

A REPORT ON THE DEVELOPMENT AND
EVALUATION OF A SLIDE/TAPE PROGRAM
ENTITLED PSYCHOSOCIAL NEEDS
OF THE ELDERLY

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A REPORT ON THE DEVELOPMENT AND EVALUATION
OF A SLIDE/TAPE PROGRAM ENTITLED
PSYCHOSOCIAL NEEDS OF THE ELDERLY

by

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Submitted in partial fulfillment of
the requirements for the degree of
Master of Education

Division of Learning Resources
Faculty of Education
Memorial University of Newfoundland

January 1986

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ISBN 0-315-31012-X

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Abstract

The psychosocial needs of our elderly population are often unintentionally neglected in favour of treatment of the more obvious physical needs. This is of interest to all health professionals, but particularly those actively involved with geriatric patients and those involved with the education of student nurses, who must prevent this imbalance in the nurses of tomorrow by introducing them to the psychosocial context of the elderly individual. Such health professionals recognize that while the need is there for informational-educational packages which introduce one to the psychosocial needs of the elderly, few such packages exist. If student nurses were exposed to such packages, it is felt that they would become versed not only in the early prevention and curing of psychosocial problems, but also experienced in teaching the elderly themselves to prevent and cure such problems. Thus this holistic approach would result in an elderly individual who was healthy both in body and spirit. At St. Clare's Mercy Hospital School of Nursing, the lecturers and administration were aware of their responsibility to educate their novice students to the psychosocial context of the elderly, but were unable to

review the problem due to lack of introductory material, heavy workload and time constraints. Such factors did not permit them to either conduct an exhaustive search for, or design, develop, and implement a program of the type and depth required. The solution to this problem was that an informational/attitudinal package in the form of a slide-tape presentation be developed by someone with a knowledge of educational technology. The ultimate objective of this package was to make student nurses, and other health professionals connected with geriatric patients, aware of the psychosocial nature and needs of the elderly. Such a package was produced with an instructional development model in mind, said model consisting of four major steps -- defining the problem, designing the presentation, evaluating the presentation, and developing a dissemination plan. The evaluation of the package produced a satisfactory result, and the dissemination plan is being applied as of this writing.

Acknowledgments

The developer would like to thank Drs. Ted Braffet and Mary Kennedy of the Division of Learning Resources, Memorial University of Newfoundland, for their invaluable advice and assistance during the production of this project.

Thanks are also due to Mary Keiley, Diane Brown, Brenda Porter, and Dee Braffet of the St. Clare's School of Nursing, who all helped so much during the research, planning and production stages. Also, appreciation is due in no less measure to Louise Nugent for her help.

The slide/tape presentation owes much to the cooperation of Mr. and Mrs. C. Cornick, Miss Sylvia Wigh, Mr. Arthur Gill, Miss Nicola Warrick, Mrs. Eileen Marshall, and Geoff's grandmother, whose name has been forgotten but whose distinctly lively personality never shall be. Thanks also to Geoff Ross and Paul Hewson, certain members of the staff at St. Clare's, the staff and administration of the Agnes Pratt Home, and a number of my youngest brother's friends.

Finally, deep thanks are expressed to Miss Donna Ballard and Mr. Ian Carr for their friendship and encouragement, and to all the members of my family, but most especially my father, Harry Cuff, and my mother, Doreen (Gill) Cuff, who, having both produced master's theses of their own, were able to counsel and commiserate.

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1

CHAPTER I
INTRODUCTION

Background to the Problem of Denial of the
Psychosocial Needs of the Elderly

An Overview

A most dramatic shift is occurring in the characteristics of the population of North America, with reference to the relative age of the population. The elderly are currently in a minority, but they are a fast-growing minority. (This increase is due in great part to improved health care and to the "baby boom" of the post-WWII years.) It is estimated that by the year 2031, 20% of the population will be over 65 years of age (Rosenberg & Grad, 1980). In terms of sheer numbers, this means a one-third overall increase in the needs of the elderly with a probable reduction in the labour force available to meet those needs (Isaacs & Neville, 1976). This is naturally of concern to health-care workers and health professionals, who will continue to find themselves responsible for the health of this group, as elderly patients make up an increasingly larger percentage of the average hospital's population.

However, although it is important to realize that much of the population of a hospital is elderly, it is equally if not more important to realize that only a small percentage

of the elderly are in hospital. Only 5-10% of the elderly population reside in nursing homes or hospitals (Teare, 1982), though of course many still come into contact with health professionals through short-duration hospital visits and through consultations with family doctors and/or pharmacists. The same must be seen to be true of all age ranges of the population.

It has been noted that 90% of the elderly population of Canada (Wong, Wong & Arklie, 1985) live in their own homes functioning independently or with the assistance of family, friends, and/or community health services. This indicates that unless adequate support from the community is both available and availed of, the great majority of people over 65 will have to come to grips with the experience of old age without the advantages which would be afforded by such support.

As the years roll by, more people live alone, without their spouses and without family. This has been seen to be especially true of women, as the trend of women to outlive men has increased since 1951 (Rosenberg & Grad, 1980). Consequently the therapeutic benefits of continuing contact with close friends is often severed at a time when the manifestations of the aging process are at a traumatic level.

The Aging Process -- Physical Change

Such manifestations are not limited to the obvious changes such as greying of the hair and wrinkling of the skin; nor to the physiological losses such as an increased sensitivity to disease, decrease in muscle strength and endurance (including decrease in heart muscle strength, which affects how vigorously the heart may function), reduced liver and kidney functions, and the decrease in elasticity and calcification of the skeletal system (Rockstein, 1975).

Beyond these changes which are considered to be a natural part of the aging process, there are those physiological changes which are common but not inevitable -- and therefore not considered natural. These include such things as deterioration of eyesight and of hearing and deterioration of memory and loss of mental control.

Beyond even this aging process, which can certainly be stressful, there are the psychosocial* effects of such changes. Incontinence is a purely physiological change, an extreme result of reduced kidney function. Despite the fact that this reduced function is part of the natural aging process, it can be extremely embarrassing to the elderly individual. As a result of incontinence, self-

* Defined, rather simply, by Dox (1979) as "involving psychological and social factors."

esteem may deteriorate.

Similarly, the deterioration of eyesight is a physiological change with psychosocial results. Poor vision not only inhibits the ordinary daily activities such as driving, cooking, and so on, but affects such pleasurable activity as reading, watching television and movies, and writing. If an elderly individual does not strive to overcome such physical limitations -- as indeed frequently happens -- then there will be a sharp decrease in mental stimulation. The change itself may be difficult enough to cope with, but the result of the change can have pronounced negative psychosocial effects.

The Aging Process -- Psychosocial Change

Even when the physiologically-related psychosocial factors are not sufficiently varied, numerous, stressful, insidious and constant to necessitate professional care, we must still consider those psychosocial events which are unrelated to the physiological aspects of aging. These include the loss of friends and/or family through immobilization and/or death (and, in the case of the death, the related bereavement), the trauma of retirement (voluntary or enforced) and its effect on self-concept, status in the community, and income reduction; fear of impending institutionalization, the imminence of death, the change in physical appearance and the resulting effects on

self-concept.

Most psychosocial change for the elderly individual can be attributed to one of a variety of misunderstandings about the psychosocial needs of the elderly. This tendency to misunderstanding derives from a tendency to translate change in psychosocial events to change in psychosocial needs. The elderly population do not have special psychosocial needs -- rather, they have needs which are intensified. It is important to realize that it is in fact the intensity of the needs, and not the needs themselves which are different for the elderly.

It is because of the fact that, quite often, people do not realize that the elderly are not widely different in the needs and social character that certain myths about the elderly have been perpetuated. These myths (discussed at length Appendix A, and pages 11-14 of Appendix O) are one more source of stress with which the elderly must come to grips. Included among these myths are visions of the elderly as grumpy, frail and ill (and consequently spending most of their time in nursing homes or hospitals), boring, senile, lonely, unproductive, having difficulty learning new skills, and sleeping a great deal. Even more insidious are the subconscious assumptions people make about the elderly -- that they are uninterested and/or incapable of sexual behaviour, that they tend to be or become religious, that all elderly people are very much alike...and that old age

begins promptly at sixty-five years. Weakness and problems are often focused on and thought of as characteristic of old age.

These negative stereotypes are so strongly entrenched in our society (Kennedy, 1978), that the elderly person may share these mythical beliefs him/herself, and may do so either consciously or subconsciously, thus adding to or creating his/her own problems without any awareness of such a contribution. All these considerations inevitably point to the necessity for psychosocial counselling and care for the elderly.

Education of the "Care-givers"

Those people responsible for the care of the elderly need additional guidance, not so much in the physical care of their charges (in which they are considered to be, on the whole, sufficiently well-versed), but in the psychosocial realms. The care-givers -- whether they be nurses in a hospital, student nurses in a classroom, workers in a nursing home, volunteers or social workers in contact with those elderly living at home or even the elderly themselves -- need concrete practical information to enable them to deal with specific problems such as wandering behaviour and adjustment to retirement, and to help them realize that psychosocial care, like physical care, should be dealt with

on a preventative rather than strictly curative basis:

A vital part of the education of all care-givers necessarily includes the correction up of any misinformation about the psychosocial nature of the elderly. Before care-givers can be effectively taught about practices and methods of dealing with problems, they should be made cognizant of the underlying causes in order to help them eradicate in themselves their belief in misconceptions and myths about the elderly.

Corey and Corey (cited in Landreth & Berg, 1977) list "the ability to get old people to challenge many of the myths about old age" as "an essential personal quality in order to work successfully with old people." This need for a new professional context has been documented by Kerschner (1976), who states that all professionals working with old people need new training, which should include consciousness-raising as to the capabilities of older persons and strategies to combat stereotyping. His view is supported by Kennedy (1978), who states that society should provide a new image showing older persons capable of growth. The need for national training programs designed to change attitudes towards the elderly was documented in the White House Conference on Aging (cited in Reichel, 1983), which recommended that:

Educational programs be initiated to promote the breakdown of stereotypes, enhance media

responsibilities, recognize the value of the elderly as a human resource and increase aging awareness through a combination of experience of lifelong learning, role counseling (including preretirement preparation) and intergenerational learning. (Recommendation 57).

Education of the Elderly Themselves

That the elderly themselves must be aware of the own psychosocial problems, and therefore require education, may seem to be an extension of education of the care-givers rather than a separate and discrete category. Some the psychosocial problems which the elderly encounter simply demand that the care-givers educate the elderly (and, incidentally, society in general) as to the nature and real cause of the problem, if such a problem is ever to be solved. Exemplary of these problems which require the educated co-operation of the sufferer him/herself are those created by the myths about the elderly: an elder person, believing him/herself to be limited by frailty, will cease strenuous physical activity, and thereby lose the opportunity for not only valuable physical and mental exercise, but also needlessly lose control over his or her own life.

That the elderly sometimes view themselves as others so wrongly perceive them -- as malfunctioning, decrepit units -- indicates only one way through which education of the elderly could help to prevent and solve problems. Through

education some of the common fears of old age could be allayed -- fear of hospitalization, fear of senility, fear of poverty, and so forth. Education could help the elderly deal with loss of identity by helping them to create new identities, and to boost the feeling of self-worth by attending to physical appearance.

Beyond Education

Some of the psychosocial problems and syndromes which the elderly experience are not solvable through education. Their effects may be anticipated, losses compensated for, and possibly the intensity of the problem lessened, but it must be seen that this is not the same as solving the problem. Take the case of the loss of individuality: elderly men often lose their identity through their retirement. In North American culture, the occupation of an individual provides what is probably the most important identity. While the elderly person can be encouraged to create new identities to lessen feelings of confusion and apathy often surfacing as a result of the losing of a primary identity, this is not the same as replacing the original identity. The difference is subtle, but important.

Some of the problems the elderly face require massive social change. Other solutions are equally unlikely to occur quickly. To begin with, education itself should not be allowed to halt at the boundaries of the elderly.

themselves and their care-givers. If all society were to be educated, many problems would disappear, including the one created by the lack of balance between treatment of physical and psychosocial ailments -- but education cannot answer for everything.

Consider the fact that some elderly, due to relative physical frailty, are particularly vulnerable to crime, especially violent crime ("Crime and the Elderly", 1978). Education, while it can help to prevent it, cannot eradicate this problem. Some of the fears of old age can be allayed. Some can not. As Dr. Charles M. Gaitz put it, "it should be kept in mind that depression in old age is often a reaction to reality, not a distortion of it." (Gaitz, 1983)

Individuality is often denied as a result of identity loss. Many people -- males especially -- take their principal identity from their work. This is of course no longer possible after retirement. Other identities come from the family unit, and the parental identity cannot be returned once the children have all left home. What can be done? Certainly the elderly cannot return to work, and the children should not be brought back to preserve the family atmosphere. To complicate matters, the loss of a person's identity may result from lack of certainty about his/her new role or from society's restricted, stereotypical image of elderly. In attempting to solve this problem, people may make up false, non-identities for people which claim to

identify but which merely classify. By saying a person is black, Jewish, old, we are fooling ourselves that we are identifying, when we are really obscuring identification. Here we see clearly that while education may alleviate, it cannot always prevent or solve.

Self-worth often deteriorates because of the change in physical appearance. Here again, not much can be done about this except be aware of it; certainly the "attractive" youthful appearance can not be restored. Self-worth may also deteriorate because of others' impatience with the new limitations of old age, or other evidence that their limitations are being overridden rather than taken into account. Such things as the cutting of food for elderly persons can be extremely damaging to their sense of self-worth.

Aspects of the need for control which cannot be cured by education are such things as lost physical control (eyesight, hearing, inability to walk alone), and the regulations in nursing homes. (Often the care-givers are not the administrators, and an attempt by a care-giver to intervene on behalf of an elderly person may not be welcomed by the administrators.)

Security is the need which is denied quite often in spite of education, since it is not people's attitude but merely the realities of the world which helps this deterioration. Worries about money, crime, illness and

death are all too often justified and there is little that the elderly person or the care-givers can do about it.

Communication deteriorates as a result of the other needs deteriorating. Because others cannot identify an old person as a person, but merely as someone old, very little quality communication is afforded the elderly individual. So, too, does communication deteriorate if there is a memory problem, or hearing problem, as communication becomes much more difficult. What is required in all these cases is for people to make more effort ... and how, practically speaking, is an elderly person or health professional, supposed to arrange such a thing? Similar phenomena may be noted in that elderly people in old age homes are kept out of the way of society -- which includes keeping them out of the way of communication, since the only people that the elderly might come in contact with (other than health professionals) would be similarly disadvantaged elderly people. And if all the people in the elderly community, or old age home, are not facile in communication then they will have difficulty setting up new relationships.

In summary, there are certain ways in which psychosocial needs are denied that make it difficult to see a practical way of stopping and reversing the denial. They may be ways of compensating against the denial by supplementing the need in question, but the needs are still denied to some extent.

The Problem

At the St. Clare's Mercy Hospital School of Nursing, the problem of the psychosocial needs of the elderly was purely one of education -- the educators and nursing staff wanted to educate the elderly themselves and the health professionals about the needs, the denial of needs, and the satisfaction of needs. They wanted to produce health professionals capable of not only helping the elderly but also capable of educating the elderly.

The three-fold problem of under-educated elderly, under-educated health professionals and an under-educated general public could be addressed by an informational package, but the main emphasis was on education of the elderly through education of the health professionals.

The School of Nursing visualized a study of the research and problems related to the psychosocial needs of the elderly which would serve as a basis for an educational / attitudinal package for use by health professionals in educating themselves, the elderly and the general public about denial and satisfaction of psychosocial needs.

CHAPTER II

NEEDS ASSESSMENT

Statement of Needs

There existed an awareness and growing concern, on the part of the administration of St. Clare's Mercy Hospital, that the psychosocial needs of the elderly patients were not being met: an awareness which resulted in a request from that institution for the production of an information package which could be presented to the elderly patients to enable them to enhance their own psychosocial care.

To analyze the problem, discussions and interviews were held with teaching staff at St. Clare's School of Nursing lecturing in gerontology, to elicit specific concerns and to discuss the perceived objectives and requirements of the project. Interviews were conducted individually, and in addition there were group conferences to discuss progress, and to refine and clarify objectives.

An information-gathering session with Sister Margaret Williams, Chief Administrator for St. Patrick's Mercy Home, and the staff at St. Clare's School of Nursing elicited the information that those people responsible for the care of the elderly need additional guidance in the psychosocial spheres. The care-givers -- whether they be nurses in a hospital, students nurses in a classroom, workers in a

nursing home, social workers or the elderly themselves -- need practical information which allows them to seek help for and deal with identifiable needs and specific problems, with a view to prevention as well as cure.

A related problem reported was a feared misinformation about the psychosocial nature of the elderly. Before care-givers can be taught to identify problems and their symptoms, they must know not only what causes problems but must also address themselves to the misconceptions and myths about the elderly.

