of their own lives.

(Redford, 1981, p. 130).

The Opportunity: Seniors' Wellness Program Development

In March of 1985, the city of Vancouver announced the funding of seniors' wellness coordinators throughout the city for a one-year period. Their mandate was to develop programs that address the needs of each unique community of elders. The success of these programs would depend, to a large extent, upon seniors taking an active role in the planning of programs to meet their needs; however, many older adults were believed to lack either skill or motivation to take an active role in health promotion. There was, therefore, a need for a program to initiate the active involvement of seniors in identifying their own needs and planning their own programs.

The opportunity to implement, evaluate and refine the self-directed advocacy program came when the wellness coordinator for South Health Unit expressed an interest in the program as part of her plan for community wellness program development. The program would serve as both a framework and a mechanism for:

- (a) facilitating personal responsibility for health and wellbeing
- (b) strengthening groups in the community to function more.
 effectively as self-help, support networks and
- (c) ennabling joint input into wellness program development by seniors and professionals in the community.

The research project. The project that evolved represents action research in response to the opportunity presented in South Vancouver. The purpose of the study was two-fold: (a) to outline the field development of the self-directed advocacy program and (b) to present empirical evidence for its effectiveness in helping seniors to take control of their health and their lives. The working hypothesis was that a self-directed advocacy program would be effective in increasing a sense of personal control. To test this hypothesis, the program was evaluated using both experimental and case study methods.

Summary

This thesis has both developmental and empirical goals:

<u>Developmental.</u> To present a case study of the development of a self-directed advocacy program at a seniors' network in South Vancouver.

<u>Empirical.</u> To demonstrate the effectiveness of the program in increasing ILC, using both experimental and case study analyses.

In the following chapters, both developmental and empirical components will be presented. Chapter 2 contains a review of the literature on educational program development for older adults with the focus on recent developments in the area of health promotion. Chapter 3 outlines the conceptual development of the original self-directed advocacy program model. Chapter 4 presents a case study description of the field development of the program and chapter 5, the empirical evaluation of the program. The final chapter summarizes the study and its contributions to health promotion and educational program development for the older adult.

Definition of Terms

Wellness. This is a term adopted by the health promotion movement which refers to a positive state of health and wellbeing. It is distinct from the clinical concept of health which implies absence of disease, and is perhaps best described by Green and Anderson's (1982, p. 39) definition of health as:

...a vitality, buoyancy and abundance of energy that enables people to do the things they reasonably expect to do, with a corresponding enjoyment and gratification in living...a level of well being in which life is found stimulating.

Health Promotion. In both the United States and Canada, Health Promotion is a service area within the federal healthcare system; it is an area which is becoming more clearly defined (according to Leeb, 1983). No longer synonymous with prevention, risk reduction, or health education, the concept of health promotion encompasses strategies and activities that promote positive health. "This scope allows for the highest level of health to which a client aspires and is capable" (Leeb, 1983, p. 6): the end goal is defined by the client.

Modified traditional health drop-in. A traditional health drop-in program includes an exercise class and the opportunity to receive blood pressure checkups, foot care treatments, body massage, etc., followed by a professionally prescribed and delivered health care topic of the day. The program which served as a quasi-control group in this study is described as modified traditional because seniors participated as volunteers and were encouraged to suggest topics of interest.

Self-directed learning. This is a process whereby the individual takes the initiative, with or without the support of others, in deciding learning needs and goals, identifying human and material resources, choosing appropriate strategies for learning and evaluating his or her own progress. (Knowles, 1975).

Advocacy. This means "pleading in favor of, vindicating or espousing a cause by argument; active espousal" (Random House Dictionary of the English Language, 1969, p. 22). One who acts as a personal advocate speaks out on behalf of his or her best interests to ensure that needs are met.

Internal locus of control. This concept was first defined by Rotter (1966) as the extent to which people believe they are in control of their own actions, particularly in pursuit of desirable outcomes.

Self-directed advocacy program. A program model developed by the author designed to give older adults the skill and the motivation to act as personal advocates. The model uses a self-directed learning paradigm and teaches the skills of personal advocacy, encouraging older adults to identify personal needs and goals and take an active role in developing resources and social support systems to meet those needs. The conceptual development of the model, field development of the program, and the evaluation of its effectiveness are the subjects of this thesis.

CHAPTER 2

Review of the Literature

A review of the literature was undertaken focusing first on the state of the art of education for older adults, then on program development for seniors within the context of health promotion.

Education for Older Adults: The State of the Art

Adults continue to face developmental challenges to the end of life, challenges that education can help them face with confidence and competence. "The case has been well-made for educational programs for the older adult" (Bolton, 1976, p. 555). Nevertheless, traditional education seems to have failed to serve them (Barnes & Wiles, 1980; Cross, 1981; Hiemstra, 1976).

Cross (1981) reports statistics for 1978 that show only 12% of the adult population of the United States participate in adult education programs. In a study of the learning activities of 214 adults over the age of 55 (average age 68.11), Hiemstra (1976) found that only 17% of older adults took part in organized learning. In an interview with Shirley Abrams (1982), Chuck Bayley (a prominent Vancouver senior and seniors' advocate) claimed that seniors simply do not believe that organized education addresses the real life problems of older people. With the growing awareness of the inadequacies of the formal classroom, there is interest in new models and informal learning situations (Wilson, 1980).

In recent years, educational researchers have begun to show

serious interest in the phenomenon of self-planned learning. Two studies have been particularly influential in highlighting the importance of the non-traditional movement. Johnstone & Rivera (1965) in the United States and Toughs (1971) in Canada produced overwhelming evidence that the great majority of adult learners participate in non-traditional learning experiences. While only 17% of Hiemstra's (1976) population of older adults participated in organized education, 60% were involved in non-traditional learning activities.

Given the propensity of adults for non-traditional learning experiences, it would seem useful to explore the principles of effective non-traditional programs in order to develop a comprehensive model for educational program development and delivery. The objective is, as Wilson (1980) suggests, to synthesize ideas into a coherent framework for provision for the older adult.

The Development of a Non-traditional Model for Educational Program Development for Older Adults

The first task, given the need for a non-traditional model, is to distinguish what is distinctive about non-traditional learning. In the traditional system, the institution or professional controls the content and method of learning (Gibbons et al., 1980; Knowles, 1975). The method is generally a lecture format: the educator's goal is the transmission of content. While the goal is expressed in terms of what the learner is expected to do (i.e. learner outcomes), the learner's interests are not typically represented in a traditional model. Figure 1 depicts the relationship between the elements of a traditional learning model.

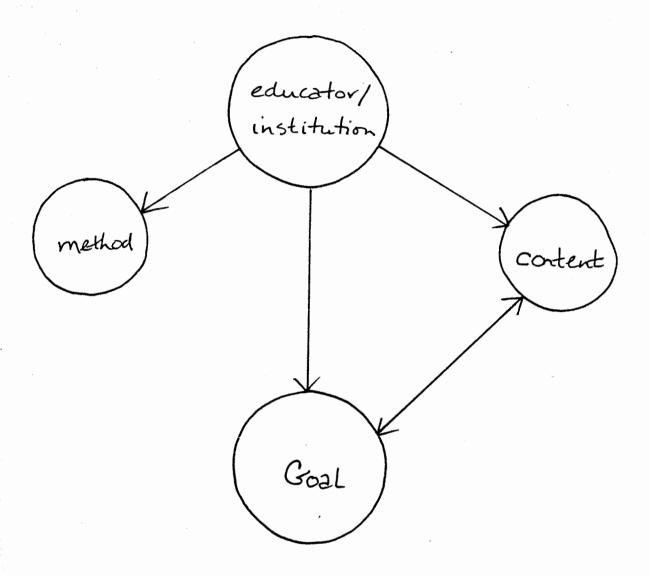


Figure 1. A traditional model of education.

The learner's needs are, however, central to a non-traditional model. While non-traditional education takes many forms and lacks a conceptual definition, the Commission on Non-traditional Study (1973, p. XV) has concluded that it is:

...more an attitude than a system...This attitude puts the student first and the institution second, concentrates more on the former's need than the latter's convenience, encourages diversity of individual opportunity rather than uniform prescription.

Since adults have a preference for non-traditional learning, a model that places the learner's needs first and encourages diversity of opportunity is most appropriate to the learning needs of older adults.

Needs of adult learners. A great deal of emphasis has been placed on polling each adult population to determine what the potential participant wants. Peterson (1983) points out that it is difficult to determine what an individual's needs really are for stated wants are often transitory and neither reflect underlying needs nor insure that participation will follow. However, despite individual and group differences in expressed needs and interests, a fundamental concern that emerges from the literature is the need for autonomy.

The need for autonomy. Despite the existence of special needs or disabilities, the older adult wants to be as independent as possible and to maintain control over fate (Tappen & Touchy, 1983). The drive to master events in the environment is thought to be as basic as the need for food and shelter. Adults have a deep need to be self-directing (Knowles, 1978); seniors want to be in charge of their lives (Radcliffe, 1982).

When there is a conflict between professionally assessed needs

and personally identified wants, a compromise is reached and a program built upon expressed needs that are consistent with the mandate of the professional agency (Peterson, 1983). With respect to the need for autonomy, however, there would seem to be universal agreement.

Older people are constantly engaged in a struggle to maintain that margin of power (autonomy) they have enjoyed in earlier years (McClusky, 1974). With the trend away from institutional authority identified by Naisbitt (1982), personal control and responsibility is becoming a social imperative. Therefore, the central fact in old age, the struggle to remain in control of one's life, must be a guiding principle for educational program development for the older adult.

Having established that the goal of education for adults must be learner autonomy, one must define the concept of autonomy so as to preclude misconceptions. There is a tendency to equate independence with autonomy and an important distinction must be made.

Independence, so highly valued in western society, is defined as "unwillingness to be under obligation to others" (Concise Oxford Dictionary, 1956, p. 606). Autonomy is defined as "freedom of the will...right of self-government" (p. 178). Autonomy suggests a sense of personal power or what psychologists refer to as internal locus of control. Autonomy is not to be confused with independence, for true autonomy is often achieved through interdependence or mutual support, and may also mean dependence by consent. The essence of the concept of autonomy is freedom of choice.

The learning needs of older adults are best served by a non-traditional model in which the individual's needs are central.

The model must provide for diversity of opportunity with the central

goal being the development of learner autonomy. Since self-directed learning represents the ultimate in learner autonomy (Mocker & Spear, 1982; Smith, 1982), it is proposed that the self-directed process be incorporated into a comprehesive model for program development.

Self-directed learning. The self-directed learner controls both the goals and methods of learning (Knowles, 1978; Mocker & Spear, 1982; Toughs, 1971) The learner sets both longterm and shorterm goals, seeks out learning and is in control of the learning process.

In self-directed education, the individual masters all the activities usually conducted by the teacher: selecting goals, selecting content, selecting and organizing learning experiences, managing one's time and effort, evaluating progress and redesigning one's strategies.

(Gibbons et al. 1980, p. 51-52)

The process of self-directed learning involves a sequence of component skills:

- (1) creating a vision
- (2) identifying a goal or personal challenge
- (3) developing a plan
- (4) identifying resources and supports
- (5) taking action that focuses on small steps that guarantee success
 - (6) evaluating progress
 - (7) celebrating and sharing success.

Figure 2 shows the relationship between the elements of a self-directed learning model.

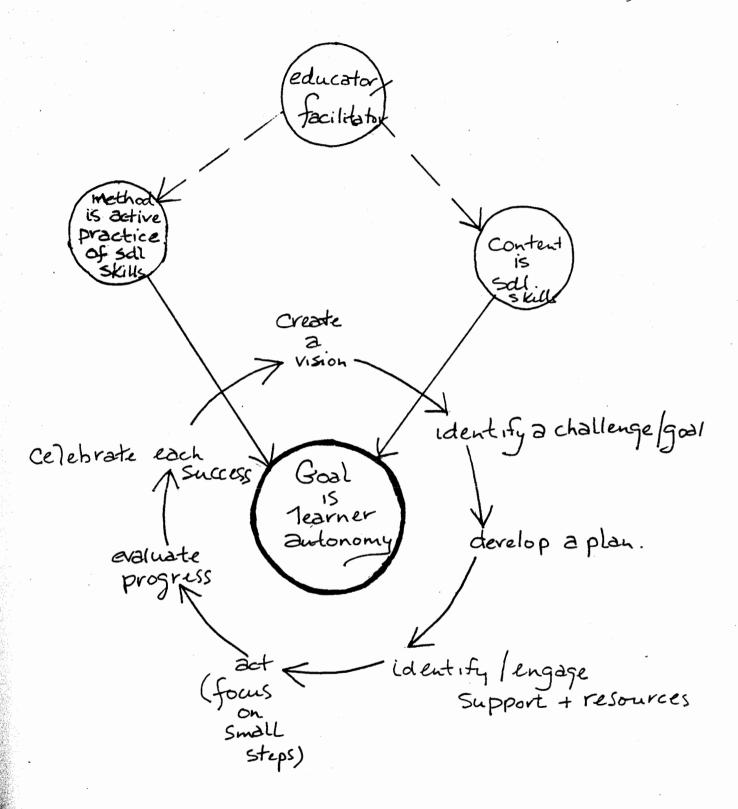


Figure 2. A self-directed learning model.

Successful mastery of the component skills of the self-directed learning process, however, does not ensure that the individual will initiate self-directed action. While traditional educational programs provide motivation and reinforcement in the way of credits and exams, the success of a self-directed education program depends on the individual being intrinsically motivated.

Motivating the individual to be self-directed. How does one motivate older adults to initiate self-directed action beyond a supportive learning environment? That was the central question addressed by the author in an earlier paper (Fedorak, 1984). In the absence of external reinforcement it is a vision of personal success that provides the initial motivation (Gibbons & Phillips, 1980; Mocker & Spear, 1982). It is also important to develop a support system, to focus on small manageable steps, and to celebrate each success. But, in the final analysis, it is the successful self-directed learning project which leaves the individual with the skill and the motivation to pursue learning and take control of his or her life in accordance with personal values (Gibbons & Phillips, 1980). Although no hard data could be found to support the effectiveness of these strategies, they have been applied to the development of challenge education programs for children and would seem to be equally appropriate to program development for older adults.

Self-directed learning and interdependence. Smith (1982) suggests there are three styles of learning: traditional, collaborative, and self-directed. While collaborative learning refers to egalitarian, shared learning experiences, self-directedness refers to independent learning. However, just as autonomy does not mean

independence, so too self-directed learning is not, strictly speaking, independent learning (Brookfield, 1984; Fellenz, 1982; and Knowles, 1978).

This myth of self-directed learning as independent learning is unfortunately supported by the fact that "self-directed learning" in the research literature is cross-referenced to "independent learning" and invariably included within the context of "independent learning". Self-directed or autonomous learners are never wholly independent, however, for they always need assistance in determining the range of choice and in the use of resources (Chene, 1983). Knowles (1978), considered to be the author of self-directed learning theory, did not conceptualize self-directed learning as independent learning:

Self-directed learning does not imply isolation. It usually takes place in cooperation with various helpers, teachers, and peers. There is a great deal of mutuality among a group of self-directed learners.

(Knowles, 1975, p. 18).

Indeed, self-directed learning often involves more interpersonal contact than traditional methods of learning (Knowles, 1978; Mocker & Spear, 1982).

Brookfield (1984) concurs that the social context of self-directed learning has been largely forgotten. Perhaps, it might be more appropriate to ask the question 'independent of what' to which the reply might be 'independent of a traditional learning environment or a professional educator'. It is independent only from the egocentric position of a traditional educator. Brookfield cites the prevalence of informal learning networks and information exchanges, where knowledge is transmitted by discussion in informal settings, reminiscent of the oral tradition which predates the present

traditional system.

The fourth step of the self-directed process (see figure 2, p. 13) is identifying resources and supports. This might better read 'developing' supports and resources, for the success of a self-directed program depends largely on the learner's ability to enlist and engage others to provide information, feedback, and encouragement (Fellenz, 1982; Gibbons & Phillips, 1980; Knowles, 1978). Given the importance of cooperative learning skills and learning networks to the self-directed learning paradigm (Brookfield, 1984; Mocker & Spear, 1982), the development of supports and resources is proposed as an important component of a self-directed learning model.

The self-directed process as both method and content. The content of the program consists of the component skills of the self-directed learning process. To encourage autonomy, the individual is actively involved in every aspect of the learning experience. The ultimate goal of self-directed initiative is achieved by actively engaging participants in the self-directed process.

If students are to learn to think for themselves, solve problems, and make decisions, they must be allowed to do so. If they are to learn to regulate their lives in accordance with realistic aims and goals, they must be involved in goalsetting. If they are to learn to work effectively with other people, they must have the opportunity to work with others in cooperative problem-solving, decision-making and goal-setting activities. If they are to develop responsibility, they must be given freedom to act on their own decisions but be held accountable for and helped to examine the consequences of their actions. If they are to develop self-confidence and self-esteem, they must experience success in self-initiated activity.

(Bell-Dora, D. & Blanchard, L. J., 1979, p. 34).

However, the teaching of process as content may be confusing to many adults who are familiar with traditional educational practices.

A program in teaching 'how to take control of your life' may seem either too grandiose or too vague. Initially, there may need to be a more tangible focus. In this regard, McClusky (1974) identifies healthcare as an important focus for older adults; typically, there may be an expressed interest in nutrition, exercises, arthritis management, etc. There is always a special need or interest that brings a group of adults together and this may provide the initial focus for learning. Any request for information is an opportunity for the educator with vision, skill, and careful planning to incorporate self-directed learning content and method to motivate the older adult to become self-directed.

Summary

In summary, traditional education has failed to serve the present population of older adults. A non-traditional model is needed and a number of principles have been suggested to guide the development of a comprehensive non-traditional model for educational program development for older adults:

- 1. The needs of the learner must be central.
- 2. A primary need for adults is the need for autonomy, and a self-directed learning approach is proposed because it represents the ultimate in learner autonomy.
- 3. Developing cooperative learning skills and resources and networks is an important component of a self-directed learning model.

Self-directedness is both a need and a goal for adults and must, therefore, be incorporated into a comprehensive model for program development for older adults. Using this framework programs can be

designed to respond to specific requests and needs while addressing the central goal of education in developing learner autonomy. The self-directed learning paradigm provides a framework for developing cooperative learning skills and learning networks which are so essential to successful living in the present information age. A self-directed learning model is particularly appropriate to the needs of the elderly, and can be used to put older adults in touch with their potential for learning and creating their individual and social environments in an age of reduced institutional wealth and authority.

