COUNSELORS' GOALS AND ROLES TO ASSIST OLDER PERSONS IN FEDERALLY SUPPORTED PROGRAMS

BY

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For My Loving Wife, Sandra

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This study has assisted the specialty of gerontological counseling by specifying and confirming the most appropriate goals and the potential roles for counselors of older persons. Additionally, this study identified and rank ordered the possible placement sites within the federally supported aging network, where gerontological counselors could be of greatest assistance to older persons.

A panel of 41 gerontological counseling experts was assembled after each counselor education department (N=448) in the nation was asked for nominations. Each expert was asked to react, on a seven point Likert scale, to 18 gerontological counselor roles and five counselor

goals which the researcher abstracted from the literature. Experts confirmed all goals and roles, and added 2 additional goals and 3 additional roles for a total of 7 and 21, respectively. Experts also rated, on a seven point Likert scale, 13 possible placement sites for counselors within the aging network.

A clustered, random sample of Area Agency on Aging (AAA) executive directors (N=253) was asked to react in two ways to the newly confirmed lists of goals and roles. The first was the degree of conformity each goal and role had to the present objectives of their AAA office. The second was the degree to which each goal and role could assist older persons in their public service area. One hundred sixty-eight AAA directors responded to the survey. Like the experts, AAA directors also rated the 13 possible placement sites for counselors within the aging network.

Directors of AAAs endorsed each goal and each role confirmed by the panel of experts as relevant for aging network. Goals and roles which were rated as highly conforming to present AAA objectives were likewise rated as of generally greater value to older persons by AAA directors. Directors ranked the site of "senior centers" as their number one potential placement location for gerontological counselors.

Experts and AAA directors generally agreed with respect to the goals and roles for counselors, but disagreed with respect to the priorities for these goals and roles. Directors of AAAs tended to rank higher those goals and roles which had direct application to existing AAA programs, while experts ranked higher those goals and roles which focused directly on the individual, rather than on programs. Experts and AAA directors were in greater agreement with respect to the priority of placement sites for counselors within the aging network.

This study helped to define further the specialty of gerontological counseling by identifying the appropriate goals and roles for its professionals. Gerontological counseling experts favor a preventative, developmental approach to counseling older persons, but recognize the need for remedial counseling as well.

A relatively high degree of conformity exists between the confirmed goals and roles for gerontological counselors and the present objectives of the aging network. Directors of AAAs perceive the goals and roles of gerontological counselors as of great benefit and high need to older persons. Directors of AAAs rated the roles of medical outreach support counselor, counselor of the terminally ill, pre-retirement counselor, family counselor, bereavement counselor, marital and sex counselor, and financial counselor as being of immediate need in the aging network.

This study demonstrated that counseling services are directly applicable to and needed in the federally supported aging network. This study generated an operational definition of counseling as it relates to older persons. Because of this clear definition and measure of need, federal and state legislation can now more confidently address older persons' psychosocial concerns which impact so greatly on their ability to take full advantage of existing programs.

CHAPTER I

INTRODUCTION

Background Information

In 1965 The Older Americans Act was passed into law (H.E.W., 1965). This landmark legislation recognized the elderly population of this country as having special, aged-related needs, and appropriated funds to provide four general categories of services to elderly in need: (1) housing, (2) transportation, (3) homemaker services, and (4) legal and other counseling. The language of the Act did not indicate that any one of these four service categories would carry a higher priority than another (Murphey, 1979). The intent of the legislation was to establish national priorities and programs to remedy the recognized negative effects of aging.

Numerous writers and researchers have attempted to enumerate the complex problems of older persons (Brine, 1979; Buckley, 1972; Cottrell, 1974; Fine and Therrien, 1977, Fleer, 1975; Manney, 1975; Uroda, 1977). Butler (1975) recognized widowhood, late life marital and sexual problems, retirement, sensory loss, aging, disease, pain, hospitalization, surgery, institutionalization, and dying as major crises in old age. The Department of Health, Education, and Welfare (H.E.W., 1974) identified these problems, in perhaps wider terms, as physical decline, resistance to change, sense of isolation and loneliness, reduced or fixed income and lack of access to adequate social services.

A division of D.H.E.W., the Administration on Aging (AoA), was created by the Older Americans Act to establish national guidelines and policies, and carry out public programs designed to address the problems associated with age.

Other legislation designed to meet specific aging problems has been passed. There are presently seven federal legislative actions relating in whole, or in part, to health care for the elderly; six federal acts concerning elderly housing problems; 10 involving social service programs for the aging; five covering elderly income maintenance; and five acts, or sections of acts, authorizing research and training in the aging field (Odell, 1979). Both houses of Congress have established committees on the elderly. The Senate has a Special Committee on Aging, currently chaired by Senator Lawton Chiles (D. Florida), with units on housing, employment, community services, consumer interests, health, retirement, and long term care (Sinick, 1977). The House has a Select Committee on Aging presently chaired by Congressman Claude Pepper (D. Florida).

This massive federal effort has, however, created its own problems. Kerschner and Herschfield (1975, p. 357) have asserted that:

> Aging legislation has been caught in a morass of conflicting and competing interests and issues. The result of these fragmented approaches is that in most cases involving major aging legislation, policy makers have abdicated moral responsibility by passing laws based on flimsy and often inaccurate data.

Birren and Woodruff (1975) reinforced the Kerschner and Herschfield position when they stated that the "aging landscape is dotted with specialized divisions: Institutional Care, Home Health Care, Supplemental Security Income, Nutrition and Recreation" (p. 355). They have called for a unifying aging philosophy upon which could be based well coordinated public policies

and programs for the older American. Birren and Woodruff (1975, pp. 371-72) advocated aging programs which were specified, holistic, rational, and based on long range planning rather than programs which are ill-defined, segmented, crisis oriented, or forged as the expediency of the "prevailing political atmosphere."

In 1973 the Older Americans Comprehensive Service Amendments created a new community-based organizational network called the Areawide Agency on Aging (AAA). The AAAs were designed to emphasize planning the coordination of programs for the aged. They were "charged with developing plans for a comprehensive and coordinated network of services to older people and with offering facilitating services in the areas of information and referral, escort, transportation, and outreach" (Atchley, 1977, p. 262). The intent of the amendments were to create, on a nationwide basis, a structure capable of offering basic services to all elderly in need. Presently, there are over 600 AAAs established nationally (Cone, 1979) with several dozen more yet to be organized. This concept of community level planning and coordination recognizes the need for regional variation in program implementation. The AAA structure is still in its nativity state and "it will be some time before the effectiveness of the community approach to federal programs can be assessed" (Atchley, 1977, p. 263). Each AAA is administered by a director whose job it is to contract and monitor all federally funded aging programs in the district. Among functions, this position includes the roles of policy maker and policy implementor. On the area level, the director plays a key role in negotiating and monitoring contracted services for the elderly. On the community level, the AAA director, together with the AAA Advisory Board, community representatives, and state agency services administrators,

conducts needs assessments and decides aging services priority. The AAA director is also in a unique position to affect aging program policy on a state and national level. The AAA structure maintains direct administrative lines to both the State Agency on Aging and the Federal Administration on Aging. Suggestions and needs identified "in the field" by the AAA director and staff are communicated to the state and federal level. The director plays vital policy making roles in both a direct way on the area level, and in an indirect way on the state and national levels (Odell, 1979).

Concern for the problems associated with age and legislation designed to remedy the problems of the aged are not likely to decrease in the future (H.E.W., 1978; Murphey, 1979; Vasey, 1975). The aged population in the United States is growing in actual numbers and in proportion to the total population (Atchley, 1977; Birren and Woodruff, 1975; Blake & Peterson, 1979, Puner, 1974; Schultz, 1975).

The elderly population in the United States is not homogeneous. Puner (1974) divided this population into three categories for purposes of needs and program identification: age 45-59, "middle aged;" age 60-74, "elderly;" and age 75 and over, "aged." Neugarten (1968) postulated two divisions of older persons: "young-old," those 55-70; and old-old," 70 and over. Individual exceptions naturally exist within these broad categories since age is regulated by a social rather than a biological clock (Neugarten, 1968). Aging programs must, therefore, be guided by an overarching philosophy which allows for the variety of needs expressed by older Americans. Individualization of services within a broad framework of programs and policies seems mandatory in

view of a population characterized by heterogeniety (Toward a National Policy on Aging, 1971).

Purpose of the Study

This research sought, first to compile a list of gerontological counselors' goals and roles, which would be confirmed by a nationally identified panel of gerontological counseling experts. Confusion exists with regard to the specific goals and roles of the professional counselor (Garfinkel, 1975). Research questions such as what are the capabilities, the priorities and the objectives of the professional counselor of the aged, are clarified by this study.

The second purpose of this study was to determine the degree of relevancy that the goals and roles confirmed by the panel of experts have for federally supported aging programs as perceived by executive directors of AAA, to determine the need for gerontological counselors, and to identify their appropriate placement sites within the aging network. Specifically, three research questions were used to achieve this second purpose.

1. To what extent do the confirmed goals and roles which gerontological counselors assume in working with the elderly, conform to and assist the objectives of current programs for the aged as perceived by AAA directors?
2. What is the expressed need for gerontological counselors, as perceived by AAA directors?
3. Where can gerontological counselors be placed within aging programs to be of greatest benefit to the older population, as perceived by AAA directors?

Rationale

Many authors have recognized the part that professional counselors can play in assisting older persons to adjust to the aging process (Brine, 1979; Buckley, 1972; Butler, 1975; Harris and Associates, 1975; Lombana, 1976; Quirk, 1976; Riker, 1979). Counselors, with professional education in the needs and problems of aging can do much to alleviate the discomforts caused by the losses experienced by older persons (Pressey, 1973; Pressey and Pressey, 1972). The specific goals and roles of the counselor in a gerontological service site have been implied by those writing in the profession of gerontological counseling (Butler and Lewis, 1973; Goodyear, 1976; Pfeiffer, 1976; Schmidt, 1976; Sinick, 1977; Ullman, 1976). These goals and roles are based upon perceived and quantified needs, as assessed in various studies (Fleer, 1975; Ganikos, 1977; Myers, 1978).

Counseling has been advocated to assist older persons living alone (Berry, 1976; Lopata, 1970); those in the bereavement process (Insel, 1976; Uroda, 1976); those with depression and other mental health problems (Gordon, 1973; Herdell, 1975); those attempting to find suitable employment (O'Dell, 1957; Riker, 1979; Sinick, 1977); those older persons in search of meaningful leisure time activities (Goodman et al., 1974; Havinghurst, 1961); and those with marital and sexual concerns (Medley, 1977; McKain, 1979). Counseling has been used to assist nursing home and age-segregated housing residents (Kelly, 1976; Pressey, 1972) to help in the preparation for death (Carey, 1976; Jackson, 1977; Kubler-Ross, 1979); to prepare maturing persons for retirement roles (Monk, 1971; Riker, 1979; Ullman, 1976), and to help older persons effectively utilize the maze of services and programs presently available (Lewis and Lewis, 1977; Miller, 1971).

In none of the research and writing on gerontological counseling have the specific goals and roles of the counselor been enumerated. Yet, defining goals and roles is a desirable and necessary task for any profession to accomplish. The professional identity of the gerontological counselor is an ambiguous one without concrete goals and succinctly enumerated roles. Role confusion and conflict experienced by the counselor of the elderly might have the negative results of diminished effectiveness and inadequate evaluative criteria for accountability. Without specific goal and role knowledge, it is difficult to communicate the potential impact of counseling services for older persons to aging services administrators and policy makers. Blake and Peterson (1979, p. 23) have stated:

> Older people are attracting a lot of attention and if professional counseling is to be a part of the service system for older people, counselor organizations, counselor education programs and individual counselors should react quickly and qualitatively.

Gerontological counseling has not developed into a specialty within the larger counseling profession (Vontress, 1975). Its present maturity level may be likened to the state attained by school counseling in the late 1950s and early 60s when the need to define the role of the professional school counselor was apparent (Boy, 1968). School counseling was suffering from an "identity crisis" which required resolution before the profession could attain the next developmental state and solidify its position in the schools. According to Shertzer and Stone (1973, p. 687), "confusion surrounding the school counselor's role stems from the contradictory and conflicting expectancies of his various publics."

The need for role definition prompted the American Personnel and Guidance Association (APGA), to assemble a committee to create a statement outlining the roles of the school counselor. The APGA statement of policy, "The Counselor: Professional Preparation and Role," was passed by the APGA Senate in March of 1964 (Loughary, Stripling and Fitzgerald, 1964). This document enumerated the broad working guidelines and roles for counselors, thereby providing a model for professional behavior and appropriate accountability. Such a policy statement with a succinct identification of goals and roles has yet to be accomplished for professional counselors functioning with or preparing to work with the elderly populations.

Myers (1978, p. 40) defined the goal of counseling as "achieving individual well being." The concept of life satisfaction can become an index of adjustment and well being. Adams (1979) described the satisfied person as one who has a zest for life, high resolution and fortitude, a sense of accomplishment, high self-concept and one who is generally happy and optimistic. The symptoms of low life satisfaction might be: apathy, resignation, sense of uselessness, low self-regard, and pessimism. These negative symptoms describe some segments of the elderly population (Butler, 1975). Lemon (1972, p. 512) viewed life satisfaction as a goal of counseling and defined it as "the degree to which an individual is presently content or pleased with his or her general life situation."

Personal adjustment could also be viewed as a counseling goal. Britton (1963) described a well adjusted older person as acting responsibly, maintaining health, activity, independence, self-sufficiency and interpersonal relationships. She defined the goal of counseling as "intervention that will enable people to take control, and to feel in control of their lives" (p. 85).

Lombana (1976) categorized counseling services for the elderly into those which are remedial and those which are preventative. She defines remedial counseling as providing services to older persons with problems, while preventative counseling concerns itself with providing information programs to the elderly and pre-elderly population. Examples of preventative counseling could be pre-retirement programs, life-long health education, avocational opportunities, resources information, counseling for families of senior citizens, and educational opportunities (p. 144). Shertzer and Stone (1978, 1974) classified counseling goals in five generalized categories: increased personal effectiveness, problem resolution, positive mental health, behavioral change, and decision making (pp. 88-90).

If counseling is to secure a place in the services network for older persons, the specific goals for gerontological counseling must be agreed upon and communicated to policy makers who have the capability of generating the resources necessary for counseling services to become a reality. The goals of gerontological counseling and the goals expressed in legislation must converge at strategic points and be perceived as working in concert before policy makers will seek the services and skills of counselors.

Among the goals of the Older Americans Act of 1965 are: "Freedom, independence, and the free exercise of individual initiative in planning and managing their (older Americans) own lives" (Sinick, 1977, p. 92). These goals were probably articulated more functionally four years earlier when the 1961 White House Conference on Aging passed a list of Rights of Senior Citizens. Some of the rights were usefulness, freedom from want, ability to secure employment, fair share of community resources, decent housing, independence, and death with dignity (Sinick, 1977, p. 82).

The congruence between the goals and roles of gerontological counselors and the objectives of public programs for the elderly has yet to be determined.

For the purposes of this study, counselor role will be defined as "expectations and directives for behavior connected with the position" (Shertzer and Stone, 1968, 1974, p. 131). The concept of counseling "goal" will be defined as, "the end result sought or, the objective which counseling strives to accomplish" (Shertzer and Stone, 1974, p. 87).

Several needs assessment surveys have been conducted to identify and measure the counseling needs of older persons (Fleer, 1975, Ganikos, 1977, Myers, 1979). The next step for the profession in establishing accountability criteria is to state goals and performance objectives (Burck and Peterson, 1970, p. 120). This role and goal defining step is requisite to any further steps of devising program designs, improving programs, or reporting outcomes (Burck and Peterson, 1970). Leadership must be exercised in establishing goals and roles if the services of the gerontological counseling profession are to remain organized and coordinated (Butler, 1975).

Administrators of programs providing services to the elderly have not been given a clear statement describing the ways that the special skills and services of gerontological counselors can assist aging services programs in achieving their objectives. It will be possible to draw statements concerning the capabilities of gerontological counselors from the study, and to generate a measurement of the level of assistance counselors can give to current aging network program objectives.

The local AAA director is a services administrator and policy maker who can exercise decisive power in securing the services and skills of

professional gerontological counselors. Only when directors are assured that the services gerontological counselors can offer will augment the goals of the AAA structure, will professional counselors be able to exercise their specialized capabilities on behalf of the elderly.

In the maze of legislation and consequent services presently being offered to the elderly, in what physical sites and as part of what programs would gerontological counselors be most helpful in addressing the needs of the elderly? The 1973 Amendments to the Older Americans Act sought increased planning and coordination of programs and services offered to the elderly. This research sought to identify the most beneficial placement of gerontological counselors within the contracted services offered through AAAs.

Definitions

Area Agency on Aging (AAA) Executive Director--The chief administrative officer of an AAA. The person responsible for all activities of the particular AAA, and the person called upon to provide policy making information to state and federal agencies concerned with the older population. The position of AAA executive director is referred to as AAA director in this study.

Aging network--The term used to describe the total configuration of federally supported services for older persons which are contracted and monitored through Area Agencies on Aging.

Area Agency on Aging (AAA)--The name of the administrative office which is charged by the Older American Act and its amendments with the responsibility of contracting and monitoring services for older persons within a specific geographic area called a public service

area (PSA). There are over 600 AAAs currently organized and operating within the United States and its territories and possessions.

Counseling--"A learning process in which individuals learn about themselves, their interpersonal relationships, and behaviors that advance personal development" (Shertzer and Stone, 1974, p. 162).

Counseling goal--"The end result sought or the objective which counseling strives to accomplish" (Shertzer and Stone, 1974, p. 87).

Counseling role--"Expectations and directives for behavior connected with the counseling position" (Shertzer and Stone, 1974, p. 131).

Gerontological counseling--"The process through which a professionally educated counselor assists an individual or group to make satisfying and responsible decisions concerning personal, educational, and vocational adjustments" (HR. 1118, p. 36).

Gerontological counseling expert--An academic member who has competencies and knowledge in both gerontology and counseling and who has, or is currently teaching one or more courses in the area of counseling older persons.

Gerontological site--the physical location of any one of a number of aging network programs contracted and monitored by AAA.

Older person--any person 60 years of age or older (H.E.W., 1975).

Public service area (PSA)--a specified geographic area under the director of an Area Agency on Aging Executive Director for the purposes of contracting and monitoring services for older persons as outlined in the Older Americans Act. Public service area is referred to as PSA in this study.

CHAPTER II

REVIEW OF THE LITERATURE

The Counseling Needs of Older Persons

Goals and roles specification for any profession is dependent upon a sharp identification of the needs of the clientele who are to be served (Burck & Peterson, 1970). Gerontological counseling has thus far produced three such needs assessment studies (Fleer, 1975; Ganikos, 1977; Myers, 1979). These studies have surveyed separate populations. Fleer (1975) chose members of the Gerontological Society and counselors currently functioning in gerontological sites as separate Delphi panels to determine aging needs in two categories: (1) physical needs and (2) psychological needs of the elderly. Each need category produced clusters of needs when the results from the Delphi rounds were analyzed. Identified clusters in the physical category were health, income, housing, personal enhancement (i.e., work activity, status, safety and personal grooming), recreation and services (i.e., transportation and homemaker) (Fleer, 1975, p. 60-64). In the psychological category three clusters emerged: internal, external, and a combination of internal and external. Internal psychological needs included (in rank order) sense of self-worth, feeling productive, control in decision making, overcoming loneliness and ability to cope (Fleer, 1975, p. 66). External needs included close family ties, opportunities for growth, satisfying relationships with children, supportive counseling, and help in preparing for change. Examples of the inter-external cluster

were to have at least one close friend, reduction of agism, feeling involved, and feeling useful (Fleer, 1975, p. 66-67). A priority breakdown of expressed psychological needs revealed that "internal" and "internal-external" needs were rated as most necessary. The highest rated needs were (1) sense of worth, (2) to have at least one close friend, (3) to feel productive, (4) reduction of societal agism, (5) meaningful roles and a sense of belonging, (6) control of decision making, (7) to feel useful, and (8) to overcome loneliness (Fleer, 1975, p. 66). Fleer concluded that "psychological needs are identifiable as they contribute to the central need of a sense of self-worth, ego strength, and personhood" (Fleer, 1975, p. 85).

Ganikos (1977) conducted a counseling needs assessment of a Florida sample of elderly community college students. This sample represented a segment of the elderly population which was relatively active and healthy. Ganikos identified counseling needs in six categories: educational, adjustment to life situation, personal adjustment, socio-interpersonal adjustment, vocation, and family relationships. The "adjustment to life" and "personal adjustment" categories emerged as those containing the counseling needs of highest priority. The specific needs of discovering new interests, exploring new life options, finding more meaning in life, learning to make better decisions, adjusting to a new life style, developing new personal goals, and learning to be more self-accepting were identified as the most urgent counseling needs. Two other needs outside the categories of "adjustment to life" and "personal adjustment" received significantly high need scores; these were learning about new course offerings at the college and learning better communication skills (Ganikos, 1977). Ganikos (1977, p. 121) concluded, "about

half of the older adult students expressed needs with which a counselor could be of help."

Myers (1978) randomly sampled a cross section of elderly persons from a number of gerontological sites and a variety of socio-economic and racial backgrounds. She divided the concerns of older people, as expressed by her sample, into four categories: personal concerns, social concerns, activity concerns and environmental concerns. The sample rated "self-acceptance" as their most urgent concern, followed by health, transportation, income, legal services, peer group interaction, and activities (Myers, 1979). The "personal concerns" category emerged as the area of greatest expressed needs of the elderly, followed by the environmental concerns of transportation and legal services. Myers (1978, p. 243) concluded that "counseling should be directed towards an impact upon general need states, rather than attempting to alleviate one or more specific problem areas."

These three counseling needs assessments clearly demonstrated the demand for supportive counseling services among older persons. Their findings confirmed the suppositions by Butler (1975) and others (Blake, 1972; Brine, 1979; Buckley, 1972, Harris, 1974; Pressey, 1972; Sinick, 1977) that older persons need and want professional counseling services. In all three studies, intrapsychic needs emerged as those most pressing the older individual. Fleer (1975) called such needs "inter psychological;" Ganikos (1977) identified counseling needs which she labeled "personal concerns." In each study, needs which can be described best as "affective needs," "psycho-social concerns" or, "personal concerns" emerged as most urgent for the elderly populations.

The finding that the emotional and psychological needs of older adults are "real" and personal, and that they require professional concern has been well documented in the gerontological literature. Kastenbaum (1969, p. 699) chided professional psychologists interested in gerontology for neglecting the intrapsychic realm of older American life, ". . . old people do have their inner lives and we do not have a comprehensive gerontology unless we know something about this realm." Culbertson (1974, p. 84) indicated that "the various investigators suggest that the major problems of the elderly are affective in nature." He lamented, however, that limited research had been accomplished in the area. Hickey, Davies and Davies (1972, p. 235) criticized the 1971 White House Conference on Aging for avoiding the obvious needs of the affective/experiental domain of the elderly. They found the level of participation and discussion on these subjects to be insufficient, and that which did take place lacked resolution.

Studies which identify lowered self-esteem as an aging problem, seem quick to suggest services of an external and physical nature to elevate the depressed emotional state of the aging individual rather than services of an affective nature. Zubin (1973, p. 6) stated this succinctly; "The lowered self-image of the aged is one of the most pervasive findings in gerontological surveys." Lowered self-image is a depressed psychic-emotional state, quite "personal" and "internal," characterized by withdrawal, pessimism, and apathy. Counseling could directly address these negative states of mind. Lowenthal and Havens (1972, p. 304) expressed a dismaying hypothesis about successful aging when they stated "the dull may be the most likely to grow old gracefully

and happily in our culture." The high suicide rate among older persons suggests dramatic testimony to this distressful suggestion.

Affective needs and concerns of the elderly are a part of a complex of interdependent and interconsequential needs which arise as a result of the losses experienced by the elderly (Myers, 1979). The needs of the elderly are not simplistic, nor can unilateral programs designated to alleviate the stress caused by one loss find solution to the multi-faceted needs of the aging population. The material needs of the elderly are critical and can be the presenting problem for a counseling session (Buckley, 1972). Yet the emotional reactions to the material loss is the subject matter which gerontological counseling can focus upon and bring to personal resolution. The physical needs of the elderly are more obvious and have attracted the bulk of the legislative effort to assist older persons. "Counseling type needs may require more action from counselor organizations if they are to be recognized and counselors' potential contributions better known" (Blake, 1979, p. 23). Erikson's (1959) description of growth in old age as a struggle between ego integration and despair speaks to an internal perception of the basic purpose and meaning in life as opposed to a empty psychic life of uselessness. Services designed to stimulate emotional health are no less necessary than are services designed to maintain physical health.

Goal Theory

It has been suggested that men can agree upon goals but will differ in the approach they use to accomplish the goal. The specific priority of goals for counselors has yet to be determined by the counseling profession. If agreement could be reached regarding what the

specialty of gerontological counseling is attempting to accomplish, the roles of the counselor could be more easily defined and hence communicated to the various segments which constitute the counselor's public.

Shertzer and Stone (1968, 1974, pp 242-243) differentiated among nine different counseling approaches with respect to 10 common characteristics. One of these characteristics was "counseling goals." The goals ranged from "to mature, to grow to take responsibility for one'e life," (Gestalt), to "self-understanding and self-management" (Trait/Factor). Other goal statements included "self-actualization," "preservation of mental health," "relief of suffering and removal of causes," "solution of problems," "personality reorganization," "self-direction and fully functioning of client," and "develop a commitment." Glad (1959) regarded the goals of the different counseling approaches to be so diverse that one therapist might view a counseling sequence to have been a success while another would regard it as a failure. Such nonconformity of goals presents a dilemma for the counselor seeking guidelines for behavior and to supervisors seeking criteria upon which to assist and evaluate the counselor.

Knapper (1978), in an effort to stimulate counselors to develop evaluative criteria for their positions, recognized the necessity for accountability in a cost-conscious milieu, and encouraged counselors to develop skills lists in the broad areas of counseling, consultation and coordination. Such lists, he asserted will "specify predetermined goals, activities, and expected outcomes" (p. 28). The precise connection between skills lists and counseling goals remained unclarified.

The behaviorists have been quite vocal in insisting upon clearly defined, observable counseling goals. Krumboltz (1968, p. 28) asserted, "I shall argue that stating the goals of counseling in terms of observable behavior will prove more useful than stating goals on terms of inferred mental states." Other writers agreed with the behaviorist position that behavioral change is a necessary goal of counseling, but are more comfortable with goals stated in less immediate and more affective terms. They question whether the behaviorists are simply treating symptoms rather than seeking insight into the causes of the unwanted behavior (Patterson, 1964). Wrenn (1965, p. 60) arched the chasm between the behaviorists and the client-centered approaches when he stated,

> It is important that the counselor assist the student in better self-understanding . . . but I see this more as a means to an end rather than an end in itself. The outcomes should include observable behavior changes as well as changes in self-attitudes.

Such a position is not a compromise between the two camps, but rather an additive response, enhancing and clarifying each position. Indeed, Samler (1968, p. 68) offered accommodating words, "we should be able to accept without quibbling the objective in counseling of modification of client behavior and therefore of attitudes and values." Perhaps the furor rests upon a sequential question, does behavior change cause a resultant modification in self-concept or vice versa? Samler (1968, p. 62), however, was definitive in his appraisal of what happens in counseling when he enumerated personality appraisal, evaluation of misconception, examination of self-acceptance, change in behavior, acceptance of responsibility, and assumption of independence as common elements in all counseling.

Counseling goals have been categorized in several different ways. Krumboltz (1968, p. 31) divided goals into three categories: goals which alter maladaptive behavior, goals which teach decision making, and goals which aim at problem prevention. Another classification of goals was used by Byrne (1963). He stated that goals can be either immediate, those which require almost spontaneous intervention; intermediate, goals which concern themselves with the presenting problem of the client; or ultimate, those which deal with self-responsibility, concern for others and self-actualization. Dolliver (1965) used the terms "expressive" and instrumental" to describe the differences between counseling goals which describe self-fulfillment or potential dimensions of counseling (expressive) as opposed to the more specific task oriented goals (instrumental). Self-actualization would therefore be an expressive goal, while successively desensitizing a phobia would involve a sequential chain of instrumental goals.

Still another classification of goals has been postulated by London (1964) who categorized counseling goals on a continuum ranging from insight goals on the one hand to action goals on the other. Insight goals would include such goals as self-acceptance, accurate perception of one's place in the environment and understanding of personal worth; while action goals would include cutting down on cigarette consumption, speaking to at least three persons in one day, or scheduling an evening yoga session.

An underlying tension, or perhaps a natural distinction, seems to exist between those counseling goals which are objectively identifiable in physical reality and those goals which focus on internal, quite subjective perceptual modifications.

Counseling Goals for the Aged

Gerontological counseling currently lacks comprehensive and functional goals which could form the basis for theory building and serve as a blueprint for service providers and policy makers. The purpose of professional counselors working with the aged seems to be shrouded in uncertainty and ambiguity. Hoyer (1973, p 18) suggested the need to move away from an "overreliance on intuition, emotionalism, and rhetoric in developing remedial strategies for the elderly." He advocated a behavioral modification approach which could clearly define what the counselor is attempting to accomplish. One of the blocks to effective goals identification is the controversy as to whether to accept a developmental model of aging, or a "problems" model. Should the goals of gerontological counseling focus on fostering personal growth by devising strategies and interventions which would facilitate development, or should counselors concentrate on solving problems as they arise in the elderly population?

Erickson (1950) first postulated a succession of developmental tasks over the life span. Developmental tasks are those life events which must be learned and mastered in each life stage. Unless mastery is achieved, life satisfaction and resolved adjustment will remain low. Erikson (1960, p. 235) postulated a series of life crisis dichotomies which defined health on the one hand and disease on the other. His last stage (of eight) was "ego integration versus despair" (Erickson, 1950, p. 235). Ego integration defined a state of developmental growth which involved life resolution and recognition that one's life has been meaningful and is worth living. Havinghurst (1949, 1972) pioneered the work of specifying the developmental tasks of old age. He identified six tasks: (1) adjusting to decreased physical strength and health, (2) adjusting to retirement and

reduced income, (3) adjusting to the death of a spouse, (4) establishing affiliation with one's own age group, (5) meeting civic and social obligations, and (6) establishing satisfactory living arrangements. The developmental approach recognizes the necessary role transformation of aging (Rosow, 1973) in a context of positive growth with new opportunities for personal development emerging even from the continual losses which characterize the life of the older person (Kurtz and Wolk, 1975). Ponzo (1978, p. 144) described how agism assails the concept of positive development for the aged. Agism defines the older person in terms of "less vital, less potent, and less romantic." He asserted that, "We need to encourage people to see themselves and others for what they are without looking through the distorted filter of age." Harris et al. (1975) identified the fact that agism not only is practiced by the young but is also an internalized construct for many elderly, preventing them from engaging in activities which may seem restricted to younger persons.