Those responsible for the care of the elderly have a tendency to ensure that the physical needs are not only dealt with as soon as they are encountered, but actually anticipated, as opposed to concentrating on the psychosocial wants and needs of the elderly. As it can be observed that elderly people may be in as equally a poor psychosocial state when they are caring for themselves as when they are under the care of a medical or quasi-medical institution (Brockington and Lempert, 1966), it seems logical to conclude that psychosocial needs are not satisfied in the elderly because of priorities which are biased towards physical care, -- and to note that this bias may be a subconscious one, due to a lack of awareness of human psychosocial needs in general on the part of the care-givers rather than to time constraints.

Informal interviews were conducted with several elderly

people to discuss the proposed need for an educational package. Care was taken to include subjects across age groups to include the young-old, medium-old, and old-old, and to include those elderly living in private residence with family, those living independently in private residence and those living in institutions. It was felt that it was of limited value to define need for a program as expressed by responses of the elderly people to a specific questionnaire since subconscious denial of psychosocial needs could neither be prevented or circumvented. Consequently, a review of the literature on aging was initiated.

Gerontological Research

The last ten years have seen a dramatic increase in research on the elderly population. Understandably, research direction was initially restricted to fields which might be expected to get public and industrial support. Clinical studies on major problems of the elderly which held out hope of early application and the likelihood of paying off in patients' care in the near future were a priority (Hall, 1980).

Knight Steel (1981) noted:

During the later 1970s, geriatric medicine rather suddenly was received with a surge of enthusiasm. The lay press and even traditional medical journals published articles about the health-care needs of the elderly. Conferences directed at geriatric medicine and the diseases of old age, predominantly at the level of post-

graduate medical education, abounded. The federal government offered funds for the development of programs in geriatrics at the undergraduate and graduate levels of medical education.

What has become apparent to the increasing numbers of persons interested in geriatric medicine is the need to institutionalize programs that were subsidized by granting agencies initially only for a limited time. In order for a teaching effort to endure beyond the life of a grant or the impetus engendered by the still-small number of faculty, geriatrics must find its place within the structure of academic medicine. Given both the demands for time in the curriculum by more-established units and subunits and the limited resources available to all, it is clear that geriatric medicine faces significant problems in the 1980s.

(Steel, Geriatric Education, p. xv)

It is only since the 1970s that geriatric medicine has had any real place in the undergraduate curriculum of most medical schools, and many general practitioners and educators are aware of gaps and defects in their knowledge and education as they deal with increasing numbers of elderly people (Brocklehurst, 1977).

The direction and brevity of these years of research make it obvious that geriatric medicine faces significant problems in the 1980s; including the need for a change in educational programs designed for medical personnel. It may be observed that these gaps are to be filled as physiological knowledge and concepts expand, but equally important, if an holistic approach to care of the elderly is to be targeted, is the need for extending the education of care-givers to include expertise and research in the psychosocial realm.

The information elicited from available sources documented the need for:

I. an information package that addresses not only the need to provide accurate and precise information but also the need for attitudinal change;

II. a change in overt audience from the elderly themselves to those who come in contact with the elderly; and

III. more research to obtain consensus of important psychosocial needs and their underlying causes.

Due to the relatively short history and limited thrust of geriatric medicine and research in gerontology, it was concluded that the development of a program aimed at developing an awareness of psychosocial needs of the elderly would pay off in terms of patient care -- both self-care and professional -- and prevention.

If in fact the absence of good psychosocial care for the elderly is due to a lack of awareness, information or education about the psychosocial nature and needs of mankind, then what is required by the care-givers (and potential caretakers) of the elderly is an introduction to these concepts, and one which identifies the psychosocial needs which are specifically relevant to and representative of the average elderly person. This must precede any discussion of the method of satisfaction of needs which are being denied. Ultimately, an educational package should

exist as an introduction to the psychosocial needs of the elderly and to the methods of satisfying those needs.

Alternative Solutions

There are three alternatives as regards the development of an educational package. First of all, existing materials can be sought out, and, if found, be adopted for use. Secondly, existing materials can be adapted by means of inclusion in a package, or by rearranging the content or changing the method of presentation to the user(s). Thirdly, an original package can be developed to meet the needs of the users.

The advantages of the first two alternatives are that they can save a great deal of time and money for the developer. The problem is that the unique needs of the users often dictates that new and original packages must be developed.

It seemed likely that there would be many educational materials available in the area of gerontology, so the process was begun by searching for and evaluating all existing materials related to the psychosocial character and problems of the elderly. Foremost in the evaluation were considerations of cost and availability.

Survey of Existing Materials

A search was conducted in major libraries for all existing materials related to the psychosocial care of the elderly. Two 16mm films and one slide-tape presentation were found, but no booklets or small pamphlets. More than a few medical textbooks were found with chapters on the psychosocial care of the elderly, and even a few texts solely concerned with that topic.

There follows a description and assessment of each of the materials thought most promising.

1. Peage.

Phoenix Films Ltd.

This is a 28-minute 16mm colour film dramatization of a family's visit to their grandmother in a nursing home. Although this film is very moving, and it does demonstrate some basic right and wrong approaches to communicating with the confused elderly, its overt approach does not make it a suitable teaching film by itself, though it might make an excellent chapter or topic summary. In any case, it was felt that the cost of the film and unavailability of projection equipment in some settings might disqualify it. In summary, this film is of limited scope.

2. Look Closer -- See Me

(?)

This 16mm colour film of the Phyllis McWhitney poem of the same title had insight into the poor treatment of the elderly in some nursing homes, but its severely limited scope and biased portrayal of the nursing home staff make it unsuitable, even if the consideration of cost and lack of projection equipment did not.

3. Human Development: The Elderly

(?)

This package consists of a set of two filmstrips, both over 25 minutes in length! It demands a patient and interested viewer with a long attention span. Aside from this, a very technical approach is taken, making it suitable for nursing students but not very practical. Nor is it useful to show to the elderly themselves.

This was all the audio-visual material available, and though the content and presentation of the two 16mm films made them likely candidates for adaption, for use with the package, the technical difficulties this presented both for the developer and the user ruled them out.

Of all print material studied, there was virtually no practical material on the psychosocial needs or care of the elderly. The following two works are good examples of the

two basic types of books found during a search of the literature.

4. Irene Mortensen Burnside, Psychosocial Nursing Care of the Elderly

This book was basically a collection of papers -- which was a very common approach to a text in this area. No overview was at any time attempted, which makes this book and the many others like it unsuitable for untrained nursing-home workers, first-year nursing students and the elderly themselves (i.e., those without extensive medical training and knowledge). The first section of the book contained an introduction for the new-comer, which ran, in part, as follows:

Sometimes neophytes coming into the area of gerontological nursing are not quite certain what comprises psychosocial care. Therefore, a list of common problematic areas [sic] is included at the end of this introduction. (Burnside, 1980)

The list which follows claims to be listing the psychosocial needs of the elderly. On this list are found such diverse things as problems common to the elderly ("low morale", "loss of confidence"); common syndromes ("role reversal"); needs ("Touch", "To be with an individual who shows a warm interest"); solutions to problems ("Maximize strengths of individual", "Participate in treatment plans"); causes of problems ("no interested family"); methods of solving a problem ("discharge planning"); and topics which the writer

is at a loss to categorize -- perhaps discussion topics would best describe them ("Staff interpersonal relationships with patients", "Aged vs. youth and cultural value systems"). It is important to remember that according to the heading, this is ostensibly a list of the psychosocial needs of the elderly. (For the entire list of psychosocial needs as listed in the Mortenson book, see Appendix B.)

The later chapters are, as mentioned above, papers and dissertations, and are not overly complicated, but are still not appropriate for the beginner who has no sense of the topic -- the book offers no overview, and its attempt to provide one flounders. As Farrell (1982) puts it, this book "is a sharing of nurses' thoughts, expertise and experience...". It is not suitable for the beginner.

5. Patricia Hess and Condra Day, Understanding the Aged Patient.

For the beginning student or lay-person attempting to understand the context of the psychosocial needs and characteristics of the elderly population, this is an excellent work. The first two chapters concern themselves with reporting on the population and their characteristics: Who are they? How do they live? Standards of Care. Myths. Social Demography. Psychosocial Process. All the above are chapter sub-headings.

Unfortunately, this book does not meet the needs

because of two things. Firstly, later chapters quickly become technical to the point of delving into something akin to clinical psychology. Secondly, it deals with the nature of the elderly and does not get around to mentioning the psychosocial needs, which is a large part of the material supposed to be covered.

One work which Farrell (1982) describes in her excellent Compendium of Gerontological Nursing Resources as being "an excellent book for both health professionals and lay persons..." was R.N. Butler and M.M. Lewis, Aging and Mental Health: Positive and Psychological Approaches (1982), but it could not be located. Obviously, if a book cannot be obtained, it cannot be adapted or adopted.

Decision to Produce Materials

All existing materials were deemed unsuitable for use for various reasons. Of primary concern was that the material provide a short introduction to the psychosocial nature of the needs of the elderly. The two 16mm films, while short, worked better as examples of specific needs and problems, rather than as an overview. Only portions of other lengthier textbooks were found suitable, and then only if rigorously adapted.

It was decided that as the package had to be suitable for use by groups as well as individuals, an original audio-

visual presentation would have to be produced.

Educational technologists state that effective instructional materials can best be produced by the following of an established developmental process. Most such plans are similar in that they have four basic stages: defining, designing, developing and disseminating the package. The four-D model developed by Thiagarajan, Semmel and Semmell (1974) was chosen as being most suited to the project at hand.

Still remaining, however, was the basic problem with all material examined, which was that none stated clearly the nature and number of psychosocial needs. These tasks would have to be accomplished by the developer.

The most important of these tasks would be the research for and creation of a list of the psychosocial needs of the elderly, which was not to be found in any work, and the subsequent and concurrent task of preparing a psychosocial profile of the elderly would also have to be performed. As regards preparing a list of the psychosocial needs, the following argument was used.

All human beings have needs -- conditions of the organism (produced within by external stimulation; e.g. hunger, thirst, or by appropriate external stimulus) -- which energize the person, causing him or her to act. Some psychologists consider needs to be synonymous with drives, while others give a broader interpretation to needs;

acknowledging the force of personality (Saylor & Alexander, 1966).

For the purposes of list compilation, a broad meaning of the term "need" was used. Thus, while giving recognition to the traditional use of the term as implying that need denotes "necessity arising from circumstances of case; imperative demand for presence or possession of" (Oxford Illustrated Dictionary, emphasis mine), this study proceeded on the assumption that the presence or absence of psychosocial conditions constituted a legitimate form of need.

A well-known statement of human needs has been developed by Abraham Maslow (1954). It is acknowledged that one could argue that some of the needs identified by Maslow should more accurately be described as wants or desires; but since he has developed a hierarchy with, of course, the more essential needs identified at the top of the hierarchial pyramid, and since those needs capable of being classified as wants are not trivial but very fundamental ones, this study proceeded on a premise similar to Maslow's.

A good summary of Maslow's hierarchy is made in Saylor and Alexander (1966), a precis of which follows:

1. The physiological needs: food, water, air, elimination, activity, rest. If the individual is actually deprived of these, all other needs are submerged until the primary physiological need is met. Once these needs are met,

the person can address the gratification of higher levels of needs of a social nature.

2. The safety needs: to feel safe from physical harm, from loss of support, from things which cause illness or accidents. Tension often results from failure to satisfy this type of need.

3. The "love" needs: affection, recognition, belonging. The lack of satisfaction of this classification of need, when the other two primary needs in this hierarchy are met, may manifest itself in cases of maladjustment and psychopathology.

4. Esteem needs: a sense of adequacy; of achievement; of having status, approval, attention, prestige, and appreciation. Gratification of such needs results in self-confidence and a sense of worthwhileness. Lack of satisfaction in such areas is an obstacle to being able to face up to situations.

5. Need for self-actualization: human beings need to be able to reach their potentials.

Maslow considered the above categories as falling within the category of basic needs, arranged in their hierarchy of needs satisfaction. But he also believed that humans have a need to acquire knowledge in order to satisfy native curiosity, and to enable them to analyze and understand that knowledge. (Maslow, cited in Combs, 1962). He further expressed the belief that most people have

esthetic needs.

In common with other humans, the elderly possess the needs enumerated by Maslow. The needs are the same, although the intensity of the drive to satisfy some of them might be different -- stronger in some cases for some individuals: less intensive in the case of other needs and for other individuals.

Application to the Elderly

A study of the literature indicated that in general the institutions for the elderly have an adequate measure of success in meeting the physiological needs of the residents. Since such needs are at the apex of Maslow's hierarchy, it can with logic be assumed that they have to be reasonably well-met. But since immediate danger and the public focus are not important factors with less basic psychosocial needs, such needs are sometimes overlooked or inadequately met.

Although the needs of the elderly are not different from the needs of all society, a list of the psychosocial needs could not be produced simply by transferring all non-physical needs from Maslow's hierarchy, by reason of detail. Some of Maslow's needs have to be broken down into their component parts and types in order for them to be applied to the elderly population.

Perhaps the best thing at this point would be to list

the eight psychosocial needs of the elderly the research team eventually decided upon as belonging on the basic list, and then discuss their derivation. Here, then, are the eight psychosocial needs:

Individuality. Old people are no more alike than plumbers, nurses, or teachers are alike; and it is essential that we remember that most old people have retired from a job as mentioned above -- thus they have lost one of the most important ways of being identified by occupation. But many of them have lost many of their other identities -- by hobby, family head or sports. It is important that old people, whose individual aptitudes or interests are things of the past, be encouraged to maintain a meaningful role in society.

Self-Worth. Like all humans, the elderly need a sense of self-respect and dignity. Some people, often with the best of intentions, treat the elderly as if they were children -- washing and dressing them, cutting their food, and addressing them by their first names. Changes in physical appearance are often emphasized by lack of attractive clothing -- both demoralizing to old people. The elderly need to feel comfortable in and good about their roles.

Healthy Philosophy. Most of us have something we believe, or believe in, which keeps us moving forward; for such people life has meaning or purpose, and they can

overcome obstacles and enjoy life. Traditionally, religions have provided people with healthy philosophies; but while churches should provide religious experiences, they should not have unrestricted access to the elderly. Well-trained care-givers and informed lay-people (informed in the needs of the elderly) could cooperative with equally well-prepared clergy in helping elders maintain or build healthy philosophies. As B. F. Skinner aptly observed: Depression comes from discouragement at not having done anything that you do well. The solution is to find something to be successful at. (Jennes, 1983)

Control. Control over our lives and environment may be our most intense psychosocial need, and this is denied the elderly (particularly those in institutions) more so than any other group in the free society. The administration controls when the elder gets up, eats, leaves the building, and much more. There is little opportunity for privacy in the institutions. All people need to be able to be alone when solitude is desired and desirable. But loss of control is not limited to the 10% of the elderly who live in old age homes. The deterioration of sight, hearing and mobility can steal control from old people just as efficiently.

The key to satisfying this need for control is to give as much control as is possible and appropriate.

Mental Stimulation. Just as joints become stiff and muscles become weak if they are not used, so does the brain

become lazy if it is not used. Exercise programs have been developed to make sure that the elderly do not get out of shape physically. A similar program is necessary to see that they keep in shape mentally.

Mental stimulation often has to be specially provided because elderly people are often unable or forbidden to do many things we take for granted, such as shopping or doing household jobs. Elderly people could be encouraged to pursue some of the interests they had had earlier in life but had not found time to continue; for example, reading, listening to or playing music, doing volunteer work.

Security. The elderly often feel insecure as a result of what might be called an "over-awareness" not only of what will happen or is happening, but of what might happen: we often fear what we do not understand.

One of the major losses of security which old people face is financial security -- for many of them have fixed or minute incomes. They also fear illness, senility, being attacked physically, and death. Often an understanding person can help them lessen their fear of insecurity.

Reality Acceptance. As people grow older, there is an increasing number of realities which must be dealt with -- dependence on others, bereavements, deterioration of physical functions, etc. We all need help at some times in our lives in facing realities -- the elderly often need help from new sources, especially since their former helpers

(family members and friends) may no longer be alive or available to provide the help.

Communication. Communication encompasses a great many things -- touch, contact, friendship and love, talking, expressing feelings and even relationships. The elderly, like all of us, need all of these, but they are often denied such things at a time when they are most vulnerable.

Because many or all of their former friends and relatives have died or are absent, they have little opportunity to continue communications they had had earlier in life. One problem in trying to communicate with new acquaintances is the amount of time people are able or willing to give them. People who look after them, and old people who are their potential new communicators, often need only to be aware of this fact in order to help them communicate.

Translation of Maslow's Hierarchy

Maslow's needs are organized in such a way that the most important are at the top: It was decided that a different approach was needed for determining the psychosocial needs of the elderly -- instead, an attempt was made to list the needs in an order which would suggest to nursing students and other health professionals which needs to ensure satisfaction of first, since it was necessary for

an elder to have a sense of individuality and of self, before he/she could feel good about that self (self-worth). this was not always easy, as the denial of one need often leads to the denial of another need. In short, the needs are not exclusive and cannot really be dealt with in a linear fashion.