Once adults believe that the act of learning can be undertaken without the approval or assistance of professional educators and that the locus of control can remain centred in the adult learner, then a realization is created that adults have the power to alter their individual and social environment and to create their own reality.

(Brookfield, 1984, p. 69).

Program Development Within the Context of Health Promotion

A central need in later years is to maintain good health. McClusky (1974) singles out the domain of health for special attention because achievement of good health has the highest priority for persons in later years. Poor health interferes with the ability to function independently and healthcare information assists older adults in maintaining that "margin of power" (autonomy) which McClusky holds to be the primary struggle and, therefore, a prime motivation for education in later years. The current proliferation of self-care and self-help networks and the development of both provincially and federally funded health promotion programs are evidence that this is an important area for educational program development for the older adult.

Health promotion and wellness. The traditional orientation to health education is disease specific, emphasizing compliance with medical regimes (Neufeld, 1984). In contrast, the health promotion movement goes beyond a risk-prevention, disease-oriented model in promoting optimal wellbeing. Leeb (1983) conceptualizes health promotion as a dynamic process, an ongoing search for health enhancement and life enrichment. This represents an important conceptual shift, embracing all that is involved in the quality of life and placing both the definition of health and the control of health firmly in the hands of the individual rather than the health professional.

The goal of health promotion is to promote seniors taking responsibility for personal wellbeing (Pickard & Collins, 1982; Griffin, personal communications, November 1985; Labonte & Penfold, 1981). Furthermore, there is accruing evidence to support an important relationship between wellness and a sense of personal control.

The relationship between wellness and internal locus of control. Schulz and Hanusa (1980) suggest that perceived choice and a sense of personal control are critical determinants of physical and psychological wellbeing in the elderly. They cite two studies, one by Schulz (1976) and one by Langer and Rodin (1976), which are of particular importance because they include experimental manipulation. In Schulz's (1976) study, institutionalized elderly were randomly assigned to four conditions that varied in terms of the degree to which subjects could predict and control the timing and frequency of visits by undergraduate students. The results supported the

hypothesis that predictable positive events have a powerful impact upon wellbeing of the institutionalized aged.

The purpose of Langer and Rodin's study (1976) was to encourage residents to maintain control of their lives. The treatment group of institutionalized elderly were exposed to a talk by the hospital administrator emphasizing their responsibility for themselves. They were also given a plant to care for. The control group heard a communication stressing the staff's responsibility for them. The positive impact of increased self-attribution of control on physical and mental health was confirmed and persisted over time.

Reid and Ziegler (1981) focused on psychological wellbeing, which is synonymous with the concept of wellness as it has been defined by the health promotion literature. They developed a working hypothesis that a central factor affecting life satisfaction and happiness is the degree of control over significant events in everyday life. Results confirmed the importance of an internal sense of control to subjective wellness in a sample of non-institutionalized older adults.

A limitation of Reid and Ziegler's work is that it is correlational. Furthermore, Ziegler and Reid (1984) point out that neither of the two major experimental studies referred to (i.e. Schulz, 1976,; Langer & Rodin, 1976) actually confirmed that the consequence of the manipulation was an increase in a sense of personal control. There is a need for replication which unambiguously demonstrates that subjects did indeed experience a feeling of greater control as a result of the experimental manipulations.

Implications for program development. The evidence suggests that locus of control is related to health or wellness in the older adult with a higher ILC associated with positive wellbeing and reduced ILC with ill health. Given these findings, efforts must be directed toward developing strategies to increase ILC in the older adult.

To enhance the individual's capacity to cope with the world successfully, one must influence the generalized expectancy for internal control. We are only beginning to focus on the investigation of techniques to bring about such influence.

(Phares, 1966, p. 135).

A top priority in health promotion is given to programs that support older adults in taking responsibility and control of personal wellbeing (Labonte & Penfold, 1981). Because many older adults find taking responsibility for their own health overwhelming, the philosophy of responsibility should be replaced by one that acknowledges the constraints inhibiting a person's ability to freely choose. The focus must be on the process of empowering people to take control while providing the necessary support. Innovative methods need to be tested that will effect a change in personal attributes inherent in self-directedness in learning (Leeb, 1983).

Health Promotion Programs for Seniors

The conceptual shift in the definition of health to include all that is life enriching (Leeb, 1983), gives the community healthcare system a strong mandate to provide a variety of educational experiences for older adults. If health is considered to be the search for life enrichment, then education of any kind is conceivably health promoting. This puts the community healthcare system in the business of teaching older adults and gives professional educators an important role to play in improving educational strategies to meet the needs of seniors. While on the one hand there has been a gradual increase in the participation of seniors in traditional education in general (Covey, 1983; Cross, 1981), the more innovative developments appear to be within the context of health promotion.

The goal of health promotion is to encourage the individual to be responsible for health. The task is to teach the client self-care principles and to encourage health-promoting behaviors (Butler, 1979; Collins & Pickard, 1982; Labonte & Penfold, 1982). Self-care is defined as deliberate action on the part of the client to improve health (Butler et al, 1979) and this represents a departure from the traditional practice of medicine. In this respect, the teaching of self-care is a non-traditional approach to health. Indeed, health promotion, by definition, may be considered non-traditional simply because it represents a departure from the traditional medical model.

In the context of education and for the purpose of this thesis, however, health promotion includes both traditional and non-traditional methods of education with the basic difference being

the locus of control of learning. The traditional method in self-care emphasizes one-to-one education by a healthcare professional (eg. nurse or doctor) and consists of content preselected by the professional with the emphasis on client compliance (Neufeld, 1984). The client's need to be well is addressed by the professional who has control of both method and content of learning and instructs the client in how to take care of his or her own health. A non-traditional method puts the <u>client</u> in control of the learning process.

In a review of the health promotion literature, a variety of both traditional and non-traditional programs were discovered and these are outlined briefly below with respect to methods of learning and the issue of control. The review does not presume to be exhaustive for the very nature of non-traditional learning (i.e. often occurring informally without the assistance of a professional) makes the formal documentation of programs difficult. The programs which are reviewed here are: (1) self-care and the nurse-educator (2) the health drop-in (3) the Be Well program (4) the self-help support group (5) the seniors' network concept and (6) peer counseling.

- 1. Self-care and the nurse- educator. The teaching of self-care procedures is typically the function of a nurse-educator. One variation on the traditional approach has been to locate nurse-educators in seniors' complexes as reported by Pickard and Collins (1982) and Redford (1981). In another model, the nurse was available on request by telephone (Pickard & Collins, 1982).
- 2. The health drop-in concept. Another variation of the traditional approach to health promotion is the health drop-in

concept. This is a mode of delivery which provides health promoting activities and self-care information to a large number of seniors in the community. Carole Griffin, seniors' wellness coordinator for the Vancouver Health Department, estimates there are presently about eight health drop-ins sponsored by the Vancouver Health Department (personal communications, November 1985).

Health drop-ins sponsored by the community healthcare system take place in convenient locations in the community (often either the community health centre or a seniors' recreation centre). The health drop-in provides the opportunity for anyone over 55 years of age to 'drop in' during specified hours one day a week to have blood pressure taken, to participate in exercises, perhaps enjoy a shoulder and neck massage or footcare treatment, consult with a health professional and hear a presentation on the healthcare topic of the day. The drop-in may include collaborative or cooperative group experiences. Seniors are typically involved in registering people, preparing refreshments, requesting topics of interest, and sometimes presenting the talks. The degree of professional control and the extent of involvement of seniors in planning and implementing the drop-in varies considerably with each group and program.

3. The Be Well program model. This program model, developed by Nancy Nelson (1984), is a variation of the health drop-in concept which includes collaborative group learning techniques, such as those outlined by Smith (1981). In promoting wellness, Nelson urged seniors to

love yourself;

be responsible;

maintain a sense of purpose;
go for excellence;
be aware;
be involved;
be assertive; and
use the healthcare system wisely.

Nelson used cooperative group work, developing the group as a support and resource for promoting healthy living principles. The program begins with an emphasis on physical fitness with workshops on nutrition, exercise and relaxation techniques. A later emphasis was on developing assertiveness and community advocacy. The goal was to promote personal responsibility for health and to facilitate seniors taking a more active role in health promotion.

4. The self-help support group . In a practical guide to starting and maintaining a self-help group, Karen Hill (1984) claims that self-help and mutual aid is growing by leaps and bounds throughout North America. A self-help group is a cluster of individuals with the same experience who offer one another mutual aid and support, and groups have been formed to address almost every conceivable need (Butler et al., 1979). Organizations such as Alcoholics Anonymous, the Alzheimers' support group, stroke clubs, Emotions Anonymous (a group for those with emotional problems) and L.I.F.E. (Life is For Everybody—for widowed and divorced persons) are examples of self-help support groups. While self-care programs may be traditional or non-traditional in terms of educational methodology, self-help groups are characteristically non-traditional and make maximum use of collaborative learning techniques. Members share

experience and knowledge and support one another in achieving personal goals. While professionals are engaged to provide information and act as a resource to the group, the locus of control of learning resides in the group.

Self-help groups and professionals can help each other. In working together both need to be sure the interests of the members of the self-help group come first, and that the group as a whole agrees on the task the professional will carry out.

(Hill, 1984, p. F-3)

5. The senior's network concept. A recent phenomenon has been the development of networks which function as a central resource for needs common to the handicapped and seniors. These groups operate on the same basic principles as do other self-help support groups.

The purpose of the South Vancouver Seniors' Network, as outlined by the program coordinator, Bern Grady (personal communication, November 29, 1985) is to make it possible for a senior or handicapped person with a specific need to be connected with the appropriate resource through one phonecall to the network. A secondary function is to identify needs that are not being adequately met and to assist and cooperate with the appropriate agencies to see that services are provided. Seniors operate the network; professionals are marginally engaged to provide pertinent information at the request of the network and to assist in the development of services that are needed. The control of content and the actual dissemination of most information, however, rests with the autonomous group of seniors.

<u>6. Peer counseling.</u> Another innovative development in health promotion is the peer counseling movement. A model which has been influential in this area was the peer-advocacy concept formulated by

Bolton and Dignum-Scott (1979). This was founded on the premise that

...older adults are capable of maintaining their independence and autonomy only when they are capable of coping with the ever-present changing social conditions of today's America. Peer-advocacy counseling operates from the idea that persons having minimal training and adequate perceptual skills, coupled with an inherent desire to be helpful to others of similar circumstances, are capable of providing the rudimentary counseling necessary to aid elderly individuals in maintaining their ability to cope with and accommodate to present day pressures and living requirements.

(Bolton & Dignum-Scott, 1979, p. 321)

With variations on the theme (eg. Bolton & Dignum-Scott, 1979; France & Gallagher, 1984; France, 1984; Larsen, 1985), seniors who have been identified as "natural helpers" are trained in "helping skills". The group is developed as a support network and senior "helpers" are connected with needy seniors with whom they develop "helping relationships"—— acting as advocates, supporting the client in decision—making and maintaining control, etc. In Larsen's approach (1985) seniors are trained as health educators who are then available, on a volunteer basis, to teach healthy living principles to other seniors' groups.

The issue of control. In all of these programs, the issue of control is a pervasive one. With any of the traditional approaches, there is concern that professional control over the process will thwart transfer of skills to the client and maintain dependency on the healthcare system (Levine, 1978; Redford, 1981). There is always the threat of "professionalization" which adapts the client's needs to the healthcare system and not the system to the client's needs (Neufeld, 1984). The traditional approach does not address the need for learner autonomy and may not motivate individuals to take personal

responsibility for health. Redford (1981) claims the emphasis is invariably on what the health provider can do and not how to assist the elderly to take a more active role in health promotion. And traditional approaches to health services (eg. health assessment and blood pressure screening) do little to promote the health of many older adults. "...for any program to be effective...the consumer must become an active and involved participant in the program". (Redford, 1981, p. 125).

Self-help groups are ideal in assisting the individual, through group support, to take care of personal needs. Professionals are generally engaged to provide information and act as resource persons at the request of the group. There are, however, two problems with respect to control which are identified by Butler et al., (1979): (1) how to maintain the active involvement of the individual and (2) how to define the limits of self-care and the responsibility of the professional.

A central premise of the peer counseling movement is the potential of an egalitarian relationship to promote autonomy and motivation of the client to exercise control and use personal resources. Just as with the healthcare professional, however, there is a critical question of control that must be addressed, for concerned helpers may tend to "take care" of their peers rather than motivate them to take care of themselves. By acting as peer advocates, peer counselors may create yet another dependency unless the counselor makes a concerted effort to develop the client as an autonomous advocate. In Larsen's (1985) model, senior peer educators may be as traditional in their teaching methods as professionals unless they are

specifically trained in facilitation skills.

Nelson's (1984) seniors' wellness program is exemplary in the use of collaborative group learning, combining the power of group support and group problem-solving with the expertise of a professional group leader. Nelson uses homework and personal change contracts in motivating individuals to take greater responsibility for their own health. Graduates of Nelson's original program have since become active on the Mayor's committee, promoting wellness programs for seniors in greater Vancouver, and this supports the effectiveness of the program in helping seniors take control of wellness.

Nelson's evaluation included measures of physical and psychological wellbeing and utilization of healthcare services and social resources. She did not, however, attempt to document either a change in ILC or evidence of an increase in initiative or personal responsibility for wellness.

What is missing?

The implicit goal of health promotion is to encourage the individual to take responsibility for wellness; however, program planning seems to have failed to consider the reality that many older adults may lack either the skill or the motivation to take control of their health. Griffin (1985) feels there is a need for programs that emphasize empowering processes to encourage individuals who are disadvantaged to take responsibility for their health, programs that reinforce the competence of seniors and their ability to manage their own lives. Such programs would begin by building self-esteem and cultivating initiative.

Older adults are being asked to define their needs and to take an active role in the development of resources to meet those needs (Begin, 1984; Griffin, 1985). Griffin, however, feels that not all seniors are capable of identifying their own needs and participating in planning and implementing programs to address those needs. For many, taking responsibility for their own health is just another overwhelming task. They must first be encouraged to identify their own needs and develop personal initiative before they can be expected to define how they would like to be served by health professionals.

Using an interactive approach, the system must be prepared to adapt to the needs of the individual, not adapt the individual to the system. This requires creativity and flexibility on the part of professionals as well as active participation by seniors. The relationship is a cooperative one of shared responsibility for promoting optimal wellbeing, but with the emphasis always on empowering the individual. There is need for a program that focuses on empowering the individual, while providing a mechanism for shared responsibility between client and professional (Butler et al, 1979; Griffin, personal communication, 1985; Labonte & Penfold, 1981; and Neufeld, 1984).

The literature search failed to yield an example of a program focused on increasing autonomy that systematically applied the principles of effective education and self-directed learning outlined in this chapter. Self-directed learning models are used widely with children and professionals, yet the theory does not appear to have been explicitly applied to health promotion programs for the elderly.

To develop efficient and effective programs in health promotion,

Pickard and Collins (1982) suggest a need to design programs using the principles of effective education. While there may be a variety of opinions as to what the important principles are, the recommendations which they have specifically made are:

- 1. learner identification of the problem
- 2. a variety of teaching techniques with maximum effort to engage active participation.
- 3. wide use of the group method of instruction. Neufeld (1984) concurs that group work is a key component in developing personal responsibility for health. Groups may increase motivation in addition to meeting social needs.
- 4. active involvement of the learner in all stages of planning, including evaluation. Durability of change is in direct proportion to the active involvement of the client. For...

Unless program planning utilizes the experiences and resources of the learner's themselves, the value and effectiveness of the program will be vastly diminished.

(Pickard & Collins, 1982, p. 391).

The principles identified by Pickard & Collins, (1982) for health promotion are those principles of a self-directed learning model outlined previously in this chapter and the principles promoted implicitly in Nelson's (1984) Be Well program.

In summary, older adults need to take responsibility for personal wellbeing. A review of health promotion programs revealed many innovative strategies for educating older adults about the principles of self-care and healthy living. Program planning, however, seems to have failed to consider that many older adults have been socialized to be dependent and lack either the skill or

motivation to take increased control of their health and wellbeing. While Nelson's (1984) model incorporated techniques to help seniors take increased responsibility for wellness, a model was not found that explicitly teaches the skills of self-directed learning, providing a mechanism for shared responsibility and measuring locus of control. Such a model would cultivate initiative and develop skill to enable all seniors to take increased responsibility for wellness and be able to work cooperatively with professionals in planning programs to meet their needs. The purpose of this thesis is to develop a program to bridge the gap and fill in what is missing.

The Proposal: A Program in Self-directed Advocacy

The need for autonomy is pervasive and the self-directed learning model proposed in this chapter provides a framework that addresses the need for autonomy while at the same time incorporating collaborative learning strategies to develop the group as a support and resource. Building on this framework, the following chapters outline the conceptual development of a self-directed advocacy program for seniors, the field development of the program within the context of health promotion and the empirical evidence for the effectiveness of the program in helping adults to take control of their learning and their lives.

CHAPTER 3

Conceptual Development of the Program

The Vision and the Goal

The development of the original personal advocacy curriculum was guided by a vision of older adults fully involved in learning, growing, and maintaining control of the quality of their lives. It was a vision of older adults actively creating new social systems to serve their personally defined needs. To this end, a program model was needed which would develop skills and provide the opportunity for personal advocacy.

Briefly, the task was to:

- (a) outline the requisite skills for personal advocacy and
- (b) incorporate the process of self-directed learning.

 The challenge was to use the most effective teaching strategies to assist older adults to speak up for what they need to maintain control of their lives.

Selecting and Organizing Content

In planning curriculum content it was necessary to: (1) consider the concept of advocacy and develop a specific statement of objectives (2) define the necessary skills to achieve personal advocacy and (3) develop an organizing principle to guide the sequence of content.

1. Advocacy. The purpose of the program was to encourage older adults to act as personal advocates. "Advocacy", as defined by the Random House Dictionary of he English Language (1969, p. 22), means

"...pleading in favour of, vindicating a cause by argument; active espousal". The major objective was that the individual will be able to identify a need or concern and choose the most effective way of expressing that need in order to achieve a personally defined goal.

2. Skills (content) . Identifying a personal need involves:

(a) Knowing one's rights (b) recognizing feelings and (c) developing an awareness of dissonance. The awareness of need may be facilitated by assertiveness training. Once a need is identified, there are basically two ways of communicating: speaking and writing.

Identifying a personal need, a goal and a plan to express personal advocacy is a self-directed activity. Therefore, content should include all of the components of a self-directed learning program:

visualization;
goal-setting;
planning;
management strategies, use of resources;
action;
self-evaluation; and
celebration.