Several suggestions have been postulated regarding the directions gerontological counseling goals could pursue. Schlossberg (1977) suggested that counselors need to understand the decision making process in order to help clients regain a sense of control over their lives. Britton (1963) viewed life adjustment as a natural goal for social services. He defined the adjusted person as one who is reasonably satisfied with life, healthy, active, independent, self-sufficient, and adept at interpersonal relations. The White House Conference on Aging (Toward a National Policy on Aging, 1971, p. 9) seemed to take a life adjustment viewpoint when it stated, "older people tend to change more rapidly and to be called upon to make more adjustments in their lives than at any other time except childhood." The concept of life satisfaction

is also seen as the logical goal of gerontological counselors (Adams, 1969; Lemon, Bengston and Peterson, 1972; Myers, 1979). Being pleased with one's life in general would include a zest for life, fortitude to go on, internal congruence between desired and achieved goals, high self-concept, and optimistic mood (Adams, 1969). A final gerontological counseling goal is independence. Brine (1979) recognized the predisposition of older persons to become increasingly dependent as they face multiple losses. Macione (1979, p. 59) asserted, "Independence and assertiveness are ideal goals." She advocated counseling for stress removal so that older persons could again function more freely.

These identified gerontological goal descriptors remain unspecified and lacking in the depth necessary to construct counseling theory frameworks and to direct counselors in their everyday activities working with the elderly. Shertzer and Stone (1968, 1972) have outlined five counseling goal categories which seem to have applicability for the aging network and assist in the search for goal congruence between public aging programs and gerontological counseling.

Problem Resolution

The counseling goal of problem resolution is the first category recognized by Shertzer and Stone (1974, p. 88). This performance goal seeks to identify the problem or problems currently giving stress to the client and to remediate the stress by attempting to find a solution to the problem. The assumption generating the goal is well stated by Krumboltz (1965, p. 383-384). "The central reason for the existence of counseling is based on the fact that people have problems that they are unable to solve themselves." Those who view aging as a problem, or believe that aging generates problems for the persons who are experiencing

the losses associated with the process, find this counseling goal attractive. The problems created by aging are generally those caused by losses which are irrevocable. The loss of youth, the loss of physical strength and capabilities, the loss of community status due to retirement, the loss of a spouse, or friends, are all examples of aging problems which cannot be reversed.

There exists no way to remove these losses. The loss itself however is not the problem; the problem is a result of the reactive behavior exhibited by the individual. Feeling the effects of the loss stimulates behavioral responses which might be best described by "life was better back when." Counseling can do little to eliminate the loss from occurring; counseling, however, can allow the older person the opportunity to assess his/her objective world, express the intense emotions surrounding the loss, identify behavioral alternatives, establish goals, and support the individual in pursuing a life of meaning and purpose beyond the loss.

Behavioral Change

The second counseling goal outlined by Shertzer and Stone (1974) is "behavioral change." They defined the concept as "redirection of typical responses to frustrations or different attitudes toward other people or self" (p. 89). The idea of behavioral change as a counseling goal has caused no small amount of discussion among proponents from different theoretical foundations. The behaviorist view sees behavioral change as the only goal which counseling should pursue; "the behavioral counselor is primarily interested in helping the client change whatever behavior the client wishes to change . . . he makes no pretenses of working toward high sounding and elaborate goals which involve a whole restructuring of the client's personality" (Krumboltz, 1964, p. 121).

Krumboltz's reference to elaborate and high sounding goals refers to the client-centered counseling approach which advocates self-understanding and self-acceptance as goals. Even Rogers (1951) himself, founder of the client-centered counseling model, appreciated the value of behavioral change in the counseling process when he stated: "This therapy produces a change in personality organization and structure and a change in behavior, both of which are relatively permanent" (Rogers, 1951, p. 125).

Patterson chided the behaviorists, however, by asserting that their goal approach is simplistic and produces "dependence, short-term gratification or accomplishment, or removal of symptoms" (Patterson, 1964, p. 125), rather than attempting to resolve the cause of the stress. Shertzer and Stone (1974, p. 87) defined behavioral change as change "which will enable the counselee to live a more productive life as he defines it within society's limitations." This goal of behavioral change has direct applicability for gerontological counseling. Edwards and Klemmack (1973) described the process of growing old as one which involved a complex and interdependent exchange between the self and the environment, involving behavioral change. Rose and Peterson (1965, p. 4) indicated that older persons are becoming behavioral minorities; "the greater the separation of older people from other categories . . . the greater the extent and depth of subculture development." Aging involves role transformation (Rosow, 1973) resulting in behavioral change which can be either growth enhancing or withdrawing in nature.

Decision Making

The third overall goal of counseling as described by Shertzer and Stone (1974, p. 90) is that of "decision making." The goal of the counselor is "to enable the individual to make decisions that are of

critical importance to him" (Shertzer and Stone, 1974, p. 90). Reaves and Reaves (1965, p. 663) stated this same goal in another way, "The primary objective of counseling is that of stimulating the individual to evaluate, make, accept and act upon his choice." Planning consists of making decisions and setting goals. The developmental tasks faced by aging individuals require many decisions which pertain to both short term and long term behavior (Havinghurst, 1972). The crisis in time which characterizes the aging process as described by Havinghurst (1961) necessitates personal decisions of many dimensions. Many of the crises of old age, from retirement to preparation for death are life events which can be either prepared for through adequate decision making, or more healthfully resolved with the aid of competent decision making; "the purpose of counseling is to facilitate wise choices of the sort on which the person's later development depends" (Tyler, 1969, p. 13).

Positive Mental Health

Counseling goal number four is "the goal of achieving and maintaining positive mental health" (Shertzer and Stone, 1974, p. 88). Positive mental health includes such dimensions as: emotional adjustment, positive identification with others, learning to accept responsibility, independence, and behavioral integration (Shertzer and Stone, 1974). Counseling represents the most viable means of fostering mental health in old age (Dorfman, 1970; Kobrynski, 1975). "Attack, restraint, and stress lead to significant psychological stress for the older American " (Levin, 1963, p. 307). Working with older persons in groups has been demonstrated to be a beneficial means of promoting positive mental health (Klein, LeShan and Furman, 1965), not only for the severely distressed individual but also for the "normal" older person for the purpose of maintaining healthy

attitudes. Butler and Lewis (1973) advocated counseling for both preventative and remedial purposes for older persons.

Personal Effectiveness

The last goal suggested by Shertzer and Stone was personal effectiveness (1974, p. 89). "Closely related to preservation of good mental health is the goal of improving personal effectivensss." Butler and Lewis (1973, p. 18) indicated that one of the approaches to reversing the predicament of the older American was to adopt the World Health Organization's definition of health: "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." The authors suggested that there must be an attempt to "enable humans to thrive and not merely survive."

One of the dimensions of personal effectiveness is learning coping mechanisms of assertiveness to obtain the community resources which many older persons are denied (Butler, 1975). Many older persons experience difficulty in securing services from public agencies (Donahue, et al. 1953; Murphey, 1979). Learning strategies and developing perspectives of positive self-esteem would enhance the personal effectiveness of the elderly. Counseling could assist older persons in developing the needed resources and skills to adequately address their environment (Butler, 1975). Continued personal growth of the individual has not been a priority issue in public legislation for the elderly. The potential for gerontological counseling to become a cost effective service by facilitating personal effectiveness for the elderly has not yet been recognized in federal and state policy initiatives and recommendations. "Clearly much remains to be done in convincing policymakers of the necessity to accept

the concept of life-span policies as a foundation of social policy" (Quirk, 1976, p. 142).

Social policy goals for the elderly, as evidenced in aging legislation, seems to be the elimination of or the alleviation of the problems associated with age. The resultant services created have addressed the physical needs of the elderly: nutrition, transportation, housing and the like. There seems to be a marked deficit in programs designed to eliminate or alleviate the emotional stress produced by the problems of aging. This oversight represents a grave omission in terms of the holistic health of the individual.

Remediation-Prevention

A theme which runs through much of the aging literature is independence of the individual (Fact Book, 1978; Kalish, 1972; Lopata, 1970, Myers, 1978; Roscoe, 1970). The goal statement of the Older Americans Act of 1965 stressed the maintenance of independence. Brine (1979, p. 73) stated that, "Elderly clients experience multiple losses. One of the aspects of such losses is the client's predisposition to become more dependent." The question is to what degree should gerontological counselors pursue goals which are reactive, that is responding in a remedial sense to current needs, and what level of services should be proactively offered in a preventative sense, anticipating needs and preparing clients for the inevitable losses they will encounter? This question has yet to be adequately answered.

Should gerontological counseling be remedial or preventative? Lombana (1976, p. 143) shed light on this question by specifying gerontological counseling services which she considered to be remedial and those which could be provided in a preventative mode. She identified four

areas of remedial counseling: (1) personal counseling for persons with mental health problems, most notably depression, (2) supportive counseling for persons with health problems, (3) adjustment counseling for persons living alone or in institutions, and (4) avocational counseling and retraining. Preventative counseling includes information services such as preretirement programs, counseling to families of older persons, educational and recreational opportunities, life-long health education, and environmental resources training. Preventative counseling involves any effort to raise the personal understanding and insight level of the individual as a preparation for the role changes ahead. Burdman (1974, p. 36) urged preventative type counseling to forestall the social disability which so often accompanies role loss. He indicated that "this implies giving help to persons still active in their social roles; it is essentially preparation for facing the future with dignity." Schaie (1973) carried the concept of preventative counseling beyond the elderly population when he argued for intervention not only with the older population but with the middle aged category as well, as a way of revising present stereotypic images of aging.

Boyd and Oakes (1973) proposed the creation of "well-aging" clinics as elderly community care centers which would focus on preventative measures. The interfacing of the gerontological counseling goals of independence and prevention are well summarized by Macione (1979, p. 60). She wrote, "once the sources of stress are removed, an older adult may be capable of functioning in a more independent capacity." Early intervention by a qualified counselor could be the key to preventing crises that may diminish the quality and length of later life. Zubin (1973, p. 6) reinforced the independence-prevention connection;

"If we could prevent a lowering of the self-image by proper behavioral therapy, perhaps much of the so-called aging effects on behavior could be prevented."

Role Theory

"Role is what a person actually does" (Bentley, 1965, p. 13). Role might also be "used vaguely to describe what one does or is expected to do" (Bentley, 1968, p. 71). Role is a perceptual phenomenon in that its definition changes with each evaluator for any given position. Roles are inextricably connected with expectations; "roles provide a method of organizing expectations by reference to a social structure" (Ivey and Robin, 1966, p. 30). Yinger (1965) suggested that expectations formalize into role requirements which range from mandatory to optional depending upon their perceived urgency. "Role is a unit of culture; it refers to the rights and duties, the normatively approved patterns of behavior for the occupants of a given position" (Yinger, 1965, p. 99). Bentley (1968, pp. 74-75) identified four components of role. Role performance refers to what the position occupant actually does. Role expectations consist of what is expected of a person. Role conception refers to expectations the position occupant holds for him/herself, while role acceptance refers to the degree of identity and commitment demonstrated by the position occupant.

If any of these dimensions of role may for some reason become misaligned, role conflict can result. "Conflict and ambiguity represent the discrepancy between the perception of the determiner . . . and the expectations of the focal person" (Bentley, 1968, p. 78). Role conflict is distinguished by Yinger (1965) as either internal or external. External

role conflict is caused when incompatible expectations are held by two or more individuals. Internal role conflict refers to the internalization of personally contradicting expectations. Bentley (1968, p. 75) categorized role conflict further by pointing out: (1) the role definer may be inconsistent in his/her expectations, (2) situations where experts cannot agree, (3) the role has inherent contradictions, (4) too high a psychological price is paid by the position occupant, and (5) the occupant refuses to accept the defined role.

Roles have been further defined through comparison and categorization. Roeber (1968, p. 312) identified three categories: "ultimate" roles, i.e., where do you eventually want to go, "intermediate" roles, i.e., your plan or strategy, and "immediate" roles which translate into specific functions. This hierarchy of roles is useful in that specific functions, i.e., what I do right now, are dependent upon ultimate roles. Gross (1958) classified roles into two groups, normative roles which represent expected standards and behavioral roles which describe actual action.

Counselor Roles

"The role of the counselor is most simply defined as the expectations and directives for behavior connected with his position. As such it is the counselor's blueprint for action" (Shertzer and Stone, 1974, p. 131). The APGA policy statement, "The Counselor: Professional Preparation and Role" stated: "The role of the counselor is influenced by his professional skills, his professional interests, the environment in which he works, and the definition of function established by the profession" (Loughary, Stripling and Fitzgerald (eds.), 1965, p. 78). It is clear that the counselor does not shoulder the responsibility alone

for defining the roles which will in turn constitute the position's job description. Assistance is seen as coming both from the environment and from the profession. Expectations for role performance arise from the individual counselor and from those persons directly or indirectly concerned with the position. "Other individuals in the social structure interact with and desire certain behavior from the role occupant" (Shertzer and Stone, 1974, p. 131).

The resultant performance of the role occupant is a combination of that behavior which is unique to the counselor and his/her interpretations of role expectancies from the surrounding social structure (Hill, 1977; Sarbin, 1958). Role conflict results when a counselor behaves in a manner which is perceived to be inconsistent with what is anticipated. Conflicting expectancies from the various publics of the counselor has created much of the confusion surrounding the roles of the counselor. Bentley (1968, p. 77) urged counselors to remember that they function as part of a total social system. "By accepting the systems concept as applicable to the process of defining the counselor role , . . . much more progress can be achieved."

Roles are not to be confused with the concept of counselor function (Shertzer and Stone, 1974, p. 129); "role and function have been erroneously used in the literature as being synonymous." Both Wrenn (1965) and Roeber (1965) distinguished between role and function. "A role is seen as a purpose or as an end, while a function is a process or a means" (Wrenn, 1965, p. 235). Roeber (1965, p. 6) echoed, "role is the part taken by the professional worker, while function refers to the way in which the worker carries out his role." Roles are implemented by the counselor when specific functions are exercised. Function identifies

a smaller behavioral segment than does role. Identification of roles assists the counselor in specifying functions which will best carry out the role.

Accurately defining roles is beneficial not only for the individual counselor but it also educates the various counseling publics to what expectancies are realistic and potential. Boy (1968, p. 221) urged the professional counselor associations to provide leadership in role definition and to circulate these roles among their members for confirmation. He stated "Counselors have long existed without such a role definition coming from an official body . . . our job function has become rather nebulous because of (the) lack of role concept." Stevic (1963) argued that because counselors lack adequate role definitions they lack a clear role commitment, which has the effect of reducing their effectiveness to reactions to situational pressures. Others have expressed similar lamentation: "Counselors have allowed their work tasks to be largely defined by others, as if they were a group of "reactors" (Hannam, 1977, p. 50). The obligation of the profession to define counselors' roles was acted upon by the American Personnel and Guidance Association (APGA) in 1964 (Loughary, Stripling and Fitzgerald, 1965.) As early as 1973, however, the cry for further role definition was already heard (Banks, 1973). Indeed, Shertzer and Stone (1974, p. 143) expressed the continued need for role definition. "The role of the counselor . . . is but in the formative stages in most work settings." The increased call from the public for accountability of publicly financed professions is an obvious and demanding requirement to perform needs assessments and to define both the goals and roles of the profession (Burck and Peterson, 1970). Walton (1969) suggested that accountability questions should be

addressed even before the professional counselor begins any formalized practice. Knapper (1978, p. 17) warned that without clearly defined role statements the decision makers who control resources ". . .are left to their subjective judgments of counselor performance and worth." He went on, "the existence of counseling profession depends upon the ability of the profession to adapt realistically to society's needs and goals."

Gerontological Counseling Roles

The profession of gerontological counseling has yet to define roles for its practitioners. The dangers inherent in this omission have been previously stated. Steffire (1964, p. 654) in explaining the identity crisis of many school counselors made a poignant statement which may express the position gerontological counselors find themselves in today.

> In this marginal man-- the school counselor-- simply a teacher who has a new assignment; is he a psychologist who has strayed temporarily from his clinic; is he a sub-administrator who has managed to place himself on the administrative salary schedule; or is he a kind of office worker who is giving prestige and dignity to what are essentially clerical tasks?

It is clearly the time to identify the roles which gerontological counselors can play. The aging network is in its nativity stage, but is fast becoming solidified into proving services of a material nature, seemingly disregarding the affective needs of its target populations. Unless the profession of gerontological counseling defines itself and identifies those areas of service overlap between itself and the present aging network, its effectiveness and perhaps even existence as a viable profession will be held in question. "One of the crucial problems for any emerging profession lies in its efforts to communicate

itself to other related groups and so establish some degree of professional identity" (Blocker, et al., 1968, p. 211).

The following section of this literature review outlines gerontological counselors' roles which have been identified in the abstract. Counseling literature has advocated and implied many roles for the gerontological counselor; the following is an attempt to organize and summarize the pieces into discrete and definable roles.

Provider of Services to Persons Living Alone

A consequence of increased longevity and a differential mortality rate between males and females is that large numbers of older persons are living alone. The findings of Harris et al. (1975) indicated that older persons are hesitant to live with their children and preferred to live independently as long as possible. The number of single person households has risen among the elderly population, to the extent that fewer than half of all women 60 years of age and older are currently living with their spouse (Califano et al. 1978). The need for home services is expected to increase. Murphey (1979, p. 21) stated that "most aging legislation has a goal of mandatory maintenance of independent living." Kent and Matson (1972) maintained that wodows, especially, have special problems and that, due to their contrasting social world, loneliness becomes a chief cause of depression among the aged (Richardson, 1964; Roscoe, 1970). Berry (1976) identified ways that counselors can be effective in working with elderly widows. Among these is organization of wodow support groups, informational services, assertiveness training, communication skills training, employment counseling and guidance, as well as support in seeking new social contacts. Many widows and persons living alone are reluctant to take the necessary risks required to make new

relationships (Buckley, 1972). They may lack the social skills necessary to develop friendships outside of the security of marriage. Many view their situation as irreversible and see no alternatives. Counselors are uniquely qualified to intervene in such cases to prevent a continued withdrawal from society. Schmidt (1976) identified the counselor role of building coping skills to deal with loneliness as a primary one for those working with the aged.

Bereavement Counselor

The death of a loved one has dramatic effects upon survivors. Often they experience a great sense of personal and environmental disorganization and an inner life questioning of the value of living (Insel, 1976). The process of grief has been defined by Kubler-Ross (1969) as a five step phenomenon where counseling skills of empathy and support leading to acceptance can be beneficial (Altameir, 1957; Uroda, 1977). Salisbury (1974) described the grief process as a natural role focus for the counselor. The event of widowhood has the negative social effect of breaking social ties at a time when the support from a friendship network is most needed (Lopata, 1970). "During the period of intense grief soon after the death of a spouse the most pressing need is usually for empathy and strong emotional support in returning to a normal social life" (Koff, 1979, p. 132).

Withdrawal and isolation are natural reactions to and symptoms of the bereavement process (Insel, 1976). Should these withdrawal symptoms persist a process of mental deterioration may ensue, setting the stage for a complex of further life problems to debut (Amster, 1974). Older persons can experience a succession of mourning periods due to the loss of others significant in their lives. These periods may overlap in time, creating

a situation which Kastenbaum (1969) calls "bereavement overload." The symptoms of this "disease" are the same as with "normal" bereavement only more so; loneliness and susceptibility to life stress are heightened. Insel (1976, p. 127) wrote, "anxiety generated by such a separation and the nature of the grief reaction become the issues of the professional counselor in counseling the bereaved."

Change Agent

Older persons suffer in a society which maintains negative myths about the capabilities, the intelligence and social skills, the life style and usefulness of the aged (Cotrell, 1974; Kimmel, 1974). Counselors can assume a proactive role in attempting to dispel these myths at strategic places where they have the most deleterious effect upon the life satisfaction of the elderly (O'dell, 1976). Counseling literature is abundant with encouragement for counselors to act in the capacity of societal change agent as another level and means of assisting their clients (Friend, 1977). Need for change agents with regard to aging is of particular importance because of the stereotypic perceptions which are overlaid upon older persons. Murphey (1979, p. 42) asserted that "there is . . . a viable role for counselors' leadership in interrupting the cycle of negative attitudes held by service providers." Prejudice against age can be broken into three categories: (1) age restrictedness, i.e., age grading behavior; (2) age distortion, i.e., assumption of capabilities on the basis of age, and (3) agism, i.e., dislike based on age along (Ponzo, 1978). Ponzo (1978) outlined specific behavioral objectives that counselors can use in their counseling and training to combat age prejudice. "Counselors should be in the forefront

as change agents and as practitioners reaching out to middle aged and older persons as a new challenge" (O'dell, 1976, p. 147).

Personal Counselor

The fact that personal counseling is needed and desired by older persons has been well documented (Blake, 1975; Fleer, 1975; Murphey, 1979; Myers, 1978). Older persons are effectively denied access to counseling services as a result of a complex of problems and events (Fact Book, 1978). Murphey (1979) has documented that the negative attitude toward the elderly held by social service practitioners and administrators manifests itself in the lowered level of services offered to older people. The acronym YAVIS was created by Butler (1975) to describe the type of clients that counselors preferred: young, active, verbal, intelligent and successful. Of all the psychiatric services offered in the United States, older persons participate in only about 2%, while their absolute numbers range to 10% of the population (Fact Book, 1978). The attitude that psychological and emotional distress is a normal part of aging has been purported as a reason for this poor delivery record (Fact Book, 1978). Harris et al. (1975) found that the societal conception of old age as inevitably producing mental problems is shared by a large proportion of older persons themselves.

Rosow (1967, p. 34) sees role loss as the basic contributor to the negative social and individual perception of the elderly. The loss of major life roles and the loss of identity in group membership, result in the older person becoming a "marginal participant in his own world." Lowenthal and Haven (1968) suggested that the ability to cope with losses and trauma can be enhanced by an intimate relationship which provides emotional sustenance.

Depression has been recognized in many elderly persons (Fleer, 1975). Depression is caused by what Rosow (1967, p. 33) cited as the "essence of the aging problem," that being "socialization to the loss of status." Herdell and Kidd (1975) researched non-senile and moderately senile persons 60 and over, with respect to the degree of depression present in each group. They stated that "depressed geriatric patients may be those who always have been somewhat depressed and who become more seriously so when faced with the actual problems of aging" (Herdell and Kidd, 1975, p. 645). Their research findings included that moderately senile persons scored significantly higher on the Zung Self-Rating Depression Scale (SRDS) than did non-senile persons. This research is not strong enough to establish a positive correlation between senility and depression, nor can it conclude a causal relationship between depression and senility; the implications, however, will generate more research.

Consultant

Professional counselors are trained in the techniques of consultation. Professional gerontological counselors are therefore uniquely qualified to offer consultive services to the aging network in whatever geographic or community area they operate. Bellak and Karasu (1976) found that devaluation of the older person is a common problem in agencies offering services to the elderly. A process consultation approach as outlined by Shien (1969) would be most helpful to an agency which was experiencing either personnel or functional problems. The counselor/consultant could focus on the presenting problem, regardless of how nebulous, and work within the agency group structure to bring the problem(s) to resolution, thereby enhancing the client sensitivity of the staff and the efficiency of the agency. Murphey (1979, p. 15) recognized this

consultive role of counselors when he stated, "Counselors and counseling techniques could facilitate and humanize agency procedures as well as educate social workers to the needs and sensitivities of older persons."

Counselors could also be available to the local aging network to perform third party or mental health consultation (Caplan, 1970; Walton, 1969). Professionals who experience a problem in dealing with an older person could call on the services of the mental health consultant who could focus on the interplay between the consultee and the client with the aim of enhancing the human relationship between the two. Fine and Therrien (1977) outlined the part played by the use of empathy in the doctor-patient relationship. Such concerns are the province of the mental health consultant who could offer his/her services to the medical, educational, social service, and other communities within a given area.

Specialist in Psychological Education

Closely related to, but qualitatively different from, the consultation role of the gerontological counselor is the role of psychological educator. There are two populations which require continued educational opportunities in the human communication and understanding areas where counselors are qualified to teach (Grabowski, 1972). The first group is the professional and paraprofessional population who either deal directly or peripherally with the elderly. Ernst and Shore (1975) found that the exposure to gerontological information has the effect of improving unfavorable attitudes toward the elderly. Kinlaw (1978, p. 10) concluded that "helping skills training should be included in programs designed to prepare professionals." Counselors, especially counselor educators, are trained in curriculum development and can well execute this educational role (Ivey, 1976).

The second group who would benefit from the psychological educator role of the counselor are the older persons themselves. A number of developmental psychologists have noted that personal and social skills are essential to successful coping with the last stages of life (Waters et al., 1976). The problems which are of particular impact among the elderly, including suicide and alcoholism, could be specific targets for educational programs offered by the counselor through the aging network (Lee, 1976). Life-long learning, both in the instrumental and the expressive areas, has been advocated by many educators (Geron, 1976; Havinghurst, 1976; Wasserman, 1976). Educational programs dealing with these mental health problems associated with aging, which are characterized by changes and adjustments, are ideal topics for the counselor educator to handle (Buckley, 1972).

Employment Counselor

"As older persons change careers, or enter and reenter the labor force, they can be helped to evaluate their motivations and characteristics toward finding self-actualizing occupational roles" (Sinick, 1977, p. 19). O'Dell (1957) outlined that the employment needs of the elderly are likely to increase. This is true because of the increased longevity and health of older persons who desire the status a job can give, the need for additional financial resources, the desire to structure time and to find meaningful activity (Palmore, 1976).

Current career developmental theory makes little note of the employment needs of older persons (Super, 1957). Carp (1968) discovered, however, that older persons who held part time jobs scored significantly higher on a life satisfaction instrument than did equally healthy persons who volunteered their time a corresponding number of hours per week.

Carp concluded that the status and money provided by work are variables of high value to most older people.

Quirk (1976, p. 141) estimated that there are over three million persons over the age of 65 who would be interested in some kind of second career training. Vocational training programs seem to be offered to those who have the longest working life ahead, which has the effect of barring older workers (Murphey, 1979). "There is a decline in the proportion of aid services, including counseling, provided by employment services to older age groups as compared with those provided to younger applicants" (Quirk, 1976, p. 141). Gerontological counselors in the role of employment counselor would represent a needed addition to the services provided to older persons (Sinick, 1977).

Services Coordinator--Services Enhancer--Client Advocate

It is difficult to draw sharp distinctions among the roles of services coordinator, services enhancer, and client advocate. Each role has functions which overlap with the others, yet no single role descriptor adequately summarizes the three roles in concert.

Pfeiffer (1976) suggested that the role of services coordinator, one which could facilitate the creation of a "services mix" to meet the individual needs of a client, is a needed one in the aging network. The network tends to be fragmented, disorganized, seemingly uncaring, and complicated to an elderly client (Butler, 1975; Ohio, 1960). The heterogeneity of the population demands that unique and personalized services "packages" be created for each client. Such a role requires not only the knowledge of the aging network, but also demands the communication of caring, genuineness, and respect to the service user, in an attempt to recognize and deal with the actual presenting problem.

Goodyear (1976) examined the viability of using community psychology to provide a framework for unifying the diverse activities of the counseling profession.

A service enhancer is one who maximizes the amount and quality of assistance any agency or program is capable of providing. In the complicated social services system it is sometimes difficult to procure the level of service necessary to remediate a problem (Butler, 1975; Murphey, 1979). Lewis (1977) identified the role of community developer. The functions of broker and referral agent are subsumed in this role. A counselor could enhance the use of social services by helping to dispel fear and by building self-confidence in the client so that maximum benefit could be derived from the system (Murphey, 1979). Community resources availability is a function of the assertiveness with which the older person pursues and has the resources to use the aging network (Miller, 1971).

Acting as older person client advocate is a role which has appeared frequently in gerontological counseling literature (Griswold, 1971; Lewis, 1977; Macione, 1979). Elderly service seekers may lack the knowledge, the energy and fortitude, and the assertiveness sometimes needed to penetrate the aging network of services. They require not only informational assistance but emotional supportive help as well. Fleer (1975) has pointed out that the elderly may regard public assistance as a charitable hand-out. They may either find the process personally demeaning, since they have never used such agencies before, or assess themselves as ineligible by virture of past perceptions. Advocates who can deal with such clients using positive regard and empathy can enhance the use of existing programs. The need for an advocate, a guide, or a coordinator to lead older persons through existing agencies has been noted (Murphey, 1979, p. 43).

Financial Counselor and Manager

Within the limits of the counseling relationship and according to the knowledge and training of each counselor, the elderly have financial management needs which often require attention (Myers, 1978). The reference here is not to high level finance, but rather to the daily money skills that may be viewed as elementary by younger persons. The accounting procedures in today's computerized economy are many times baffling to older persons (and younger too) who are restricted by income, mobility and financial inexperience.

Two areas of special consideration are health care and residential planning. Myers (1978, p. 32) stated that the "elderly need to understand their physical changes in order to react appropriately and to maximize their health dollar." Without adequate health insurance plans, a sense of vulnerability can cause stress on the elderly person which may distort perception of reality. The trauma caused by sudden losses can isolate the older person to the extent that matters of financial necessity somehow slip away unnoticed only to emerge later as knotty problems which require assistance. Wolff and Meyer (1979, p. 188) assert that, "too often no deliberate, thoughtful planning is given to long term living and the 'choice' becomes the least objectionable crisis solution for older adults and their families."

In-Service Counselor--Educator

Staff members working in existing agencies and institutions can benefit from the counselor--educator role played by the gerontological counselor. Hurst (1977, p. 61) used the term skills dissemination to refer to "therapeutic interventions which train individuals in human development process skills for their own benefit and that of those around

them." The term intervention refers to in-service, educational settings. In-service education can also be provided to persons who desire to become peer counselors. Waters, Reiter, White and Dates (1979) have devised an in-service peer counselor program which includes recruitment, selection, training, supervision and assessment. Perhaps Maddox (1972, p. iii) dramatized the importance of the in-service role when he wrote:

> Special environments for vulnerable aging persons will not be satisfactory no matter how much money is spent, until all the personnel in these settings are technically and socially competent to help and find personal satisfaction in helping.

Leisure Time Counselor

Havinghurst (1961) described retirement as a crisis in the meaningful use of time. Older people have an abundance of free time and seek to fill it with life enhancing activities (Alston, 1973). The loss of the work role represents not only the loss of financial stability and status in the community, but also the loss of purposeful activities which previously structured time for the individual. This "loss of dignity" produces a corresponding depression when activities become too limited (Hallåck, 1971, p. 222). "It is possible to predict that the future contentment of a retired person will be directly related to how active he remains" (Hallack, 1971, p. 222). The activity theory of aging posits a positive relationship between meaningful life activity and life satisfaction (Lemon, et al., 1972). Time management skills, especially time sequencing and planning, take on a heightened value in later years. Avocational pursuits take on the importance after retirement that vocational activities held prior to the event. Counselors can use a variety of techniques and materials to assist the older person in finding leisure interests which are pleasing and purposeful. Lowered activity levels indicate the first signs

of social and psychological withdrawal which marks entry into a less effective life state characterized by disengagement and decline (Super, 1957).

> Once counselors understand what leisure is and what it can do they should be alert to the variety of related client needs. One major need may be for information. Another . . . the need for clarification of preferences . . . a third might be to develop skills for leisure activities. (Riker, 1979, p. 112)

Marital and Sex Counselor

The role adjustments necessary after retirement often have consequent impact upon the relationship of the retired couple. Excess free time can lead to invasions on the "territorial right" of each partner and necessitate a modification in the informal marriage contract. Medley (1977) has devised a program designed to enrich the marital lives of older persons. The program stresses relationship analysis and goal setting as requisite components to marital adjustment in the post-retirement years.