For example, prerequisite to all of Maslow's needs and all those on the final list of psychosocial needs, or perhaps inherent in all of them, is the need for control -- control over one's body, its facilities and abilities, and to a certain extent, control through one's abilities over the environment in which one lives. (This in turn implies control over one's own mind.) Control is a sine qua non; one of the givens; something unconsciously assumed to be present. This assumption is a dangerous, for in the case of the elderly, control is all too often absent.

On this basis, one would expect control to be the first psychosocial need on the final list as compiled by the development team, but it can be seen, by looking at Table 1 (p. 34), that it is in actuality the fourth. This is due to the non-linear nature of the needs. That is, one needs control (over one's mind) before one can have a sense of one's individuality, but then again, one needs a sense of individuality in order to exert control over one's environment. In some senses, most of the needs are prerequisite to most of the others.

Table 1

Comparison Between the Psychosocial Needs of the Elderly
and Maslow's Hierarchy of Needs

Psychosocial needs	Maslow's categorization
1. Individuality	4. Esteem needs
2. Self-worth	4. Esteem needs
3. Healthy philosophy	4. Esteem needs 5. Self-actualization
4. Control	5. Self-actualization 1b. (implied by category 1)
5. Mental Stimulation	1b. (implied by category 1).
6. Security	2. Safety
7. Reality Acceptance	5. Self-actualization
8. Communication	3. Love

An attempt has been made in Table 1 (p. 34) to identify each of the psychosocial needs in terms of, and in relation to, the original Maslow hierarchy. The following paragraphs should clarify any uncertainties raised.

Such needs as control and mental stimulation come under a heading not in Maslow's hierarchy, but under one which is implied by the first category of physiological needs, where such things as activity, rest, and nourishment are listed. However, the mind also needs these three things, and Maslow does not mention them per se.

The need for security is really a direct translation of Maslow's safety needs, and requires no further explanation.

The need for communication comes under Maslow's "love" (social) needs. It should be pointed out at this time that the need for communication is used in its broadest sense -- to encompass all from simple physical contact to conversation to relationships, which are the ultimate expression of communication.

The needs for individuality, self-worth and healthy philosophy all come under Maslow's esteem needs, as all pertain to the individual's concept of him/herself and the way he/she approaches the world.

Finally, healthy philosophy, reality acceptance, and to a certain extent, control, come under the "self-actualization" needs envisioned by Maslow.

Once the basic framework of psychosocial needs was

hammered out, a reverse process was tried whereby an exhaustive list of problems, complaints, and syndromes of the elderly were examined. In each case, the question was asked of this problem, "This problem is a result of the denial of some need -- which need was denied?" In this manner, it was ensured that the list really did contain all the psychosocial needs of the elderly, even if based, in the main, on Maslow's hierarchy of needs.

Summary

Elderly people, in common with all human beings, have needs and desires which must be satisfied at an acceptable level. It would appear that institutions for the elders have been most successful in meeting those needs which can be classified as physiological.

This is due in large part to the non-existence of a clearly defined list of non-physiological, or psychosocial needs. Because of the need for such a list, one was derived from Maslow's hierarchy of needs and from lists of common problems of the elderly.

CHAPTER III

LEARNER ANALYSIS

It was originally intended that the elderly themselves share the title of primary audience with nursing students, in the following fashion: that the elderly be the primary overt audience, in that the tone of the script address itself to them; and that the nursing student be the primary covert audience in that (a) the package would contain much information they needed to know, and (b) through the package, they would learn how to address some of the problems of educating the elderly. The reader is directed to Carr's Medicine and Illness (1985) for an example of this type of approach.

However, after a meticulous search of the literature, it became obvious that such an approach was not appropriate to the subject area of the psychosocial needs of the elderly, by reason of the fact that this approach requires the developer educate the learner (a nursing student) to educate another "second-generation" learner (an elderly individual). It was clear that time and space would not permit the extensive teacher-training required.

As mentioned in Chapter I, only a few of the psychosocial problems which the elderly face can be dealt with by education of the elderly. The solutions to many of the problems require education of the health professional as

a prerequisite, and many more cannot be dealt with by education at all.

On this basis, it was seen that the primary audience of the package could not possibly be the elderly themselves, but rather, that audience who held in their hands the most problems likely to be solvable by the application of knowledge resulting from an educational approach -- that is, the health professional; specifically, the beginning health professional, due to the limited depth and scope of the package.

However, as some of the problems which might be described as "not solvable through education" are ones which require education of all society, and hence should more accurately be termed "not practical", it was seen as desirable that the package be suitable, with few or no amendments, to the general public. This resolve was slightly altered, as will be seen shortly.

Primary Audience

The concept of a typical first-year nursing student is as inaccurate as the concept of a typical elder. However, as of this writing, these general descriptive characteristics, would seem to be representative (though not exclusively so) of the population:

First of all, most of the first-year nursing students are young; that is, between the ages of seventeen and

twenty. This is important for a number of reasons, the most important of which is that it shapes both their attitudes and their knowledge. There are, of course, exceptions to this, but they are doubtless insignificant [reference needed].

Secondly, a large percentage of nursing students are female. While this is particularly so locally -- that is, within Newfoundland -- it seems that it is not true to as great an extent as it was, and it seems likely that the number of male nurses will grow. The implications for the developer of this descriptive characteristic, if any, are not clear.

Thirdly, most of the nursing students will be North American by birth. In particular, most Newfoundland nursing students will in fact be native Newfoundlanders. This is important in terms of attitude towards the elderly -- in American/Canadian culture, an elderly person, particularly a parent, may be respected but will be neither thoroughly revered nor thoroughly despised. In addition, a culture also dictates customs which pertain to other aspects of the psychosocial needs of the elderly. For instance, the job or occupation is extremely important in the American/Canadian context. To demonstrate just how deeply-rooted the work experience is in our culture, witness the disfavoured attitude towards idleness -- as opposed to the more amiable oriental tradition. This strong cultural tendency to identify on the basis of occupation is one which

discriminates against, or at least disables, the elderly.

As mentioned, the three descriptive characteristics of the primary audience are most helpful in that they affect and help us to understand educational and attitudinal characteristics.

With reference to educational characteristics, it is essential to define these so that one can define the "entry-requirements" or "entry-behaviour" of a learner. In a sense, we are listing the assumptions the developer has made about his learners' educational experience and history.

In this case, all nursing students will have completed high school. This is an "entry requirement" into the vast majority (if not, indeed, the entirety) of nursing schools, so we can safely assume this. However, there is another assumption behind this first assumption, and that is that all those who have completed high school (and been accepted into a nursing school) are of an average or better intelligence.

Beyond this, the developer requires no other training. In fact, there is an assumption that the learner comes to the package with absolutely no medical training of any kind. This is a reasonable assumption in terms of first-year nursing students, and has the advantage of keeping the non-primary audiences broad. It should be noted that a lack of medical training is not required by the developer as an entry-point (i.e., the package is not designed so that

people with medical training would find this package of no use), it is merely assumed that there will be no such knowledge or training.

The final educational characteristic of this primary audience is that, having been born (for the most part) in the late 1960s and possibly early 1970s -- that is, since they are young -- they will not have had any first-hand experience of a time in their own North American culture when the elderly, particularly parents and grandparents, were greatly respected and revered. The post-sixties social conscience and attitude towards older generations is, to the young nursing student, quite natural, and in most cases, unconscious. Not so for those older generations, who look on the change brought on during the sixties as a social upheaval. This lack of experience of anything but a youth-oriented society, which the average nursing student of today conceives of as being the status quo, is best classified as knowledge, and is perhaps the most important educational characteristic of the primary audience.

As the slide-tape package was seen to be largely attitudinal in purpose rather than informational, it was determined, that in looking at the intended primary audiences it was necessary to look at their attitudes rather than their training and knowledge.

Except for the assumptions about difference and possible disparity in attitudes, the developer makes only

two assumptions about the attitudinal characteristics of the learners, and the first is quite simple -- that the learners are not directly opposed to the package. The other assumption comes directly from the first assumption. It is assumed that the learner has some interest in the topic of the psychosocial needs of the elderly, and alternatively (or possibly, in addition to the interest), recognizes the value of such a package. A nurse in today's world should recognize the need to be aware of all facets of the care of the elderly, as they are health professionals in a world where the proportion of the elderly population is growing.

For the most part, the developer cannot do a great deal in anticipation of the various kinds and strengths of the audience's attitudes towards the elderly, but it is important to realize what the individual him/herself probably does not: how certain of these attitudes were formed, and why, and how strong they are in relation to certain other attitudes. First and foremost in the strength category are those personal attitudes towards the elderly; that is, those formed through contact with elderly relatives and other elderly individuals which one has known personally. The learner's conception of elderly people depends upon their experience from personal relationships with their own parents or grandparents. Relationships can be influenced by the presence of such factors as contact with elderly people who have been ill, or uncommunicative.

How one thinks of elderly people must be seen to be ruled primarily by one's personal relationships with elderly people, both in the past and in the present. After these attitudes, come the cultural attitudes -- those thoughts about and feelings towards the elderly very widely held by the American/Canadian culture. While these beliefs are often accurate, they are often very strong too. To begin, there is a tendency for negative stereotyping, with the elderly being "regarded as poor, isolated, sick, unhappy, desolate and destitute" (Neugarten, 1982), or as "persons in need". There is much condescension to, and avoidance of, elderly people. Indeed, prevalence of negative attitude towards the elderly is matched only by the variety of such attitudes.

These negative attitudes lead to stereotyping of the elderly, and the creation of irrational but lingering myths, such as the myth that age equals illness. (For a more detailed discussion of the common myths about the elderly, see Appendix A, or pages 11-14 of Appendix Q.) Thus what started as an emotional obfuscation has become a cognitive one.

It is important for the developer to realize that all learners will have unique and very different perceptions of the average elderly person, and that all these perceptions cannot, or need not, be altered.

Secondary Audience

The secondary audience for this package may be loosely described as the general public (with the implication that the audience is from a North American culture). This description, not particularly expressive, is based on the fact that the requirements of this package do not have previous medical training or knowledge as a prerequisite. Thus, when referring to the general public, the intended meaning is that non-medical people are capable of using and understanding the package.

However, as this is an attitudinal package for the most part, this distinction is not as important as health professional might think. Rather than describing the package as suitable for "the general public", it would be more accurate to describe it as being suitable for "members of the general public both sufficiently motivated and interested in the psychosocial care of the elderly". (This assumes some of the same attitudinal characteristics of the primary audience, viz., that they are not directly opposed to the package, and are interested in and/or see the value of the package.)

While the attitudes of "the general public", as re-defined above, are likely to be both similar and similarly diverse, there is an increasing possibility that their motivation for viewing such a package is that they have old parents or other relatives, for whose care they are

responsible (or for whose care they are eventually to be responsible). Either a care-giver or potential care-giver is likely to be more highly motivated to learn about this topic than the average first-year nursing student.

One restriction associated with this package is that it does in fact assume learners with an intelligence of average or above. While this is a fair and reasonable assumption in the case of nursing students, it is not so in the case of the general public. Whether or not it is possible to introduce some of the topics covered in the slide-tape package to those below average intelligence is beyond the scope of this package, and is probably, in any case, a debatable point.

To counterbalance this restriction, it is helpful that some members of the general public will have personal first-hand knowledge of their society when it was not quite so youth-oriented.

The use of this package by the general public would be of great benefit to all concerned, and might conceivably make possible solutions to some problems not normally achievable without massive turnaround in general social attitude towards the elderly.

"Tertiary" Audience

While some educational developers might term this next

group as one of the secondary audiences, it is, in some senses at least, a tertiary audience. Originally conceived as the primary overt audience, the elderly capable of using this package (i.e., those not prevented of doing so by physical restrictions such as poor hearing or eyesight) could certainly benefit by use of this package. It should be noted that some of the same characteristics apply to the elderly as to the general public -- that they have known a time when the society was not as youth-oriented, that they may not be of average intelligence, and that their motivation is quite likely to be strong.

The elderly are likely to benefit from viewing the package in a number of ways, especially in the dispelling of the myths about the elderly. To begin with, they can help in the education of those who still believe those myths. Even more important, the elderly who actually believe these myths about themselves can learn to overcome their self-imposed restrictions. For example: it is quite a common occurrence for elderly people to fear they are becoming senile if they become forgetful. The knowledge that what was once rather inaccurately called senility is not a natural part of aging could save the elderly individual much worry.

In addition, the elderly individual could very easily benefit through use of the package in that he or she might, now being aware of his/her needs, prevent denial of them before

it occurs, or treat his/her own denial once it occurs.

An increased awareness on the part of the elderly would, of course, benefit all concerned -- the elderly person him/herself, the care-giver(s), whether health professionals or not, and ultimately, all of society.

CHAPTER IV

TASK AND CONCEPT ANALYSES

The development of any instructional package typically includes the creation of task and concept analyses. Complete versions of charts for these analyses may be found in Appendices E and F, respectively. The purpose served by preparation of such charts is an important but basic one -- it allows the developer to determine what concepts and other information will be included in the package.

The task analysis, for instance, provides a framework of those tasks required by the learner. These tasks should not be confused with the objective(s) of the package -- the tasks are the steps the learner must take in order to achieve that objective. For example, the principal objective of the package under study was to heighten awareness of the psychosocial needs of the elderly. In order to achieve this, the concept of elderly had to be defined (which includes the dispelling of all myths; that is, the clearing away of any misinformation about the subject). It will be seen from the task analysis, on which the ultimate task is listed at the top, and the primary task is at the bottom, that this is the first task to be accomplished by the learner.

It will be seen that the ultimate task listed is satisfaction of the needs. It should be noted that this task analysis is the one prepared not for the slide-tape package

(which is the only portion of the presentation being discussed and evaluated in this report) but for the presentation as a whole, inclusive of the booklet. Thus, although there is some attempt in the slide-tape package at introducing the process whereby psychosocial needs are satisfied, the majority of this work is done in the booklet (see Appendix O). The major objective of the slide-tape package is to heighten awareness of psychosocial needs and their importance.

While the package objective and task analysis chart are for the most part self-explanatory, the concept analysis (Appendix F) requires more elaboration, in the form of the listing of the critical attributes of each of the concepts present in the concept analysis chart. This elaboration follows. (Note that the primary concept of the psychosocial needs of the elderly, which is at the top of the chart, is not explained or defined by virtue of the fact that it is this complex primary concept that is defined by the culmination of all those concepts -- and their critical attributes -- which are below it.)

Psychosocial

Attributes

- pertaining to an individual's mind (the mental, or psychological)
- pertaining to an individual's relationships with others
- to do with an individual's perceptions of self, others, and environment
- that which is not physical
- may be closely related to the physical
- may involve the mental (or psychological) only, and not the social
- may involve the social only, and not the mental (or psychosocial)

Examples

- one's religion is a psychosocial matter in that it deals with perceptions of the meaning or purpose of life and in that it affects one's interactions with society
- poverty, though a deprivation in the physical sense, also affects one psychosocially; the physical effects of hunger, cold, etc. are separate from but possibly the cause of psychosocial effects such as anti-social behaviour

Non-examples

- death occurs as a result of ceasing of physical function
- incontinence is a physical problem (though the cause could be physical or psychological)

Definition

Involving psychological and social factors.

(Human) Needs

Attributes

- often confused or used synonymously with wants
- closely tied with the concept of inalienable rights
- things absolutely required
- implication of human needs is often unconscious -- that is, human needs are often classified simply as 'needs.'
- sometimes confused with symptoms of need denial

Examples

- air to breathe is a physical, individual need ... without it, the individual will die
- mental stimulation is a psychosocial need ... without it, the individual will become mentally unhealthy, and in extreme cases, insane

Non-examples

- sexual activity ... that is, the individual will survive without it (though the human race would not)
- education

Definition

Things required by human beings to maintain good physical and mental health.

Psychosocial Needs

Attributes

- required to maintain mental health
- required to maintain relationships with society, or the ability to maintain such communication

Examples

- control over one's life (freedom)
- a feeling of dignity, of self-worth

Non-examples

- happiness: this is a result or symptom of fulfilled needs
- physical exercise: this is a need, but a physical one

Definition

Those things required by human beings (see Needs) which are not of a physical nature.

(NOTE: For detailed discussion of each individual psychosocial need, see Appendix O or Chapter II.)

Physical Needs

Attributes

- might be required for the individual
- might be required by the race
- required for survival
- required by the body, as opposed to the mind

Examples

- nourishment (food and water)
- warm shelter (protection from the elements)

Non-examples

- freedom
- love

Definition

Those things absolutely required for the continued physical existence of the organism or of all such organisms.

Elderly

Attributes

- advanced in age (generally over 65 years old)
- refers almost exclusively to human beings (of either sex)
- does not refer to a specific physical condition (not necessarily ill or frail, or possessed of poor eyesight and/or hearing)
- not necessarily in poor financial condition
- not necessarily forgetful
- often no longer working on a daily basis (i.e., retired)
- perception of age often related to presence of grey hair and/or wrinkled skin (a physical change with no direct positive correlation with number of years)

Examples

- Sir John Gielgud is an elderly actor, though he began acting as a young man
- Santa Claus is generally assumed to be an elderly man

Non-examples

- An antique vase is said to be old, not elderly.
- People between fifty and sixty-five are generally not considered to be elderly, even though they display some grey hair, et cetera.

