THE EFFECTS OF BIBLIOTHERAPY ON ANOMIA AND LIFE SATISFACTION OF THE ELDERLY

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CHAPTER I

INTRODUCTION

For decades, the idea of aging in our youth-oriented culture has been considered with disdain, and, for the most part, not considered at all (Busse, 1969). One did not actually think about growing old, one only thought of somehow remaining young. However, growing old is a subject that has finally begun to emerge as an important, much considered issue (Lieberman, 1975). With the recognition of such an important issue has come the task of discarding erroneous myths and replacing them with facts and efforts to prepare for this new frontier of the elderly (Kurtz & Wolk, 1975).

One myth cited by Bane (1976) involving growing old is a belief in the existence of the "extended family." This myth is the belief that households are composed of parents and their married children or married children and their aged parents. Bane argues that this has never been the case. Historically speaking, relationships among relatives appear to have been what they are now: complex patterns of companionship and help that only occasionally involve sharing bed and board. Contemporary families, like those in the past, provide a bed and board to adult family members in situations of economic and social distress (divorce, death of spouse,

loss of job, etc.), but the help generally is abandoned with the improvement of the situation (Bane, 1976).

Another myth relating to the elderly is that of the "golden years" of retirement (Davidson, 1979). The golden years has been viewed as a time when the retiree can leisurely spend the remaining years doing as he/she pleases, surrounded by a loving and doting family. However, according to Eisdorfer and Wilkie (1977), the retirement years are especially stressful ones. Old age is a time period where many people feel frustrated and worthless due to the lack of having a productive job, decreased health and income, and the attitudes displayed by their families (Atchley, 1975; Chown, 1977; Eisdorfer & Wilkie, 1977).

For many people, the retirement years are experienced as a time of hopelessness and limited or no control over their destiny (Seligman, 1975). There are many external changes that converge on the elderly influencing them to discontinue personal growth and spawning the feelings of hopelessness suggested by Seligman. Therefore, rather than finding leisurely hours of relaxation, a great many find themselves constantly worried about health, finding sufficient amounts of money to pay the bills, and somehow maintaining a sense of independence. For many elderly, instead of being cared for by loving children and grandchildren, they are ignored, placed in institutional settings, or even physically and psychologically abused (Block & Sinnott, 1979). These harsh realities are a far cry from the fantasies envisioned by the myth of the golden years.

The need for helping the elderly come to terms with these fantasies and to assist them in coping with the many crises associated with aging has become paramount (Davidson, 1979). The advancement of modern medical technology has caused an increase in life expectancy for most of the American population (Spicker, Woodward, & Van Tassie, 1978). Thus, the geriatric population is rapidly rising while efforts to aid that segment of society have not kept pace (Spicker et al, 1978).

Since too much "free time" is one problem often faced by the elderly (Back, 1969), properly selected reading material could occupy some of that free time, as well as help to alleviate many of the other problems they may experience. Therefore, in an effort to aid the elderly, bibliotherapy, or the reading of assigned material, should be considered.

The idea of using bibliotherapy in treating personal problems is a fairly recent one. Sclabassi (1973) defines bibliotherapy as "a technique which involves the utilization of literature for therapeutic purposes" (p. 70). Even though therapists over the years have recommended the reading of literature as a means of modifying behavior, the effectiveness of this technique has rarely been investigated. As far as can be determined, there is no specific reason why this is so. However, Schrank and Engels (1981) do report in their findings that bibliotherapy is effective in attitude change and therapeutic gain. Three additional researchers, Caffee (1976), Hagen (1974), and Weingarten (1954), have conducted

such studies. Their results suggest promise in the use of bibliotherapy to effect change. Their studies suggest that the use of bibliotherapy alone can facilitate change in attitude, while bibliotherapy combined with group process can promote attitudinal and behavioral change. Mardoyan and Weis (1981) also support the use of group counseling with older adults. This method of facilitating attitudinal and behavioral change seems worthy of investigation in application to the elderly.

Theoretical Background

First, the external environment changes that occur during the process of aging will be discussed. Second, the internal changes that occur to the elderly will be addressed in the form of locus of control.

External Environmental Changes

As a person nears retirement, there are several areas of concern that begin to surface. Chown (1977) states those areas most commonly encountered by the elderly are impending retirement (whether they can continue some aspect of their career after retirement), health, income, family, relocation, bereavement, illness and loneliness. These are often seen as potentially frustrating crises which can be disruptive to the morale and life satisfaction of elderly individuals.

Eisdorfer and Wilkie (1977) state that with advancing age there is an apparent increase of deaths attributed to

diseases suspected of being related to stress. Diseases of the heart, cancer, and stroke are the major causes of death, accounting for about 70 percent of the deaths for those 45 years of age and older. Heart disease is the leading killer. Relocation is a high risk for the elderly and the death rate for elderly people shortly after admission to homes for the aged is high (Neugarten, 1968).

Thus, it can be seen that as one grows old a new set of stressful situations and crises are encountered. Lieberman (1975) describes crises as highly demanding situations in which individuals must adjust their behaviors to new sets of circumstances. These are events that elicit subjective experiences of control and loss. The aging adult thus often finds his/her environment somewhat stressful and hostile with decreased income, the loss of loved ones, poor health, and less control. These external changes inevitably affect the elder person causing internal changes, usually in the form of constriction and withdrawal (Albrecht & Gift, 1975).

Internal Changes

Older persons may find that this period of their lives is not a time of comfort and freedom as had been anticipated (Davidson, 1979). The external changes confronting the aged, especially the reduced income, health, and lack of purpose in life, contribute to this lack of comfort and freedom.

> For the aged person himself, the losses he has sustained--an identity of usefulness and productivity, significant status within the family, independence and mobility, and contact with

> friends and peers . . . can contribute to an attitude of worthlessness and hopelessness (Strow & MacKreth, 1977, p. 30-31).

Thus, what may result is older persons' sense of control over their own lives may decrease and dependency increase.

The older person also may have increasing physical and mental impairment with age. Physical characteristics of the house itself, such as stairs, low bathtubs, or doorways too small for wheelchairs, may limit older persons' mobility and create stress in their lives (Davidson, 1979).

Even though stress is a phenomena experienced throughout life, Loeb (1975) suggests that the adaptation to stress is not the same among older people and among the young. He proposes that the young have a high degree of inherent concern for survival of the species and for reproduction, while an older person is primarily concerned with personal survival.

Individuals vary a great deal in the extent to which they make their own decisions. Some important dimensions of this include the individual's self-esteem and self-confidence, as well as the support received from others. Elderly adults are often discouraged by their families from assuming a self-confident attitude about making their own independent decisions (Atchley, 1975). Ageism within American society is indicative of the way elderly people are generally viewed. Stereotypes and negative attitudes toward the handicapped in our culture create an additional discouragement in the lives of the elderly, who are often considered as being handicapped (Davidson, Hennessey, & Sedge, 1979).

The way the elderly perceive their own age and disabilities, and the loss of a sense of control as manifested in "learned helplessness" (Seligman, 1975) are relevant factors in relation to decreased life satisfaction. The elderly person may internalize society's prejudices toward age and thus may tolerate abusive treatment due to poor self-esteem (Davidson et al, 1979).

Wells and Marwell (1976) believe the way a person perceives and defines self has a direct effect upon behavior. How individuals relate to others, what tasks they attempt, what states of tension they experience, and how they subsequently perceive themselves is influenced by self-definition. They further state "each person places some kind of estimate upon himself as an object of value" (p. 59). This evaluative, judgmental, or affective aspect of a person's self-conception involves the process of self-esteem which is influenced by the perception of locus of control. The term locus of control refers to the degree to which an individual perceives that reinforcements are contingent on his/her own behaviors and actions (Hiroto & Seligman, 1975). An internally controlled person tends to perceive reinforcements as a consequence of his/her responses and to attribute the reinforcement contingencies to his/her skills and abilities. On the other hand, an externally controlled person tends to perceive reinforcements as unrelated to his/her responses and to attribute outcomes to luck, chance, or another person (Hiroto &

Seligman, 1974). The externally controlled person is one who feels helpless or powerless.

Lowenthal and Chiriboga (1973) state that maintaining a sense of continuity, especially in the value system, appears to be a significant part of the adaptive processes of aging. The stability of an internal locus of control becomes increasingly crucial as one ages. One of the most pervasive findings in gerontology studies is the lowered-self-images of the aged (Zubin, 1973). Zubin (1973) states that changes in the behavior observed in the elderly are the result of learning--the elderly learn to be "old" through reinforcement. They learn not to be internally controlled, but to rely on external resources. He further states that the lowered state of our elderly's self-esteem is based upon the learning theory model which is also supported by Hiroto and Seligman's (1975) suggestion that socialization may be responsible for learned helplessness. Srole (1956) addresses the idea of learned helplessness in his study of anomia, or the feeling of being powerless. He found that as a person begins to feel helpless or powerless, the ability to manage crises is weakened. Therefore, what seems to be an overriding factor in determining homeostasis through the crises of old age is the perception of having power or control over one's own life. If, as adults pass through the various stages of life and into old age, they can maintain a feeling of control in life and disregard the often degrading attitudes of society in general concerning

the elderly, the chances for successful adaptation are increased. The feeling of having power over one's life should also help the elderly maintain a higher level of life satisfaction.

Significance of the Study

The aged is one of the fastest growing and most often neglected minority groups in the United States (Spicker et al., 1978). During the past century, the aged population has increased in size seventeen times, more than triple the rate of the population in general. Current demographic projections estimate another 50 percent increase before the completion of one more generational cycle (Spicker et al., 1978).

The rationale for the study was based upon the assumption that life satisfaction experienced by the elderly would be enhanced by maintaining a feeling of control as one enters the stage of old age. The rationale rested upon the statements made by Lieberman (1975) and Atchley (1975). Their reviews of the aging process indicated that as elderly persons decrease in self-esteem, so does the ability to control their destiny, while the maintaining of self-esteem tends to help the individuals retain a sense of independence and worth. Thus, the elderly person whose self-esteem and locus of control has not suffered through the aging process appears to have the ability to successfully adapt to crises and maintain a higher level of life

satisfaction. Perhaps the maintaining of a feeling of control and life satisfaction can be promoted through the use of bibliotherapy.

This study was undertaken in an effort to test the effectiveness of the use of bibliotherapy in helping the elderly more appropriately deal with the problems associated with growing old. This study is significant in that therapeutic strategies are presently few and far between when it comes to helping people cope with growing old. According to Back (1969), one of the major problems confronted by the elderly is the excess amount of idle time they experience after retirement. Perhaps one method for making that idle time more productive might be the reading of therapeutic material. Therefore, this study was to observe the effect that assigned therapeutic reading might have on helping the elderly to more effectively deal with the problems commonly associated with growing old. It was hoped that the study would provide valuable data to the present literature and promote further studies concerning the problems of the aging. Hopefully, with further research the elderly will be able to live more productive and less stressful lives.