Issues involving sexual activity have been addressed in the literature. Many older persons remain sexually active, according to the availability of partners (Hess, 1974). Many older couples require reassurance and accurate information that sex remains a natural and normal part of the relationship and should not be regarded as unhealthy (deBeauoir, 1972; Neugarten, et al., 1961).

In those cases where the older person has moved in with married children, marriage counseling of the host couple by a professional gerontological counselor is often helpful for the continued growth of the couple and the elderly parent (Bock, 1972). This function of assistance to adult children goes beyond marital counseling. Ideally the counselor could act as an informational agent for aging problems in terms of remediation, personal communications, referral, and support. Such a function

is very much in keeping with aging policy thrusts attempting to prolong independent living and postponing institutionalization as long as possible. Living in the knowledgeable and supportive atmosphere of an adult child's home may be an attractive alternative to the nursing home for many older persons and their children.

Counselor and Outreach Agency to Minorities

The elderly as a group tend to exhibit characteristics which conform to the definition of minority: defensiveness, self-hatred, sensitivity and self-consciousness (Myers, 1978, p. 22). Palmore (1976) suggested that because the elderly have been negatively sterotyped, they have developed a group consciousness of inferiority, which he associated with the tendency to reduce activity with advancing age. The stereotypes as listed by Busse and Pfeiffer (1969, pp 47-52) center around illness, sexual activity and interest, mental abilities, morale, activities in general, productivity and isolation. Busse and Pfeiffer (1969, p. 29) wrote: "There is little doubt that the elderly American can be identified as belonging to a deprived minority."

The second dimension of the minority status of the elderly concerns itself with those older persons who are in "double jeopardy" (Hill, 1971), first because of their age and second because of their race. Solomon (1979, p. 154) cited Blacks, Hispanic Americans, Indian elderly, and Asian-American elderly as those groups who are suffering from "cultural barriers, language problems and a general erosion of resistance to the negative effects of age due to life in a dual culture." The U.S. Commission on Civil Rights; The Age Discrimination Study points out that: "Being black and aged frequently means the piling up of life problems associated with

each characteristic . . . less education . . . less income . . . less adequate medical services . . . fewer family supports." (USGPO, 1977, p. 17)

Counselors can assist those suffering in this multiple discrimination by first understanding their complex need structure, and then by taking a proactive posture in reaching out to these people who may be reluctant to identify themselves by living and suffering in silence (Furgess, 1976). Racial differences among the various minorities do exist; the implication for gerontological counseling, however, is in the depth rather than the type of services required (Ehrlick, 1975).

Provider of Services to Nursing Home and Housing Complex Residents

Fewer than 5% of the elderly population live in a nursing home at any given time, yet 19% die in nursing homes (Manney, 1975; Montgomery, 1972). Many authors have called for the services of gerontological counselors in nursing homes (Boyd and Oakes, 1973;Freidman, 1975; Salisbury, 1974; Vontress, 1975). Fear of extended illness which would deplete remaining financial reserves is, according to Shanas (1962), the single greatest threat and cause of stress among the elderly. Butler (1975) refers to this fear of nursing homes when he describes that they are perceived by the elderly as being "halfway houses between life and death" (Butler, 1975, p. 263). Adjusting to health care training, leisure counseling, life review and peer counselor education are only some of the functional services gerontological counselors can bring to the nursing home (Friedman, 1975).

Age segregated housing is becoming increasingly popular and is expected to grow in the future (Pressey, 1973). Kelly (1976, p. 522) outlined the many functions that professional counselors are currently performing in a housing complex in Norfolk, Virginia. These include:

direct services, consultation and coordination, guidance and counseling, advocacy, referrals, and administration. He concluded (p. 523), "these services offer hope and help to severely pressed clients and are an example that counseling is a broad service that can operate beneficially in a setting closely tied to the community it is serving." Pressey and Pressey (1972, p. 356), themselves in their 80s and living in an age segregated housing complex, advocated the role of what they call the resident gerontological counselor. Such a person could greatly aid in "developing a helpful neighborhood," fostering "mutual understanding" among the residents, reshaping "attitudes toward death," and attending to the welfare of the dying and their families."

Preparation for Death Counselor

Erikson (1950) spoke of the fear of death as a failure to achieve ego transcendence and a consequent unhealthy focus on self. Many authors have commented upon and urged that the services of counselors be made available to dying persons (Buckley, 1972; Carey, 1976; Dickstein, 1966; Jackson, 1977; Koff, 1979; Kubler-Ross, 1969).

> Personal freedom in decision making, the availability of alternatives, and opportunities for independence should be considered innate human rights that may require special effort to safeguard and sustain for the dying. The dying person may need the support of a counselor to maintain control over his/her own life and therefore his/her own dying. (Koff, 1979, p. 129)

Dying is the ultimate life crisis and individuals need to find the coping skills necessary so that they can deal with it (Jackson, 1977). Persons near death many times become overburdened with concerns, doubts, and questions which require an understanding, yet impartial, "other" with whom they can relate. Death has become a social taboo in our society, eventuating in an inability to deal with it in realistic terms (Feifel,

1963). "Counselors can help with regard to many matters that dying persons care about, from the mundane to the immortal" (Sinick, 1977, p. 123).

Buckley (1972, p. 756) suggested that dying is a solitary experience but that the quality and meaning of death can be heightened by someone who cares, who supports, and who can empathize deeply. The goal of death counseling, as outlined by Carey (1976, p. 124) "is in assisting each patient to live each day as joyfully and peacefully as possible." The five states of grief, as conceived by Kubler-Ross (1969), apply as well to the terminally ill patient who is anticipating death. Sinick (1977, p. 69) maintained that "counselors can pick up communications crucial in identifying suicidal individuals" and play a preventative function as well as an enrichment function as part of their role as counselor for the dying.

Pre-retirement Counselor and Educator

The importance of work in our society is underscored by the trauma which envelopes some persons when they move from the structure and status of the work role to the role-ambiguity of retirement. Manion (1976, p. 119) described retirement as the "first insult of aging . . . it is tangible evidence that one is publicly recognized as an 'older' person, a 'senior citizen.'" Retirement sometimes brings lowered finances, decreased time structure, loss or uncertainty of status in the community, lowered life meaning, and decreased association with fellow workers. Adequate retirement planning is a requisite to accommodate the losses incurred by the retirement event.

Many pre-retirement programs have been created (Greene, 1969). Ullman (1976, p. 118) suggested, however, that, "most retirement programs focus on the economic factor because they can deal with these problems

successfully." Siegel and Reaves (1978) and Manion (1976) both echoed this supposition. Manion (1976, p. 119) divided all pre-retirement programs into four categories: coping, prescriptive, pedagogical, and T-group. He evaluated each and singled out the T-group format as the one which deals most comprehensively with the pre-retiree because it usually deals with such intangibles as: development, attitudes, awareness, options, and life planning skills. Ullman (1976, p. 118) stated that the "central function of the retirement counselor is to understand the meaning of work and leisure in the dynamics of the individual."

Riker (1979, p. 117), in a comprehensive statement on pre-retirement counseling identified 14 separate counselor functions for the pre-retirement setting. Among these are: training in decision making, person-to-person relationship training, presenting information on financial and housing concerns and referring people for remedial education. Sheldon et al. (1975, p. 148) questioned whether pre-retirement programs of any kind or mode can adequately prepare a person for the life shock of retirement and advocated the creation of post-retirement programs to deal with the "strains generated in the family, the cessation of interpersonal supports . . . and the way in which a community reinforces and degenerates status." According to Sinick, "The developmental state of retirement calls for stock-taking, preparation for role adjustments, planning for optional use of time and managing matters such as income, housing and health" (Sinick, 1977, p. 39). All of these concerns are the natural domain of the professional gerontological counselor.

Public Relations Provider

The public has a need to know about the special problems associated with aging, both as citizens who can be encouraged to help older persons, and as future older persons themselves so that they can begin to prepare for old age. This public relations role is targeted at both the middle-aged and the elderly populations. Public relations constitutes outreach to persons who are ignorant of or who are too timid to approach the aging network. Buckley (1972, p. 756) understood this when she said, "counselors need a counseling model based on the recognition that the unique problems of these persons mitigate against their seeking help."

Public relations to the non-elderly community alerts them to the current problems of aging, may educate them to the needs of their aging parents, and could stimulate them to begin to prepare for their own elderly years. Butler and Lewis (1973, p. 24) urged the creation of GAPS, "Group for Advancement of Psychiatry," in all mental health centers and argued that each GAPS should contain an advocate for the elderly. Public relations is important for gerontological counselors from the standpoint of generating support for the profession. "Counselors must communicate their role . . . in the community . . . to gain support for their work" (Braden, 1975, p. 25).

Gerontological Researcher

More information regarding the counseling needs, the counseling strategies, the intervention points, and the service sites for the elderly is needed before counselors can adequately carry out the task of providing comprehensive gerontological counseling services. Virtually every study on gerontological counseling urges that a heightened research

effort be undertaken (Fleer, 1975; Ganikos, 1977; Murphey, 1979, Myers, 1978; Sinick, 1977; Wolff and Meyer, 1979).

Pressey (1973, p. 356) called for the "furtherance of highly personalized research." Case studies and on-site observations, as well as historical sketches and individual needs assessments, constitute the mechanics of "personalized research." "An old age counselor, especially if so functioning in an institution and preferably in some relationship with a university, has research opportunities now almost unrecognized," according to Pressey and Pressey (1972, p. 366). The role of the resident gerontological counselor, who is in an ideal position to research the possibilities "to investigate potentials regarding longevity, maintained ability, and personality" is well stated by Pressey and Pressey (1972, p. 366).

Summary of Related Literature

This literature review has presented a comprehensive survey of available research and writing dealing with the identification of the goals and roles of gerontological counselors. A summary of three gerontological counseling needs assessments was presented. It can be concluded that the elderly express a need for counseling to deal with the affective dimensions of their lives. An overview of goal theory was then presented as it applies to professional counseling in general and gerontological counseling in particular. The survey addressed the problems associated with counseling goal specification. It then identified the five goals of counseling as outlined by Shertzer and Stone (1974) with particular reference to gerontological counseling. These five goals are:

1. problem resolution
2. behavioral change
3. decision making
4. positive mental health
5. personal effectiveness

An overview of role theory followed with discussion of counselor roles and a section on the roles of the gerontological counselor. A total of 18 gerontological counselor roles was then identified. These are:

1. provider of services to persons living alone
2. bereavement counselor
3. change agent
4. personal counselor
5. consultant
6. specialist in psychological education
7. employment counselor
8. services coordinator/enhancer/client advocate
9. financial counselor and manager
10. in-service counselor educator
11. leisure time counselor
12. marital and sex counselor
13. counselor and outreach agent to minorities
14. provider of services to nursing homes and housing complexes
15. preparation for death counselor
16. pre-retirement counselor and educator
17. public relations provider
18. gerontological researcher

CHAPTER III

METHODOLOGY

Introduction

From the preceding review of literature one might conclude that older persons have needs which can be satisfied through receiving professional counseling. The profession of gerontological counseling has developed to the level where a need exists among its practitioners to specify the goals and roles of the professional counselor of the aged. It has been demonstrated further that the aging services network has evolved into a system most directly concerned with providing services of a physical and material nature. Those needs and concerns of the elderly which are best described as "affective" have been given scant attention by the aging network.

In Chapter II the researcher has specified both the goals and the roles of the professional gerontological counselor as they appear in the literature. This identification in the abstract required evaluation and confirmation from experts in the profession of gerontological counseling. In order to determine the utility of these newly confirmed goals and roles, this study was designed to communicate them to aging network administrators for their evaluation. This study, therefore, generated identification, confirmation, evaluation, and utilization data concerning the roles and goals of gerontological counselors.

Research Objectives

The objectives of this descriptive research study were to: compile a confirmed list of gerontological counselors goals and a confirmed list of gerontological counselors roles. The confirmation process was accomplished by a panel of gerontological counseling experts identified through counselor education department chairperson on a national basis. A goal or role was considered "confirmed" if the responses given it by the panel of counseling experts attained a mean score of 3.5 or above on a 7 point Likert scale.

Determine the degree of relevance that the goals and roles confirmed by the panel of gerontological counseling experts have for federally supported aging programs as perceived by Area Agency on Aging Executive Directors. Three specific research questions were used to achieve this objective.

1. To what extent did the identified and confirmed goals and roles of gerontological counselors conform to and assist the objectives of current programs for the aged as these services are contracted and monitored through Area Agencies on Aging?
2. What was the need for gerontological counselors?
3. Where can gerontological counselors be most beneficially placed within the aging services network to assist older persons? What were the most appropriate sites for gerontological counselors?

Sample Selection and Research Procedures

Two sample groups were necessary to conduct this study. The first was a panel of gerontological counseling experts. The second sample required by the study was one composed of administrators in the aging network. For this purpose, a national clustered randomized sample of AAA directors was taken, (N=253).

Statements of cooperation were secured from the Adult Development and Aging Committee of APGA, and the Center for Gerontological Studies and Programs at the University of Florida. These agencies assisted this study by enhancing subject participation and by offering credibility and consultive services to the researcher throughout this study.

An eight phase process constituted the mechanics of the study:

Phase one. A letter and survey form were sent to all counselor education department chairpersons nationwide (N=448). This letter and survey (Appendix A) outlined the purpose of the study and asked each chairperson to identify any gerontological counseling experts that may be residing at his or her college or university. A gerontological counseling expert was defined as an academic faculty member who had competencies and knowledge in both counseling and gerontology, and who had taught, or was currently teaching, a course exclusively devoted to the content area of counseling older persons. A total of 253 (56.4%) department chairpersons responded to the survey.

Phase two. Of the 253 responding department chairpersons, 160 indicated that no persons conforming to the criteria of the definition could be identified on their campuses. A total of 93 counselor education department chairpersons did identify 99 persons whom they reported as satisfying the definition of gerontological counselor.

Phase three. A mailing was sent to the identified 99 authorities in gerontology. Each of these received a letter (Appendix B) which described the purpose and sequence of the study and provided participation instructions. Along with this letter was a list of 18 goals and five roles for gerontological counselors which had been abstracted from the literature by the researcher, and which are outlined in Chapter II, (Appendix B). Participants were asked to react to the value of each goal and each role for gerontological counselors, by rating them on a seven point Likert scale. Particpants were also asked to list any other goals or roles they perceived as viable and important for gerontological counselors.

Phase four. The researcher compiled the responses. A goal or role which received a 3.5 or above rating on the seven point Likert scale was considered to be a confirmed role or goal. All 18 goals and all five roles were rated above 3.5 and were therefore considered confirmed goals and roles. Participants also added a total of two additional goals and three additional roles for counselors which were added to the original lists. A new list of seven goals and 21 roles resulted. A total of 25 of the originally identified 99 authorities in gerontology either did not respond or self-selected themselves out of the study indicating that they did not consider themselves to be gerontological counseling experts.

Phase five. A second mailing was sent to each of the 74 remaining authorities in gerontology who responded to the round one survey. This second mailing (Appendix C) indicated the mean scores and standard deviations given to each goal and role by the group, as well as the numerical rating given in the first round by that participant. Respondents were again asked to rate each goal and each role on the newly created lists

on a seven point Likert scale, according to their importance for gerontological counselors. Respondents were also asked to rate on a seven point Likert scale each of the 13 potential sites where gerontological counselors could assist older persons within the aging network. These 13 sites were identified by the researcher from the literature and from his experience, and represented all possible location sites within a public service area (PSA).

Phase six. The researcher computed the ratings of each goal and role on both lists according to the responses given by the authorities in gerontology. Through analysis of the demographic data of the 68 respondents of round two, it was determined that 27 did not, in fact, satisfy the criteria of the definition of gerontological counseling expert. Therefore, 41 respondents were retained and used as the panel of experts. The data from these 41 were used to confirm the goals and roles of gerontological counselors.

Phase seven. A letter and survey (Appendix F) was sent to a national random sample of Area Agency on Aging executive directors (N=253). The random sample was compiled from the National Directory of Area Agencies on Aging by use of a random numbers table. The letter outlined the purpose of the study, summarized what had already transpired, and requested the AAA directors' participation. All sampled AAA directors were requested to perform three evaluations on the information provided them:

1. Appraise, on a seven point Likert scale, the degree to which each expert panel confirmed goal and confirmed role conformed to the objectives of the total aging network services currently contracted and monitored in their PSA.

2. Appraise, on a seven point Likert scale, the degree to which each confirmed goal and role could assist older persons in their particular PSA.
3. Rate the 13 potential gerontological counseling sites with regard to the degree of benefit the AAA directors perceive gerontological counselors could be to older persons at those sites.

Phase eight. The researcher computed mean scores and rank ordered each goal and each role on the basis of responses on the survey form as returned by AAA directors. These responses were, first, the degree of conformity of each goal and role to the objectives of existing services, and second, the degree to which each goal and role could assist older persons. Additionally, the researcher rank ordered the gerontological sites identified as those where gerontological counselors would be most likely to have maximum impact.

Analysis of the Data

A number of demographic items was requested of each gerontological counseling expert: geographic area of employment, sex, academic department, college affiliation, number of gerontology courses taught, contributions made to gerontology, preparation in gerontology, preparation in counseling, degree attained, and other specialty areas. Likewise, AAA directors were requested to provide the following demographic items: geographic area of employment, sex, age, number of years of schooling, degree level and population density characteristics of their public service area (PSA).

Various statistical manipulations of the resulting data were accomplished. A percentage breakdown of all demographic categories was

undertaken (Tables 1 and 2). Crosstabulations between demographic items for both experts and AAA directors were produced (Tables 4 through 9 and appendices H through Q). Frequency response for goals, roles and sites, as given by the panel of experts and the sample of AAA directors, appear in Tables 9 and 12. A one-way analysis of variance procedure was undertaken for each goal, each role, and each site in relation to each demographic item for both experts and AAA directors. These appear in Tables 10 and 13. Means scores standard deviations, and rank order for all goals, roles and sites responses for both experts and AAA directors, as well as correlations between the two groups, appear in Table 15. A one-way analysis of variance between experts' and AAA directors' responses is found in Table 16. Finally, factor analysis of all goal role, and site responses results were computed and appear in Tables 18 through 29. Chapter IV is an indepth presentation of the results of these statistical manipulations.

CHAPTER IV

RESULTS

The data results of the eight phase survey of 41 gerontological counseling experts and 253 Area Agency on Aging (AAA) directors are presented in this chapter. Phases one through six involved the selection of the panel of gerontological counseling experts and the confirmation process of the goals and roles of gerontological counselors. Phases seven and eight involved selecting the sample of the AAA directors, their appraisal of the degree to which gerontological counselors' goals and roles conformed to the objectives of the aging network, and their evaluation of the degree to which these same goals and roles could assist older persons in their public service areas (PSA). Both the panel of counseling experts and the sample of AAA directors also were asked to rate 13 sites within PSAs with regard to the degree each site could serve as a possible physical location for the placement of gerontological counselors to best serve older persons. This chapter further describes the characteristics of each of the samples, gerontological counseling experts and AAA directors, and contains the analysis of the responses made by all participants.

Demographic Information Relating to the Panel of Experts

Area, Sex, and Academic Department

Table 1 displays the frequency data for the experts for all demographic characteristics. For the purposes of this study, the nation

was divided into six sections: Northeast, South, Midwest, Southwest, West, and non-continental. The Northeast included the states of Maine, New Hampshire, Vermont, Maryland, Rhode Island, Connecticut, New York, New Jersey, Pennsylvania, Ohio, Delaware, and Massachusetts. A total of 16 (38%) of the "expert" sample resided here. The South included the states of Virginia, West Virginia, Kentucky, North Carolina, South Carolina, Tennessee, Georgia, Alabama, Mississippi, Louisana, Arkansas, and Florida. A total of five, or 12.2% of the sample resided in the South. The Midwest included the states of Indiana, Michigan, Illinois, Wisconsin, Missouri, Iowa, Minnesota, Oklahoma, Kansas, Nebraska, North Dakota, and South Dakota, where nine (22.0%) of the sample resided. The Southwest, Texas, New Mexico, Arizona, and Nevada, included six (14.6%) of the sample. The West, Utah, Wyoming, Montana, Idaho, California, Oregon, and Washington, included a total of five (12.2%) of the sample. No department chairpersons resided in the non-continental United States, which included the states of Alaska and Hawaii, and all possessions, identified any gerontological counseling experts.

Of the 41 experts, 12 or 29.3% were female and 29 or 70.7% were male. When asked to which department do you most closely identify, 34 (82.9%) indicated "counselor education." Three experts (7.3%) said the psychology department. One expert each (2.4%) identified the departments of gerontology, educational psychology, continuing education, or other.

Thirty-six expert respondents (87.8%) identified the College of Education as the college to which they belonged. Two experts indicated the College of Arts & Sciences, one identified the College of Medicine. One indicated an interdisciplinary appointment, and one did not respond to this item.

Experts were asked to list any contributions they had made to the field of gerontology. These data were reduced to six categories: dissertations, professional journal articles, texts or parts of texts, service projects, presentations at professional conventions, and others. A total of three dissertations, eight articles, eight texts or parts of texts, 21 service projects and five presentations were contributed to the field by the experts. Ten respondents did not report any contributions. Experts also listed the number of contributions each had made to gerontology. Ten (24.4%) indicated that they had not contributed to the field. Fourteen (34.1%) listed one contribution; seven (17.1%) listed two; six (14.6%), three to the field; two (4.9%), four contributions; and two (4.9%), listed six contributions.

Academic Preparation, Degree, and Specialties

Experts indicated the following types of preparation in the field: seven (17.1%) listed seminars; 14 (34%) stated that they were self-taught; 10 (24.4%) indicated they had taken post graduate courses; two (4.9%) listed experience; and two (4.9%) responded that they had been graduated from formal gerontology programs. Experts also reported their preparation in counseling. Four (9.8%) responded that they had taken post graduate courses in the subject, while 37 (90.2%) reported that they had a formal graduate degree in counseling.

Experts listed their highest degree. Four (9.8%) responded that the master's degree was their highest degree. Twenty-two (53.7%), held the Ed.D. degree, and 15 (36.6%), held the Ph.D. degree. Experts also listed the content area of their highest degree. Nineteen (46.3%) indicated that counseling was their highest degree; eight experts (19.5%) responded counseling psychology; six (14.6%) answered educational psychology;

four (9.8%) student personnel; two (4.9%) answered education; and one (2.4%) each responded sociology, and "other."

Experts were asked to list their specialities other than gerontology. One (2.4%) listed no other specialities; eight (19.5%) listed one speciality; 18 (43.9%) listed two other specialities, five (12.2%) listed three specialities; four (9.8%) listed four specialities, and three experts (9.3%) listed five additional specialities other than gerontological counseling. A wide variety of specialities were listed. These specialities seem no different from what could be expected from any sample of counselor educators. No comparative data, however, could be found by the researcher.

Crosstabulation Analysis of Selected Demographic and Other Characteristics of the Panel of Gerontological Counseling Experts.

Table 3 displays the crosstabulation of geographic area and sex characteristics of the counseling experts. Of the 12 female experts, seven were from the Northeast; one from the South; two from the Midwest; and two from the Southwest. No female experts responded from the West. Of the 29 male experts, nine resided in the Northeast; four in the South; seven in the Midwest; four in the Southwest; and five in the West. No counseling experts responded from any non-continental sections of the United States.

Table 4 displays the crosstabulation of the geographic area and highest degree subject area of all counseling experts. Nineteen (46.3%) of the responding experts listed counseling as their highest degree. Of these 19, five were from the Northeast; six from the South; eight from the Midwest, and three came from the Southwest. None came from the West. One expert listed sociology as his highest degree area. Eight experts

TABLE 1

SUMMARY OF DEMOGRAPHIC CHARACTERISTICS
OF COUNSELING EXPERTS

Characteristics	N	% Total
1. Area of Country		
Northeast	16	39.0
South	5	12.2
Midwest	9	22.0
Southwest	6	14.6
West	5	12.2
Non-Continental	0	0
2. Sex		
Female	12	29.3
Male	29	70.7
3. Department		
Counseling	34	82.9
Psychology	3	7.3
Gerontology	1	2.4
Educational Psychology	1	2.4
Continuing Education	1	2.4
Other	1	2.4
4. College		
Education	36	87.8
Arts & Sciences	2	4.9
Medicine	1	2.4
Interdisciplinary	1	2.4
Other	1	2.4
5. Gerontology Course		
Counseling Oriented	40	97.6
Non-counseling oriented	0	0
Both	1	2.4

TABLE 1--Continued

Characteristics	N	% Total
6. Number of Gerontology Courses		
One	22	53.6
Two	10	24.4
Three	4	9.8
Four	4	9.8
Five	1	2.4
7. Gerontology Contributions		
Dissertations	3	6.6
Articles	8	17.7
Texts	8	17.7
Service	21	46.6
Presentations	5	11.1
None	10	22.2
8. Number of Contributions		
None	10	24.4
One	14	34.1
Two	7	17.1
Three	6	14.6
Four	2	4.9
Six	2	4.9
9. Gerontology Preparation		
Seminar	7	17.1
Self-Taught	14	34.1
Post Graduate Courses	10	24.4
Gerontology Program Graduate	2	4.9
Experience	2	4.9
None	6	14.6
10. Counseling Preparation		
Post Graduate Courses	4	9.8
Counseling Program Graduate	37	90.2

TABLE 1--Continued

Characteristic	N	% Total
11. Degree		
Masters	4	9.8
Ed.D.	22	53.7
Ph.D.	15	36.6
12. Degree Field		
Counseling	19	46.3
Sociology	1	2.4
Counseling Psychology	8	19.5
Educational Psychology	6	14.6
Student Personnel	4	9.8
Education	2	4.9
Other	1	2.4
13. Specialities		
None	1	2.4
One	8	19.5
Two	18	43.9
Three	5	12.2
Four	4	9.8
Five	3	7.3

indicated that counseling psychology was their highest degree area. Of these, five came from the Northeast, one from the Midwest; and two from the West. No counseling psychology degree holders reported from the South or the Southwest. Six experts listed educational psychology as the content area of their highest degree. Two of these were from the Northeast; one from the South; one from the Southwest; and two were from the West. Four experts listed student personnel as their highest degree. One each of these came from the Northeast and the South, while two came from the Southwest. Two experts listed education as their highest degree; one came from the Northeast and one came from the West. The one expert who listed "other" as the highest content area came from the Northeast.

Table 5 is a crosstabulation of the sex and the number of gerontology courses taught characteristics. Twenty-one experts indicated that they taught one gerontology course, seven females and 14 males. Of the 10 (24.4%) who listed that they taught two courses, four were female and six were male. All four experts responding that they taught four courses were male. One female and three males responded that they taught five gerontology courses. One male did not respond to this item and consequently was listed as teaching no gerontology course.

Additional crosstabulation tables for the counseling experts can be found in appendices H through N. These crosstabulations cover characteristics such as contributions to the field of gerontology, preparation in gerontology and number of additional specialties.

Crosstablulation Analysis of Selected Demographic Characteristics of the Sample of AAA Executive Directors

Table 6 is the crosstabulation of the geographic area and sex characteristics of the sample of AAA Executive Directors. Of the 82

TABLE 2

SUMMARY OF DEMOGRAPHIC CHARACTERISTICS
OF SAMPLE AAA DIRECTORS

Characteristic	N	% Total
1. Area of Country		
Northeast	48	28.9
South	35	21.1
Midwest	43	25.9
Southwest	12	7.2
West	24	14.5
Non-Continental	4	2.4
2. Sex		
Female	84	50.6
Male	82	49.4
3. Age		
25-34	54	32.9
35-44	57	34.8
45-54	25	15.2
55-64	23	14.0
65+	5	3.0
4. Number of Years of School		
9	1	0.6
12	3	1.8
13	1	0.6
14	3	1.8
15	9	5.5
16	44	27.0
17	36	22.1
18	41	25.2
19	6	3.7
20	10	6.1
21	3	1.8
22	3	1.8
23	1	0.6
26	2	1.2

TABLE 2--Continued

Characteristic	N	% Total
5. Degree		
Bachelors	47	28.8
Masters	84	51.5
Specialist	5	3.1
Doctorate	7	4.3
Other	19	11.7
6. Area of PSA		
Urban	14	8.4
Suburban	6	3.6
Rural	82	49.4
Mixed	63	38.0
Missing	1	0.6

TABLE 3

CORSSTABULATIONS OF EXPERTS' CHARACTERISTICS:
REGIONAL AREA BY SEX

Area	Sex	
N % Total	Female	Male
Northeast	7 17.07	9 21.95
South	1 2.44	4 9.76
Midwest	2 4.88	7 17.07
Southwest	2 4.88	4 9.76
West	0 0.00	5 12.20
Total	12 29.27	29 70.73

TABLE 4

CROSSTABULATION OF EXPERTS' CHARACTERISTICS:
REGIONAL AREA BY DEGREE AREA

Area	Degree Area						
N % Total	Counseling	Sociology	Counseling Psychology	Educational Psychology	Personnel	Education	Other
Northeast	5 12.20	1 2.44	5 12.20	2 4.88	1 2.44	1 2.44	1 2.44
South	3 7.32	0 0.00	0 0.00	1 2.44	1 2.44	0 0.00	0 0.00
Midwest	8 19.51	0 0.00	1 2.44	0 0.00	0 0.00	0 0.00	0 0.00
Southwest	3 7.32	0 0.00	0 0.00	1 2.44	2 4.88	0 0.00	0 0.00
West	0 0.00	0 0.00	2 4.88	2 4.88	0 0.00	1 2.44	0 0.00
Total	19 46.34	1 2.44	8 19.51	6 14.63	4 9.76	2 4.88	1 2.44

TABLE 5

CROSSTABULATION OF EXPERTS' CHARACTERISTICS:
SEX BY TEACH GERONTOLOGY COURSE

Sex	Teach Gerontology Course					
N % Total	0	1	2	3	4	5
Female	0 0.00	7 17.07	4 9.76	0 0.00	1 2.44	0 0.00
Male	1 2.44	14 34.15	6 14.63	4 9.76	3 7.32	1 2.44
Total	1 2.44	21 51.22	10 24.39	4 9.76	4 9.76	1 2.44

TABLE 6

CROSSTABULATION OF AAA DIRECTORS' CHARACTERISTICS:
REGIONAL AREA BY SEX

Area N % Total	Sex Female	 Male
Northeast	25 15.24	22 13.41
South	24 14.63	10 6.10
Midwest	12 7.32	31 18.90
Southwest	7 4.27	5 3.05
West	11 6.71	13 7.93
Non-Continental	3 1.83	1 0.61
Total	82 50.00	82 50.00

females or 50% of the sample responding, 25 came from the Northeast; 24, the South; 12, the Midwest; seven, the Southwest; 11, the West; and three, non-continental. Of the 82 males responding or 50% of the sample, 22 listed the Northeast as their PSA area; 10, the South; 31, the Midwest; five, the Southwest; 13, the West; and one, non-continental. Two directors did not respond to this item.

Table 7 is the crosstabulation of the geographic area and highest degree level characteristics of the AAA Directors. Forty-six directors (28.5%) indicated they had earned a bachelor's degree. Of these 46, 13 came from the Northeast; nine, the South; 14, the Midwest; four the Southwest; 11, the West; and two, non-continental. Five directors (3.1%) have sixth-year degrees. Of these five, two came from the Northeast; two, the Midwest; and one, the Southwest. Seven (4.3%) AAA Directors hold doctoral degrees, of these, two came from the Northeast; one, the Midwest; one, the Southwest; and three, the West. A total of 19 directors (11.9%) indicated that they hold other degrees; these degrees are most probably associate degrees from two year institutions. Of these 19, four came from the Northeast; six, the South; two, the Midwest; one, non-continental. Five respondents indicated that they have no educational degree.