3. Organizing principle — a heuristic process. Awareness of a need was considered to be the starting point, followed by a logical development of skills necessary to express and ultimately satisfy that need. Visualization was considered by the author to be a useful technique for developing awareness of needs and goals (although no data could be found to support its effectiveness), and visualization became the subject of the first learning unit.

The content of the original personal advocacy program included

the following units:

Unit I: Creative visualization

Unit II: Assertiveness training

Unit III: Effective speaking

Unit IV: Effective letter writing

Unit V: The process of self-directed learning.

The component skills of the self-directed learning process were implicit in the first four units (i.e. practiced throughout); however, the content of the final unit was explicitly the component skills of the self-directed process outlined above, beginning with visualization and ending with the celebration of personal success.

Selecting and Organizing Learning Activities

The ten principles of good learning activities outlined by Gibbons and Common (1985) have particular relevance—for older adults.

- 1. Capacities of learners are important. Given that many seniors lack formal education, the facilitator-leader of each group will want to obtain information about the particular educational background, level of independence, assertiveness, ability to speak out, written skills and community activities of individuals in the group.
- 2. Motivation is a first priority. Since many seniors have not experienced success in learning, the facilitator will want to generate enthusiasm, perhaps by sharing an exciting personal vision, then guiding the individual in creating his or her personal vision of excellence.

- 3. Learning is facilitated by a reward system; intrinsic reward is preferable to extrinsic. To ensure success, the facilitator should instruct participants to focus on small manageable steps that guarantee success and encourage self-evaluation and self-reward. Each small success must have recognition and celebration.
- 4. Tolerance for failure is best taught through providing a backlog of success. Seniors have a vast amount of experience from which to draw. The facilitator will want to emphasize strengths and past accomplishments. The focus on small steps that guarantee success in group work then serves to build a repertoire of success.
- 5. Personal history may hamper or enhance abilities. The facilitator will encourage self-knowledge of strategies and use of 'what works for you'. The individual builds on strengths and develops a plan for overcoming deficits.
- <u>6. Active participation is preferable.</u> Wherever possible, the individual will practice essential skills of self-directed learning, visualization, assertive behavior, effective speaking and writing.
- 7. Meaningful tasks are learned more readily. This is a very important principle to consider for learning in later life. To ensure that tasks are meaningful, every opportunity should be taken to draw on the personal experiences of the group and to prepare learning activities that reflect meaningful experiences.
- 8. There is no substitute for practice. As much opportunity as possible needs to be given for individuals to practice the skills.
- 9. Information about the nature of a good performance. Leaders will both model and demonstrate a good performance. Individuals will be given opportunity to formulate for themselves what constitutes a

good performance and to determine 'what is success for me'.

10. Transfer of training. This is perhaps the most important principle. If educators are to make an important difference in the lives of seniors, empowering them to speak out for the things they need, particular emphasis must be placed on activities that will facilitate transfer. Teach broad principles. Brainstorm ways the skills could be used. Encourage personal homework. Use an action contract. Elicit commitment. Celebrate success.

Using these important guidelines, the self-directed learning process, and a strong commitment to create the best possible learning opportunities for older adults, the original personal advocacy program was produced.

Summary: The Original Program

The purpose of the program was to motivate adults to act as self-directed advocates. Through the development of assertiveness, speaking and writing skills, group sharing and problem-solving of needs and concerns, and finally, the completion of action contracts; it was expected that older adults would develop the confidence and competence to be active in creating their own futures.

The content of the program consisted of the component skills of personal advocacy; the method was active practice of the content skills. The five units were visualization, assertiveness, effective speaking, effective letterwriting, and self-directed learning. Figure 3 is a model for developing personal advocacy, showing the relationship between the educator, method, content, and goal of the program.

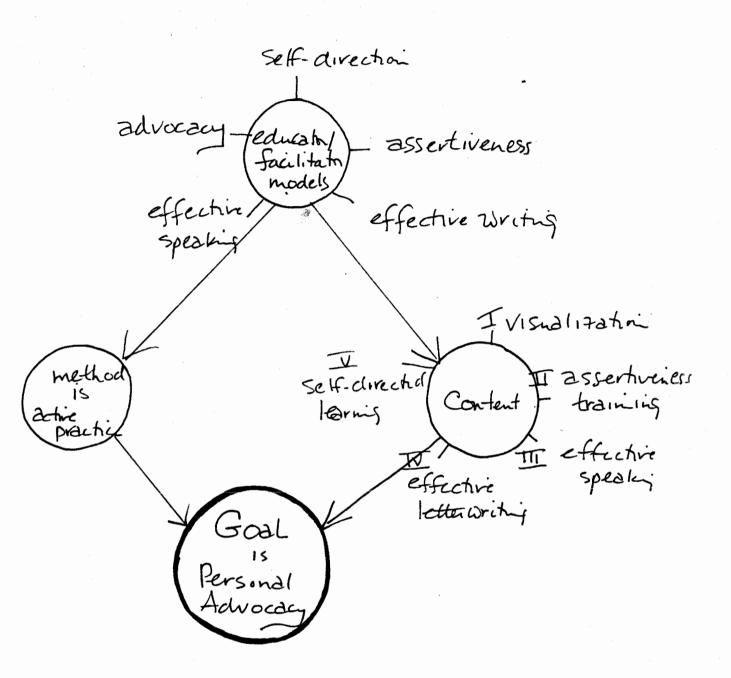


Figure 3. Developing personal advocacy: A model that incorporates self-directed learning.

The Challenge

The original program (see appendix A) was intended as a guide. It represented the author's recommendations for the best learning experiences to accomplish the central objective of motivating seniors to be self-directed. The challenge to group leaders was to adapt these experiences to match their own personal styles and skills and the unique characteristics of each group in order to have the greatest impact. The challenge for the author was to find the opportunity to implement, evaluate and refine the program model.

The big question was, would it work? The principles of self-directed learning have been applied to the development of "challenge education" programs for children (Gibbons et al., 1980), but they have not been explicitly applied to the development of programs for seniors. Would older adults, perhaps in their 80's and 90's, actually find the visualization process and the self-directed action contract helpful in taking control of their lives?

CHAPTER 4

Field Development of the Program

Introduction

In March of 1985, the City of Vancouver announced the funding of seniors' wellness coordinators throughout the city for a one-year period. The mandate was to develop programs that address the needs of each unique community of elders. The success of these programs depends, to a large extent, upon seniors being able to articulate their needs and taking an active role in planning health promotion programs to meet those needs. However, many older adults have been socialized to be passive and dependent, often relying upon institutional authority. They cannot be expected to identify their own needs and express themselves effectively. This was a perspective shared by both the developer of a personal advocacy program for seniors' and the seniors' wellness program coordinator at South Health Unit.

The wellness coordinator's task was to develop a community wellness program in cooperation with seniors residing in South and East Vancouver. In general, seniors in that community have a blue collar work history and few have graduated from high school. In her experience with these people, the coordinator found the seniors to be more comfortable allowing health professionals to determine what they needed and to prescribe solutions. Even when directly questioned, they were unable to suggest ways they would like to be served by the health department. They had little expectation that their

self-perceived needs would be considered, let alone met.

There appeared to be a gap between the health department's expectations that seniors would be actively involved in conceiving, planning, and implementing wellness programs and the apparent expectations of the seniors to be passive recipients of healthcare services. Therefore, the wellness coordinator felt that an advocacy program was needed to bridge the gap and she expressed an interest in the personal advocacy program model conceived by the author in a graduate studies program at Simon Fraser University.

Following discussion and in cooperation with South Vancouver Health unit, a decision was made to implement the program model in conjunction with the development of health drop-in programs in South and East Vancouver. Shortly thereafter three professionals (a wellness coordinator, the author, and a social work consultant) came together as a group who shared a common interest in helping seniors take increased control and responsibility for personal wellbeing. To this end, they agreed to work cooperatively as facilitators, developers, and evaluators of the program. For the remainder of this thesis they will be referred to collectively as "the group leaders".

A case study approach was used to document the development of the program in South Vancouver. The narrative description of what happened focuses on a number of specific issues which will be outlined in this chapter; improvements to the program model are based on the narrative.

The focus of the summative evaluation was on the effect of the program in altering perceived locus of control in a more internal direction. It was felt that personal responsibility and control would

be reflected by the ILC construct. In addition to the case study analysis, a quasi-control group was enlisted and compared on dependent measures of control derived from a personal interview procedure. A complete description of the empirical evaluation procedures and the results is documented in chapter 5.

Introduction to the case study method. The case study approach has a long history in educational research (Borg & Gall, 1983) and is beginning to assume greater importance as a wiable approach to understanding educational phenomenon. Smith (1979) refers to it as an emerging 'genre of research' which is still relatively imprecise.

In attempting to provide a more specific definition, Kenny and Grotelueschen (1984, p. 37) suggest case studies are "intensive investigations of single cases which serve both to identify and describe basic phenomena, as well as provide the basis for subsequent theory development". A case study may have the following characteristics:

...data are qualitative, data are not manipulated, studies focus on single cases, ambiguity in observation and report is tolerated, multiple perspectives are solicited, holism is advocated, humanism is encouraged and common and or nontechnical language is used.

(Kenny & Grotelueschen, 1984, p.

38).

Using naturalistic observation procedures, the researcher chooses the most coherent and relevant information and attends to the more important aspects, emphasizing the uniqueness of the group. Through vicarious experience of the context in which the research was gathered, the reader is able to go beyond the data.

Program Implementation

<u>Developing the plan.</u> The group leaders proposed to adapt the original program to their personal needs and the particular needs and interests of the group. They proposed to meet for a planning session once a week beginning a month prior to implementation of the program and to be jointly involved in planning, facilitating, and evaluating each workshop session. The purpose of the presession meetings was:

- (a) to become familiar with the original program model
- (b) to share experience and knowledge
- (c) to share personal values and goals[®]
- (d) to outline a joint vision, overall goals, goals for each session and the best way to achieve them, and evaluation procedures.
 - (e) to get to know each other's style of working and interacting
- (f) to recognize personal strengths and weaknesses and to learn from each other, to develop personal excellence
- (g) to keep a positive attitude and encourage and support each other.

In the presession meetings, a number of conclusions were reached with respect to needs, vision, goals, and plans for implementing the program. First, a number of individual needs were identified. The seniors' network, which was a co-sponsor of the program, wanted input into future programs and activities for their members. The coordinator of the network indicated interest in a group advocacy project. The wellness coordinator was looking for information about needs that could be incorporated into future wellness programs and she wanted to develop some personal skills in group facilitation. The social work consultant expressed an interest in developing personal

co-facilitation skills and developing group process. The researcher expressed her need to have detailed plans and to be rigorous and systematic in the development and evaluation of the advocacy program.

Prior to establishing objectives, the leaders felt it was important to share a common vision. They shared a vision of a community in which seniors are clearly included, not just marginally—where seniors are fully politicized and use their numbers to make a real difference, resulting in a community that is more sensitive to seniors, willing to accept seniors as valued and respected members—where the wisdom and experience of senior citizens is both treasured and utilized in creating the best possible future for all.

Guided by this vision, the leaders established that the goal of the advocacy program was to help seniors recognize that they have the power to make positive changes in themselves and in their communities. Specifically, the program objectives were:

- 1. to increase personal control and responsibility for wellness
- 2. to develop a supportive, cohesive group
- 3. to involve seniors in planning programs
- 4. to develop a group goal.

In order to achieve the objectives, the group leaders planned to focus on two processes throughout the program: (a) developing individual autonomy through the use of the self-directed learning process and (b) developing a cohesive support group. The development of group process was considered to be an effective strategy for encouraging individuals to achieve personal goals. A cohesive group was also considered to be essential to the formulation of a group goal

or project.

During the presession meetings, a number of issues were identified. The personal advocacy program model contained a series of units on visualization, assertiveness, speaking, writing, and the process of self-directed learning within which learning activities were organized heuristically. The conceptual program, however, contained no recommendations about implementation strategies (eg. daily and weekly agendas, number of leaders, optimal group size, etc.).

There were decisions to be made about:

- 1. How to work together to plan each session.
- 2. How to collect data.
- 3. What should be the core content of the program.
- 4. What should be the daily agenda.
- 5. How to use paper and pencil activities.
- 6. How to select the best learning activities.
- 7. How to use visualization to the best advantage.
- 8. How to develop a cohesive support group.
- 9. How to deal with the issue of control.
- 10. What is the optimal group size.
- 11. What to call the program.

With respect to these issues, the following strategies were agreed upon:

- Program planning. The leaders proposed to meet each week
 several days prior to the session to
 - (a) focus on the goals of the session
 - (b) develop the best sequence of activities to accomplish those

objectives

- (c) divide activities so as to utilize their skills in the best way. Some guidelines were established for "inflight adaptations".

 The intent was to make the interactions between leaders and participants as spontaneous as possible but with consideration for the researcher's need to follow the program plan. The leaders agreed:
- (a) to feel free to add anything at any time and to make any suggestions that would improve the clarity of the process
- (b) to respond to individual needs to be heard and to receive clarification
 - (c) to keep a positive attitude and support each other
 - (d) to encourage humor
- (e) to assist in dealing with anyone who might be disruptive or monopolizing group time and to ensure that everyone has the opportunity to be heard.

Finally, the leaders proposed to arrange for a suitable celebration when the program was completed.

2. Program evaluation. The summative evaluation procedures form the basis for the empirical study designed by the researcher and will be described in chapter 5. To evaluate the program formatively, the leaders would encourage participants to speak out, engage them in a brief verbal evaluation at the end of each session, and hold a debriefing session immediately following each workshop. (See appendix B for an outline of the questions addressed in these two informal evaluation procedures). A continuous participant observation record would be kept to provide data from which to make recommendations for future programs. The plan was to tape each session and to analyse

data related to the issues and the program goals (i.e. problems, needs, plans, group support, evaluation, success, and control).

- 3. Content. Visualization, assertiveness, speaking, writing, and the self-directed process skills were considered by the author to be essential content to a personal advocacy program. However, the group leaders decided that, within a 6-week timeframe, they would focus on the component skills of the self-directed process. They felt their best contribution could be made through promoting individual initiative and control. It was, therefore, decided to make the process of self-directed learning the core content of the program (i.e. visualization, goal-setting, planning, identifying supports and resources, self-evaluation and celebration). The program would begin with a positive affirmation, visualizing a past success, followed by a unit on assertiveness to get people focused on their needs and rights. Speaking and writing skills would be practiced throughout. Visualization was considered by the leaders to be an effective technique in motivating positive action and would be practiced each session as part of a relaxation exercise.
- 4. Agenda. The original model did not have a daily or weekly agenda. The proposed daily agenda included an informal opening, a relaxation exercise, a skill development session and a closure with a brief informal evaluation.
- 5. Materials. There was some question about the effectiveness of paper and pencil activities. The preferred method of learning was felt to be the process of verbal discussion and group problem-solving promoted by Freire (1974). Older adults with visual or fine motor problems may find paper and pencil tasks a frustration and a deterrent

to learning. The plan was to use individual file folders introducing paper and pencil tasks throughout the program so people could chart their own progress.

- 6. Learning activities. The guidelines outlined by Gibbons and Common (1985) and the program guide were used in selecting and organizing learning activities. It was considered important to maximize the use of the particular skills of the group leaders. Carole (the wellness coordinator) had experience with visualization, stress management, and relaxation exercises. Leg (the social work consultant) had experience in peer counseling and in working with support groups. Sandra (the author) had experience with assertiveness training and the self-directed learning process.
- 7. Visualization. The leaders were not sure how the seniors would respond to visualization. It was important to solicit feedback and to experiment with guided visualization relaxation exercises, which were a particular area of interest for Carole.
- 8. Group process. What are the strategies for developing effective support groups? Based on his experience with peer counseling and the development of group process, Len suggested the following strategies:
- (a) provide opportunity for dyad sharing and group problem-solving
- (b) always seat participants in a closed circle with the group leaders interspersed with participants
- (c) have the group leaders fully participating as equal members of the group
 - (d) use an informal opening to encourage people to say how they

feel and an informal group closure when participants are encouraged to share honestly how they felt about the day's session.

- (e) have group leaders model acceptance of each individual member of the group
- (f) finally, and most importantly, have the leaders model teamwork and support for each other.
- 9. Control. This was an important issue and one that was dealt with on many levels. The central goal was to motivate seniors to take control. This means not 'giving' control but rather 'allowing' that sense of control to emerge. The question raised was invariably 'who controls what?' It seemed useful to deal with the control issue through a consideration for personal choice and responsibility. The leaders began by taking some responsibility for creating a positive environment for learning. Initially, participants were given choices about coffee breaks and group business. It was important for the leaders to model self-direction and control of their own learning and development. The leaders planned to encourage members but never coerce, advise, or control.
- 10. Size. This was arbitrarily set at 15. The original plan was to run the group with 2 facilitators but when a third became available who was not only very skilled in group process but also a male, the team became 3.
- 11. Name. While the program was originally called <u>Personal</u>

 <u>Advocacy</u>, the leaders felt that advocacy was a term generally associated with the law and not always easily understood. Initially, however, it was necessary to avoid a name that described what the program was about and thus contaminate program evaluation data.

The program was therefore advertised through the network as "an informal discussion group" .

The program implemented in South Vancouver. The program consisted of a series of 6 workshops held at a seniors' network meeting room on 6 consecutive Wednesdays. Thirteen independent-living seniors, members of the network and relatively mobile, committed themselves to the program. The facilitators met each Monday to draw up an outline of activities for the weekly sessions.

The weekly outline was:

Week 1: Introductions and affirmations

Week 2: Assertiveness

Week 3: Values clarification

Week 4: Goal-setting and planning ☀

Week 5: Management: resources and strategies

Week 6: Evaluation and celebration.

The daily agenda consisted of an informal opening, introduction, a statement of workshop rules, guided visualization relaxation exercise, skill development, evaluation, and closure.

Ultimately, the goal was to coach each individual in the group through the self-directed learning process to help them:

visualize themselves having a success; identify a personal challenge;

develop a plan;

identify resources and support each other;
take action, focusing on small manageable steps;
evaluate progress; and

celebrate a personal success.

Data collection procedures. While the original intent was to tape the sessions, this seemed inadvisable, as will become evident from the narrative. Therefore, the researcher elected to keep a continous observation record of each session. This involved recording all dialogue and observations relative to the issues identified by the leaders and the program goals (eg. problems, concerns, goals, planning, resources, group support, action, evaluation, success, assertiveness, etc.). Debriefing sessions were held by the leaders immediately following each session and a written record of these sessions was also kept. Material from both sources was integrated into a case study narrative which:

- (a) describes the experiences of individuals throughout the 6-week program
 - (b) provides evidence of the potential of the program for:
 - 1. helping seniors take responsibility for personal wellness
 - 2. developing a cohesive support network
- ennabling participation by both seniors and professionals in program planning
 - 4. promoting a group project.
 - (c) suggests improvements to the original program model.