Statement of the Problem

The elderly population is one of the fastest growing minority groups in our society and yet they are also one of the most highly neglected groups (Spicker et al., 1978).

As individuals grow old, they often are presented with reduced income, decreased health, less mobility, and increased dependency on others. These crises, if not successfully managed by the adaptive processes, will generally result in poor self-esteem and a feeling of powerlessness, which can cause a decrease in the elderly person's level of life satisfaction (Hiroto & Seligman, 1975, and Lowenthal & Chiriboga, 1973). One therapeutic tool that might prove useful with the problems faced by the elderly is bibliotherapy, or the use of assigned reading material. Schrank and Engels (1981) report that bibliotherapy is effective in promoting therapeutic gain. Therefore, this study was conducted in an effort to investigate the following question: Will bibliotherapy increase internal locus of control and enhance life satisfaction of senior citizens?

Definitions

The following definitions of terms are important to this study:

Anomia--Anomia is an individual's feeling of being powerless, helpless, or alienated (Miller, 1977). Anomia in this study is reflected by a score of 4 or 5 on the Srole Anomia Scale (Miller, 1977).

Elderly Person--An elderly person is anyone aged 65 or older.

Life Satisfaction--An individual is regarded as being at the positive end of the continuum of psychological well

being to the extent that he (a) takes pleasure from whatever the round of activities that constitute his everyday life; (b) regards his/her life as meaningful and accepts resolutely that which life has been; (c) feels he/she has succeeded in achieving his major goals; (d) holds a positive image of self; and (e) maintains happy and optimistic attitudes and mood (Wood, Wylie, & Sheafor, 1969). In this study, scores on the Life Satisfaction Index Z will reflect the following: 0-6, dissatisfied; 7-14, fairly dissatisfied; 15-20, fairly satisfied; 21-26, satisfied.

Limitations

1. The subjects used in this study were members of Senior Citizen Centers in one metropolitan community in Oklahoma. Since only three Senior Citizen Centers were used, the results are not generalizable to other elderly populations.

2. The sessions with the elderly were limited to 18 hours. Other periods of time may be more appropriate in dealing with the aged.

3. The books used in the study were only two of several available. Others may have been more appropriate for the aged.

4. The instruments selected seemed appropriate for use in the study. Other instruments measuring anomia and life satisfaction may have been used.

5. The subjects participating in this study were

volunteers. Therefore, the results are not generalizable to those who would not be voluntary participants.

6. The health reported for the participants was reported as at least fair. Different results might be experienced by those elderly who report better or worse health.

Hypotheses

The .05 level of significance was established as necessary to support or not support the following null hypotheses, which apply to both anomia and life satisfaction:

1. There are no differences in post and delayed post test anomia and life satisfaction levels among the three treatment groups (no treatment control, bibliotherapy alone, and bibliotherapy and group discussion).

2. There are no differences across the testing sessions (pre, post, delayed post) for the no treatment group.

3. There are no differences across the testing sessions (pre, post, delayed post) for the bibliotherapy alone treatment group.

4. There are no differences across the testing sessions (pre, post, delayed post) for the bibliotherapy and group discussion treatment group.

Organization of the Study

Chapter I has presented an introduction to the study, theoretical background, significance, statement of the problem, limitations, and hypotheses. Chapter II offers a review of the literature. Chapter III presents the methodology and instruments. Chapter IV presents the reader with a report of the findings of this research. Chapter V provides a summary, conclusions, and recommendations.

CHAPTER II

REVIEW OF RELATED LITERATURE

This chapter is divided into four major sections. The first section deals with the general attitudes associated with aging in American society. The second section is devoted to the concept of learned helplessness and its effect on anomia. The third section addresses the crises and concerns adults face as they enter the stage of the elderly. The final section concerns itself to the adaptation techniques used by the elderly and potential counseling strategies used in aiding the elderly to more adequately adapt.

Aging

People in American society have always regarded old age as a dreaded fate, a time of life that should be postponed as long as possible. According to Busse (1969), people have always attempted to delay the aging process. He feels this is best exemplified by Ponce de Leon's search for the Fountain of Youth. Today, the Fountain of Youth is being searched out by way of face lifts, health spas, cosmetics, and the like (Palmore, 1969). American society is a youth-oriented culture that views productivity of the person by way of physical attractiveness (Palmore, 1969).

What happens to the individual when he/she finally realizes that youth is in the past tense? This brings forth the problem of one's self-image or identity. Busse and Pfeiffer (1969) believe the person must come face to face with the fact that he/she is now no longer young, no longer even middle aged, but that instead he/she has entered the last phase of life, the phase preceding death. This is a time when losses occur more frequently than the establishment of new relationships (Busse & Pfeiffer, 1969).

Kurtz and Wolk (1975) suggest that the key to a more satisfied, fulfilling experience during old age is the continuation of personal growth. They contend that effective living involves developmental task accomplishment which promotes personal growth and feelings of satisfaction. Seligman (1975), however, suggests that society forces the aged to retire at age 65, places them in old age homes, ignores grandparents, shunts them aside. "We are a nation that deprives old persons of control over the most meaningful events in their lives; we kill them" (Seligman, 1975, p. 184).

Should society then expect that when the vestiges of control over the environment of already weakened human beings (the elderly) are removed, it may result in a decrease in their life satisfaction and possibly kill them?

Learned Helplessness

During the early stages of infancy, people learn the contingency between responses and outcomes. Throughout life,

people continue to place a high value on the idea of independence and environmental control. The person found in the perplexing situation of receiving no correlation between responses and outcomes may exhibit subsequent behavioral defects, namely, the psychological state of helplessness. Seligman (1975) formulated the learned helplessness model which postulates that an individual may feel as if he/she has no control over the environment or that the outcome of a situation will occur regardless of efforts to control or escape it.

Learned helplessness was first used to describe the interference dogs experienced with shuttle box escape behavior after first being given uncontrollable electric shock (Seligman, 1975). The experimental dogs were placed in a Pavlovian harness and received electrical shocks randomly. They quickly learned that regardless of the responses made, they could not control the shock. After being placed in a shuttle box, the dogs soon settled down and accepted the shock, whining quietly. When faced with an outcome that is independent of all responses, an animal or person learns that the outcome is independent of his/her responses. The dogs' learning of the uncontrollability of the traumatic shock was key to developing the helpless situation.

Fear is the emotion first produced in an organism when a traumatic event occurs. If the organism is able to control the situation, then the fear state decreases. However, if the situation is perceived to be uncontrollable, fear is replaced by depression (Abramson & Seligman, 1978).

The learned helplessness state seems general among species that learn (Abramson & Seligman, 1978; Hiroto & Seligman, 1974; Hiroto & Seligman, 1975; Seligman, 1975). These researchers have shown that when species ranging from cockroaches to man are faced with noxious events that can not be controlled, the motivation to respond is drastically undermined.

Seligman (1975) suggests that simple exposure to an uncontrollable situation is not enough to create helplessness. His learned helplessness hypothesis is dependent on the assumption that the person must perceive the situation as uncontrollable before the consequence of helplessness is demonstrated. Helplessness, or the state of anomia, involves circumstances where the subjects believe they are not in control of the situation. Someone suffering from illness or a terminal disease is an example of external helplessness and is applicable to elderly people. Block and Sinnott (1979) report approximately 85 percent of people aged 95 or older report at least one chronic disease and nearly 50 percent report some limitation of normal activity related to chronic health conditions. Similar conditions and limitations could have the consequence of creating helplessness in the lives of many of these older people.

The elderly population, according to Seligman (1975), are prime targets for the acquisition of learned helplessness. The very process of growing old can be seen as an uncontrollable event which, if not safeguarded against, can lead to a sense of being powerless or helpless. Seligman (1975)

further recognizes physical disease and growing old as helpless conditions "par excellence" (p. 94), where the person finds his/her own responses ineffective and is thrown upon the care of others.

Men and animals are born generalizers. Once they learn they are helpless in one situation, much of their adaptive behavioral repertoire may be undermined (Seligman, 1975). Gelles (1976) suggests that the more frequently a woman was struck by her parents as a child, the more likely she is to grow up and be struck by her husband. The battered woman carries through her life a feeling of helplessness, powerlessness, and a futile disposition of being able to escape the situation. It is possible that the same feelings of powerlessness and futility can easily be adopted by the aged when faced with crisis situations.

Hiroto and Seligman (1974) conducted studies on subjects who were judged to be externally controlled individuals and internally controlled individuals. In their efforts to escape aversive tones, after receiving an inescapable pretreatment, it was found that the external individuals were significantly more helpless than the internal individuals. From this, it might be assumed that externally controlled elderly are more susceptible to states of helplessness and, therefore, decreased life satisfaction.

The learned helplessness state produces a cognitive set in which people believe that successes and failures are independent of their own skilled actions (Seligman, 1975). Along with the cognitive set is the expectation that the

situation or situations will not improve. "Expectation is the causal condition for the motivational, cognitive, and emotional debilitation that accompanies helplessness" (Seligman, 1975, p. 48). It would seem, therefore, that the incentive to initiate voluntary responses to control any outcome stems from the expectation that responding will produce that outcome.

As a result of studies undertaken by Abramson and Seligman (1978), Beck (1967), Gelles (1976), Hiroto and Seligman (1974), Seligman (1975), and Walker (1977-78), it seems conceivable to suggest that man can and does fall victim to a state of learned helplessness when the individual feels out of control in governing his/her responses and outcomes. It further seems plausible to suggest that the uncontrollable crises situations that often lead to learned helplessness are heightened as one enters old age.

Concerns of the Elderly

As a person continues to mature through the developmental stages of life, particular concerns become paramount within each successive stage. At the time an individual reaches his/her prime and begins the downward trend to increased wrinkles, graying hair, and a slower gait, particular concerns come to the forefront as he/she nears the supposedly "golden years" (Eisdorfer & Wilkie, 1977). The suggestion the golden years myth makes is a time of life when people who have had a long reign of productivity and stressful years can relax into a time of plenty, with abundant

relaxation, comfort, and freedom from worry (Strow & MacKreth, 1977). However, for a multitude of the elderly, the golden years is a time of increased stress where troubles appear to be magnified with little resources to combat them. Those concerns that seem to be foremost to the elderly are retirement and their decrease in economic clout, decreasing health, relocation, and being a burden to one's family.

According to Kreps (1969), to live in retirement in the 1960's was to suffer an income gap that separated the old man from the young--a gap that has widened over the following years. He also states that low income is now the number one problem of the aged. Atchley (1975) supports the statement by suggesting that in later life, inflation may erode real income to the point where the individual is forced to become financially dependent on family or the welfare system.

In American society the retirement years have tended to be, at first glance, anxiously anticipated until those years are actually upon the individual (Kreps, 1969). The trend has been to push for early retirement so that the elderly can more quickly begin to enjoy the golden years, and also so that younger company men are able to take newly opened positions. However, Kreps believes this trend is detrimental to the aged due to particularly low benefits available to early retirees. He also suggests that the added length of the retirement period thins the annual income from savings and other assets meant to spread over the nonworking period.

The retirement stage of life is an emerging status in present day that is becoming a recognized position during a person's life (Back, 1969). Retirement has become regarded as an achievement in principle but dreaded as a crisis when it actually occurs. In many ways contemporary American society identifies the individual by his/her occupation (Back, 1969), thus, it would seem that retirement is a giving up of a role and not an acquisition of a new status.

Besides the obvious problems associated with retirement and decreased income (less resources to pay for housing, food, medical treatment, etc.), one of the major consequences of retirement, in addition to the economic and status considerations, is the sheer availability of time (Back, 1969). Time, which is scarce for the working person, becomes suddenly excessive and can acquire a negative value. Thus, Back further states that much of the practical concern society has begun to show the retiree has been directed toward the problem of the use of leisure time. He further cites case studies of successful and unsuccessful retirement showing the activities that might be enjoyed. However, it is not the activities themselves but the meaning which the individual is able to give to the activities which determines adjustment.

Thus, it would seem that for the elderly, the prospect of retirement and decreased economic clout for an unknown number of years is an anxiety evoking thought. The idea of not being able to manage financial matters without the assistance of family or the welfare system is indeed a

sobering situation for those who have seen themselves as strong, productive, and independent (Estes, 1969).

The second area of concern that tends to dominate the elderly is that of decreasing health. According to Estes (1969), most older persons face the unknowns of the future (an unknown span of life, an unknown degree of economic inflation, and unknown expenses) with a fixed amount of savings or income. Medical care is costly, and is becoming more so. Therefore, it is not difficult to understand why many older persons, with a fixed reserve to cover an unknown period of years, delay or avoid altogether seeking medical care.

> In our youth-oriented culture, many people believe that the aged inevitably suffer a steady deterioration in physical and mental abilities and, therefore, should withdraw from the central arenas of our society (Palmore, 1969, p. 33).

The acceptance of illness, with its dependence on others, is extremely difficult, and denial of illness is common particularly in men according to Estes (1969). The fear of the discovery of fatal or progressive illness is another common factor leading to the delay or avoidance of needed medical care. It, therefore, would appear that the very concern an elderly person places on decreasing health is the factor that would, in fact, produce ill health. In their effort to deny an illness or the possibility of it, by delaying or avoiding treatment altogether, the elderly may find themselves actually placed under another's care due to their own negligence. Paradoxically, in their efforts to avoid

becoming a burden to others because of poor health, many aging people find their tactics actually aggravate an otherwise treatable malady (Estes, 1969).

The aged frequently underestimate the extent of their health problems or simply deny their existence (Eisdorfer & Wilkie, 1977). With advancing age there is an apparent increase in the relative increase of deaths attributed to diseases suspected of being related to stress. Palmore (1969) suggests that a major part of the stress is a combination of economic concerns and the worries over illnesses that cannot be afforded. It appears then that the concerns the elderly exhibit over decreasing health is part of a vicious cycle. The stress produced by worries of potential illnesses in years to come produce the very illnesses they are attempting to avoid.

At the turn of the century, Charles Horton Cooley developed the concept of the "looking-glass self" (Palmore, 1969, p. 34). This meant that the attitudes and behaviors of others toward a person serve as a mirror in which the individual sees self. This mirror largely determines the image a person forms of self which, in turn, strongly influences his/her behavior. Therefore, as a result of our youth-oriented culture, once persons have reached the elderly stage of life, they are expected to slow down and experience low back pain, stiff joints, or diminished hearing (Estes, 1969). The fact is, by attempting to deny that expectation, the elderly do find themselves, many times, in the very situation they so desperately avoid.

Relocation is also a grave concern to the elderly which, like medical care, is directly related to economic crisis. The relocation of the elderly, according to Neugarten (1968), is an extremely high risk. Neugarten (1968) and Seligman (1975) agree that an unwanted move for the elderly is representative of being powerless and unable to control their destiny. This feeling of helplessness often results in "giving up" and, subsequently, death.

The primary fear of relocation is that it will eventually lead to institutionalizing the elderly where it is regarded as a prelude to death (Goldfarb, 1969). Even though there is not concrete evidence that families dump troublesome old persons into institutions or old age homes, it is still considered a relevant fear to the elderly who may not be able to take care of themselves economically (Goldfarb, 1969).

Whether relocation means moving to an institution, a retirement settlement, a smaller apartment, or into a family member's home, it remains a distasteful concern to many of the elderly (Bane, 1976; Goldfarb, 1969; Neugarten, 1968). The potential loss of one's familiar surroundings represents another area of lost control over one's environment and increased susceptibility to learned helplessness.

The last major area of concern the elderly contend with is that of being a burden to one's family. As stated by Jeffers and Verwoerdt (1969, p. 170), it appears from the expressions of older persons that death is feared much less

than prolonged illness, dependency, or pain, which may bring several threats of rejection and isolation, as well as loss of social role, self-determination, and dignity as an individual. To some of the elderly ill who are cared for in their own homes, life may still seem worth living, but even here regret is often expressed for "the bother I am to those I love."

Especially in the fast-paced, mobile American society, it is becoming increasingly difficult for the elderly to expect help from their children. Alienated children can hardly be expected to take on the daily ministrations, and even well-meaning relatives may find that custodial care is simply too much (Treas, 1977). Where the actual custodial care by family members has diminished, Shorter (1975) contends that the historical emergence of the modern family has been marked by unprecedented demands on kin for intimacy and affection.

Due to the limitations of the elderly's children, caused by proximity to parents or having active families of their own, and little time to spend with aged parents, a new service industry has been created (Treas, 1977). This industry and professional corps provides regular meals, housekeeping services, and institutionalized care. It may relieve the elderly's loved ones from having to personally tend to them, but most often, it does not relieve them of paying for at least part of the services. Therefore, regardless of whether the aged parents' children are physically present

or not, there still remains the agonizing feeling of being a bother to their loved ones.

A major concern that the elderly face appears to be that they are fearful of becoming dependent upon others. Whether their concerns primarily focus on finances, decreasing health, relocation, or burdening significant others, the central concern is suggested to be the loss of control over one's environment (Seligman, 1975). This learned helplessness is a generalized condition that, when experienced in one uncontrollable situation, can easily be carried over in one's behavioral repertoire when encountering any crises.

Counseling the Elderly

When a counselor undertakes the position of counseling the elderly, there are certain considerations that must be made concerning their method of adapting to the crises of aging. According to Busse and Pfeiffer (1969, p. 186)

> the actual transition from one phase of life to another is never automatic, simple, or quick; but the amount of upheaval or distress depends on whether the new phase is welcomed and whether adequate preparation has been made for it.

The counselor should be able to help the elderly realistically prepare for a time when decreased income, decreased health, relocation, and partial dependence on family is possible (Busse & Pfeiffer, 1969).

In situations where the person has much to lose (in aged people, it is their self-esteem and a sense of control over their lives), the common reaction to fear is

constriction and withdrawal (Albrecht & Gift, 1975). Albrecht and Gift further state that the elderly's reactions to failures are (1) to simply give up (die), (2) play the role of the defeated, where they maintain membership in the system but do not actively participate, (3) conform--accepts defeat, acquiesces to the consequences of loss, and adapts by conforming to the expectations of those around them, and (4) denial, where they either redefine the situation so that they have not failed, or refuse to acknowledge the failure.

According to Busse (1969), the most often followed theory of successful adaptation in aging has been the disengagement theory. This theory purports that a high level of satisfaction in old age is usually present in those who accept the inevitability of reduction in social and personal interactions. However, later studies have revealed those elderly citizens who reduce their activities as they age tend to suffer a reduction in overall satisfaction (Busse, 1969). Palmore (1969) and Busse (1969) view the activity theory of aging as more suitable in dealing with the elderly. This theory states that the majority of normal aging persons maintain fairly level amounts of activity and engagement. The amount of engagements or disengagements is influenced more by past life styles. Activity theory also suggests that maintaining or developing substantial levels of physical, mental, and social activity is usually necessary for survival.

Whether one chooses to take stock in the disengagement theory or the activity theory of aging, the roles the elderly population eventually adopt is a result of "anticipatory socialization" (Atchley, 1975, p. 275). Anticipatory socialization is the process of learning the rights, obligations, resources, and outlook of a position or situation one will occupy in the future. Therefore, if an elderly person's loved ones send messages of expectations that the elderly are passive and disengaged, chances are those expectations will be fulfilled. If, on the other hand, relatives and significant others are supportive of the elderly's autonomy and right to self determination, the aging adults are generally more successful in their adaptations to the aging process (Busse & Pfeiffer, 1969).

Those aging adults who do not successfully adapt to the crisis situations presented by advanced age are generally victims of suicide, drug or alcohol abuse, conformity and quick death, or passivity (Albrecht & Gift, 1975; Block & Sinnot, 1979; Miller, 1978; Schuckit, 1977). The overriding factor for each of these dreadful fates is the presence of depression resulting from loss of control and feelings of powerlessness (Block & Sinnot, 1979). Gatz, Smyer and Lawton (1980) suggest that depression is probably the most common psychiatric complaint among older adults experiencing dissatisfaction with their lives. It is further suggested that the importance of attending to depressive symptoms among the elderly is underscored by the high rate of

suicide among older adults. Therefore, in counseling the elderly, it is important to consider the expectations society as a whole has placed on the elder population as well as those expressed by loved ones. If the fulfillment of those expectations results in a loss of self-esteem, autonomy, and control over one's environment, the adaptation employed by the elderly might be suicide, drug or alcohol abuse, passive acquiescence, or conformity and quick death (giving up) (Seligman, 1975).

Once the mental set of the elderly has been examined (Birren, Woods, & Williams, 1980), the counselor can surmise the degree of helplessness being experienced. Seligman (1975) has pointed out that helplessness seems to make people more vulnerable to the pathogens that are always around us, and Block and Sinnott (1979) believe one of those pathogens for the elderly is physical or psychological abuse. Therefore, it would appear that one of the target areas for counseling the elderly should be in helping them control their environment, or at least as much as is possible.

Since fewer of the productive functions are carried out within the home, there are fewer opportunities for auxiliary but useful tasks for the aged. Much of the decline in abilities that does occur among the aged may be due more to declining exercise and activity than to any inevitable aging process (Palmore, 1969). Thus, with the absence of meaningful tasks available to the aging in the home, creative use of leisure time is imperative in helping them to remain active (Back, 1969).

Zubin (1973, p. 8) says "to permit the aged to breakdown and then bring in the repairman to put them together again is wasteful of personnel, funds, and human happiness." He suggests that what is needed is preventive treatment; counseling with the aging before they are aged. Zubin believes if counselors can prevent a lowering of the self-image by proper behavioral therapy, perhaps much of the so-called aging effects on behavior could be prevented. Palmore (1969) suggests that American society could create a useful role for every adult if it were willing to devote the necessary attention and resources to this end. There would be major economic and political problems involved, but there is an unlimited number of goods and sources needed and desired in American society, not to mention the suicides, drug abuse, psychological and physical abuse, isolation and feelings of powerlessness that might be avoided by the opportunity to feel productive, independent, and satisfied. But what of the elderly who are already entrapped by the state of learned helplessness? What is their fate? Those who are experiencing frustration due to feelings of helplessness, and futile thoughts of not being in control of their environment are deserving of dignity; but what can be done?

According to Seligman (1975), the central goal in therapy should be to have clients come to believe that their responses produce the gratification they desire (internal locus of control)--that they are effective human beings.

Seligman claims that what produces self-esteem and a sense of competence, and protects against depression is not only the quality of experience, but the perception that one's own actions control the experience. The main theme of counseling the elderly who have experienced learned helplessness would then seem to be the regaining of a sense of power in controlling their lives. But how does one approach persons who have long been victims of learned helplessness?

Abramson, Seligman, and Teasdale (1978), Klein and Seligman (1976), Seligman (1975), and Walker (1977-78) suggest that the only effective way to combat learned helplessness is to provide the client with experiences of controllable events. Walker (1977-78) found in her work with battered women who had experienced a life-long pattern of physical abuse, the only successful treatment to reverse the cognitive, emotional, and motivational deficits was for them to learn under which conditions responses would be effective in producing results. Klein and Seligman (1976) found that subjects who had induced helplessness in a laboratory setting were able to reverse escape deficits associated with depression after being provided with solvable problems.

Abramson, Seligman, and Teasdale (1978) and Klein and Seligman (1976) suggest the following steps in dealing with people who are victims of learned helplessness: (1) change the estimated probability of outcomes; that is, change the environment by reducing the likelihood of aversive outcomes and increasing the likelihood of desired outcomes, (2) make

highly preferred outcomes less preferred by reducing the aversiveness of unrelievable outcomes, (3) change the expectation from uncontrollability to controllability when the outcomes are attainable; when the responses are not yet in the individual's repertoire, train the appropriate skills, and (4) change unrealistic attributes for failure toward lack of effort and change unrealistic attributes for success toward lack of ability. In other words, it is suggested that therapy with learned helplessness victims should center on helping the individuals recognize, realistically, their abilities and limitations and then providing solvable problems in areas the clients consider important. Reducing the individuals' "catastrophizing" (Abramson et al., 1978, p. 70) about uncontrollable outcomes might reduce the intensity of future depressions.

Seligman (1975) suggests that if the central problem in lack of response initiation (ex. the elderly who passively acquiesce to expectations) is the expectation that responding will not work, cure should occur when the expectation is reversed. Seligman (1975) further suggests that victims of learned helplessness are not only those who receive uncontrollable pain or injury, but also includes those who receive reward, regardless of response. This could also include the elderly whose adult children attempt to take care of their every need, in order to relieve them of worry.

Seligman (1975) suggests that among its effects, poverty brings about frequent and intense experiences of

uncontrollability; uncontrollability produces helplessness, which causes the depression, passivity, and defeatism so often associated with poverty. If this is the case, and with economic difficulty residing as the number one concern of the elderly, it would seem that the aging population may be in great need of counseling. The number and proportion of older people in American society has been increasing steadily, with the greatest increases found for women and for those over 75 years of age. The fact that the retirement years are generally financial hardship times and that couples are having fewer children means there will be even fewer resources available for the future elderly to find psychological and financial support. The problem of increasing learned helplessness is possible unless the aging begin making preparations.

The important aspect of counseling the elderly, whether it be in preparation for retirement or depression caused by a general dissatisfaction with life, is to help them maintain some sense of control, a sense of hopefulness. Seligman (1975) speaks of institutionalized patients. He says,

> institutionalized patients, whether in terminal cancer wards, leukemic children's wards, or old-age homes, should be given maximum control over all aspects of their daily lives: choice of breakfasts, activities, sleep hours, etc. (p. 183).

The important point is that loss of control may further weaken a physically sick person and cause death (Seligman, 1975).

Mardoyan and Weis (1981) state that one effective tool for counseling the elderly is that of group counseling. They continue that one on one counseling is less effective many times due to the counselor's own unresolved feelings towards aging and death, age bias (when the counselor is younger than the client), and countertransference, where the counselor assigns clients the role of a significant other in his/her own life and threats them as such. Group counseling helps to neutralize these potential problems while at the same time provides the older adult with the opportunity to learn new social roles. The group experience with other older adults also provides an environment for the sharing of similar problems and the opportunity to work through these common problems together. Finally, group counseling for the elderly rekindles social drives and helps to develop much needed close personal contacts.

Bibliotherapy is another potential therapeutic tool for use with the elderly and the problems they face. A problem mentioned earlier by Back (1975) that is encountered by the elderly is the availability of time during retirement. This excessive idle time could be made more productive by the assigning of therapeutic material to read.

Even though few studies have been made concerning the effectiveness of bibliotherapy in modifying behavior, some promise has been shown. Weingarten (1954) conducted a study using 1,256 college students ranging in age from 16 to 30. He administered a retrospective questionnaire to them

to document the subjective effects of reading literature. A total of 60.5 percent of the respondents claimed they had received help in developing attitudes for living or for understanding life through reading; 39.1 percent said they had changed their behavior due to something they had read. Weingarten's study suggests that while one-third had changed a behavior, two-thirds of the respondents changed a value due to the reading of literature.

Hagen (1974) conducted a study on the effectiveness of bibliotherapy effecting change in weight loss. He tested the relative effectiveness of three groups: group therapy, bibliotherapy in the form of a manual, and a combination of group therapy and bibliotherapy. All groups did lose weight even though the loss was not significant. However, he found the weight loss to be significant for all treatment groups when compared to the no treatment control. Hagen concluded that bibliotherapy with a specific manual for weight loss is as effective as bibliotherapy or group therapy alone.

Caffee (1976) devised a study using high school students in an attempt to improve self-concept. He had three groups: one where the instructor recommended books for a group to read and discuss; one where these books were available to students but not specifically recommended; and an individual counseling and bibliotherapy control group. While his subjects showed no improvement on provided self-concept scales, the subjects meeting in the group/bibliotherapy as well as the individual counseling/bibliotherapy group showed some

positive movement. The positive movement was expressed in a desire to pursue more reading material in the area of self-improvement. Had the study continued, the support from the group discussion and individual counseling might have reinforced the learning and been incorporated in each person's self-concept. Caffee reported that not only reading but also responding in the groups to the reading was important.

Schrank and Engels (1981) reviewed the effectiveness of bibliotherapy being used as a counseling adjunct. Their review suggested that bibliotherapy may not be effective for increasing academic achievement or marital accord. Findings also suggested mixed results in regards to effecting behavioral change, fear reduction, or changes in self-concept. However, they strongly suggest that bibliotherapy can foster self-development and does cause therapeutic gains.

Summary

The final stage of life preceding death, old age, can be a frustrating experience filled with external and internal changes caused by retirement, decreasing health, and possible relocation and/or dependency on one's family (Estes, 1969; Jeffers & Verwoerdt, 1969; Kreps, 1969; Neugarten, 1968). While the elderly are undergoing such radical changes and potential trauma, they are also the most often neglected minority group in American society (Spicker et al., 1978). They often find little help from family members and even less from outside agencies.

The fact that the elderly population is the fastest growing group in the United States gives rise to an urgent need to ensure a better quality of life for this rapidly rising populace. According to Seligman (1975), the best way to improve the quality of life for the elderly is not to provide for their every need, but to help them to provide for their own needs as much as possible. Helping them to have a hand in controlling their own destiny, as suggested by Seligman, will help the elderly to retain a sense of worth and increase their level of life satisfaction.

The studies conducted by Caffee (1976), Hagen (1974), and Weingarten (1954) suggest that one possible technique that could be used with the elderly is bibliotherapy. It would appear that the availability of time the elderly experience would provide ample opportunity to recommend therapeutic literature. These researchers also imply that the use of bibliotherapy can be valuable in effecting change in attitude, while bibliotherapy and group discussion can effect change in attitude and behavior. The feeling of helplessness (anomia) and decreased life satisfaction among the elderly seems to be a tragic situation that requires immediate attention from the counseling profession. Therefore, this study was conducted in an effort to test the effectiveness of using bibliotherapy and group discussion in aiding the elderly to decrease feelings of powerlessness and increase their life satisfaction.

CHAPTER III

INSTRUMENTATION AND METHODOLOGY

This chapter presents the instrumentation, procedures for selecting the population, subjects, book selection, and co-leaders used in this study. The group treatment methods are described, followed by the statistical design.

Instrumentation

Two instruments were used in this study. The Srole Anomia Scale (Srole, 1956) and the Life Satisfaction Index Z (Wood, Wylie, & Sheafor, 1969) were selected.

Srole Anomia Scale

The Srole Anomia Scale refers to the individual eunomia-anomia continuum representing "the individual's pervasive sense of self-to-others belongingness at one extreme compared with self-to-others distance and self-to-others alienation at the other pole of the continuum" (Miller, 1977, p. 375). The loss or absence of social norms is seen to bring personal insecurity, the loss of intrinsic values that might give purpose or direction to life. Srole has sought to isolate this variable by measuring self-to-others sense of belonging (Miller, 1977).

The five items contained in the scale were selected to measure: (1) the individual's sense that community leaders are detached from and indifferent to one's needs, reflecting severance of the interdependent bond within the social system between leaders and those they should represent and serve; (2) the individual's perception of the social order as essentially fickle and unpredictable; (3) the individual's view beyond abdication of future life goals, that he/she and people like him/her are retrogressing from goals they have already reached; (4) the deflation or loss of internalized social norms and values, reflected in extreme form in the individual's sense of the meaningless of life itself; and (5) the individual's perception that his/her framework of immediate personal relationships is no longer predictive or supportive (Srole, 1956). This scale measures a person's sense of feeling helpless, or powerless.

Srole's Anomia Scale contains five items (see Appendix A) with which the respondent may either agree or disagree. Each item is scored 0 to 1 according to whether the subject agrees or disagrees. Thus, respondent scores fall in a range from 0 to 5; the higher the score, the greater anomia manifested by the respondent. In this study, high feelings of anomia are expressed in scores of 4 or 5, and low feelings of anomia are expressed in scores of 0, 1, or 2.

Reliability and Validity of the Srole Anomia Scale. Miller (1977) shows a coefficient of reproducibility when used as a Guttman Scale to equal .90 according to Killian

and Grigg (1962) and Meier and Bell (1959). To determine the validity of the instrument, a hybrid sample design combining randomized selection of city blocks in Springfield, Massachusetts, and age-sex quota selection within these blocks was used. The subjects used the transit system where a series of anti-discrimination card advertisements were posted under controlled conditions. The sample was comprised of 401 individuals between the ages of 16-69 (mean 40.3 years, SD 14.5 years) who were interviewed in their homes. The sample included white, Christian, native-born transit riders.

Subjects were classified by degree of attitudinal acceptance or rejection of minority groups in general, on the basis of two different kinds of data in combination:

1. Responses to five structured social distance questionnaire items referring by indirection to Negroes, Jews, foreigners, etc.

2. Spontaneous comments revealing underlying attitudes toward minority groups. These were unexpectedly elicited in many cases by the projective nature of the special versions of the posted car cards used in the interview to test message recall.

The hypothesis within the researcher's framework was this: social malintegration, or anomia, in individuals is associated with a rejective orientation toward out-groups in general and toward minority groups in particular. The respondent's definition or perception of his own interpersonal situation were gathered from the interviews held and from

these one item was selected and revised for each anomia concept in the Springfield questionnaire.

Data on the five component items of the anomia measure were assessed by the procedures of latent structure analysis, designed to determine whether as an entity they contain one or several underlying attributes or dimensions. It was found that they satisfy the criteria of unidimensionality.

Life Satisfaction Index Z

The Life Satisfaction Index Z (Wood et al., 1969) was designed to measure self-reports of life satisfaction or morale. It is a revision of the Life Satisfaction Index A which was designed by the same authors as a modification of the Life Satisfaction Ratings (LSR) (Neugarten, Havighurst, & Tobin, 1961).

The Life Satisfaction Indexes are composed of five components of life satisfaction: zest, resolution and fortitude; congruence between desired and achieved goals; positive self-concept; and mood tone.

> An individual is regarded as being at the positive end of the continuum of psychological well-being to the extent that he (a) takes pleasure from whatever the round of activities that constitutes his everyday life; (b) regards his life as meaningful and accepts resolutely that which life has been; (c) feels he has succeeded in achieving his major goals; (d) holds a positive image of self; and (e) maintains happy and optimistic attitudes and moods (Wood et al., 1969, p. 466).

Index Z requires of the respondent only that he/she make an "X" in one of the three spaces for each of a total of 13 statements--agree, disagree, or if not sure one way

or another, to mark in the space under the question mark (see Appendix B). The answer indicating life satisfaction is scored "2," "1" for a question mark or no answer, and "0" for the answer indicating dissatisfaction. Thus, the higher the score, the higher the level of life satisfaction.

Reliability and Validity of the Life Satisfaction Index Z. The Life Satisfaction Index Z was a result of a study made by Wood, Wylie, and Sheafor (1969) where the relationship between Life Satisfaction Index A and Life Satisfaction Ratings was examined. The LSR is an instrument of a clinical psychologist in the Kansas City Study of Adult Life--the Life Satisfaction Ratings (Neugarten et al., 1961). The ratings are made by trained judges. The Index A measures life satisfaction by the respondent's score on a direct self report instrument.

The sample used in this study consisted of 30 men and 70 women, aged 63-92, from rural Kansas. Over one-fourth of the subjects reported having more than a high school education, 54 of the respondents were married and living with their spouse, 41 were widowed, and 5 had never married. The study population, according to self-report, was relatively healthy, and all agreed to be interviewed by the trained judges. Fewer than 20 reported handicaps that limited mobility or interfered with daily activities.

The trained judges using the LSR rates each of the components of life satisfaction (zest, resolution, etc.) on a

five-point scale and summed to obtain an overall rating with a possible range from 5 (low) to 25 (high).

The LSR interviews were, on the average, an hour to an hour and a half in length. They were tape recorded and the ratings were made later. The LSR ratings were made by the authors of Life Satisfaction Index A and Index Z, and the senior author was a member of the research seminar in which the LSR instrument was developed in the Kansas City study.

The sample of 100 older persons for whom both measures of life satisfaction were available was randomly divided into two equal groups, and scores on the two instruments were compared for the first group of 50. The coefficient of correlation between Life Satisfaction Index A and Life Satisfaction Ratings was .56.

Seven questions on Index A were found to be questionable and discarded, thus forming the Life Satisfaction Index Z. The coefficient of correlation was found to be a .57 between LSR and the Life Satisfaction Index Z. The Kuder-Richardson Formula 20 "Coefficient Alpha," which computes on the average of all conceivable split halves, was applied to the 100 Index Z scores and test reliability was found to be .79.

Procedure

A list of names of the senior citizens was provided to the researcher by the directors of the three Senior Citizen Centers in a large metropolitan community in Oklahoma. The

directors presented the volunteer program to their senior citizens as a "study group" available for them. The Senior Citizen Centers used were randomly selected from a list provided by the director of the city-wide Senior Citizens Center program. The subjects were at least 65 years of age and participants at one of three Senior Citizens Centers.

A total of 36 subjects were randomly selected from the names appearing on the volunteer list. From this list of randomly selected volunteers, the Senior Citizens Centers were then randomly assigned to three treatments by the table of random numbers (Kirk, 1968). The three treatment groups were: no-treatment control (C), bibliotherapy alone (B), and bibliotherapy and group discussion (B+DG). There were 12 elderly persons assigned to each condition.

Demographic data was obtained from each person during the initial session with each group (see Appendix C), after each person completed the pre-test of the Srole Anomia Scale and the Life Satisfaction Index Z.

Description of Sample

The subjects who participated in this study were volunteers which, in and of itself, separates them from many elderly people. The groups were difficult to separate in terms of differences due to the number of subjects choosing not to report some of the information on the demographic sheet (Appendix C). The No Treatment Control (C) group showed a mean age of 75.4, while the Bibliotherapy Alone (B)

group reported a mean age of 67.8, and the Bibliotherapy and Group Discussion group (B+DG) showed a mean age of 83.8. Most members of each group had at least a high school education, had at one time been married, but were presently single, and most experienced a drop in income after retirement. The No Treatment Control group (C) had an even distribution of men to women participants, while B and B+DG had a much higher ratio of women to men participants. Health for the three groups was reported as at least fair, and those subjects who reported taking medication did so as a result of conditions associated with aging (high blood pressure, hardening of the arteries, etc.) The demographic information for the three groups is presented in Tables I (p. 47), II (p. 48), and III (p. 49).

TABLE I

DEMOGRAPHIC INFORMATION FOR NO TREATMENT CONTROL SUBJECTS
(N = 12)

AGE		MARITAL STATUS	
65-70	2	Married	5
71-75	4	Widowed	6
76-80	3	Divorced	1
81-84	2	Separated	0
85-90	1	Never Married	0
$\bar{X}$ AGE=75.4		Not Reported	

SEX		LEVEL OF EDUCATION	
Female	6	Less than High School	3
Male	6	High School Graduate	3
		Some College	3
		Bachelor's Degree	2
MEAN # OF LIVING CHILDREN		Advanced Degree	1
2.2			

	INCOME	
	PRE-RETIREMENT	CURRENT
Less than $10,000	3	1
$10,000-$20,000	5	3
$20,000-$30,000	0	0
$30,000-$40,000	0	0
Not Reported	4	8

REPORTED HEALTH			
Poor	0	Good	5
Fair	7	Excellent	0

TABLE II

DEMOGRAPHIC INFORMATION FOR
BIBLIOTHERAPY ALONE
SUBJECTS
(N = 12)

AGE		MARITAL STATUS	
65-70	5	Married	2
71-75	2	Widowed	3
76-80	4	Divorced	3
81-85	0	Separated	0
86-90	0	Never Married	0
Not Reported	1	Not Reported	4
$\bar{X}$ AGE=67.8			

SEX		LEVEL OF EDUCATION	
Female	10	Less than High School	0
Male	2	High School Graduate	4
		Some College	2
MEAN # OF LIVING CHILDREN		Bachelor's Degree	5
1.8		Advanced Degree	1

	INCOME	
	PRE-RETIREMENT	CURRENT
Less than $10,000	2	4
$10,000-$20,000	5	4
$20,000-$30,000	1	0
$30,000-$40,000	0	0
Not Reported	4	4

REPORTED HEALTH			
Poor	0	Good	4
Fair	6	Excellent	2

TABLE III

DEMOGRAPHIC INFORMATION FOR BIBLIOTHERAPY AND DISCUSSION GROUP SUBJECTS (N = 12)

AGE		MARITAL STATUS	
65-70	2	Married	4
71-75	4	Widowed	6
76-80	3	Divorced	1
81-85	3	Separated	0
86-90	0	Never Married	1
$\bar{X}$ AGE=83.8		Not Reported	0

SEX		LEVEL OF EDUCATION	
Female	10	Less than High School	1
Male	2	High School Graduate	6
		Some College	4
MEAN # OF LIVING CHILDREN		Bachelor's Degree	1
.5		Advanced Degree	0

	INCOME	
	PRE-RETIREMENT	CURRENT
Less than $10,000	6	5
$10,000-$20,000	1	0
$20,000-$30,000	1	1
$30,000-$40,000	0	0
Not Reported	4	6

REPORTED HEALTH			
Poor	0	Good	4
Fair	0	Excellent	8

Book Selection

The two books used in this study were Breaking the Age Barrier (Partnow, 1981) and Your Erroneous Zones (Dyer, 1976). These books were selected for several reasons. First, both books presented their information in a straightforward, easy-to-read fashion. Secondly, Breaking the Age Barrier was relevant to the study since its main topic dealt with the various myths and biases concerning growing old. Your Erroneous Zones, on the other hand, presented simple suggestions to help regain a sense of control, or mastery, over one's life. Finally, these two books seemed to complement each other. Breaking the Age Barrier set the stage for the participants by exploring the myths and biases surrounding the elderly, and Your Erroneous Zones provided the means to confront feelings of helplessness. In essence, these two books dealt with the topic of this study in an easy-to-read format and provided easily implemented steps to increase one's feeling of control and satisfaction.

Co-Leaders

The co-leaders working with the three groups in the study were screened by the researcher and the Head of the Counseling Department at a metropolitan university after prospective co-leaders responded to a flyer posted at the university.

Both leaders had courses in group process during their education. During the time of the study, one was a doctoral

student in counseling enrolled at the metropolitan university. The other is a social worker and during the time of the study was an "outreach worker" for the County Senior Citizens Centers. Both co-leaders were women who had indicated a strong interest in working with the elderly.

Once the co-leaders were selected, they were instructed to read the books Breaking the Age Barrier (Partnow, 1981) and Your Erroneous Zones (Dyer, 1976). They spent two hours in training with the researcher, discussing the questions pertaining to the readings, the administration of the scales to be used, and the group process itself.

Treatment

No Treatment Control. The senior citizens in the no treatment control group met for three sessions during the autumn months in one of the Senior Citizen Centers. They were asked to complete the information sheet and the two assessment scales during the first meeting. They were then asked to return two more times, once in November, 1981, and again in December, 1981. At the end of the final session, they were offered the treatment administered to the bibliotherapy and group discussion group.

Bibliotherapy Alone. The senior citizens in the bibliotherapy alone group met for four sessions during the autumn months in one of the Senior Citizen Centers. They met every fourth week after the initial session. Each session was conducted by the co-leaders in the following format:

Session One. During this session, the co-leaders allowed the members of the group an opportunity to get acquainted with each other. The leaders introduced themselves and then asked each member to introduce him/herself. The members were then presented a brief overview of the purpose of the meeting, which was to recommend books for reading. Before actually recommending the first book, the leaders asked each person to complete the Srole Anomia Scale, the Life Satisfaction Index Z and the demographic data sheet.

After the information had been compiled, the leaders provided each group member a copy of the book Breaking the Age Barrier (Partnow, 1981) and a study guide. They asked the members to read the book and then return to meet in four weeks when they were to hand in the completed study guide that was provided with the book (see Appendix D).

Session Two. During this session, the members were asked to hand in the completed study sheet pertaining to the book, Breaking the Age Barrier. After receiving the questionnaire, they were given the second book, Your Erroneous Zones (Dyer, 1976) and again asked to read it and return to meet in four weeks when they were to hand in the completed study guide provided with the book (see Appendix D).

Session Three. During this session, the members were asked to hand in the completed study sheet pertaining to the book, Your Erroneous Zones. The group members were also

asked to again complete the Srole Anomia Scale and the Life Satisfaction Index Z. After completion of the two scales, they were asked to return for one final session in four weeks.

Session Four. During this final session, the members were asked to once again complete the Srole Anomia Scale and the Life Satisfaction Index Z. Afterwards the leaders discussed with the members what they felt they had gained, if anything, from reading the two books. Following the exchange of feedback, the co-leaders thanked the senior citizens for their participation.

Bibliotherapy and Discussion Group. The subjects in the bibliotherapy and discussion groups (B+DG) met with the same co-leaders who facilitated the bibliotherapy alone group. The senior citizens in this group met once a week for nine weeks for two-hour sessions; a total of 18 hours. The group members met at one of the Senior Citizen Centers.

The co-leaders conducted the nine sessions in the following format:

Session One. During this initial session, the co-leaders introduced themselves to the group members. They briefly discussed when the group would meet, the members' responsibilities for reading the material, and their responsibility for being present at every group discussion. After this brief introduction, the leaders asked the group to introduce and tell a little about themselves. After the

senior citizens introduced themselves, the co-leaders asked them to complete the Srole Anomia Scale, the Life Satisfaction Index Z, and the demographic data sheet. Once this was completed, the co-leaders discussed the purpose of the group (to learn something from the reading and from each other). The leaders then provided each member with a copy of the book, Breaking the Age Barrier, and asked to read the first five chapters by the next meeting.

Sessions two through nine are found in Appendix E. Between the eighth and ninth meetings, the participants were contacted by telephone as a reminder of the final meeting.

Testing

Each group C, B, and B+DG were administered the Srole Anomia Scale and the Life Satisfaction Index Z at a pre, post, and delayed post setting. The pretest was administered during the initial session with each group, the posttest was given eight weeks after the initial administration, and the delayed post was given four weeks after the posttest administration. The pretest period for all groups was during the third week in September, 1981, the posttest occurred during the second week in November, 1981, and the delayed posttest occurred during the second week of December, 1981.

Design of the Study

The design of this study can be symbolized in the following manner (Gay, 1976):

R	O_1	X_1	O_2	O_3
R	O_1	X_2	O_2	O_3
R	O_1		O_2	O_3

As mentioned in the procedure section, all elderly persons participating in this study were randomly assigned to three groups: (1) bibliotherapy, (2) bibliotherapy and group discussion, and (3) no treatment control. The independent variable for this study was the treatment each group received (bibliotherapy, bibliotherapy and group discussion, and no treatment control). The Senior Citizen Centers used were randomly assigned to the three treatment groups by way of the table of random numbers. The dependent variable for this study was the scores made on the Srole Anomia Scale and the Life Satisfaction Index Z by the subjects.

Statistical Procedure

The statistical analysis for this study is a split plot factorial analysis of variance (Kirk, 1968). This design compares the differences between and within the three treatment groups to see if there are any significant differences over time. The data compiled by the two instruments was looking for any differences as a result of treatment between the groups and the relationship between anomia and life satisfaction within each group.

Summary

This chapter has described the two instruments utilized

in this study. Those instruments are the Srole Anomia Scale and the Life Satisfaction Index Z. The procedures, selection process, subjects, book selection, and the co-leaders were also presented. A description of the four sessions for the bibliotherapy alone group and the nine sessions for the bibliotherapy and group discussion was provided. This chapter concluded with the design of the study and the statistical procedure for analyzing the data.

CHAPTER IV

RESULTS

The purpose of this chapter is to present the results of the statistical analysis of the four null hypotheses in the study. The emphasis of the study is to examine the effects of bibliotherapy on locus of control and life satisfaction of the elderly. Separate split-plot factorial analyses of variances were conducted on the two dependent measures. Additionally, the comparability of the three groups (No Treatment Control, Bibliotherapy Alone, and Bibliotherapy and Group Discussion) is presented in tabular form.

Test of the Hypotheses

Hypothesis I: There are no differences in post and delayed post test anomia and life satisfaction among the three treatment groups.

A split-plot factorial analysis of variance used to measure anomia resulted in a significant main effect for Groups ($F_{2,33}=7.82$, $p=.0017$), and a significant main effect for Periods ($F_{2,66}=5.94$, $p=.0042$), as presented in Table IV (p. 58). The absence of significant Groups by Periods interaction ($F_{4,66}=1.77$, $p=.1453$) indicates that the

groups were not differentially affected by the treatment conditions.

TABLE IV

SUMMARY TABLE FOR THE ANALYSIS OF VARIANCE: ANOMIA

Source	SS	df	MS	F	P
Between Subjects	301.60	35			
A (Groups)	96.95	2	48.48	7.82	.0017
Subj. w. groups	204.65	33	6.20		
Within Subjects	300.50	72			
B (Periods)	42.02	2	21.01	5.94	.0042
A X B	25.05	4	6.26	1.77	.1453
B X Subj. w. groups	233.43	66	3.54		
Total	602.11	107			

The simple main effects were tested by Tukey's Honestly Significant Difference (HSD) mean comparison test. Results, as indicated by Table V (p. 59), show no significant difference between the three groups at the pre-test period or the post test period. However, a significant difference does exist between the No Treatment Control group and the Bibliotherapy and Group Discussion group at the delayed Post period. This difference is seen as a drop in anomia for B+DG and an increase for C. B+DG maintained the same level of anomia across the post and delayed post periods.

Thus, null hypothesis one regarding anomia is not supported.

TABLE V

TUKEY'S HSD MEAN COMPARISON OF TREATMENT GROUPS: ANOMIA

	C	B	B+DG
PRE TEST	3.083	2.000	2.083
C 3.083	-----	1.083	1.000
B 2.000		-----	.083
B+DG 2.083			-----
	C	B	B+DG
POST TEST	.833	1.333	.417
C .833	-----	.5	.416
B 1.333		-----	.916
B+DG .417			-----
	C	B	B+DG
DELAYED POST	2.333	2.167	.417
C 2.333	-----	.166	1.916*
B 2.167		-----	1.75
B+DG .417			-----

*Critical Value for significance at the .05 level is 1.846.

A split-plot factorial analysis of variance used to test life satisfaction, as presented in Table VI, resulted in a significant main effect for Group ($F_{2,33}=9.65$, $p=.0005$), a significant main effect for Periods ($F_{2,66}=9.64$, $p=.0002$), and a significant Groups by Periods interaction ($F_{4,66}=4.78$, $p=.0019$). This interaction indicates that the groups were differentially affected by the treatment groups.

TABLE VI

SUMMARY TABLE FOR THE ANALYSIS OF VARIANCE: LIFE SATISFACTION

Source	SS	df	MS	F	P
Between Subjects	1496.00	35			
A (Groups)	552.17	2	276.09	9.65	.0005
Subj. w. groups	943.33	33	28.60		
Within Subjects	2350.00	72			
B (Periods)	434.06	2	217.03	9.64	.0002
A X B	430.44	4	107.61	4.78	.0019
B X Subj. w. groups	1485.50	66	22.51		
Total	3846.00	107			

The simple effects breakdown, Table VII (p. 61), indicates that the treatment groups had a significant effect at the post test period, but not at the pre or delayed post periods. The test periods indicated significant differences for the B and B+DG groups but not for the C group. Post hoc

tests (Table VIII, p. 62), using Tukey's HSD, show there were no significant differences between the three groups at the pre test period, but that C and B+DG were significantly different from B at the post test, and B and B+DG were significantly different from C at the delayed post test period. The results indicate that the level of life satisfaction was significantly affected for B+DG at both the post and delayed post periods, but was only significantly affected for B at the delayed post period. Therefore, null hypothesis one for life satifaction cannot be supported.

TABLE VII

SIMPLE EFFECTS BREAKDOWN OF THE GROUPS BY TEST PERIODS INTERACTION: LIFE SATISFACTION

Source	SS	df	MS	F
A	434.06	2	217.03	3.92*
A at b_1	40.41	2	20.21	.37
A at b_2	600.5	2	300.25	5.43*
A at b_3	341.72	2	170.86	3.09
B	552.16	2	276.08	4.99*
B at a_1	132.05	2	66.03	1.19
B at a_2	363.39	2	181.69	3.29*
B at a_3	369.05	2	184.53	3.34*
AB	430.44	4	107.61	1.95
Subj. w. groups	3650.33	66	55.31	

* $p<.05$

TABLE VIII

TUKEY'S HSD MEAN COMPARISON OF TREATMENT GROUPS: LIFE SATISFACTION

	C	B	B+DG
PRE TEST	14.750	15.833	17.333
C 14.750	------	1.083	2.583
B 15.833		------	1.500
B+DG 17.333			------
	C	B	B+DG
POST TEST	19.417	14.167	24.167
C 19.417	------	5.250*	4.750*
B 14.167		------	10.000**
B+DG 24.167			------
	C	B	B+DG
DELAYED POST	16.667	21.583	24.083
C 16.667	-----	4.916*	7.416**
B 21.583		------	2.500
B+DG 24.083			------

*Critical Value for significance at the .05 level=4.66.

**Critical Value for significance at the .01 level=5.87.

Hypothesis II: There are no differences across the testing sessions (pre, post, delayed post) for the no treatment group.

Tukey's HSD resulted in a significant difference between mean scores of the pre tests and post tests for both anomia and life satisfaction (Table IX, p. 64). Results showed a decrease in anomia and increase in life satisfaction. There were no significant differences between pre tests and delayed post tests, or post tests and delayed post tests. Due to the significant difference found between pre and post test periods, null hypothesis two is not supported.

Hypothesis III: There are no differences across the testing sessions (pre, post, delayed post) for the bibliotherapy alone treatment group.

Tukey's HSD resulted in a significant difference over the testing sessions for life satisfaction but showed no difference over the testing sessions for anomia. The results are shown in Table X (p. 65). Results indicate that for life satisfaction, there was no significant gain from the pre to post testing session, but a significant gain at the .01 level between post and delayed post testing sessions. These results indicate that the bibliotherapy alone treatment did not affect a change from the pre to post periods, but did affect an increase in life satisfaction from the post to delayed post periods. The treatment affected no change for anomia. Thus, null hypothesis three is supported for the measurement of anomia but is not supported for the

measurement of life satisfaction.

TABLE IX

TUKEY'S HSD MEAN COMPARISON OF
NO TREATMENT CONTROL
TESTING PERIODS

ANOMIA

	PRE	POST	DELAYED POST
C	3.083	.833	2.333
PRE 3.083	------	2.250*	.750
POST .833		------	1.500
DELAYED POST 2.333			------

*Critical Value for significance at the .05 level=1.846.

LIFE SATISFACTION

	PRE	POST	DELAYED POST
C	14.750	19.417	16.667
PRE 14.750	------	4.660*	2.750
POST 19.417		------	1.917
DELAYED POST 16.667			------

*Critical Value for significance at the .05 level=4.66.

TABLE X

TUKEY'S HSD MEAN COMPARISON OF
BIBLIOTHERAPY ALONE
TESTING PERIODS

ANOMIA

	PRE	POST	DELAYED POST
B	2.000	1.333	2.167
PRE 2.000	------	.677	.167
POST 1.333		------	.834
DELAYED POST 2.167			------

*Critical Value for significance at the .05 level=1.846.

LIFE SATISFACTION

	PRE	POST	DELAYED POST
B	15.833	14.167	21.583
PRE 15.833	------	1.666	5.750*
POST 14.167		------	7.416**
DELAYED POST 21.583			------

*Critical Value for significance at the .05 level=4.66.

**Critical Value for significance at the .01 level=5.87.

Hypothesis IV: There are no differences across the testing sessions (pre, post, delayed post) for the bibliotherapy and group discussion treatment group.

Tukey's HSD was used to compare the mean scores for each testing session of anomia and life satisfaction. Results indicate no difference over the testing sessions for anomia but show a significant difference for the testing sessions for life satisfaction (Table XI, p. 67). These results show that for life satisfaction, significant differences appear between the pre and post test sessions, between the pre and delayed post test sessions, but not between the post and delayed post sessions. The difference between the pre and delayed post test sessions was significant at the .01 level of confidence. The analysis indicates that treatment affected an increase in life satisfaction at the post test period, and this significant increase was maintained at the delayed post period. No such difference was evidenced for anomia. Therefore, null hypothesis four is supported for the measurement of anomia but is not supported for the measurement of life satisfaction.

Discussion

The following discussion will focus on three major areas. First, the interpretation of the findings will be addressed. Second, the findings of the present study will be discussed in relation to bibliotherapy and group discussion. Finally, implications of the present study will be considered in relation to life satisfaction and anomia.

TABLE XI

TUKEY'S HSD MEAN COMPARISON OF BIBLIOTHERAPY AND GROUP DISCUSSION TESTING PERIODS

ANOMIA

	PRE	POST	DELAYED POST
B+DG	2.083	.417	.417
PRE 2.083	------	1.666	1.666
POST .417		------	------
DELAYED POST .417			------

*Critical Value for significance at the .05 level=1.846.

LIFE SATISFACTION

	PRE	POST	DELAYED POST
B+DG	16.667	21.583	24.083
PRE 16.667	------	4.916*	7.416**
POST 21.583		------	2.500
DELAYED POST 24.083			------

*Critical Value for significance at the .05 level=4.66.

**Critical Value for significance at the .01 level=5.87.

The results provide statistical evidence demonstrating that life satisfaction was increased from the pretreatment to delayed posttreatment assessment periods for the bibliotherapy alone treatment group and the bibliotherapy and group discussion treatment group. The results indicate that the use of bibliotherapy may have been effective in enhancing the elderly's perception of life satisfaction. From the results of the bibliotherapy and group discussion treatment group (B+DG), it can be seen that the B+DG evidenced a more rapid increase (at the post test period), which was maintained through the delayed post period. The bibliotherapy alone group showed a significant increase only at the delayed post assessment period. This suggests that even though the use of bibliotherapy may be effective in enhancing life satisfaction, it is even more effective when combined with group discussion. These results, then, tend to support the studies made by Caffee (1976), Hagen (1974), and Weingarten (1954), which suggested the use of assigned reading material. The results also give credence to the review performed by Schrank and Engels (1981) concerning the effectiveness of bibliotherapy, as well as Mardoyan and Weiss' (1981) belief that group process is effective for use with the elderly.

Anomia scores showed little change over time for the treatment groups. The only significant change seen was in the Control (C) group, between its pre and posttest assessment periods, and when comparing B+DG to C at the

delayed post period. The decrease seen in the C group from pre to posttest periods was not maintained through the delayed post period. Therefore, the change may have been a result of the simple act of living, and the situational factors associated with that day-to-day living. The results of the analyses indicate that the treatment was not effective in decreasing the feeling of anomia in the elderly.

Consideration of the life satisfaction scores in conjunction with the anomia scores is important. The B+DG group evidenced an increase in life satisfaction while, at the same time, showing a decrease in anomia, even though this decrease was slight. The B group also showed an increase in life satisfaction and a decrease in anomia, even though both were less dramatic than the B+DG group. One would question whether life satisfaction is more amenable to change than anomia, and whether a change in anomia might occur after an increase in life satisfaction has been maintained over time. The importance of group discussion must also be considered. It appears that a change in anomia may occur more readily when people can regularly interact and share, rather than deal with concerns alone, as those in the B group did. It appears from the analyses that life satisfaction can increase and be maintained without experiencing a significant decrease in anomia. This may imply, as suggested by Abramson and Seligman (1978), Beck (1967), Gelles (1976), Hiroto and Seligman (1974), and Seligman (1975), that an acquired

feeling of powerlessness is difficult to change and may require a greater length of treatment than was provided by this study.

CHAPTER V

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Summary

As previously mentioned, the geriatric population in the United States is one of the fastest growing minority groups, as well as one of the most highly neglected groups (Spicker et al., 1978). The need for aid to these people has become paramount in their struggle with the problems associated with old age. In regards to the plight of the elderly, it was questioned if bibliotherapy would increase internal locus of control and enhance life satisfaction of senior citizens.

This study examined the effects of bibliotherapy on anomia and life satisfaction of elderly people. Three Senior Citizen Centers were randomly selected as sites to conduct the investigation, and 12 subjects per site were randomly selected from a list of volunteers provided by directors of the centers. Treatment for each center was randomly assigned, which consisted of: no treatment control, bibliotherapy alone, and bibliotherapy and group discussion. Subjects in the no treatment control group met three times to complete the scales measuring anomia and life satisfaction. The subjects in the bibliotherapy

alone group received two books (Dyer, 1976; Partnow, 1981) and study guides geared to promote a feeling of controlling one's own life and increase the level of life satisfaction. They were also assessed three times. Subjects in the bibliotherapy and group discussion treatment group received the same two books, but also met once a week for two hours for a nine-week period, to discuss the readings. This group of subjects was also assessed a total of three times. The scores from the anomia and life satisfaction, derived from the Srole Anomia Scale and the Life Satisfaction Index Z, were analyzed by separate split-plot factorial analyses of variances (Groups by Assessment Periods) with repeated measures on periods.

The results of the study indicate that both bibliotherapy and group discussion may be effective as therapeutic tools in working with the elderly. Bibliotherapy was effective in effecting an increase in life satisfaction, but even more so when used in conjunction with group discussion. Neither bibliotherapy nor bibliotherapy and group discussion was effective in decreasing anomia.

Conclusions

Within the limits and scope of the present study, the following conclusions are drawn from the results presented in Chapter IV.

1. Anomia exhibited a decrease when comparing the bibliotherapy and group discussion (B+DG) to the control

group (C) at the delayed post period. However, no significant change was seen within the B+DG or B assessment periods. It can be concluded that neither bibliotherapy alone nor in conjunction with group discussion is effective for decreasing anomia when used as a short-term treatment strategy. The lack of significant change in the anomia scores may possibly be attributed to subject heterogeneity within each treatment group. The pre-existing differences for the subjects in each group may have negated any change that may have actually occurred. Another factor to be considered in regards to the lack of anomia change is the power of the study. That is, for this particular study, there may have been too small a population used to evidence a change on the instrument. Finally, the precision or sensitivity of the measurement tool must be questioned. The fact that the Srole Anomia Scale offers a restricted range of only five points is reason to consider whether it is sensitive enough to detect actual change in the population. When considering the change in scores for the B+DG group, it can be seen that for both post and delayed post periods, a drop in scores of anomia produced a difference of 1.66 from the pretest period. The critical value necessary to show a significant difference was 1.846, thus it must be questioned whether the measuring instrument used was sensitive enough to detect change.

2. Life satisfaction was increased when comparing the B and B+DG treatment groups to the control group. Results

indicate, therefore, that the use of bibliotherapy and group discussion is effective when used to enhance the level of life satisfaction of the elderly. This conclusion is supported by the results indicating that the levels of increased life satisfaction were maintained through the delayed post assessment period. This maintained level of satisfaction might be a result of the ceiling effect. That is, their knowledge of participating in a study may have caused the effect and, therefore, the increased scores may be due to the favorable setting of being a part of something special, rather than the treatment itself. Also, the fact that these people volunteered their participation may indicate that they were wanting to make a change, regardless of treatment.

3. Anomia decreased and life satisfaction increased at the post test period for the no treatment control (C) group. The changes in anomia and life satisfaction are concluded to be a result of situational factors and not a result of long-term internalized factors. The fact that the anomia and life satisfaction returned to their original levels at the delayed post periods tends to support this conclusion.

4. Results indicate that bibliotherapy as a treatment strategy does not decrease anomia but does increase the level of life satisfaction. It can be concluded that bibliotherapy as a therapeutic tool is not effective for promoting a feeling of control over one's life over a relatively brief treatment period, but is effective in enhancing life satisfaction in the elderly. The assigned reading material can

be concluded to be effective for those elderly who are motivated to read.

5. The bibliotherapy and group discussion (B+DG) treatment did not decrease anomia but did increase life satisfaction. It is concluded that bibliotherapy and group discussion as a therapeutic tool is not effective in promoting an attitude of regaining control, but is effective in enhancing life satisfaction. Bibliotherapy is less effective in enhancing life satisfaction when group discussion is not used adjunctively. The use of bibliotherapy and group discussion produced more dramatic results in increased life satisfaction when compared to the control group and the bibliotherapy alone group. The B+DG results were maintained over time. The B+DG group was able to maintain their increased levels of life satisfaction, most likely as a result of the weekly gatherings. The fact that these people had a scheduled weekly activity with their peers may have produced these results. Since so many of the elderly lose family and friends during this time of life, the chance to once again socialize and find a support group may raise the level of life satisfaction. The opportunity to socialize with others in the same phase of life may actually be more therapeutic than bibliotherapy.

6. The implications of the present study suggest that the enhancement of group discussion among the elderly may promote therapeutic gains that are maintained over time. The fact that those subjects in the B+DG group did meet

regularly, may have rekindled their social drives, resulting in increased life satisfaction. The question this raises, however, is whether or not those changes will be maintained once the group discussion ceases to meet. It can be concluded that group discussion does promote therapeutic gains in the elderly. Therefore, bibliotherapy and group discussion strategies should be instituted in those facilities designed for the elderly. These strategies might be effective for use in nursing homes, retirement villages, and senior citizen centers where the target population is available and, many times, willing to participate in activities involving their peers.

To further support the conclusion that bibliotherapy is effective with the elderly, the participants made positive statements upon completion of the study. Many of the participants expressed an interest in purchasing these books for their families and friends. They also expressed a desire to locate other books by Dyer and Partnow. Several of the participants suggested that these books should be placed on tapes for those individuals who have poor eyesight or poor reading skills.

Recommendations for Future Research

Although the present study indicated that bibliotherapy and group discussion was effective in increasing the level of life satisfaction, assessments of the subjects' feelings of anomia failed to indicate that the treatment enhanced a

feeling of having control over one's life. Due to the limitations and findings of this study, the following recommendations are made:

1. This study should be replicated to substantiate the results.
2. Future research should investigate the maintenance of increases in life satisfaction. The findings of the present study indicated significant increases of life satisfaction following a relatively brief intervention. The stability of such a change should be examined by follow-up assessments over a longer interval.
3. Future research should investigate the effects of bibliotherapy and group discussion on anomia over a longer treatment period.
4. Anomia should be researched and should include the use of another assessment tool that may be more sensitive to detecting change.
5. Future research should be designed so that all treatment groups receive the same amount of time in treatment, to control for possible changes due to attention rather than specific treatment.

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APPENDIXES

APPENDIX A

SROLE ANOMIA SCALE

SROLE ANOMIA SCALE

Here are some statements about life in general that people feel differently about. Please read each statement and decide whether you "AGREE" or "DISAGREE." Please circle the answer you select.

1. In spite of what some people say, the lot of the average man is getting worse.

   AGREE DISAGREE

2. It is hardly fair to bring children into the world with the way things look for the future.

   AGREE DISAGREE

3. Nowadays a person has to live pretty much for today and let tomorrow take care of itself.

   AGREE DISAGREE

4. These days a person does not know who he can count on.

   AGREE DISAGREE

5. There is little use writing to public officials because they are not really interested in the problems of the average man.

   AGREE DISAGREE

APPENDIX B

LIFE SATISFACTION INDEX Z

LIFE SATISFACTION INDEX Z

Here are some statements about life in general that people feel differently about. Please read each statement on the list, and if you agree with it, put a check mark in the space under "AGREE." If you do not agree with a statement, put a check mark in the space under "DISAGREE." If you are not sure one way or the other, put a check mark in the space under "?." Please be sure to answer every question on the list.

		AGREE	DISAGREE	?
1.	As I grow older, things seem better than I thought they would be.	____	____	____
2.	I have gotten more of the breaks in life than most of the people I know.	____	____	____
3.	This is the dreariest time of my life.	____	____	____
4.	I am just as happy as when I was younger.	____	____	____
5.	These are the best years of my life.	____	____	____
6.	Most of the things I do are boring or monotonous.	____	____	____
7.	The things I do are as interesting to me as they ever were.	____	____	____
8.	As I look back on my life, I am fairly well satisfied.	____	____	____
9.	I have made plans for things I will be doing a month or a year from now.	____	____	____
10.	When I think back over my life, I did not get most of the important things I wanted.	____	____	____

		AGREE	DISAGREE	?
11.	Compared to other people, I get down in the dumps too often.	____	____	____
12.	I have gotten pretty much what I expected out of life.	____	____	____
13.	In spite of what people say, the lot of the average man is getting worse, not better.	____	____	____

APPENDIX C

INFORMATION SHEET

INFORMATION SHEET

Name _____ Birthdate _____

Address _____ Age _____

Phone _____ Sex: Male _____

Female _____

Marital Status:

Never Married _____
Divorced _____
Married _____
Widowed _____
Separated _____

Number of living children: ____

Education Level:

Less than High School ____
High School Graduate ____
Some College ____
College Degree ____
Advanced Degree ____

Income Level:

	Before Retirement	Current Status
Under $10,000	____	_____
$10,000 - $20,000	____	_____
$20,000 - $30,000	____	_____
Over $30,000	____	_____

Health:

Excellent _____ Good _____ Fair _____
Poor _____ Very Poor _____

Are you taking medication? Yes ___ No ___
If yes, for what ailments? _____

APPENDIX D

BIBLIOTHERAPY ALONE STUDY GUIDES

BIBLIOTHERAPY ALONE STUDY GUIDES

Session One Study Guide

1. How would you define "aging"?

2. How has the media (television, radio, etc.) influenced current views on aging?

3. What role or roles do you play as an older person in your family?

4. What are your thoughts about being alone?

5. How has your family relationships changed over the years?

6. What were your Middle Ages like for you and how have you changed since that time?

7. How does our everyday language shape the concepts of aging?

8. What activities have you stopped due to your aging?

9. What were your expectations for yourself in aging when you were Middle Aged?

10. What is your outlook for the future?

Session Two Study Guide

1. Can and do you accept yourself as you are? What do you accept? not accept?

2. What are some strategies for eliminating worry?

3. What are some strategies for coming to grips with the mysterious and the unknown?

4. What does internal and external locus of control mean?

5. What are some strategies for eliminating some of the behaviors we think we "should do"?

6. What are some strategies to get rid of the futile insistence for justice in everyday life?

7. What are some strategies to get rid of dependency behaviors?

8. What are some ways you can replace anger?

9. What are some ways of getting rid of procrastination?

10. How would you describe someone who is free of erroneous zones?

APPENDIX E

BIBLIOTHERAPY AND GROUP DISCUSSION SESSIONS

BIBLIOTHERAPY AND GROUP DISCUSSION SESSIONS

Session Two. The co-leaders greet the group members and spend a few minutes simply visiting with them. The leaders, once the ice is broken in the group, will then present the following questions for discussion pertaining to their reading.

1. How would you define aging?
2. How has your perception of aging changed now as opposed to when you were 40 years old?
3. How has television, newspapers, and movies influenced current views on aging? (a) How do you feel about that?
4. How does our everyday language shape the concepts of aging? (i.e., age before beauty; she looks old for her age, etc.)
5. How old do you feel and why?
6. Could you really tell you were aging or is it something that has crept up on you?
7. What activities have you stopped due to your age? Why?

At the end of the session, the co-leaders asked the group members to read chapters 6-10 and to be prepared for discussion at the next meeting.

Session Three. During this session, the following questions will be discussed pertaining to the assigned reading:

1. What kind of shape are you in? Do you partake in any sort of exercise?
2. Are you concerned about your physical health? How often do you see your doctor? Do you see any chance for increased health?
3. What role do you play as an older person in your family?
4. What are your expectations for yourself in aging?
5. How has marriage contributed to the quality of life to those of you who are or have been married?
6. How has the single life contributed to the quality of life for those of you widowed, divorced, or never married?
7. What are your thoughts about being alone?

At the end of the session, the co-leaders asked the group members to read chapters 11-14 and to be prepared for discussion at the next meeting.

Session Four. During this session, the following questions will be discussed pertaining to the reading:

1. Who in your family do you feel you can rely on (children, spouse, brother, etc.)? Why?
2. How has your family relations changed over the years?

3. What were your Middle Ages like for you and how have you changed since that time?
4. How do you manage financially? Is it strained? Are you working? Do you live day to day? Are finances a worry for you?
5. What has been the best time of your life? Why?
6. How much time do you spend thinking about the past? present? future? Why?
7. What is your outlook for the future?

At the end of this session, the co-leaders asked the group members to read chapters 1-4 from the book, Your Erroneous Zones, and to be prepared for discussion at the next meeting.

Session Five. During this session, the following questions will be discussed pertaining to the assigned reading:

1. Do you believe that you make most of your decisions of daily living?
2. Are you capable of controlling your own feelings or do others around you seem to have control?
3. How much approval do you feel you need from others?
4. Can and do you accept yourself as you are?
5. What are some ways you believe you can control more of your life?
6. Do you believe you are capable of giving and receiving love freely?

7. Are you motivated by your potential for growth or a need to repair your deficiencies? How does this make you feel?

At the end of the session, the co-leaders asked the group members to read chapters 5-8 and to be prepared for discussion at the next meeting.

Session Six. During this session, the following questions will be discussed pertaining to the assigned reading:

1. How often during your daily living do you worry? What do you worry about?
2. What are some strategies for eliminating worry?
3. What are some typical "fear of the unknown" behaviors evident in our society? Do these apply to you?
4. What are some strategies for coming to grips with the mysterious and the unknown? How can these strategies apply to you?
5. What is internal and external locus of control? Where do you fit in this scheme of control? Are you satisfied where you are?
6. What are some of the common payoffs for holding on to behaviors you think you "should" do, even though you may not want to do them?
7. What are some strategies for removing some of these "shoulds"?

8. How are we conditioned to look for justice in everyday life?

At the end of the session, the co-leaders asked the group members to read chapters 9-10 and to be prepared for discussion at the next meeting.

Session Seven. During this session, the following questions will be discussed pertaining to the assigned reading:

1. What are some typical ways in which you procrastinate? What are some reasons for procrastinating?
2. What are some techniques for getting rid of procrastinating? How can this apply to your own life?
3. What are some common dependency and dependency promoting behaviors? Do any of these behaviors belong to you?
4. How can you rid yourself of some of these dependency behaviors? Would you be willing to try some of these strategies? What are the payoffs for being dependent?

At the end of the session, the co-leaders asked the group members to read chapters 11-12 and to be prepared for discussion at the next meeting.

Session Eight. During this session, the following questions will be discussed pertaining to the reading:

1. What are some causes of anger? Do you handle your anger the same as you did during your middle age years? What are some common forms of anger?
2. What are some ways you can replace anger?
3. How would you describe someone who is free of erroneous zones? Can you picture yourself coming closer to being free of erroneous zones?
4. What are some of your erroneous zones?
5. Do you feel you have gained anything from these books and discussions?
6. How would you tell younger people to prepare for growing older and to remain satisfied with life?

After the discussion has ended, the co-leaders re-administered the Srole Anomia Scale and the Life Satisfaction Index Z. The leaders brought the reading and discussion to closure after receiving feedback from the group members in regards to the book, discussions, etc. The leaders then asked the group members to return once more in four weeks for a final meeting to once again complete the scales.

VITA

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Doctor of Philosophy

Thesis: THE EFFECTS OF BIBLIOTHERAPY ON ANOMIA AND LIFE SATISFACTION OF THE ELDERLY

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