Definition

Over the age of sixty-five years. It should be noted that physical and psychological change are not tied to the concept of years, and that since all measurements of time, years included, are of necessity somewhat arbitrary and created by man for his convenience, this definition is not particularly expressive.

Young-Old	Middle-Old	Old-Old
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Attributes of Young-Old, Middle-Old, and Old-Old

- refers only to human beings, of either sex
- refers only to number of years the individual has lived
- does not refer to anything else, such as attitude change, physical disabilities, etc.

Definition Young-Old

A human being between the ages of 65 and 69 years.

Definition Middle-Old

A human being between the ages of 70 and 79 years.

Definition Old-Old

A human being above the age of 80 years. There is no upper limit, though humans have been known to live to be as old as 130 years.

CHAPTER V

RATIONALE FOR CHOICE OF MEDIA

The literature in the field of educational technology has addressed the question of media selection, and has come up with two main approaches to the problem.

The first and more traditional approach states that media selection should be made on the basis of analysis of the instructional goals, learners, tasks and concepts involved, as well as the instructional setting. This involves reference to numerous charts and flow-charts delineating specific media attributes. Stolovitch (1976) states that there are six factors which are essential to the selection of the best possible medium for a given instructional unit:

- I. Selection of media should be made systematically;
- II. Selection should take into account learner characteristics;
- III. Selection should take into account task characteristics;
- IV. Selection should take into account the pragmatic constraints of the producer;
- V. Selection should take into account the pragmatic constraints of the consumer;
- VI. Selection should be based on the optimal combination of media attributes which match the requirements of the instructional objectives.

In addition to these six factors, Stolovitch also notes that media selection should be influenced by the nature and requirements of four principal considerations -- the learners themselves, the instructional task(s) in question, the production facilities and capabilities, and the plans for dissemination to the potential audience for the finished presentation. In order to keep in mind the six factors and the guiding result of the four main areas, the instructional developer should consult a chart similar to the one in Appendix D.

Two approaches are suggested by Romiszowski (1974), the first of which is somewhat similar to Stolovitch's. However, Romiszowski notes two additional factors which may potentially influence the selection of a medium. First of all, he suggests that the choice of any given instructional model will limit the choice of media. Secondly, he suggests that the success of the presentation will be affected by the extent to which the presenter accepts the medium in question.

Romiszowski's second approach owes much to Briggs' (1970) selection-by-rejection technique. This method still encourages analysis of the instructional task, et cetera, but is based on the elimination of media based on unsuitability. The chart used for this process (Appendix G) is, of course, a brief and simple representation of the characteristics involved, and should not be adhered to

either too strongly or too closely. Briggs himself warns of the dangers of doing this.

Carrying this school of thought one step further, we arrive at the "inverted approach", as Stolovitch and Thiagarajan (1975) have labelled it, where the developer begins by attempting to identify the most suitable medium -- that is, the one with the maximum number of desirable attributes -- at the smallest cost. This approach is justified by its belief that any medium is as good as any other as far as instructional effectiveness goes. There are, after all, comparison studies whose findings show that there is no significant difference in the medium used.

This approach was used to some extent in the production of this package, principally because the client requested a slide-tape/booklet presentation. And yet, having discussed the request with the project co-ordinator for the St. Clare's School of Nursing, it may be said with equal conviction that the more traditional approach recommended by Stolovitch was used. The request was made to the developer by the School of Nursing on the three following bases:

First, that the two media were suited to the task -- the slide-tape would in fact introduce vital information as well as attempt to help the learner define a more accurate attitude, and the booklet would provide a more concrete source of information, which would of course be more detailed than was allowed by the length restrictions of the

slide-tape portion.

Second, that the two media were capable of being produced by the development team, given the time and financial restraints (the presentation, was after all, being partially funded by a grant from Summer Canada which allowed for the hiring of three individuals for ten weeks) and closely related to these realistic production expectations, the two media were capable of being disseminated within the the School of Nursing and hospital, and across the province if financially possible and/or necessary.

Third, that the media -- especially the dual medium of slide-tape -- would be suitable for use with elderly people. That is to say, not only would the advantages of amplifiable sound and projectable pictures be useful, or perhaps necessary, for those elderly with impaired facilities, but also the media would be sufficiently familiar to the learners that they would not reject it through fear of it, or unfamiliarity with it. (The reader is reminded that at the time the School of Nursing requested the presentation be in the form of a slide-tape package, they conceived of the primary audience as being the elderly themselves.)

In their request, then, the School of Nursing, though presumably without training in the field of educational technology, had applied the Stolovitch approach to the selection of media.

At this point, more as a re-confirmation than anything

else, the developer felt obligated to use the inverted approach put forth by Stolovitch and Thiagarajan in order to determine the suitability of the three media -- slide, tape, and print. By referring to a chart (Appendix H), it is evident that this combination includes virtually all media attributes, the exceptions being the qualities of motion and three-dimensionality. Since these attributes were not critical to the project topic, it was decided that use of the slide-tape/booklet combination would be entirely appropriate.

In addition to the advantages and reasons envisioned by the program co-ordinators, the slide-tape/booklet combination possesses other qualities which make it particularly appropriate for use with the subject matter of psychosocial needs of elderly people. To begin with, delivery of presentation may easily be adapted to the requirements on unique individual situations. As the package contains a tape with automatic advance signals, manual advance signals, and a script so that the narration can be read aloud by the presenter, it is obvious that the speed of delivery can be tailored to virtually any learning situation. Similarly, the advantages of random access afforded by slides (as opposed to say, a filmstrip) allows that certain sections may easily be isolated, for the purpose of review and clarification.

The slide-tape combination shows a similar flexibility

in terms of presentation to various groups sizes. Because a variety of equipment is available for the viewing of such packages, it is possible to project images onto a small screen which is an integral part of the projection unit, thus making it suitable for individual and small-group viewing, even in situations where it is not possible to darken the viewing location. Of course, built-in tape recorders with automatic advance mechanism are other features often found in such equipment, and as the capability still exists for projecting larger images onto walls and screens, this makes it possible to use this presentation/equipment combination with larger groups. As this equipment is typically more lightweight and portable than the average film projectors and video-cassette recorder-players, it is more easily disseminated to the audience.

On the topic of dissemination, it should be noted that slide-tape packages are usually sufficiently inexpensive so that more copies may be made for wider distribution, and that many institutions have in their possession the equipment for the presentation of such packages.

As the slide-tape/booklet combination was approved by both the instructional development and health professional teams, production was begun at the photographic facilities of the St. Clare's Mercy Hospital School of Nursing and at the Division of Learning Resources, Memorial University of

Newfoundland. The narration was recorded by the School Broadcasts Division of the provincial Department of Education in St. John's, Newfoundland, and the booklet was written, designed and produced with the assistance of word-processing equipment on loan from Harry Cuff Publications Ltd., and the production facilities of St. Clare's School of Nursing and the Division of Learning Resources at the Memorial University of Newfoundland.

CHAPTER VI

DEVELOPMENT PROCEDURES AND FORMATIVE EVALUATION

Once the needs assessment, audience analysis, task analysis and concept analysis were completed, the production phase was begun. This included scripting, storyboarding, photography, graphic art, writing of the booklet, recording of the audio tape, and so on.

Through the stages of the previous (pre-production) phase, the developer consulted with various members of the staff at the St. Clare's Mercy Hospital School of Nursing, including Ms. D. Brown and Ms. B. Turner, who served as content experts. The primary content expert was Mary Kielley, R.N., B.N., Head of First-Year Studies at that School.

Working with the final revision of objectives for the package and with research notes gleaned from individual research of available materials in the various libraries, medical and otherwise, in Newfoundland, a draft of the script was produced and sent to each of the three content experts who read the script and made notes individually before meeting to bring together all of their comments. They suggested very few changes, most of which were in the interests of clarity and style. They did supply correct medical terminology -- for example, it was noted that "senility" is not a recognized term, as it implies

(incorrectly) that it is a natural process whereby memory control and deterioration of the brain occur, directly related to aging. Also, the first script stated that deterioration of eyesight and hearing are natural losses connected with old age, and as this has yet to be proved, all references to poor eyesight and hearing were referred to as a common occurrence rather than a natural one.

It can be seen that little of importance was changed. What is important is what was not changed: the eight psychosocial needs (which had previously been made clear to our content experts did not appear in any list in any book), were not challenged. This is of importance since the needs were gleaned not from a reference work, but compiled by the project staff after its researching of available literature.

Furthermore, no major changes were suggested in sequencing, language level, or in the visual images chosen to appear in the script. This was, of course, encouraging but not as surprising as it might have been had there not been a model to follow, in the form of a slide-tape package, Medicine and Illness: the Cause or the Cure produced for St. Clare's School of Nursing by Ian Carr, in the previous year, 1983. This package provided the production team with a guide to overall visual look and feel. Mr. Carr mentions in his thesis, A Report on the Development and Evaluation of a Slide/Tape Program Entitled "Medicine and Illness: the Cause or the Cure", that his content experts had recommended

that he avoid identification with any recognized health care facilities in the province and had observed that he avoided stereotyping and biased representation of both sexes (Carr, 1985). As this project was closely based on his previous work, we, by following his lead, avoided such problems.

Based on the changes suggested, a second draft of the script was produced. This script was given to the primary content expert, Ms. Kielley, for her comments, and also to Ms. D. Braffet, librarian and media specialist at the School of Nursing.

Ms. Kielley had few changes, and most of them related to style and tone rather than actual information. Since the manner in which information is presented is a legitimate topic of concern, these recommendations were adopted. The single greatest change was the revision of the wording of the ending, which the developer disagreed with, but which the expert considered essential. It was recommended at this point that the script be shortened slightly so that the presentation time of the package should not be overlong.

Ms. Braffet was pleased with the way the script held the tone and format of Mr. Carr's previous package in the series, while submitting that the script might possibly run too long.

A third draft of the script was written with the above changes in mind. It happened that when the script was actually recorded, it was too long by about five minutes and

had to be cut. (It is generally recognized that a slide-tape show should be ten minutes in length; fifteen is about the allowable maximum.) These cuts, supervised by both Ms. Braffet and Ms. Kielley, were made solely on the basis of a need to shorten the overall length of the slide-tape show to the desired maximum of approximately fifteen minutes.

Speaking to the quality of the slide-tape show while in production, Ms. Braffet noted that the package was completely satisfactory:

The quality of the slides is excellent. They are consistent in color, lighting and the composition is well thought-out. The pictures are appropriate to the narration and enhance the meaning of the text. The pacing is good.

(Braffet, 1985)

CHAPTER VII

SUMMATIVE EVALUATION

Evaluation of the slide-tape package was conducted in two basic ways: content experts and other professionals were contacted, as well the elderly themselves; also, the package was tested with different groups of nursing students, who are the primary audience.

User Appraisal

The importance of this appraisal was seen to be important, as the evaluators could determine with reasonable reliability the validity of the package, and it was felt that their opinions were useful and informed.

Each educator lecturing in gerontology at the St. Clare's School of Nursing who viewed or used the package with his/her classes was asked to complete an evaluation form (see Appendix J) which posed a number of questions. This questionnaire included requests for information such as the quality of the package and its appropriateness for use with a variety of groups (and audience levels) in a variety of situations. What follows is a cumulative look at the evaluation of the health professional group.

Given the informality of the questions and the lack of scaling questions, the results cannot and probably should

not be statistically analyzed, but they can be of help in determining the impressions of the educators, and health professionals about the strengths and weaknesses of the package.

Results

Three forms of questions were included on the evaluation form. Most questions were of an open-ended type, designed to elicit an individual and unbiased response and allowing the evaluator to comment on any aspect of the package which occurred to him/her (as opposed to aspects which occurred to the developer). Some questions were of a combined open-ended and "yes-no" type, which provided for individual responses first, and required answers to specific questions, thus insuring that issues which the developer had considered vital were answered but which did not limit the responses to those issues alone. One question was purely a forced-response situation, where the evaluators were asked to respond to twelve statements ranging from educational content to technical esthetics. This was recorded on a four-point scale in order to prevent non-committed responses.

The open-ended questions were geared to situations where answers were unpredictable and in which the developer wanted to uncover any problems, et cetera, that he might be unaware of. The responses to these questions were varied,

including no response at all, brief non-committal responses, and much more detailed responses. For example, when asked if there were any inappropriate slides, all evaluators indicated that there were not. However, in response to question number 10, in which evaluators were asked to mention any groups which they believed would benefit from viewing the package or from having it at their disposal, responses included "general audience" and "children of aging parents". One evaluator responded:

I think personnel in any/all nursing homes should view this -- even on a regular basis, e.g. monthly or every third month.

The final question, asking for general comments, was invariably answered in some detail, all responses being positive in nature. The package was described as being useful, concise, clear, and so on. The following response was typical of those received:

A very good presentation, easy to follow -- variety of slides very suitable. Interesting and informative.

That one health professional complimented the package as being interesting is to the writer's mind particularly significant.

The issues in the forced-responses section varied between positive and negative responses, thus, leaving the evaluator no choice but to select carefully the appropriate response. In other words, care was taken that the

respondent did not simply check one side of the scale without thought. Absolutely no negative responses were recorded. One evaluator thought that the package was a bit long, but not overly so; however, no other similar responses were made. In one case, an evaluator felt very strongly that the concepts were clearly conveyed, noting at a different point that the package was "useful and concise". It is interesting to note that one only of the respondents agreed -- though not strongly -- that the presentation was too long. All other respondents disagreed with this statement.

With regard to the combination open-ended and "yes/no" questions, all respondents indicated their intention to use the package again. None of the respondents used the package as an introduction to the topic, but considered it suitable as a summary or for review purposes. In terms of level of student, all but one respondent indicated that the package was suitable for all levels but was particularly suitable for beginning, first-year students. One respondent indicated that it was suitable for first-year nursing students and for Grade XI and XII high school students.

This same respondent indicated that she thought the presentation, while appropriate for people other than nursing students, was not suitable for the elderly. Another respondent, however, commented on suitability thusly:

Certainly gives insight into needs and concerns of elderly which can be for any

audience. Elderly [people] could probably gather insight for themselves from such a presentation.

All respondents indicated the suitability of the package for the general public, doctors, nurses, hospital and nursing home workers -- in addition, of course, to nursing students. The package was described by one respondent as being "geared to either the lay person and/or the professional".

In addition to the formal response of the health professionals, it was felt that the response of the elderly community itself might be valuable in evaluating such a package. On two occasions, a small number (two or three) of elderly people viewed the slide-tape show and were encouraged to comment upon and discuss it. On both occasions, comments were uniformly complimentary but not effusively so. When asked whether the overall portrayal of the elderly was accurate or inaccurate, the consensus was that within the limits of a short slide-tape show, the picture was accurate. When asked whether they were offended, pleased or displeased by the way elderly people were portrayed, all said that they were pleased. One lady stated that she was pleased that hospital and nursing home slides had not dominated the show. Another lady, referring to the 'security' sections of both the slide-tape presentation and the accompanying booklet, said she thought the package ought to be sent to the provincial minister of

social services. She thought the authorities had little understanding of the psychosocial aspects of aging and concentrated solely on the physiological aspects.

While it has been suggested that the elderly are grateful for any attention given to them (Carr, 1985), thus rendering them unobjective and biased towards acceptance of material, not only has this proposition not been documented, but the writer found that the elderly who had viewed the package were positive but not uncritical. While it would be inappropriate to ask the elderly people about the degree to which they thought the package under discussion was a good one (as they were neither health professionals nor educators), it is perfectly appropriate to determine whether or not they thought it poorly- or well-made. In other words, it is significant that no negative response to the package was made by the elderly groups. The extent or degree of positive response cannot be said (or at least not proved) to be significant in these terms.

Analysis of Results and Conclusions

Both in the cases of the groups of health professionals and the elderly themselves, the sample was relatively small. However, all those interviewed responded in a positive manner, indicating that they thought the presentation successful overall, true both to the elderly character and

to its objectives.

The evaluation forms indicate that it was well-received by all respondents, and appropriate for a wide variety of audiences, especially for first-year nursing students. The general public, including relatives of elderly people, and hospital/nursing home workers were also mentioned as potential audiences.

The discussions with the elderly viewers indicated that they were pleased with the package overall -- most significantly, they did not disapprove of its content nor its attitudes.

Audience Appraisal

A series of "final evaluations" of the slide-tape package was carried out with the St. Clare's School of Nursing students. (Note that the booklet, though developed as part of this educational package, was at no time evaluated for the purposes of this report for the reason that the school of nursing deemed it strong enough to use as a separate package.) As the project was designed to educate the untrained first-year students and other novices to the field of gerontology, a group of first-year students was used, as well as a group of third-year students in order to ensure that the package was most useful for those students that it was in fact designed for.

The slide-tape show was designed primarily to educate

the students about the myths concerning the elderly and the importance of their psychosocial needs -- its goal, as noted, was attitudinal. It also provided an introduction to some of the problems, symptoms, and solutions regarding the psychosocial needs of the elderly, but as has been noted, the medium of slide-tape is not particularly suitable for presentation of vital information as it is a fugitive medium. (It was to achieve the second objective -- viz., that the package should help learners to know the needs and common denials, recognize and then treat the symptoms, and ultimately satisfy and prevent further denial of the needs -- that the accompanying booklet was designed.)

As the main objective of the slide-tape portion was attitudinal, a questionnaire (Appendix K) which asked the users to rank the importance of both physical and psychosocial needs for the elderly and young was designed. (The users were asked to rank the needs of their own age set, in the hope that they would translate this into "my own needs". This was done partly to draw their attention to "old vs. young" rather than have them concentrate on the way they would rate the elderly on the pre- and post-questionnaires, and partly so as to measure the transference effect noted by Mullins & Merriam in 1983, in which a study of dying elderly patients resulted in no attitude change toward the elderly being noted, but in which the nursing home staff being tested registered an increased death

anxiety themselves.) It was predicted that the physical needs would be rated highly on a pre-viewing questionnaire, and that psychosocial needs would gain high ranks in a post-viewing questionnaire.

To find an average pre-viewing and post-viewing rank (referred to in tables as pre \bar{X} and post \bar{X}), it was necessary to use a method of calculating the means of a particular need across the group, as the pre- and post-ranks of each individual were not recorded as tied -- that is, the identity of each user was not requested on the questionnaire. The method of calculating an average rank in such a case requires that the rank (in this case, one through to twelve) be multiplied by the number of times that rank was chosen. Adding all these products together and multiplying them by the number of respondents gives the mean rank for the need for that group. (See Appendix L for a sample of this method.)

In both cases, the students were asked to fill out a questionnaire immediately before viewing the slide-tape show. They then viewed the show, and completed another identical questionnaire, requiring them once again to rank needs. (In the case of the third-year students, they were also asked on the post-viewing questionnaire to respond to the technical/educational quality of the package.)

Results and Analysis of Results

Overall, no great change in the ranking of the psychosocial needs over the physical needs was shown by the group of 71 first-year students who viewed the slide-tape show, at least not in a numerical sense. As can be seen from the Table 2 (p. 77), the largest change from pre-viewing to post-viewing questionnaire was 1.8. This is by no means insignificant, but it should be remembered that the needs were ranked on a twelve-point scale. A difference of 3.0 and above would have been more reassuring. The reasons for such quantitative differences not occurring will be discussed below.

It was hoped that the psychosocial needs would all be ranked as more important on the post-viewing questionnaire, and the physical needs would be ranked as less important. As one can see from the importance column, this happened to a certain extent. All physical needs were rated as less important or of the same importance; this is entirely satisfactory. However, three of the psychosocial needs are rated as less important. Why?

The three psychosocial needs rated less important were Love, Companionship, and Relationship with God. In the case of Love, the change was a scant -.3. It is important that on the pre-viewing questionnaire, Love is already rated as being the most important need for the elderly (Table 3, p. 78). In a sense, then, the need for Love had nowhere

Table 2
Change in First Year Students' Ranking of Importance
of Needs of the Elderly

Physical Needs	pre- \bar{X}	post- \bar{X}	change	importance
Dignity	6.6	5.0	1.6	more
Freedom of choice	7.9	6.4	1.5	more
Sex	11.6	10.7	0.9	more
Privacy	7.7	7.3	0.4	more
Security	4.3	4.1	0.2	more
Love	3.6	3.9	-0.3	less
Companionship	4.3	5.3	-1.0	less
Relationship w/ God	5.3	7.1	-1.8	less
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Physical Needs				
Medical care	6.8	7.7	-0.9	less
Money	8.5	9.0	-0.5	less
Food	5.2	5.2	0.0	same
Warm shelter	5.1	5.1	0.0	same

Table 3
First Year Students' Ranking of Importance of
Needs of the Elderly

Pre-Viewing		Post-viewing	
Need	Rank	Need	Rank
Love	3.6	Love	3.9
Security	4.3	Security	4.1
Companionship	4.3	Dignity	5.0
Warm shelter	5.1	Warm shelter	5.1
Food	5.2	Food	5.2
Relationship w/ God	5.3	Companionship	5.3
Dignity	6.6	Freedom of choice	6.4
Medical care	6.8	Relationship w/ God	7.1
Privacy	7.7	Privacy	7.3
Freedom of choice	7.9	Medical care	7.7
Money	8.5	Money	9.0
Sex	11.6	Sex	10.7

to go but down -- and it did not go down much in terms of numbers, and not at all in terms of rank...on the post-viewing questionnaire, the first-year students still rank Love as the most important need. Readers are directed to the discussion of ipsative and normative measure on pages 508-9 in Kerlinger (1973).

The explanation of why the needs for Companionship and Relationship with God were rated as less important are more interesting -- certainly the differences of the -1.0 and -1.8, respectively, between the pre- and post-means, cannot be ascribed to insignificance. In all probability, the rating of these two needs as less important may be due to the fact that certain myths concerning these needs were addressed. To illustrate this point, let us look first at Relationship with God. The slide-show, in the "healthy philosophy" section, frames 32-36 (see script, Appendix M), notes that religion may be a part of an elderly person's life, but in frame 20 points out that the elderly do not necessarily become more religious, nor more interested in going to church (Hess & Day, 1977). It would seem logical to suggest that this fact impressed itself on the first-year students, and resulted in the need for Relationship with God being less important.

A similar explanation concerning the lower post-rank for Companionship seems plausible. Frames 35 and 66 of the script points out that elderly people sometimes want to be

alone, and are not always lonely. This might account for the group rating Companionship as less important on the post-viewing questionnaire.

Turning from the numerical difference in pre- and post-viewing ranks, let us look at the way in which the needs were ranked in relation to each other on the pre- and post-viewing questionnaires (Table 3, p. 78). Love (position 1), Security (position 2), Warm Shelter (position 4), Food (position 5), Privacy (position 9), Money (position 11) and Sex (position 12) did not change their positions. Only one physical need, Medical Care, changed its position to drop two ranks on the post-questionnaire.

Of the psychosocial needs, Dignity and Freedom of Choice placed much higher on the post-viewing questionnaire. It seems likely that here the first-year students were responding to the dramatic story of Mr. A. in the "control" section of the slide-tape show (frames 38-42).

(It is interesting to note that when the presenter returned to the room after the slide-tape show was over, the students applauded as he entered, showing their approval of the show.)

On the whole, the first-year students reacted to the slide-tape pretty much as hoped, but on a more limited scale. It was hoped that all psychosocial needs would be rated as more important on the post-questionnaire, and indeed they were, except in the case of the three needs

already mentioned. That the change in importance of needs was not greater can be likely be attributed directly to the fact that the first-year students tested had, just previous to having had the package administered, been listening to a lecture on the psychosocial needs of the elderly. (This was not known to the writer at the time. Presumably the lecture was not directly based on either the slide-tape show or the booklet.) Had the concepts, et cetera, discussed in the package been fresh to them, the change might conceivably have been greater. However, the students were already thinking of such things as love and companionship as being important (which helps explain why these more general needs went down in importance on the post-questionnaire); their minds were already on the subject when they completed the pre-questionnaire.

As the thirty-one third-year students to whom a questionnaire was administered were not being lectured immediately beforehand, it seems logical to assume that their post-questionnaire responses should show a greater disparity, as in fact they do.

All psychosocial needs were rated as more important by the third-year students on the post-questionnaire, with the exception of relationship with God, for the reasons mentioned above --, that is, the frame which mentioned that the elderly did not become more religious as they grew older (see Table 4). Not only that, but the majority (5 out

of 8) of the change was +1.0 and greater, while there were only two such positive changes in the case of the first-year students. Companionship and Sex rated as +0.5 and +0.4, respectively, and as these are still positive changes, it is encouraging. The fact that the changes are small can be attributed to the fact that, in the case of the need for Sex, this very important issue is not directly dealt with in the package; and in the case of companionship, once again, this is a very broad and vague need which people would not be as inclined to choose after more pressing needs had been outlined for them.

This trend of greater difference extends itself to the third-year students' rating of the physical needs, where, as hoped, all physical needs were rated as less important -- three of the needs were below -1.0 at -1.9, -1.5 and -1.4.

In non-numerical terms, Love, Security, Dignity, Companionship, Warm Shelter and Food all retained their positions 1 through to 6 (Table 5). Relationship with God dropped from position 7 to position 9 on the post-questionnaire, and Medical Care dropped from position 8 to position 10. Freedom of Choice moved from position 9 to position 7, and Privacy moved from position 11 to position 8. Money dropped one position of importance, and Sex retained its last-place position.

The six lowest needs identified by the third-year students included the four physical needs, Privacy (for no

Table 4
 Change in Third Year Students' Ranking of Importance
 of Needs of the Elderly

Physical Needs	pre- \bar{X}	post- \bar{X}	change	importance
Privacy	8.8	7.2	1.6	more
Freedom of choice	8.1	6.8	1.3	more
Dignity	4.9	3.8	1.1	more
Security	4.3	3.2	1.1	more
Love	3.9	2.9	1.0	more
Companionship	5.0	4.5	0.5	more
Sex	10.7	10.3	0.4	more
Relationship w/ God	6.6	8.0	-1.4	less
<hr/>				
Physical Needs				
Medical Care	6.9	8.8	-1.9	less
Food	5.3	6.8	-1.5	less
Warm shelter	5.2	6.6	-1.4	less
Money	8.2	8.9	-0.7	less

Table 5

Third Year Students' Ranking of Importance of
Needs of the Elderly

Pre-viewing		Post-viewing	
Need	Rank	Need	Rank
Love	3.9	Love	2.9
Security	4.3	Security	3.2
Dignity	4.9	Dignity	3.8
Companionship	5.0	Companionship	4.5
Warm shelter	5.2	Warm shelter	6.6
Food	5.3	Food	6.8
Relationship w/ God	6.6	Freedom of choice	6.8
Medical care	6.9	Privacy	7.2
Freedom of choice	8.1	Relationship w/ God	8.0
Money	8.2	Medical care	8.8
Privacy	8.8	Money	8.9
Sex	10.7	Sex	10.3

known reason, though it should be noted that Privacy was the need with the greatest positive numerical change), and Relationship with God (for the reasons set forth above).

The third-year students probably had demonstrated greater numerical change because they did not have the material fresh in their minds before viewing the package, as their first-year colleagues did. However, their rating of psychosocial needs was not lower (as it might have been if these had been first-year students), because they have extra years of training; that is, they already knew a fair amount about the psychosocial care of the elderly.

The third-year students were also asked to complete a rating of the show they had seen in terms of its educational value and appropriateness, and technical quality. While they were not qualified as educators or media evaluators, it was decided to record their reactions. Results were in a sense predictable, in all categories, on a five-point scale, the average in all categories, except two, was 4.6 or higher, with the median response being 4.7. However, when asked to rate the length of the program, the rating was 3.0 -- at almost exactly the medium point. The show was in fact a trifle long, and the fact that the great majority of the students rated it as of medium (suitable) length would appear to be due to the fact that they found it simple in content for their level. This is encouraging, as it was designed not for the third-year students but for those in

their first year; the beginning students. This theory is also supported by the evidence of their ranking of level of difficulty, where the slide-tape presentation was given a rating of 1.9 on a difficulty scale of five, with "one" being the easiest. The students thought that it was best suited for a beginning student -- again an encouraging thought.

Conclusion

Overall, the results obtained were respectable if not spectacular, and suggest that this slide-tape package would be particularly useful in helping to modify the attitudes of beginning nursing students new to the area of gerontology.

That the results obtained are not as dramatic as the developer has originally hoped can be attributed to a misunderstanding of results possible when using ipsative rank statistics, and also that flaw in the planning stage by which the learners representing the intended primary audience of first-year nursing students viewed the package immediately after a lecture dealing with the same subject.

As noted, however, the results are positive and do suggest that novices viewing this package would have more positive attitudes towards the elderly, and would tend to view physiological needs as (relatively) less important, and psychosocial needs as (relatively) more important.

CHAPTER VIII

IMPLEMENTATION, SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Both major sections of the audiovisual package, Psychosocial Needs of the Elderly, appear to be successful in their attempt to introduce novice learners to the psychosocial context in which many elderly people find themselves. The exact effectiveness of the booklet portion has not, as noted elsewhere, been statistically evaluated, but the reception accorded it seems to reinforce its value.

The slide-tape portion of the package is currently part of the collections of St. Clare's Mercy Hospital School of Nursing Library, and of the Centre for Audio-visual Education (CAVE) at Memorial University, and can be disseminated to a wide audience of nursing students and family members with elderly relatives.

In addition, the slide-tape portion is used regularly in the education of student nurses by the St. Clare's School of Nursing -- that is to say, it is a required part of their curriculum. Copies of the package and projectors are available upon request from the audio-visual centre of that institution.

Although originally intended for use by nursing students, the slide-tape package appears to have another major audience not envisioned by the producer, but which was suggested by those who evaluated the package: it could

be put to good use by members of families with elderly relatives -- parents, grandparents, aunts and uncles, et cetera. It is hoped that the staff of St. Clare's who originally made this recommendation, since they are aware of this potential audience for the package, will, in their daily contact with such family members, recommend the slide-tape package to them when appropriate.

Though the slide-tape portion was designed as a self-contained package, it could be used more effectively with the elderly at a slower, user-controlled pace, in which there would be plenty of room for comment from the elderly learners. This approach could also be used for review -- for example, review of one or two of the sections dealing with a specific need -- in any learning situation. The advantages afforded by the random-access nature of the presentation should not be ignored.

Although not tested as a part of this report, and viewed as a self-contained instructional unit rather than the supplementary unit it was originally conceived as being, it would seem appropriate to make mention of the considerable success with which the booklet portion of the Psychosocial Needs of the Elderly package has been received. To begin with, the main content expert for the package, Mary Kieley, was, in a personal interview with the developer, most enthusiastic about the booklet. This accolade was followed by the recommendation to the St. Clare's School of

Nursing that the booklet be adopted as required reading for its students...a recommendation which was quickly approved. The school of nursing at the Grace Hospital has also expressed interest in the package, as have various other medico-social institutions.

In addition, the booklet was accepted for commercial publication by a local publisher, Creative Publishers, and it is intended that this edition of the booklet be placed before Mr. Charlie Brett, provincial Minister of Social Services, for consideration for placement in nursing homes for the elderly across the province. Though the booklet is a separate instructional package, this certainly has highly satisfactory implications for the topic of this report, the slide-tape portion of the package. Indeed, it is hoped that this proposed wide distribution of the booklet will lead to wider distribution of the slide-tape package as well.

Thus it may confidently be said that the presentation has been well-accepted, and of benefit to the elderly, who are after all, those with whose welfare the package is concerned.

Elderly individuals and health professionals have both indicated that the healthy, unbiased view of the elderly and the resulting tone are desirable, and the developer recommends that other areas of concern to the elderly be addressed in a like fashion.

However, the developer also cautions those addressing

themselves to similar areas of concern that the learner-approach of addressing the nursing student directly through the visual and narrative style, rather than addressing the elderly directly, is one which should not be adopted unless -- as in this case -- the material itself demands such an approach. The developer recommends that, if at all possible, the elderly be the learners addressed. It will still be perfectly possible to address the nursing-students as the major covert audience, as explained in Chapter III.

The developer also reinforces the recommendation that presentations for the elderly be sufficiently brief and simple so that the hearing- and visually-impaired members of an elderly audience will not have undue strain placed on their facilities.

In closing, let it be noted that 'becoming old' is not something which will happen to us all some day -- it is something which is continually happening to us all, every day. With this in mind, it behooves all of us -- nursing students, elderly individuals, family members, and all of society -- to prepare for the time when the psychosocial syndromes herein discussed are upon us.

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APPENDICES

APPENDIX A
COMMON MYTHS ABOUT THE ELDERLY

One problem which is constantly surfacing for those people who are responsible for (or who assume or take on the responsibility for) the elderly, is that many people, consciously or subconsciously, subscribe to at least a portion of the cadre of prevalent myths concerning the elderly.

Some of the most serious of these myths were enumerated by Norma Ruby in an article entitled "Ageism and Attitudes" (Ontario Association for the Aged, Quarterly publication Vol. 19, No. 4, January 1984). Others can be noted by any observant person who associates with the elderly.

1. Similarity. Perhaps the greatest myth about the elderly, in part because other myths grow from it, is that people lose their individualities as they grow older. But no two people are alike, and there is no reason to believe that the art of aging will change this fact. For example all old people do not want to attend religious services on Sunday; holiness does not spring on you when you get old any more than loneliness, illness or forgetfulness does.

2. Inflexibility. There are stubborn elders and cooperative ones -- just as there are stubborn and cooperative middle-aged humans. Inflexibility has nothing

to do with age -- it is a personality trait of some individuals, which might intensify with age if the individual is ignored when appearing inflexible instead of the reasons being determined.