Case Study Narrative

The continous participant observation record was used to prepare a narrative description of what happened in each of the workshop sessions. In the following description, material deriving from the workshops is identified as "observations": the debriefing sessions provided the material for "reflections". Group leaders Len, Carole, and Sandra (the author) are identified by name throughout the narrative. The names of the senior participants have been changed to protect their anonymity.

Session 1

Observations. Thirteen seniors met with the 3 group leaders at a seniors' network meeting room. As the leaders prepared to begin, Len noted several people outside the circle and immediately made it a closed circle. One of the participants, who is training as a fitness leader, was asked to lead a short exercise session before we began.

Sandra requested that the group permit her to tape the sessions. Everyone agreed, with one exception (Gertrude: "You can go ahead and tape; I just won't say anything") and therefore the decision was made to keep a continuous written record in view of Gertrude's discomfort with taping.

In setting the climate for learning, Sandra presented the workshop rules (courtesy, anonymity, and personal responsibility) and considerable discussion followed about courtesy.

Carole led a deep-muscle relaxation exercise.

Len conducted the introductions. Participants first recorded their names and purpose in coming on individual cards for their files. (These files were kept for the personal use of participants and cards were gathered at the end of each session and stored in a locked cupboard in the network office.) Participants were next asked to introduce themselves to a neighbour and share their purpose in coming. Participants were then asked to introduce each other to the group. Len recorded names and purpose in coming on the blackboard. Reasons for coming were:

- to be more assertive, more in control of myself
- to learn, to help others (2 people)
- to learn about my own needs
- to be aware of a better potential for the future (this by an 87 year old lady)
- to learn how much control I really have, and how to deal with difficult people
- to speak in such a way that people will listen to me.
- to find solutions to my problems
- to develop group skills
- to develop more control over the future.
- to develop more control over my life
- to speak up diplomatically (2 people).

The purpose of the next exercise was to visualize a personal success. Carole conducted this exercise and participants were asked to share a past success. People were reluctant therefore she volunteered to go first. Nine people then shared personal experiences of success. Sally talked about a prize for flower arrangements, at

which point she said she just had to speak up and tell us that the bouquet on the table was a prime example of a very bad arrangement. With encouragement from the group, Sally then proceeded to show her skill by rearranging the bouquet.

For homework, participants were given a personal assessment sheet and asked to take it home and be prepared next week to identify an area of their life they would like to improve.

In response to the evaluation questions at the end of the session, participants said they had learned that their needs were very much the same as others and that it was important to learn to have more control of their lives. What they said they enjoyed most was the social aspects and discussion.

Reflections. The leaders felt generally positive about the first session and impressed with the enthusiasm of the group. The researcher was impressed with the natural group skills of the other group leaders, and aware of her own difficulty in trying to work as facilitator and participant, as well as Keeping the continuous participant observation record of what happened in the sessions.

Several people seemed uncomfortable with the relaxation and visualization procedures. An introduction and explanation were obviously needed. Everyone was comfortable with keeping a file and writing things down, with the exception of Charles.

Ruth is a concern. She is a very solitary individual who spends her days riding the buses and visiting libraries, neighbourhood houses, and free lectures all over the city. She carries four huge plastic bags with her at all times and has been often identified by health department personnel as "the bag lady". The group leaders were

initially concerned that her antisocial behaviour would have a negative effect on the group by making people uncomfortable. She is very disruptive and anxious. It was decided to have a group leader sit next to her at all times and to place a hand on her to calm her down when she is disruptive. The general plan is to allow the group to be assertive and to develop skill in responding to her. Participants have already said they want to learn to deal with difficult people and here is a natural opportunity.

Flora expressed privately to one of the leaders that she might not continue because she is uncomfortable with a lot of personal discussion. She is a very private person, very active at 87 and doesn't like to analyze feelings. The leaders were aware that some people had shared very personal feelings and may feel they had disclosed too much too soon. This will be discussed at the beginning of next session.

In the future sessions, the leaders will attempt to build on past success and encourage the idea that each person has something to offer the others. For next time, Rose will be encouraged to offer exercises again at the beginning, and Sally will be provided with more flowers to arrange.

Session 2

Observations. Six new people arrived and joined the circle and the leaders were at a loss as to what to do. These people were health drop-in people who had not been interviewed.

Sandra began with a round robin on 'how is everybody' to which

Alex (who would not commit himself to the group) said 'lousy' and a

number of others followed with negative comments.

Carole led us through an autogenic relaxation exercise and everyone appeared to participate.

With regard to the homework assignment (instructions to identify an area of your life you would like to improve and a goal for yourself), Charles said he had filled out a personal assessment and had changed the wording to describe how his life was, because his life is almost over and he lives a day at a time. Charles also commented on one of our goals: to get to know each other better. He said there are some people you simply don't want to get to know better!

Hilda's goal was 'to be more assertive to my kids so they will keep in touch with me'. A new member talked for some time about her struggles to get her driver's licence and the ageism she encountered. Another new member talked at great length about how he took a policeman to court when his licence was suspended.

Mabel wants to take a plane trip. She can fly for free, compliments of one of her children, but is afraid of flying. There was lots of advice about what she should do and many offers to go along with her. Mabel talked a lot and paced up and down because of pain in her back that prevented her from sitting and this seemed quite disturbing to some of the group members.

When asked how the group might best proceed for next week, the seniors were unable to offer suggestions. Since a number of people had expressed goals that included an assertive component, the leaders contracted to do some assertiveness exercises but input from the group. Participants were asked to take the assertiveness handouts home

and to come back with a particular situation they would like to roleplay.

There was no time for evaluations.

After the meeting, Ethel came to one of the leaders privately and protested, "You weren't very assertive; you should have told the new people that they couldn't stay because they hadn't been interviewed".

Reflections. The first concern was what to do about a lot of negative comments. How can the group keep a positive attitude with a lot of complaining? Carole stressed the need for people to have their negative feelings heard and validated. False cheerfulness is to be avoided. Honest expression of thoughts and feelings is a component of assertive behavior and therefore negative thoughts and feelings must be heard.

What about people who say they have no goals because they are too old? This also needs to be heard.

Sandra expressed the feeling that this was not a good session. The session consisted of a lot of grumbling and complaining but without the development of any strategies or progress. Also, with the addition of 6 new people and Len's absence, there was a feeling of a lack of control over the workshop. Ethel's comment that the leaders had not been assertive is an important one. Leaders must model control of themselves and the group. How much control do leaders have and how much rests with the group? This is an ongoing issue.

There was no time for evaluations or a proper group closure and this left Sandra with an incomplete feeling. The challenge was to take greater responsibility for the climate for learning next week and to create specific scenarios for assertive roleplaying that addresses

specific problems that had been raised in the group.

Session 3

Observations. In reviewing last week's session, Sandra mentioned the difficulty the group leaders had in dealing with new members and the decision to include them. It seems the people who had turned up unexpectedly had made a mistake and were in the wrong place but decided to stay because it looked interesting. (Of the 6 people who dropped in, 1 continued to attend regularly and 1 attended 3 out of the 6 sessions; they were, of course, not included in the case study analysis). Discussion followed about the need to express negative feelings and that it was okay. However, dwelling on the negative often means not agetting on with making positive changes. Participants were told that this was both a support group and an action group. There is a time to listen and a time to get on with the action. This week was time for an emphasis on action. Hilda - I am already becoming more assertive. I took it upon myself to phone my daughter-in-law who is separated from my son. As a result my grandaughter is coming over this weekend to visit. Gertrude - I think I am being more assertive with my grandchildren who are now living with me.

Len led us in a visualization exercise, visualizing 'your special place'.

The goal of the session was to develop assertiveness. Sandra opened with a discussion of the differences between aggression, assertiveness, and passivity. Carole and Len then put on a lively roleplay of Dr. Wise and Mrs. Sick, simulating doctor-patient

relationships which fall into the three categories. This stimulated some lively discussion of personal experiences with doctors.

The group then broke up into three smaller groups to actively practice roleplay situations. The roleplay scenarios created by the leaders addressed specific issues raised by participants in previous sessions. Wherever possible, an attempt was made by the leaders to place individuals in roleplay situations that were personally relevant.

In the evaluation, participants said they had learned they all needed to be more assertive. One person expressed a need for patience and another that she worried too much about hurting other people.

They enjoyed most the roleplay of the scenes with the doctor. To improve small group work in the future, it was suggested that groups be placed further apart to avoid distractions and stay better focused.

Len concluded with a quick round robin closure which included the following comments:

Rose - I feel good. I got some of my feelings out.

Mabel - I can talk here in this group and I can't at home. I can't communicate there because everyone is smarter than I am.

Alex - It went better than last week.

After the group broke up Alex said, "The bag lady is real interesting. I wonder what she has in those bags. She is real smart you know. Wouldn't it be interesting if she wrote down all she saw in her travels around the city?"

Reflections. The leaders felt that today had been a lot of fun with everyone participating.

Individuals who need special attention:

Ethel - appears to be living with a violent husband and may be a battered wife (Len and Carole will follow up on this in their roles as community health professionals.).

James - is very long-winded. His philosophical dissertations are far too lengthy. Once again the plan is to let the group deal with it. Hilda - has a real problem communicating with her son. She finds it impossible to be assertive and slips back into passive behavior but she is beginning to be aware of this.

Mabel - has obviously suffered from being treated as the dumb one in the family and needs a chance to develop confidence.

In general, the feeling was that the group is becoming very honest and open. The climate has been set to move into individual contracts next week and give people support to achieve some goals.

Session 4

Observations. Alex' first comment was 'where is the bag lady'?

Rose - The roleplay last week really helped me. I went home and had a talk with my son and we were able to communicate. I feel I have really achieved something important. Also, I confronted someone in one of my exercise classes who has been upsetting me. I took her aside and told her what had been bothering me. She took it well and changed her routine.

Rose led the group in some gentle exercises and this was followed by a discussion on the merits of different kinds of exercises.

In the skill development demonstration, Len wrote out Carole's goal and her contract on the blackboard. Participants then broke into 3 groups of 4 and each person was assisted in developing a personal

goal and contract by members of their small group. Len's group was quite task oriented, Carole's group became somewhat like a therapy session complete with hugs. In Sandra's group Ruth proceeded to give Alex a back massage and a dissertation on smoking.

When the large group reconvened each person, with the exception of Charles, had a goal and a contract to be completed for the following week. These were:

Nelson - I procrastinate, mismanage my time. I need to set time aside to accomplish things. Specifically, I am going to make time to complete a painting I have been putting off for 2 years.

Edna - I want to be open to new experiences and also more organized. Specifically, I am going to make time each day for exercises first thing in the morning.

Ethel - I have a global goal to run my own life and not be manipulated. Specifically, when people ask me to do things with them I want to be able to say yes or no and really do what I want to do.

Rose - I'm going to keep communication lines open with my son and set specific goals to change things at home.

Mabel - When someone wants to do something nice for me or pay me a compliment, I'm going to accept it.

Sally - I want to catch up on my correspondence, specifically to write one letter that I have been putting off.

Gertrude - I want to make a dress. I have had the material for a year now.

Ruth - I want to move, but I have been trying for 6 years with no luck. I know it's hopeless. A more manageable goal will be to arrive here on time for the next two weeks.

Alex S. - I would like to quit smoking. I'll try to cut down to 5 a day.

Len - I am going to enrol my dog in obedience school Sandra - I am going to do my exercises every morning.

Reflections. Rose is really blossoming and becoming more confident. Her volunteer work, teaching exercise classes at the stroke club, seems to have given her new skills and a sense of purpose. As a result of the very personal nature of today's discussion, the leaders felt empathy for the very difficult situations in which some of these people live and we also gained added respect for their ability to cope and survive. This discussion prompted the leaders to share their personal problems. They discussed personal sources of strength, what has pulled them through very difficult times. In so doing, they gained an additional measure of respect for each other and the ability to survive and strive for humanistic values. As Mabel had said 'I think we are a very special group'.

In summary, it was felt this had been an excellent session. The original objective had been accomplished with each person formulating a goal and a contract by the end of the session. It had taken four weeks to get to this point, but the consensus was that it was valuable to allow people time to get to know each other and to explore their needs. With only two weeks left in the program, the task was to ensure that these people complete their contracts and celebrate a measure of success.

Session 5

Observations. During the opening review of the week:

Edna - I had success. I did my exercises on the rebounder each morning.

Nelson - I went to Art class last night and I am working on my painting and I feel really good about it. This group is really working for me.

Gertrude - Well, I didn't do what I said but I accomplished other things. Lena phoned me during the week and we talked it over and I qot support.

Carole led us through a guided visualization exercise, imagining ourselves at the beach. Reactions were very positive. Discussion of visualization followed.

In the skill development demonstration, Carole went over what happened for her during the week with her contract. She did not achieve her goal, which was to have a 15 min. quiet time each day. The group was very helpful and supportive:

Len - Carole, I think you have been putting your needs second. You have to take time to be good to yourself.

Ethel - I used to be like that but now I am more assertive.

Nelson - I have a suggestion. Why not take 15 minutes right when you first get to work.

Participants broke up into small groups and each person gave a progress report and received encouragement and support and suggestions.

For next week, everyone was asked to be prepared to share their success with the group and to evaluate the program. Sandra suggested

that the group invite guests to a celebration and the response was 'I don't think they would understand what we are doing and what has happened in this group.' Someone offered to bake a cake. For homework, people were asked to fill out the questionnaire on interests to be explored for future programs.

Some very positive comments were made during the informal group closure.

Nelson - This has been so worthwhile. It really got me thinking and doing things and I have been making great progress.

Sally - I have regained some confidence through getting to know people here.

Gertrude - I feel a lot better than when I came.

Rose - I feel good.

Hilda - I feel very comfortable with everyone here.

Ethel - I feel good.

Alex - I wasn't going to come but I'm glad I did.

Agnes - I feel comfortable in coming even though I have missed some sessions.

Reflections. The visualization is working surprisingly well.

Carole is very skilled and comfortable with this technique and this accounts for much of the success with this group.

It is exciting to hear of the very concrete results people are having. The small groups work well for giving individuals feedback and support.

It seems apparent that Charles, at 88 years of age, is reluctant to plan for the future. What is the value of a group such as this for people like Charles who may say 'I live one day at a time... I have no

goals'? Is it possible these people will change and become more self-directed and purposeful in time? It will be important to see what Charles perceives to be his success in the group.

The group is really developing a closeness. It is unfortunate some of the positive expressions have not been captured on tape. It would be particularly gratifying to compare how far some have come from being shy and cautious to being open, supportive, and accepting of each other. On the other hand, the presence of a tape recorder may have inhibited the openess of the group. It is interesting that the group is treasuring a special closeness and not wanting to invite guests to the last session. The group was, in fact, very assertive and refused to allow the leaders to persuade them to invite guests, despite Sandra's wish to invite academics to hear the success stories. This is evidence of a group strength and cohesiveness that is beginning to develop in just five weeks.

It is important to note that individuals in the group are increasingly offering advice and support to the leaders. People are taking increased initiative and control as individuals and as a group.

Session 6

Observations. In the opening minutes, Sally said she felt good about walking all the way from 49th Avenue. Len talked about his broken finger and Alex went into a long dissertation on the history of a finger he broke about forty years ago, which somehow got onto a discussion of honesty and how dishonesty buys peace with one's spouse. Gertrude followed with a long story about her grandaughter.

In sharing personal successes:

Sally - I have lost some of my timidity, thanks to this group. I feel now that I can stand up and be more assertive.

Ethel - I set out to have more control over my life. I've had some small successes. They are a start. The group support and the literature has helped me to see where I'm at and that has been helpful. My greatest success has come from the realization that I must 'accept the things I cannot change and change the things I can', just like it says in the serenity prayer.

Hilda - I have appreciated being with all you nice people. I've been made aware of a number of aspects about myself. And I have become more determined. I'm making notes to myself in the evening and getting things done. I felt sad when I was coming today and realized we wouldn't be meeting again.

Alex - That doesn't have to be the case. Why don't we meet regularly? Gertrude - I've learned quite a bit. I've always been one to make up my mind and just go ahead and do things. The planning and taking things step by step makes it easier. The goal I set was unrealistic. It was just not possible to get that dress made with the confusion in my house but I did do something else. I also enjoyed everyone's company. I'm like Hilda. I need people.

Alex followed with a rambling recount of the breadlines during the war.

Sally - I enjoy my privacy too and my view from my window. But my view of the mountains is being cut off by new buildings. (This was followed by some general discussion of how the new buildings are ruining the view of the mountains).

Mabel - Well, my success was that I let somebody treat me for a

change. I have learned to be good to myself here. This group has really helped me.

Nelson - I have prought my painting to show you. This is a very unusual group and I have really enjoyed the friendship and support.

Finally, a graduation ceremony was held. Len played his tape "Pomp and Circumstance" and Carole formally presented certificates to each person.

Edna cut the cake and Gertrude served the coffee.

Reflections. It is noteworthy that of 13 people who were interviewed originally, 10 were here today: 1 dropped out after the first session, 1 had to babysit and 1 has gone to Europe. It has been the author's experience with seniors' groups that attrition may be as high as 50% over a 6-week period and a 3:13 attrition rate suggests a strong commitment to the group.

The leaders had decided to let this session be somewhat freewheeling and to give up control and responsibility for what happened. The results were interesting. Much of the discussion seemed to be disconnected. Many mentioned personal problems and a lot of group problem-solving was initiated. Some of the common concerns touched on were: honesty, not taking proper care of yourself, the obstruction of the mountains, need for people, need for privacy, loneliness. Len explained that this was common with the breaking up of a group. It seemed like a last cry for help--/just when I need you to help me with all my problems, you are deserting me. Help!'.

It was noteworthy that so many had mentioned how the group had helped them. Even Ruth, who lives a solitary life on the streets, was able to develop a feeling for the group that had accepted her.

The leaders were somewhat disappointed when no group project emerged at the end of 6 weeks. The conclusion was that this may have been an agenda held by the leaders which was not shared by the group. It was important at this point for the leaders to resist any urge to control or coerce and to see what plans emerge from the seniors themselves following the program. The leaders felt the 6 weeks had been very personal and very intense for these people and they needed time and space to digest what had happened. It was now up to Carole and Bern within their respective professional roles as wellness and network coordinators to be prepared to respond and to assist in whatever way is requested.

The group leaders found it difficult to relax and celebrate with so much on the agenda in the final session. They, therefore, made a date to celebrate over lunch the following week and to develop a plan to share the success of this project with the larger professional community.

