THE ROLE OF HIGHER EDUCATION IN THE FIELD OF AGING

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Throughout human history man has viewed a long life as a reward for a good life. In a time when precious few attained the age of 60 years, much less 80, when the survivors represented the most naturally fit, old age was in fact a prize. Even at the turn of this century, the average male, born in the U. S., could only expect to live to 48 years of age. Today, he is born with a legacy of 70 or more years. Furthermore, he is born into a different culture, a changing and more complex society in which he must compete with a much larger number of men. As he approaches old age, he is no longer viewed as a unique survivor of the past, as a purveyor or font of accumulated knowledge, but rather, more often, an obsolete competitor in a productive society where machines and computers can replace man’s hands and minds.

In such a social setting, old people are often viewed not as successful survivors of the natural evolutionary process, but rather as having less then, or being deficient in, the necessary qualities and strengths needed to compete in an aggressively competitive society.

Just as an example, let us look at the way in which we presently characterize the knowledgability of our older population. Standardized tests, consisting of questions about historical events, literature, mathematics are administered. When an older adult produces fewer right answers than a young adult, we are likely to interpret this as indicative of a decrement in his performance due to memory deficits. It is just as likely, however, to reflect changes in our culture. Despite the fact that old people
have had the opportunity to accumulate more information due to their longer life span, old people may also have had limited amount of schooling, less information from mass media such as newspapers, books and travels, and little if any, information through radio and T. V. Therefore, an older person's potential for producing information is more restricted than that of a contemporary young adult.

Seen from the average person's viewpoint however, older people are considered less capable, less competent than younger adults. Old dogs can't learn new tricks. Old people dwell on the past not the present. They are forgetful, sick, slow, fussy, crabby, dogmatic and conservative. They are dependent and leave their care to those of us who are productive but have more important things to do than contribute to their financial and social needs. These are typical attitudes toward the aged which act as background for our individual and group behavior toward them.

It is the cumulative effect of these kinds of attitudes that make the building of nursing homes and retirement villages the boon to the construction industry. These are the attitudes that determine retirement policies in industry. These are the attitudes that offer artsy/craftsy courses in continuing education programs (despite evidence gathered from polls of senior citizens that they would rather be involved in academic courses). These are the attitudes that those of us in higher education must deal with when we are attempting to teach about old age as another development phase in the life cycle.

As I see it, the primary role of higher education is to attempt to change some of these misconceptions through presenting scientifically sound evidence
to the contrary. As far back as the early 50's the University of Michigan began experiments with activity programs in homes for the aged and later in county hospitals. These led to the milieu therapy project at Ypsilanti State Mental Hospital. The spectacular results of this project (which showed firmly that old people can learn, can change, can be rehabilitated) have been used as a basis for the training of a myriad of hospital personnel nationwide. It has also provided us with knowledge about the processes of aging and new insights into the specific behavioral problems of the latter stage of the life span. The key to such learning, however, is gerontologically trained personnel who can provide the information and experiences needed to enlarge the understanding of old age as a time of special and different needs and responses. Higher education can reach a variety of students from those who show specific interest in the helping professions to the less directed liberal arts student. Dr. Ann Hudis has shown that even exposure to one course on the undergraduate level, which presents research evidence from behavioral studies, demographic information on the differences in our population of older people, and field experiences which expose students to the life-styles and problems of the elderly can radically change the misconception these students had held about aging and the aged. Other educators have created courses geared to vocational training in the helping professions and through positive and informative exposure, encouraged students to choose working with older rather than younger populations. It has been said by many that we are a "youth-oriented" society. This means that we often place greater value on youth than middle or old age. Because they are often the most visible, we hold onto our false beliefs that all "old" people are weak, sick or not very intel-
ligent. Since the older person is nearer death and death is unavoidable, we also tend to see the acquiring of chronic disease as a harbinger of decline, a pathological concomitant of the aging process, an irreversible slide toward ultimate non-functioning, rather than a natural erosion or wear and tear brought about by the stress and strains of accumulated years of functioning. Medical students see older people as "crock" - uninteresting debilitated old ladies and men who can teach them little that is exciting and who are going to die anyway so why get involved. But what about the challenge to the medical student presented with an 89 year old lady in a nursing home who complains of no pain, raises no fever, evidences no digestive upset who suddenly slumps in her wheel chair and becomes uncommunicative and when operated on is found to have a ruptured appendix? What happened to all the tried and true signals our medical student has learned to recognize an appendicitis attack? Did he forget them? Or do these signals change with age and does he have to be more alert to other kinds of signals? Could he have saved her or did she just die of old age? I think I can answer that question. She was my grandmother. She lived for an hour after the operation last week, her heart was very strong. Her daughters had visited her the day before and said she looked and acted very tired: she asked not to be bathed that night because she just wanted to lay down in bed. The daughters were concerned because her behavior was so different from her usual spry outgoing self. The doctor wasn't concerned until the next day when he decided to do a blood count and it was abnormal. It was the only sign of abnormality and our hypothetical medical student should know that with older people it very often is the only evidence of appendicitis. He needs exposure to older patients to begin to learn these
differences. But despite the enormous amount of book and ward time he spends in pediatrics or in male vs. female wards, he gets little if any higher education in geriatrics. Surveys of education in geriatrics in the medical schools of the United States show that fewer than 1 in 3 seniors feel they have received sufficient specific geriatric training.

Despite their relative minority in the total aging program (taking care of less than 5% of the population over age 65), nursing homes have been forced to bear the burden of much of the applied education in the field. This has given a bias to our knowledge about geriatric care because we are dealing only with individuals of advanced age and debilitating diseases. Again we are given a picture of aging as pathological rather than developmental.

Those of us active in gerontology and gerontological education find it hard to accept this picture of aging. Because sick people are treated differently from the well, it is critical to the training of those who will and do work with the elderly population to differentiate between the aged who are ill and deteriorated and the definition of the aged as the people who are passing through a normative phase of growth and development. Some of the illness and particularly the individuals focusing on physical problems and complaints so often seen in elderly persons may be more socially than physically or psychologically defined.

That is, in a society where few roles are offered older people, in a society where work is halted at 65, where grandparents are not the purveyors of culture or education, where one is defined as unnecessary by virtue of reaching old age, one way to be socially acceptable, to gain some kind of attention, is to be sick. We expect sickness and its complaints to accompany
old age and we accept their articulation. We provide extra medical care and special payment for it on the basis of chronological age. Therefore, it is not surprising that old people also accept the premise that illness is part of the aging process. We know that we can not see, smell or hear as well when we get older. Is this not a physical impairment? We are less strong, is this not illness? People are not interested in hearing what we have been, and what of interest could we be doing now that we are retired? A doctor or even a friend will lend an ear to a list of medical complaints, if not to reminiscences of the past. If an aged person is not really sick, what excuse can he/she offer him/herself for being in a nursing home? How better to gain a few moments of the aid's attention than to list arthritis through rectal pains?

Again, studies of older persons, whether institutionalized or living in the community show that given a chance to play other than the sick role, given a chance to socialize with other people in an atmosphere accepting of individual differences and potentials, older people can find rewards for other than their chronic complaints. Older people have much to cope with and do cope with a variety of problem situations. They often are financially deprived, socially isolated, facing the problems of no work in retirement and the stresses of a new life style. Yet the majority of our elderly population do cope and adapt (as they have through other developmental crises).

When they are allowed to share their experiences with others and made to feel that the ways in which they are adapting are perfectly acceptable, that asking for help with their problems need not be demeaning but rather part of life's give and take, they often don't need to feel that sickness is their ticket to dependency and giving up.
But we need to know much more about this segment of life before we can freely help our aged population. We need trained personnel to explore the variety of coping styles adopted by aged persons in problem situations in family life, in housing, in regard to socio-economic needs, and in regard to health problems.

This need to know more about our older population brings us to the next role of higher education in gerontology.

Since many professional persons with contacts with old people often themselves have no technical background or necessary sympathy for their responsibilities, it is suggested that the number-one priority be given to "gerontologizing" the professions - introducing the content of the field to those already in practice. This means improving and extending existing academic training programs in medicine, nursing, health administration, the social sciences, education, recreation and all other helping professions.

The great expansion of effort can lie in the training of persons who give service to the older population.

Perhaps most important to this educational process is helping the practitioner to identify him/herself as one who intervenes. Whether physician, psychologist, social worker or nurse, a gerontologist must be able to envision intervention at the community, family, as well as, individual level. Such intervention must be based on an understanding of the interaction of environment and individual, of needs and achievement goals. Such intervention must always include seeing oneself as a change agent based upon a real understanding of the rights of self-mastery and inherent potential of every individual. In simple terms, we need professional training for those who will begin to listen to the elderly, to their needs, their cries, their solutions
to their own problems before using our professional clout to bring about change. Education must be tied closely to a conceptual framework based upon social facts and the implication these facts have on the processes of aging. It must be based therefore upon research, whether basic or applied. We must help students to recognize that research methodologies can be and are tied to practice, that the problems of the aged today can be studied and solved by a marriage of research and its application.

We need to push the development of persons competent in evaluative research with the necessary skills to measure ongoing programs and projects and problems of the elderly population and to measure what such programs have demonstrated and whether or not they were successful.

It is not enough to open a new Senior Center, to begin a new recreation program in an institution, or to increase Social Security payments. We must know also, how these innovations affect the lives of the people who are being touched by them. This moves practice from the level of "doing" to being critical of what is being done and its relevance to the people whose lives it affects. Daily reports, charts, notes, become then, not a chore but an important fund of knowledge and questions for improvement and change.

Thirdly, higher education plays a practical role in any society in providing needed manpower.

The manpower problem in the field of aging arises largely from society's recognition of the importance of meeting the needs and improving the quality of life and opportunities of a rapidly growing older population. Ultimately, it derives from the rapid rise in the number of middle-aged and older adults living beyond the period of parental responsibility and increasingly freed
participation in the work force. The two achievements of longer life and a relatively earlier completion of these adult roles have given rise to many problems for the aging individual, for his family and community, and for society. These include: maintenance of income during the retirement years, preservation of health and the capacity for social participation, making suitable housing and living arrangements, finding new activities and roles which afford meaning and satisfaction, and establishing new social relationships to replace those broken by the departure of children from the home, retirement from work and death of friends and relatives.

According to studies undertaken in response to the 1967 amendment of the Older Americans Act, there is a need for thousands of trained personnel, at all levels, for planning and administration; for administration of homes for the aged and related facilities; for direction of multiservice senior centers; for recreation leadership in aging; for adult education; vocational, college and university teaching; for social welfare work with older people; and for providing the wide range of health services required by the older population.¹

The AoA has understood the intent of the Congress to be unequivocally that support be provided for training professional and technical personnel serving older people, primarily in newly emergent occupations which have come into existence in response to needs of the older-age population and for which training support was not available under existing grant programs.

The primary goal and broad objective of education and training programs

in aging is to equip adequate numbers of personnel, including older people themselves, for leadership and professional practice in programs and services through which the older population can find (1) opportunity for continued independence, self-expression and fulfillment (2) assistance in coping with changes and crises characteristic of the later stages of life.

The following represent the AoA priorities for training in the field of Gerontology as of 1970:

1. Broad planning and administration in aging for work in public and voluntary programs at Federal, State and local levels. Career training toward this end is needed at masters and doctoral levels; also needed is short-term training for currently employed persons seeking to develop competency for work in the field of aging.

2. Planning, administrative and management training in the field of retirement housing, villages and homes for the aged.

3. Planning, administration and program supervision for personnel of multiservice centers for older people.

4. Training for specialists in aging within such professions as recreation, counseling, adult education, architecture, library work, home economics and retirement preparation.

5. Preparation of faculty personnel broadly trained in applied social gerontology, and preparation of specialists in aging within established professions. This is really the key to the production of all other types of personnel.

6. Leadership training, for members of State and community committees on aging and for older adults who wish to become active in their communities.

7. Training for semi-professional and technical personnel, to serve under professional direction.

Finally, I should like to propose another challenge to higher education in gerontology - that of developing more meaningful educational roles for older people themselves. This involves something other than a time-filler, another activity organized by a well-meaning Senior Center administrator or recreation therapist. This involves ways in which the aged individual could be retrained through the educational agencies of our society. This involves second career training for new occupational activities, refresher courses for maintaining technological knowledgeability as well as increasing the educational attainment of those whose life styles prohibited school advancement during working years.

Various studies have indicated that the aged who have successfully adjusted in their older years, have been actively concerned with their community, have been in relatively good physical health and continue their personal relationships with their friends and families. They have continued into their later years to pursue activities and concerns which are traditionally part of their lives prior to retirement.

Since the amount of education an individual achieves appears to be related to his successful handling of the problems of aging, it may be possible to provide, to intervene, in the lives of our present older population (who for the most part are the least educated segment of the population) to the extent of increasing their educational attainments.

Various programs presently attempting to deal with this problem show promising results. Although no thorough evaluation has been made, programs such as the Institute for Retired Professionals at N. Y.'s New School for Social Research which offer courses taught by and for retirees in subjects ranging from Hindu philosophy to Jewish cooking seem to meet a variety of needs of their rather
restricted sample as well as offering opportunities for continued feelings of social usefulness, maintenance of continued learning abilities and experiences. New York Community College has been offering courses in a variety of settings from college class rooms to nursing homes at the request of older persons throughout the New York community. These courses are, for the most part, subjects elected by the participants and taught by students of adult education or gerontology from N. Y.'s colleges. Perhaps, this rounds our circle. For here is the perfect educational setting - older people deciding what they want to learn from younger people who are learning what it means to grow old gracefully.