3. Sexuality. Sexual relations between old people may seem unnatural and embarrassing to those who view old age as repugnant. Yet, despite the fact that the elderly are not always encouraged to dress and groom themselves attractively, their sexual desires do extend into old age.

4. Infirmity and Illness. Old age and illness are not synonymous: for many people there are decreases in bodily functions, but few losses. Some elders do experience a loss of hearing, but all of them do not need to be always shouted at, or, worse still, have questions put to them through nurses or younger relatives.

5. Senility. Some people look on memory loss or spasmodic periods of confusion as senility. But slight loss of memory is normal for all aged people, and confusion is often attributable to a sudden change in environment -- a fact which can be dealt with effectively by understanding and caring people.

6. Creativity and Productivity. Artists, authors, poets, painters and so on do not lose their talents in old age. In point of fact, many noted creative people produce their greatest works in their old age. Whether particularly gifted or not, all people (old and the not-so-old) need to

feel wanted and useful, and should live in an atmosphere in which the opportunity exists for them to perform creative as well as menial tasks.

7. Difficulty in Learning. Contrary to the old adage, one can teach an old dog new tricks. Some middle-aged people find that it takes them more time to master certain skills (such as operating computers) than it took their children. In like manner, it might take an elderly person longer to acquire specific abilities than it would take a middle-aged individual. But given time and patience, many elders can create new and exciting interests by learning new skills.

8. Loneliness. Some people who look after the elderly seem to think that old people ought to be kept occupied by doing "almost anything" -- in order that they will not be lonely. But many elders, like many other people of all ages, at times simply wish to be left to themselves. They want to experience an "interiority", an examination of themselves and their lives in order to make sense of it all. At times, they want to enjoy, or savour, or merely reflect on their memories -- or plan things to be done later on.

APPENDIX B

BURNSIDE'S LIST OF PSYCHOSOCIAL NEEDS

PSYCHOSOCIAL NEEDS OF THE ELDERLY*

Acceptance as a person -- maintaining personal identity
Acceptance or rejection of illness
Aged vs. youth and cultural value systems
Alienation and segregation from community life
Ambulation -- restricted mobility -- confinement
Anxieties
Communication -- use of native language
Confusion and memory loss
Constructive use of time -- boredom
Difficulty in adjustment to institutionalization --
dependence
Discharge planning
Expression of feeling, e.g., anger
Expression of religious beliefs
Fear of unknown
Feelings of being unwanted -- rejection
Feeling of death and dying
Feeling of no longer being useful
Hopelessness, depression, frustration
Inability to understand what is happening
Loneliness -- isolation
Loss of confidence
Loss of control in life situations
Loss of esteem
Loss of functions
Loss of self-care and independence
Loss of status
Low morale
Maximize strengths of individual
No interested family
Participate in treatment plans
Reduction or loss of income (also concern for payment of
services)
Response to treatment -- motivate toward reasonable recovery
Role reversal
Self-devaluation

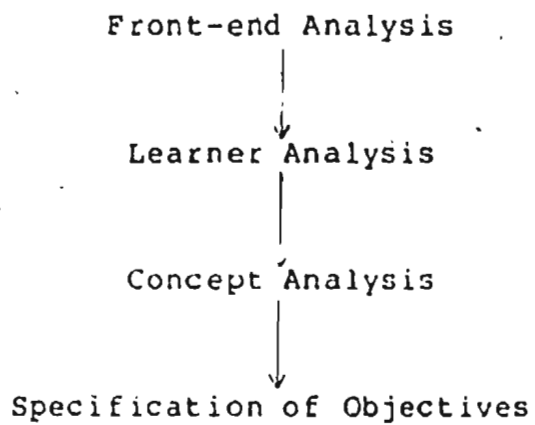
* Used with permission of Donald Kristola, Social Work
Consultant, Division of Professional Standards Review,
Health Care Financing Administration, Department of Health,
Education and Welfare, Region V, Chicago.

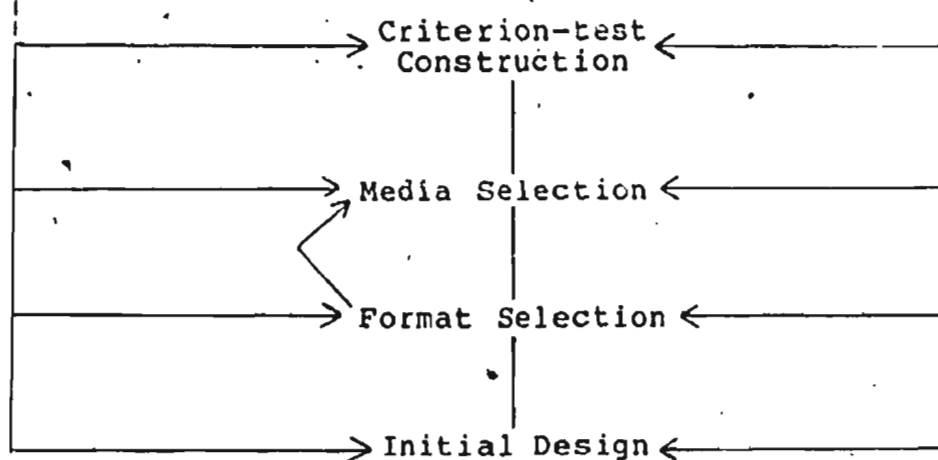
Separation from family and home
Sexuality
Social death
Social withdrawal
Staff interpersonal relationships with patients
To be with an individual who shows a warm interest
Touch
Unemployed -- current use of skills
Unfamiliar surroundings (abnormal)

[from Irene Mortensen (ed.), Psychosocial Nursing Care of the Aged (New York: McGraw-Hill, 1980), pp. 2-3.]

APPENDIX B
POUR D MODEL

Stage 1: Define

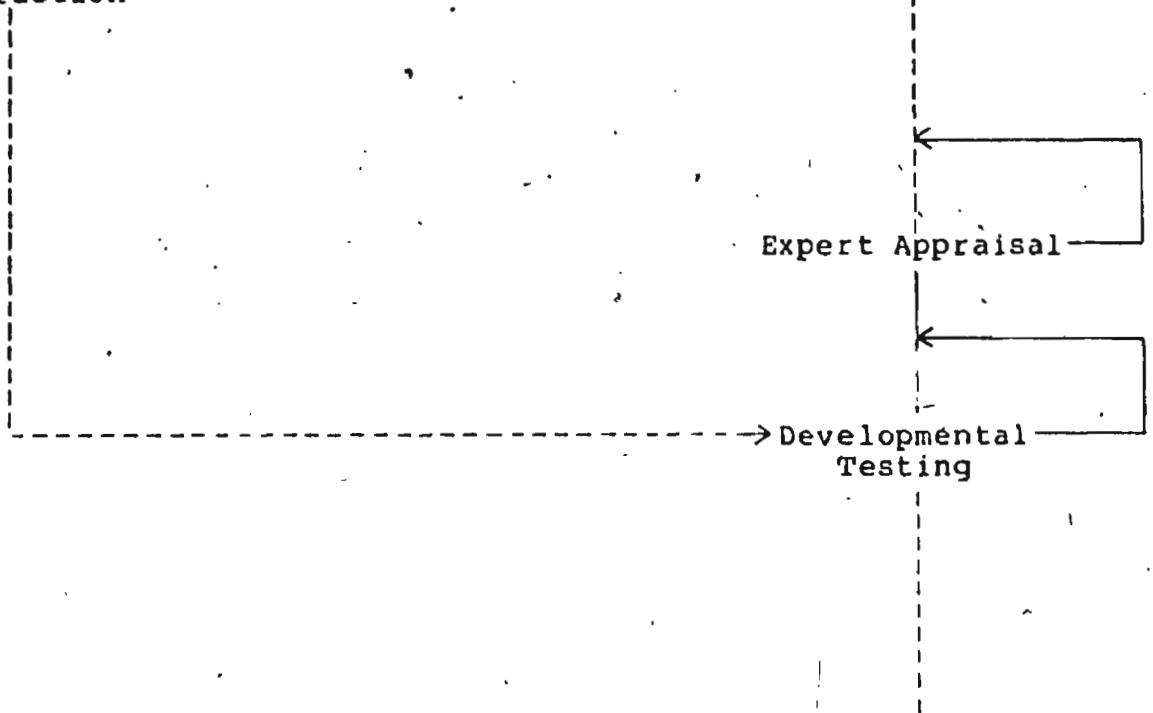


Stage 2: DesignLearner
AnalysisSpecification
of Objectives

Stage 3: DevelopCriterion-test
Construction

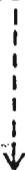
Initial Design

Expert Appraisal

→ Developmental
Testing

Stage 4: Disseminate

Developmental Testing



Validation Testing

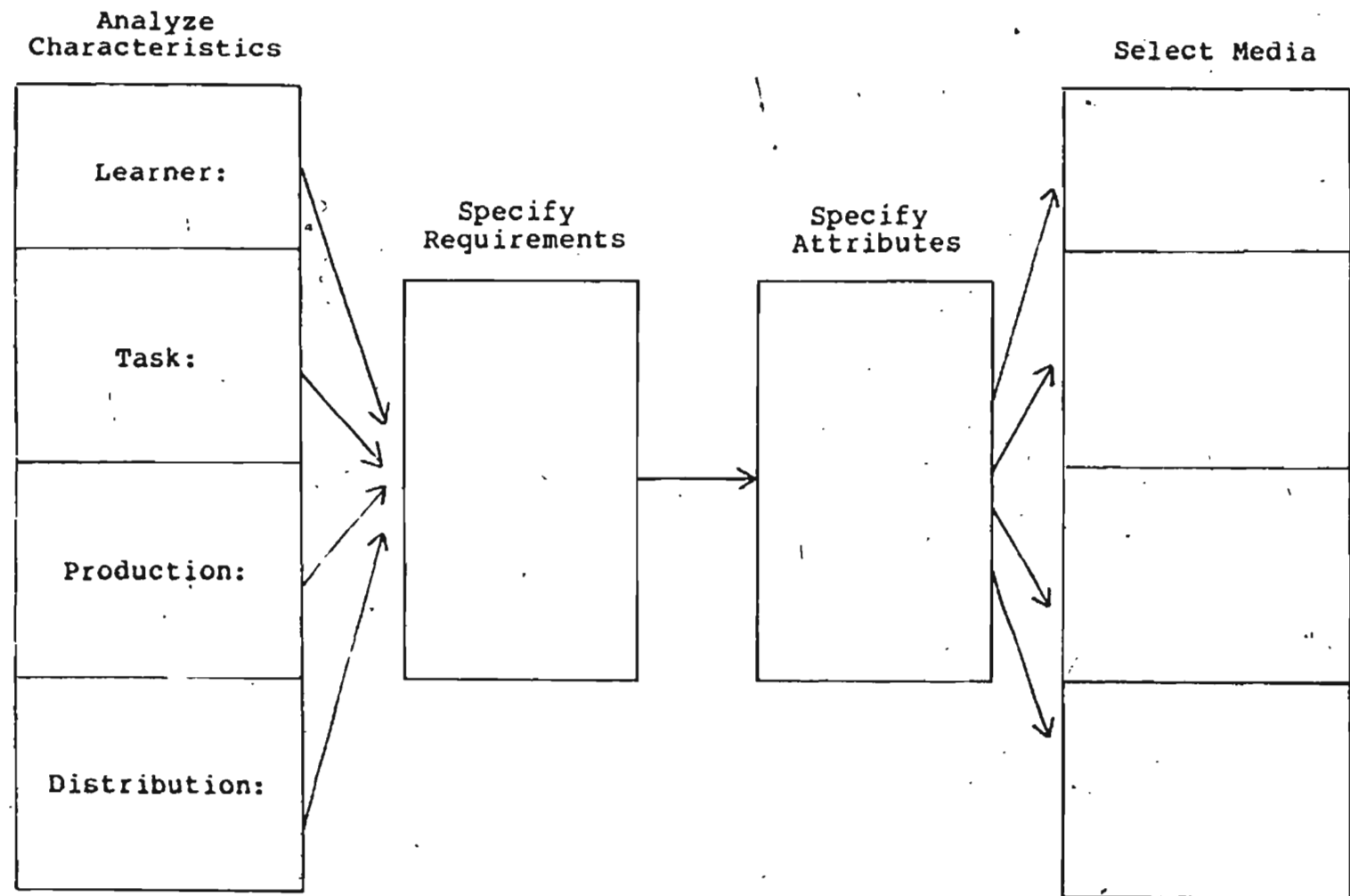


Packaging



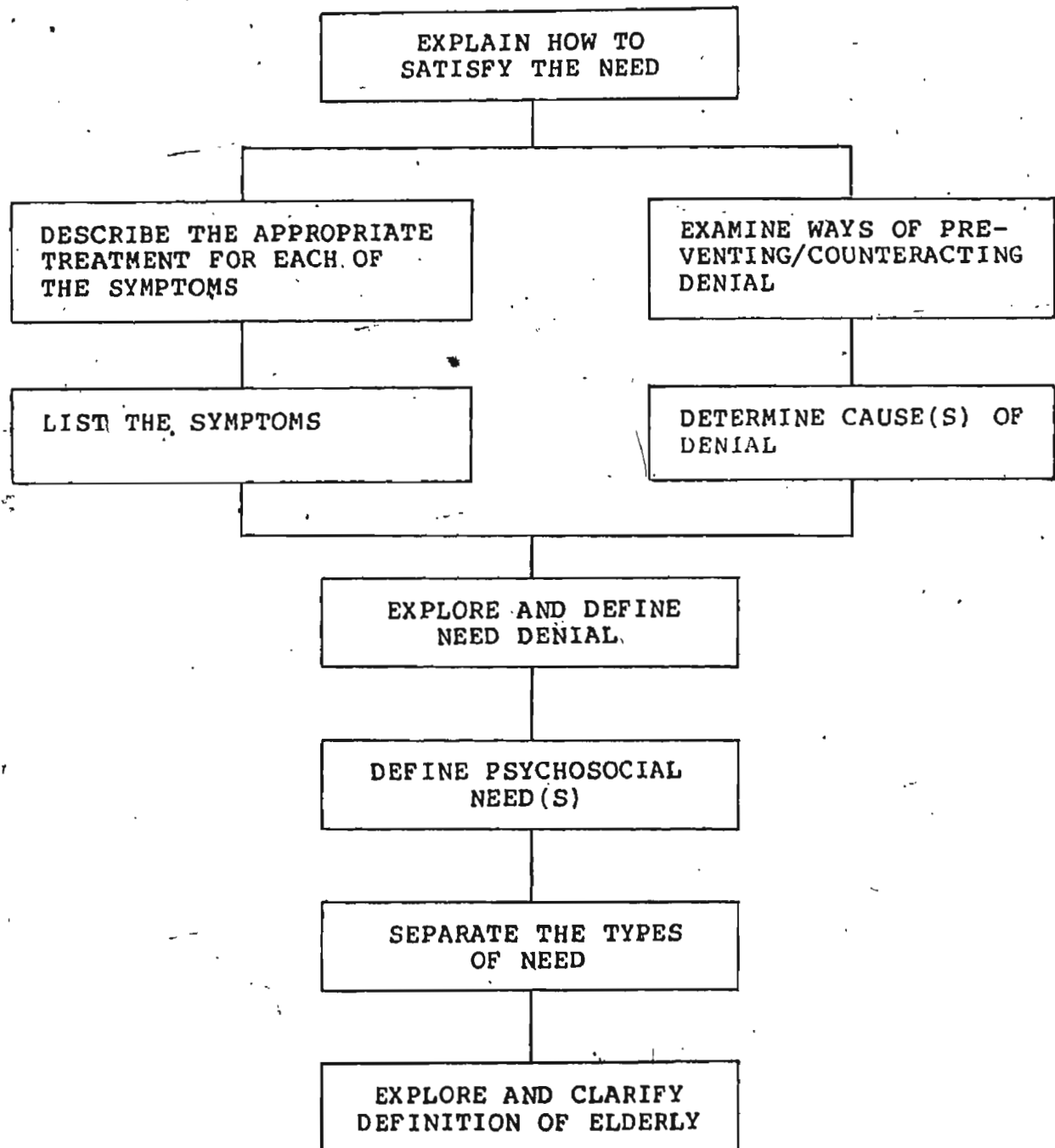
Diffusion and Adoption

Thiagarajan, Semmel and Semmel, 1974, pp. 6-9.