A Summary of the Effectiveness of the Program in Meeting the Objectives

The program was intended to serve as a framework and a mechanism for: (1) helping seniors take responsibility for their own wellness (2) developing a cohesive support group (3) providing input from seniors into program development, and (4) initiating a group project. The following evidence for the effectiveness of the program in meeting these objectives was derived from the case study narrative.

- 1. Personal responsibility . The continous participant observation record documented how 9 out of 10 seniors had identified specific goals, developed self-directed initiative and demonstrated both observable behavior and expressed feelings indicative of personal initiative and success. This suggests the potential of the program to motivate seniors to take increased control of wellbeing.
- 2. The development of group process. The leaders felt that the support and the encouragement of the group played a big part in motivating individuals to take self-directed action. Initially, the participants had directed all questions and inquiries to the group leaders, a common occurence when groups are first formed. As the group progressed, the participants became intimate with other members of the group and were more comfortable in expressing feelings and thoughts. Dyads changed to triads. Participants became more active in offering advice and extending support to leaders and others. And, finally, increased references were made to "the group" and the helpfulness of the group as a collective. This change toward greater intimacy and evidence of identification with a group in such a short period of time suggested the potential of this program for developing a cohesive support network.
- 3. Seniors involvement in program planning. Increased participation by seniors was noted in three ways. Seniors became more actively involved in the health drop-in, they requested another advocacy program, and their recommendations were used to formulate improvements to the program model.

4. A group project. No group project emerged at the end of the 6-week program. The leaders decided they needed to be patient and to allow the seniors time to absorb what had been a fairly intensive 6 weeks. The wellness coordinator and the seniors' network coordinator were prepared to respond to requests from the seniors and to continue to be nondirective, allowing control and ownership of any emerging group project to come from the seniors.

Addendum

Two months after the group closed, the wellness coordinator prepared to shut down the health drop-in in South Vancouver for the summer vacation. Graduates of the advocacy group lobbied to keep the drop-in open in the absence of the wellness coordinator and proposed to take full responsibility for running it. This was, in fact, a group advocacy project unantic pated by the group leaders, demonstrating seniors taking self-directed group action. While there are conceivably many other contributing factors, it was felt that the advocacy program played a considerable role in empowering this group to take increased responsibility for their own wellness programs.

Recommendations for Improvements to the Model

Based on the program implemented in South Vancouver, the following recommendations were made for the development of community advocacy programs for seniors.

- 1. Program planning. The three leaders became a cohesive professional support team. They learned from each other and worked well together. Values were shared and mutual support was given. As a result, it is recommended that group leaders take time to share values and to use the self-directed process to develop both a unique program and their personal skills. Leaders will also want to be fully engaged as participants in the program so as to create an egalitarian atmosphere of shared control and a sense of partnership in the learning experience.
- 2. Program evaluation. Evidence from the case study narrative suggests the program was effective in helping participants to take control of their lives. The seniors were able to use the self-directed action contract and the support and encouragement of the group to help them achieve personally identified goals. Whether there was, in fact, empirical evidence of increased ILC is the subject of chapter 5. The formative evaluation procedures served to elicit ongoing feedback from the group to guide the development of the program. Since self-evaluation is a component skill of the self-directed process, evaluation of both program and self are essential components of the program. A continous participant observation record was found useful for both formative and summative evaluation purposes with a small group. While audio and visual

recordings of each session might seem to be ideal, it is extremely important that data collection methods be unobtrusive and not interfere with the spontaneity of the group.

3. Content. The original personal advocacy program model was used as a guide. In this project, the decision was made to make the content of the program the component skills of self-directed learning with the addition of a session on assertiveness to get people focused on needs and rights. Visualization was used as a technique and practiced during relaxation training sessions. Speaking and writing skills were practiced but not included as explicit content.

If the purpose of the program is "health-actualization"—
motivating seniors to take responsibility for wellbeing— then a
program priority is to facilitate the process of taking control and to
motivate seniors to initiate action in response to personal goals.
Having identified personal needs and goals and having experienced
success, participants may then wish to pursue further skill
development, such as improving speaking and writing skills. However,
it is recommended that all additional content, such as requests for
resource information, skill development, etc., must emerge from the
expressed needs and interests of the group.

While, ideally, professionals might wish all groups to be active as seniors' advocates, just as Nelson's Be Well graduates were, the process begins with developing self-esteem and initiative and allowing the seniors to define their own personal and group politics if they so choose. It is therefore recommended that, if the focus is activation of seniors, the content consist of the component skills of the self-directed process and that all additional content proceed from the

expressed needs and interests of each unique group of seniors.

4. Agenda. A daily agenda is recommended. This should be prepared in consultation with the group. It is important to pay particular attention to time; to start and finish on schedule.

5. Materials. Cards and file folders were used to record individual progress and most of the seniors participated.

Facilitators will want to ascertain from the group whether written work will constitute added stress or be an aid to learning. Dealing with the files was an extra task for the leaders. Since the purpose of the files is the encourage participants to write down ideas, goals, and plans in order to have a personal record of progress, it was felt that the use of a personal journal would be more appropriate and less work for the leaders.

<u>6. Learning activities.</u> Based on the principles outlined by Gibbons and Common (1985), the leaders attempted to match learning activities to the attributes of the group. This requires sensitivity and constant evaluation.

7. Visualization. This is an effective technique for developing motivation and should be introduced gradually and practiced at each session as part of a relaxation exercise. It is advised that leaders begin with exercises that are fairly concrete and familiar (eg. breathing, deep-muscle relaxation) and work up to the more esoteric varieties of experience. It was felt that the success with visualization in this group was partly due to the particular skill of the wellness coordinator in using this technique.

- 8. Control. There must be a shared agenda. The individuals in the group are gradually given choice and control. Initially, leaders must be prepared to exercise control over the climate for learning. To set the climate for personal responsibility and mutual respect, 'workshop rules' were introduced in the first session and reinforced each week. These were: (a) courtesy and respect (b) anonymity and (c) personal responsibility for participation and learning. Leaders will occasionally want to temper behavior of individuals who are disruptive or monopolizing time, but with sensitivity to the need of each individual to be heard. Wherever possible the group should be encouraged to deal with members who are disruptive. It is important to be explicit about the nature of a shared agenda and the responsibilities of leaders and participants. This attitude of shared responsibility models the ideal partnership between seniors and community healthcare professionals in promoting optimal wellbeing.
- 9. Group process. Because cooperative learning skills are so essential to lifelong learning in an information society, the development of group strength and cohesiveness is considered to be of central importance to the development of educational programs for seniors. Participants must make a commitment to attend each week and no curious observers or guests should be invited. Respect for the privacy of the group facilitates both individual control and the development of group control and cohesiveness. While the leaders used strategies based on personal experience, there has been research on effective group interventions, such as the work of Lago and Hoffman (1978), and resources should be consulted in order to develop the best strategies for creating group cohesiveness.

10. Size. Originally, 13 seniors were recruited; the final numbers were 10 seniors and 3 leaders, a situation the group leaders found to be ideal. A group size of 10 - 15 is recommended in order to individualize the program, thus allowing each member opportunity to be heard and to have his or her needs met. It is unrealistic to expect 3 skilled leaders to be available for 10 seniors and, therefore, the recommendation is made that 2 skilled leaders be available per group. This permits one leader to attend to content while the other offers support and attends to group process. The modeling of mutual support and cooperation between leaders was felt to be essential to the success of the program.

11. Name of the program. The program was originally called Personal Advocacy. The research program was eventually referred to as the Assertiveness Program by the participants. It has also been recently advertised by the Vancouver Health Department as:

Rediscovering Personal Power. Douglas College has provided the following title: It's Your Life: Speaking Up and Taking Control.

For the purpose of this project, since the goal is to facilitate self-direction and personal advocacy, the basic framework that underlies all these programs and which has evolved as a result of this study is a self-directed advocacy model.

Summary

This chapter has used a case study method to describe the field development of the advocacy program model in South Vancouver. The case study narrative of the program documented the effectiveness of the program in helping seniors (1) take responsibility for wellness (2) develop a cohesive support network (3) contribute to program planning and (4) initiate a group project. On the basis of the South Vancouver experience, recommendations were made for improvements to the program. The next chapter deals specifically with summative evaluation. It outlines the empirical evidence of the effectiveness of the program in helping seniors develop increased initiative and control.

CHAPTER 5

Empirical Evaluation of the Program

Introduction

The purpose of the summative evaluation procedures was to obtain evidence of the effectiveness of the program in assisting older adults to take control of their lives. The ILC construct was perceived to reflect a sense of personal efficacy and control, and the working hypothesis was that a self-directed advocacy program would be effective in increasing ILC in a group of older adults. To test this hypothesis, personal interviews, final written evaluations, and participant observation procedures were used to gather empirical evidence from participants in the self-directed advocacy program of change in locus of control. For comparison purposes, the personal interview procedure was also carried out with a quasi-control group of seniors participating in a modified traditional health drop-in.

This chapter provides a detailed description of the subjects, the methods used in collecting the data, and the results of the summative evaluation.

Method

Recruitment. Seniors attending two community-based wellness programs participated in a discussion of wellness initiated by the program coordinator and the researcher. The researcher then made the following request:

At the present time in greater Vancouver there is great opportunity for community program development for older adults. To assist the professionals in providing programs that meet your needs, we are asking for your help. You can assist us by attending the program regularly and agreeing to take part in a short personal interview this week and at the end of a 6-week period.

Thirteen older adults were initially recruited as participants in a 6-week advocacy program which became group 1 (G1); 12 seniors participating in a modified health drop-in were engaged as the control group (G2). Subjects in both groups were encouraged to attend 6 sessions over a period of 6 weeks: a minimum of 3 weeks was required in order for an individual to be included in the study. Of the 7 subjects who were not included in the final analysis, 5 did not attend the required number of sessions, 1 dropped out after the first session to take on fulltime babysitting duties and 1 decided she would not be comfortable with a personal discussion group.

Subjects. Subjects in this study were seniors living in the community who were voluntary participants in two community-based wellness programs, one offered in South and the other in East Vancouver. Ten subjects participated in a 6-week self-directed advocacy program (G1) and 8 subjects attended a modified traditional health drop-in during the same 6-week period of time (G2). Table 1 gives a sociodemographic profile of participants in the two groups.

Table 1
Sociodemographic Characteristics of Subjects in Two Treatment Groups

		G1 - SDA n = 10	G2 - HDI n = 8		
Age (in years)	range mean	58-88 68.0	61-78 66.8		
<u>Sex</u>	female male	8 2	8		
<u>Marital status</u>	married divorced or separated widowed	4 2 4	6 1 1		
<u>Education</u>	high school graduate some high school less than grade 8	1 7 2	3 3 2		
Occupational h	some high school 7 3 less than grade 8 2 2 cupational history				
	housewife skilled labour	7 3	3 5		
<u>Pensions</u>	OAP GIS GAIN	9 5 3	5 2 2		
<u>Housing</u>	house apartment	8	6 2		
<u>Health</u>	seniors' housing excellent good fair poor	1 5 3 1	0 1 6 1 0		

As shown in table 1, the mean ages of the two groups were 68.0 and 66.8 years. In both groups, a majority of participants were female, had not completed high school education, and were receiving the Old Age Pension (OAP). Primary work history was typically housework or a blue collar occupation. Health was generally rated 'good' with the most common concerns being heart disease, high blood pressure and arthitis. There appeared to be no important differences between groups on any of the independent variables. Where appropriate, statistical analysis was applied and no significant differences were found (age: t=.41; education: t=-.65; health: t=-.69 at p>.05).

Data collection.

(a) Experimental procedures. The design was a 2X2 quasi-experimental non-equivalent control group design for small samples of convenience (Campbell & Stanley, 1966). Subjects in both treatment groups were interviewed prior to and at the end of the 6-week program.

The inventory (see appendix D), which was administered during the personal interview, consisted of three sections labelled A, B, and C. Section A: part I elicited sociodemographic information and part II contained open-ended questions concerning program expectations.

Section B contained Reid and Ziegler's Desired Control Measure (short form). Reid and Ziegler's Desired Control Scale (short form) measures the extent to which individual's perceive themselves as in control of desirable outcomes. It is "essentially a unidimensional index of generalized expectancies of control over a range of desirable outcomes" (Reid & Ziegler, 1981, p. 149).

This scale consists of 16 pairs of items, one member of each pair indicating the extent to which a particular event is desired and the other member the extent to which an individual has control over the occurrence of the event. Both desire and control are assessed on a 5-pt. scale, with the total score for this measure consisting of the sum of the cross-products of the desire and expectation rating for each pair.

(Ziegler & Reid, 1984, p. 7).

Reid and Ziegler's scale was developed from a survey of 143 older persons in Metropolitan Toronto, 78 institutionalized and 65 living in their own homes (Reid & Ziegler, 1981). The questionnaire probed the personal control beliefs of older adults. The original inventory was a 2-part questionnaire containing 70 items: 35 items in the first part measuring the extent to which an individual desires a particular reinforcer and 35 parallel items in the second part measuring the extent to which the individual can obtain these specific reinforcers. Internal consistency was in the high 80's and 90's (Cronbach's alpha coefficient) in four separate studies. Of particular relevance to this study is the finding that results had high concurrent and predictive validity to measures of subjective wellbeing. The original measure was, however, found to have only moderate to low test-retest reliability.

Because the complete questionnaire took over an hour to administer, a short form was developed with a systematically selected sample of 87 females and 48 males. (Reid & Ziegler, 1981). It was found to have an internal consistency of .73. A reanalysis of 469 cases using the long form and selecting those items contained in the short form for analysis, showed that internal consistency remained high. Reliability on the short form is given as .73 on Cronbach's alpha (Ziegler & Reid, 1984).

Because of its development with a large population of representative Canadian seniors and its correlation with measures of wellbeing, Reid and Ziegler's control scale was deemed to be the standard measure most appropriate to this study. The short form was chosen because of its high internal consistency and, most particularly, the short time required to gather the data.

Section C, part I, of the interview schedule contained 20 questions developed by the author which were designed to reflect specific content of the self-directed advocacy program. In developing the questions in part I, an attempt was made to:

- (1) balance positive and negative statements
- (2) avoid ambiguity, i.e. be clear and parsimonious
- (3) cover the range of program objectives
- (4) solicit a maximum spread of scores and
- (5) reflect both behavioral and attitude change.

Part II contained five questions related to general program objectives, to be rated on a 5-pt. Likert scale. The questions concerned perceived level of (1) speaking out, (2) assertiveness, (3) group participation, (4) helping behavior, and (5) sense of control.

Interviews were conducted by two females in their early 40's and one 36 year old male. In order to ensure standard procedures, a training session was held. Interviewers were given an interview protocol sheet (see appendix E) containing a description of the inventory and the specific instructions to be given verbally to the subjects (see underlined material). All questions were to be read and scored by the interviewer. The protocol and the inventory were reviewed for clarity.

- (b) Additional data collection procedures. The primary dependent measure was Reid and Ziegler's Desired Control Scale (short form) administered to both groups during the personal interview. However, three additional data collection methods were used with G1 in attempting to ascertain the effectiveness of the self-directed advocacy program.
- 1. Open-ended questions from the interview. As part of the interview schedule, subjects in G1 were asked four open-ended questions: two, on the pretest, were to determine their expectations and two, on the postest, to describe what they had gained from the program.
- 2. Written final evaluation. Participants in group 1 were given a final written evaluation questionnaire (see appendix C).
- 3. Participant observation record. A continuous record was kept which emphasized content relating to personal problems and concerns, individual and group control. The descriptive narrative, derived from the continuous participant observation record, was used in chapter 4 to provide a basis for making improvements to the program model. In this chapter it provides data for a case study analysis (see appendix F) which presents evidence of behavior suggestive of an increase in ILC.

Results

Statistical analysis of selected measures of control from the interview data (G1 and G2). In presenting the results of the study, analysis of selected measures of control from the interview data will be discussed first. Four measures of control derived from the

interview schedule were analyzed.

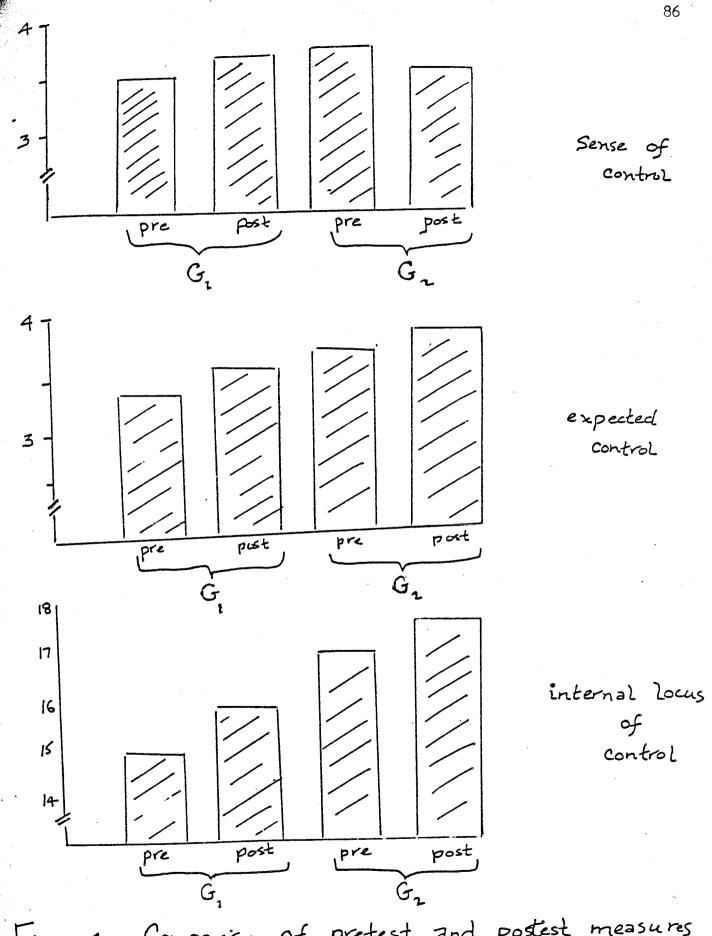
- 1. Desired control (BI) represented the extent to which individuals <u>desired control</u> in different areas of their lives (family, health, etc.). A mean score was obtained from 16 questions from the Reid and Ziegler Scale each scored on a 5-pt. Likert scale. These questions are contained in part I of section B of the questionnaire (see appendix D).
- 2. Expected control (BII) was calculated from the 16 parallel questions from the Reid and Ziegler Scale measuring expected control in the various areas. These are contained in part II of section B of the questionnaire.
- 3. Locus of control (L) represented the sum of the cross products of BI X BII.
- 4. Sense of control (CII5) derives from responses made on a 5-pt. scale, anchored by the terms "very high" and "very low", to the question "what is your level of control over your life?". This question was asked in part II, section C of the questionnaire.