Table 8 displays the crosstabulation of the sex and public service area (PSA) characteristics. Of the 83 females responding to this item, eight listed their PSA as predominently urban; two, suburban; 42 rural; and 30 "mixed." Eighty-one males described their PSA district. Six listed urban; four, suburban; 39, rural; and 32 "mixed." Two directors, one male and one female, did not respond to the PSA item.

Additional information regarding the remaining demographic characteristics of the AAA Executive Director sample can be found in

TABLE 7

CROSSTABULATION OF AAA DIRECTORS' CHARACTERISTICS:
REGIONAL AREA BY DEGREE

Area	Degree				
N % Total	Other	Bachelor's	Master's	6th Year	Ed.D./Ph.D.
Northeast	4 2.48	13 8.07	26 16.15	2 1.24	2 1.24
South	6 3.73	9 5.59	17 10.56	0 0.00	0 0.00
Midwest	2 1.24	14 8.70	24 14.91	2 1.24	1 0.62
Southwest	1 0.62	4 2.48	4 2.48	1 0.62	1 0.62
West	5 3.11	5 3.11	11 6.83	0 0.00	3 1.86
Non-Continental	1 0.62	1 0.62	2 1.24	0 0.00	0 0.00
Total	19 11.80	46 28.57	84 52.17	5 3.11	7 4.35

TABLE 8

CROSSTABULATION OF AAA DIRECTORS' CHARACTERISTICS:
SEX BY PUBLIC SERVICE AREA

Sex	Public Service Area			
N % Total	Urban	Suburban	Rural	Mixed
Female	8 4.88	2 1.22	42 25.61	30 18.29
Male	6 3.66	4 2.44	39 23.78	32 19.51
Total	14 8.54	6 3.66	81 49.39	62 37.80

appendices O through Q. These appendices are crosstabulation tables between geographic area and PSA, sex and highest degree and PSA.

Demographic Information Relating Executive Directors of Area Agencies on Aging (AAA)

Table 2 displays data showing the demographic characteristics of all AAA directors responding to the survey (N=168).

Geographic Area, Sex, Education, and Public Service Area (PSA)

Directors were identified by geographic area. The same six geographic regions (Northeast, South, Midwest, Southwest, West, and non-continental) used to identify counseling experts were used to categorize the AAA directors. Forty-eight (28.9%) directors resided in the Northeast; 25 (21.1%) in the South; 43 (25.9%) in the Midwest; 12 (7.2%) in the Southwest; 24 (14.5%) in the West; four (2.4%), non-continental.

The sample of AAA Director respondents was almost evenly divided between males and females. Eighty-four (50.6%) were female, while 82 (49.4%) were male.

Directors of AAAs reported their age in five categories. Fifty-four (32.9%) listed their age as between 25 and 34 years old; 57 (34.8%) listed between 35 and 44 years of age; 25 (15.2%) answered between 45 and 54 years old; 23 (14%) were between the ages of 55 and 64, and five (3%) were 65 and older.

Directors of AAAs reported the number of years of education. The range of responses was from nine to 26 years, The mode response was 16 years reported by 44 (27%) of the respondents. These responses were made regarding years of school: 41 (25.2%), 18 years of schooling; 36, (22.1%), 17 years; 10 (6.1%), 20 years; nine (5.5%), answered 15 years. A small

number of respondents listed other numbers of years of schooling.

Nineteen AAA directors (..17%) indicated they held an "other" or an associate's degree; 47 (28.8%) had a bachlor's degree; 84 (51.5%), a master's degree, five (3.1%), specialist's degree, and 7 (4.3%) held the doctorate degree.

Evaluation of Experts Confirmation of Goals, Roles and Sites

The responses given by the panel of gerontological counseling experts are outlined in this section. Responses listed and discussed are those received from the second round survey sent to the experts. These second round responses include the two additional goals and three additional roles compacted by the researcher after examination of the first round solicited additions. Second round goals and roles are regarded as confirmed goals and roles because each achieved an expert panel rating of 3.5 or higher on a seven point Likert scale, as specified for confirmation in Chapter I. All goals, roles, and sites listed in round two achieved confirmation by the expert panel. The complete lists of confirmed goals, roles and sites appear below.

Confirmed goals

1. Problem resolution
2. Behavioral change
3. Decision making
4. Positive mental health
5. Personal effectiveness
6. Knowledge of the aging process
7. Self-advocacy

Confirmed roles

1. Service provider to persons living alone
2. Bereavement counselor
3. Change agent

4. Personal counselor
5. Consultant
6. Specialist in psychological education
7. Employment counselor
8. Services coordinator--services enhancer--client advocate
9. Financial counselor and manager
10. In-service counselor educator
11. Leisure time counselor
12. Marital and sex counselor
13. Outreach agent to minorities
14. Service provider to nursing home and housing project residents
15. Counselor of the terminally ill
16. Pre-retirement counselor and educator
17. Public relations worker
18. Gerontological researcher
19. Family counselor
20. Educational counselor
21. Medical support outreach counselor

Confirmed sites

1. Senior centers
2. Area agencies on aging
3. Mental health centers
4. Nursing homes
5. Adult congregate living facilities
6. Adult congregate nutrition sites
7. Retirement projects
8. Day care centers
9. Hospice programs
10. Homemaker's programs
11. Respite care programs
12. Housing projects
13. Physician's offices

Three tables describe the responses of the experts regarding goals, roles and sites. Table 9 shows a frequency distribution, Table 10 outlines F-ratios for selected demographic characteristics for all goal, role, and site ratings, while Table 11 displays the mean score breakdown for each F-ratio which achieved significance. These three tables together give a comprehensive overview of the responses made by the panel of gerontological experts.

Table 9 summarizes the response frequencies of the experts for ratings of all goals, roles and sites, along the seven point Likert scale.

TABLE 9

FREQUENCY OF RESPONSE CHOICES, MEAN AND STANDARD DEVIATION OF GOALS, ROLES & SITES FOR EXPERTS (N=41)

	% of Responding Experts								
Goal Number	1 very low	2 low	3 below medial	4 medial	5 above medial	6 high	7 very high	$\bar{X}$	S.D.
1	0	2.4	0	0	24.4	29.3	43.9	6.10	1.04
2	0	0	2.4	2.4	29.3	29.3	36.6	5.95	.99
3	0	0	0	9.8	7.3	26.8	56.1	6.29	.98
4	0	0	2.4	0	2.4	24.4	70.7	6.61	.77
5	2.4	0	0	2.4	0	22.0	73.3	6.61	.83
6	0	0	0	10.0	15.0	20.0	55.0	6.20	1.04
7	0	0	5.0	7.5	25.0	32.0	30.0	5.75	1.12
Role Number									
1	0	0	7.3	4.9	9.8	34.1	43.9	6.02	1.19
2	2.4	0	0	0	24.4	43.9	29.3	6.00	0.81
3	0	0	4.9	4.9	19.5	26.8	43.9	6.00	1.14
4	0	0	0	4.9	4.9	41.5	48.8	6.34	0.79
5	0	0	0	4.9	17.1	43.9	34.1	6.07	0.84
6	0	0	0	4.9	24.4	26.8	43.9	6.10	0.94
7	0	0	4.9	19.5	26.8	31.7	17.1	5.36	1.13
8	0	2.4	2.4	12.2	34.1	29.3	19.5	5.44	1.16
9	0	2.4	12.2	9.8	39.0	22.0	14.6	5.10	1.28
10	0	0	2.4	4.9	14.6	29.3	48.8	6.17	1.02
11	0	2.4	0	9.8	31.7	31.7	24.4	5.63	1.11
12	0	0	4.9	9.8	31.7	26.8	26.8	5.61	1.13
13	0	2.4	4.9	7.3	34.1	22.0	29.3	5.56	1.26

TABLE 9--Conitnued

Role Number	% of Responding Experts 1 very low	2 low	3 below medial	4 medial	5 above medial	6 high	7 very high	$\bar{X}$	S.D.
14	0	0	0	9.8	24.4	31.7	34.1	5.90	0.99
15	0	0	0	2.4	22.2	34.1	14.5	6.15	0.85
16	0	0	0	2.4	9.8	22.0	65.9	6.51	0.78
17	0	2.4	7.3	9.8	26.8	29.3	24.4	5.46	1.30
18	0	2.4	0	7.3	34.1	29.3	26.8	5.68	1.10
19	0	0	2.4	4.9	4.9	31.7	56.1	6.34	0.96
20	0	0	2.4	12.2	26.8	31.7	26.8	5.68	1.08
21	2.4	0	7.3	4.9	31.7	34.1	19.5	5.43	1.30
Site Number									
1	0	0	0	4.9	16.8	22.0	56.1	6.17	1.34
2	0	0	9.8	9.8	29.3	19.5	31.7	5.44	1.55
3	0	0	0	9.8	26.8	14.6	48.8	5.88	1.43
4	2.4	2.4	2.4	7.3	12.2	26.8	46.3	5,85	1.62
5	2.4	2.4	2.4	0	26.8	34.1	31.7	5.71	1.50
6	4.9	2.4	12.2	9.8	41.5	17.1	12.2	4.76	1.62
7	0	2.4	4.9	7.3	22.0	36.6	26.8	5.61	1.41
8	7.3	4.8	7.3	14.6	24.4	14.6	26.8	4.90	1.93
9	2.4	2.4	4.9	12.2	7.3	12.2	56.1	5.82	1.78
10	2.4	4.8	17.1	22.0	14.6	22.0	17.1	4.71	1.73
11	2.4	0	7.3	22.0	24.4	17.1	17.1	4.69	1.93
12	0	0	9.8	29.2	26.8	14.6	19.5	4.95	1.50
13	2.4	17.1	17.1	17.1	9.8	24.4	12.2	4.22	2.01

TABLE 10

SUMMARY OF F RATIOS FOR ONE-WAY ANALYSIS OF VARIANCE
FOR GOALS, ROLES & SITES AND DEMOGRAPHIC ITEMS AS RESPONDED BY COUNSELING EXPERTS

	Demographic Items						
Goals	Area	Sex	# Gerontology Courses Taught	Contributions to Gerontology	Preparation	Degree	Degree Area
1	1.66	1.09	0.78	0.67	0.33	1.06	1.20
2	1.28	0.04	0.58	2.32	0.70	2.65	1.13
3	1.53	0.27	0.44	0.74	0.53	0.14	2.01
4	2.03	2.81	0.74	0.66	1.65	0.58	1.43
5	0.52	2.38	0.36	0.47	0.68	0.15	6.37**
6	0.82	0.28	0.95	0.86	1.83	1.39	1.10
7	0.42	0.00	0.24	1.93	0.79	0.02	1.57
Roles							
1	0.81	1.14	1.21	0.74	1.99	2.29	2.40*
2	1.69	0.18	0.77	0.34	0.51	0.77	1.39
3	0.46	0.81	0.17	0.82	0.79	0.68	1.67
4	0.95	0.15	1.04	1.10	0.92	0.03	0.53
5	0.72	4.69*	1.50	0.40	1.42	8.94**	0.96
6	0.91	9.92**	1.05	1.10	3.26*	3.40*	0.61
7	0.90	0.01	1.82	0.51	0.35	1.01	1.36
8	0.43	4.27*	0.29	0.41	1.54	0.73	3.21*
9	0.14	0.57	0.97	0.23	3.78**	0.81	1.57
10	0.57	6.15**	1.31	0.58	1.33	1.50	3.37**
11	0.30	5.83*	0.65	0.45	1.73	0.96	3.53**
12	0.45	6.05*	0.23	0.30	2.12	4.35*	2.29*
13	0.61	4.19*	0.96	1.09	1.41	3.95*	2.83*

TABLE 10--Continued

Roles	Demographic Items: Area	Sex	# Gerontology Courses Taught	Contributions to Gerontology	Preparation	Degree	Degree Area
14	0.16	2.13	1.52	1.11	1.24	0.31	1.18
15	2.35	0.49	0.51	0.33	0.84	0.24	1.39
16	0.49	0.89	0.90	0.43	1.27	0.94	3.72**
17	0.97	4.12*	1.27	0.65	1.63	1.81	3.73**
18	0.90	4.90*	0.75	0.52	1.14	1.02	1.36
19	0.87	1.98	0.64	1.19	0.95	1.09	3.76**
20	0.69	0.32	1.04	1.76	0.71	2.31	2.64*
21	0.98	0.73	0.80	1.12	0.74	0.66	1.77
Sites							
1	0.22	0.06	0.67	2.16	0.63	0.48	0.82
2	0.55	0.08	0.37	0.44	0.13	0.47	0.74
3	1.19	1.74	1.61	0.59	0.87	1.38	1.82
4	0.19	0.07	0.66	0.64	0.70	0.24	0.51
5	0.42	0.01	0.29	1.27	0.61	1.92	1.07
6	0.30	2.94	0.65	1.18	0.35	0.34	1.41
7	1.48	1.95	0.15	0.72	0.51	3.37*	3.18*
8	0.54	2.16	0.58	0.87	1.07	1.39	2.27*
9	0.91	0.03	1.36	1.27	0.41	0.42	0.42
10	0.62	0.01	2.30	1.68	0.37	0.82	0.46
11	0.07	1.04	0.61	1.39	0.75	0.92	0.36
12	0.92	1.11	0.44	1.42	0.94	0.12	0.59
13	0.11	2.10	1.05	1.47	1.89	0.58	0.67

*$p < .05$
**$p < .01$

TABLE 11

SUMMARY OF MEANS OF GOALS, ROLES AND SITES AND DEMOGRAPHIC ITEMS FOUND TO BE SIGNIFICANT BY F-RATIOS FOR COUNSELING EXPERTS

Demographic Item	N	Role 5	Role 6	Role 8	Role 10	Role 11	Role 12	Role 13	Role 17	Role 18
Sex										
Female	12	6.50	6.75	6.00	6.75	6.25	6.25	6.17	6.08	6.25
Male	29	5.90	5.83	5.20	5.93	5.38	5.34	5.31	5.21	5.45

Preparation	N	Role 6	Role 9	Degree	N	Role 5	Role 6	Role 12	Role 13	Site 7
Seminar	7	6.57	5.14	Masters	4	6.75	7.00	7.00	6.75	6.50
Self-Taught	14	5.71	4.28	Ed.D.	22	5.64	5.82	5.32	5.14	5.90
Post Grad Courses	10	6.60	5.40	Ph.D.	15	6.53	6.27	5.67	5.87	4.93
Gerontology Program Grad	2	7.00	4.50							
Experience	2	6.00	7.00							
None	6	5.33	6.00							

TABLE 11--Continued

Degree Area	N	Goal 5	Role 1	Role 8	Role 10	Role 11	Role 12	Role 13	Role 16	Role 17
Counseling	19	6.53	5.74	5.21	6.00	5.63	5.42	7.00	6.58	5.00
Sociology	1	3.00	3.00	2.00	3.00	2.00	3.00	2.00	4.00	2.00
Counseling Psychology	8	6.75	6.75	5.62	6.12	5.50	5.75	5.75	6.75	5.62
Educational Psychology	6	6.83	6.17	5.50	6.33	5.67	6.00	6.17	6.50	6.00
Student Personnel	4	7.00	6.00	6.00	7.00	5.75	5.25	5.75	6.50	6.75
Education	2	7.00	7.00	7.00	7.00	7.00	7.00	7.00	5.00	6.50
Other	1	7.00	6.00	6.00	7.00	7.00	7.00	6.00	7.00	6.00

Degree Area	N	Role 19	Role 20	Site 7	Site 8
Counseling	19	6.21	5.42	6.05	5.26
Sociology	1	3.00	3.00	3.00	2.00
Counseling Psychology	8	6.37	5.75	4.37	3,25
Educational Psychology	6	6.67	5.83	5,50	5,16
Student Personnel	4	7.00	6.50	6,25	6.25
Education	2	6.00	7.00	7,00	6.00
Other	1	7.00	6.00	5.00	5.00

The mode rating of each goal was seven, the highest possible except for goal seven, self-advocacy, which achieved a mode score of six. Goal number four, positive mental health, received the highest mean score (6.61) but a slightly higher standard deviation (.83), indicating less agreement among the panel on this goal. Goal number seven, self-advocacy, received the lowest rating (5.75) and the highest standard deviation (1.12). This rating, however, can in no way be construed as low. The mean scores and standard deviations in the goal section indicate panel responses which are highly homogeneous.

Likewise the response ratings by the experts of the roles and sites produced high mean scores. Role number 16, preretirement counselor, received the highest mean rating (6.51) and lowest standard deviation (.78), while role number nine, financial counselor and manager, received the lowest mean rating (5.10). The range of the means was 1.41, the standard deviation range was .51. Mean scores for possible sites ranged from site number three, mental health center, at 5.88, to site number 13, physician's office at 4.22, a range of 1.66. Standard deviations ranged from 1.34 to 2.01, a range of .69. Lower mean scores and higher standard deviation scores for the sites, as compared with the scores for the goals and roles, indicate less homogeneity among the panel with regard to the ratings of sites.

Table 10 displays F-ratios generated from the one-way analysis of variance procedures between all confirmed gerontological counseling goals, roles, and sites, and selected demographic characteristics of the experts. Only one F-ratio achieved significance when demographic characteristics and responses were compared. For the highest degree area characteristic, the goal, personal effectiveness, five F-ratios attained significance at the

.01 level. This statistic was produced by the fact that the sociology degree cell contained only one expert. This person ranked many items lower than the other panel members, producing a radically different profile for the highest degree area variable. Therefore, this significant F-ratio can be discounted; the experts represent a highly homogeneous panel with regard to goals.

More differences are exposed when the F-ratios generated by the experts' rating of roles are reviewed. No F-ratio in geographic area achieved significance, as did none with regard to the number of gerontology courses taught and the contributions to gerontology. Nine F-ratios achieved significance under the sex characteristic, females generally rating the roles higher than males. Two F-ratios emerged as significant under the preparation variable; the self-taught experts registered lower mean scores, indicating that formal training in gerontology produces a heightened regard for the roles which gerontological counselors can play (see Table 11). Four F-ratios registered significance under the highest degree area with regard to counseling roles. The reason is the extremely low ratings given by the one sociology trained expert. Experts from the three largest degree categories, counseling, counseling psychology, and educational psychology, rated the roles in a generally high and homogeneous manner.

Only three F-ratios achieved significance in all of the demographic categories with regard to possible counseling sites. The highest degree characteristic produced one significant ratio, while the degree area produced two ratios of significance. These three are considered to be minor and indicate a highly homogeneous response across

characteristic lines with regard to the sites. Table 11 lists mean scores for all characteristics which achieved significance.

Evaluation of Goals, Roles and Sites by AAA Directors

AAA Directors rated each goal and role on a seven point Likert scale with respect to two questions (see Appendix H). Question one asked AAA directors to measure the present level of conformity of the goals and roles of gerontological counselors to existing objectives in their PSA. These responses are termed "conforming goals" and "conforming roles." The second question asked AAA directors to measure the need for gerontological counseling by rating the degree to which these same goals and roles could assist the older persons in their particular PSA district. The resulting ratings are called "assisting goals" and "assisting roles." Assisting goals and assisting roles are discussed first.

Table 12 indicates the response frequencies of the AAA Directors for all goals, roles, and sites on a seven point Likert scale, as well as mean scores and standard deviations for all goals, roles, and sites. Responses are skewed toward the high rating side of the continuum although not to the degree of the responses by the experts. Goal number one, problem resolution, emerges as the highest rated (5.72), with goal number two, behavioral change, receiving the lowest rating (4.33). The range of the means was 1.39 and the standard deviation range was .17. The highest rated role was number eight, services coordinator - services enhancer - client advocate, with a mean rating of 5.66 and a standard deviation of 1.44. The lowest rated role was number 12, marital and sex counselor (3.87), with a standard deviation of 1.51. The mean range was 1.79, the standard deviation range was .56. The site rated the highest was number one, senior centers, with a mean score of 5.99. The lowest

TABLE 12

FREQUENCY OF RESPONSE CHOICES, MEAN AND STANDARD DEVIATION OF GOALS, ROLES & SITES FOR AAA DIRECTORS (N=168)

	% of Responding AAA Directors								
Goal Number	1 very low	2 low	3 below medial	4 medial	5 above medial	6 high	7 very high	$\bar{X}$	S.D.
1	0.6	2.4	2.4	11.3	19.6	29.8	33.9	5.72	1.29
2	3.6	8.3	13.1	32.1	19.0	16.7	7.1	4.33	1.48
3	0	1.2	9.6	18.7	19.3	24.1	27.1	5.37	1.37
4	0.6	4.2	8.3	14.9	23.8	23.2	25.0	5.27	1.46
5	0	1.8	6.0	14.4	22.2	24.6	31.1	5.55	1.32
6	0.6	3.6	6.6	18.1	22.9	24.1	24.1	5.27	1.42
7	1.2	1.8	1.8	13.3	19.4	26.7	35.8	5.71	1.33
Role Number									
1	0.6	1.2	3.6	20.8	27.4	28.6	17.9	5.30	1.21
2	2.4	7.8	10.8	20.4	28.1	20.4	10.2	4.66	1.49
3	0.6	1.8	6.0	17.9	19.6	26.2	28.0	5.45	1.36
4	1.2	4.8	11.3	26.2	19.6	23.8	13.1	4.82	1.44
5	4.2	7.2	7.8	17.5	30.1	19.9	13.3	4.75	1.58
6	2.4	6.1	6.7	27.9	27.3	21.2	8.5	4.69	1.39
7	1.2	4.8	6.5	15.5	29.2	26.2	16.7	5.12	1.40
8	1.2	3.0	3.6	12.6	18.0	23.4	38.3	5.66	1.44
9	0.6	4.2	8.3	14.9	21.4	23.8	26.8	5.31	1.48
10	1.8	4.2	9.0	21.0	25.7	24.0	14.4	4.94	1.43
11	4.8	7.8	12.6	27.5	25.1	16.2	6.0	4.33	1.49
12	7.8	10.8	18.7	31.9	14.5	12.7	3.6	3.87	1.51
13	6.0	6.6	8.4	15.1	24.1	16.3	23.5	4.87	1.77

TABLE 12--Continued

Role Number	% of Responding AAA Directors 1 very low	2 low	3 below medial	4 medial	5 above medial	6 high	7 very high	$\bar{X}$	S.D.
14	2.4	5.4	10.7	17.9	23.8	20.2	19.6	4.95	1.57
15	4.8	6.5	23.2	39.9	28.6	15.5	16.1	4.68	1.64
16	3.0	3.6	7.1	19.6	25.0	28.0	13.7	4.99	1.45
17	1.8	3.6	7.7	19.0	21.4	23.2	23.2	5.17	1.50
18	6.0	7.2	12.7	23.5	17.5	16.9	16.3	4.55	1.73
19	3.6	3.6	6.6	21.0	23.4	23.4	18.6	5.01	1.54
20	2.4	5.4	14.5	27.1	26.5	11.4	12.7	4.55	1.47
21	6.0	4.2	7.8	17.4	18.0	22.8	24.0	5.01	1.73
Site Number									
1	0.6	1.8	0.6	12.0	8.4	32.5	44.0	5.99	1.23
2	12.7	10.8	7.8	12.0	16.9	21.1	18.7	4.47	2.03
3	3.6	1.8	9.1	15.8	15.8	23.6	30.3	5.30	1.62
4	2.4	1.8	6.6	15.0	23.4	22.2	28.7	5.36	1.47
5	1.2	1.8	3.0	12.7	21.2	35.8	24.2	5.55	1.28
6	0.6	2.4	2.4	11.4	20.5	33.1	29.5	5.66	1.26
7	1.2	4.8	5.5	22.4	24.8	26.1	15.2	5.04	1.39
8	1.2	3.0	4.8	18.2	18.8	30.9	23.0	5.35	1.40
9	2.5	1.2	3.7	15.5	19.3	29.8	28.0	5.49	1.41
10	1.2	4.2	4.2	23.5	27.1	22.9	16.9	5.07	1.37
11	1.2	3.7	5.6	25.5	27.3	24.2	12.4	4.96	1.32
12	3.0	3.0	8.4	16.9	24.7	27.7	16.3	5.05	1.48
13	9.6	8.4	16.3	22.3	18.1	13.9	11.4	4.18	1.76

rated site was number 13, physician's office, with a mean score of 4.18. The mean range for all sites rated by AAA directors was 1.81, while the standard deviation range was .77.

Table 13 displays F-ratios for one-way analysis of variance between selected demographic characteristics of AAA directors and all assisting goals, assisting roles, and sites. The geographic area characteristic produced two F-ratios of significance, both with regard to sites. These are site number two, Area Agency on Aging Office, and site number five, adult congregate living facilities. Table 14 shows mean scores for all factors and items reaching significance. Directors from the Southwest rated site two, Area Agency on Aging Office, the lowest (3.09), while Northwest directors rated it highest (5.22). Midwest directors rated site five, adult congregate living facilities (ACLFs), the lowest (5.02) while directors from the South rated it the highest (6.03).

The sex characteristic generated the most F-ratios of significance. Females rated the following goals higher than did the males: four, positive mental health; six, knowledge of the aging process; nine, financial counselor; 12, marital and sex counselor, and 18, gerontological researcher. Likewise, females gave a significantly higher rating than did the males to site 12, housing projects. Females consistently rated items in all goal, role and site categories higher than did males.

The differing academic degrees of the AAA directors produced signficant F-ratios in the cases of goal one, problem resolution, and goal six, knowledge of the aging process. Holders of bachelor's degrees and other degrees generally rated items lower than did those with master's, sixth year, and doctoral degrees. AAA directors holding graduate degrees generally, but not always, rated the goals, roles and

TABLE 13

SUMMARY OF F RATIOS FOR ONE-WAY ANALYSIS OF VARIANCE
FOR GOALS, ROLES & SITES AND DEMOGRAPHIC ITEMS AS RESPONDED BY AAA DIRECTORS

Goals	Area	Sex	Degree	PSA	Age
1	1.31	0.05	2.45*	2.24	0.04
2	0.56	0.10	0.77	2.01	0.81
3	1.06	1.03	1.37	2.32	0.23
4	0.48	4.41*	0.70	2.41	0.42
5	0.39	1.01	0.60	3.65**	0.98
6	0.18	5.55**	2.57*	2.18	1.67
7	1.30	0.04	2.02	1.91	1.10
Roles					
1	0.28	1.17	0.17	0.75	1.84
2	0.67	3.06	0.92	2.15	1.39
3	0.68	2.19	0.63	0.92	0.58
4	0.94	0.01	0.74	2.32	1.26
5	1.04	1.44	1.65	0.89	2.14
6	0.61	0.71	0.28	0.57	1.75
7	0.70	0.02	0.81	0.29	0.32
8	0.34	0.09	0.18	0.46	0.21
9	0.63	4.71*	0.77	0.45	1.05
10	0.12	2.22	0.24	0.80	0.62
11	0.95	1.28	1.93	0.75	0.95
12	1.61	4.36*	1.38	1.22	1.73
13	2.27	0.20	1.77	2.72*	2.62*

TABLE 13--Continued

Roles	Area	Sex	Degree	PSA	Age
14	0.23	0.12	0.61	0.68	0.01
15	1.98	1.12	0.81	1.50	0.85
16	1.27	3.25	1.23	0.64	1.63
17	0.63	3.03	1.18	0.20	0.79
18	1.08	3.75*	1.17	0.11	1.19
19	1.55	3.35	1.68	1.01	0.89
20	0.64	0.65	1.17	1.11	1.67
21	0.68	0.16	0.76	0.43	1.07
Sites					
1	1.30	0.01	2.01	2.21	0.41
2	3.41**	0.23	0.04	1.97	2.26
3	1.00	0.09	0.68	0.20	0.69
4	0.72	0.49	0.62	0.48	1.98
5	2.82**	0.10	0.61	1.08	.99
6	0.96	0.11	1.17	2.01	0.82
7	1.98	0.30	1.72	0.35	2.01
8	1.55	0.02	0.70	2.20	2.12
9	1.19	2.34	0.26	0.89	3.73**
10	0.22	0.71	0.50	0.08	1.31
11	0.13	0.05	1.31	0.06	4.36**
12	1.09	5.37*	1.25	1.06	0.76
13	0.89	1.79	0.34	0.28	1.66

*$p < .05$
**$p < .01$

TABLE 14

SUMMARY OF MEANS OF GOALS, ROLES AND SITES AND DEMOGRAPHIC ITEMS FOUND TO BE SIGNIFICANT BY F-RATIOS FOR AAA EXECUTIVE DIRECTORS

Area	N	Site 2	Site 5	Degree	N	Goal 1	Goal 6
Northeast	46	5.22	5.69	Bachelors	45	5.11	4.73
South	30	4.40	6.03	Masters	83	5.72	5.05
Midwest	43	4.39	5.02	6th Year	5	6.60	6.20
Southwest	11	3.09	6.00	Doctorate	6	5.00	5.33
West	22	3.56	5.45	Other	19	5.16	4.31
Non-Continental	4	5.00	6.00				

Sex	N	Goal 4	Goal 6	Role 9	Role 12	Role 18	Site 12
Female	82	5.40	5.12	5.17	4.52	4.88	5.24
Male	82	4.91	4.70	4.64	3.08	4.40	4.87

PSA	N	Goal 5	Role 13	Age	N	Role 13	Site 9	Site 11
Urban	14	4.50	6.28	25-34	54	4.33	5.76	5.05
Suburban	6	6.00	5.66	35-44	56	4.67	5.31	4.59
Rural	79	5.68	4.30	45-54	25	5.56	6.16	5.83
Mixed	59	5.69	5.05	55-64	23	5.08	4.86	4.73
				65+	5	5.80	5.00	5.25

sites higher than did those directors who did not possess a graduate degree. As with the experts, higher levels of formal education are associated with higher ratings of the goals, roles, and sites.

The public service area (PSA) variable produced F-ratios of significance for goal five, personal effectiveness and role 13, outreach agent to minorities. Urban directors rated goal five, personal effectiveness, significantly lower than did directors from suburban, rural, and mixed districts. Rural directors rated role 13, outreach agent to minorities, at significantly lower levels than did directors from other category districts. With the possible exception of the South, rural PSAs have low minority populations and would, therefore, give a lower rating to role 13.

The age variable among AAA directors produced three significant F-ratios. Role 13, outreach agent to minorities, was rated by middle aged directors (aged 45-54) significantly higher (5.56) than by younger directors (aged 25-34) who rated it the lowest at 4.33. Age was also a significant variable for directors in connection with sites nine, hospice programs, and 11, respite care programs. Again, middle aged directors rated these sites lower than younger age group directors; the older directors (aged 55 and over) generally gave a lower rating th these sites. This finding is difficult for the researcher to explain. Could it be that, as AAA directors approach ages when remedial medical care becomes fore likely, they react by rating these sites lower?

An Analysis and Comparison of Goals, Roles, and Sites as Rated by Counseling Experts and AAA Directors

The responses of both the counseling experts and the AAA directors regarding their ratings of goals, roles and sites were compared and

analyzed. Each goal, role and site is described separately. Mean scores, standard deviations, rank order, response frequencies, mode scores, and selected F-ratios produced from one-way analysis of variance are reported.

Confirmed Goals

1. Problem resolution. Experts ranked this goal number five of the total of seven goals, while AAA directors ranked it number one. The mode response for this goal was seven (very high) for both experts and AAA directors as seen in Tables 9 and 12, respectively. This first goal received an expert mean response, as displayed in Table 11, of 6.10, and a standard deviation of 1.04. Directors of AAAs rated this goal with a mean score of 5.72 and a standard deviation of 1.29. Problem resolution generated no significant F-ratios among experts but did produce one significant F-ratio among directors (Tables 10 and 13). Table 14 shows that directors with a sixth year degree rated this goal significantly lower than did directors with doctorates. The low number of sixth year and doctorate degree holders among AAA directors, however, weakens the significance of this difference. Table 16 displays an F-ratio for this goal of 4.29, indicating that the mean rating difference between experts and directors is a significant one at the .05 level. Experts and AAA directors differ in the priority given to this goal (Table 15).

2. Behavioral change. Ratings ranked this goal as number six among experts and last seven among directors. The mode response given by experts was seven (very high) while the mode response among AAA directors was four (medial). Experts confirmed this second goal by rating it at a mean score of 4.33 and a standard deviation of 1.48. Behavioral change produced no significant F-ratios among experts' ratings and their

demographic characteristics, and none among directors. No within group variability is detectable among either experts or AAA directors. Responses from experts and directors are varied, producing an F-ratio of 37.52, significant at the .01 level. A statistical divergence is again indicated between the goal priorities of experts and AAA directors.

3. Decision making. Experts ranked this goal as number three, while directors ranked it number four. Fifty-six point one percent of the experts rated this goal as seven (very high), the mode rating for the experts, and 27.1% of the directors also rated it seven (very high), the mode rating for the directors. The decision making goal generated mean and standard deviation scores of 6.29 and .98, and 5.36 and 1.37 among experts and directors, respectively. Decision making generated no significant F-ratios among either experts or directors with regard to the various demographic characteristics. An F-ratio of 12.98, significant at the .01 level, was produced when expert and director scores were compared using a one-way analysis of variance. While the experts and AAA directors responded similarly among themselves, they differed in the priority given this goal.

4. Positive mental health. Experts ranked this goal number one with a mean score rating of 6.61 and a standard deviation of .77. Directors ranked it number five, with a mean score rating of 5.27 and a standard deviation of 1.46. An overwhelming majority (70.7%) of the experts ranked this goal seven (very high), while 25% of the directors ranked it seven (very high); each of these scores was a mode score. No significant F-ratios were produced by experts in terms of demographic characteristics. However, female directors rated this goal at 5.40, significantly higher than the 4.91 given it by male directors. When all expert and director ratings

were analyzed by a one-way analysis of variance, a significant F-ratio of 23.88 emerged, significant at the .01 level, indicating the variation between the two groups.

5. Personal effectiveness. This fifth goal was ranked a very close number two by counseling experts with an identical mean score to the positive mental health goal score of 6.61, but a standard deviation slightly higher at .83. Directors ranked this goal number three with a mean rating of 5.55 and a standard deviation of 1.32. Mode scores for experts and directors were seven (73.3%) and six (31.1%), respectively. Experts generated one significant F-ratio, under the characteristic of highest degree area. Again, the one sociology degree holder skewed the results by ranking this item significantly lower than the other degree holders. (see Table 11). Directors generated one significant F-ratio, under the characteristic of PSA. Table 14 shows that urban directors rated this goal significantly lower than did directors in other PSAs. When all experts' and directors' ratings for the goal were subjected to a one-way analysis of variance, a significant F-ratio of 16.50 emerged (Table 16), again demonstrating the variability between the two groups.

6. Knowledge of the Aging Process. This goal was ranked number four by the experts and number six by the directors. Experts gave it a mean score of 6.20 and a standard deviation 1.42. The expert mode score was seven, with 55% ranking it very high. The directors' mode score was a tie between six and seven, each receiving 24.1% of the directors' responses to high and very high, respectively. No significant F-ratios were generated by the experts with regard to any demographic characteristics, illustrating group similarity. Two significant F-ratios, however, were produced by the directors' scores, one under sex (5.55)

TABLE 15

SUMMARY OF MEANS, STANDARD DEVIATIONS, RANK ORDER OF AND CORRELATION BETWEEN GROUPS (EXPERTS AND AAA DIRECTORS) FOR GERONTOLOGICAL COUNSELING GOALS, ROLES AND SITES

	Experts (N=41)			AAA Directors (N=168)		
Goals	$\overline{X}$	S.D.	Rank	$\overline{X}$	S.D.	Rank
1	6.10	1.04	5	5.72	1.29	1
2	5.95	.99	6	4.33	1.48	7
3	6.29	.98	3	5.36	1.37	4
4	6.61	.77	1	5.27	1.46	5
5	6.61	.83	2	5.55	1.32	3
6	6.20	1.04	4	5.26	1.42	6
7	5.75	1.12	7	5.71	1.33	2
	$\overline{\overline{X}}$= 6.214			$\overline{\overline{X}}$ =5.314		
				Correlation +0.1157		
Roles						
1	6.02	1.19	8	5.30	1.21	4
2	6.00	.80	9	4.66	1.49	17
3	6.00	1.14	10	5.45	1.36	2
4	6.34	.79	2	4.82	1.44	13
5	6.07	.84	7	4.75	1.56	14
6	6.09	.94	6	4.69	1.39	15
7	5.36	1.13	19	5.12	1.40	6
8	5.43	1.16	18	5.66	1.43	1
9	5.09	1.28	21	5.31	1.48	3
10	6.17	1.02	4	4.94	1.43	11
11	5.63	1.11	14	4.32	1.48	20
12	5.60	1.13	15	3.87	1.51	21
13	5.56	1.26	16	4.87	1.77	12

TABLE 15--Continued

Roles	Experts $\bar{X}$	Experts S.D.	Experts Rank	AAA Directors $\bar{X}$	AAA Directors S.D.	AAA Directors Rank
14	5.90	.99	11	4.95	1.57	10
15	6.15	.85	5	4.68	1.64	16
16	6.51	.78	1	4.99	1.45	9
17	5.46	1.30	17	5.17	1.50	5
18	5.68	1.10	13	4.55	1.73	19
19	6.34	.96	3	5.01	1.54	7
20	5.68	1.08	12	4.55	1.47	18
21	5.43	1.30	20	5.01	1.74	8
	$\bar{X}$ = 5.83			$\bar{X}$ =4.89		
					Correlation -0.1104	
Sites						
1	6.17	1.34	1	5.99	1.23	1
2	5.43	1.55	7	4.47	2.03	12
3	5.87	1.43	2	5.30	1.62	7
4	5.85	1.62	3	5.36	1.49	5
5	5.70	1.50	5	5.55	1.28	3
6	4.75	1.62	10	5.66	1.27	2
7	5.60	1.41	6	5.04	1.40	10
8	4.90	1.93	9	5.35	1.40	6
9	5.82	1.78	4	5.49	1.41	4
10	4.70	1.73	11	5.07	1.37	8
11	4.69	1.93	12	4.96	1.33	11
12	4.95	1.49	8	5.05	1.48	9
13	4.21	2.01	13	4.18	1.76	13
	$\bar{X}$ =5.28			$\bar{X}$ =5.19		
					Correlation +0.584	

TABLE 16

SUMMARY OF F RATIOS FOR ONE-WAY ANALYSIS OF VARIANCE FOR SURVEY GOALS BY GROUP EXPERTS AND AAA DIRECTORS

Goals	F Ratio	Significance
1	4.29	0.039
2	37.52	.0001
3	12.98	.0004
4	23.88	.0001
5	16.50	.0001
6	17.97	.0001
7	0.01	.9082
Roles		
1	12.72**	.0005
2	40.55**	.0001
3	5.95**	.0157
4	34.07	.0001
5	27.92	.0001
6	42.06	.0001
7	2.89	.09
8	.01	.94
9	.20	.657
10	21.75	.0001
11	34.21	.0001
12	64.14	.0001
13	7.01	.0088
14	21.69	.0001
15	48.03	.0001
16	46.45	.0001
17	5.01	.026
18	15.52	.0001
19	48.28	.0001
20	29.24	.0001
21	9.00	.0031

TABLE 16--Continued

Sites	F Ratio	Significance
1	0.54	.46
2	8.37**	.0043
3	6.24**	.0134
4	1.46	.2277
5	.09	.7618
6	5.36*	.0218
7	6.18**	.0138
8	.10	.7484
9	1.36	.2447
10	.92	.3394
11	.23	.6303
12	.21	.6486
13	.22	.6430

and one under degree (2.57). Female directors rated this goal significantly higher (5.12) than did males (4.70). Likewise, directors with graduate degrees rated this goal significantly higher than did those directors not holding graduate degrees, emphasizing the influence of education. Holders of doctorates rated it at 5.33, sixth year holders at 6.20, and master's degree holders at 5.05, while bachelor degree holders rated it at 4.73 and other degree holders at 4.31. An F-ratio of 17.97 (significant at .0001) was produced when expert and director ratings were compared, showing between group variability.

7. Self-Advocacy. The seventh goal was ranked number seven by experts with a mean score rating of 5.75 and a standard deviation of 1.12. Directors ranked it number two, producing a mean score rating of 5.71 and a standard deviation of 1.33. The modal rating for experts was six, with 32% responding to high. Directors' modal rating was seven, with 35.8% responding to very high. No significant F-ratios were generated by the experts along any demographic characteristics. Directors, likewise, produced no significantly different scores among demographic items, showing within group homogenity. A non-significant F-ratio of .01 was generated when experts' and directors' ratings of goals, roles, and sites were subjected to a one-way analysis of variance, making this the only goal that experts and directors rated similarly, even though the rank order was quite different. Directors seem to value the self-advocacy goal of counseling higher than do the experts.

Confirmed Roles

1. Services to persons living alone. Experts ranked this role number eight (of 21) with a mean score rating of 6.02 and a standard deviation of 1.19. Directors ranked it number four with a mean score

rating of 5.30 and a standard deviation of 1.21. The mode score among experts was seven (very high) with 43.9% responding. Among directors, the mode score was six (high) with 28.6% responding. Experts produced one significant F-ratio (2.40) with regard to the demographic variable of highest degree. Counseling degree holders rated this role 5.74, while counseling psychology and educational psychology degree holders rated it 6.75 and 6.17, respectively. Again the lone sociology degree holder skewed the results with a rating of 3.00. Directors produced no significant F-ratios with regard to demographic characteristics. An F-ratio of 12.72 (significant at .0005) emerged when experts' and directors' scores were statistically analyzed by a one-way analysis of variance. Experts and AAA directors differed as groups in their responses as they had done when rating goals.

2. Bereavement counselor. Experts ranked this role number nine while AAA directors ranked it number 17. Experts rated this role with a mean score of 6.00 and a standard deviation of .80. Directors of AAAs gave this role a mean rating of 4.66 with a standard deviation of 1.49. The mode score for experts was six (high) with 43.9% responding; for directors it was five (above medial) with 28.1% responding. No significant F-ratios emerged for experts among any of the demographic characteristics when a one-way analysis of variance was used. Likewise, none emerged for AAA directors. An extremely high F-ratio of 40.55, significant at the .0001 level, was generated when experts' and directors' scores were subjected to a one way analysis of variance. This high F-ratio dramatized the rank variability of the ranking by the two groups.

3. Change Agent. Experts ranked this role as number 10 with a mean score rating of 6.00 and a standard deviation of 1.14. Directors

ranked this role number two with a mean score and standard deviation of 5.45 and 1.36, respectively. The experts' mode score was seven with 43.9% responding to very high, while the directors' mode score was also seven with 28% responding. Experts' scores generated no significant F-ratios, indicating a homogeneous group across demographic characteristics. Directors' scores, likewise, produced no F-ratios of significance. An F-ratio of 5.95 (significant at .015) between experts' and directors' mean scores for this role indicated between group heterogeneity. Again, experts and AAA directors seemed to rate the goals, roles, and sites from differing perspectives.

4. Personal counselor. With a mean score rating of 6.34 and a standard deviation of .79, experts ranked this role as number two (of 21). Directors ranked it number 13, with a mean rating of 4.82 and a standard deviation of 1.44. Mode scores were seven, very high, (48.8%) and six, high, (23.8%) for experts and directors, respectively. No significant F-ratios were produced by experts among demographic items. Likewise, directors produced no demographically related differences, and generated no significant F-ratios. Each group responded with internal consistency. An F-ratio of 34.07 (significant at .0001) evolved from a one way analysis of variance between means scores of experts and directors. Between group variability was again demonstrated.

5. Consultant. Experts rated this role with a mean score 6.07 and a standard deviation of .84, for a ranking of seven. Directors ranked the consultant role at 14 with a mean score rating of 4.75 and standard deviation of 1.56. The mode score for expert was six, high, with 43.9% responding, and five, above medial, for directors, with 30.1% responding. Experts produced one F-ratio (8.94) significant at the .01 level.

Master's degree experts rated the role at 6.75, Ed.D. holders at 5.64, while Ph.D. degree holders rated it at 6.53, a significantly higher rating. Curiously, Ed.D. holders did not value the consultant as highly as did either the master's degree holders or the Ph.D. degree holders. Directors generated no significant F-ratios among demographic items. A significant F-ratio, at the .0001 level, was produced when overall mean scores of experts and directors were analyzed using a one way analysis of variance. Between group difference was once again evident.

6. Specialist in psychological education. Experts ranked this role number six with a mean score rating of 6.09 and a standard deviation of 1.39, for a ranking of 15 (of 21). The experts mode score was seven, very high, with 43.9% responding and the directors' mode score was four, medial, with 27.9% responding. Three significant F-ratios were produced among demographic characteristics; sex at 9.92 (.01 level), preparation in gerontology at 3.26 (.05 level), and highest degree at 3.40 (.05 level). Females rated this role significantly higher at 6.50 than males did at 5.90. The preparation variable was significantly different in that self-taught experts rated the role lower (5.71) than those who had taken postgraduate courses (6.60), seminars (6.57) or graduated from gerontology programs (7.00). Experts with formal training in gerontology were more confident in confirming this role for gerontological counselors. Again, Ed.D. degree holders rated this role lower (5.82) than Ph.D. degree holders (6.27). Directors produced no significant F-ratios among demographic characteristics. A significant F-ratio (42.06) did emerge when group mean scores were compared by means of a one way analysis of variance. This comparison emphasized the extreme variability in the ranking that this role received from the two groups.

7. Employment counselor. Experts confirmed this role at a ranking of 19 with a mean score rating of 5.36 and a standard deviation of 1.13. Directors ranked this role as number six with a mean score rating of 5.12 and a standard deviation of 1.40. The F-ratio produced when group means were compared was not significant (2.89) making this the first role where experts and directors statistically agreed. However, the wide range in rank order between experts and AAA directors shows that directors value this role much higher than do the experts. Experts' mode score was six with 31.7% responding. Directors' mode score was five with 29.2% responding. No significant F-ratio were generated by either experts or directors when demographic characteristics were analyzed by means of a one way analysis of variance.

8. Services coordinator--services enhancer--client advocate. This multifaceted role was ranked number 18 by experts, but number one by directors. Experts rated the role below directors with mean score ratings of 5.43 and 5.66, respectively. The experts' mode score was five, above medial, with 34.1% responding, while the directors' mode score was seven, very high, with 38.3% responding. Two significant F-ratios emerged when the experts' demographic characteristics were analyzed, sex at 4.27 (.05 level) and degree area at 3.21 (.05 level). Females rated this role significantly higher than did males with 6.00 and 5.20 mean scores, respectively. The degree area difference was primarily generated by the single sociology degree holder and can, therefore, be minimized. Directors responded homogeneously, producing no F-ratio of significance. The between groups F-ratio (.01) was not significant. Again, however, the extreme range in rank order demonstrates that experts and AAA directors value this role quite differently.

9. Financial counselor. Here again the mean score rating of the directors for this role (5.31) was higher than that of the experts (5.09). Standard deviations were 1.48 and 1.28, respectively. Directors' mode score was five, above medial, with 39% responding, while it was seven, very high, for experts with 26.8% responding. One significant F-ratio was generated by the experts' ratings, that being gerontology preparation at 3.78 (.01 level). Once again, self-taught experts rated the role significantly lower (4.28) than did experts trained in seminars (5.14) and post graduate courses (5.40). Female directors rated this variable significantly higher at 5.17 as opposed to 4.64 for males. A between groups one-way analysis of variance did not produce a significant F-ratio indicating that, statistically, experts and AAA directors rated this role similarly.

10. In-service counselor--educator. Experts ranked this gerontological counselor role number four with a mean score rating of 6.17 and a standard deviation of 1.02. Directors ranked it number 11, with a mean score of 4.94 and a standard deviation of 1.43. The mode score for experts was seven, very high, with 48.8% responding, and five, above medial, for directors, with 25.7% responding. Two significant F-ratios were generated by experts' scores: sex at 6.15 (.01 level) and degree content at 3.37 (.01 level). Female experts rated this role significantly higher (6.75) than did male experts (5.92). The highest degree area difference was again produced by the sociology degree holder. Agency directors produced no significant F-ratios among demographic characteristics, indicating they rated this role homogeneously. A significant F-ratio of 21.75 (.0001 level) was generated when a between groups one-way analysis of variance was used to analyze scores, demonstrating the

divergence between experts' ratings and AAA directors' ratings.

11. Leisure counselor. Experts again rated the role higher (5.63) than did directors (4.32) with a 1.11 and 1.48 standard deviation, respectively. Experts ranked this role as number 14, while directors ranked it number 20. Mode scores were tied between five, above medial, and six, high, for experts, each having 31.7% responding, and fell to four, medial, for the directors with 27.5% responding. As with role 10, the same two expert demographic characteristics emerged as significant, when subjected to a one-way analysis of variance; namely, sex at 5.83 (.05 level) and degree content at 3.53 (.01 level). Females rated this role significantly higher (6.25) than did male experts (5.38). Once again the sociology degree holder skewed the data with a rating of two, to generate the significant F-ratio. Directors' ratings produced no significant F-ratios. A between group F-ratio of 34.21 (.0001 level) was generated by a one-way analysis of variance which indicated that the responses of the experts and AAA directors differed significantly.

12. Marital and sex counselor. This role was ranked number 15 and 21, respectively, by experts and directors. Experts' mean scores were 5.60 with a 1.13 standard deviation, while those of the directors were 3.87, with a standard deviation of 1.51. The mode score for experts was five, above medial, with 31.7% responding, and four, medial, for directors, with 31.9% responding. In the case of the experts, three significant F-ratios were produced. These were: sex at 6.05 (.05 level of significance); degree at 4.35 (.05 level); and degree area at 2.29 (.05 level). Female experts rated this role significantly higher (6.25) than did directors (5.34). Experts with master's degrees rated this role with a

mean score of 7.00, Ed.D. degree holders, 5.32; and Ph.D. degree holders, 5.67. Counseling degree holders rated the role at 5.42; sociology, at 3.00; counseling psychology at 5.75; educational psychology at 6.00, student personnel at 5.25, education at 7.00, and "other" at 7.00. Directors also produced a significant F-ratio for the sex characteristic at 4.36 (.05 level). Female directors rated the role significantly higher (4.52) than did males who rated it at (3.08). Between group one-way analysis of variance produced a highly significant F-ratio of 64.14 (.0001 level), indicating a high statistical difference in reponding to this role between experts and AAA directors.

13. Outreach to minorities. Experts ranked this role as number 16 with a mean rating of 5.56 and a standard deviation of 1.26. Directors ranked the role as number 12, with a mean score rating of 4.87 and a standard deviation of 1.77. The expert mode score was five, above medial, with 34.1% responding. The directors' mode score was also five, with 24.1% responding. The three significant F-ratios generated by the experts' ratings were sex at 4.19 (.05 level); highest degree, 3.95, (.05 level); and degree area, 2.82 (.05 level). Female experts rated this role significantly higher (6.17) than did male experts (5.31). Master's degree holders rated the role at 6.75, Ed.D. degree holders rated it at 5.14, while Ph.D. degree holders experts rated it at 5.87. Counseling degree holders rated this role at 7.00, significantly higher than the 6.17 rating by counseling psychology degree holders, the 5.75 rating by educational psychology degree holders, and the 5.75 rating by student personnel experts. Directors produced one significant F-ratio, 2.72 (.05 level) for the variable of public service area (PSA). Directors in urban districts rated this role significantly higher, with a mean score

of 6.28, than did directors in suburban districts (5.66), rural districts (4.30), and "mixed" districts (5.05). This difference is consistent with population demographics in that a higher percentage of minorities reside in urban areas than in suburban, rural, or "mixed" areas. A significant between group F-ratio of 7.01 (.008 level) was generated when experts' and directors' scores for this role were analyzed by a one-way analysis of variance. The results indicated that experts and AAA directors reacted differently to this role.

14. Services to nursing homes. Experts rated this role at a mean score of 5.90 with a standard deviation of .99, producing a rank order position of 11. Directors rated the role at a mean score of 4.94 and standard deviation of 1.57, for a ranking of number 10. The mode score for experts was seven, very high, with 34.1% responding, while directors registered a mode score of five with 23.8% responding at this above medial level. Neither experts nor directors produced any significant F-ratios among any demographic characteristics, indicating that each group responded with internal consistency. A significant F-ratio of 21.69 (.0001 level) was generated when between group scores were analyzed using a one-way analysis of variance. Again, experts' and AAA directors' rating of this role was quantitatively different, even though the rank order was very similar.

15. Pre-retirement counselor. This role emerged as the number one ranked role among counseling experts with a mean score rating of 6.51 and a standard deviation of .78. Directors ranked it number nine with a mean score rating of 4.99 and a standard deviation of 1.45. Mode scores were seven, very high, for experts with 65.9% responding, and six, high, for AAA directors with 28% responding. Experts generated a significant F-ratio

of 3.72 (.01 level) with respect to degree area. Counseling degree holders rated the role at 6.58, sociology at 4.00, counseling psychology at 6.75, educational psychology at 6.50, student personnel at 6.50, education at 5.00, and other at 7.00. The difference was produced by the range between the sociology expert and the "other" experts. The categories to which most of the experts belonged, counseling, counseling psychology, and educational psychology did not contribute to this difference. No significant F-ratios were generated among the demographic characteristics of AAA directors. A between groups F-ratio of 46.45 (.0001 level) was produced when a one-way analysis of variance was performed, indicating, once again, the statistical divergence between the ratings of the experts and those of the AAA directors.

17. Public relations worker. Experts confirmed and ranked this role number 17 with a mean score of 5.46 and a standard deviation of 1.30. Directors ranked it number five with a rating of 5.17 and a standard deviation of 1.50. The experts' mode score was six with 29.3% of the experts responding. The directors' mode score was divided between six and seven, each sharing 23.2% of the sample. Two significant F-ratios were generated from a one-way analysis of variance between the ratings of the experts and the demographic characteristics of sex, 4.12 (.01 level) and degree area, 3.72 (.01 level). Females rated this role significantly higher with a mean score of 6.08 than did males (5.21). Counseling degree holders rated this variable at 5.00; sociology, 2.00; counseling psychology, 5.62; educational psychology, 6.00; student personnel, 6.75; education, 6.50; and other, 6.00. Again, the lone sociology degree holder seems to have skewed the data. No significant F-ratios were produced by the ratings of directors. An F-ratio of 5.01 (.05 level) was produced

by the one-way analysis of variance between the groups. This analysis indicates that the ratings given to this role by the experts are higher and statistically different than the ratings given it by AAA directors.

18. Gerontological researcher. This role was ranked as a number 13 by gerontological counseling experts with a mean score of 5.68 and a standard deviation of 1.10. Directors ranked this role as number 19, with a mean score of 4.55 and a standard deviation of 1.73. Mode scores for each group were five for the experts with 34.1% responding, and four for the directors with 23.5% responding. Only the demographic characteristic of sex produced a significant F-ratio when compared to the rating given this role by the experts (4.90, .04 level). Females' mean score was 6.25 while males' mean score was 5.45. Female directors likewise rated this role significantly higher (4.88) than did males (4.40), with an F-ratio of 3.75 (.05 level). It is difficult to determine why females from both groups would rate this role significantly higher than males. An F-ratio of 15.52 (.0001 level) was produced when a between groups one-way analysis of variance was performed, indicating that experts and AAA directors responded differently to this role.

19. Family counselor. Experts rated this role with a mean score of 6.34 and a standard deviation of .96, making this the number three ranked role. Directors likewise ranked this role quite high at seven, with a mean score of 5.01 and a standard deviation of 1.54. Mode scores were seven, very high, with 56.1% responding and 6, high, with 23.4% responding for experts and directors, respectively. One significant F-ratio (3.76) was generated by the experts in the characteristic of degree area. The sociology degree holder rated the role the lowest at 3.00, while the "other" degree holders rated it the highest at 7.00.

This divergence produced the significant F-ratio. Directors' ratings generated no significant F-ratios when compared to the demographic characteristics by a one-way analysis of variance. An F-ratio of 48.28 (.0001 level) resulted from a between groups one-way analysis of variance performed on the responses given the role by experts and AAA directors, indicating a difference in the responses of the two groups.

20. Educational counselor. Experts ranked this role as number 12 with a mean score of 5.68 and a standard deviation of 1.08. Agency directors ranked it number 18 with a mean score of 4.55 and a standard deviation of 1.47. Mode scores for experts and directors were six, high with 31.7% responding and four, medial, with 27.1% responding, respectively. Experts again produced a significant F-ratio of 2.64 (.01 level) in the degree area characteristic. The mean score range was between 7.00 for education degree holders and 3.00 for the single sociology participant. Directors' ratings produced no significant F-ratios when compared to demographic characteristics. A between group F-ratio of 29.24 (.0001 level) was generated, indicating very high variability between the ratings of experts and those of AAA directors for this role.

21. Medical support outreach counselor. This role was ranked number 20 by the experts and number eight by the directors. The mean score for the experts was 5.43 with a standard deviation of 1.30. The directors' mean score rating was 5.01 with a standard deviation of 1.74. Mode scores were six, high, with 34.1% responding for experts and seven, very high, with 24.0% responding for directors. No significant F-ratios were produced by comparing experts' ratings with demographic characteristics. Likewise, directors' ratings generated no significantly different scores. A between groups F-ratio of 9.00 (.01 level) was produced from a one-way

analysis of variance of overall mean scores for this role, indicating, once again, high divergence between the ratings given this role by the experts and those given by the AAA directors.

Gerontological Counseling Sites

1. Senior centers. Experts ranked this site a number one with a mean score of 6.17 and a standard deviation of 1.34. Directors also ranked it number one with a mean score of 5.99 and a standard deviation of 1.23. Mode scores were seven, very high, with 56.1% responding for experts and seven with 44% responding for AAA directors. Neither experts' nor directors' ratings produced any significant F-ratios among demographic characteristics when subjected to a one-way analysis of variance. A non-significant F-ratio was produced when a between groups one-way analysis of variance was performed. This result illustrates that relative homogenity existed between experts' and directors' ratings for this site.

2. Area Agencies on Aging. A mean rating of 5.43 and a standard deviation of 1.55, producing a ranking of seven out of 13, were generated by counseling experts for this site. Directors ranked the site number 12 with a mean score of 4.47 and a standard deviation of 2.03. This was the largest standard deviation spread relating to sites; it highlights the variability of opinion among AAA directors about the presence of a professional gerontological counselor at this site. Mode scores were seven, very high, with 31.7% responding for experts and six, high, with 21.1% responding for directors. Experts' ratings generated no significant F-ratios for this site, but directors' ratings produced one, 3.41 (.01 level) on the geographic area characteristic. Directors in the Northeast gave this site a mean score of 5.22; in the South, 4.40; in the

Midwest, 4.39; in the Southwest, 3.09; in the West, 3.56, and non-continental, 5.00. A significant F-ratio of 8.37 (.004 level) was produced in a between group one-way analysis of variance indicating between group variability.

3. Mental health centers. Experts ranked this site as number two with a mean score of 5.87 and a standard deviation of 1.43. Directors ranked this site as number seven, registering a 5.30 mean score and a 1.62 standard deviation. Mode scores were seven, very high, with 48.8% responding for experts and seven 30.3% responding for directors. Neither experts nor directors generated any significant F-ratios with regard to demographic variables, demonstrating within group homogenity. A significant between groups F-ratio of 6.24 (.01 level) was produced, showing group differences.

4. Nursing Homes. A mean score of 5.85 and a standard deviation of 1.62 gave this site a number three ranking among experts. Directors ranked this site number five with a mean score of 5.36 and a standard deviation of 1.49. Mode scores were seven, very high, with 46.3% responding for experts and seven with 28.7% responding for directors. Neither experts' nor directors' ratings registered any significant F-ratios when compared to demographic characteristics using a one-way analysis of variance. A non-significant F-ratio of 1.46 emerged when a between groups' analysis of variance was performed. This analysis indicated between group similarity with the ratings of experts and AAA directors very much the same for this site.

5. Adult congregate living facilities. Experts ranked this site number five with a mean rating of 5.70 and a standard deviation of 1.50. Directors ranked it as number three, with a mean score of 5.55 and a

standard deviation of 1.28. Mode scores were six, high, with 34% responding for experts and six with 35.8% responding for directors. Experts' ratings generated no significant F-ratios among demographic characteristics. One significant F-ratio was generated by the directors' ratings. In the characteristic of geographic area a F-ratio of 2.83 (.01 level) indicated that Midwest directors rated this site significantly lower (5.02) than did directors from the South who rated it at 6.03. It may be that there are fewer ACLFs in the Midwest. Northeastern directors rated this site at 5.69, Southwestern at 6.00, Western at 5.45, and non-continental at 6.00. Directors and experts reacted quite similarly to this site producing a non-significant between groups F-ratio of .09.

6. Adult congregate nutrition sites. Experts rated this site with a mean score of 4.75 and a standard deviation of 1.62 for a ranking among sites of 10. Directors gave it a mean score of 5.66 and a standard deviation of 1.27 for a high ranking of two. Mode scores were five, above medial, with 41.5% responding for experts and six, high, with 33.1% responding for directors. Neither experts nor directors' ratings produced any significant F-ratios among demographic variables. However, a significant F-ratio of 5.36 (.05 level) was generated by a between groups analysis of variance indicating between group differences.

7. Retirement projects. A mean score of 5.60 and a standard deviation of 1.41 ranked this site number six among experts. Directors ranked it number 10 with a mean score of 5.04 and a standard deviation of 1.40. Experts produced a mode of six, high, with 36.6% responding while directors generated the same mode of six with 26.1% responding. Experts generated two significant F-ratios for this site, one in highest degree of 3.37 (.05 level) and one in degree area 3.18 (.05 level).

Ph.D. degree holders rated this site at 4.93; Ed.D. degree holders at 5.90; and master's degree holders at 6.50. It is curious that the nine highly educated experts ranked this site lower. A similar range of mean scores was produced between degree disciplines with the sociology degree holder rating the site lowest (3.00) and education degree holders rating it the highest, 7.00; this divergence produced the significant F-ratio. Directors' ratings produced no significant F-ratios among demographic characteristics. A significant F-ratio of 6.18 (.01 level) was generated by a between groups' analysis of variance indicating that experts and AAA directors perceived the relative value of this site for gerontological counselors as significantly different.

8. Day care centers. Experts produced a mean score of 4.90 and a standard deviation of 1.93 for a rank of nine for this site. Directors ranked this site at number 10 with a mean score rating of 5.04 and a standard deviation of 1.40. Mode scores were seven, very high, with 26.8% responding for experts and six, high, with 30.9% responding for directors. Experts' ratings produced one significant F-ratio of 3.18 (.05 level) under the characteristic of degree area. Student personnel and education degree holders rated this site significantly higher than did the sociology degree holder. Directors' ratings produced no significant F-ratios among demographic characteristics. A non-significant F-ratio of .10 resulted from the between groups' analysis of variance indicating similar ratings by experts and AAA directors.

9. Hospice programs. Experts ranked this site as number four, giving it a mean score of 5.82 and a standard deviation of 1.28. Directors likewise ranked it number four with a mean score rating of 5.49 and a

standard deviation of 1.41. Experts' mode score was seven, very high, with 26.8% responding while directors' mode score was six, high, with 30.9% responding. Experts' ratings produced no significant F-ratios among demographic variables. Directors' ratings, however, produced a significant F-ratio with regard to age. Directors, aged 25-34 rated this site at 5.76, those aged 35-44 rated it at 5.31; those aged 45-54 rated it at 6.16; those aged 55-64 rated it at 4.86; and those 65 and over rated the hospice programs site at 5.00. Older directors rated this site significantly lower than did younger directors. A non-significant F-ratio of 1.36 resulted from a between groups one-way analysis of variance. Both experts and AAA directors rated this site in a similar manner.

10. Homemaker's projects. Experts gave this site a mean score of 4.70 with a standard deviation of 1.73, and with a rank ordering of 11 out of 13. Directors ranked this site as number eight with a mean score rating of 5.07 and a standard deviation of 1.37. Experts produced a bimodel score of four, (medial) and six (high), each sharing 22% of those experts responding. Directors' mode score was five with 27.1% responding. Neither experts' nor directors' ratings generated any significant mean F-ratios by a one-way analysis of variance. Again, experts and AAA directors rated this role similarly.

11. Respite care programs. A rank order of 12 emerged from the experts' mean score of 4.69 and a standard deviation of 1.93. Directors gave a mean score of 4.96 and a standard deviation of 1.33 for a ranking of 11. Mode scores for this site were five, above medial, with 24.4% responding for experts and five, with 27.3% responding for directors. Experts' ratings produced no significant F-ratios in a one-way analysis

of variance among demographic characteristics. However, directors were significantly different among themselves with respect to the age characteristic with an F-ratio of 4.36 (.01 level). Directors, aged 25-34, rated the site at 5.05; those aged 35-44, rated it at 4.59; those aged 45-54 rated it at 5.83; those aged 55-64 at 4.73; and those aged 65 and over at 5.25. Again, older AAA directors tended to rate this site lower. A non-significant F-ratio of .23 was generated when each group's scores were analyzed using a one-way analysis of variance. A similarity in group responses was indicated.

12. Housing projects. Counseling experts ranked this site number eight, giving it a mean score of 4.95 and a standard deviation of 1.49. Directors ranked the site number nine with a mean score rating of 5.05 and a standard deviation of 1.48. The expert group's mode score was four, medial, with 29.2% responding while the directors' mode score was six, high, with 27.7% responding. Neither group produced any significant F-ratios when a one-way analysis of variance was performed between their ratings and their demographic characteristics. The F-ratio generated when group scores for the site were analyzed was a non-significant .21 indicating the two groups were quite similar in their appraisal of this site.

13. Physician's offices. Experts gave it a mean score of 4.21, while director's mean score was 4.18. High standard deviation scores of 2.01 for experts and 1.76 for directors indicated high within group variability. A mode of six, high, with 24.4% responding was produced by the experts while the directors generated one of four, medial, with 22.3% responding. No significant F-ratios between ratings and demographic characteristics were produced by either group. A non-significant F-ratio of .22 from a one-way analysis of variance between groups was produced, again showing between group similarity.

Comparison of Evaluations of Goals, Roles, and Sites by Experts and AAA Executive Directors

Table 15 displays correlation figures comparing the mean scores for all goals, all roles, and all sites produced by each group. A positive correlation of 0.115 was found for potential gerontological counselors' goals, indicating relative agreement between experts and directors concerning the aims of gerontological counseling. A correlation figure of -0.1104 resulted when the mean scores of roles were compared, while a positive correlation of 0.5840 was generated between the ratings given possible placement sites by experts and AAA directors. Experts and AAA directors generally agree more on the goals of counselors than on the implementation of these goals and where these goals could be best exercised.

In an effort to measure the degree to which gerontological counseling services were needed in their PSAs, AAA executive directors were asked two questions with regard to each goal and each role. The first question was, to what degree does this goal or role conform to the overall objectives of the PSA? Responses to this question are called conforming goals and conforming roles. The second question asked to what degree each goal and role offered assistance to the elderly in the PSA. Responses to this second question are called assisting goals and assisting roles.

Table 17 displays mean scores for all conforming goals, conforming roles, assisting goals and assisting roles, as well as difference scores between these two sets of mean scores. Assisting goals and assisting roles are generally higher than conforming goals and roles. Only two assisting goals, personal effectiveness and self-advocacy were rated lower

than their paired conforming goal. Only one assisting role, gerontological researcher, was rated lower than its corresponding conforming role. All other assisting goals and assisting roles were rated higher than conforming goals and conforming roles. Differences among roles ranged from -.08 to +.39 (range .47), while differences among roles ranged from -.09 to +.86 (range .97). The mean goal difference was 17.4, and the mean role difference was 37.6. Correlations between conforming goals and assisting goals, and between conforming roles and assisting roles were +0.972 and +0.857, respectively, indicating a very high similarity between the pairs of goals and the pairs of roles. AAA directors rated the conforming goals and roles, and the assisting goals and roles very much the same.

FACTOR ANALYSIS

Intercorrelations were computed for responses of both experts and directors concerning all goals, roles, and sites. Results are displayed on Tables 18 through 23. Table 18 presents the obtained intercorrelations between the seven goals confirmed by the experts. These correlations ranged from -0.15 to .56 (range .71). Four correlations were significant at the .01 level and seven at the .05 level; 10 did not reach significance. Table 19 displays the intercorrelations among the 21 roles confirmed by the panel of experts. Correlations range from -.07 to .84 (range .91). Of these correlations, 109 were significant at the .01 level, 47 were significant at the .05 level, and 50 did not achieve significance. Table 20 displays the intercorrelations between all 13 sites as rated by the panel of gerontological counseling experts.

TABLE 17

SUMMARY OF MEANS OF CONFIRMING GOALS AND ROLES
AS COMPARED TO ASSISTING GOALS AND ROLES
FOR AAA DIRECTORS WITH CORRELATION MEASURE

Goals	Confirming $\overline{X}$'s	Rank	Assisting $\overline{X}$'s	Rank	Difference
1	5.46	3	5.72	1	+.26*
2	3.94	7	4.33	7	+.39*
3	5.18	4	5.36	4	+.18*
4	5.13	5	5.27	5	+.14
5	5.59	2	5.55	3	-.04
6	4.89	6	5.26	6	+.37*
7	5.79	1	5.71	2	-.08
	$\overline{X}$ = 5.14		$\overline{X}$ = 5.31		$\overline{X}$ =17.4
Roles					
1	5.05	3	5.30	4	+.25
2	3.97	19	4.66	17	+.69*
3	5.41	2	5.45	2	+.04
4	4.49	9	4.82	13	+.33
5	4.38	13	4.75	14	+.37
6	4.35	12	4.69	15	+.34
7	5.01	4	5.12	6	+.11
8	5.60	1	5.66	1	+.06
9	4.90	10	5.31	3	+.41*
10	4.88	6	4.94	11	+.06
11	3.98	18	4.32	20	+.34
12	3.32	21	3.87	21	+.55*
13	4.79	7	4.87	12	+.08
14	4.45	11	4.95	10	+.50*
15	3.82	20	4.68	16	+.86*
16	4.19	16	4.98	9	+.79*
17	4.94	5	5.17	5	+.23
18	4.64	8	4.55	18	-.09
19	4.26	14	5.01	7	+.75*
20	4.22	15	4.55	19	+.33
21	4.11	17	5.01	8	+.90*
	$\overline{X}$ = 4.51		$\overline{X}$ = 4.89		$\overline{X}$= 37.6
				Goals Correlation + 0.972	
				Roles Correlation + 0.857	

*above the mean difference

TABLE 18

INTERCORRELATIONS OF GOALS FOR EXPERTS

Goal #	1	2	3	4	5	6	7
1		.24	.35*	-.15	.09	.38*	.25
2			.34*	.30*	-.11	.22	.28
3				.41**	.22	.56**	.36*
4					.35*	.13	.17
5						.44**	.35*
6							.50**
7							

*p $\prec$ .05
**p $\prec$ .01

TABLE 19

INTERCORRELATIONS OF ROLES FOR EXPERTS

Roles #	1	2	3	4	5	6	7
1		.54**	.45**	.20	.56**	.51**	.56**
2			.30*	.51**	.29	.49**	.44**
3				.28	.39*	.35*	.46**
4					.26	.35*	.36*
5						.55**	.52**
6							.36*
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							

*$p < .05$

**$p < .01$

TABLE19--Continued

Roles #	8	9	10	11	12	13	14
1	.64**	.42**	.55**	.42**	.52**	.64**	.55**
2	.53**	.34*	.36*	.33*	.30*	.47**	.50**
3	.68**	.46**	.36*	.57**	.33*	.55**	.13
4	.37*	-.03	.48**	.25	.29	.13	.30*
5	.50**	.36*	.45**	.37*	.42**	.54**	.30*
6	.60**	.32*	.60**	.34*	.57**	.58**	.41**
7	.52**	.35*	.48**	.50**	.46**	.53**	.41**
8		.56**	.61**	.63**	.57**	.64**	.34*
9			.16	.45**	.40**	.54**	.20
10				.58**	.68**	.54**	.56**
11					.54**	.56**	.28
12						.66**	.45**
13							.38*
14							
15							
16							
17							
18							
19							
20							
21							

*p $\lhd$ .05

**p $\lhd$ .01

TABLE 19--Continued

Roles #	15	16	17	18	19	20	21
1	.51**	.52**	.55**	.37*	.54**	.34*	.46**
2	.84**	.32*	.19	.22	.39*	.09	.50**
3	.10	.42**	.55**	.24	.32*	.30*	.17
4	.40**	.28	.08	.35*	.24	-.07	.24
5	.05	.17	.53**	.56**	.34*	.27	.20
6	.23	.27	.53**	.58**	.54**	.25	.35*
7	.36*	.49**	.34*	.43**	.34*	.38*	.43**
8	.34*	.41**	.65**	.42**	.53**	.43**	.36*
9	.19	.22	.45**	.23	.13	.13	.50**
10	.31*	.48**	.61**	.60**	.67**	.46**	.26
11	.27	.45**	.60**	.37*	.31*	.42**	.04
12	.24	.46**	.51**	.58**	.44**	.24	.14
13	.41**	.36*	.64**	.34*	.62**	.50**	.38*
14	.43**	.32*	.40**	.49**	.43**	.18	.42**
15		.37*	.12	.13	.39*	.08	.43**
16			.40**	.16	.49**	.35*	.17
17				.50**	.45**	.41**	.24
18					.32*	.10	.22
19						.61**	.31*
20							.21
21							

*p $\prec$ .05

**p $\prec$ .01

TABLE 20

INTERCORRELATIONS OF SITES FOR EXPERTS

Site#	1	2	3	4	5	6	7
1		.59**	.44**	.43**	.56**	.54**	.59**
2			.41**	.41**	.62**	.53**	.56**
3				.56**	.47**	.44**	.72**
4					.68**	.60**	.45**
5						.75**	.56**
6							.56**
7							
8							
9							
10							
11							
12							
13							

*$p < .05$

**$p < .01$

TABLE 20--Continued

Site #	8	9	10	11	12	13
1	.34*	.36*	.38*	.47**	.61**	.37*
2	.26	.60**	.56**	.55**	.39*	.50**
3	.44**	.46**	.37*	.28	.62**	.26
4	.16	.59**	.47**	.45**	.35*	.27
5	.41**	.78**	.67**	.64**	.53**	.38*
6	.30*	.64**	.50**	.63**	.36*	.50**
7	.52**	.45**	.34*	.52**	.57**	.39*
8		.34*	.32*	.33*	.44**	.37*
9			.75**	.60**	.36*	.46**
10				.64**	.56**	.64**
11					.46**	.57**
12						.40**
13						

*$p < .05$

**$p < .01$

TABLE 21

INTERCORRELATIONS OF GOALS FOR AAA DIRECTORS

Goal#	1	2	3	4	5	6	7
1		.31*	.50**	.34*	.29	.28	.30*
2			.55**	.47**	.32*	.36*	.14
3				.54**	.51**	.47**	.38*
4					.48**	.40**	.29
5						.46**	.38*
6							.52**
7							

*p $\lhd$ .05
**p $\lhd$ .01

TABLE 22

INTERCORRELATION OF ROLES FOR AAA DIRECTORS

Role #	1	2	3	4	5	6	7
1		.37*	.42**	.29	.34*	.36*	.26
2			.37*	.53**	.43**	.29	.15
3				.30*	.36*	.28	.20
4					.33*	.28	.10
5						.42**	.31*
6							.07
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							

*$p < .05$

**$p < .01$

TABLE 22--Continued

Role #	8	9	10	11	12	13	14
1	.33*	.35*	.41**	.13	.26	.32*	.28
2	.18	.44**	.34*	.31*	.42**	.29	.37*
3	.43**	.40**	.45**	.29	.13	.41**	.24
4	.31*	.46**	.36*	.44**	.29	.25	.37*
5	.24	.30*	.36*	.37*	.39*	.31*	.31*
6	.27	.34*	.50**	.44**	.26	.16	.38*
7	.22	.29	.25	.21	.20	.27	.26
8		.48**	.36*	.26	.05	.33*	.29
9			.45**	.40**	.34*	.32*	.39*
10				.39*	.26	.32*	.44**
11					.28	.34*	.48**
12						.19	.35*
13							.35*
14							
15							
16							
17							
18							
19							
20							
21							

*$p \leq .05$

**$p \leq .01$

TABLE 22--Continued

Role #	15	16	17	18	19	20	21
1	.28	.39*	.28	.28	.32*	.34*	.31*
2	.59**	.49**	.35*	.24	.43**	.41**	.36*
3	.28	.42**	.57**	.41**	.26	.40**	.15
4	.40**	.35*	.32*	.18	.50**	.36*	.33*
5	.44**	.47**	.36*	.26	.33*	.37*	.31*
6	.27	.32*	.29	.21	.32*	.46**	.34*
7	.08	.24	.26	.42**	.22	.21	.26
8	.08	.14	.36*	.28	.34*	.29	.34*
9	.38*	.42**	.36*	.30*	.57**	.37*	.47**
10	.29	.32*	.46**	.47**	.36*	.56**	.37*
11	.26	.34*	.38*	.25	.33*	.45**	.28
12	.51**	.43**	.15	.17	.40**	.18	.20
13	.25	.16	.36*	.34*	.19	.36*	.16
14	.47**	.38*	.28	.28	.38*	.43**	.40**
15		.58**	.23	.17	.46**	.23	.38*
16			.40**	.30*	.48**	.35*	.42**
17				.42**	.27	.48**	.28
18					.21	.44**	.24
19						.28	.51**
20							.46**
21							

*$p \leq .05$

**$p \leq .01$

TABLE 23

INTERCORRELATION OF SITES TO AAA DIRECTORS

Site #	1	2	3	4	5	6	7
1		.01	.17	.13	.42**	.60**	.22
2			.02	-.01	.04	-.03	-.02
3				.34*	.23	.24	.22
4					.46**	.24	.50**
5						.56**	.65**
6							.36*
7							
8							
9							
10							
11							
12							
13							

*p $\prec$ .05

**p $\prec$ .01

TABLE 23--Continued

Site #	8	9	10	11	12	13
1	.31*	.02	.11	.13	.23	.14
2	-.15	-.25	.02	-.05	.02	.15
3	.27	/15	.06	.18	.20	.14
4	.53**	.54**	.38*	.56**	.38*	.37*
5	.50**	.39*	.41**	.43**	.68**	.36*
6	.42**	.12	.25	.31*	.35*	.25
7	.59**	.53**	.42**	.50**	.58**	.43**
8		.61**	.48**	.65**	.43**	.29
9			.42**	.58**	.37*	.35*
10				.67**	.51**	.39*
11					.49**	.46**
12						.44**
13						

*p $\prec$ .05

**p $\prec$ .01

Correlations ranged from .16 to .78 (range .62). Of these, 57 were significant at the .01 level and 17 at the .05 level; only four did not achieve a significant difference.

Tables 21, 22 and 23 display intercorrelations produced by AAA executive directors with regard to assisting goals, assisting roles, and sites. Directors generated 10 correlations at a .01 level of significance, seven at an .05 level of significance, and four which did not reach significance. These correlations ranged from .14 to .55 (range .41). Table 22 presents the intercorrelation results among roles as assessed by directors. Of these correlations, 57 attained an .01 level of significance, 72 reached an .05 level of significance, while 78 did not attain significance. Table 23 displays the intercorrelations for sites as registered by directors. Correlations ranged from -.25 to .68 (range .93). Of these, 31 attained an .01 level of significance, 12 reached a .05 level of significance, while 34 did not reach significance.

Tables 24 through 29 display the principal axes factor analysis of the goals, roles, and sites for both experts and directors, following an oblique rotation to simple loadings. Table 24 shows that three factors emerged from the rotation for experts' goals. Goal six, knowledge of the aging process and goal three, decision making, were heavily loaded on factor one. Factor two was heavily weighted by goal four, positive mental health. Goal five, personal effectiveness, was loaded on factor three. Table 25 indicates that only one factor emerged for directors' goals after rotation.

Five factors resulted from the rotation to simple loading of experts' role reactions. Factor one was loaded by role three, change agent, role 11, leisure time counselor, and role eight, services

TABLE 24

PRIMARY FACTOR LOADINGS FOR EXPERT RATED
COUNSELING GOALS RESPONSES
FOLLOWING A PRINCIPAL-AXES FACTOR ANALYSIS
WITH AN OBLIQUE ROTATION TO SIMPLE SOLUTION

Goals	Factors 1	2	3	Communality
1. Problem Resolution	.58	-.13	-.02	.35
2. Behavioral Change	.46	.35	-.29	.42
3. Decision Making	.64	.37	.09	.55
4. Positive Mental Health	.00	.98	.21	1.01
5. Personal Effectiveness	.17	.16	.83	.76
6. Knowledge of Aging Process	.74	.05	.37	.69
7. Self Advocacy	.52	.13	.26	.36

TABLE 25

PRIMARY FACTOR LOADINGS FOR AAA DIRECTORS
COUNSELING GOALS RESPONSES
FOLLOWING A PRINCIPAL-AXES FACTOR ANALYSIS
WITH AN OBLIQUE ROTATION TO SIMPLE SOLUTION

Goals	Factor 1	Communality
1. Problem Resolution	.52	.27
2. Behavioral Change	.57	.33
3. Decision Making	.81	.66
4. Positive Mental Health	.68	.46
5. Personal Effectiveness	.65	.42
6. Knowledge of Aging Process	.65	.43
7. Self-Advocacy	.51	.27

TABLE 26

PRIMARY FACTOR LOADINGS FOR EXPERT'S
COUNSELING ROLES RESPONSES
FOLLOWING A PRINCIPAL -AXES FACTOR ANALYSIS
WITH AN OBLIQUE ROTATION TO SIMPLE SOLUTION

Roles	Factors 1	2	3	4	5	Communality
1	.38	.47	.38	.35	.16	.66
2	.24	.88	.17	.03	-.05	.86
3	.76	.09	.14	.15	.00	.63
4	.18	.44	.33	-.10	-.51	.61
5	.35	.08	.59	.11	.14	.51
6	.23	.27	.64	.21	.05	.59
7	.44	.35	.33	.21	-.01	.47
8	.66	.30	.38	.26	.05	.74
9	.58	.25	.19	-.07	.53	.73
10	.28	.20	.63	.50	-.30	.86
11	.72	.08	.25	.24	-.15	.67
12	.39	.15	.57	.25	-.06	.56
13	.50	.29	.36	.44	.26	.74
14	.03	.45	.49	.23	-.01	.49
15	.10	.86	-.02	.16	-.13	.80
16	.40	.27	.09	.41	-.19	.45
17	.52	-.02	.49	.35	.17	.67
18	.15	.07	.85	.04	-.07	.76
19	.12	.30	.31	.74	-.03	.76
20	.27	-.01	.07	.71	.11	.60
21	.07	.57	.21	.10	.35	.52

TABLE 27

PRIMARY FACTOR LOADINGS FOR AAA DIRECTORS
COUNSELING ROLES RESPONSES
FOLLOWING A PRINCIPAL-AXES FACTOR ANALYSIS
WITH AN OBLIQUE ROTATION TO SIMPLE SOLUTION

Roles	Factors 1	2	3	4	5	Communality
1	.27	.36	.14	.23	.19	.31
2	.61	.25	-.00	.20	.23	.53
3	.19	.86	.00	.14	.12	.82
4	.39	.18	-.07	.39	.29	.42
5	.46	.26	.18	.07	.31	.41
6	.22	.15	-.03	.17	.57	.42
7	.11	.16	.83	.14	.07	.76
8	-.08	.39	.10	.57	.20	.54
9	.31	.24	.14	.60	.24	.60
10	.17	.36	.14	.22	.56	.54
11	.23	.15	.08	.20	.53	.41
12	.60	.00	.14	.09	.15	.41
13	.14	.39	.69	.13	.25	.29
14	.36	.09	.16	.23	.47	.44
15	.80	.10	-.03	.13	.13	.69
16	.64	.26	.12	.14	.34	.48
17	.16	.55	.13	.14	.34	.48
18	.09	.41	.38	.07	.31	.41
19	.48	.06	.08	.59	.17	.61
20	.15	.32	.11	.13	.67	.61
21	.30	.02	.16	.44	.35	.43

TABLE 28

PRIMARY FACTOR LOADINGS FOR EXPERT'S SITE RESPONSES FOLLOWING A PRINCIPAL-AXES FACTOR ANALYSIS WITH AN OBLIQUE ROTATION TO SIMPLE SOLUTION

Sites	Factors 1	2	3	Communality
1	.30	.56	.30	.49
2	.40	.35	.48	.52
3	.38	.75	.02	.70
4	.75	.28	.11	.64
5	.73	.34	.41	.82
6	.60	.31	.40	.62
7	.30	.79	.21	.76
8	.07	.51	.28	.35
9	.67	.18	.50	.73
10	.42	.19	.71	.71
11	.39	.27	.63	.63
12	.16	.66	.33	.58
13	.11	.25	.73	.61

TABLE 29

PRIMARY FACTOR LOADINGS FOR AAA DIRECTOR'S SITE RESPONSES FOLLOWING A PRINCIPAL-AXES FACTOR ANALYSIS WITH AN OBLIQUE ROTATION TO SIMPLE SOLUTION

Sites	Factors 1	2	3	4	Communality
1	.06	.71	.02	.07	.52
2	.01	-.01	-.49	.02	.24
3	.11	.15	-.03	.71	.55
4	.60	.07	.13	.39	.53
5	.59	.55	-.09	.14	.67
6	.22	.78	.04	.11	.67
7	.68	.27	.05	.18	.57
8	.62	.30	.40	.23	.69
9	.68	-.05	.44	.17	.69
10	.70	.10	.01	-.07	.51
11	.78	.09	.16	.09	.66
12	.67	.30	-.16	.06	.57
13	.57	.11	-.20	.09	.39

coordinator. Factor two was loaded by role 15, counselor of the terminally ill, and role two, bereavement counselor. Factor three was loaded by role 18, gerontological researcher, and to a lesser degree by role six, specialist in psychological education, and role 10, in-service counselor educator. Factor four was loaded by role 19, family counselor, and role 20, educational counselor. No roles, with the possible exception of role nine, financial counselor and manager, can be clearly seen to be loading on factor five.

Five factors also emerged from the ratings given by directors with regard to roles. Factor one was loaded by role 15, counselor of the terminally ill, and to a lesser degree by role two, bereavement counselor, and role 16, pre-retirement counselor. Factor two was heavily loaded by role three, change agent. Factor three was clearly loaded by role seven, employment counselor. Factor four was weakly loaded by roles nine, 18 and eight, financial counselor and manager, family counselor, and services coordinator, respectively. Factor five was loaded by role 20, educational counselor, role six, specialist in psychological education, and role 10, in-service counselor educator.

Tables 28 and 29 display the primary factor loadings for experts and directors site responses following a principal axes factor analysis with an oblique rotation to simple solution. Three factors emerged for the experts, while four emerged for the AAA directors. Experts' factor one was loaded by sites four and five, nursing home and adult congregate living facilities, and to some degree by site nine, hospice programs. Factor two was loaded by site seven, retirement projects, and by site three, mental health centers. Factor three was loaded by site 13, physician's offices, and site 10, homemaker's programs. Directors

produced four site factors. Factor one was loaded by sites 10 and 11, homemaker's care programs and respite care programs. Factor two was loaded by site one, senior centers. Factor three was not strongly loaded by any site. Factor four was so heavily loaded by so many factors that an accurate analysis was impossible. The meanings of these loadings and the names of the factors which emerged as a result of the factor analysis will be discussed in Chapter V.

CHAPTER V

SUMMARY, DISCUSSION, CONCLUSIONS, IMPLICATIONS AND SUGGESTIONS FOR FURTHER RESEARCH

Summary of the Study

The purposes of this study were, (1) to clarify the objectives and the types of services which professional gerontological counselors can offer to older persons, and (2) to measure the degree to which these services are important to the federally supported programs for older persons. To accomplish the first purpose, a panel of gerontological counseling experts was identified. This identification process was accomplished by contacting each counselor education department nationwide seeking persons who were knowledgeable in both disciplines of counseling and gerontology, and who had taught at least one course exclusively devoted to the content area of "older persons." A panel of 41 experts was identifed. This panel was asked to react to five gerontological counselors' goals and 18 gerontological counselors' roles which had been abstracted from the literature by the researcher. In two successive survey rounds, the panel confirmed the original goals and roles and added two goals and three roles which created a final, confirmed list of seven goals and 21 roles. Experts also were asked to react to 13 possible placement sites for gerontological counselors within the aging network.

The second purpose of this study was accomplished by forwarding the confirmed goals and roles and the possible placement sites to a nationwide, random sample of Area Agency on Aging (AAA) executive directors (N=253). One hundred sixty-eight useable responses were received. AAA directors were asked to react to two questions concerning each goal and each role. Question one asked AAA directors to measure the degree to which each goal and role currently conformed to the overall objectives presently being pursued in their public service area (PSA). This question was designed to measure the level of congruence between the confirmed goals and roles of gerontological counselors' and the federal and state mandated guidelines established for AAAs, as perceived by their AAA directors. Question two asked AAA directors to measure the degree to which each goal and each role could potentially assist older persons in their public service area (PSA). This question was designed to measure the value of gerontological counseling in federally supported programs as perceived by AAA directors. The difference between responses to question one and question two for each goal and role provided a measure of the level of unmet need for gerontological counseling in the aging network. Directors also were asked to evaluate the same 13 potential sites for counselors in the aging network was the panel of experts.

The data as outlined in Chapter IV, were analyzed using various statistical manipulations, including such descriptive statistics as measures of central tendency: mean, mode, standard deviation and frequency distributions. Measures of association, including crosstabulations and correlations, as well as analysis of variance and factor analysis, were also performed on the data.

Discussion

The purposes developed for this study provide the organizational framework for discussion of the findings.

Identification of the Goals and Roles of Gerontological Counselors

The first purpose of this study was to identify the specific goals and roles which gerontological counselors could play. This purpose was accomplished by the panel of gerontological counseling experts who, in successive survey rounds, created two comprehensive lists of the capabilities of gerontological counselors, one of the goals and one of the roles. Attempts have been made by Murphey (1979) to construct a comprehensive definition of counseling as it relates to older persons. However, his definition is, of necessity, generalized. The composite list of goals and roles produced by this study can be used to define operationally the professional roles and goals which gerontological counselors can perform. Such an operational definition should enable the professional and non-professional alike, to understand better the process of, and benefits to be derived from, counseling older persons.

Priority of Goals

The rank order of the goals and roles, as computed from mean scores provides insight into the relative importance given to each by the experts and AAA directors. Experts seem to value a preventative posture rather than a reactive or remedial one when they rank positive mental health as their number one goal and personal effectiveness as their number two goal for gerontological counselors. The descriptive phrases used in the survey forms for positive mental health emphasize personal integration, adjustment, socialization, and independence. These

descriptors suggest that experts favor a developmental approach to gerontological counseling, a growth approach, rather than a reactive approach. The high ranking of personal effectiveness buttresses this interpretation. Personal effectiveness is an overarching goal, imprecise in its exact meaning, but clear in its implications of proactive growth for the individual. The descriptive sentence used in the survey emphasized that older persons could thrive as opposed to simply survive. Personal effectiveness conforms well to the World Health Organization's definition of health as, "a state of complete physical, mental and social well being" (Butler and Lewis, 1973, p. 18).

The goal of decision making was ranked number three by the experts. Here again, the emphasis seems to be a preventative one, in that decisions made today about life events have impact on tomorrow. Decision making is a process made up of a number of skills which can facilitate the level of the success of aging and consequently have a positive effect upon life satisfaction in later life. The goal ranked fourth, knowledge of the aging process, is a coordinate to decision making in that an accurate understanding of aging and its effects will stimulate the person to undertake preventative measures including decision making as a means of preparing for the future.

The ranking of the goals of problem resolution and behavioral change as numbers five and six, respectively, indicates that the panel takes a more client-centered approach to gerontological counseling. Experts seem to feel that counseling should focus on the aging individual as opposed to focusing on the problems of the individual. The rankings

given the goals and roles by the experts seem to indicate that gerontological counselors should be concerned with the personal and psychic responses older persons have to their problems, rather than exclusively focusing on the problems themselves. Problem resolution and behavioral change are processes undertaken today to remediate today's problems. Problems need resolution and behavior requires modification because preparation was inadequately accomplished. The battle between behaviorists and client-centered camps, briefly outlined in Chapter II, does not seem to be of major concern to the panel. The majority of the panel of experts do not appear to be behaviorists.

It is interesting to note that the goal of self-advocacy was ranked last by the panel. This ranking further strengthens the notion that the panel favors a preventative rather than a remedial approach. Even though the quantitative rating of self-advocacy was high, generating a mean score of 5.75, the relative low rank testifies to the low priority given it. The wording of the survey description would classify self-advocacy as a remedial goal rather than a developmental goal. This description made reference to referral to governmental and community agencies which may be construed by some as a remedial rather than a developmental task.

Three factors emerged from the factor analysis of the ratings given the goals by the experts. These three factors can be titled: knowledge and competencies of aging, concern for mental health and, being growth oriented. Factor one, knowledge and competencies of aging, was heavily loaded by goal six, knowledge of the aging process, and by goal three, decision making. These two goals refer to the acquisition of knowledge necessary to plan for aging by becoming aware of the

possible problems aging can cause, and the ability to exercise life skills, such as decision making so older persons can deal effectively with these problems. Factor two, concern for mental health, refers to the need to adjust to being an older person, to accommodate one's needs and desires to the reality of age. Adjustment and accommodation can be accomplished by being as physically, socially, and mentally active as possible. Factors three, being growth oriented, goes beyond adjustment and accommodation by referring to the desire to enjoy life to the fullest, to recognize the value of age, to develop fresh perspectives, and to be aware of and strive for developmental growth. These three factors contain both preventative and remedial aspects, but can be regarded as emphasizing a developmental perspective of aging. Indeed, the goals which can be most closely associated with a remedial or reactive approach to aging did not emerge to create distinct factors in the factor analysis. These goals are: goal one, problem resolution; goal two, behavioral change; and goal seven, self-advocacy.

Priority of Roles

The rank order to the counselors' roles confirmed by the panel of experts is more difficult to explain. The roles of preretirement counselor, personal counselor, and family counselor were ranked one, two, and three, respectively. These three roles have both preventative and remedial elements associated with them. While the role of pre-retirement counselor is preventative in nature, the descriptors used in the survey to identify the roles of personal counselor and family counselor were primarily remedial in function. The role ranked number four, in-service counselor educator, focused on the staff development skills of the gerontological counselor rather than on services to older persons which

the three top ranked roles include. The three bottom rated roles, financial counselor, medical support outreach counselor, and employment counselor, ranked 21, 20, and 18, respectively, are direct service oriented. The only commonality between these three is that they all refer to rather specific problems experienced by various segments of the older population. It is surprising that employment counselor was ranked so low, when numbers of older persons seek renumerative employment.

How Gerontological Counselors Assist Older Persons in Federally Supported Programs

The second purpose of this study focused on how gerontological counselors can assist older persons through federally supported aging programs. The confirmed goals and roles generated by the panel of experts describe the capabilities of gerontological counselors. The ratings assigned to these goals and roles by the AAA directors indicate that these goals are supportive of current AAA objectives. In fact, the AAA directors endorsed every goal and role as relevant to their current aims.

The mean score rating of conforming goals by AAA directors ranged from between 3.94 (behavioral change) and 5.79 (self-advocacy). By identifying the self-advocacy goal as number one, AAA directors underscored the importance of the physical service dimensions to their operations. The goal of self-advocacy relates directly to other AAA services considerations. Older persons who are counseled to act more assertively in their own behalf can avail themselves of a wider range of services which are contracted and monitored through AAAs. Through realization of the self-advocacy goal of gerontological counselors, the overall objectives of the AAAs could be measurably enhanced. It is interesting

to note that this particular goal was added by the panel of experts in their first round but subsequently they ranked it in last place.

Directors perceive the goal of behavioral change as the least important goal in terms of present AAA objectives. Apparently, AAA directors see the varied programs for which they contract and which they monitor to be producing services rather than stimulating behavioral change for older persons. The term, behavioral change, could be a misleading one for the AAA directors who may not be familiar with the incremental possibilities for change. The term may connote considerable modification of behavior which AAA directors may regard as inappropriate for their AAAs to foster.

The theme of emphasizing activities which can augment social type services was extended into the ratings of the conforming roles by the AAA directors. All but one of the top ranked conforming roles are social service oriented. In order, the five top ranked conforming roles were: services coordinator, change agent, service provider to persons living alone, employment counselor, and public relations worker. These roles which might be presently performed in PSAs by other personnel are seen by AAA directors as appropriately played by professional counselors. However, while role titles might be shared with other professionals, the manner in which the role is actualized by counselors could be far different. Personnel trained counseling skills could substantially modify the performance of each of these social service type roles.

The confirming roles seen by AAA directors as least conforming to public service area (PSA) objectives were: marital and sex counselor, ranked 21; counselor of the terminally ill, ranked 20; bereavement counselor, ranked 19, leisure time counselor, ranked 18; and medical

support outreach counselor, ranked 17. As compared to the top five ranked conforming roles, these last ranked conforming roles may not directly augment existing service programs contracted and monitored through Area Agencies on Aging. The degree of conformity these counseling roles would have to augment public service area objectives would perforce be lower than those roles with more obvious service program applicability. All conforming roles, however, were rated favorably by AAA directors, whose responses produced mean scores which ranged from 3.32 to 5.60, indicating a generally high congruence between counseling roles and public service area (PSA) objectives. Clearly, gerontological counseling roles, as perceived by AAA directors, are of central concern in the aging service network as it presently exists. It would not be necessary to modify objectives or organization to incorporate the goals and roles of gerontological counselors into the aging network.

Need for Gerontological Counselors

The third purpose of this study was to quantify the need for gerontological counselors. This purpose was addressed by examining the assisting goals and assisting role responses made by AAA directors. In Table 17, a comparison between conforming goals, which measure the degree of relevancy to the directors objectives, and assisting goals, which measure the degree to which goals could help older persons and between conforming roles and assisting roles is presented. A reasonable measure of the need for counselors in the aging service network can be ascertained by contrasting the conforming goal and conforming role response of AAA directors with their assisting goals and assisting roles responses. The question which generated the assisting goal and assisting

role rankings asked the degree to which these goals and roles would assist older persons in a particular public service area (PSA). This question made it necessary for directors to appraise the impact each goal and role would have upon older persons in their public service area (PSA). This appraisal may be construed as a measure of the need for gerontological counselors.

Table 17 shows that the mean score ratings for assisting goals were generally higher than those mean scores for conforming goals and that their mean score ratings produced a change in rank order. There are three features of these data which can assist in ascertaining need levels. The first is the actual mean score ratings. The only goals which were not rated higher as assisting goals were the two top ranked conforming goals, self-advocacy and personal effectiveness, both of which declined slightly in mean score when rated as assisting goals. The other five goals were rated higher as assisting goals than they were rated as conforming goals by AAA directors and therefore increased in mean scores between .14 and .39 points. The mean change was .17 points. These difference scores represent the second measure of need. Those assisting goals which received mean difference scores of .17 or above can be viewed as those goals which AAA directors regard as goals of increasing need. Goal two, behavioral change, increased .39 points between the AAA directors' appraisal of it as a conforming goal and their appraisal of it as an assisting goal, for the highest mean difference. Knowledge of the aging process was second with a mean score increase of .37, followed by problem resolution with a mean difference score of .26, decision making with a mean difference score of .18, and positive mental health with a mean difference score of .14. These mean score changes in an upward direction indicate that AAA directors view the goals of counselors as

substantially valuable to older persons in their PSA. The third data indicator was rank order. The difference in the AAA directors' ratings between conforming goals and assisting goals changed the rank order of three assisting goals. Problem resolution shows the most dramatic rank order change moving from the number three position as a conforming goal to the number one position as an assisting goal. Personal effectiveness moved from two to three and self-advocancy moved from one to two. These three data changes created a composite assisting goals' rating and ranking which indicate a generally high level of need for gerontological counseling in federally supported problems as perceived by AAA directors. The average mean score for assisting goals was 5.31 which is between a medial level of relevance five and a high level of relevance six.

It is believed that these difference scores between conforming goals and assisting goals are somewhat suppressed because of a tendency on the part of many AAA directors to rate conforming goals and assisting goals in an idential fashion. Apparently, some AAA directors regarded the two questions which asked for appraisals of the goals and roles from different perspectives as being two ways of asking the same thing. Several directors indicated their confusion and reported very similar, if not idential ratings, for both the conforming and assisting goals. The correlation between the sets of ordered pairs of conforming goals and assisting goals was +0.972, a high correlation. Perhaps directors reasoned that, if their ratings on assisting goals and assisting roles were too high, they would be indicating that their particular PSA was not functioning at peak effectiveness and that they were not reaching

desired performance levels. Such an attitude of protectionism would not be surprising in a relatively new agency, the guidelines for which seem to be in a frequent state of change. This apparent suppression of scores for assisting goals seemed to be equally true for assisting roles.

The factor analysis of the assisting goals as seen in Table 25 produced only one all-encompassing factor. This uni-factor result indicates that AAA directors did not discriminate among assisting goals as the experts had done, nor could they be expected to do so. AAA directors are primarily administrators who are not as familar with the field of counseling as are the experts. It is appropriate that the experts could identify and confirm goals and roles while directors would assess their relevance for aging services network.

AAA directors generated mean scores for assisting roles substantially higher than mean scores for conforming roles. These mean scores for assisting roles ranged from 3.87 to 5.66, thus attesting to a higher level of need than the conforming roles would have indicated alone. Only one role, gerontological researcher, was rated lower as an assisting role. AAA directors apparently feel that enough research is being conducted already; indeed, several letters from AAA directors so implied. Perhaps AAA directors are more action and application oriented than research oriented. All other conforming roles, however, were ranked highly. The five most highly ranked assisting roles were, again, clearly social service augmentation roles. Two changes in rank order did occur between conforming roles and assisting roles. The role of financial counselor moved from a ranking of 10 to the number three ranking, while the employment counselor role slipped from the four to the six ranking. The dramatic rise in ranking for the financial counselor role underscores

the importance of the monetary and consumer decision making needs of older persons. The fact that the roles of services coordinator, change agent, service provider to persons living alone, and public relations worker remained in the top five ranked confirming roles is evidence of the importance given to these social service roles by AAA directors.

The conforming role ratings also reordered the roles at the bottom of the list. In ascending order, the roles of marital and sex counselor, ranked 21, leisure time counselor, ranked 20, educational counselor, ranked 19, gerontological researcher, ranked 18, and bereavement counselor, ranked 17, emerged as the least important roles to assist older persons in public service areas (PSA) as perceived by AAA directors. Education counselor and gerontological researcher did not appear on this lower five role ranking when they were evaluated as conforming roles by AAA directors. The mean difference of +.376 is considerably higher for the assisting roles than the +.174 difference generated by the assisting goals' rating. There were eight confirming roles which rated above this .376 mean difference. These eight can be considered the roles which AAA directors view as being deficit roles and are therefore needed in the public service areas (PSA). They are: medical support outreach counselor, with a mean score difference between its rating as a conforming role and as an assisting goal of .90; counselor of the terminally ill, .86; preretirement counselor, .79; family counselor, .75; bereavement counselor, .69; marital and sex counselor, .55; service provided to nursing home and housing complex residents, .50; and financial counselor, .41. By rating these eight roles above the mean score difference, AAA directors made a clear statement that these services either do not exist

in their public service areas (PSAs) or exist at inadequate levels to meet the assessed demand.

The factor analysis of the assisting roles produced five factors (Table 27). These factors were discernable. Factor one which might be named "concern for death and dying" was heavily loaded by bereavement counselor and counselor to the terminally ill roles. Factor two might be termed "community action," in that the role of change agent was heavily loaded here. Factor three is the "employment" factor having been loaded by the employment counselor role. Factor four is of only moderate clarity and may be termed "environmental counseling" due to the loading of financial and family counselor, each of which may be regarded as environmental concerns. Factor five is the "educational concerns" factor, being heavily loaded by the educational roles of educational counselor, specialist in psychological education, and in-service counselor educator.

Gerontological Counseling Sites

The fourth purpose and research question of the study was to identify appropriate sites for gerontological counselors, locations where they best might pursue their goals and execute their roles within the federally funded aging services network. Both the panel of experts and AAA directors were asked to react to 13 possible placement sites on a seven point Likert scale. There was much more agreement between the two groups with regard to the ranking of sites than to the ranking of goals and roles. A correlation of +0.584 was produced between expert site responses of the experts and site responses of AAA directors. For only four sites were significant differences registered between the experts' and AAA directors' responses. These four were: AAA offices, mental health centers, adult congregate nutrition sites, and retirement projects.

Directors of AAAs rated AAA offices, mental health centers, and retirement projects significantly lower, and adult congregate nutrition sites significantly higher than did the experts.

There was substantial agreement between experts and AAA directors in rankings for the top five ranked sites. Both experts and AAA directors ranked senior centers as their number one site. Experts rated mental health centers number two, nursing homes, number three, hospice programs, number four, and adult congregate living facilities, number five. AAA directors placed adult congregate nutrition sites, second, adult congregate living facilities, third, hospice programs, fourth, and nursing homes, fifth. Directors of AAAs ranked mental health centers, number seven, while experts placed adult congregate nutrition sites tenth. Mean score ratings for sites by both experts and AAA directors were substantially higher than those for roles. The range of mean score ratings by experts was from 4.21 to 6.17 (range, 196), while the ratings by AAA directors ranged from 4.18 to 5.99 (range, 191). The mean scores of all ratings for all sites were 5.28 and 5.19, respectively, for experts and directors which places the overall degree of relevance for gerontological counseling between above medial and high relevances.

Conclusions

A number of interesting and useful conclusions may be made based upon the findings of this study.

1. A small number (N=41) of gerontological counseling experts does exist in this country. These experts agree on the purposes, the

activities, and the capabilities of gerontological counselors. This panel of experts is geographically diverse but homogeneous in its appraisal of the goals, roles, and sites most appropriate for the specialty of gerontological counseling.

2. Lists of confirmed goals and roles for counselors of older persons generated by the group of experts provide a comprehensive overview and thorough description of gerontological counseling. This description and overview are valuable to both the specialty of gerontological counseling and to the federally supported aging network by providing the bases for job descriptions and accountability measures for counselors who work in service programs contracted and monitored through Area Agencies on Aging (AAA).

3. The confirmed goals for gerontological counselors cluster around three factors: knowledge and competencies of aging, concern for mental health, and being growth oriented. Confirmed roles are a combination of three themes: direct service, staff development, and community outreach. The various roles all cluster around these themes.

4. Gerontological counseling experts favor a preventative, developmental, positive, growth approach to counseling older persons rather than a remedial, reactive, or crisis oriented approach. However, they recognize the need for both preventative and remedial services for older persons. At the theoretical level, experts seem to favor a client-centered as opposed to a behavioral approach to counseling older persons.

5. A high degree of conformity exists between gerontological counselors' goals and roles and aging services network objectives. AAA directors endorsed all goals and roles which were identified and

confirmed by counseling experts. At the same time, AAA directors emphasize goals and roles which seem to augment or facilitate the accomplishment of services which meet the material needs of older persons. Counselors' goals and roles which seem to be oriented more toward the individual than toward a program are evaluated by AAA directors as being of lower priority to the objectives of the PSA.

6. The generally high level of congruence between the objectives of AAA programs and the goals and roles of gerontological counselors, leads to the conclusion that gerontological counselors can be readily incorporated into, and substantially beneficial to, the federally supported aging services network. Now that their goals and roles have been clarified, and demonstrated relevant for integration into the aging services network, gerontological counselors need only be given the opportunity to exercise their competencies to assist older persons in federally supported aging network programs.

7. Directors indicate a very high need for the services which gerontological counselors can provide. AAA directors rate the goal of problem resolution as the number one counselor goal, and the role of services coordinator--enchancer--client advocate, as the number one counseling role.

8. Directors perceive the counselor roles of services coordinator, change agent, service provider to persons living alone, employment counselor, and public relations worker as those roles most conforming to the present objectives of federally supported aging services.

9. Directors identified the following eight counselor roles as being of greatest deficiency within the aging services network: medical outreach support counselor, counselor of the terminally ill,

preretirement counselor, family counselor, bereavement counselor, marital and sex counselor, service provider to nursing home and housing complex resident, and financial counselor.

10. Experts and AAA directors generally agree on the appropriate placement sites for gerontological counselors. The senior center site was ranked number one by both experts and AAA directors.

11. Experts and AAA directors agree with respect to the specific goals and roles gerontological counselors can play within the aging services network but generally disagree with respect to the priority of goals and roles each group perceives as most appropriate to assist older persons.

Implications

1. These data regarding counseling goals and roles for gerontological counselors can serve to provide: (a) guidelines for professional behavior, and (b) baselines for pre-service and in-service education programs. Counselors should now be prepared to deal with the primary concerns of the aging services network so they can effectively augment and enhance the manner and direction of existing programs.

2. These data should help to stimulate an increased dialogue and enhanced respect between counselors and aging services network personnel. Evidence of similarity in their points of view regarding the goals and roles of counselors for older persons demonstrates the congruence of their purposes, even though their priorities differ.

3. This study should demonstrate to policy makers and legislative planners at the national and state levels that counseling is directly applicable to, and clearly needed in, the federally supported aging

services network. AAA directors nationwide have given clear testimony to the need for gerontological counselors in their public service areas (PSA). This study, provides an operational definition of counseling as it relates to older persons. This definition, and other data from this study could have an impact on the focus of some parts of future aging legislation. Sometimes critized for failure to recognize the phycho-social needs of older persons, federal legislation may now address these needs which have substantial impact upon older persons and their ability to take full advantage of existing programs.

4. Evidence that gerontological counseling experts support a preventative rather than a remedial approach to counseling older persons opens up significant opportunities for the profession to develop counseling strategies, models, and time schedules more directly applicable to the needs of older persons.

5. The knowledge gained in this study can provide the basis for developing a theoretical framework for gerontological counseling so necessary for future research. Such a framework might well contribute to theories about aging.

6. By giving support to the need for more counseling activites within the aging network, this study can be of significant value to older persons themselves, the recipients of the services of aging programs.

7. As a result of taking part in this research, participating AAA directors will have a greater awareness and increased understanding of counseling. Almost 30% of all AAA directors gave direct input into this study. Hopefully these and other directors will take steps to incorporate more counseling activities into the services for which they contract and which they monitor. Examples of such efforts might be in-service

education for program staff in counseling skills and the values of counseling. Directors well may raise the priority of counseling or more assertively monitor sites where counseling is presently offered in order to enhance the quality of this service.

8. This study has identified priorities for counseling services for older persons, as visualized by gerontological counseling experts and by AAA directors. In the case of services given lower priority, two actions seem possible. In the first place, appropriate information programs could provide AAA directors with a greater understanding of and appreciation for counseling services. One example would be leisure counseling. In the second place, some of the counseling services given lower priority might better be provided outside the aging services network and in such settings as community colleges, state employment offices, and medical facilities. In this event, the development of linkages between the aging services network and other organizations concerned with older persons would become very important.

Suggestions for Further Research

Further research in gerontological counseling will hopefully continue so that the most effective services possible can be offered to those older persons in need within the boundaries of available resources. Specific recommendations for research coming from this study are clustered in five different areas.

The first area is concerned with the functions of gerontological counseling. With a clear understanding of the goals and roles of counseling older persons, it is imperative that further study attempts to identify the specific behavioral functions which counselors would be

most effective in using with each counseling role. The distinction between function and role is that function is an incremental part of the larger concept of role. A role is composed of many functions. Research concentrating on what kinds and intensity of functions are most appropriate with each role would assist counselors in injecting increased confidence, efficiency and effectiveness into their work.

The second area involves further studies to assist aging program administrators and professional counselors to arrange their goal and role priorities in more aligned patterns. The differences in priority emphases given counseling goals and roles by AAA directors and counseling experts should be resolved so that the best possible programs for older persons can be developed within existing aging services. Further research is needed to create strategies targeted at developing concensus among the counseling professionals and the aging services network.

The third area concerns the need for studies which measure the specific impact that counseling services have on aging programs in public service areas (PSA). One effective way to perform these impact studies would be to establish several pilot PSA sites where the necessary counseling personnel would be given freedom to establish programs of direct service, community outreach, and staff development. With appropriate controls and sufficient time, reasonably accurate assessment of the impact of counseling could be measured and analyzed.

Because of the fact that the specialty of gerontological counseling is still in its early stages of growth, the literature does not yet include a comprehensive discussion of counseling strategies, models and techniques on any broad scope. Research is needed in this fourth area to verify particular methods for counseling older persons.

Finally, additional research is necessary to identify constructs which can be utilized to create a theoretical foundation for gerontological counseling. At present, two approaches are utilized: first, a developmental approach to counseling older persons, emphasizing a preventative, growth perspective; and, second, a problems approach emphasizing remedial, crisis-type counseling. Research projects should analyze the benefits and deficiencies of each approach and perspective.

It is hoped that these data will not be interpreted by reviewers as advocating a unilateral approach to helping older persons. The concerns of older persons are multidimensional and demand professional counseling services which are equally comprehensive in nature. The individual itemization of the roles for gerontological counselors which these data outline, must not be construed as advocating a single concern approach to older persons. Counselors serving the older population must be educated to serve the composite of the individual person rather than focusing on one or two problems alone. Persons who are narrowly trained to function, for example, as a financial counselor, cannot be regarded as assisting older persons in the breath nor depth with which a professionally educated gerontological counselor could. Older persons, no less than anyone else, deserve a level of excellence which will continuously assure that they are the recipients of the best in human services which our society has to offer.

APPENDIX A

LETTER AND SURVEY TO COUNSELOR EDUCATION DEPARTMENT CHAIRPERSONS

NGCS The National GERONTOLOGICAL COUNSELING Study

c/o Richard P. Johnson
4715 NW 40th Street
Gainesville, Florida 32601

Dear Counseling Department Chairperson,

This letter is the first step of a five phase national study attempting to specify the goals and roles of gerontological counseling. The five minutes necessary for you to complete this survey will be the only instance your time will be requested.

This study is funded by a dissertation grant from the Administration on Aging (AoA) and is endorsed by the APGA Committee on Adult Development and Aging. It could have important implications for the specialty of counseling older persons. The study will:

1. identify a national sample of gerontological counseling experts.
2. generate an expert confirmed list of goals and roles for counselors of older persons.
3. communicate to and solicit feedback from a national sample of Areawide Agency on Aging (AAA) directors.

All department heads who participate in this first phase will receive a succinct summary of findings at the termination of the study.

Please complete the short survey on the reverse side of this letter and return in the enclosed addressed envelope. Your speedy disposal of this item is appreciated. I have established **October 20, 1979** as the suspense date for this first phase. Your cooperation is invited.

Thank you for your time and consideration.

Sincerely,

Richard P. Johnson
Project Coordinator

APPENDIX B

FIRST ROUND AND LETTER SURVEY TO GERONTOLOGICAL COUNSELING EXPERTS

The National
GERONTOLOGICAL COUNSELING
Study

1. Is there a gerontological counseling expert in your department, division, school, college or section? For the purpose of this study, a gerontological counseling expert is a person who fulfills both of the following criteria:
   1. A counselor educator or counseling psychologist.
   2. Has taught a complete semester or quarter course(s) exclusively devoted to gerontology in some respect. This course could be "counseling older persons", "the psychology of aging", "social gerontology", etc., as long as its exclusive subject matter is gerontological in nature.

☐Yes ☐No

Name of expert _____
Title _____
Institution _____
Address _____
_____ Zip _____

If answer is "no": are any courses taught in your department which are partially devoted to gerontological counseling?

☐Yes ☐No

_____ % devoted to gerontology

name of course(s) _____

2. Would you offer a gerontological counseling course if instructors with an adequate background were available?

☐Yes ☐No

reasons: _____

3. Do you receive inquiries and requests for counselors of older persons?

☐Yes ☐No

explain: _____

4. Do you forsee an increasing demand for gerontological counseling?

☐Yes ☐No

comments: _____

5. Would you like to receive the newsletter of the APGA Committee on Adult Development and Aging?

☐Yes ☐No

6. Number of faculty members in your counseling department _____

7. Number of students presently enrolled _____

8. Is your institution in an urban or rural setting _____

9. Counseling degrees offered in your program _____

☐Masters ☐Ed.S. ☐Ed.D./Ph.D.

10. Your personal counseling specialities.... _____

THANK YOU

APPENDIX B--Continued

The National
GERONTOLOGICAL COUNSELING
Study

c/o Richard P. Johnson
4715 NW 40th Street
Gainesville, Florida 32601

phase two
November 2, 1979

Dear Gerontological Counseling Expert,

In the first phase of this national study you were selected as one of a panel of gerontological counseling experts. You were identified by your department head as meeting the criteria specified and/or by your contribution to the field. In this second phase, I am requesting that you take the 10 to 15 minutes necessary to react to the enclosed survey and to provide minimal demographic information.

This study is funded by a dissertation grant from the Administration on Aging (AoA) and is endorsed by the APGA Committee on Adult Development and Aging. It could have important implications for the specialty of counseling older persons. The study will:

1. identify a national sample of gerontological counseling experts (of which you are one).

2. generate an expert confirmed list of goals and roles for counselors of older persons.

3. communicate to and solicit feedback from a national sample of Areawide Agency on Aging (AAA) directors.

The goals and roles appearing on the enclosed survey form are those suggested in existing gerontological counseling literature as being relevant for the practitioner. The specialty of gerontological counseling has a need to define its goals and roles so that they can be communicated to counselors, counselor educators, legislative policy makers, and to the public. Your participation in this study can measurably assist this effort.

Your responses will be compiled with those of the other panel members and sent back to you a second time for your further review and final confirmation. This refined list, generated by experts in the profession, will then be sent to AAA directors for their feedback. All participants in this study will be sent a succinct summary of the findings at the termination of the study.

Please complete the enclosed survey and the requested information on the reverse side of this letter. Mail them both back in the enclosed, addressed envelope. Your speedy disposal of this item is appreciated. If at all possible for you, I would like to set November 15, 1979 as the suspense date for this phase. Your cooperation is invited.

Very truly yours,

Richard P. Johnson
Project Director

APPENDIX B--Continued

phase two

Gerontological Counseling Expert Information Form

Please fill in the following requested information and mail it back with the enclosed survey form:

Name of Expert _____

Title _____

Institution _____

Address _____

_____ Zip _____

Phone _____

1. Full name of the department to which you are most closely associated.

Department _____

School of College _____

2. Name(s) of gerontology course(s) which you teach:
(course outlines would be greatly appreciated)

_____

_____

_____

3. List any contributions you have made to the field of gerontology.

_____

_____

_____

4. What is your preparation in gerontology?

_____

_____

_____

5. Institution where you received your highest degree.

_____ degree _____

what subject area? _____

6. What is your preparation in counseling?

_____

_____

_____

7. Other than gerontology, what are your particular specialities?

_____

_____

_____

APPENDIX B--Continued

Gerontological Counseling Expert Survey I

The
National Gerontological Counseling
Study

DIRECTIONS: Listed below is the list of gerontological counseling goals and the list of roles abstracted from the literature. Please rate the degree of relevance (value) you perceive each goal and role as having for use as a guideline for gerontological counselors according to the following scale:

1. . . . VERY LOW relevance . . .
2. . . . LOW . . . relevance
3. . . . BELOW MEDIAL relevance . . .
4. . . . MEDIAL . . . relevance . . .
5. . . . ABOVE MEDIAL relevance . . .
6. . . . HIGH relevance . . .
7. . . . VERY HIGH relevance . . .

Please write in the spaces marked "others" any additional goals or additional roles that you perceive as important (i.e. value as a guideline for gerontological counselors) for the profession. Your combined responses will be regarded as a measure of confirmation of these goals and roles. Your time and patience is appreciated.

GOALS

1 2 3 4 5 6 7 (1) Problem Resolution: counseling aimed at assisting persons in solving problems that they are unable to solve themselves.

1 2 3 4 5 6 7 (2) Behavioral Change: counseling aimed at a redirection of typical responses to frustrations or different attitudes toward other people or self.

1 2 3 4 5 6 7 (3) Decision Making: counseling aimed at stimulating the individual to evaluate, make, accept, and act upon his/her own choice.

1 2 3 4 5 6 7 (4) Positive Mental Health: counseling aimed at behavioral integration, adjustment, positive identification with others, accept responsibility and independence.

1 2 3 4 5 6 7 (5) Personal Effectiveness: counseling aimed at enabling persons to thrive and not merely survive.

1 2 3 4 5 6 7 (6) Other _____

1 2 3 4 5 6 7 (7) Other _____

ROLES

1 2 3 4 5 6 7 (1) Service Provider to persons living alone: widow support groups, informational services, assertiveness training, communication skills training, support in seeking new social contacts.

1 2 3 4 5 6 7 (2) Bereavement Counselor: empathy and strong emotional support to those mourning a lost loved one.

1 2 3 4 5 6 7 (3) Change Agent: dispel myths about the aged in the community, stimulate positive change in services offered to the elderly.

APPENDIX B--Continued

1 2 3 4 5 6 7 (4) Personal Counselor: personal counseling services to those experiencing the effects of aging.

1 2 3 4 5 6 7 (5) Consultant: process consultation to aging network agencies, and mental health consultation to professionals (doctors, lawyers, accountants, etc.) dealing with the elderly.

1 2 3 4 5 6 7 (6) Specialist in psychological education: human relations training to those who deal with the elderly as well as directly to the elderly population.

1 2 3 4 5 6 7 (7) Employment Counselor: assisting the elderly with their vocational needs and aspirations.

1 2 3 4 5 6 7 (8) Services Coordinator - Services Enhancer - Client Advocate: facilitating the proper "services mix" for the individual client, maximizing the quality of services any agency is capable of giving, supportive assistance in expediting services.

1 2 3 4 5 6 7 (9) Financial Counselor and Manager: consumer information and support so elderly can maximize their health, housing, and services dollar.

1 2 3 4 5 6 7 (10) In-Service Counselor-Educator: offering in-service programs to aging network staffs on gerontological issues and techniques in dealing with elderly.

1 2 3 4 5 6 7 (11) Leisure Time Counselor: assisting elderly in identifying avocational interests, thereby fostering the meaningful use of time.

1 2 3 4 5 6 7 (12) Marital and Sex Counselor: assisting healthy marital adjustment for elderly couples, offering accurate information on matters of sex.

1 2 3 4 5 6 7 (13) Outreach Agent to Minorities: understanding unique problems of minority elderly and proactively seeking their participation in service programs.

1 2 3 4 5 6 7 (14) Service Provider to nursing home and housing complex residents: helping residents adjust to reality of declining health, communication skills, health care training, time and life review, peer counselor training.

1 2 3 4 5 6 7 (15) Preparation for Death Counselor: assisting those terminally ill in decision making, alternatives scanning, opportunities for personal independence and control.

1 2 3 4 5 6 7 (16) Pre-Retirement Counselor and Educator: assist older persons making the transition from the work role to the retirement role.

1 2 3 4 5 6 7 (17) Public Relations Worker: information to the community to sensitize them to their own aging and the needs of the aged.

1 2 3 4 5 6 7 (18) Gerontological Researcher: conducting local needs assessments, studying counseling strategies, demographic data collecting, etc.

1 2 3 4 5 6 7 (19) Other: _____

_____

_____

1 2 3 4 5 6 7 (20) Other: _____

_____

_____

THANK YOU

APPENDIX C

SECOND ROUND LETTER AND SURVEY TO GERONTOLOGICAL COUNSELING EXPERTS

NGCS The National GERONTOLOGICAL COUNSELING Study

c/o Richard P. Johnson
4715 NW 40th Street
Gainesville, Florida 32601

phase three

expert: _____

January 10, 1980

Dear Gerontological Counseling Expert:

Let me first thank you for your kind participation in this study. Of the 101 potential panel members identified, fully 70 responded to the survey. I am most gratified at this conscientious display of commitment to an emerging and much needed counseling speciality. Those who participate in this second, and most important, round of the study will be listed along with their institution in the final report when it is delivered to AoA in Washington, D.C. this Spring.

You will recognize the second page as very similar to the survey form to which you formerly reacted. Several important changes have been made to this form however. First, you will notice that the means and standard deviations for the entire panel appear to the left of the rating scale for each item. Secondly, your rating of that particular goal or role on the first round appears to the right of each rating scale. Thirdly, two additional goals and three additional roles appear below the heavy line in each section. These additions are the result of first round responses which were compacted into their present form from the 28 additional goals and 13 additional roles suggested by the panel. There were many duplicates and overlaps among these suggestions. Again, let me ask you to thoughtfully respond to the goals and roles statements. Your responses in this second round will be the final confirmation of the lists before they are sent to AAA executive directors for their appraisal, and before they can be confidently identified as appropriate for gerontological counselors.

For the purpose of this study the following definitions have been accepted for the concepts of "goal" and "role." These may be helpful to you in your rating determinations:

Counseling goal: the end result sought or, the objective which counseling strives to accomplish.

Counseling role: expectations and directives for behavior connected with the counseling position.

On the reverse side of this letter you will find a short survey regarding the possible placement sites in the aging network where gerontological counselors would most beneficially serve older persons. Let me ask you to patiently react to these potential placement sites.

At the termination of this study you will be sent a synopsis report of the findings which I trust will be useful to you in your teaching, writing, and service endeavors in the aging field. Several panel members have forwarded copies of course outlines which they teach. All such outlines dealing with gerontological counseling will be gratefully received.

Thank you once again for your valuable time and thoughtful consideration. Feeling the need to move along with the project, I would like to ask you to have the survey in the mail by January 20th. Your cooperation is most heartily appreciated.

Sincerely,

Richard P. Johnson

APPENDIX C--Continued

$\bar{X}$ = 6.00 SD = 1.14	1 2 3 4 5 6 7	(5) Consultant: process consultation to aging network agencies, and mental health consultation to professionals (doctors, lawyers, accountants, etc.) dealing with the elderly.
$\bar{X}$ = 6.07 SD = 1.05	1 2 3 4 5 6 7	(6) Specialist in psychological education: human relations training to those who deal with the elderly as well as directly to the elderly population.
$\bar{X}$ = 5.41 SD = 1.30	1 2 3 4 5 6 7	(7) Employment Counselor: assisting the elderly with their vocational needs and aspirations.
$\bar{X}$ = 5.19 SD = 1.53	1 2 3 4 5 6 7	(8) Services Coordinator - Services Enhancer - Client Advocate: facilitating the proper "services mix" for the individual client, maximizing the quality of services any agency is capable of giving, supportive assistance in expediting services.
$\bar{X}$ = 5.02 SD = 1.36	1 2 3 4 5 6 7	(9) Financial Counselor and Manager: consumer information and support so elderly can maximize their health, housing and services dollar.
$\bar{X}$ = 6.19 SD = 1.07	1 2 3 4 5 6 7	(10) In-Service Counselor-Educator: offering in-service programs to aging network staffs on gerontological issues and techniques in dealing with elderly.
$\bar{X}$ = 5.63 SD = 1.21	1 2 3 4 5 6 7	(11) Leisure Time Counselor: assisting elderly in identifying avocational interests, thereby fostering the meaningful use of time.
$\bar{X}$ = 5.65 SD = 1.23	1 2 3 4 5 6 7	(12) Marital and Sex Counselor: assisting healthy marital adjustment for elderly couples, offering accurate information on matters of sex.
$\bar{X}$ = 5.56 SD = 1.18	1 2 3 4 5 6 7	(13) Outreach Agent to Minorities: understanding unique problems of minority elderly and proactively seeking their participation in service programs.
$\bar{X}$ = 5.85 SD = 1.06	1 2 3 4 5 6 7	(14) Service Provider to nursing home and housing complex residents: helping residents adjust to reality of declining health, communication skills, health care training, time and life review, peer counselor training.
$\bar{X}$ = 6.04 SD = 0.97	1 2 3 4 5 6 7	(15) Counselor for the Terminally Ill: assisting those terminally ill in decision making, alternatives scanning, opportunities for personal independence and control.
$\bar{X}$ = 6.41 SD = 0.80	1 2 3 4 5 6 7	(16) Pre-Retirement Counselor and Educator: assist older persons making the transition from the work role to the retirement role.
$\bar{X}$ = 5.56 SD = 1.37	1 2 3 4 5 6 7	(17) Public Relations Worker: information to the community to sensitize them to their own aging and the needs of the aged.
$\bar{X}$ = 5.68 SD = 1.31	1 2 3 4 5 6 7	(18) Gerontological Researcher: conducting local needs assessments, studying counseling strategies, demographic data collecting, etc.

PANEL IDENTIFIED ROLES

1 2 3 4 5 6 7	(19) Family Counselor: working with elderly parents and their adult children to assist both groups in coping with newly emerging problems associated with age.
1 2 3 4 5 6 7	(20) Educational Counselor: assisting older persons in participating in educational opportunities; developing linkages within the community between existing educational resources; and encouraging new educational services.
1 2 3 4 5 6 7	(21) Medical Support Outreach Counselor: assisting physicians in giving more comprehensive care to elderly patients, both in the office and in the home.

THANK YOU

APPENDIX C--Continued

phase three

Gerontological Counseling Expert Survey II

DIRECTIONS: Listed below is the modified list of gerontological counseling goals and the modified list of gerontological counseling roles which you rated in the first round of this study. The first round expert panel added two goals and three roles to the original lists. The mean scores and standard deviations obtained in the first round rating appear to the left of each item rating scale. The rating that you personally gave to each goal and role is also listed to the right of each rating scale, in pencil. Please rate once again, the degree of relevance (value) you perceive each goal and role, including the newly identified ones, as having for use as guidelines for gerontological counselors according to the following scale:

1. . . . VERY LOW relevance . . .
2. . . . LOW relevance . . .
3. . . . BELOW MEDIAL relevance . . .
4. . . . MEDIAL relevance . . .
5. . . . ABOVE MEDIAL relevance . . .
6. . . . HIGH relevance . . .
7. . . . VERY HIGH relevance . . .

GOALS

$\bar{X}$ = 5.92 SD = 1.11	1 2 3 4 5 6 7	(1) **Problem Resolution:** counseling aimed at assisting persons in solving problems that they are unable to solve themselves.
$\bar{X}$ = 5.90 SD = 1.15	1 2 3 4 5 6 7	(2) **Behavioral Change:** counseling aimed at a redirection of typical responses to frustrations or different attitudes toward other people or self.
$\bar{X}$ = 6.12 SD = 1.12	1 2 3 4 5 6 7	(3) **Decision Making:** counseling aimed at stimulating the individual to evaluate, make, accept, and act upon his/her own choice.
$\bar{X}$ = 6.53 SD = 0.74	1 2 3 4 5 6 7	(4) **Positive Mental Health:** counseling aimed at behavioral integration, adjustment, positive identification with others, accept responsibility and independence.
$\bar{X}$ = 6.58 SD = 0.70	1 2 3 4 5 6 7	(5) **Personal Effectiveness:** counseling aimed at enabling persons to thrive and not merely survive.

PANEL IDENTIFIED GOALS

	1 2 3 4 5 6 7	(6) **Knowledge of the Aging Process and its Effects:** counseling aimed at awareness, knowledge of age related changes, self-acceptance, and striving for optimal functioning within the limitations imposed by aging
	1 2 3 4 5 6 7	(7) **Self-Advocacy:** counseling aimed at developing self-advocacy techniques and actions, including information about and referral to governmental/community agencies.

ROLES

$\bar{X}$ = 5.87 SD = 1.45	1 2 3 4 5 6 7	(1) **Service Provider** to persons living alone: widow support groups, informational services, assertiveness training, communication skills training, support in seeking new social contacts.
$\bar{X}$ = 5.85 SD = 1.07	1 2 3 4 5 6 7	(2) **Bereavement Counselor:** empathy and strong emotional support to those mourning a lost loved one.
$\bar{X}$ = 5.95 SD = 1 32	1 2 3 4 5 6 7	(3) **Change Agent:** dispel myths about the aged in the community, stimulate positive change in services offered to the elderly.
$\bar{X}$ = 6.09 SD = 0.96	1 2 3 4 5 6 7	(4) **Personal Counselor:** personal counseling services to those experiencing the effects of aging.

APPENDIX C--Continued

Survey

Possible Placement Sites for Gerontological Counselors
Within the Emerging Aging Network

The following is a list of possible placement sites for gerontological counselors. Please rate each possible site according to the following scale.

"In my opinion, a gerontological counselor can be of 1 - 2 - 3 - 4 - 5 - 6 - 7 benefit to older persons if placed here."

1. minimum
2. low
3. below medial
4. medial
5. above medial
6. high
7. maximum

1 2 3 4 5 6 7	Senior Centers
1 2 3 4 5 6 7	Area Agencies on Aging
1 2 3 4 5 6 7	Mental Health Centers
1 2 3 4 5 6 7	Nursing Homes
1 2 3 4 5 6 7	Adult Congregate Living Facilities
1 2 3 4 5 6 7	Adult Congregate Nutrition Sites
1 2 3 4 5 6 7	Retirement Projects
1 2 3 4 5 6 7	Day Care Centers
1 2 3 4 5 6 7	Hospice Programs
1 2 3 4 5 6 7	Homemakers Programs
1 2 3 4 5 6 7	Respite Care Programs
1 2 3 4 5 6 7	Housing Projects
1 2 3 4 5 6 7	Physicians' Offices
1 2 3 4 5 6 7	_____ (others)
1 2 3 4 5 6 7	_____
1 2 3 4 5 6 7	_____
1 2 3 4 5 6 7	_____

APPENDIX D

FIRST REMINDER LETTER TO GERONTOLGOCIAL COUNSELING EXPERTS

NGCS The National GERONTOLOGICAL COUNSELING Study

c/o Richard P. Johnson
4715 NW 40th Street
Gainesville, Florida 32601

February 8, 1980

Dear

I hope this letter finds you well and working to capacity. Several weeks ago you should have received a second letter and follow-up, confirming survey form covering gerontological counseling goals and roles. I am writing to you once again because we have not as yet received your completed form. Perhaps you never got the letter, or perhaps you didn't realize that your responses are very important to the eventual success of this study.

I would like to ask you once again if you could respond to the enclosed survey form in its entirety and mail it back to me at your earliest convenience. I realize that the letter arrived at precisely the wrong time, when you were beginning a new semester or quarter. Please let me apologize for this inconvenience. Your participation in this second phase is most urgently needed and equally appreciated.

Looking forward to your response, I shall, as I have stated previously, ensure that you receive a summary of the findings of this study at its termination.

Sincerely,

Richard P. Johnson
Project Director

RPJ:cml

Enclosure

APPENDIX E

SECOND REMINDER LETTER TO GERONTOLOGICAL COUNSELING EXPERTS

NGCS The National GERONTOLOGICAL COUNSELING Study

c/o Richard P. Johnson
4715 NW 40th Street
Gainesville, Florida 32601

March 15, 1980

Dear

The National Gerontological Counseling Study is nearing its end. We will soon be processing the responses of the counseling experts and the AAA Executive Directors through the computer.

There are just a very few of the counseling panel who we have not heard from. Perhaps our letters are getting crossed in the mail, but we have not received your last response questionnaire. There are only a very few needed to reach a 100% participation rate among counselors - you are one.

May I ask that you look at this second survey at your earliest convenience and take the 5-10 minutes necessary to complete it. Once we receive your response we can process the data and send all those concerned a summary of the findings of this study which you can hopefully use in your classes and or writing.

Thank you so much for your cooperation.

Appreciatively

Richard P. Johnson
Project Director

RPJ/mpz

Enclosure

APPENDIX F

LETTER AND SURVEY TO AAA DIRECTORS

NGCS The National GERONTOLOGICAL COUNSELING Study

c/o Richard P. Johnson
4715 NW 40th Street
Gainesville, Florida 32601

phase four

Dear AAA Executive Director:

The Administration on Aging has funded this study which seeks to determine the degree to which gerontological counseling services could be offered to older persons through Area Agency on Aging programs. We are especially interested in learning the degree to which you, as an Executive Director, see counseling as assisting older persons.

Your planning and service area (PSA) was selected from a national sample and I shall greatly appreciate your assistance in taking 10 to 15 minutes of your time to complete the attached survey. Your views on counseling could have important implications for the future direction and scope of this helpful service which could enable older persons to improve the quality of their lives.

The attached survey lists seven (7) counseling goals and twenty-one (21) roles for gerontological counselors. These goals and roles were reviewed and agreed upon by a national panel of specialists in gerontological counseling. You will also find on the survey form a list of possible placement sites where counselors could work. Please rate these sites as most favorable or unfavorable for counseling older persons. Would you rate all sites listed eventhough some may not exist in you PSA. Please respond to all items and, if at all possible, mail the completed form back in the enclosed, stamped envelope by March 1st.

Your cooperation is most heartily appreciated and will be most helpful to the successful completion of this study. I shall be glad to send to you a summary of the findings.

Thank you again for your time and consideration. I am looking forward to your reply.

Sincerely,

Richard P. Johnson
Project Director

APPENDIX F--Continued

DEMOGRAPHIC DATA

1. Name: _____
   (of AAA Director completing the survey)
2. Full Address: _____
   _____
   _____ zip _____
3. Age: ☐ 25-34 ☐ 35-44 ☐ 45-54 ☐ 55-64 ☐ 65 and over
4. Sex: ☐ Female ☐ Male
5. Years of schooling: _____
6. Graduate Degree(s): ☐ masters ☐ specialist (sixth year)
   ☐ Ph.D. or Ed.D. ☐ other _____
7. Predominent setting of planning and service area:
   ☐ Urban ☐ Suburban ☐ Rural ☐ Mixed
8. Number of employees on your AAA staff: _____

Gerontological Counseling Survey

Directions: Outlined below is the list of counseling goals and the list of counseling roles which were reviewed and agreed upon by a national panel of specialists in gerontological counseling. Please rate each goal and each role on both of the 7 point rating scales. The scale to the left of the goal or role and the scale to the right refer to different questions. Circle the number which best describes your present opinion on each question for all 7 goals and all 21 roles.

1. very low degree
2. low degree
3. below medial degree
4. medial degree
5. above medial degree
6. high degree
7. very high degree

Question No. 1		Question No. 2
To what degree does this goal conform to the overall objectives you are pursuing in your PSA?	GERONTOLOGICAL COUNSELING GOALS	To what degree do you perceive this goal as offering assistance to the elderly in your PSA?
1 2 3 4 5 6 7	(1) **Problem Resolution:** counseling aimed at assisting persons in solving problems that they are unable to solve themselves.	1 2 3 4 5 6 7
1 2 3 4 5 6 7	(2) **Behavioral Change:** counseling aimed at a redirection of typical responses to frustrations or different attitudes toward other people or self	1 2 3 4 5 6 7
1 2 3 4 5 6 7	(3) **Decision Making:** counseling aimed at stimulating the individual to evaluate, make, accept, and act upon his/her own choice.	1 2 3 4 5 6 7
1 2 3 4 5 6 7	(4) **Positive Mental Health:** counseling aimed at behavioral integration, adjustment, positive identification with others, accept responsibility and independence.	1 2 3 4 5 6 7
1 2 3 4 5 6 7	(5) **Personal Effectiveness:** counseling aimed at enabling persons to thrive and not merely survive.	1 2 3 4 5 6 7

APPENDIX F--Continued

1 2 3 4 5 6 7	**(6) Knowledge of the Aging Process and its Effects:** counseling aimed at awareness, knowledge of age related changes, self-acceptance, and striving for optimal functioning within the limitations imposed by aging	1 2 3 4 5 6 7
1 2 3 4 5 6 7	**(7) Self-Advocacy:** counseling aimed at developing self-advocacy techniques and actions, including information about and referral to governmental/community agencies.	1 2 3 4 5 6 7
Question No. 1		Question No. 2
To what degree does this role conform to the overall objectives you are pursuing in your PSA?	GERONTOLOGICAL COUNSELING ROLES	To what degree do you perceive this role as offering assistance to the elderly in your PSA?
1 2 3 4 5 6 7	**(1) Service Provider to persons living alone:** widow support groups, informational services, assertiveness training, communication skills training, support in seeking new social contacts.	1 2 3 4 5 6 7
1 2 3 4 5 6 7	**(2) Bereavement Counselor:** empathy and strong emotional support to those mourning a lost loved one.	1 2 3 4 5 6 7
1 2 3 4 5 6 7	**(3) Change Agent:** dispel myths about the aged in the community, stimulate positive change in services offered to the elderly.	1 2 3 4 5 6 7
1 2 3 4 5 6 7	**(4) Personal Counselor:** personal counseling services to those experiencing the effects of aging.	1 2 3 4 5 6 7
1 2 3 4 5 6 7	**(5) Consultant:** process consultation to network agencies, and mental health consultation to professionals (doctors, lawyers, accountants, etc.) dealing with the elderly.	1 2 3 4 5 6 7
1 2 3 4 5 6 7	**(6) Specialist in psychological education:** human relations training to those who deal with the elderly as well as directly to the elderly population.	1 2 3 4 5 6 7
1 2 3 4 5 6 7	**(7) Employment Counselor:** assisting the elderly with their vocational needs and aspirations.	1 2 3 4 5 6 7
1 2 3 4 5 6 7	**(8) Services Coordinator - Services Enhancer Client Advocate:** facilitating the proper "services mix" for the individual client, maximizing the quality of services any agency is capable of giving, supportive assistance in expediting services.	1 2 3 4 5 6 7
1 2 3 4 5 6 7	**(9) Financial Counselor and Manager:** consumer information and support so elderly can maximize their health, housing and services dollar.	1 2 3 4 5 6 7
1 2 3 4 5 6 7	**(10) In-Service Counselor-Educator:** offering in-service programs to aging network staffs on gerontological issues and techniques in dealing with elderly.	1 2 3 4 5 6 7
1 2 3 4 5 6 7	**(11) Leisure Time Counselor:** assisting the elderly in identifying avocational interests, thereby fostering the meaningful use of time	1 2 3 4 5 6 7
1 2 3 4 5 6 7	**(12) Marital and Sex Counselor:** assisting healthy marital adjustment for elderly couples, offering accurate information on matters of sex.	1 2 3 4 5 6 7
1 2 3 4 5 6 7	**(13) Outreach Agent to Minorities:** understanding unique problems of minority elderly and proactively seeking their participation in service programs.	1 2 3 4 5 6 7

APPENDIX F--Continued

1 2 3 4 5 6 7	**(14) Service Provider to nursing home and housing complex residents:** helping residents adjust to reality of declining health, communication skills, health care training, time and life review, peer counselor training.	1 2 3 4 5 6 7
1 2 3 4 5 6 7	**(15) Counselor of the Terminally Ill:** assisting those terminally ill in decision making, alternatives scanning, opportunities for personal independence and control.	1 2 3 4 5 6 7
1 2 3 4 5 6 7	**(16) Pre-Retirement Counselor and Educator:** assist older persons making the transition from the work role to the retirement role.	1 2 3 4 5 6 7
1 2 3 4 5 6 7	**(17) Public Relations Worker:** information to the community to sensitize them to their own aging and the needs of the aged.	1 2 3 4 5 6 7
1 2 3 4 5 6 7	**(18) Gerontological Researcher:** conducting local needs assessments, studying counseling strategies, demographic data collecting, etc.	1 2 3 4 5 6 7
1 2 3 4 5 6 7	**(19) Family Counselor:** working with elderly parents and their adult children to assist both groups in coping with newly emerging problems associated with age.	1 2 3 4 5 6 7
1 2 3 4 5 6 7	**(20) Educational Counselor:** assisting older persons in participating in educational opportunities; developing linkages within the community between existing educational resources; and encouraging new educational services.	1 2 3 4 5 6 7
1 2 3 4 5 6 7	**(21) Medical Support Outreach Counselor** assisting physicians in giving more comprehensive care to elderly patients, both in the office and in the home.	1 2 3 4 5 6 7
	THANK YOU	

Survey
Possible Placement Sites for Gerontological Counselors
Within the Emerging Aging Network

The following is a list of possible placement sites for gerontological counselors. Please rate each possible site according to the following scale.

"In my opinion, a gerontological counselor can be of 1 - 2 - 3 - 4 - 5 - 6 - 7 benefit to older persons if placed here."

1. minimum
2. low
3. below medial
4. medial
5. above medial
6. high
7. maximum

1 2 3 4 5 6 7	Senior Centers
1 2 3 4 5 6 7	Area Agencies on Aging
1 2 3 4 5 6 7	Mental Health Centers
1 2 3 4 5 6 7	Nursing Homes
1 2 3 4 5 6 7	Adult Congregate Living Facilities
1 2 3 4 5 6 7	Adult Congregate Nutrition Sites
1 2 3 4 5 6 7	Retirement Projects
1 2 3 4 5 6 7	Day Care Centers
1 2 3 4 5 6 7	Hospice Programs
1 2 3 4 5 6 7	Homemakes Programs
1 2 3 4 5 6 7	Respite Care Programs
1 2 3 4 5 6 7	Housing Projects
1 2 3 4 5 6 7	Physicians' Offices
1 2 3 4 5 6 7	_____(others)
1 2 3 4 5 6 7	_____
1 2 3 4 5 6 7	_____
1 2 3 4 5 6 7	_____

APPENDIX G

REMINDER LETTER TO AAA DIRECTORS

NGCS The National GERONTOLOGICAL COUNSELING Study

c/o Richard P. Johnson
4715 NW 40th Street
Gainesville, Florida 32601

March 16, 1980

Dear AAA Executive Director,

The National Gerontological Counseling Study is nearing its end. Very soon all the data will be key punched, processed through the computer, statistically analyzed, interpreted, and forwarded to AoA in Washington,D.C.

I have been encouraged at the high response rate of our nationwide sample of AAA Executive Directors to date. Your responses to the questionnaire which you should have received last month have not yet arrived. Perhaps you never got the questionnaire, or perhaps our letters are crossing in the mail. In any event, your reactions to the questionnaire are most important for the successful completion of the study.

May I ask that you take the 5-10 minutes necessary to complete the enclosed questionnaire and mail it back to me in the envelope provided. Your cooperation is vital to this project. Again, I shall be happy to mail you the findings of this study at its termination.

Thank you again for your time and consideration.

Sincerely

Richard P. Johnson
Project Director

RPJ/mpz

Enclosure

APPENDIX H

CROSSTABULATION OF EXPERTS' CHARACTERISTICS:
REGIONAL AREA BY NUMBER OF GERONTOLOGY COURSES TAUGHT

Area	Number of Gerontology Courses Taught					
N % Total	0	1	2	3	4	5
Northeast	0 0.00	10 24.39	4 9.76	1 2.44	0 0.00	1 2.44
South	0 0.00	3 7.32	0 0.00	1 2.44	1 2.44	0 0.00
Midwest	1 2.44	4 9.76	3 7.32	1 2.44	0 2.44	0 0.00
Southwest	0 0.00	2 4.88	2 4.88	1 2.44	1 2.44	0 0.00
West	0 0.00	2 4.88	1 2.44	0 0.00	2 4.88	0 0.00
Total	1 2.44	21 51.22	10 24.39	4 9.76	4 9.76	1 2.44

APPENDIX I

CROSSTABULATION OF EXPERTS' CHARACTERISTICS:
REGIONAL AREA BY NUMBER OF CONTRIBUTIONS TO GERONTOLOGY

Area	Number of Contributions to Gerontology					
N % Total	0	1	2	3	4	6
Northeast	3 7.32	8 19.51	4 9.76	1 2.44	0 0.00	0 0.00
South	2 4.88	0 0.00	2 4.88	0 0.00	0 0.00	1 2.44
Midwest	2 4.88	4 9.76	0 0.00	3 7.32	0 0.00	0 0.00
Southwest	3 7.32	0 0.00	0 0.00	1 2.44	2 4.88	0 0.00
West	0 0.00	2 4.88	1 2.44	1 2.44	0 0.00	1 2.44
Total	10 24.39	14 34.15	7 17.07	6 14.63	2 4.88	2 4.88

APPENDIX J

CROSSTABULATION OF EXPERTS' CHARACTERISTICS:
REGIONAL AREA BY GERONTOLOGY PREPARATION

Area N % Total	Gerontology Preparation None	Seminar	Self Taught	Post Graduate	Gerontology Program	Experience
Northeast	1 2.44	2 4.88	7 17.07	4 9.76	1 2.44	1 2.44
South	2 4.88	2 4.88	0 0.00	0 0.00	1 2.44	0 0.00
Midwest	1 2.44	1 2.44	4 9.76	2 3.88	0 0.00	1 2.44
Southwest	1 2.44	2 4.88	1 2.44	2 4.88	0 0.00	0 0.00
West	1 2.44	0 0.00	2 4.88	2 4.88	0 0.00	0 0.00
Total	6 14.63	7 17.07	14 34.15	10 24.39	2 4.88	2 4.88

APPENDIX K

CROSSTABULATION OF EXPERTS' CHARACTERISTICS:
REGIONAL AREA BY HIGHEST DEGREE HELD

Area	Highest Degree Held		
N % Total	Master's	Ed.D.	Ph.D.
Northeast	2 4.88	6 14.63	8 19.51
South	0 0.00	3 7.32	2 4.88
Midwest	2 4.88	7 17.07	0 0.00
Southwest	0 0.00	5 12.20	1 2.44
West	0 0.00	1 2.44	4 9.76
Total	4 9.76	22 53.66	15 36.59

APPENDIX L

CROSSTABULATION OF EXPERTS' CHARACTERISTICS:
REGIONAL AREA BY NUMBER OF SPECIALITIES OTHER THAN GERONTOLOGY

Area	Number of Specialities other than Gerontology						
N % Total	0	1	2	3	4	5	6
Northeast	0 0.00	5 12.20	10 24.39	0 0.00	1 2.44	0 0.00	0 0.00
South	0 0.00	1 2.44	2 4.88	0 0.00	1 2.44	1 2.44	0 0.00
Midwest	1 2.44	1 2.44	4 9.76	1 2.44	1 2.44	1 2.44	0 0.00
Southwest	0 0.00	0 0.00	1 2.44	2 4.88	1 2.44	1 2.44	0 0.00
West	0 0.00	1 2.44	1 2.44	2 4.88	0 0.00	0 0.00	1 2.44
Total	1 2.44	8 19.51	18 43.90	5 12.20	4 9.76	3 7.32	2 4.88

APPENDIX M

CROSSTABULATION OF EXPERTS' CHARACTERISTICS:
SEX BY NUMBER OF CONTRIBUTIONS TO GERONTOLOGY

Sex	Number of Contributions to Gerontology					
N % Total	0	1	2	3	4	6
Female	3 7.32	5 12.20	2 4.88	1 2.44	1 2.44	0 0.00
Male	7 17.07	9 21.95	5 12.20	5 12.20	1 2.44	2 4.88
Total	10 24.39	14 34.15	7 17.07	6 14.63	2 4.88	2 4.88

APPENDIX N

CROSSTABULATION OF EXPERTS' CHARACTERISTICS:
NUMBER OF GERONTOLOGY COURSES TAUGHT BY GERONTOLOGY PREPARATION

Number of Courses Taught	Gerontology Preparation					
N % Total	None	Seminar	Self Taught	Post Graduate	Gerontology Program	Experience
0	0 0.00	1 2.44	0 0.00	0 0.00	0 0.00	0 0.00
1	6 14.63	2 4.88	5 12.20	4 9.76	2 4.88	2 4.88
2	0 0.00	2 4.88	6 14.63	2 4.88	0 0.00	0 0.00
3	0 0.00	1 2.44	2 4.88	1 2.44	0 0.00	0 0.00
4	0 0.00	1 2.44	1 2.44	2 4.88	0 0.00	0 0.00
5	0 0.00	0 0.00	0 0.00	1 2.44	0 0.00	0 0.00
Total	6 14.63	7 17.07	14 34.15	10 24.39	2 4.88	2 4.88

APPENDIX O

CROSSTABULATION OF AAA DIRECTORS' CHARACTERISTICS:
REGIONAL AREA BY PUBLIC SERVICE AREA

Area	Public Service Area			
N % Total	Urban	Suburban	Rural	Mixed
Northeast	7 4.27	3 1.83	18 10.98	19 11.59
South	2 1.22	0 0.00	21 12.80	12 7.32
Midwest	0 0.00	0 0.00	28 17.07	15 9.15
Southwest	1 0.61	0 0.00	5 3.05	6 3.66
West	4 2.44	3 1.83	6 3.66	10 6.10
Non-Continental	0 0.00	0 0.00	3 1.83	1 0.61
Total	14 8.54	6 3.66	81 49.39	63 38.41

APPENDIX P

CROSSTABULATION OF AAA DIRECTORS' CHARACTERISTICS:
SEX BY HIGHEST DEGREE HELD

Sex N % Total	Highest Degree Held Other	Bachelor's	Master's	6th Year	Ed.D./Ph.D.
Female	12 7.36	25 15.34	43 26.38	1 0.61	1 0.61
Male	7 4.29	22 13.50	41 25.15	4 2.45	6 3.68
Total	19 11.66	47 28.83	84 51.53	5 3.07	7 4.29

APPENDIX Q

CROSSTABULATION OF AAA DIRECTORS' CHARACTERISTICS:
HIGHEST DEGREE BY PUBLIC SERVICE AREA

Highest Degree / N / % Total	Public Service Area			
	Urban	Suburban	Rural	Mixed
Other	1	0	11	7
	0.62	0.00	6.83	4.35
Bachelor's	4	3	27	12
	2.48	1.86	16.77	7.45
Master's	6	2	36	40
	3.73	1.24	22.36	24.84
6th Year	0	0	5	0
	0.00	0.00	3.11	0.00
Ed.D./Ph. D.	3	1	1	1
	1.86	0.62	0.62	0.62
Total	14	6	80	60
	8.70	3.73	49.69	37.27

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BIOGRAPHICAL SKETCH

Richard P. Johnson was born in 1947, in Newark, New Jersey. After several years of elementary school he moved, with his family to Northford, Connecticut (outside New Haven). He attended public junior high school, and graduated from Notre Dame High School in West Haven, Connecticut, in 1964. The following September, he entered Southern Connecticut State College, in New Haven, from which he graduated with a bachelor's degree in secondary education in February, 1969. Having participated in the Yale University Army Reserve Officer's Training Corps (R.O.T.C.), Mr. Johnson was commissioned a second lieutenant upon graduation.

Mr. Johnson spent three years in military service; two in Heidelberg, Germany, and one in Viet Nam. During his tour in Germany, he attended the Boston University overseas extension program and was awarded a master's degree in education in 1971.

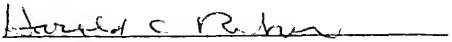
Mr. Johnson taught high school psychology and sociology and was social studies department chairman at the Morgan School in Clinton, Connecticut, for three years. Following this, he was an educational consultant/representative for Addison-Wesley Publishing Company for two years. In 1977, Mr. Johnson was awarded a second master's degree; this one in counselor education from Southern Connecticut State College.

In 1977, also, Mr. Johnson moved to Gainesville, Florida, to enroll in the doctoral program at the University of Florida. During his three years as a doctoral student, Mr. Johnson began the Center for Career

Transition, a counseling service for persons 40 years of age and older, at the university. Upon receipt of his doctoral degree Mr. Johnson will commence work in the newly established Center for Retirement Counseling which will be part of the counselor education department at the University of Florida.

Mr. Johnson resides in Gainesville, with his wife Sandra and their two sons, Ethan, aged 8, and Justin, aged 6.

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.



Harold C. Riker, Chairman
Professor of Counselor Education

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.

Robert O. Stripling
Distinguished Service Professor
of Counselor Education

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.

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Professor of Educational Administration and Supervision

This dissertation was submitted to the Graduate Faculty of the Department of Counselor Education in the College of Education and to the Graduate Council, and was accepted as partial fulfillment of the requirements for the degree of Doctor of Philosophy.

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Dean, Graduate School