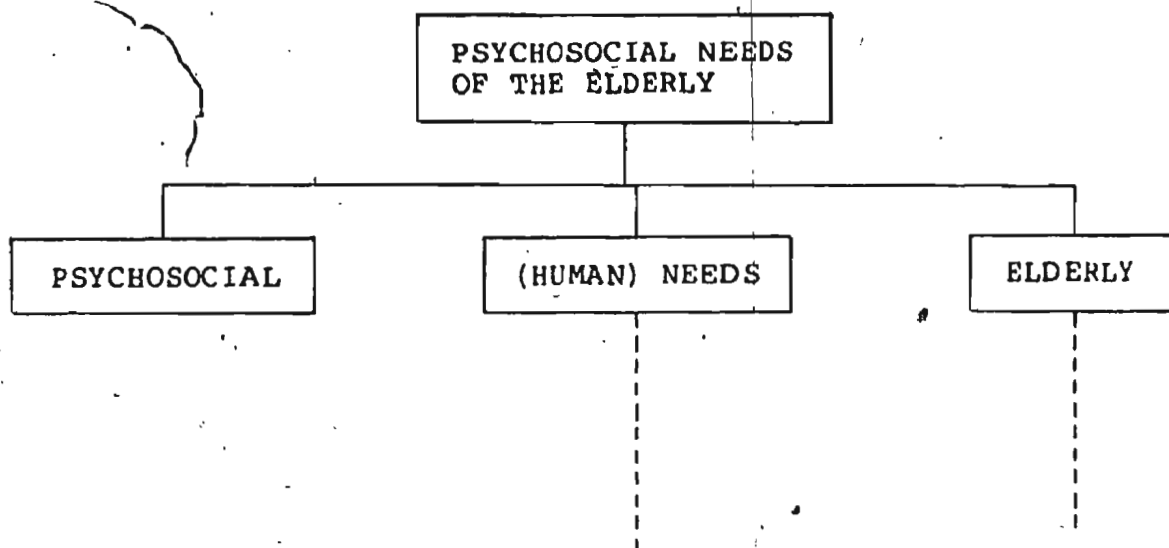


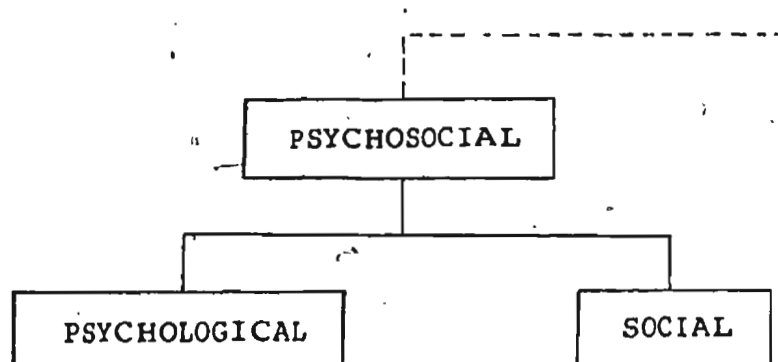
APPENDIX D
A NORMAL MEDIA SELECTION MODEL

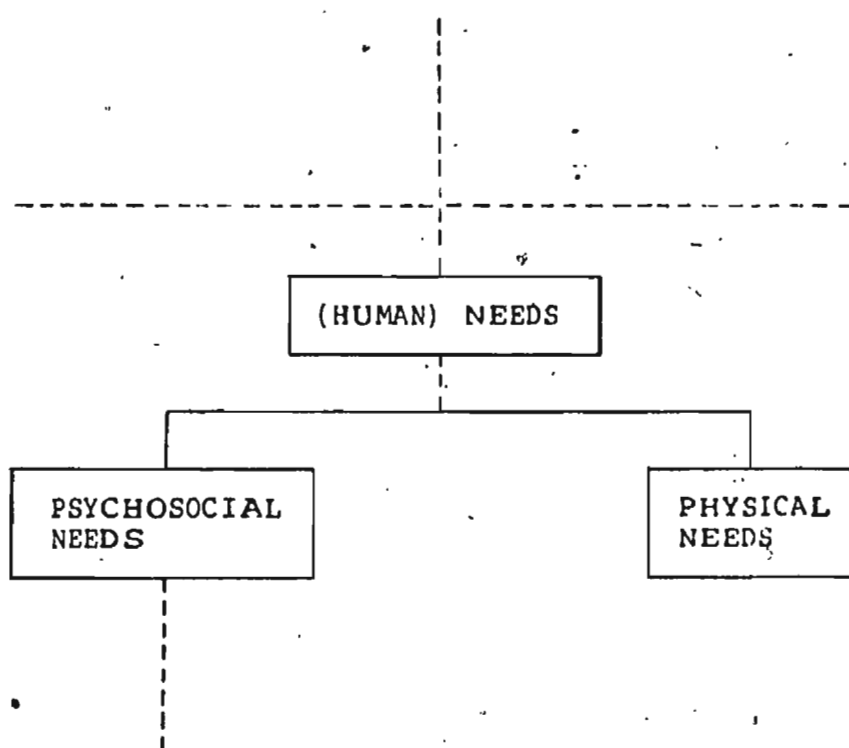
APPENDIX E
MODIFIED TASK ANALYSIS

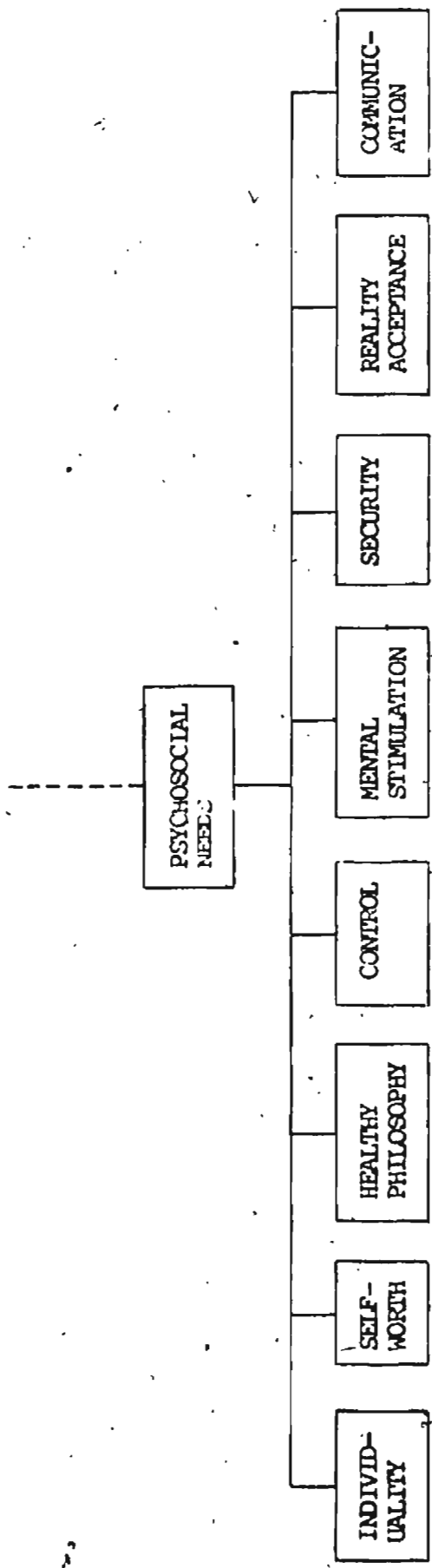


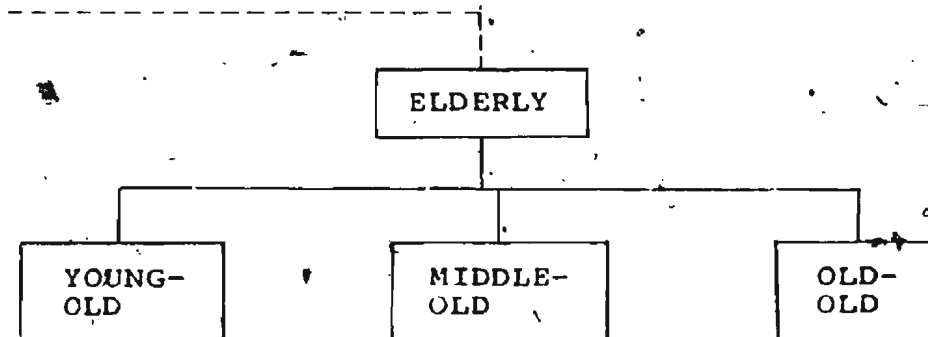
APPENDIX F
CONCEPT ANALYSIS











	LEARNER CHARACTERISTICS										TASK REQUIREMENTS							MATERIALS			TRANSMISSION					
	Large 100 +	Medium 30 - 100	Small 2 - 30	Individual	Visual	Audible	Learner Paced	Response	Self-Instructional	Motion	Time (Exp/Contract)	Fixed Sequence	Flexible Sequence	Sequential Dicto	Reversibility	Context Creation	Affective Power	Obtainability	Reusability	Time to Outfit	Cost (4 Copies) *	Simplicity (Eq 1)	Availability (Eq 1)	Controlability	Freedom from Dist	Learning not Req
IF →																										
THEN ↓																										
Real Object																										
Model of Real Object																										
Live Voice																										
Audio Tape Record																										
Print																										
Programmed Instruction																										
Chalk Board																										
Overhead Transparency																										
Filmstrip																										
Slide																										
Motion Picture																										
TV																										
Flat Picture																										

Summarising characteristics which make certain media unsuitable or partly unsuitable for instruction. Produced by J.G. Wilshusen and R. Stowe (from L.J. Briggs, Handbook of Procedures for the Design of Structures, 1970).

APPENDIX G
"IF-THEN" CHART

APPENDIX II MEDIA/MEDIA ATTRIBUTES

Media

Media attributes

		CAI Input/output (terminal)	Super 8- filmloop Videotape	Overhead transparency 16mm film	Slide	Filmstrip	Reels	Print	Audio tape (cassette)	Audio tape (reel)		
TASK	Audio	/	X		X	X	X	X	X	X	X	X
	Visual	/	X	X	X	X	X	X	X	X		
	Motion	/	X	X	X	/	X	X	X	/		
	Color		/	X	X		X	X	X			
LEARNER	3-Dimensionality		X	X	X	/	/	/	/	/	/	/
	Realism		X	X	X		/	/	/	/	/	/
	Response Acceptance	X	/	/	/	/	/	/	/	/	/	/
	Feedback	X	/	/	/	/	/	/	/	/	/	/
PRODUCTION	Audio	/	X	X	X	X	X	X	X	X	X	X
	Visual	X	X	/	X	X	X	X	X	X	X	X
	Self-Pacing	X	X	/	X	X	X	X	X	X	X	X
	Random Access	X	/	/	/	/	/	/	/	/	/	/
DISTRIBUTION	Editability	X	/	/	/	X	X	X	/	X	X	X
	Transportability	/	/	/	/	X	X	X	/	X	X	X
	Simplicity		/	/	/	X	X	X	/	X	X	X
	Low Cost					X	X	/	/	X	X	X
	Short Time Requirement	/				X	X	/		/	X	X
	Editability	X		X	X	X	X	X	/	X	X	/
	Self-Contained	X		X	X	X	X	X	X	X	X	X
	Scheduling		X	X	X	X	X	X	X	X	X	X
	Flexibility					X	X	X		X	X	X
	General		/		/	X	X	X		X	X	X
	Availability					X	X	X		X	X	X
	Ease of Use	X		X		X	/	X	X	X	X	/
	Low Cost					/	X	X	X	X	X	X
	Quick Set-up Time	/		X		X	/	X	X	X	X	X
	No Special Environment	/	X	/		X	/	X	X	X	X	X
	Grouping Flexibility	/	/	/	/	/	X	X	X	X	X	X
	Compactness Handling/Storage		/	X	/	/	/	X		/	X	/

- X = Is usually present in the medium
- / = Can be obtained, but is not a usual attribute of the medium
- = Is usually not associated with the medium

APPENDIX I
SCRIPT VERIFICATION

Dear Context Expert,

Enclosed you will find the proposed script for the slide-tape portion of the Psychosocial Needs of the Elderly. Please read it carefully and make note of any omissions, inaccuracies, et cetera. Any and all comments are most welcome. Particularly welcome are comments pertaining to the eight psychosocial needs we have listed.

While you should note any omissions, large or small, please note that some of the material mentioned briefly in this draft is intended to be dealt with in the booklet portion of this package.

Please feel free to make notes directly on the enclosed script and/or on separate pieces of paper. I would appreciate it very much if you could have your scripts and comments back to me by four o'clock Friday afternoon. You may either return the script directly to me or leave it in care of Mary Kieley.

Thank you very much for your time and expertise, I remain

Yours very sincerely,

Douglas Cuff

APPENDIX J

SLIDE/TAPE PRESENTATION -- USER EVALUATION FORM

PSYCHOSOCIAL NEEDS OF THE ELDERLY

1. Which of the following categories would you put yourself in?

<input type="checkbox"/> Nurse	<input type="checkbox"/> Patient
<input type="checkbox"/> Doctor	<input type="checkbox"/> Senior Citizen
<input type="checkbox"/> Educator	<input type="checkbox"/> General Public
<input type="checkbox"/> Health Professional	<input type="checkbox"/> Student

Would you place yourself in another category not listed?

2. About the package itself:

A. Have you used it just once, or a number of times?

B. Do you plan to use it again? (yes / no)

3. Please state whether you agree or disagree with the following statements:

A. The content is accurate	SA	A	D	SD
B. The presentation is too long	SA	A	D	SD
C. The presentation is effective overall	SA	A	D	SD
D. Slides are clear and well-chosen	SA	A	D	SD
E. The production is not realistic	SA	A	D	SD
F. The concepts are clearly conveyed	SA	A	D	SD
G. The narration is too fast	SA	A	D	SD
H. The sequencing/flow is logical	SA	A	D	SD
I. Useful information is presented	SA	A	D	SD
J. Suitable only to a male audience	SA	A	D	SD
K. Approach is too vague and emotional	SA	A	D	SD
L. The train of thought is easily followed	SA	A	D	SD

[SA=Strongly Agree/A=Agree/D=Disagree/SD=Strongly Disagree]

4. When in a lesson do you use this presentation?

-
-
- A. At the beginning, as an introduction? (yes / no)
 - B. At the end, as a summary? (yes / no)
 - C. In the middle, as a separate lecture? (yes / no)
 - D. Do you use it for review purposes? (yes / no)

5. What level of student would you say this was most suitable for?

-
-
- A. Is it suitable for beginners? (yes / no)
 - B. Is it suitable for intermediate students? (yes / no)
 - C. Is it suitable for advanced students? (yes / no)

6. Is it suitable for people other than students?

-
-
-
- A. Is it suitable for doctors and nurses? (yes / no)
 - B. Is it suitable for workers who have never studied gerontology but work in this area? (yes / no)
 - C. Is it suitable for the general public? (yes / no)
 - D. Is it suitable for the elderly? (yes / no)

7. Is there anything in this presentation which you disagree with, or which is inaccurate?

8. Is there anything inappropriate, or unnecessary?

9. Are there any slides in particular that bother you?

10. Can you suggest anyone else who might benefit from viewing this package, or from having it at their disposal?

11. Any other comments?

APPENDIX K

SLIDE/TAPE PRESENTATION -- LEARNER EVALUATION FORM

Please relax. This questionnaire is not to test you -- it is to test the slide-tape show you are about to see, or which you have just seen.

* * *

Please rank the following needs according to how important and/or desirable you think they are to the average older person (age 65 and older).

MOST IMPORTANT = 1

- | | |
|--------------------------|-------|
| A. Money | _____ |
| B. Warm Shelter | _____ |
| C. Food | _____ |
| D. Dignity | _____ |
| E. Medical care | _____ |
| F. Sex | _____ |
| G. Freedom of choice | _____ |
| H. Love | _____ |
| I. Security | _____ |
| J. Relationship with God | _____ |
| K. Privacy | _____ |
| L. Companionship | _____ |

LEAST IMPORTANT = 12

Please rank the following needs according to how important and/or desirable you think they are to the average younger person (age 18-35).

MOST IMPORTANT = 1

- | | |
|--------------------------|-------|
| A. Relationship with God | _____ |
| B. Money | _____ |
| C. Warm shelter | _____ |
| D. Security | _____ |
| E. Food | _____ |
| F. Freedom of choice | _____ |
| G. Privacy | _____ |
| H. Medical care | _____ |
| I. Dignity | _____ |
| J. Love | _____ |
| K. Companionship | _____ |
| L. Sex | _____ |

LEAST IMPORTANT = 12

[THIS SECTION ADMINISTERED TO THIRD-YEAR STUDENTS ONLY.]

Please rate the quality of the slide-tape show on the following items, according to the scale provided, by circling the number of the scale.

(Educational quality)

- | | | | | | | | |
|--|---------|---|---|---|---|---|-------|
| 1. Appropriateness of Instructional Format | Inapp. | 1 | 2 | 3 | 4 | 5 | App. |
| 2. Organization of Materials | Poor | 1 | 2 | 3 | 4 | 5 | Good |
| 3. Length of Program | Short | 1 | 2 | 3 | 4 | 5 | Long |
| 4. Clarity of Presentation | Unclear | 1 | 2 | 3 | 4 | 5 | Clear |
| 5. Appropriateness of Language | Inapp. | 1 | 2 | 3 | 4 | 5 | App. |
| 6. Level of Difficulty | Low | 1 | 2 | 3 | 4 | 5 | High |
| 7. Sequencing of Materials | Poor | 1 | 2 | 3 | 4 | 5 | Good |
| 8. Style of Presentation | Poor | 1 | 2 | 3 | 4 | 5 | Good |
| 9. Appropriateness of Illustrations to Narration | Inapp. | 1 | 2 | 3 | 4 | 5 | App. |

(Technical quality)

- | | Poor | | | | Good |
|-----------------------|------|---|---|---|------|
| 10. Overall | 1 | 2 | 3 | 4 | 5 |
| 11. Print | 1 | 2 | 3 | 4 | 5 |
| 12. Illustration | 1 | 2 | 3 | 4 | 5 |
| 13. Quality of slides | 1 | 2 | 3 | 4 | 5 |
| 14. Audio | 1 | 2 | 3 | 4 | 5 |

APPENDIX L

A SAMPLE OF RANK AVERAGING TECHNIQUE

Change in Ranking of Companionship
as Needed by the Elderly, as Ranked by the
First-Year Students

Rank	Pre-viewing		Post-viewing	
	No. of Ranks	Product	No. of Ranks	Product
1	5	5	2	2
2	14	28	10	20
3	16	48	10	30
4	6	24	9	36
5	6	30	8	40
6	6	36	9	54
7	5	35	10	70
8	6	48	2	16
9	2	18	6	54
10	0	0	4	40
11	2	22	1	11
12	1	12	0	0
Total Product 306		Total Product 373		
Mean 4.3		Mean 5.3		

Change in Mean -1.0

APPENDIX M

SCRIPT:

PSYCHOSOCIAL NEEDS OF THE ELDERLY

<u>Detail of slide</u>	<u>Narration</u>
1. Title: FOCUS.	1. [Silent.]
2. Dark slide.	2. [Silent.]
3. Title: PSYCHOSOCIAL NEEDS OF THE ELDERLY Accompanied by Mr. and Mrs. C. sitting on their porch.	3. [Music fades up.]
4. Title: MADE IN COOPERATION WITH SUMMER CANADA AND... Accompanied by an outdoor summer scene of windsurfing.	4. [Music continues.]
5. Title: ST. CLARE'S SCHOOL OF NURSING, ST. JOHN'S, NFLD. Accompanied by a view of the entrance to the nursing school.	5. [Music continues.]
6. Title: PRODUCED BY DOUGLAS CUFF Accompanied by a close-up of an elderly hand clasping a younger hand.	6. [Music continues.]
7. Mr. and Mrs. C. sitting on their front porch.	7. Who are the elderly? [Music continues.]

8. Title:
YOUNG-OLD 65-70
MIDDLE-OLD 70-80
OLD-OLD 80+
9. Split screen: Mr. C. asleep in bed. Mrs. C. sitting by a fire.
10. Mr. A. walking along a street, clutching his back.
11. Title: PSYCHOSOCIAL =
PSYCHOLOGICAL + SOCIAL
12. A young couple and an elderly couple sitting on park benches.
13. Title:
INDIVIDUALITY
SELF-WORTH
HEALTHY PHILOSOPHY
CONTROL
MENTAL STIMULATION
SECURITY
REALITY ACCEPTANCE
COMMUNICATION
8. There are three groups of elderly people: the young-old, aged 65 to 70; the middle-old, aged 70 to 80; and the old-old, aged 80 and over.
9. What are their needs? Like all people, the elderly have physical needs -- oxygen, food, drink, sleep and warmth.
10. Because they've lived for a long time, the elderly may find their bodies wearing out. As a result, their physical needs may be more intense.
11. Besides physical needs, people also have psychosocial needs, which are a mixture of psychological and social needs.
12. Although the basic psychosocial needs remain the same throughout the life cycle, the intensity of the needs may change with age.
13. The eight basic psychosocial are: individuality; self-worth; healthy philosophy; control; mental stimulation; security; reality acceptance; and communication.

14. Elderly lady wandering in a hospital corridor.
15. Mr. C. reading and showing signs of having a headache.
16. Close-up shot of Mr. C. opening aspirin bottle.
17. Mr. C., now wearing glasses, reading happily.
18. Split screen: Mrs. C. looking worried. Close-up of spectacles. Close-up of liquor bottle.
19. Title: INDIVIDUALITY. Accompanied by a cartoon of an older man thinking, "I am a person!"
14. Quite often people confuse needs with the symptoms of denied needs. A symptom -- such as wandering behaviour -- is a problem which shows us that a need is being denied.
15. For example: if a person has a headache, he may need glasses. The physical need for glasses is being denied and produces the symptom of a headache.
16. If a person takes aspirin for his headache, he is treating the symptom. He must still satisfy the need for glasses, or he will probably continue to get headaches.
17. It's important to look for the cause underlying the symptom so that one can treat the symptom as well as satisfy the need.
18. It is very important to look for all the possible causes of a symptom. For instance, a headache may be caused by eyestrain, by stress, or may be even due to over-drinking.
19. Too often people treat the elderly in ways they would think of treating others -- they deny them their individuality and treat them as part of a group.

20. Mr. and Mrs. C. talking to minister, after church service.

21. Mrs. C. sitting in a lawn chair. Mr. C. is standing behind her. They are looking at each and smiling.

22. Old photograph of young man in uniform.

23. Mrs. B. sitting in a gloomy, untidy room.

24. Close-up of Mrs. B.

25. Young female social worker trying to talk to Mrs. B.

20. How often is it assumed that all people become more religious and want to go to church when they grow older?

21. How often is an elderly man thought of as a man rather than an old person? The elderly are viewed as unattractive by society, and so it takes their sexual identity away.

22. Society totally ignores other identities they have or used to have -- occupation, parent, spouse and marriage roles.

23. Consider this elderly lady: she was once a beautiful young woman, wife and mother -- now her children are gone, her husband is dead ... and she thinks of herself as unattractive.

24. She sits in her house all day, though she is healthy and capable of walking. She wears her false teeth only at mealtimes, and sometimes forgets where she has left her glasses.

25. Her identities are lost to society. Worse than that, they are lost to her. They can be retrieved, if someone will take the time to see her as an individual.

26. Mrs. D. sitting in a wheelchair, accepting a cup of tea.

27. Title: TAKE TIME.
TAKE TROUBLE.

28. Title: SELF-WORTH.

Accompanied by a cartoon of an older man thinking, "I am a person of worth!"

29. Mr. A. sitting on a park bench.

30. Mrs. C. holding a political poster and cheering.

31. Mr. and Mrs. C. sitting in office, talking to a nurse.

26. It does take time. Elderly people are often slow because of physical restrictions, and it can be necessary to call on patience and understanding.

27. Remember these things when coming into contact with the elderly -- Take the time. Take the trouble. It's worth it.

28. If an elderly person loses his individuality, then his self-worth is likely to deteriorate.

29. And if this happens, the person may complain of feeling useless -- of not accomplishing anything of worth -- even if he is relieved to be rid of the responsibility of former roles.

30. Whenever possible, the elderly person should maintain some role in society. This can help self-worth by emphasizing strengths and skills of the individual.

31. Elderly people often become embarrassed about loss of agility, frequency of urination and forgetfulness. They can reclaim much of their dignity if assured that is part of a natural process, and many others have the difficulties.

32. Title: HEALTHY PHILOSOPHY.

Accompanied by a cartoon of an older man thinking, "...and my life is worth living."

33. Mrs. D. praying in front of a stained-glass window.

34. Mr. C. coaching young boy in baseball.

35. Mr. C. standing alone on a wooden bridge.

36. A young woman in the foreground, looking hesitantly at Mr. C., who is sitting in the background, thinking.

32. If a person maintains his individuality and self-worth, he will have the foundation for the third psychosocial need -- a philosophy to provide him with purpose or meaning.

33. Sometimes a religion will provide a person with purpose and meaning -- this is certainly a common source of healthy philosophy.

34. If an elderly person does have a healthy philosophy, there is often a willingness to engage with society. *However, an elderly person who spends time alone does not necessarily have problems.

35. There is an "interiority" which the elderly experience -- an attempt to make sense out of a the life that's drawing to a close. Sometimes this is seen as a withdrawal from society, whereas it is actually an attempt to accomplish something -- perhaps attain wisdom.

36. A healthy philosophy must be created and fostered by example and life's experiences. It is a very personal thing, and nobody, the elderly included, will welcome intrusion.

37. Title: CONTROL.

Accompanied by a cartoon of an older man thinking, "I am in charge of my life."

38. Mr. A. being led into a nursing home by an orderly.

39. A nurse telling Mr. A. that he cannot remain in bed.

40. Close-up shot of Mr. A.'s possessions: razor, spectacles, false teeth, scraps of paper.

37. Too often, the control over their lives which the elderly lose is not taken away by their physical disabilities but by society. They have had control all their lives, but when any sign of loss of control occurs, all remaining control begins to be taken away.

38. Maria Abarca tells the story of Mr. A., an elderly man with extremely poor vision and difficulty in walking, who was placed in a nursing home by his doctor.

39. He found that he was assigned furniture and space but did not own it -- he could not lie on his bed during the day, but had to lie there all night. He could not keep his pajamas in his nightstand but had to keep his shoes there.

40. His only possessions were his razor, his teeth, his glasses and some scraps of paper with vital phone numbers written on them. He attempted to arrange his possessions so that he could function despite his disabilities.

41. Mr. A. searching through his nightstand.

42. Mr. A. yelling at a nurse and pointing at his nightstand.

43. Terminally ill patient lying in a hospital bed.

44. Nurse holding up dresses for Mrs. D. to choose from.

45. Title: MENTAL STIMULATION.

Accompanied by a cartoon of an older man thinking, "I will keep my brain as well as my body active."

41. He could not function. The maid would move the furniture to suit herself. Other patients could take Mr. A.'s chair without permission. The nurse would remove his scraps of paper. The orderly could take his razor and use it on another patient.

42. Mr. A. attempted to create order out of the disorder by complaining and chasing away those who rearranged his life. He was labelled uncooperative.

43. It can be difficult to grant control in an institutional setting -- for example, it is difficult to provide privacy to a patient who requires constant care and attention.

44. Still, the elderly person should be allowed all the choices that he can cope with. For example, patients who are unable to dress themselves can be asked what they would like to wear.

45. If the elderly are allowed control, they will seek their own mental stimulation and show their desire to accomplish something worthwhile.

46. Close-up shot of Mrs. B. gazing out a window and looking depressed.

46. There is a problem, though -- the elderly have restricted mobility, even if not in institutions. Because they cannot drive or, afford transportation, they cannot get out and their friends cannot get in.

47. Mr. C. watching TV.

47. A very basic way to provide mental stimulation is through sensory stimulation. Very often the elderly become mentally lazy because they have the same sensory input day after day.

48. Close-up shot of silk gown, sandpaper, popcorn, bread and brightly-coloured squares of paper.

48. How often does the elderly person have the chance to touch silk, sandpaper, or hold cold steel? Or smell fresh bread or popcorn? How often will they see bright colours, or taste a fresh peach or green pepper?

49. Close-up shot of Mrs. C. smelling flowers.

49. The idea is to provide a variety of stimuli for all the senses which normally diminish with age.

50. Mr. and Mrs. C. sitting in a theatre, looking at a programme.

50. However, sensory stimulation addresses only the basic need -- people crave mental activity that's pleasurable -- activities such as reading, playing cards, theatre, and bingo.

51. Mr. C. using a home computer.

51. New experiences should not be ignored, either. Contrary to popular belief, the elderly are productive, creative and capable of learning new skills. There is absolutely no reason why a person shouldn't take up painting, swimming or even computing.

52. Title: SECURITY.

Accompanied by a cartoon of an older man thinking, "I need to feel secure."

52. Security is one need which many elderly people are denied almost constantly, and there is very little that can be done about it in many cases.

53. Close-up shot of a frosted glass door with the legend "Missing Persons Division".

53. One of the greatest fears is "loss of" mental control. It is not uncommon for there to be some memory loss in old age, and unfortunately, many people attribute this to senility. It need not be.

54. Close-up of old-age pension cheque.

54. Financial circumstances also produce worries -- elderly people often live on fixed pensions. They fear starvation and dying without enough money for their own funeral.

55. Mrs. B. arguing with a doctor and gripping his coat lapels.

55. The elderly fear going to hospital because they will never be discharged. Another concern is the dying process, although they may not actually fear death itself.

- 56.. Close-up of young nurse pointing to a blackboard.
57. Split screen: Door with "Missing Persons Division". Mrs. B. arguing with doctor.
58. Title: REALITY ACCEPTANCE.
Accompanied by a cartoon of an elder man thinking, "I am old...I might as well grow old with grace."
59. Mrs. B. being examined by a doctor in the doctor's office.
60. Black-and-white photo of frail elderly lady in a nursing home.
56. Because people fear what they do not understand, the best way to approach insecurity is by educating the elderly.
57. They need to understand that every illness does not mean hospitalization, and that hospitalization need not be long-term. They need to be told that memory loss and even confusion are not necessarily signs of mental deterioration.
58. The fears of old age are often due to myths and misconceptions about the realities of old age. The realities need to be shorn of their mythical horror and looked at squarely.
59. There are certain realities -- the body is decline. There is no general effect produced by aging -- sight and hearing, for instance, are not necessarily lost -- but not some deterioration is unavoidable.
60. One of the greatest myths is that the elderly are almost invariably ill or infirm. Age does not equal illness. Another great myth is that large numbers of the elderly are in institutions. Only about 10% of the people over 65 are in nursing homes or hospitals.

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| <p>61. Young lady helping Mrs. C. with her grocery shopping.</p> <p>62. Mrs. B. sitting in a nursing home lobby, clutching her purse and some plastic bags.</p> <p>63. Mrs. C. looking at a photograph album.</p> <p>64. Close-up shot of an elderly hand clasping a younger hand.</p> <p>65. Title: COMMUNICATION.

Accompanied by a cartoon of an older man saying, "I need people. I need friendship. I need love."</p> | <p>61. Elderly people must realize that they may still need some help with the performance of daily tasks and functions even if they are not ill or frail.</p> <p>62. Coming to grips with dependency is not easy. This elderly woman sits in the lobby of her nursing home, clutching her possessions and waiting for the day when she can go home. She cannot come to terms with her dependency.</p> <p>63. Another great difficulty the elderly have is facing up to their many losses. They may lose some of their physical functions. They may lose a spouse, close friends or family.</p> <p>64. The elderly cannot deal with stress as well as younger people, so they need people willing to help them adjust to the realities of old age.</p> <p>65. Elderly people need people who are patient. More to the point, they need people. They need to communicate, and remain an integral part of society. They need a sense of belonging.</p> |
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66. Mr. C. in a park, walking away from the camera.
67. Mrs. B. in a wheel-chair, being pushed along a hospital corridor by a nurse.
68. Mrs. B. sitting by a phone, looking glum.
69. A man talking animatedly to an old woman in a nursing home.
70. Close-up shot of a young lady looking through a hospital ward door with a concerned expression on her face.
66. While some elderly people prefer to be on their own, there are others who are lonely and depressed because their friends are far away or dead, or because their family's not interested in them.
67. Elderly friends may not be far away but may still be inaccessible. Imagine living in a nursing home, with your oldest friend next door but being unable to visit each other without help from the staff!
68. Elderly people sometimes feel unwanted. The answer to this problem is both simple and difficult -- encourage establishment of new relationships with people of all ages.
69. The elderly need quality communication, because they sometimes have less energy to invest in socializing. They need warm and sincere companions who are genuinely interested in them.
70. How many times during this presentation did you imagine how you would react if the needs mentioned were denied you? Even if the answer is "only once", you're on your way to a healthy attitude to the elderly.

71. Title:
INDIVIDUALITY
SELF-WORTH
HEALTHY PHILOSOPHY
CONTROL
MENTAL STIMULATION
SECURITY
REALITY ACCEPTANCE
COMMUNICATION
72. Graphic: cartoon of an old man walking along a road which is signposted "Happy old age this way." Above the road is a huge weight, set to fall.
73. Nurse lecturing to a group of young people.
74. Mr. and Mrs. C. standing on a hill, looking off into the horizon.
75. Title: SCRIPT BY DOUGLAS CUFF
76. Title: PHOTOGRAPHER GEOFFREY ROSS
77. Title: GRAPHIC ARTIST PAUL HEWSON
78. Title: THE END
STOP AND REWIND TAPE
- You will have realized by now that the elderly have the same psycho-social needs as all society.
72. What is peculiar to the elderly is that society may not always be aware of or attend to their needs. They have to fight to achieve what are really their rights.
73. The elderly need help in satisfying their needs. More than that, they need the help of all health professionals in educating society.
- [Music fades]
74. You must encourage the elderly to fight back. And you must help them in their fight. Think of it as an investment in the future.
- [Music continues.]
75. [Music continues.]
76. [Music continues.]
77. [Music continues.]
78. [Music fades out.]

APPENDIX N
SLIDE-TAPE PACKAGE

Psychosocial Needs of the Elderly

(under separate cover)

APPENDIX O

BOOKLET

Psychosocial Needs of the Elderly

(under separate cover)