Subjects in G1 showed a small increase in scores on expected control (BII), locus of control (L) and sense of control (CII5) between the pre and post tests, but a small decrease in desired control (BI). Subjects in G2 showed a slight increase in expected control (BII), and locus of control (L), with small reductions in desired control (BI) and sense of control (CII5). Table 2 shows pretest and postest scores on each of these measures and figure 4 compares pretest and postest scores on 3 measures for subjects in two treatment groups.

Table 2

Mean Scores on Four Measures of Control For Subjects in Two Treatment Groups

		G1 - SDA n = 10		62 - HDI n = 8		
		pre		post	pre	post
Measures of cont	<u>rol</u>					,
Desired control	(BI) x sd	4.23 0.42	1	4.16 0.45	4.49 0.24	↓ 4.33 0.31
Expected control	(BII) x sd	3.51 0.46	1	3.72 0.43	3.82 0.16	3.98 0.40
Locus of control	(L) x sd	14.90 2.84	1	15.83 2.09	16.83 1.33	17.27 2.83
Sense of control	(CII5) x sd	3.40 0.97	1	3.60 0.84	3.63 1.30	3.50



Comparison of pretest and postest measures Figure 4. of control for two treatment groups.

Because of the small sample size and the inability to obtain either a random or a matched sample, a multiple analysis of variance was the statistical procedure considered to be most appropriate. The MANOVA showed no initial difference between groups on 3 measures of control (FBII=3.01, FL=2.70, FCII5=1.16; p>.05). (The fourth measure, desired control, showed a very minimal reduction in both groups and was not included in the analysis.) No difference in control was found as a result of participation in either of the programs (FBII=4.95, FL=2.21, FCII5=.14; p>.05) and no difference was found between groups on the postest (FBII=.06, FL=.27, FCII5=1.16; p>.05).

The measures of general program effect (which were designed by the author and contained in parts CI and CII of the inventory) were also analyzed using a multiple analysis of variance. For completeness, item CII5 (self-perceived level of control) is included in the analysis of program effect scores. The MANOVA showed no difference between groups on initial level of advocacy (FCI=.00, FCII1=2.97, FCII2=.94, FCII3=.55, FCII4=.02, FCII5=.05: p>.05). No difference was found on the 6 program effect scores as a result of participation in either of the groups (FCI=.19, FCII1=2.08, FCII2=.00, FCII3=.18, FCII4=.46, FCII5=.62; p>.05) or between groups on the postest (FCI=.19, FCII1=2.07, FCII2=.00, FCII3=.18, FCII4=.46, FCII5=.62; p>.05). Table 3 shows mean advocacy scores (program effect) on 6 items for subjects in two treatment groups.

Table 3

Mean Advocacy Scores (Program Effect) for Subjects in Two Treatment Groups

	G1 - SDA n = 10		G2 - HDI n = 8	
	pre	post	pre	post
Measures of advocacy				
General program effect (CI) x sd	68.5 13.9	\ 69.6 9.9	69.5 12.8	68.8 8.1
Speaking out (CIII) x sd	2.9 1.0	3.4 0.5	2.6	2.8 0.50
Assertiveness (CII2) x sd	3.2 1.0 —	3.2 → 0.8	2.9 1.1 —	2.9 > 0.6
Group participation (CII3) x sd Helping others (CII4)	3.6 / 0.7	3.8	3.5 1.1	→ 3.5 0.5
x sd Control (CII5)	3.8	3.7 1.0	3.6 0.7 ↑	3.8 0.7
x sd	3.4 / 1.0	3.6 0.8	3.6 1.3	3.5 1.20 -

Empirical evidence from the additional procedures (G1 only).

- 1. Analysis of open-ended questions from the inventory. Analysis of the pretest data indicated that subjects' reasons for participating in the program were relatively nonspecific. Among the reasons mentioned were: curiosity, to learn, to be aware, or simply to pass the time. The responses to the question asking them to describe what they had gained from attending the program were more specific. One individual said: "I expected someone would be giving lectures rather than us doing all the participating. I thought you would be the experts but you let us do all the work." Other comments were:
 - I did something for myself
 - more aware of self
 - more self-assurance.

These responses suggest an increase in self-awareness and a more active involvement in learning--outcomes that apparently were not anticipated by the participants.

- 2. Analysis of written evaluations. In response to the question "Do you feel this program helped you to feel more in control of your life?", 9 out of 10 indicated 'yes'. In response to the question "What have you learned from this program?", 3 indicated they had learned to speak up for their rights and 4 felt that sharing problems with others was helpful.
- 3. Case study analysis. There was evidence from the participant observation record that individuals had identified important areas, had initiated self-directed action, and were feeling good about themselves. The case study narrative describes how 9 participants developed a contract and achieved a personal success

during the course of the 6-week advocacy program. They had, according to Rotter's (1966) definition, taken control of their actions in pursuit of desirable outcomes.

The following case studies are a composite of data from the personal interviews, written final evaluations, and continuous participant observation record (see appendix F for the format of case study analyses). Four individuals have been arbitrarily selected to represent the group. They provide evidence that self-directed action was taken in response to personally identified needs. In addition, they provide that richness of context to which Stake (1985) alludes.

Hilda:

Hilda was a 65 year old lady living alone in her own home. She had recently been widowed, had received whiplash injuries in a car accident and appeared to be frequently on the verge of tears during the first few sessions. She spoke of wanting more contact with her two sons who were both separated from their wives and living at a distance from her.

Her purpose in coming was "to learn something new... to learn about my own needs". Her goal was "to be more assertive to my kids so they will keep in touch with me".

During the third session, the leaders arranged for Hilda to roleplay her concern, using a telephone to simulate actual conversations with her sons. As a result of her roleplay experience, she realized she could not be assertive with her sons. However, she was able to call her estranged daughter-in-law and invite her grandaughter to visit for a weekend.

In response to what she had gained from the program, she said "I learned that by sharing we can help each other. I feel more in control knowing I am not alone...others have problems too. I can make the effort to be more positive in my thinking and follow through with being a whole person. I enjoyed most the friendliness of our group, the willingness to share experiences and also the helpful advice given".

During the 6-week period, an improvement was observed in Hilda's health. On the last day of class, she announced that she was off to the Volunteer Grandparent Association to register as a foster grandparent, something she had been thinking of doing for some time. The leaders felt that Hilda had, as she intended, learned what her needs were and had discovered a need to be needed and valued as a family member. It was interesting that her solution was not to pursue contact with her sons or grandchildren, but to substitute involvement with another family in the community.

Charles:

Charles was an 88 year old former marine engineer, recently widowed and living alone in his own home. Charles stated that he had no expectations in coming to the program, but "I want to learn and to help others". He was the only participant who refused to develop a goal or a contract. He insisted that all his goals were in the past. Members of the group insisted that Charles should have goals and should not live in the past. But he was firm. "At my age, I live One day at a time".

Nevertheless, Charles did experience success in the program. "I

confirmed here some of the things I have done in my life". Charles' major goal in life was to make a good life for his children and he was proud that he had achieved that goal. It was apparent that Charles had used the self-directed process as a method of life-review.

His activities and his sociability suggested that Charles lived very much in the present. In a private conversation with one of the leaders, Charles said he was a very lonely man. The leaders felt he had used the group to meet his need for contact with people. He never failed to have a cheery comment and his gratitude for the good in his life added an optimistic tone to the group. "If you look out today, you just have to be glad you're alive on such a beautiful day as this".

Six months after the program had ended, Charles said he was planning a trip to England to visit his relatives and he ordered copies of the picture taken with Len, the group leader, to take to his family in Britain. Our final assessment was that he was, in fact, an 88 year old gentleman definitely planning for the future.

Nelson:

Nelson was a 66 year old retired building maintenance man, living with his wife who also attended the advocacy program. His purpose in coming was "to help others. I am fortunate...whatever I can do, I want to do. What I get out of this program is up to you. You are the experts". (He was in for a shock!)

Nelson contracted "to finish a painting I started two years ago".

His success was in finishing his painting and bringing it for the class to admire. The program did not meet Nelson's expectations. "I

expected someone would be giving lectures rather than us doing all the participating. I thought you would be the experts but you let us do all the work".

The leaders observed changes in Nelson. When he first came to the group, he was very talkative, very much a cheerleader, encouraging everyone else and complimenting them, always trying to be helpful. As the weeks wore on, Nelson became more thoughtful and he listened to others. The leaders felt it was important for him to focus on a goal for himself and to produce something of which to be proud. It was as if permission had been given for him to be selfish. And, in addition, the group discovered that Nelson was a very talented artist.

Ruth:

Ruth was a 58 year old female divorcee, living in a subsidized housing unit on GIS & GAIN supplements. Ruth lives essentially on the street. She spoke of spending her days riding the buses, visiting libraries and health drop-ins, and attending free lectures all over the city. She said she had been to every health drop-in in the city. Ruth became known as the "bag lady" because she carried four huge plastic bags with her at all times, full of what seemed to be newspapers and health drop-in handouts and programs.

Her stated purpose in coming was 'to pass the time... someplace to go' although she also stated that she had big problems she couldn't solve. "I want to find solutions to my problems. I feel like the mouse against the lion". She felt her problems really couldn't be solved and she refused to make any attempt to either define what those problems were or consider that solutions might be possible. When she

was prompted to choose a small manageable goal, she contracted on her own initiative to attend each week on time and to join in the group circle. (During the first two sessions, she wandered in late and stayed on the periphery of the circle).

When asked in the final session to share a success, she said "I'm not prepared to talk. I still have my problems" but she did offer that she had 'enjoyed the friendly people' and that 'this was the best drop-in in the city'. And she had managed to attend four sessions on time. She was, in fact, often the first to arrive.

The leaders observed profound changes in Ruth. When she first came she was very anxious and disruptive. She insisted on sitting outside the circle. She seemed to have a need to be heard but had great difficulty relating to people. As time went on, she relaxed and became an accepted member of the group. Rather than feeling irritated by her, people became interested ...and particularly curious about the contents of her bags!

In summary, these case studies show individuals expressing needs, moving to identify specific goals, taking self-directed initiative and demonstrating both observable behavior and expressed feelings indicative of personal success and improved wellbeing.

Discussion

There were a number of problems with this study that made it difficult to demonstrate the effectiveness of the program.

Subject attrition. The sample size was small in both groups.

The attrition rate was 7 out of 25; 3 dropped out of the advocacy program and 4 dropped out of the control group. In regard to the

control group, it should be noted that a health drop-in is typically not a committed activity, however, participants in the drop-in program who were interviewed as part of the control group were asked to commit themselves to coming for a 6-week period. While other participants tended to drop in irregularly, those who were interviewed were more regular in attendance.

Sampling procedure. It was not possible to randomly select and assign subjects to the two treatment groups nor to match them on initial level of control. Differences on initial level of control (the key variable) were, however, not statistically significant. An analysis of sociodemographic variables also indicated the groups were comparable.

Ceiling effect. Scores on the pretest were high (eg. the mean for G1 on B1 was 4.23 out of a possible 5) which left little room for increase in scores. This indicates that participants in both groups were initially high on ILC which is consistent with Leeb's (1983) findings that those who engage in health promoting activities are more self-directed. Given the trends in the data, one might expect to find a more important change with a group initially low on self-directedness.

Time factor. Six weeks is a short period in which to make fundamental changes in one's belief system, particularly when those belief systems have been forming for some 80 years! While the experimental data failed to yield a significant change in ILC over a 6-week period, the case study analysis provided considerable evidence for increased ILC. Furthermore, the evidence was in the form of observable behavior which some researchers suggest (eg. Fullan, 1985)

precedes change in attitude and belief. Change in a global belief system might be expected to occur over a longer period of time following change in behaviour.

It is unfortunate that time and logistics did not permit the collection of data from observation of the seniors in G2. In the final analysis, however, the most definitive evidence of the effectiveness of the program was the participation rate in both programs 6 months after they were initially implemented. The modified health drop-in program closed down for the summer due to insufficient attendance, whereas graduates of the advocacy program lobbied the health unit to keep the health drop-in open during the summer months. The health drop-in in South continued without the supervision of the wellness coordinator during the months of August with an average attendance of approximately 25 seniors per session. In addition, the seniors in South requested another 6-week advocacy program which was scheduled to begin in January. The general observation is that the graduates of the advocacy program have developed initiative and taken greater responsibility for health and their own health promotion programs, in comparison with the control group (who appear to have lost interest).

Group support effect. One of the program objectives in G1 was to develop the group as a support network and to increase the sense of group control. Encouragement and support from the group was an important factor in an individuals achieving personal goals. With the dissolution of the group on the final day, there were expressions of sadness and a 'what will I do without the group' phenomenon. The anticipated loss of the support and resources of the group may have

had the effect of reducing subjects' general feeling of personal control.

Problems with the standard locus of control instrument. While ILC is perhaps the most well-researched psychological construct, it is a very complex construct which presents many measurement problems (Palenzuela, 1984). There are many spheres of influence included in the inventory (e.g. control of family, friends, health, activities). In this study individuals in G1 made gains in control related to a specific area of concern (eg. taking control of an activity, initiating communication with family). However, there was little evidence of an increase in a global sense of control that includes other spheres of influence.

Reid and Ziegler's balance of dimensions (eg. family, activity, etc.) represents a balance of spheres of influence common to a general population of older adults residing in metropolitan Toronto. There are gross individual differences, however, in an elderly population (Ziegler & Reid, 1984). Furthermore, results from the case study analysis suggest that a sense of competence and wellbeing follows alteration of control in one area of specific importance to the individual. If we examine scores on specific items for each subject, there is some support for the importance of minor fluctuations in control. Table 4 shows desired and expected control ratings on specific items from Reid and Ziegler's scale related to purposes and goals that were identified by individuals. (Sally, Mabel, Ethel, and Gertrude stated purposes that were not clearly related to specific items and were, therefore, not included in the table.)

Table 4. Desired and Expected Control Rating on Items from the Reid and Ziegler Desired Control Scale Related to Purposes or Goals Identified by Individuals in the Program.

subject	purpose; goal i		control rating			
		item #	des	ired	expected	
			bre	post	pre	post
S1. Rose	to be assertive; communicate with son	8 13 15	4 5 5	5 5 5	2 2 1	4 2 2
S2. Hilda	to learn what my needs are; to be assertive to family	8 13 15	5 5 5	5 5 4	2 3 4	4 4 2
S3. Charles	to help others no stated goals (social goals determined in private conversation)	1 3 10 11 13 15	4 5 4 4	4 5 5 5 4 5	4 4 4 2 4	4 4 4 2 4
S4. Nelson	to help others; complete a painting	1 3 10 11 13	5 3 5 5 4	4 3 4 4 5	3 5 4 2 4 4	3 4 4 3 4 4
S5. Edna	to be assertive; do exercises every day	2 9	5 5	4 4	5 4	5 4
S6. Ruth	someplace to go; to arrive on time	4 6 9	5 4 4 5	5 4 5 5	4 2 3 3	4 4 5

Hilda, for example, (ref. table 4, p. 98) had spent a lifetime as wife and mother and at age 65 she found herself without a husband and having little contact with children and grandchildren. Of interest, on both pretest and postest, Hilda rated "5" on <u>desired</u> control with respect to family on the inventory and, following the program, her self-rating on <u>expected</u> control in the area of family increased on two dimensions from 2 to 4 and 3 to 4. On the third item, desired control rating went from 5 to 4 and expected control from 4 to 2, reflecting a loss of both desired and expected control, which may suggest acceptance and positive adjustment.

The question, of course, is whether Hilda would have had the same feeling of wellbeing if the program she attended had been primarily designed to improve her level of health and fitness. The experience with this group, which is supported (though somewhat tenuously) by an item analysis of desired and expected control measures, suggests the achievement of a reasonable, meaningful goal <u>identified by the individual</u> may be a critical determinant of wellbeing.

Results from this study suggest the importance of each individual identifying a specific area of concern and achieving a small success in that area. The control of friendly visits may be an important goal for institutionalized elderly; control of physical activity may be important to a retired professional athlete. However, Reid and Ziegler's locus of control instrument may simply not be sensitive to a change in control in one small area of importance to the individual—particularly if success and increased control in one area results in reductions in desired or expected control in other areas.

Limitations of the case study analysis. In comparison to the experimental data, the case study data would appear to provide the more valid and reliable empirical evidence of a change in ILC. For, not only did Reid and Ziegler (1981) report only moderate retest reliability, they stated they <u>anticipated</u> changes in control on retest 6 months later in the absence of any intervention strategies. However, the method of participant observation also has its problems with reliability.

Despite experimental rigour, the participant observer loses a measure of objectivity by virtue of belief and commitment to the effectiveness of the program; and full participation in the program is inhibited by the business of recording. Two of the group leaders collaborated on the case study analysis, which enhances reliability; however both were strong in their belief in the effectiveness of the program and this not only adds bias to the results but is also a factor contributing to the success of the program. These two problems, observer bias and instructor bias, can only be alleviated by a larger study using unbiased, nonparticipant observers and uncommitted professionals acting as group leaders. This, of course, presents a conflict of interest since commitment to the process is important to the effectiveness of the group leaders and nonparticipant observation techniques may interfere with the development of group process. (It must be noted that the three group leaders were also involved as professionals in the modified health drop-in, which would rule out the effect of personalities on the relative success of the two programs in the longterm.)

Summary

This chapter has outlined the empirical evaluation of the program using both experimental and case study methods. The case study analysis supported the effectiveness of the program in helping seniors take increased initiative and control of wellbeing. While the experimental analysis failed to support the effectiveness of the program in increasing general ILC, an item analysis of Reid and Ziegler's scale suggested the importance of a minor shift in control to subjective wellbeing in the older adult.

CHAPTER &

Conclusions

Adults are required to maintain responsibility for the quality of their lives in later years. In response to the pervasive need for autonomy and personal advocacy, a self-directed advocacy program was conceived, implemented and evaluated using both experimental and case study methodologies. The case study method outlined the implementation and formative development of a 6-week program; the case study analysis clearly described how 9 out of 10 seniors developed initiative and achieved a personal success. The experimental analysis, while inconclusive, served to enhance understanding of the issue of control in a group of 10 seniors living independently in South Vancouver; and there are a number of implications for health promotion and educational program development for older adults.

Relative contributions of the experimental analysis and the case study analysis to the understanding of control in the elderly.

Despite the failure of the experimental procedures to demonstrate the effectiveness of the program, the standard measures are interesting as an adjunct to the less formal procedures. The low test-retest reliability of Reid and Ziegler's Desired Control scale instrument may render it inappropriate for measuring intervention effects, however, it does not diminish the value of the instrument as a measure of psychological adjustment. Reid and Ziegler's (1981) findings that correlations with measures of wellbeing remain high on retest adds further support to the importance of the relationship between ILC and

wellbeing which is critical to this study.

By examining specific items on the scale, additional information can be obtained about beliefs, attitudes, and areas of concern to the individual. For example, discrepancies between desired and expected measures of control on a single item may suggest a specific area of concern and a potential source of anxiety for the individual. Reid and Ziegler's scale may be more useful as an "ipsative' rather than a "normative" instrument, providing information about the relative values on each item—the unique pattern of the numbers for each individual.

By using both case study data and the Desired Control Scale, the researcher or developer is able to supplement and compare the behaviour that was observed with the self-report measures of attitudes and beliefs of the individual. In this way, a greater understanding is gained of the issue of control in a selected sample of older adults.

The relationship between locus of control and wellness reconsidered. The leaders of this particular program felt that the exercise of control in a specific area of interest (eg. completing a painting, completing a knitting project, improving communication with a family member) gave participants a feeling of competence and improved wellbeing. Schulz and Hanusa (1980, p. 37) suggest that perhaps "wellbeing (which is the central focus for wellness program development) is more likely the result of relative changes occurring over a short period of time than absolute levels of control". And the comparison of case study data and standard measures in this study provides support for this position.

It may have been naive to expect that a significant change in general locus of control belief could be demonstrated with a small group over a short duration of time. However, a change in a global measure of control might be expected to occur over the long term. Given the importance of ILC to wellbeing and the social imperative for personal responsibility and control, a change in locus of control should continue to be a program objective, particularly in the area of health education and promotion. A much larger sample over a longer period of time may be required in order to demonstrate a significant treatment effect; however, results from this study suggest Reid and Ziegler's scale may not be suitable to measure intervention effects on generalized ILC.

With respect to the manipulation of control, however, there is an ethical consideration that has been noted by Langer and Rodin (1976). The anxiety that accompanies loss of control and support systems has great potential for morbidity and mortality. In a followup study to their control manipulation, Schulz and Hanusa (1978) documented evidence for increased mortality occurring for the group that received greater control and predictability, which was subsequently withdrawn. The implication is that older adults may be better served by leaving them in a passive dependent situation than by giving them a temporary experience of increased control.

Professionals who provide the opportunity for the development of a sense of control and an increased expectation of control, have a moral obligation to ensure that the resources are available for support and control to continue. Given the difficulty in doing this, it is not surprising that since Schulz and Hanusa's tudy (1978), there

have been few others manipulating control belief in the elderly.

In view of the cultural imperative for autonomy, however, the issue of control should not be abandoned. There must be a continued effort to discover new ways to encourage older adults to exercise personal initiative and control; and professionals must be active advocates for educational programs for the elderly that incorporate advocacy skills, such as this program does. Once older adults are given the opportunity to identify their own needs and to be involved in planning strategies to meet them, they can then act as personal advocates and, regardless of their level of need for support, they can then maintain an active role in making deciions that affect the quality of their lives.

Internal locus of control and self-directedness. Increased ILC is logically consistent with increased responsibility for health and wellbeing. However, given the difficulty of conducting an experimental study that is ethically defensible and of sufficient duration and size to demonstrate a significant change in ILC, a more expedient focus might be on self-directedness.

If wellbeing is associated with the development of competence over a short period of time, the construct of self-directedness, its measurement and manipulation deserves important consideration in the development and evaluation of health promotion programs.

Self-directedness may, in the final analysis, be a construct which is more appropriate than ILC to both the goal of health promotion and the

socio-political climate of the 80's.

The mandate for health promotion and the role of education. If wellness in its broadest context encompasses all that gives life meaning, there are fundamental implications for the role of health promotion and education for older adults. The community healthcare system has been given a strong mandate for the development of a wide range of educational programs for older adults and strategies for teaching the expanding population of elderly have become a priority for educational gerontology. There is a need to define the limits of health promotion and to develop the role of the health professional as facilitator and resource, connecting the older adult with other resources for education in the community. The public healthcare system cannot be expected to provide the full range of educational opportunities for the elderly.

The contribution of education to seniors' wellness can be made through refining the methods that facilitate older adults taking control of their health and becoming active in creating their own futures. Once seniors realize their personal power and control over wellbeing, it is important that health professionals be comfortable in an interactive role that focuses on reinforcing the initiatives of the client. Efforts to make use of knowledge and experience of the elderly will require attitudinal change on behalf of both older adults and health professionals (Redford, 1981). Many professionals will require training in facilitation skills (Neufeld, 1984) so that the partnership between the professional and the elderly client is egalitarian, reflecting a shared responsibility for health and the quality of life.

Education's particular contribution must be in the refinement of

process and facilitation skills, developing new ways to motivate the older adult to become self-directed, and contributing to the understanding of the dynamic between educator and learner that facilitates mutual growth and understanding. Continued work needs to be done in developing cooperative learning techniques and the potential of both learning partnerships and collaborative group work in creating a society of autonomous lifelong learners. The task is to focus on what Cross (1978), Fellenz (1982), Jensen (1970), and Kidd (1959) maintain is, after all, the true purpose of adult education: developing self-direction.

Future Directions in Program Development and Research

Program development. The program implemented in South

Vancouver was different from the original model, both as a result of

the implementation procedures and formative evaluations. Because the

original model was conceptual, there were no formal procedures to

indicate that the program implemented in South Vancouver was, indeed,

an improvement; development was based largely on shared consensus of

the group leaders. The group leaders felt that it was superior

because 3 experienced professionals had been jointly involved in

program planning. They felt it was an improvement because it

incorporated the unique needs and skills of both group leaders and

participants. The program was better because it involved only the

explicit teaching of the self-directed process, with no preconceptions

by the leaders about the need for speaking or writing skills. Needs

for information, practice, and skill development in particular areas

were defined by the seniors themselves and addressed by the leaders

to the best of their abilities.

The case study narrative indicated the program was effective in motivating individuals to be self-directed and ultimately to act as program advocates, and it is, therefore, considered to be an important component of a comprehensive community-based wellness program. The next step is continued refinement and application in a variety of contexts and settings. Each unit requires systematic evaluation with respect to specific learning objectives in order to create the best possible learning experiences and an improved program model.

Plans are underway to implement four new programs in 1986.

Improvements to the model include:

- the development of a more expedient preassessment procedure in the form of a written questionnaire.
- 2. the addition of a unit to identify a group "charter of rights" in order to improve group cohesiveness and promote a group advocacy project.
- 3. the use of a personal journal to help participants chart and evaluate their own progress
- 4. specific objectives and evaluation criteria for each session. The goal is to create a model that can be easily adapted to a variety of groups, needs, and goals—a model that will be useful in instructing professionals, as well as for institutionalized elderly.

Research. Future directions for research in education and health promotion for seniors suggested by this study are:

1. Use of larger samples over a longer period of time to ascertain possible changes in locus of control, with the postest administered 6 weeks following the final session in order to avoid a possible letdown effect immediately following the loss of the group.

- 2. Wider use of naturalistic observation procedures and the case study method of analysis in program evaluation and research. Programs in health promotion focused on helping seniors take increased control of wellness are a relatively new phenomenon in the field of healthcare. If a program is designed to teach participants how to take initiative and control, then evaluation should document that process, rather than only or primarily quantitative measures of health status and the absence of disease.
- 3. Exploration of the relationship between ILC and self-directedness with particular emphasis on measures of self-directedness.
- 4. Implementation of the program with groups identified as low on self-directedness.
- 5. Development of training programs for professionals using the self-directed learning model proposed in this paper. The ideal training program would include seniors and professionals as participants and equal partners in learning.

In conclusion, an important contribution toward improving the quality of life for older adults can be made through efforts to identify populations low on self-direction and motivation to learn and, using an adaptation of the self-directed advocacy model proposed in this study, to bring those who have been poorly served by traditional education into the world of lifelong learning. The goal is to motivate older adults to be self-directed and thus function effectively as full participants in the information age of the 80's.

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HOW TO SPEAK UP

FOR WHAT YOU NEED

TO MAINTAIN CONTROL

OF YOUR LIFE

The Development of a Self-directed Advocacy Program
for the Older Adult

APPENDIX A

bу

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September 1985.

Introduction

Naisbitt (1982) tells us we are in the information age. This means that every member of the learning society must be able to access information. He also identifies a major trend away from institutional authority to self-reliance in every aspect of our lives. This means that every individual must able to access the information needed to maintain control of life. The goal of education for the older adult must be learner autonomy, its purpose to empower adults to make choices in harmony with self-realization (Chene. 1983).

What do we mean by autonomy? Autonomy is often equated with independence and an important distinction must be made. Independence, so highly valued by western society means "unwillingness to be under obligation to others" (Concise Oxford Dictionary, 1956, p. 606). Autonomy, on the other hand, means "freedom of will...right of self-government" (p. 178). Autonomy does not imply independence or self-reliance, for it is often achieved through interdependence or mutual support. The important aspect is the element of choice. Older adults need opportunities to make choices in accordance with a personal value system.

There is a need for learning opportunities for older adults that facilitate the development of learner autonomy. The individual must be given the skill and practice in defining goals, choosing and adapting the learning environment, and selecting content and method of learning. Older adults must become self-directed in learning (Fellenz, 1982).

insert figure. A self-directed learning model.

Furthermore, autonomous, self-directed learners need learning resources and community supports if they are to maintain control of life. And seniors have a role to play in defining the nature of those support systems. It is, therefore, necessaary that seniors be able to act as advocates in their own behalf to ensure that educational and community supports meet their needs. This means identifying personal rights and needs and speaking up to be sure that social and political systems do, indeed, address those needs. For unless we can speak up, persuade and convince; unless we have a say in what goes on we are not in control of our lives (Stone & Bachner, 1977).

The National Advisory Council on Aging is prepared to listen (Begin, 1984). Seniors across Canada are being asked to speak out about their feelings on self-respect, independence, interdependence, and autonomy. The purpose is to discover how seniors can fit in as functioning members of society. Education has a vital role to play in facilitating the development of personal advocacy skills so that seniors can take full advantage of this opportunity to speak up effectively about their fundamental needs and concerns in order to shape the future of their lives.

Furthermore, Caplan (1984) tells us medical ethics dictates that even the frail institutionalized elderly must be autonomous, must be permitted choices in harmony with a personal value system. He advocates the use of surrogates for the incompetent elderly. However,

one wonders how many healthy seniors, and indeed adults of any age, are truly autonomous or have ever acted as personal advocates.

An advocate is "one who pleads in favor of, vindicates or espouses a cause by argument" (Random House Dictionary of the English Language, 1967). Advocacy is "active espousal", not just selection of information and supports, and this can be practiced in essentially two ways:

- (1) by writing effective letters to the most influential people
- (2) by speaking out in the most strategically effective way on matters of personal concern.

The challenge for educational gerontology is how to help seniors choose the information they need and to develop the necessary supports and resources in order to maintain control of their lives (Fedorak, 1984). The development of the self-directed advocacy program is an attempt to respond to this challenge. The focus is on practice of the requisite skills of the self-directed learning process and the skills essential to speaking up in the most effective way. Through group process, individuals will learn how to speak up for what they need to maintain control of their lives.

Developing Personal Advocacy: Selected Learning Activities.

This curriculum is a guide. It is a guide that represents the author's current recommendations for the best learning experiences to accomplish the objectives. The challenge for each group leader is to adapt these experiences to match personal style and skill and the unique characteristics of each group of adults in order to have the greatest impact.

We would urge you to develop not only your program but your own personal power and skill. For, in the final analysis, your most effective teaching tool is yourself as a model of both self-directed learning and personal advocacy. You are about to embark on an exciting personal journey toward excellence as an educator who can really make a difference in the learning lives of older adults.

UNIT I

Visualization

Many seniors have not experienced success in a learning environment and may not be highly motivated to participate. It may be necessary to inject some enthusiasm through the process of visualization and guided imagery. For, in the absence of external reinforcement it is a vision of exciting possibilities that motivates. Therefore, the facilitator will want to begin by creating vision...

- Objective (1) To appreciate the power of the visualization process.
 - (a) To identify a variety of "famous" visions Suggested activity:
 - (i) Teacher-directed
 - 1. Einstein's vision
- 2. Simonton's experiments with cancer patients (see appendix)
 - (ii) Brainstorm

Any visions you know about, eg. from the Bible, when people were guided by a vision of what was possible.

(b) To experience the powerful influence of guided imagery Suggested activity:

Active practice - guided imagery exercises (see appendix).

- Objective (2) To be comfortable with the process of visualization Suggested activities:
 - (i) shared feelings bout discomfort with the experience?

- (ii) discussion of right and left brain theory
- (iii) discussion of similarities between

meditation

prayer

daydreaming

mental practice

visualization

(iv) Regular practice.

Objective (3) To demonstrate the use of visualization to guide personal development

Suggested activities:

- (i) shared experience: Think of a time in your life when you were guided in your efforts by a vision of what was possible in the future
 eg. a vision of marriage, family, etc.
- (ii) active practice: Remember a time in your life when you had a great personal success, when you really felt good about your accomplishment.

VISUALIZE THE EXPERIENCE.

HOW DO YOU FEEL?

WHAT ARE OTHERS DOING? SAYING?

ENJOY THE WONDERFUL FEELING OF YOUR SPECIAL SUCCESS.

Dyad sharing - share your vision and your feelings with a partner Group sharing - anyone want to share their success?

(iii) There is always a first: A visualization of the future.

Think of something you would really like to do...

perhaps next month

maybe tomorrow

maybe next year...

maybe it's a trip

maybe it is making peace with a member of your family...

just make sure it is something of importance to you

NOW...CLOSE YOUR EYES AND SEE YOURSELF DOING IT

HOW DO YOU FEEL?

WHAT ARE OTHERS DOING? SAYING?

ENJOY YOUR SPECIAL EXPERIENCE OF THE FUTURE.

(IV) TO IDENTIFY A PERSONAL CHALLENGE:

Consider: What could you do to make that vision a reality?

To get an idea of an area for personal improvement: Fill out the self-assessment questionnaire (see appendix).

(v) (optional) Record your vision and your progress toward making that vision a reality in a personal journal or notebook.

UNIT II

Assertiveness

The time has come for the aged to take control of their lives and destinies. Brawny bureaucratic repossessors may be quick to reclaim furniture of a dignified life and shutter the windows of an old person's self-esteem. Incomes decrease, medical bills increase, pensions are often meager... The elderly are frequently easy prey to muggers, greedy landlord, conmen, politicians, patronizing social workers and the relentless change of inflation. There is no longer a need to accept these impsoing factors with a hand on the heart and a foot in the grave. (seniors) can learn to stand up for themselves, just as young persons have done, after successfully completing assertiveness training programs.

Objective (1) To understand the meaning of assertiveness

(a) To understand the difference between assertion, aggression and non-assertion.

Suggested activities:

(i) brainstorm:

What is assertiveness? aggressiveness? non-assertiveness?

(ii) Teacher directed:

Discuss definitions from the dictionary:

- assertiveness insisting upon one's rights,
 affirming, making a positive statement.
 - 2. aggressiveness readiness for attack.
- nonassertivness passivity, being acted upon,
 submissiveness.j
 - (iii) Group work:

Form groups of 3 and imagine these situations (see appendix). Share with the larger group. Discuss differences.

(b) To clarify the meaning of assertiveness

Suggested activities:

(i) Teacher directed:

Assertiveness is... "Behavior which enables a person to act in his own best interests, to stand up for himself without undue anxiety, to express his honest feelings comfortably, or to exercise his own rights without denying the rights of other" (Alberti & Emmons, 1974,, p. 2).

(ii) Discuss verbal and nonverbal components (see appendix).

Objective (2) To become aware of one's rights.

Suggested activities:

(a) Brainstorm: What are your basic rights and freedoms?

Assertiveness is situation specific. What are some of your roles and the corresponding rights?

eg. patient

consumer

wife

citizen

senior

What happens to you personally when your rights are transgressed?

How can you stand up for your rights?

(b) Groupwork:

In groups of 3, draw up a charter of rights for seniors.

Suggest as many ways as possible to stand up for those rights.

Objective (3) To evaluate your own assertiveness in a variety of situations.

Take the assertiveness inventory (see appendix).

Objective (4) To practice assertiveness skills.

- (a) To express thoughts and feelings in a direct and honest way.
 Suggested activities: Get in pairs and roleplay the following situations:
- (i) Your husband or lover has given you a new dress for your birthday and you hate the color and know you will never wear it? What do you do and say?
- (ii) You have been wined and dined by a wealthy widower who has just proposed to you and you don't want to be more than just good friends.
- (iv) Your new daughter-in-law has just made curried shrimp for Sunday dinner and you are allergic to shellfish.
- (b) To generate alternatives that will free the individual to choose how to behave.
 - (i) To identify a real life problem area.

Suggested activity:

Identify a particular person, relationship, situation or problem that is causing you discomfort or concer, making you angry, hostile, or resentful? Recreate the scene in your mind. Take a couple of minutes to write it down clearly. Write down how you usually behave.

- (ii) To generate alternatives.
- 1. Individual: Begin to make a list. Can you be more assertive? How might you change?
 - 2. Working with a partner. Describe your problem area

and gather suggestions from your partner. Keep a list of all possible alternatives. Don't rule any out.

- 3. Share with the group. Ask for more suggestions about your particular dilemma.
- 4. Homework: Select the alternative that is best for you, put it into practice and record the results in a notebook or journal to share with the group at a future session.

Objective (5) To create a personal development plan for increasing assertive behavior.

Suggested activity:

- (a) Visualization: Consdeer a real life problem that you have with assertiveness, perhaps it is a relationship in which your self-estee suffers, perhaps it is a difficulty you have in saying "no" to friends who impose upon you. Visualize yourself in that situation, standing up for your rights, expressing your feelings and thoughts in a direct and honest way, being recognized by others as a person of worth, and really feeling good about yourself.
- (b) Goal and challenge: What can you do to make that vision a reality?
 - (c) Formulate a plan. Who can help you?
- (d) Put your plan into action. Take risks. Be assertive and observe what happens.
- (e) How can you evaluate your progress toward becoming a more assertive person? How will you know it is happening?
 - (f) How will you celebrate success?
 - (g) Make out a contract and share your plan with another person.

A basic assertiveness training course has been shown by Hudson (1983) to be effective in increasing morale and internal locus of control. A program such as this one leaves seniors with an increased sense of personal power and self-esteem. However, assertiveness is only a beginning, an awakening of potential. It is necessary to be able to express thoughts and feelings in a direct and honest way in order to exercise advocacy but it is not sufficient. Having identified one's feelings and rights and having achieved a sense of personal power, it then becomes necessary to develop skill in both written and verbal expression of those thoughts, feelings and rights.

UNIT III

Effective Speaking

The purpose of this unit is to explore the principles of effective speaking and to practice the skills essential to speaking out onn matters of personal importance.

Objective (1) To identify the principles of an effective address or dissertation.

Suggested activities:

- (a) Personal observations
 - (i) outside class eg. lectures, T.V.
 - (ii) in class video of effective speech
- (iii) group leader gives short talk demonstrating skill.

 Each person is asked to record what makes a talk memorable.
 - (b) Group sharing

Get into groups of 3 people and record important components of effective speaking. Each group shares with the larger group. Get a consensus on the basic principles.

(c) Teacher directed (optional): Supplement the list from the experts (see appendix).

While the facilitator will want to plan activites which cover the full range of principles which each particular group has identified, there are two important principles that are included here. Suggested activities are given to (1) control anxiety and (2) develop content.

- Objective (2) To reduce anxiety
 - (a) To recognize and demystify anxiety.
- (i) To recognize your own anxiety and to realize that speaking to 20 (or for that matter 100) is no different than speaking to 1.

Suggested activity: How do you know when you are anxious? What happens to your body? How do you feel?...Sitting informally in a circle, the group leader asks individuals to get in pairs and share with someone else how you feel when you are anxious. Then, each individual is asked to address the group, to allow 3 minutes to describe 3 signs that indicate you are anxious. Discuss: what was different about the two activities? Were you more anxious speaking to the group and why?

(ii) To identify some comforting facts that can be used as self-talk.

Suggested activity: Group sharing of facts to keep in mind that help to reduce anxiety? Facilitator supplements from the experts (see appendix).

- (b) To explore some ways of controlling anxiety.
- Suggested activities:
- (i) Group sharing: Each person picks 2 important facts from above that you can use to give yourself encouragement.
- (ii) Relaxation exercise: Facilitator leads the group in a relaxation exercise of choice (see appendix for suggestions).
- (iii) Brainstorm ways to control anxiety. Encourage individuals to draw from personal experience and, if possible, to instruct the group in a personal method.

(iv) Facilitator issues a challenge: Attend to your own anxiety. It is one of the most important things you can do for your own health and personal development. Find a method that works for you and use it whenever anxiety threatens to interfere with your enjoyment of life. Use it at the dentist's office, the doctor's, the bustop, in bed...don't let anxiety interfere with your ability to speak up.

Objective (3) To develop effective content.

Suggested activities:

(a) Get a group consensus re content: Reviewing the principles discussed in (1) get a group consensus on the organization of content.

(b) Active practice:

Take about 10 minutes to write a short talk on something of importance to you. Maybe it is something you want to say to your husband; maybe you have an audience with the mayor. Make your message clear and to the point; cover 2 or 3 important items.

Find a partner - someone in the group you feel comfortable with.

Read them what you want to say.

Ask them to give you feedback on the content of your message.

Now tell them EXACTLY WHAT IT IS YOU WANT TO SAY. HIT THEM BETWEEN THE EYES WITH IT.

Discuss: How can I improve the effectiveness of my content?

Objective (4) To plan a personal development program to improve speaking effectiveness.

Suggested activity: Facilitator issues a challenge. We have

discussed some of the principles of effective speaking. I want you to visualize yourself some time in the future making an important address to an individual or a group on a matter that is of fundamental concern to you. Building on your strengths and the opportunities available to you, how could you improve your speaking skill in order to make that vision a reality? What supports would you need? How could you evaluate your progress? How would you celebrate success? Draw up a plan of action and share it with someone.

UNIT IV

Effective Letter Writing

There are many opportunities for seniors both individually and collectively to express their needs and concerns by writing letters to influential persons. It may be very rewarding to receive a reply from an official or to see your letter in print. Hoewever, not all older adults are able to use this process to advantage, particularly if they have not had a formal education in this country. The purpose of this unit is to identify the principles of a good letter, to practice the skills and to encourage the older adult to exercise advocacy by writing effective letters.

- Objective (1) To identify the principles of an effective letter.

 Suggested activities:
 - (a) Personal observation
- (i) outside class check the letters to the editor, to Ann Landers, etc.
 - (ii) Facilitator provides a sample letter.

Each person is asked to record what makes a letter effective.

- (b) Group sharing In groups of 3, get a consensus on basic principles, share with the larger group and supplement from the experts (see appendix).
- Objective (2) To plan a personal development program to improve yourself as an effective letter writer.

Suggested activities:

- (a) Visualize yourself in the future writing a powerful letter, maybe having it published in the paper, maybe being congratulated by your friends.
- (b) Identify a challenge: Knowing your strengths and the principles of an effective letter, what can you do to make that vision a reality? Do you want to improve your spelling? English? your confidence?
- (c) Develop supports. Find a partner who can help you achieve your goals.
- (d) Practice. Take risks. Keep that pencil and paper handy!
 - (e) Evaluate your progress. Are you becoming more skilled?
- (f) Celebrate. Reward yourself for your productive efforts.
- Objective (3) To develop a personal list of addresses for influential people in your community that you can write to:

Suggested activities:

- (a) Group sharing of addresses from personal experiences in the group.
 - (b) Facilitator supplements (see appendix).

UNIT V

The Process of Self-directed Learning

Advocacy means standing up for your personal rights, speaking out or writing to the most influential people about something of importance to you. It means developing the best strategy to guarantee you get what you want.

Throughout the development of this program, the facilitator will have sequenced learning activities which give the individual practice in requisite skills and will have reinforced every success. However, this is not to ensure that the individual isn't going to "die on the vine" once outside the supportive social network created within the group.

The Formula for Success

How can we be sure that self-directed advocacy will orrcur beyond the learning envoironement: It is necessary to guide the individual through each stage of a self-directed learning project and to celebrate each success. Finally the facilitator will want to leave the individual with a sense of personal power and challenge to use the skills that have been practiced in an important way that really makes a difference.

Objective (1) To demonstrate application of self-directed learning to a personal challenge.

Suggested activity: The facilitator engages the individual in

drawing up a contract to demonstrate a personal advocacy project, quides him through each step and reinforces success.

Objective (2) To leave the individual with the desire and the initiative to be active as a personal advocate in the future.

Suggested activities:

- (a) To develop a sense of personal power through connectedness to others through participation in Networking visualization exercise (see appendix).
- (b) To develop a readiness for future challenge the facilitator issues a challenge:

My challenge to you all is to take every opportunity to speak up in the most effective way on matters of fundamental concern to you. In this way you will not only maintain control of your own life, but make a valuable contribution to your community. As senior citizens, you have a lifetime of varied experience that the rest of us need to hear about! By speaking up for yourself, you are performing a valuable service, taking an active role in defining the future of political and social support services. In speaking up you become part of a growing network of individuals who are expressing their fundamental beliefs and dreams to create a better world.

Summary

We are in the information age with the emphasis on self-reliance in every aspect of our lives. Our institutions are telling us 'you must maintain control of your own lives'. Our community support systems are saying 'tell us what it is we can provide so that you can remain in control of your future'. The medical profession is saying 'we will respect your right to make choices in harmony with a personal value system to the end of your life'.

However, it makes little sense to expect people, many who have been socialized to be passive and dependent and who have come to rely on institutional authority, to be suddenly capable of identifying their own needs and expressing themselves effectively. They need to know how to go about it. The challenge for professionals is to take every opportunity to help seniors identify a personal challenge, create a vision of success and with skill and careful planning to take control of their learning and their lives.

APPENDIX B

Formative evaluation procedures

Questions for Discussion by the Participants at the End of Each Session

- 1. What did you learn today?
- 2. What did you enjoy about today's session?
- 3. How could it be improved?

(questions to be considered by participants - discussion optional)

- 4. How did you contribute to today's session?
- 5. Did you speak up?
- 6. Were you heard?
- 7. Did you listen to what others had to say?
- 8. How can you improve your contribution for next week?

Questions for Debriefing Sessions by the Leaders

- 1. How did you feel generally about today's session?
- 2. What worked?
- 3. What didn't work?
- 4. Individuals who have special needs: individuals who have special skills that might be acknowledged and used in the group?
- 5. How did you feel about your participation?
- 6. What would you do differently next time?
- 7. How could we improve our effectiveness as a team?

APPENDIX C

Summative	analustion.	Unitten	Questionnaire	for	Participants
Summative:	evaluation:	ML: ((A))	MARRITON PAINT	1 31	lar cicibanca

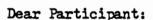
To help us in planning future programs, please answer the following questions.

- 1. What did you learn from this program?
- 2. What did you enjoy most?
- 3. How could we improve the program?
- 4. How did you contribute to the group?
- 5. Has this program helped you to develop plans for the future?
 yes ____ no ___.
- If yes, please explain...

If yes, please explain...

Thank you for your participation and your help.

APPENDIX D



My thanks to you for agreeing to take part in this interview. I hope that, through our discussion you personally will be stimulated to consider your needs and new ways to meet them.

By taking time to share your ideas and experience, you are performing a valuable service to the community. Results of our discussions will be available to you by the end of August. Based on our findings, provisions will be made for community-based wellness program development in the future.

For more information, please contact Carole Griffin,

Wellness Coordinator

South/East Health Unit

Phone: 321-6151.

Thank you for your support and your help.

Consent Form

During	our	conversation	you	will	be	asked	questions	about:
		life	in a	gene ra	al			
		your	bel:	lefs				
		your	act	ivitie	es.			

Discussion will be informal and since your participation is entirely voluntary, please note:

- 1. You may choose not to answer a particular question.
- 2. You may choose to stop the interview at any time.
- 3. The information is in strict confidence.

I understand the above and agree to participate.

(name)	(date)

THIS QUESTIONNAIRE IS:	
1) pretest	2) advocacy program
2)postest	drop-in
	control group

SECTION A

Part	I	Sociodemographic information
l) age	:	2) sex:
3) Mar	ital status:	married widowed divorced or separated
		never married
4) acc	ommodation:	house apartment seniors apt. complex.
5) num	ber of people	e in your household:
6) fir	st language:	english other (please specify).
7) edu	cation: up t	o grade 8
	some	high school
	high	school graduation
	oth e :	r(please specify)
8) pri	mary life oc	cupation: (eg. housewife, clerk, etc.)
9) Do ;	you now get:	Old Age Pension yes no
		Guaranteed Income Supplement yes no
		G.A.I.N. yes no .
		to any groups or organizations? yesno
(if yes, plea	se specify)
-		
11) Se	lf-perceived	health status: excellent
		good
		fair
•		poor
•		very poor
12) Pe	rsonal healt	h concerns (please specify)

FOR	PROGR.	AM PA	RTI	CIPANTS:	
PRETEST	ONLY:	13)	a.	Why did you enroll in this program?	
			٠		
			ъ.	What do you expect to get out of the program?	
POSTEST	ONLY:	14)	a.	What did you get out of the program?	
			_		
				Did it meet your expectations? yesno	•

Part I Rating scale: tery desirable under under very uncles rable

- 1. How desirable is it to you that people ask you for advice and suggestions? 5 4 3 2 1
- 2. How important is it to you that you maintain your health? 5 4 3 2 1
- 3. Is being able to get along with people you meet important to you? 5 4 3 2 1
- 4. Is being able to arrange for outings important to you? 5 4 3 2 1
- 5. Is being able to contact your family whenever you wish important to you? 5 4 3 2 1
- (... How important is being able to spend your time doing whatever you want? 5 2 3
- 7. How important is it that you do the chores yourself without any help? 5 .4 3 2 1
- Q. Is having your friends and family visit when you invite them important to you? 5 4 3 2 1
- 9. How desirable is it to you that you can be active whenever you wish? 3 2
- 12. How important is it that you find people who are interested in hearing what you have to say? 5 4 2
- How desirable is it to you to get away from the house? 5 4 3 2 1
- 1 12. How desirable to you is having your family visit you? 5
- How desirable is it to you to be able to help others?
 - 4 3 5 2 1

14. How important is it to you that you can have your friends over whenever
you want? 5 4 3 2 1
/: Is keeping in contact with interesting ideas desirable to you?
5 4 3 2 1
16. Is being able to find privacy important to you?
5 4 3 2 1.
Part II Rating scale: Story Angle Angl
(N) /. People tend to ignore my advice and suggestions.
5 4 3 2 1
2. Maintaining my level of health strongly depends on my own efforts.
5 4 3 2 1.
(N)3. It is difficult for me to get to know people.
5 4 3 2 1
4. I can usually arrange to go on outings that I'm interested in.
5 4 3 2 1.
(N) 5. The situation in which I live prevents me from contacting my family
as much as I wish.
5 4 3 2 1
6. I spend my time usually doing what I want to do.
5 4 3 2 1.
7. Although it is sometimes strenuous, I try to do the chores by myself.
5 4 3 2 1
8. I find that if I ask my family (or friends) to visit me, they come.
5 th () 1

- ? . I have quite a bit of influence on the degree to which I can be involved in activities. 5 4 3 2 1
- (N) 1. I can rarely find people who will listen closely to me.

5 4 3 2 1.

- (N) //. My getting away from the house generally depends on someone else making the decisions. $5\ 4\ 3\ 2\ 1.$
- (N) /2. Visits from my family or friends seem to be up to their own decisions and not to my influence.

5 4 3 2 1

(N) /3. People generally do not allow me to help them.

5 4 3 2 1

14. I can entertain friends when I want.

5 4 3 2 1

/5. Keeping in contact with interesting ideas is easy for me to do.

5 4 3 2 1.

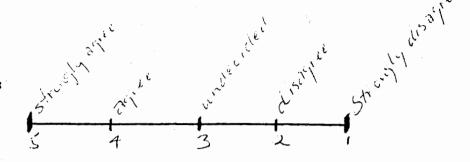
16. I am able to find privacy when I want it.

5 4 3 2 1.

SECTION C

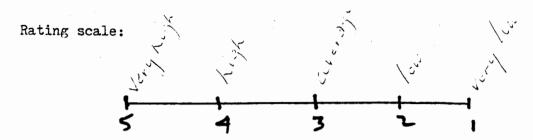
Part I

Rating scale:



- (P)1. I feel in control of my life. 5 4 3 2 1
- (N) 2. I feel my life has no real purpose. 5 4 3 2 1
- (N)3. I have difficulty expressing my feelings. 5 4 3 2 1
- (N)4. I wish I were doing more worthwhile things. 5 4 3 2 1
- (N) 5. I have a lot of time on my hands. $5 \ 4 \ 3 \ 2 \ 1$
- (N)6. I am nervous when speaking in a group. 5 4 3 2 1
- (P)7. I am good at figuring out how to get things done. 5 4 3 2 1
- (P)8. I feel good about myself. 5 4 3 2 1
- (P)9. I like to help others. 5 4 3 2 1
- (N) 10. It is a waste of time to set goals at my age. 5 4 3 2 1
- (N)11. I look after myself and expect others to do likewise. 5 4 3 2 1
- (P)12. When I feel strongly about something I take the time to speak or write to an influential person. 5 4 3 2 1
- (N) 13. I have difficulty expressing myself clearly. 5 4 3 2 1
- (P) 14. I am assertive in my daily affairs. 5 4 3 2 1
- (N) 15. There is little I can do to change social services for seniors. 5 4 3 2
- (P) 16. I don't hesitate to ask for help when I have a problem. 5 4 3 2 1
- (N) 17. I don't have much energy these days. 5 4 3 2 1
- (P) 18. When I have a problem, I develop a plan of action. 5 4 3 2 1
- "(Γ) 19. I know what I want to learn and do. 5 4 3 2 1
 - (P) 20. Other people count on me to help them in time of need. 5 4 3 2 1

Part II



At the present time how would you describe your level of:

- 1. speaking out in a group
- 2. assertiveness____
- 3. group participation _____
- 4. helping others
- 5. control of your life____.

APPENDIX E

Interview protocol

Description of the inventory and instructions to the interviewer

Before attending to the inventory, it is appropriate to converse informally in order to establish rapport and a comfortable climate. To begin, page 1 introducing the project is to be read and given to the interviewee to keep. The consent form (page 2) is then read and a signature of consent is solicited.

The inventory is composed of three sections: A, B, and C. Section A contains questions on sociodemographics and program expectations. Section B contains Reid and Ziegler's Scale and Section C is a questionnaire relating to self-directed advocacy program content. Verbal instructions to be given by the interviewer are underlined here. All questions are to be read and scored by the interviewee

Section A

<u>Part I.</u> A personal data sheet designed to get a profile of participants. The questions are straightforward and require little explanation. The interviewee is instructed: <u>To begin I'm going to ask you a few questions about yourself. Please do not hesitate to ask for clarification if a question is not</u>

clear to you.

Part II. I would like to get an idea about
your expectations for the program (read questions page
4)

Section B

This section contains Reid and Ziegler's Desired Control Scale (short form). (The numbering of the questions in the long form is retained here). The interviewee is informed that: I am going to ask you a number of questions to determine your attitudes and beliefs on matters pertaining to everyday living.

Part I: Desire of Outcomes. In part I you will be asked to rate how desirable different events are to you. (The interviewee is then given a paper on which the response scale is clearly marked). You may respond: very desirable, desirable, undecided, undesirable, very undesirable. Please avoid an undecided response whenever possible. The interviewer then reads each question slowly and clearly and circles the score which corresponds to the response.

Part II: Beliefs and attitudes. In part II you are asked to rate your level of agreement that the statements are true for you. You may respond: strongly agree, agree, undecided, disagree, strongly disagree. (The interviewee is then given a paper on

which the appropriate scale is clearly marked). The notation (N) before specific questions is for the purpose of data analysis only.

Section C

This section consists of questions developed by the author related more specifically to program objectives. In part I the interviewee is given the instruction: Please tell me the extent to which you agree or diagree with the following statements.

(The interviewee is given the sheet with the scale used in section B: part II).

Part II: The interviewee is instructed: <u>Please</u>

rate your level of ability on a scale of 1-5. A 5

would mean very high, 4=high, 3=average, 2=low, 1=very low.

APPENDIX F

Data for Case Study Analysis

Anecdotal evidence for increased internal locus of control from three sources:

- Interview schedule sociodemographic data and open-ended questions
 - 2. Written questionnaire
 - 3. Participant observation record.

Brief description of the subject:

Purpose in coming:

Goal contracted:

Success:

Observations by the leaders: