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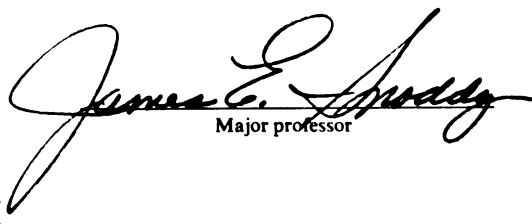
The Effectiveness of a Culturally Sensitive
Educational Programme on Self-Perception of
Health, Happiness, Self-Confidence, and
Loneliness in South East Asian Seniors

presented by

Basanti Bhaduri Majumdar

has been accepted towards fulfillment
of the requirements for

Doctorate of Philosophy degree in Education


Major professor

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**THE EFFECTIVENESS OF A CULTURALLY SENSITIVE
EDUCATIONAL PROGRAMME ON SELF-PERCEPTION
OF HEALTH, HAPPINESS, SELF-CONFIDENCE, AND
LONELINESS IN SOUTH EAST ASIAN SENIORS**

By

Basanti Bhaduri Majumdar

A DISSERTATION

**Submitted to Michigan State University in Partial fulfilment of the requirements
for the degree of**

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1995

ABSTRACT

THE EFFECTIVENESS OF A CULTURALLY SENSITIVE EDUCATIONAL PROGRAMME ON SELF-PERCEPTION OF HEALTH, HAPPINESS, SELF-CONFIDENCE, AND LONELINESS IN SOUTH EAST ASIAN SENIORS

By

Basanti Bhaduri Majumdar

Educational and Health care policies in Canada are based on the principle of universal accessibility. With this principle everyone has an equal right to access and receive educational and health services regardless of age and ethnicity.

In spite of being part of the mainstream (dominant group), a large number of seniors suffer from ageism and have difficulty in accessing available services. Seniors from non-European backgrounds are confronted with double barriers: ageism and racism. Those seniors who are from non-European culture and non-English speaking are more vulnerable than any group of seniors.

This study was aimed at exploring the effectiveness of a culturally sensitive, self-directed and self-supported educational programme for the selected population. The purpose of the programme was to increase self-confidence and alleviate social isolation among a selected group of senior, South-East Asian immigrants by providing a self-directed, self-supportive educational programme.

In this study a descriptive design was employed: the independent variables include the subjects' gender, age, ethnic origin, marital status, language, education, income, financial status. The dependent variables were perception of health, self-confidence and loneliness, and ability to speak English.

Participants included twenty seven seniors. They are all located in Hamilton, Ontario, and they immigrated from Vietnam within the last five years. All spoke Chinese and resided in apartment buildings in downtown Hamilton. Two questionnaires were developed and tested for face and content validity and reliability for this study. The health assessment questionnaire was developed to measure the perception of health, self-confidence, happiness and loneliness. Bader's (1983) oral language expression rating scale was modified to measure the seniors' ability to speak English. In addition, a weekly journal was kept to record the progress of individual seniors' ability to speak English and their group interaction.

The demographic profile questions indicated respondents were: male 73%, married 73%, a low income earner - under \$500.00/ month 65%, and Chinese origin 100%. Forty six percent of seniors had obtained an elementary school education (46%).

Significantly, the seniors have created their roles as experts among the younger generation on maintaining cultural rituals and customs for the Canadian of South East Asian origin. They have begun a self support group, independent of Provincial and Federal Government funding and started to take care of each other rather than depending on their children.

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CHAPTER I

INTRODUCTION

"Education has to increase men's (and women's) physical and mental freedom -to increase control over themselves, their own lives, and the environment in which they live. The ideas imparted by education, or released in the mind through education, should therefore be liberating ideas. The skills acquired by education should be liberating skills ... In particular, it has to help men (and women) to decide for themselves ... in co-operation ... what development is ..." (Nyerere, J., 1976, p. 10).

In 1976, four hundred participants from over 80 countries attended a conference in Tanzania to discuss the relationship between adult education and self-development. The opening address was delivered by President Julius Nyerere on "Liberated Man, The Purpose of Development". He stated that development should help to expand people's "consciousness and empowerment", their environments and their societies. He believed that adult education is a strategy to inspire a desire for change, to help people work out what type of change they want and how to create it.

"Adult education thus incorporates anything that enlarges men's (or women's) understanding, activates them, helps them to make their own decisions, and to implement those decisions themselves." (Nyerere, 1976, p. 12).

Equal access to education, health care and social services is a highly valued directive in Canadian society (Ontario Human Rights Commission, 1992; The

International "Bill of Human Rights", 1985; Canadian Charter of Rights and Freedoms, 1982). Yet for seniors, especially marginal group¹ seniors, barriers to access of such systems can seem formidable. Problems associated with ageism, sexism, racism, physical disability, and language barriers thwart seniors in their struggle to integrate themselves into Canadian society and in their pursuit of an optimal quality of life.

While most seniors suffer to some extent from the ill effects of barriers associated with ageism, minority group² seniors often face multiple barriers that isolate them from mainstream society and prevent them from achieving self-determination in a land in where historically, freedom has been considered a most precious acquisition. Many of these barriers to better living may be eliminated through the establishment of culturally-sensitive adult education programmes aimed at both providers and receivers within health care, education and the various social service sectors.

Issues related to enhancement of quality of life through adult education and their impact on the social fabric of humanity are widely recognized. According to Green (1976), adult education includes a struggle for liberation, equality and justice; "... it is more than a mild disagreement at a tea party on the governor's lawn" (Green, 1976, p. 57).

He states that adult education and national development have suffered from an isolation "from any articulated interaction with basic needs" (Green, 1976, p. 46).

¹ Marginal group includes those who are visible ethnic population, Aboriginal people, Hispanic and Europeans with first language other than English or French.

² Minority group refers to a group of people within a given society that is either small in numbers or has little or no access to social, economic and religious power.

Green's interpretation of "Basic" goes beyond what usually is referred to as the "Basic" category:

"It is necessary to underline that in speaking of self-reliance in terms of basic human needs one means basic structural changes and not marginal tinkering; liberation and not containment; and revolution (whether violent, or otherwise), not reformism" (Green, 1976, p. 46).

In his definition of the nature of adult education, Green states that adult education should address the development of community spirit awareness which potentiates community action and empowers people to overcome individual and community helplessness in the face of official, natural and man-made forces. (Green, 1976).

According to Vanek and Bayard (1975), every education programme is either "formal" or "informal"; "socializing" or "mobilizing"; "dominating" or "liberating". "Formal" refers to schooling. "Informal" sources include all out-of-school learning. "Socializing" education refers to traditional forms of education in which individuals are moulded to fit into the economic, political, and dominating cultural structures of a particular social system. Both capitalist and socialist systems have structured education to correspond to their economic and geo-political philosophies and ideologies. "Mobilizing" education, in contrast, assists people to change their fundamental socio-economic environment. Education also can be "dominating", used by one group to control another, or it can allow creative and analytic thinking that is "liberating"; the opposite of "dominating".

These authors clearly believe that the mobilizing and liberating aspects of the teaching/learning process is especially important in adult education. When adult

learners access the education network, they bring with them many life experiences, plus any formal education they have acquired. One should never underestimate the benefit that knowledge provides in adult learning situations. The adult learners' needs, goals and accomplishments in education can have a profound impact on and contribution to the communities in which they live. Indeed, these learners may prove to be one of society's greatest assets (Vanek and Bayard 1975).

RATIONALE FOR THE STUDY

"By the year 2021, Canadians will understand both the lifespan and the diversity of individuals within Canada. This understanding will result in a society which supports its members throughout the life continuum and recognizes individual rights and needs for dignity, respect, autonomy and choice. Within this society, individuals are valued as contributors to society, as they continue to grow and develop throughout their lives" (Blais, C., (ed) 1991 p. ix)

Canada has been multicultural, or as it was called at that time, "pluralistic", since it's inception. The Fathers of Confederation recognized pluralism. Sir George Cartier wrote,

"In our federation, we shall have Catholic and Protestant, English and French, Irish and Scottish. They are different races, not for the purpose of warring against each other, but in order to compete and emulate for the general welfare" (Monet, 1992, p. 21).

Often forgotten is that the Aboriginal People were the First Nations in this country and that the Blacks, who have been in Canada for more than 400 years, were among the earliest of settlers. There is considerable evidence of prejudice towards

non-white groups within Canada (Canadian Government Publishing Centre, 1984; *After the Door Has Been Opened*, 1988; Naidoo, 1989; Head, 1989; Ralph, 1989). Members of non-European minorities are vulnerable to problems related to poor self-image due to prejudice toward them in Canadian society. In addition, immigrants and refugees often must contend with language difficulties, unemployment and lack of social support (*After the Door Has Been Opened*, 1988). Personal resources, ability to communicate, and degree of community support influence the newcomer's circumstances which in turn affects his or her ability to cope with life, social and health problems.

Educational and health care policies in Canada are based on the principle of universal accessibility, that is, everyone has an equal right to access and to receive educational and health services regardless of age and ethnicity. However,

"... the system is designed for the general population and neglects the individuality of the user; in this case, the elderly and the ethnic" (Hamilton-Wentworth District Health Council, 1990, section B, 1).

According to the National Advisory Council on Aging (1993) in 1991, about 3.2 million Canadians were age 65 and over, representing about 12% of the entire population. In this group, about 94,000 Canadians were age 90 and older. Of those seniors, 37,000 were 100 years or older. The Council's (1993) statistics show that, in the period between 1981 and 1991, there was a 31% increase in the number of Canadians who were age 85 years and older (from 194,000 to 283,000). Other growth areas of the senior population included the 65 and over age group (17.5%) and the 75 and over age group (21.7%).

In spite of being part of the mainstream (dominant ethnic group³), a large number of seniors suffer from ageism and have difficulty in accessing available services. Seniors from non-European backgrounds are confronted with double barriers: ageism and racism. Those seniors who are from non-European culture and non-English speaking are more vulnerable than any group of seniors (Naidoo, 1989).

The National Advisory Council (1993) report provides statistics on ethnic seniors in Canada. In 1986, 24% of all persons in Canada, who speak neither English nor French, were seniors. Also, Canada received about 6,000 immigrant seniors per year, between 1978 and 1987. Among the seniors in Canada, about 17% were born outside the country. The top four suppliers of immigrants to Canada in 1987, (supplying an estimated 40% of all immigrant seniors) were Britain, the United States, India and the Philippines.

Despite the barrier of ageism, most seniors in the dominant ethnic group reported a high level of satisfaction with their quality of life. The National Advisory Council (1993) report gives some positive statistics about the general welfare of Canadian seniors. It reports that in 1985, 30% of dominant ethnic seniors reported that their lives were "fairly stressful" or "very stressful". This is far less than the figure of 52% for people under age 55. It was also found that loneliness affected just 27% of the surveyed seniors. Their lifestyles were described as good. The survey also showed that 60% of the respondents rated their health as "good," "very good" or "excellent" for their age. In the same year, 92% of the respondents indicated that

³ Dominant ethnic group includes those who are white Europeans with first language either English or French. European population with first language other than English or French are not considered as part of the dominant ethnic group.

they were either "somewhat happy" or "very happy."

Compare this situation to the plight of those unfortunate seniors who live out their lives trapped within the confines of the marginal population. According to Samovar and Poter (1988), until rather recently, North Americans had little contact with other cultures, even within our own country. "We are now a mobile society. Increased contact with other cultures makes it imperative for us to make a concentrated effort to get along with and understand people who are vastly different from ourselves" (Samovar and Poter, 1988, p 1).

The cultural diversity of the Ontario population has been identified in planning, implementing and evaluating the health and educational services in this province by a number of recent provincial documents. (Spasoff, 1987; Podborski, 1987; Evans, 1987; Graham, 1988; Beiser, 1988; Ontario Advisory Council on Senior Citizens, 1989; Board of Education, City of Hamilton, 1990).

In addition to its cultural diversity, Ontario has a large seniors population, many of whom are part of the marginal population. At provincial levels, Ontario, Quebec and British Columbia collectively possess the lion's share of the seniors population in Canada. Seniors living in these three provinces make up 75% of the total national elderly population.

In 1991, about 62,700 seniors, those 65 years of age and over, lived in Hamilton-Wentworth, Ontario. Ninety-three percent of those seniors spoke English. According to the 1986 census, 41% of all seniors had less than a grade nine education (Region of Hamilton-Wentworth Selected 1986 Census Table, 1989). In other words, 2 seniors out of every five had not completed grade nine. Nearly 45% of seniors in

Hamilton-Wentworth were found to have incomes below the poverty line (Reynolds, Chambers, 1991). While no attempts have been made to correlate this data, it is well-known that higher education combined with vocational or professional training is associated with higher earning potential and therefore higher potential retirement income.

According to the Multicultural Health Care Needs Feasibility Study, the majority of health care recipients from the marginal population did not have a physician and, of those who did, half of their physicians did not speak the preferred language of the recipients. Health care recipients from the marginal population also were not provided with a language interpreter (Hamilton-Wentworth District Health Council 1990). Many immigrant seniors who used medical services (physician's office or hospital) did so from a position of real need (illness, accident, injury, surgery). Consequently, few recipients from the marginal population received preventative health care. Moreover, the incidence of overuse or misuse of health care services was extremely low. By contrast, according to Hamilton-Wentworth District Health Council study (1990) dominant ethnic group seniors tended to over-utilize or misuse health care services.

In the two most utilized local hospitals, all of those in the consumer sample said they were not serviced in their preferred language. These examples reflect the barriers to service, such as language differences, lack of interpreters, unawareness of the health care system's purpose and values, inaccessibility and unavailability of services, as well as a lack of accountability of the health care organizations to provide interpreters (Hamilton-Wentworth District Health Council, 1990).

The lack of cultural sensitivity within the health care system has been identified, not only by consumers, but also by the providers of health services.

A discussion sample of health care providers (Hamilton-Wentworth District Health Council, 1990) named several barriers for the ethnic consumers, such as lack of language and communication, lack of cultural sensitivity in assessing recipients' needs for and reactions to the provision of care, and lack of ethno-specific health care services (Hamilton-Wentworth District Health Council, 1990). The providers identified the following issues: the lack of qualified interpreters; insufficient funding and resources for the education [training] of health care providers; lack of ethnic staff representation and little or no proficiency in various languages (Hamilton-Wentworth District Health Council, 1990).

Hospital administrators defined barriers to culturally sensitive care as: lack of qualified interpreters; unawareness of available services by marginal populations; and lack of funding for ethno-specific services.

According to the Multicultural Health Care Needs Feasibility Study a sample of physicians identified these barriers: lack of awareness of mainstream health services by the ethnic population (80%); lack of qualified interpreters (70%); unavailability of ethno-specific services (31.7%); cultural insensitivity by health care professionals (20%) (Hamilton-Wentworth District Health Council, 1990). Physicians also indicated that available services may not be perceived as beneficial by the marginal community. Moreover, a lack of understanding of the marginal population by the physicians who choose not to take the time with those unable to speak English, cause additional problems for the marginal group.

Investigators of the above study concluded that the lack of culturally sensitive education and in-service programmes for health professionals resulted in health care recipients from the marginal population not being treated as individuals because of a cultural or language barrier (Hamilton District Health Council, 1990). This meant that decisions related to health care and social services were made for them.

A group of Hamilton and District Social Planning and Research Council investigators completed a study on the accessibility of the social service system by the diverse racial and cultural groups. Seventy nine percent of social services agencies did not offer specific services for diverse groups. Seventy three percent of agencies have no plan to offer new services for such groups. The investigators also identified these current problems in serving these groups; language and cultural value differences, poor cultural understanding of social services programme marketing strategies and of social service systems, inadequate needs assessment, lack of funding, few available interpreters, and poor quality of interpreters that were available (Hamilton and District Social Planning and Research Council, 1990).

According to both the Hamilton-Wentworth District Health Council (1990) and the Hamilton and District Social Planning and Research Council (1990), health care recipients of the marginal population felt that health care professionals did not see them as individuals because of cultural or language barriers. They felt as though crucial decisions had been made for them and that they experienced resistance when they attempted to assert themselves. They perceived that these problems stemmed directly from cultural or language barriers. It was felt that quality of service suffered because dominant ethnic values of care givers conflicted with the recipients' own

cultural norms and values. They continued to value their right to self-determination. They felt that being old and from the marginal population, did not mean they were unable to understand or make decisions concerning their well-being.

The objective of a feasibility study entitled "The Prevalence of Multicultural Groups Receiving Service From Three Community Agencies in the Hamilton-Wentworth Region: Implications For Cultural Sensitivity Training", by Majumdar, Browne and Roberts (1992) was to assess the proportion of clients from the dominant group and the marginal group who were mostly seniors receiving services from three home health care agencies. Providers from three local agencies were asked to recall current clients served in the last two weeks. Each client was described in terms of race, language, gender, age and disability status. The study indicated that white, English-speaking clients comprised 88.3% of the sample. The remaining 11.7% of clients were non-English speaking White, 7.8%; Visible Minority 2.8%; Francophone 0.76%; Aboriginal 0.22%; and Hispanic 0.11%. Sixty-six percent of clients were female and 34% were males. Ninety five percent of the clients were 65 years of age and over. Of this group, 88% were from the mainstream dominant ethnic population, which was an over-representation when compared to the percentage of marginal group seniors in the larger population.

A feasibility study on Multicultural Issues: Aging and Health by Majumdar (1990) dealt with the perceptions of growing old and the health needs of the senior immigrant population in Hamilton, Ontario. The study identified the following issues for the marginal populations:

- ♦ Marginal group seniors are more vulnerable because of isolation due to language differences, and will often suffer longer before seeking help because of fear and/or ignorance. This problem is even more serious for those who become confused.
- ♦ There is a tremendous need for information and communication in one's own language.
- ♦ Language barriers (which include idiomatic uses of language and dialects) hinder communication and, hence, effective care within institutions. More multilingual abilities on the part of hospital workers would ensure better quality of care for seniors in the marginal population.
- ♦ It is important that seniors from the marginal population enjoy their lives and engage in social interaction.
- ♦ Seniors from the marginal population avoid associating with others because of language, thus isolating themselves as a result.
- ♦ There is reluctance on part of the marginal group seniors to break with their communities because of shared language, foods, and customs, things which are lost in an institutional environment.
- ♦ There is a need to maximize involvement and contact between seniors and people of all ages through their own programmes, youth programmes, etc.

Therefore, culturally sensitive education is needed for providers and recipients from education, health and social sectors in order to improve the condition of seniors from the marginal population. Many studies have been done to establish such needs, but few attempts have been made to plan, implement and evaluate such an

educational programme. It is important to go beyond the needs assessment stage and study the development of a culturally sensitive educational programme and its outcome with respect to the amelioration of such problems.

PURPOSE

"Differences can divide us or can provide the specific knowledge and experienced base through which we can discover and develop greater commonality and a more genuine humanism" (Kappner, A. 1991, p 1).

The present study is aimed at exploring the effectiveness of a culturally sensitive, self-directed and self-supported educational programme for marginal group seniors. The purpose of the programme is to increase self-confidence and self-reliance, and decrease language barriers among a selected group of senior, South-East Asian immigrants. It is aimed at alleviating their social isolation through participation in social activities with the mainstream population. The programme is designed to enable them to gain knowledge about the accessibility and availability of social and recreational services. Also targeted is the seniors' development of skills in problem solving to overcome cultural and language barriers in order to integrate more fully with the mainstream Canadian population.

The specific objectives of the study are as follows:

1. To describe the demographic characteristics of the participators in this study population.
2. To describe the health of the participants before and after the educational programme.

3. To describe the happiness of the participants before and after the educational programme.
4. To describe the self-confidence of the participants before and after the educational programme.
5. To describe the loneliness of the participants before and after the educational programme.
6. To describe the ability of the participants to speak English before and after the educational programme.
7. To determine the relationships among:
 - a) health and selected demographic data, including gender, level of education, age and marital status;
 - b) happiness and selected demographic data, including gender, level of education, age, and marital status;
 - c) Self-confidence and selected demographic data, including gender, level of education, age and marital status;
 - d) Loneliness and selected demographic data, including gender, level of education, age, and marital status;
 - e) Competency in English and selected demographic data, including gender, level of education, age and marital status.

STUDY QUESTIONS

1. What are the demographic characteristics of the participants in this study?
2. What is the prevalence of perception of poor health among these selected participants?
3. What is the prevalence of happiness among these selected participants?
4. What is the prevalence of low self-confidence among these selected participants?
5. What is the prevalence of loneliness among these selected participants?
6. What is the difference in pre and post test measures of English speaking ability for the selected participants who have received the culturally sensitive self-directed and self-supportive educational programme?
7. What are the differences in pre and post test measures of perceptions related to health, feelings of happiness, self-confidence, and loneliness for those selected participants who have received the culturally sensitive self-directed and self-supportive educational programme?

LIMITATIONS

- ♦ The sample size is small and the participants are selected from only the Hamilton-Wentworth Region. The Chinese community of the Hamilton-Wentworth Region may not be representative of the Chinese communities of all other cities of Ontario. Therefore, the findings can only be generalized with care.
- ♦ As there is no control group in this study design, and change of self-perception on health issues of the participants may be influenced by factors other than the

education programme under study. These factors may include church activities and other community activities, and personal life events during the three months time period.

- ♦ The data are collected by questionnaire. All information are self-reported by the participants. Therefore, perception bias need to be considered.
- ♦ The data are related to self-perception and recall of one's own health status. Therefore, perception bias (reliability of recalling information) needs to be considered.
- ♦ The instrument is tested for face and content validity, and is not tested for "construct" predictive validity.
- ♦ Though the questionnaire used for this present study has been translated to Chinese and re-translated to English, cross language and cultural problems may not be completely eliminated.
- ♦ Because some participants can not read and write Chinese, they are interviewed and the data recorded by the interviewer. Therefore, the interviewer's personal biases could influence the data.
- ♦ The investigator has completed the needs assessment, planned for an educational programme, and implemented the programme. Therefore the personal bias of the investigator needs to be considered.
- ♦ Observational data related to participants' English speaking and writing abilities have been collected by the investigator and the educational programme coordinator using a language facility observation instrument. Therefore, observational and personal bias may influence the reliability of the collected data.

DEFINITION OF TERMS

Most of the terms used in this study take their common meanings. Those terms with specific meaning are indicated here.

♦ **Access:** defined as a prerequisite to equality, i.e. the removal of institutional barriers to services and opportunities to participate in social, economic and cultural life.

♦ **Adult Learner:** is an "adult" participant in the teaching-learning process.

♦ **Ageism:** is discrimination and prejudice against aged (seniors).

♦ **Barrier:** is an overt or covert obstacle to access of systems and other resources.

♦ **Culturally Sensitive Self-Directed, Self-Supported Programme:** is a process to impart knowledge and skills by an individual or group in a way that reflects the understanding of diverse cultural behaviour.

♦ **Cultural Sensitivity:** Communication patterns are unique to a culture. Lack of understanding of these differences can lead to misunderstanding. The term cultural sensitivity refers to awareness of such similarities and differences.

♦ **Culturally Sensitive Programme:** is an educational programme based on South East Asian culture. Programme strategies for needs assessment, planning, implementation and evaluation represent the values and beliefs of the Chinese immigrants from Vietnam.

♦ **Dominant Group:** the group of people within a given society that is either largest in number or that successfully shapes or controls other groups through a social, economic, political or religious power. In this study, "dominant group" refers to

Europeans with first language English or French.

♦ **Discrimination:** defined as the denial of equal treatment, civil liberties and opportunities to individuals or groups with respect to education, accommodation, health care, employment and access to services and/or facilities.

♦ **Ethnicity:** defined as a sense of collective identity through distinct cultural heritage and traditions while living in a larger society.

♦ **Immigrants:** those who have received landed immigrant status when they entered Canada from their homeland (in this case, Vietnam).

♦ **Marginal Population:** those who are Europeans with first language other than English or French, (example: East Europeans), visible minority, (example: Asians and Blacks), Hispanic (example: Central America), and Aboriginal people.

♦ **Minority Group:** a group of people within a given society that is either small in numbers or has little or no access to social, economic and religious power. In this study, Chinese ethnic population is identified as those who immigrated from Vietnam as a minority group.

♦ **Pluralism:** a society with some degree of cultural, linguistic, ethnic, religious or other group distinctiveness which is maintained and valued by individuals.

♦ **Prejudice:** a state of mind; a set of attitudes held by one person or group about another, tending to cast the other in an inferior light, despite the absence of legitimate or sufficient evidence; means literally to "pre-judge".

♦ **Self-Directed Learning:** "designed to assist in the development of an individual who, through continuous learning, can grow and adapt as a worker, family member, and citizen in a rapidly changing society" (Tough, et al, 1982, p. 98).

- ♦ **Resources:** social, recreational and health facilities.
- ♦ **Self Supported Programme:** a planned educational programme with contents related to survival skills and self confidence.
- ♦ **Seniors:** persons 65 years of age and older.
- ♦ **Stereotype:** a false or generalized conception of a group of people which results in an unconscious or conscious categorization of each member of that group, without regard for individual differences.
- ♦ **Vietnamese-Chinese Immigrants:** immigrants come to Canada from Vietnam of the Chinese ethnic population (South East Asian origin).
- ♦ **Visible Minorities:** a term used to describe people who are distinguished from the majority by the colour of their skin or other physical features. The term is not applicable to Aboriginal People.

CHAPTER II

LITERATURE REVIEW

Self-directed process is one that is:

"Designed to assist in the development of an individual who, through continuous learning, can grow and adapt as a worker, family member, and citizen in a rapidly changing society" (Tough, et al, 1982, p.98).

This chapter is divided into five sections: section one includes literature on older adults, culture and ethnicity, section two explores attitudes and myths affecting older adults , section three focuses on self-directed adult and group learning, section four deals with the experiential learning method, and section five includes literature on both the concepts of health and of culturally sensitive education.

CULTURE, ETHNICITY AND OLDER ADULTS

In Canada's multicultural society (Appendices A and B), the older generation represents a rising proportion of the population. In 1986, seniors (defined as those age 65 and over) comprised 11% of all Canadians. By 2001, those age 65 and over are expected to comprise 14% and by 2021, population projections reach 20% for this age group (Majumdar, Browne, Roberts 1992). By 2031, a large number of seniors will be in the 80 year old and over age group (Appendices C and D).

The National Advisory Council on Aging, 1993, Aging Vignette Number 2 provides a breakdown of seniors by province (Table 1).

DISTRIBUTION OF SENIOR POPULATION BY PROVINCE

PROVINCE/TERRITORY	65+ age group as % of total population	75+ age group as % of 65+ group
Newfoundland	9.7	39.7
Prince Edward Island	13.2	45.7
Nova Scotia	12.6	42.4
New Brunswick	12.2	41.8
Quebec	11.1	38.6
Ontario	11.7	39.7
Manitoba	13.4	43.6
Saskatchewan	14.1	44.7
Alberta	9.0	40.4
British Columbia	12.9	40.7
Yukon	4.0	24.4
Northwest Territory	3.0	14.9

Table 1

Their demographic data indicated that 75% of all seniors in 1991 lived in Ontario, Quebec and British Columbia. Regionally, the city of Victoria, B.C. had the highest percentage of seniors (19%), while Calgary, Alberta had the lowest (8%).

Additional statistics gathered by the National Advisory Council (1993) show that in the period between 1981 and 1991, there was a 30% increase in the number

of Canadians who were age 85 and over (from 194,000 to 283,000). Other growth areas of the senior population include the 65 and over group (17.5%) and the 75 and over group (21.7%).

In 1991, there were 1.38 women for every man in the 65 and over age group, and this increases to two women for every man in the 85 and over age group. However, there were many variations between countries of origin. Among seniors immigrating from Portugal, for example, there were about 2.15 women for every man (National Advisory Council, 1993). Female and male ratio were also higher than the Canadian average among seniors immigrating from Caribbean, Britain and Chinese (Secretary of State, 1988). According to the marital data reported by the National Advisory Council (1993), it was found that among seniors in Canada, in 1991, 74% of men and 40% of women were married. Also, 13% of men and 47% of women were widowed, 6% of men and 5% of women were separated or divorced, 7% of men and 8% of women were never married.

Four of five seniors (83%) own their own accommodations. Unskilled labour occupations were reported as the main type of work for 32% of male seniors. Employment for female seniors was quite different: clerical, sales and service occupations: 37%, and homemaking: 33% (Infowatch, 1992).

Senior women generally did not go as far as men in formal education. About 7% of women 65 and over, compared to 11% of men, have university educations. At the other end of the scale, about equal numbers of senior men and women (45%), have less than nine years of education (Desjardins and Dumas, 1993). Other statistics from the National Advisory Council on Aging (1993) include statistics on the ethnic

seniors in Canada. In 1986, it was found that 24% of all persons in Canada who spoke neither English nor French were seniors. The Council also found that Canada received about 6,000 immigrant seniors per year between 1978 and 1987. Among the seniors in Canada, about 17% were born outside the country. It is also reported that only 20% of these seniors have neither British nor French origins. However, these statistics will increase to reflect changing immigration patterns (1981 data). Of the 2.2 million seniors in 1981, about 600,000 indicated an origin other than British or French. It was found that the largest four suppliers of immigrants to Canada in 1987, supplying over a combined 40% of all immigrant seniors were Great Britain, the United States, India and the Philippines. However by 1993, of those countries with over 1,000 immigrants to Canada in that year China had the highest percentage (10%). By 2025, the demographic characteristics will include more Asian origin seniors.

Approximately 22% of Canadian seniors belong to an ethnic group other than British or French (Ontario Advisory Council, 1988) [Appendix E]. In Canada, Hamilton, Ontario receives the third largest proportion of new immigrants each year. A large number of these immigrants are of South-East Asian origin (Majumdar, Browne, Robert, 1992). Most of them are Buddhist, which is one of the fastest growing religions in Canada (Appendices F and G).

Much of the current literature today agrees that immigrant seniors face strong challenges because of their situation (District Health Council, 1990; Naidoo, 1989). Seniors in general tend to experience more changes in life. These changes increase with advancing age. "They all must learn to cope with changes which in itself, can be

difficult" (Beckingham, and DuGas, 1993, p. 381). While coping with physical changes, seniors face social problems, such as low self-confidence and low self-esteem. These problems may come from being put down by others and having little say in what they are to do. "This factor is common in seniors, and may lead to stress, which in turn, may lead to depression" (Beckingham, DuGas, 1993, p. 381).

Psychological and emotional changes which are characteristic of the aging process in general may be exacerbated by the added stress of language barriers as well as cultural and religious differences. This, in turn, may lead to an even greater degree of isolation and loneliness. A corollary of this situation is the downward regression into lower self-esteem, impoverishment of self-image, and denigration of self-confidence. The most frequent problems experienced by seniors are fear, loneliness and social isolation (Majumdar, 1990). Marginal group seniors frequently express problems associated with language barriers. These barriers hinder communication, and hence access to effective services by community agencies and institutions (Majumdar, 1990).

These seniors are further alienated from mainstream society when they lose close relationships with their families. "Immigrant seniors find that as their children grow accustomed to the dominant or mainstream culture in Canada, they have less and less in common with their children" (Beckingham and DuGas, 1993, p. 381). This increases the burden and stress of social isolation. Social isolation is a prime trigger for the senior's inability to make personal decisions.

Depression easily can occur as a result of various factors, including the inability to work out what kind of lifestyle they want, as well as how to plan it

independently. To overcome such depression, special steps must be taken to make the immigrant seniors feel less isolated. These seniors clearly need to become more self-directed and supported through the elimination of language barriers and by increasing their decision-making abilities (Sue, 1977).

The current literature describes the negative influence of social isolation and economic deprivation on the mental health of individuals (After the Door Has Been Opened, 1988; Hamilton-Wentworth District Health Council, 1990; and Majumdar, 1991). Because these individuals are seniors and recent immigrants from a very different cultural background from mainstream Canada, this negative influence on their mental health is severe.

Due to a strong belief in the joint family system, increasing numbers of South-East Asian seniors are being sponsored by their children to join them in Canada, and maintain the family unit. Neither English nor French are major languages among the South East Asian population. Thus, senior South-East Asian immigrants have great difficulty communicating with the rest of the Canadian population. This senior population is disadvantaged as a result of social isolation and their lack of knowledge regarding availability and accessibility of health and social services (Sue and Morishima, 1982). They are further disadvantaged because they are isolated from their own children who work long hours to meet the financial requirements of the Canadian way of life. These seniors are also economically dependent on their children because they are not eligible to receive social assistance such as the Canada Pension Plan, Old Age Security, or Seniors' Drug Plan, for the first 10 years of residence in Canada (Beckingham and DuGas, 1993).

ATTITUDES AND MYTHS AFFECTING OLDER ADULTS

In the National Advisory Council on Aging (1993) survey, it was found that in 1991 27% of seniors age 65 and over had at least a high school diploma. It is predicted that by 2006, at least 37% of seniors will have at least a high school diploma. Also, it is reported that literacy is a problem for 40% of Canadian seniors, based on levels of educational attainment. This problem is focused in Eastern Canada, among Francophones and seniors with the lowest incomes (Multicultural Canada, 1990). In terms of continuing education, it was found that in 1984, 4% of seniors were enrolled in some form of continuing education. This number rises to about 20% among seniors with post-secondary education. The Council (1993) reports that it is predicted that there will be a 94% increase in adult education course enrollment by 2005, and a 141% increase by the year 2010.

Though many educators agree that education should serve adult learners, the question remains unclear as to who these "adult learners" are. Such individuals usually are perceived as "adult learners" from a chronological standpoint. One stereotypic view is that persons whose ages range between 21 and 40 years are thought to be the adult learners in society (Wigdor, 1993).

A 60 year old grandmother may face a set of negative attitudes supported by myths about her chronological age as well as her gender. Society may view her as less capable or as being able to benefit less from educational pursuits than are younger learners.

"I get tired of the 'good for you' attitude as if it were surprising that someone sixty plus can be involved in a number of physical, intellectual and volunteer pursuits" (Wigdor, B.T., 1993, 11).

Most Canadian women, 60 years and over, felt strong pressures to respect established traditions with regard to their formal education and, consequently, many gave it little priority in their lives (Desjardins and Dumas, 1993). This was a reflection of the expectations of both parents and the school system (Innova Group, 1987).

" My father thought that studies were not important for girls, but my mother was a very important influence in my life. She was very open-minded and progressive. She encouraged me to excel in school. I never felt that I was constrained in choices about my studies, although I probably was limited. Society was just set up that way and everyone accepted it" (National Advisory Council of Aging, 1993, p. 25).

It is reasonable to expect that a better educated population should be able to prepare for the challenge of old age (Desjardins and Dumas, 1993). Women appear to be more motivated than men to take adult education classes. Of the 92,000 Canadians who participated in adult education classes in 1983, 56% were women. Most took hobby and personal development courses, although job-related classes were more popular among middle-aged divorced and separated or single women. Only 4% of adult education participants were age 60 and over, but these included more than twice as many women as men. It is quite likely that the popularity of continuing education classes among middle-aged and older women will grow as they attain higher levels of education (Devereaux, 1985). Senior women who are members of cultural communities often face special challenges with regard to language skills.

The federal government has undertaken a major revision of its language services to immigrants in the Language Institution for Newcomers to Canada programme (Secretary of State, 1990). The lack of language skills makes it very difficult for these women to attain a sufficient level of autonomy and understand their rights as Canadians (Disman, 1990).

There are certain negative attitudes toward seniors today. In Canada, where the population is aging rapidly, this can be a matter for concern. The myths which support these negative attitudes include:

- ♦ A person's ability to function is based on age only,
- ♦ Seniors lose intellectual capacity, become "senile",
- ♦ Seniors have almost no productive ability,
- ♦ Older people have no ability to learn,
- ♦ Older people always strongly prefer the status quo, and
- ♦ Seniors are passive, as well as dependent (Beckingham, DuGas, 1993).

These myths are believed even among people who deal with seniors. Attitudes based on such myths and prejudice may affect seniors unfavourably and can result in a decrease in the quality of service provided to the seniors. "A simple way to deal with such a problem is to think about the seniors as people. They are as capable as any other adult to learn new knowledge and skills" (Beckingham and DuGas, 1993, p. 380).

SELF-DIRECTED ADULT AND GROUP LEARNING

The educational process is most effective when there is an interactive exchange of knowledge between facilitator and student. It is believed by some people that education should be guided by a democratic philosophy (McKeachie, 1978). Yet according to Cooper (Cooper as cited by Tarnow, 1979) "learning can be done only by the learner". There also exists the paradox: learners should be taught in order to learn just as "men should be led to freedom" (Little, as cited by Verdiun, Miller, Greer, 1977). It is for these reasons that McKeachie states "it might be more realistic for teachers to think of themselves as individuals who facilitate certain kinds of learning. They can neither learn for their student nor stop them from learning" (McKeachie, 1978, p. 51).

The facilitator requires two distinct groups of learning behaviours: "one to guide and promote his own change [of knowledge], and one to guide his activities in a relationship which promotes the learning process of [his students]" (Verdiun, et al, 1977). It is the need to possess these two learning behaviours that often leads people to think "greater teachers are born and not made" (McKeachie, 1978). However, teachers like other professionals, can be taught these skills. Teaching methodology and knowledge about learners, as well as knowledge of the subject to be taught are the focus of teacher education (Verdiun, et al, 1977). After the educator has acquired such behavioural skills, he or she can begin to focus attention on teaching. It is the main purpose of the learning process to alter behaviour. "Behaviour is the key consideration for adult educators, and learning [or changing behaviour] is the

primary focus of the instructional act" (Verdiun, et al, 1977).

Changing behaviour involves interaction between facilitator and learner, and among learners themselves. One setting that is conducive to learning is that of a group of learners and a facilitator in a group setting (Barrows, 1985). Here the learner does not only play an active role with the facilitator but also is active with other group members. The effect of such a group setting is not only the activation of learners, but enables learners to express their problems and goals in the learning atmosphere. The group setting enables learners to use others to overcome such problems and reach personal goals (Barrows and Tamblyn, 1980; Barrows, 1988).

Group activity enhances communication, comprehension, acknowledgement, and sharing of learners and facilitator through group interaction (MacQueen, 1986). As well as enhancing active communication, the group setting is an atmosphere that encourages student members to give support to others in their pursuit of goals, as well as receiving support for their own goals. Another psychosocial attribute of the group is its ability to allow competition to thrive among members in an open, and constructive manner (Hallinan, 1982; Powell, 1972). Members can clearly identify challenges and are given support to accomplish these demands. The ability of this setting to allow group members to offer both support and challenge is one reason why the group setting is one of the better atmospheres for adult learners (MacQueen, 1986).

As already stated, learning is a personal internal altering of behaviour by an individual towards a particular subject. However, learning cannot be acquired without external sources and objective observations. MacQueen recognizes this when

stating "without input from others, the individual learner can become stalled in self-perpetuating errors and false assumptions" (MacQueen, 1986, p. 31). It is the group that develops interdependent students who can effectively teach each other to self-learn. This interdependency enables individuals to share experiences, knowledge, and resources with others in such a way that self-esteem is enhanced and not threatened (Tarnow, 1979).

A small informal group is a less threatening, appropriate and effective setting in which adults can learn. Group activities such as role playing and problem-solving are possible in such a setting. Role playing enables adult learners to observe and react in realistic ways (Barrows and Tamblyn, 1980). This activity enables the learning experiences of the group to be carried out in normal everyday life. Problem-solving, a little less superficial than role playing, is also an effective activity for adult learners. Such activities enable each learner to share experiences related to a problem, and together the group can maximize and broaden the learning base on which to solve that problem (Tarnow, 1979).

It is not simply because the groups provide active, interdependent atmospheres that promote learning that they are most appropriate, effective forums for learning, but it is the suitability of groups for the adults that is responsible for success. McKeachie views adult behaviour as learned. The opportunity to practice adult behaviour must be provided, or else such behaviour will not be learned (McKeachie et al, 1978).

Adult learning is dynamic and has few limitations. The learning process is said to be a "dynamic equilibrium between change and stability, structure and process,

content and activity" (Brundage and MacKeracher 1980). The learning process, that which involves changing or altering of individual behaviour, must take place in relation to personal environments. Time, social contexts, past experiences, and present situations are factors that make up such an environment in which adults, and therefore adult learning exists. It has been stated that adults up until the moment of death are capable of learning (Brundage and MacKeracher 1980).

Adults constantly place newly acquired knowledge in relation to already obtained knowledge. Not only is new knowledge compared to 'old' knowledge, but its main purpose is to enrich previous knowledge through change or enhancement. The newly acquired facts are not simply stored in memory, but rather are carved into jigsaw puzzle pieces, and placed in the appropriate place in the "puzzle". Adult learning is therefore both the:

"Process which individuals go through as they attempt to change or enrich their knowledge, values, skills, or strategies, and to the resulting knowledge, values, skills, strategies and behaviours process" (Brundage and MacKeracher 1980, p.5).

The acquisition of knowledge, values, skills and strategies is a process that involves the altering of behaviours. More specifically, altering of behaviour, adult learning, is carried out by individuals through specific activities: activities designed to test knowledge, values, skills and strategies. For Brundage and MacKeracher (1980), the purpose of such activities is to expose adults to organizing principles in learning activities, and thus enable them to begin to develop such principles by themselves through discovery and development. It is only when these principles are personalized through internalized comparison with pre-existing principles and

experiences that an adult can begin to learn.

Adults want to be addressed and treated as individuals, and do not require the sanctity of being part of a larger group. It is this independence that enables adults to function productively in a group. They are capable of expressing individual experiences, and they extract from group discussion what is relevant to them on a personal basis. It is also adult independence that has deleterious effects in other learning situations (Coopersmith 1967; 1984 ; Powell, 1974; Rudduck, 1982).

It is recognized that adults have established organized ways to focus, absorb and sort information (Brundage and MacKeracher 1980). It is this self-directed process that has labelled adult learning as andragogy. This term, (aner), is defined as the art and science of helping adults learn (Knowles, 1975). Thus andragogy enables adults to continue to use their established ways of focusing, absorbing, and sorting information. McKenney and Keen believe that this process remains relatively constant throughout adulthood (McKenney and Keen, as cited by Brundage and MacKeracher 1980) and reinforces the self-directed approach to adult learning.

The self-directed approach to adult learning enables the educator to overcome some of the obstacles raised by the learner. The acknowledgement that learners learn in response to their own needs, and not those of the educator (Verdun et al., 1977) is allowed when implementing self-directed learning. The allowance of the adult to assess one's own needs is a part of the self-directed method, and Tarnow states that this "needs assessment is the first step in preparing an effective adult learning experience" (Tarnow, 1979). The interest of the learners must be captured in order for learning to take place. The only way to ensure that most individuals are

interested is to allow them to express their interest through self-direction. The free will of adults must be expressed in order to maintain interest and satisfy egotism (Webb, 1982; 1989).

Adult characteristics that coincide with self-directed learning are those of self-responsibility and self-reflection. They do not rely on others to teach them (pedagogy), but they rely on themselves for reflection and direction of their individual learning process (Coopersmith, 1984). This self-direction and reflection, as well as self-concept, enable adults to set their own learning objectives, as well as learning pace. It is this ability to be self-directed, that relatively and logically links self-directed learning with the self-directed adult (Barrows and Tamblyn, 1980).

In order to establish a self-directed learning process certain conditions must be met. Firstly, the learning atmosphere - content and context, must not be threatening to the individual. Threats will hamper the adult's ability to concentrate on self; and force the learner to concentrate on defending him or herself from such threats. Secondly, the content of material involved in the learning process must contain some personal relevance to each individual (Kidd, 1973, cited by Brudage and MacKeracher, 1980). The ability to use relevant material or subject matter enables the learner to apply what is being learned to his/her own experiences and situations. Relevancy will also play a role in maintaining the learner's interest. Presentation of this relevant material must be made using varied approaches, and directed towards different sensory modes. This is important not only to maintain the learner's interest, but it enables the teacher to maximize input, and appeal to different modes of perception for a variable effect (Parfitt, 1989). The last condition that must be met

in order to establish a self-directed learning process concerns communication. Communication must be bidirectional between teacher and learner with considerations to allow the learner to talk and self-reflect, and the teacher to listen and self-reflect . Only when these conditions are met can the self-directed learning process produce effective results or learning (by both educator and learner) [Brundage, and MacKeracher 1980].

According to Tough there are four steps of self directed learning process. The first step involved assessment of individuals: their needs, goals, values, and previous experiences. This step allows the learner to define personal objectives. Once these objectives are stated, the next step is the development of an appropriate structure or plan that will enable the individual to accomplish his or her objectives. The third step is one that utilizes group members, learners and teacher, to explore past experiences. Knowledge from these experiences can then be used to discuss and solve problems posed in the group. After these tutorial group sessions the final step of self-directed learning can be made (Tough, et al, 1982). This step involves the application of knowledge obtained through the problem-based seminar groups to real situations. This act of using what is learned reinforces knowledge, as well as supplying a sense of accomplishment for the learner. These four steps or stages provide a basic outline for self-directed learning. This outline incorporates the individual's objectives and the structure to obtain these objectives while providing a devise that is ordered and structured (Majumdar, 1992).

According to Brundage and MacKeracher (1980) the use of previous experiences as a basis for self-directed learning has many functions. Firstly, past

experiences can provide either a liberal or conservative attitude towards learning. A liberal, enthusiastic approach toward learning may have developed due to previous rewards (e.g., sense of accomplishment, job promotion, etc.). Contrasting this is the conservative, disinterested attitude towards learning that may have developed due to feelings such as discouragement or inferiority that evolved from previous experiences. Another use of past experiences in self-directed learning is to build a sense of self-respect and mutual respect for the individual learner (Folley, Samilasky, Yanke (1979). When previous experiences are examined by the individual, they come to realize how valuable their past is, and develop a sense of self-worth and self-respect in relation to past actions. In addition to self respect, the disclosure of past experiences by the learner in the group setting enables the learner to gain respect for others (Brundage and MacKeracher 1980).

Past experiences are not only regarded on a surface level (to analyze existing actions and reactions) but also on a deeper level. Underlying reasons and patterns for acting a particular way in specific situations of each individual's environment are partially revealed. Past experiences also provide a state of reality. For adults the influence of time as a state of reference is important to the learner. Brundage and MacKeracher depict this reference as perceived by the learner. "An adult (learner) tends to perceive time as including an ever-increasing past, a fleeting and pressured present, and a finite future. The ever-increasing past provides an ever-increasing model of reality which can both help and hinder learning" (Brundage and MacKeracher 1980, p. 8). Finally, past experiences of a learner that are related to current learning problems or objectives may distort such objectives due to the

different context or circumstances of the past experiences. The learner may need help to reassess the experience according to the new circumstances (Boud, 1985). Past experiences are essential factors in forming adult behaviour. Similarly past experiences must be examined, assessed, analyzed, and addressed so that self-directed learning, or change in behaviour, can proceed (Brundage and MacKeracher 1980).

In addition to drawing upon past experiences as an instrument to achieve self-directed learning, motivation must be addressed. Motivation in relation to the learning process is driven by two underlying issues: the desire to match or overcome un-met needs, and also the desire for growth and development (Coopersmith, 1967). The former element is often associated with the feeling of being threatened or pressured as well as the self-concept of being powerless or incompetent in a particular subject or particular situation. It is this link with self-concept that can hinder or help the learning process (Engel, 1982). To engage in learning in order to meet the expectations or demands of others is contrary to the learning process (Coopersmith, 1984). Only the learner can learn, and they can only learn for themselves, not for the satisfaction of others. However, this pursuit of knowledge that begins with the desire to meet the needs or goals of others may turn inwards. The desire to learn for the personal accomplishment of learning may result from an initial external threat to learn (Boud, 1981). The second type of motivation, that of personal growth and development, is in agreement with the concept of adult self-directed learning. Whether for ulterior or personal reasons, motivation is a key issue that must be assessed in relation to self-directed learning in order to ensure that the reasons behind learning and its success are compatible with the learning process

(Knowles, 1974, 1978).

The success and failure of learning is closely linked to learner motivation. Motivation, and how it relates to past experiences affects learning. Individuals who have been successful will tend to be more eager and adventurous as they encounter new problems, thus facilitating the learning process (Venek, 1977). Conversely, individuals who have experienced frustration and failure will be less likely to approach new experiences with an eager attitude, thus impeding the learning process. Thus, motivation as well as past experience are issues that need to be assessed by the individual and the educator in order to proceed towards a successful learning experience (Boud, 1981).

Another issue that is addressed and developed in the self-directed learning process is respect. Respect between educator and learner, and among learners is a vital component of self-directed learning. Respect of a learner's past experiences enables the learner to value his or her past as a potential learning resource. Lack of respect can cause the learner to become defensive or apologetic, and therefore regard past experiences as they relate to others, and not oneself (Knowles, 1980). Respect among learners also reinforces the individual learner's sense of self-worth, self-value, and self-definition. Mutual respect provides a non-threatening atmosphere, in which individuals are encouraged to look at themselves and reveal their true strengths and weaknesses, and in so doing can strengthen weaknesses and capitalize on strengths (Tough, Griffen, Barnard, Brundage, 1982). Respect not only reinforces self-value, self-worth, and self-definition but also develops such characteristics. The learner is encouraged to feel confident and capable in him or herself, and this

confidence and capability can be carried over into the learning process (Knowles, 1993).

Equality of group members can be established by an atmosphere of mutual respect. Respect is also an essential component of trust. Tough and colleagues defines trust in the learning process as: "the integrity of inter-dependent partners to rely on the other to be there" (Tough, et al., 1982, p. 17). Once trust has been established among group members and the educator, individual group members can begin to deal with problems in the group in an honest and open manner (Tough, et al., 1982). Finally, respect between teacher and student enables interdependence between the two to be established. This interdependence enables teacher and student to learn and teach each other.

The self-directed learning process draws upon the individual's past experiences, develops motivation, and creates an atmosphere of mutual respect in order to promote individual learning and development. The self-directed approach to learning enables the individual to set and achieve personal goals. These goals have direct and indirect relationships to an individual's daily life, environment, and problems encountered (Wren, 1977). The learning process which involves altering of behaviour causes the learner to react to his or her concerns, needs, and problems in a new manner. A self-directed learner will be able to apply what he or she has learned to his or her reality. This ability to adapt will also affect the way an individual reacts to problems and situations that are not related to those discussed in the learning groups (Venek and Bayard, 1975).

The self-directed learner has developed as an individual, and in so doing has

developed, through the learning process, an independent learning process(Barrows and Tamblyn, 1980). The self-directed method enables the learner to make sense of the chaos and confusion of raw experience; it enables the learner to reduce the unknown aspects of life to a manageable level; it teaches the learner to develop ways to predict how best to respond to, interact with, and influence his or her own particular life (Brundage, 1980). The learner is capable of assessing situations, problems, and experiences in an objective manner. The individual has through the self-directed learning process created his or her own version of this process, and in so doing has become an ongoing learner even after the groups are terminated.

According to McKeachie (1978), it is the ability of the self-directed learning approach to teach the individual how to teach him or herself that is the most valuable quality of this learning method. Conventional methods have taught the student particular subjects and information. Whether the learner in such circumstances actually learns the material is questionable. The attainment of knowledge is only part of the learning process.

McKeachie reinforces the multivariant purpose of teaching when stating:

"There are many important goals of...teaching. Not the least of these is that of increasing the student's motivation and ability to continue learning after leaving the formal learning atmosphere" (McKeachie, 1978, p. 78).

As Brundage and MacKeracher (1980) state: the goals of teaching can be as diverse as the goals of each individual learner. The self-directed learning process addresses and achieves both the teaching and learning goals through its focus on the individual, per past experiences, motivation, and want of respect. It is this individual focus that enables the learner to teach him or herself. "we believe that, in the end,

it is the individual who learns" (Brundage and MacKeracher, 1980, p. 1).

EXPERIENTIAL LEARNING

Experiential learning is a form of education that begins with "an experience" which provides a powerful psychological foundation for further study. It is a non-traditional way of dealing with traditional subject matters that adds an exciting new orientation to the process of developing cultural sensitivity. Experiential learning includes both cognitive and affective components (Gudykunst and Hammer, 1983). A unity of the two components is sought in the "internalization process" which involves continuous behaviour modification that begins with the individual's initial awareness of a phenomenon to the development of a pervasive outlook on life that influences all of his or her actions (Krathwol, Benjamin, Bloom, Masic, 1965). Experiential learning consists of placing the participant in experiential situations where the self is engaged. Such an experience offers the participant a particularly significant learning context. This fundamental pedagogic principle, elaborated by Rogers (1969), emphasizes total learning by engaging the student at intellectual and emotional levels. Each learner assumes full responsibility for his or her own learning experience and is expected to draw lessons from a given experience or set of experiences. Roger's concepts are illustrated in Figure I.

ILLUSTRATION OF ROGER'S MODEL (1969)

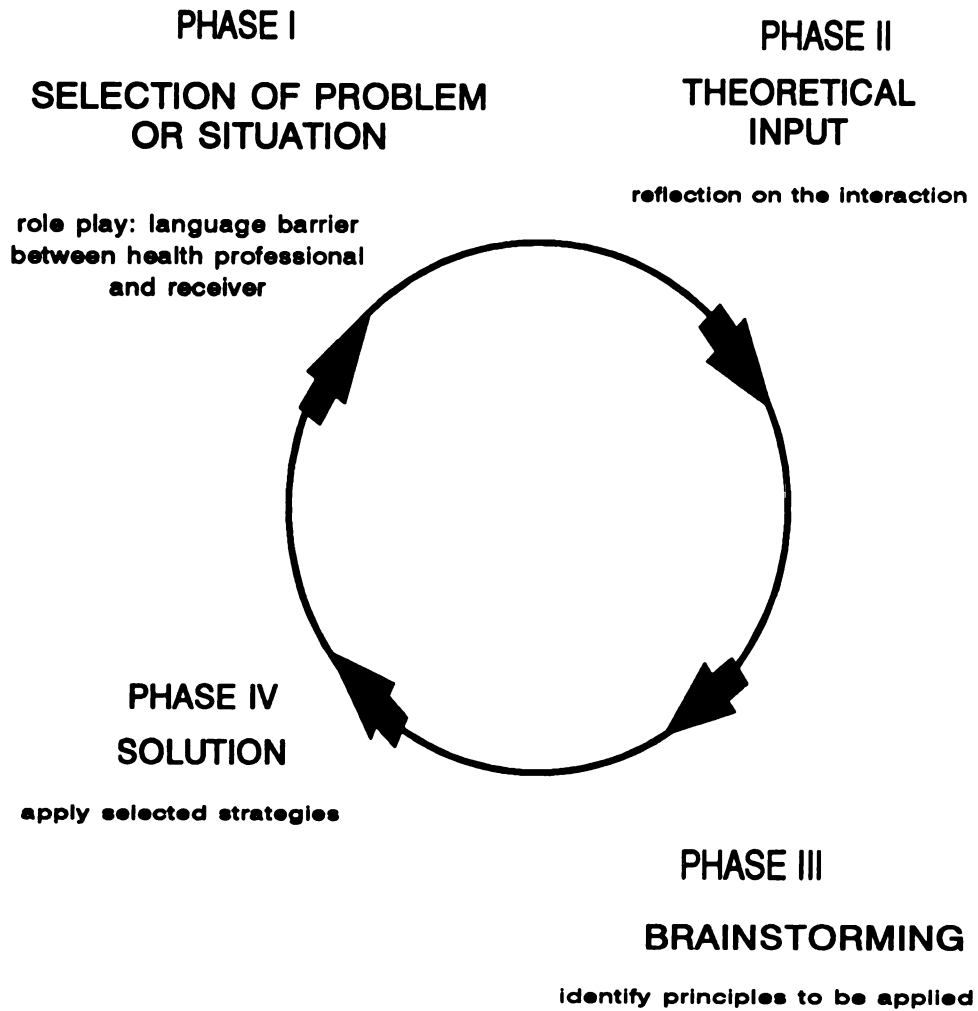


Figure 1

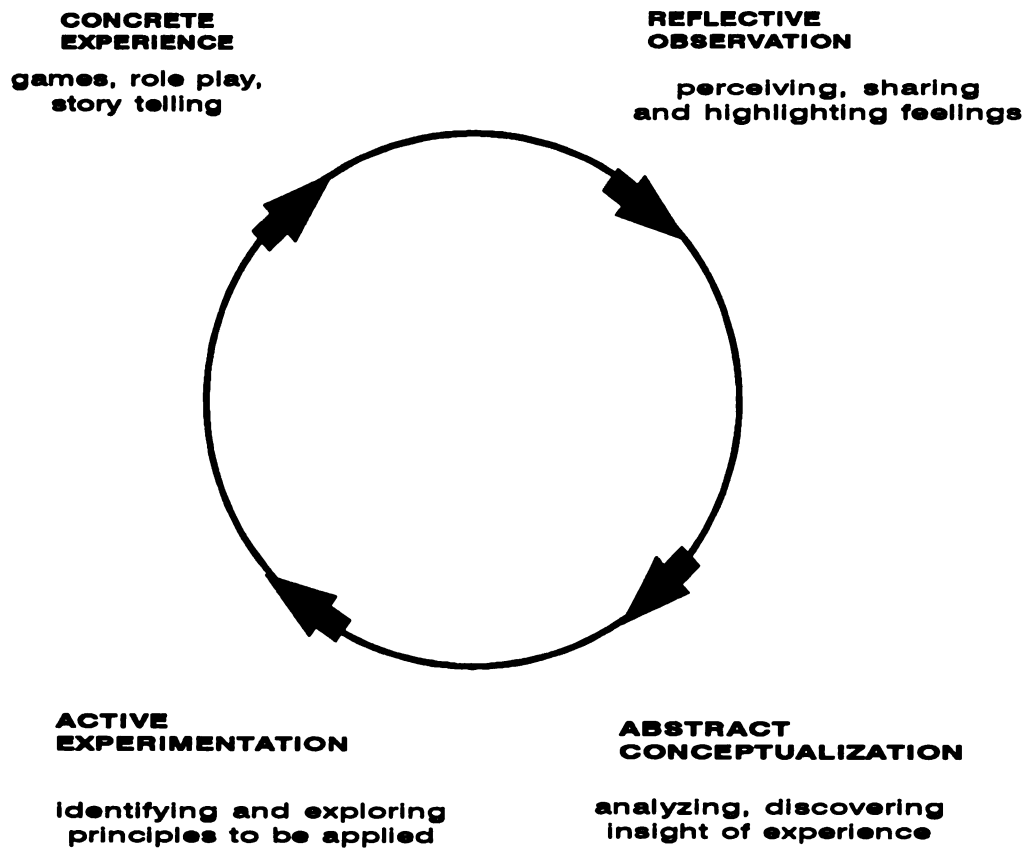
Kolb (1985) has proposed a theory of experiential learning which is applicable to education. He states that learning is the process whereby knowledge is constructed through the transformation of experience. The learning process begins with concrete experience. Learners then construct abstract representations through reflection upon these experiences and attachment of personal meaning to them. These abstractions and insights guide future responses to concrete experiences. As Kolb (1985) points out, the underlying insight of experiential learning is deceptively simple; namely that learning, change, and growth are best facilitated by an integrated process that begins with (1) the here-and-now experience followed by (2) collection of data and observation about experience. The data are then (3) analyzed and the conclusions of the analysis are fed back to the actors in the experience for their use in the (4) modifications of the behaviour and choices of new experiences (Kolb and Fry, 1975).

Kolb (1984) describes a model of experiential learning that is based on the problem-solving process. The model includes both active and passive, abstract and concrete learning. This experiential learning cycle has 4 stages: (Figure 2)

- STAGE (1). Includes concrete experiences such as feeling, experiencing, and re-living.
- STAGE (2). Involves reflective observation such as perceiving, highlighting, and noting.
- STAGE (3). Abstract concepts and generalizations are formed through thinking, analyzing, and making sense of information obtained in the first 2 stages.
- STAGE (4). Involves active experimentation (acting, planning), in which

generalizations are tested and new hypotheses are developed to be tested in future concrete experiences.

Kolb (1984) has proposed a theory of experiential learning which seems particularly relevant to learning multicultural concepts. This theory is based on the pedagogic method, which can be described as follows; An exercise, selected and presented by a facilitator, permits the participants to experience a certain situation (Phase I), to detect a series of problems (using theoretical framework if necessary) and analyze their causes and consequences (Phase II), search for possible solutions (Phase III), and to test these solutions (Phase IV) either in an intermediate way which returns the participants to a deep investigation of the problems, or more definitely which brings the participants to the selection of a new theme of research.

KOLB'S EXPERIENTIAL LEARNING CYCLE (1984)

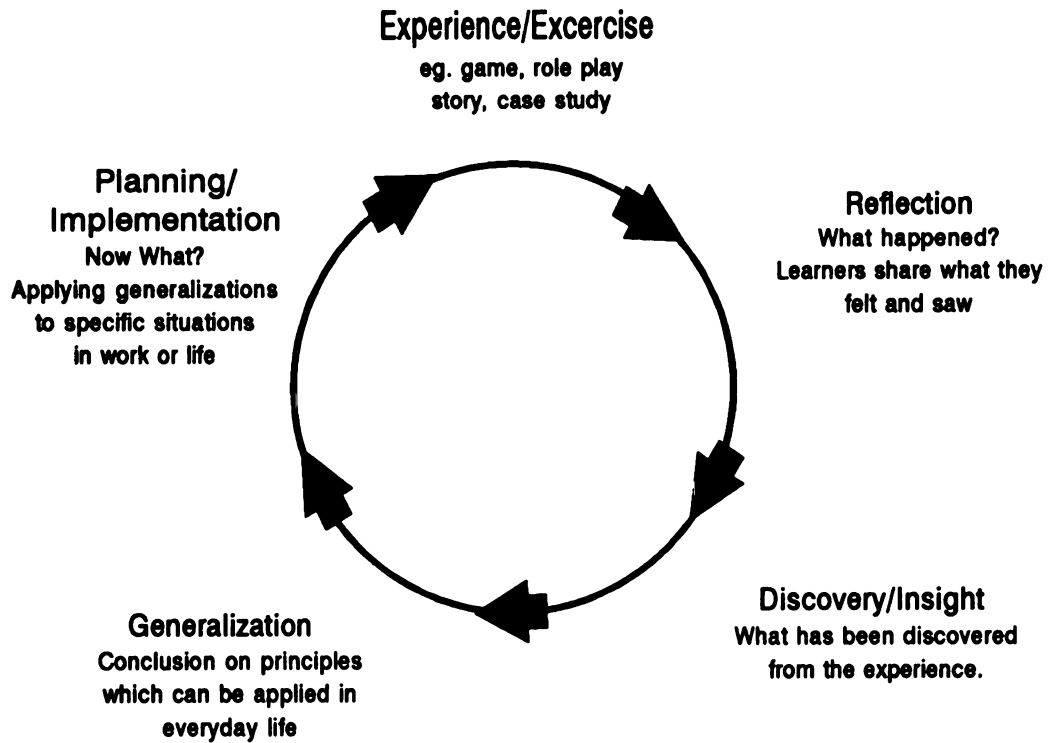
Source: Kolb, D.A. (1984). Experiential Learning, Englewood Cliffs, N.J: Prentice-Hall.

Figure 2

Learning is a life-long process resulting from continual person-environment interaction. It involves feelings, perceiving, thinking, and behaving, all of which are the essential components of cultural awareness. Experiential learning is holistic, and the reflection/analysis part of the cycle requires time and revisiting of experiences. Unfortunately, as educators we often get caught up in our own desire to "hustle (people) onward to new visions . . . rather than . . . to understand how people think about their work (experience) as it is now" (Olson, 1992, p. 51). In increasingly crowded curricula, we may feel pressured to "deliver the message and evaluate the outcome" in short, discrete segments. Experiential learning is best facilitated in a curriculum which integrates content with process. Whether the format for introducing "culture" to the curriculum is workshops, lectures, or clinical experience, no single format alone is adequate to ensure learner growth that results in increased cultural awareness.

A concern frequently expressed is that experiential learning is all "fun and games" and not as "educationally sound" as other methodologies. Hunt (1987) suggests using the term "direct experience" rather than "concrete experience" to avoid the misinterpretation of experiential learning. Direct experience as a focal point gives meaning to abstraction and provides a reference point for testing and validation. Feedback provides the basis for on-going, goal-directed action, and evaluation.

A model that can help to expel reservations about the "pedagogical rigor" of experiential learning, (especially through simulations and games) has been elaborated by Johnston and Rifkin (1987) [Figure 3].

ADAPTATION OF LEARNING CYCLE

Source: Johnson, M.P. and Rifkin, S.B. (1987). Health Care Together. London:
Macmillan Publisher Ltd., p. 11

Figure 3

Experiential Learning is learning through experience. It is an active approach to education in which knowledge is linked to the unique experiences of each learner. The process entails an integration of knowledge and doing in which both are repeatedly transformed (Gudykunst, Hammer and Wiseman, (1977). Experiential Learning should have been part of every educational curriculum long ago. The purpose of experiential learning is to assist a person to reflect on old and new ideas, beliefs and values (Penderson, 1988). These activities help the participants to shift from their "old me" to "new me" by stating "where they are" at the point of entry and through the activities introduce themselves to new and more appropriate approaches in the old or new situation (Kohl, 1987). Experiential Learning workshops are also useful in evaluating and understanding existing levels of personal cultural awareness (Hanvey, 1979; Majumdar, Hezekiah, 1990).

According to Johnston and Rifkin (1987) a successful integration of "knowing" and "doing" in experiential learning incorporates the following general principles and strategies: 1) concreteness (the learning strategies must be based on the student's own concrete experience) 2) involvement (learning which involves the "whole" person through a range of modalities [cognitive, affective, kinaesthetic, attitudinal and behavioural] is more effective) 3) dissonance (when learners temporarily face dissonance, they rethink their knowing, reshape their doing, and move towards a deeper level of understanding. Points of dissonance may be between theory and practice, cognition and emotion, expectation and reality, and "should" and "must") 4) reflection (when the learners have the ability and opportunity to step aside and think about their experience, they will be able to abstract new meaning and

knowledge relevant to other experiences (Hamnett and Brislin, 1980; Carpio, Majumdar, 1993).

Experiential learning strategies utilize the underlying principles of Gestalt-insight. Here, the learner faces confusion provided by a problem. Through restructuring his or her perceptions, the student attains new insight and learning. Various techniques may be employed for this type of learning: 1) lectures 2) discussions/workshops 3) case studies/role play 4) games/drama/songs 5) experiential exercises/structured experiences 6) field experience (Hoops, 1980, 1981; Gudykunst and Hammer, 1983).

Experiential exercises and structured experiences, covers a variety of activities; these exercises have in common the participants' engagement in an activity. These may be simulated exercises based on subject matter or human relations or they may be real issue exercises based on "this group" issue or exercise giving the individual self-insight. Various integrations of the above formats will be considered in the section on Design for Cross-Cultural Learning (Penderson 1988; Sikema and Niyekawa 1987).

The objectives of each activity must be clearly identified. It should be clear to the participants that the focus of the session is gaining knowledge, developing skill or attitude relevant to reflect on values of self, group, a society or a specific community or a problem (McCaffery, 1986). Activities should have a clear outline including stated objective, equipments, playing rules or process and evaluation. The number of participants, time, type of place for the activity should also be considered (Johnston and Rifkin, 1987).

The activity leader and the assistant leader must keep an eye on the following areas as the activity continues and at the end of the game:

- a) How the activity influences the participants,
- b) What happens to the individual participants and the group (expression of their verbal and non verbal clues),
- c) What different communication patterns evolve between participant groups, and
- d) How the groups (individuals) reflect on their old and new values (Hoops and Ventura, 1979; Juffer, 1986).

It is essential to debrief the activity sessions with the participants and discuss with them identified issues to relate the learning with the predetermined objectives and new ideas or learning beyond the identified objectives. Specific feelings of the individuals such as frustration, confusion, anger etc. should be dealt with the group before terminating the session. Emphasis should be made that these emotions are necessary for self-education and group process (Paige, 1986).

According to Johnston and Rifkin (1987), the "debriefing" component of learning experiences should include opportunity for discussion/reflection on what was "real" and what was "not real" in the exercise or simulation. This reinforces an appreciation and understanding that while every situation is unique all situations offer learning that can be applied to future situations. Rather than focusing exclusively, or even primarily, on the "culture" portrayed by the "game" simulation, the client participants explore and analyze their responses to what they perceive as new, unpredictable and unfamiliar experiences (Pusch, 1981). One of the shortcomings of

participatory learning could be making participants dissatisfied as they may think "it's a fun session" without any objective. Therefore, these activities should be carefully administered so that they reflect on learning as a social act and so that through the process, it provides reflection of self, self within a group, and group behaviour (Juffer, 1986; Carpio, Majumdar, 1993).

Finally, principles of experiential learning should be explored (CUSO, 1988).

They are:

- a) **Empowerment** - the learning process should be an empowering action process;
- b) **Learning and Reflection** - Learning is a continuous and lifelong activity. It causes us to reflect on what we have done in order to improve on what we are planning to do;
- c) **History and Analysis** - Each learner has a life history that is rich in experience, knowledge and skills;
- d) **Change** - Learning means change in understanding, knowledge, attitude, feelings or skills;
- e) **Collective Learning** - Everyone is learning, but may be different learning, together but may be learning different issues; that new knowledge is created and old knowledge is re-created into new understanding and that the knowledge and learning is a collective effort;
- f) **Strategy and Action** - Paternalistic teaching methodologies create dependency and apathy. Activity oriented learning provides concrete learning experiences with the opportunity for reflection, analysis and action (CUSO, 1988).

These principles are essential in developing positive attitudes toward multicultural concepts and initial attitudinal changes for the understanding of a multicultural outlook (Keeton, 1976).

Kolb (1984) describes how individuals construct abstract presentations from concrete experiences which direct subsequent actions in similar situations. He states that learning is the process whereby knowledge is constructed through the transformation of experience. Learning is a lifelong process resulting from continual person-environment interaction and involves feelings, perceiving, thinking and behaving. These are the essential components of cultural awareness.

An excellent example of the concrete experience proposed in Kolb's theory is the game "Bafa Bafa" (Shirts, 1977). In this game, participants are divided into two groups, each with their own distinctive culture. During the exchange of group members, attempts are made at interpreting and understanding each other. After the game, participants can reflect on how they played and examine the reasons behind their behaviour (Sikema and Niyekawa 1987).

Cultural sensitivity is essential in understanding multicultural concepts. The underlying principles of experiential learning make it particularly suitable to teaching cultural sensitivity. Just as each individual possesses a unique personality, the sum of these individuals (a group) has its own distinct culture. Chen, as cited in Nwanko, (1991) states that "to be competent in intercultural interaction, individuals must communicate effectively and appropriately". Understanding and accepting that various cultures communicate with one another and their environment in different yet valid ways is essential in the teaching-learning process. On the one hand, sensitivity

to variations in cultural style enriches this interaction but, on the other hand misunderstanding of behavioural style results in: (Inkeles, 1966; Ruben, Askling and Kealey, 1977)

- ♦ erroneous estimations of a students' or a cultural groups' intellectual capabilities,
- ♦ misjudging students' language abilities (teachers often use their own language or dialect as the norm),
- ♦ misreading of students' achievement in academic subjects such as creative expression, and
- ♦ difficulty in communication and establishing rapport.

Educators' expectations and the accompanying teaching behaviours influence and are influenced by students' performance. In the teaching-learning interaction this has led to a lower performance of racially, ethnically, and economically different students. A multicultural education system should have both its curriculum content and the delivery of its instructional services influenced by cultural sensitivity. The following is one example of how cross-cultural learning may be accomplished through experiential learning methodology (Pusch, 1981).

DESIGN FOR THE CROSS-CULTURAL LEARNING MODEL

This learning model proposed by Sikkema & Niyekawa (1987) has two overall objectives:

1. **Cross-Cultural** ► to become multiculturally oriented by developing the

capability to adapt and function competently in cross-cultural circumstances.

2. **Personal** ► to be more tolerant, flexible, and creative through a different understanding of oneself in relation to others and the world.

The proposed cross-cultural learning design accomplishes these objectives through the following process:

- i) by recognizing and amending one's personal and cultural biases in perception and interpretation of values and behaviour,
- ii) by cultivating one's sensitivity of cultural differences and appreciating the validity of various values and means of meeting life's situations,
- iii) by cultivating one's creativity through recognizing other ways to solve problems.

There are three components of this learning model. Each component is described in detail.

◆ **Pre-field Seminar**

The purpose of the Pre-Field Seminar is to help learners acquire an intellectual understanding of cultural and personal awareness. Pertinent theoretical information on cross-cultural learning is provided. Such an emphasis on cognitive learning allows for the analysis and understanding of the actual Field Experience through a framework. During the Pre-field Seminar a mental attitude in which learners assume an active role in the next phase is encouraged.

◆ **Field Experience**

This component provides the experiential complement to the cognitive learning acquired in the previous phase. The purpose is to experience culture shock:

"The students go to an essentially unknown culture with, desirably, the fewest possible preconceptions about how people there behave and what their values and customs are. As the students attempt to find their way in that culture and encounter the problems and ambiguities involved, they experience culture shock" (Sikkema, M., & Niyekawa, A., 1987, p. 23).

A crucial element of the model is the process of resolving this culture shock. The learners are assisted to face the psycho-social and philosophical differences between their own culture and that of the new one.

♦ **Post-field Program**

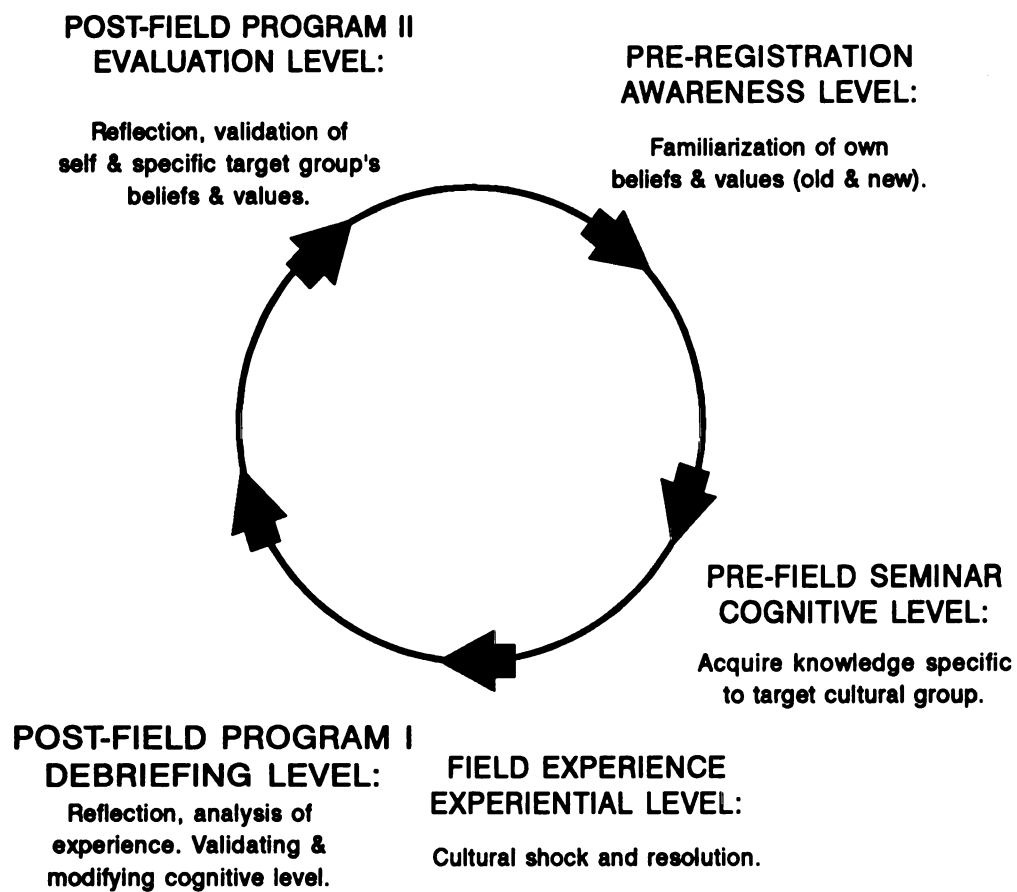
This component of the model provides the time necessary for reflection and internalizing the new learning once the learners are back within their usual environments. It is composed of a seminar and two learning summaries.

The seminar allows for retrospective analysis of the Field Experience and a consolidation of affective and cognitive learning. The first summary is a recording of basic learning and is written one month after Phase II. The second summary, within the learning experience is evaluated and is written six months after the Field Experience. The learners identify changes in their attitudes and the new insights they have acquired. They examine how the learning experience has influenced their encountering cross-cultural and other circumstances at present (Sikkema & Niyekawa, 1987) [Figure 4].

A number of factors have led to a resistance to experiential learning; Primarily budgetary restraints and lack of administrative and/or faculty support; secondly, derogation of experiential learning as "nonscholarly" and "merely vocational"; also, society continues to be influenced by epistemology (Triandis, 1975; Majumdar, 1993). Cognitive education is seen as scholarly. However, to understand

one's total environment, experience must be brought to awareness and comprehended in its affective complexity (Bennett, 1986). Besides reasoning and logic, intuition is necessary for full knowing. Lastly, experiential learning requires the teachers to use nontraditional, and possibly unfamiliar, teaching methods (Pusch, 1981). Often these imply a shift in power from that of control (traditional teaching strategies) to one of mutual openness and respect. This may lead to feelings of being threatened and lead to resistance. To overcome resistance, teachers need to be trained and willing to deal with affect as well as cognition in the teaching-learning process (Keeton, 1979).

In conclusion, everyone is assumed to be capable of all kinds of behaviour (ie., everyone is capable of learning). But, as stated by John Dewey (1987) this process can be painful. No one can enter a new world without forsaking an old one. New ideas and feelings may be exciting, but the newly acquired knowledge and experience may "rub up" against long-held beliefs and principles (Majumdar, 1990). Kolb and Fry, (1977) suggest that everybody, if they are to acquire learning, (ie., changing their behaviour or beliefs in some way) will need four different kinds of ability.

ILLUSTRATION OF SIKKEMA AND MIYEKAWA' MODEL**Figure 4**

They must be able to involve themselves in new experiences, observe and reflect in them from different perspectives, create concepts that integrate observations into logically sound theories, and use them to make decisions and solve problems (Christopher, 1987).

To increase one's knowledge and understanding of ethnic groups and cross-cultural interactions, direct experience is more effective than presenting factual information (Mio, 1989). Depth of experience is a key factor in cross-cultural sensitivity. This does not imply that breadth of experience within minority groups is useless. Cross-cultural contact should accompany academics through innovative teaching strategies. Experiential learning methods provide various techniques in increasing cultural sensitivity experientially.

Cultural awareness includes insight into "our own cultural beliefs and biases". Since it is "our culture, it is our own beliefs, and values, that filter what we see and hear". Therefore, the authors restrict "their thoughts to when and what we teach and how we communicate with others" (Majumdar and Hezekiah, 1990). This process is acquired by developing a special sensitivity to ourselves and to each other by constantly reflecting on our own behaviour, on what we believe and why, and reflecting on what we are teaching and how we communicate.

CONCEPT OF HEALTH

Borremans (1978) writes that health is radically de-medicalized, de-professionalized and yet rationally pursued by the application of modern means. The degree of vitality of a person is expressed in each language in a way that reflects

culture-specificity as each culture values a different style of vitality. She points out the differences between the modern form of "medicalized health" and the conception of health among the Aztecs before the arrival of the Spaniards. According to Borremans (1978), in a modern society the health of people will be optimum when two conditions are met:

- a. When a society distributes equally what it produces.
- b. When a society produces just barely as many goods and services as are needed to equip people equitably with the tools they need for the most effective level of autonomous action. Further, she conceives of health as an ever-surprising vitality that is manifestation of a culture.

The World Health Organization (WHO) adopted the definition of health in their constitution in 1947 as: "Health is a state of complete physical, mental and social well-being and not merely absence of disease or infirmity." The constitution of WHO has reaffirmed that health is a basic human right and that attainment of health will permit an individual to lead a socially and economically productive life (WHO, 1979).

Keller, (1981) is of the opinion that a clear definition of the term "health" is essential in enhancing the promotion of health care. The word "health" originated as a positive state, devoid of the idea of illness. Wholeness was an integral characteristic of its origin and historical development" (Keller, 1981). In defining health it is essential to consider the common health beliefs. She further discusses the views of writers and scientists from different fields and writes that the WHO definition, is the "single most quoted and criticized, yet enduring, definition of

health..." (Keller, 1981, p. 45). For the purpose of analyzing the definition of health, Keller (1981) listed 42 definitions of health from the literature and used 22 sub-concepts. She found that of the 42 listed definitions and descriptions, personal health exclusively was the focus of 40 of them and only 13 authors referred to social characteristics of health. While ranking the characteristics it was observed that physical or biological and emotional or psychological domains were ranked first and second respectively.

CULTURALLY SENSITIVE EDUCATION

Satisfaction of consumers with health care services and social services significantly increases when the provider of these services is culturally sensitive. According to the study of Hamilton and District Social Planning and Research Council (DeSantis, 1990) colleges and universities should recruit diverse members into training programmes and create ethno-specific courses. Yet, Christopher does not believe university orientation programmes should focus on cultures, although she does acknowledge that cultural differences do exist. (Christopher, 1987). The theory according to Moodley, is that the aim of education should not be harmonious co-existence between groups of different phenotype, but nonracial (colour-blindness) [Moodley, 1992].

Culture is the basis for understanding, and within each individual it defines their identity (Pendersen, 1988). Individuals have their own learning style preference. It should be recognized that culture has a significant influence on how one asks questions, answers questions, and approaches problems (Christopher, 1987).

Health care providers are more effective if given training in multicultural health issues to create a culturally sensitive environment for patients. Multicultural education has been defined with these basic premises: to maximize individual choice and flexibility; academic freedom; human diversity; personal liberation; personal empowerment (Moodley, 1992). "Professional preparation programs need to be reformed radically to develop competencies to bridge these existential gaps" (Moodley, 1992, p. 24). The classroom requires cultural tolerance and teachers need to attend to this diversity in which they have to be able to relate to differences (Paine, 1990). Yet, through interviews with prospective teachers, Paine's study found they tended to be focused, had difficulty discussing diversity as a complex issue, either in contextualized or pedagogical orientation. Often there is a denial of central differences (gender). In this context, multiculturalism was seen as problem (Paine, 1990).

In a study by the Hamilton Wentworth District Health Council (1990), barriers to service delivery were found. Language and communication barriers are apparent, although physicians attribute this to a lack of interpreters and lack of funding. This results in a poor interpretation on the parts of both the physician and the patient. (Hamilton Wentworth District Health Council, 1990). Therefore, cultural training is needed for better communication. Understanding is vital for satisfying treatment which is not possible if there is poor communication. The awareness of physicians that the influence of a person's cultural experience contributes to how a disease and illness are manifested (Majumdar, 1992). According to Dobson, an understanding of patients' cultural health beliefs is necessary in order to offer sensitive client-centred

care (Dobson, 1991). The implementation of cultural sensitivity has encountered limits such as the education and training of the workers in question, where there are differences in values and time constraints. In addition to the limitations, there are obstacles such as the lack of enthusiasm of administrators, physicians and seniors. (Hamilton Wentworth District Health Council, 1990).

According to Hennen, it has been shown that Ontario Family Medicine Residency Programmes do not provide any mandatory or structured courses looking at multicultural health issues (Hennen, 1990).

Studies on the presence of cultural sensitivity were also conducted in the nursing field. Dobson states that training of multicultural awareness should be provided. It is necessary to understand the patient's cultural health beliefs in order to provide sensitive client-centred care. Transcultural nursing (nursing in which the patient and nurse are of different cultures) may be made easier through "ethnographic interviewing" and "participant observation" (Dobson, 1991).

Cultural sensitivity can also be created in the educational environment if health care professionals make the effort to recognize their own cultural biases and attempt not to project these views on the patients. This egalitarianistic approach allows for a greater interaction between patient and health care provider (Hennen and Blackman, 1990). Access to social services encounters barriers such: information barriers; administrative; reception, forms and explanations and cultural barriers; physical/geographic; and costs. The Hamilton-Wentworth District Health Council (1990) study showed that 79% of local agencies do not offer specific services for diverse groups and 73% will not be offering new services for diverse groups. Current

problems in serving diverse groups included language, cultural value differences, a better cultural understanding in the marketing of programs, assessing needs, funding, serving special needs, lack of understanding of the system, lack of access to interpreters and quality of interpreters (DeSantis, 1990).

In Katirai's study, racism was found to be a barrier to the access of shelters for abused women for Native, Black and immigrant women. Those that did gain access encountered limitations to the services received. These women were the victims of discrimination, exclusion in the decision-making process and the undervaluing of their abilities/skills. Many suggestions were given by Katirai, such as ensuring that the women are counselled by those of the same culture and that literature is available in different languages so that the women were made aware of their rights and options (Katirai, 1992).

There have been numerous suggestions and recommendations for curriculum changes in various health care and social services programs to increase cultural sensitivity, but the obstacles lie within the administrators of the institutions (Daylor, 1990) and within the educational systems (Moodley, 1992). Moodley goes on to cite examples within Great Britain and the United States.

In Great Britain, the presence of social categories perpetuate stereotypes, which in turn perpetuate prejudice and discrimination. These social categories include class, status, race gender, religion, sexual orientation, disability, spatial location or territoriality. Children with academic problems are found to be labelled stupid instead of looking at the education system. The onus is once again placed on the individual instead of the community or society (Watson, 1973).

Moodley believes there is an underlying assumption that if minority youth learn about their own cultures they will develop ethnic pride, improve their self-image and ultimately improve their school performance. Moodley continues with an analysis of the educational environment in the United States. The issue of cultural diversity is completely ignored (Moodley, 1992).

The aim of many of these studies (Eckhardt, 1968) and subsequent recommendations for change is the "intercultural person" becomes the norm. This represents one who has achieved an advanced level in the process of becoming intercultural: that is, one is open to growth, believes in unity for all; accepts differences in and between people and cultures; and is empathetic (Milton, 1986). These changes are long-term processes. It may be necessary to change the behaviour of the person based on increased knowledge and skills development relevant to cultural awareness and care Epps (1974).

CHAPTER III

METHODOLOGY AND DESIGN

Adult education and self-directed learning programmes enable people to develop skills and capabilities which increase their control over the decisions, resources and structure affecting their lives. The goal of adult education is to empower the individual adult learner.

The following descriptive design was utilized for collection and analysis of data. The independent variables include the participants' gender, age, ethnic origin, birthplace, marital status, language, education, income, and financial status. The dependent variables are health, happiness, self-confidence, loneliness and ability to speak English (Table 2).

DEVELOPMENT OF THE EDUCATIONAL PROGRAMME

"In order to be able to be a good coordinator for a 'Cultural Circle' , you need, above all, to have faith in man, to believe in his possibility to create, to change things. You need to love. You must be convinced that this liberation takes place to the extent that man reflects upon himself in relationship to the world in which, and with which, he lives... A cultural circle is a live and creative dialogue, in which all seeks, together, to know more. This is why you, as the coordinator of a cultural circle, must be humble, so that you can grow with the group, instead of losing your humility and claiming to direct the group, once it is animated" (Freire, 1971, p. 61).

Wren (1977) views education for justice as a means to increase people's power, culturally (in terms of confidence and identity) and politically.

SCHEMATIC DESIGN OF THE STUDY

Independent Variables	Study Population	Dependent variables	Instruments
Gender Age Ethnic Origin Birthplace Marital Status Language Education Income Financial Status	Vietnam's Chinese Seniors (South East Asian) in a Selected Community Intervention: A Self-directed/Supportive Educational Programme	Perception of Health Happiness Self-Confidence Loneliness Oral English Expression	Health Assessment Questionnaire Oral Language Expression Rating Scale Journal Anecdotal Notes

Table 2

He identifies this as a critical consciousness — that is, one looks at one's own environment, analyses the situation and gains new awareness. Freire (1971), believes that the required skills and choice of strategies should be up to the members (learners). The educational programme for the seniors was developed based on Knowles' (1978) model of self-directed and adult learning. He states that:

- ♦ adults' orientation to learning is life-centred; therefore, they are more interested in application of the knowledge in real life situations
- ♦ adults have a rich resource for learning: their own experience
- ♦ adults like to be self-directed rather than being told what to do

Selection of the Teaching-Learning Method

A self-directed educational programme was planned and implemented to assist seniors to gain knowledge and to develop the necessary skills required of them in the Canadian society, which is culturally and racially diverse. Participatory and experiential learning methods based on Roger (1969); Kolb (1984); Köhls (1987); Johnson and Rifkin (1987) were implemented throughout the educational programme.

♦ Rationale for Selecting Participatory and Experiential Learning

A developmental, experiential method is consistent with the principles of adult learning (Knowles, 1980). Seniors were kept motivated by creating an aspiration and awareness of the need to learn, and by providing resources and appropriate experiences, such as a field trip to a museum, observing a traditional ritual such as "Thanksgiving" dinner, and opening a bank account (Carpio, Majumdar, 1993; Pedersen, 1988).

If learning is a lifelong process resulting from continuous interaction between an individual and his or her environment, through learning experience a person can reflect on "what" has been done in order to improve on "what" is to be done in the future. The South East Asian seniors moved from their "old" home (Vietnam) to a "new" home (Canada). To adjust in the new home environment, it was necessary for the seniors to reflect on their past and present knowledge and experience and to identify their learning needs related to their learning life style within the context of

Canadian society.

Each senior learner has an unique history, enriched with life experience and knowledge.

Implementation of the Programme

♦ Selection And Preparation Of The Coordinator

A community college student was hired as coordinator of the educational programme and as an English As A Second Language tutor for the participants. The coordinator was a 21 year old Vietnamese woman of Chinese ethnicity. She had immigrated to Canada 7 years ago and was fluent in both English and Chinese.

The investigator and coordinator worked as a team. The investigator provided extensive training to the coordinator on the problem-solving, participatory method, and in planning an educational programme. The coordinator contributed insights into the Vietnamese-Chinese culture, especially as it related to seniors.

♦ Teaching-Learning Strategy

The educational programme coordinator took the role of facilitator. Each participant was considered as an adult learner who was in search of change, new knowledge, skills and experience. He or she was expected to decide what to do with the new information, skill or experience, or how to fit it into his or her life. Language and cultural barriers were considered. Each session was flexible with a strong emphasis on peer support.

Using problem solving and participatory methods, the contents for the programme were identified by the seniors. The following participatory activities were

used:

- Warm-ups and Peer Support
- Discussion
- Field Trip
- Role Playing
- Games
- Questions and Answers, and Reflections
- Self-Evaluation and Peer Evaluation

Audio-visual materials were collected from local health, social and recreational agencies, the regional South-East Asian Community and the Chinese Embassy. Sessions were planned to be held in Chinese and English. Conversational English was used as a vehicle to express new knowledge and ideas. Seating arrangements were flexible and based on traditional cultural values for example, men prefer to sit together, away from women and vice-versa.

♦ **Content**

Based on the seniors' expression of needs, the following content was selected:

- English as a Second Language
- Canadian Society: Encountering Social and Cultural Barriers
- Culture and Health
- Beliefs and Values in Social, Recreational and Educational Service Providers
- Availability and Accessibility of Resources (local/provincial levels)
- Life Skills (for example, banking)

- Familiarization of Canadian Lifestyle (example, trip to museum)
- Development of Seniors' Inter and Intra Peer Support Systems
- Self-Evaluation

Time Schedule

Each session was three hours every week for three and a half months. Of 13 sessions, five were conducted on Saturday afternoons, and seven were done on Sunday afternoons. Each session included a 15 minute warm up and introduction of the session, a 45 minute English as a Second Language session, and two hours dealing with the specific topic for that session.

SAMPLE

In Hamilton Wentworth region most of the South East Asian senior groups have well established organizations except Chinese seniors from Vietnam. They have recently immigrated to Hamilton region. Local communities were interested to assist them in establishing their own self help group. The investigator was approached by a community organization to help the Chinese seniors from Vietnam in developing their support group. She also received a funding from the Educational Centre for Healthy Aging, Provincial Government to plan and implement a self help project for this senior group. Therefore, Chinese seniors from Vietnam was selected as a convenient sample for this study.

Participants included seventy two South East Asian seniors with ages ranging from 65 years to 82 years who immigrated from Vietnam within the last five years and living in Hamilton, Ontario. All spoke Chinese and resided in apartment buildings in downtown Hamilton. One apartment building in the area was selected as the training site, and was within a block of the participants' homes. Those seniors in this area not included in the study were excluded for the following reasons:

- ♦ transportation problem:- 11 seniors;
- ♦ participants' immigration to Canada was less than one year or more than five years:- seven seniors;
- ♦ not available during the training session times (Saturdays and Sundays):- 15 seniors;
- ♦ a serious learning deficit such as severe hearing or vision impairment:- six seniors.

Forty-two seniors were excluded from a total of 72 and 33 seniors were selected for the study. Of thirty three seniors six refused to participate in the study (Figure 5).

DEVELOPMENT OF THE HEALTH ASSESSMENT QUESTIONNAIRE

The purpose of the health assessment questionnaire was to gather demographic data and measure the perceptions of health, happiness, self-confidence and loneliness of the participants.

In the preliminary phase of the study, articles on health were reviewed. Experts in the health field associated with immigrant population and gerontology were also consulted. The Vietnamese Depression Scale by Kinzie, Manson, Vinh, Tolan, Ahn, Pho, (1982) was reviewed to determine the clinical prevalence of

symptoms suggestive of depression within the cultural context of the Vietnamese population. In addition, Zung's (1964) and Beck's (1967) instruments to detect depression were examined.

RECRUITMENT OF SAMPLE SIZE

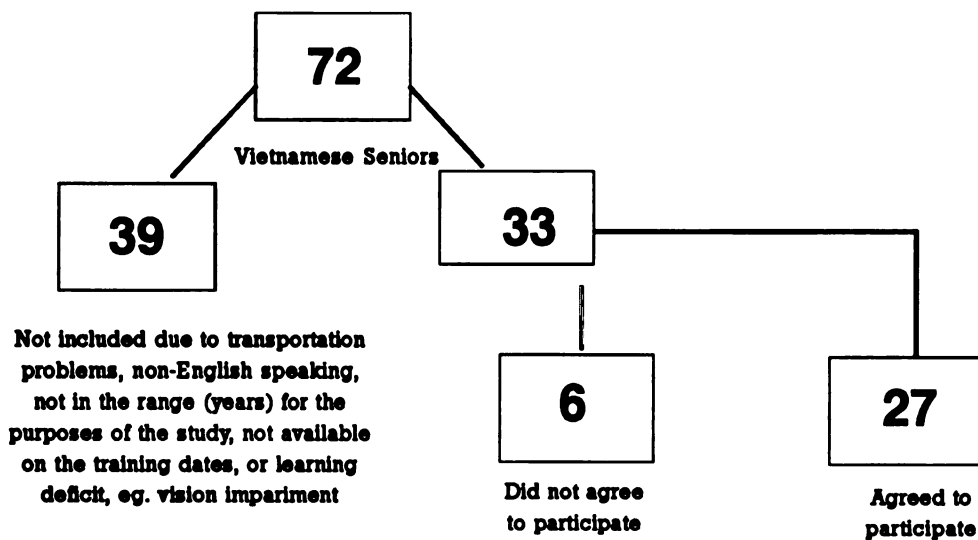


Figure 5

Zung (1964) attempted to categorize different aspects of depression disorder symptoms, and to quantitatively rate a patient's depression. A control group that

was not diagnosed as being depressed, responded to Zung's questionnaire. This was done to ensure that the questions themselves were easy to comprehend. The result was that the score index for patients diagnosed with a depressive disorder was significantly higher than the score index for patients who simply showed signs of depression, but were not actually diagnosed as such.

Test results on Zung's instrument were consistent with previous results. For example, it was known that one of the prime symptoms of depression disorder was sleep disturbance. Zung also reported that sleep disturbance was the primary symptom of the patients tested. Also, sleep disturbance was the symptom that improved the most after treatment, according to the post treatment test of patients. The general score indicated an improvement in patient well-being after the treatment process.

The Beck (1967) Depression Inventory consists of 21 categories of "depressive" symptoms and attitudes. Each category has a series of four to five evaluative statements, which are ranked according to severity. The items are chosen based on overt behavioral manifestations of depression (Beck, 1967). The total possible score range is from zero (non-depressed) to 60 (severely depressed). The internal consistency of the Beck's depression index was determined through comparison of scores for each of the 21 categories with the total score for each. With the use of the Kruskal-Wallis non-parametric analysis of variance by ranks, it was found that all categories showed a significant relationship to the total score for the inventory (Beck 1967), with a significance beyond the 0.0001 level for all categories except weight loss, which was significant at the 0.01 level. A value of $r=0.93$ was found for the split-half

reliability with the Spearman-Brown Correction.

The Vietnamese Depression Scale by Kinzie, Marson, Vinh, Tolan, Ahn, Pho, (1982) is an 18 item culture specific self-reporting instrument. There are six questions each about physical, psychological and culture-specific symptoms. In 1993 the questionnaire was tested by the researchers for reliability co-efficient. The adjusted alpha co-efficient for the entire sample (n=476) was 0.90 and ranged from a low of 0.84 (five to six years of education) to a high of 0.90 (women) for individual demographic subgroups.

Scale Items

This Scale consisted of two parts (Appendices H and I).

PART I: consisted of questions pertaining to personal data of the respondents (nine items). It was designed to provide demographic data for analysis and description of population characteristics. Items included gender, age, ethnic origin, birthplace, marital status, language, education, family income, household and financial status (Appendix H).

PART II: consisted of items seeking information on the individual's level of perception of health (nine items), happiness (13 items), self-confidence (14 items), and loneliness (nine items), [Appendix I]. Questions were also worded positively, and negatively, and were totalled for satisfaction (positive case), or dissatisfaction (negative case) [Table 3].

Each item had a series of five evaluative statements which were ranked according to

severity. Altogether, there were a total of 20 positive, and 25 negative questions on the questionnaire. The maximum total scores that anyone could record on all the positive and negative questions were 100 (Total of 20 items multiplied by five points for each item) and 125 (Total of 25 items multiplied by five points for each item), respectively.

POSITIVE AND NEGATIVE GROUPING OF ITEMS

	Positive	Negative	Total
Health	2	7	9
Happiness	12	1	13
Self-confidence	3	11	14
Loneliness	3	6	9
	20	25	45

Example of Positive: I feel happy.

Example of Negative: I feel lonely.

Table 3

Reliability and Validity

Items of both Beck's (1967) and Zung's (1964) instruments were examined by three community persons with the same ethnic background as the sample population. A total of 45 question items were identified from Beck (1967), Zung (1964) and Kinzie, et al (1993) as suitable. A few modifications were employed to make the items more culturally sensitive such as, words changed from "worthless" to "useless"; "mad" to "angry"; "functions" to "activities"; "bad luck" to "misfortune" and "suffer from" to "troubled by".

The modified health assessment questionnaire was submitted to five experts from the mental health field who had been working with the South-East Asian population, to determine its face and content validity. They were asked to judge each

item for clarity and relevancy and to provide suggestions for change. Their comments and suggestions were then used to modify the content of the instrument, and help to establish content validity. The experts were also asked to examine the structure of the questionnaire. This ensured the structural suitability of the instrument. Then, the instrument was translated to Chinese (Cantonese) with the help of a language expert, who belonged to the same ethnic population as the sample population. The Chinese version of the instrument was re-translated by another language expert to the English language. Both language experts belonged to the same ethnic population as the sample. The original English instrument and re-translated English instrument were then compared for content validity of the Chinese version. For pretesting, the questionnaire was administered to five Chinese seniors who demonstrated knowledge of English and Chinese. This questionnaire was tested first in Chinese, then retested in English after 15 day intervals. Responses were compared for congruency. The investigator found that the questionnaire conveyed the same meaning in both languages supported by the fact that responses were similar for both versions at 100% agreement. This process ensured consistency. While responding to the Chinese version of the tool, the five seniors were asked to evaluate and comment on the items of the instrument to determine if they were culturally sensitive. This process ensured that the language used in the questionnaire would be culturally sensitive for the study population. Table 4 displays the process of questionnaire development.

DEVELOPMENT OF HEALTH ASSESSMENT QUESTIONNAIRE

LITERATURE REVIEW	BECK QUESTIONNAIRE	ZUNG QUESTIONNAIRE
\	\	/
Development of Questionnaire		
▼		
Selection of Items for Cultural Sensitivity by South East Asian Experts		
▼		
Content Validity & Structural Suitability by Experts		
▼		
Translation & Return Translation (English/Chinese/Experts)		
▼		
Pretesting of Questionnaire for Language Consistency and Cultural Sensitivity		

Table 4

Internal Consistency

Psychosocial scales are often evaluated in terms of internal consistency. Ideally, scales designed to measure an attribute are composed of a set of items, all of which are measuring the critical attribute and nothing else. An internally consistent or homogeneous sub-scale is one wherein all of its subparts are measuring the same characteristic. The internal consistency approach to estimating the reliability of an instrument is probably the most widely used among researchers today (Norusis, 1988). The reason for the popularity of the procedures is that they are the most important sources of measurement error in psychosocial instruments, the sampling of items.

One of the oldest methods for assessing internal consistency is the split-half technique. In this approach, the items comprising a test are split into two groups, scored independently, and the scores on the two half-tests are used to compute a correlation coefficient. The correlation coefficient computed on split-halves of a measure tends to systematically underestimate the reliability of the entire scale. The split-half technique is easy to use and eliminates most of the problems associated with the test-retest approach (Marascuilo and Serlin, 1988). However, the split-half technique is handicapped by the fact that different reliability estimates can be obtained by using different "splits"; that is, it makes a difference whether one uses an odd-even split, a first half-second half split, or some other method of dividing the items into two groups. For this reason the split-half approach is increasingly being replaced by formulas that compensate for this deficiency. The two most widely used

methods are coefficient-alpha (or Cronbach's alpha) and the Kuder-Richardson Formula 20 (abbreviated KR-20) [Norusis, 1988; 1992].

Cronbach's alpha has several interpretations. The most common one is "the squared correlation between the score a person obtains on a particular scale (the observed score) and the score he would have obtained if questioned on all of the possible items in the universe (the true score)" [Statistics Guide, 1994, p. B-206]. The Spearman-Brown coefficient can be used to estimate what the reliability of the overall test would be. The Guttman split-half coefficient is another estimate of the reliability of the overall test. It does not assume that the two parts are equally reliable or have the same variance (Norusis, 1988).

In this study four reliability tests are done. They were Cronbach's Split-Half (Table 5), and Cronbach's Alpha, Guttman coefficient and the unequal length the Spearman-Brown coefficient (Table 6). As the number of items on each of the two parts of the four clusters of the study questionnaire: "Health Assessment" was not equal, the unequal-length of the Spearman-Brown test is preferable (Table 6). All tests indicated a high correlation coefficient within the items of each cluster of the questionnaire. The Happiness cluster, Part 2, with three items in Cronbach's split-half was low (.0716) [Table 5], but when all seven items were tested using Cronbach's test, alpha was .9587 and standardized item alpha was .9653 (Table 6). The Happiness cluster reliability test done by Guttman split-half was low (.5601), but was high using the Cronbach's standardized item alpha test (.8590), the Cronbach's split-half alpha test (.9226), and the Unequal Length Spearman Brown split-half test (.8942). Therefore the reliability of the questionnaire is between .86 to .97.

CRONBACH'S SPLIT-HALF FOR FOUR CLUSTERS

SPLIT-HALF	HEALTH	HAPPINESS	SELF-CONFIDENCE	LONELINESS
Part 1	4 Items .9610	6 Items .9226	6 Items .9623	3 Items .86453
Part 2	3 Items .8636	6 Items .0716	5 Items .8750	3 Items .8966

Table 5**RELIABILITY COEFFICIENT OF FOUR CLUSTERS**

TEST	HEALTH	HAPPINESS	SELF-CONFIDENCE	LONELINESS
Unequal-Length Spearman-Brown	7 Items: .9434	12 Items: .8942	11 Items: .9808	6 Items: .9607
Guttam Split-Half	7 Items: .9434	12 Items: .5601	11 Items: .9708	6 Items: .8889
Cronbach's Alpha Standardized Item Alpha	7 Items: .9587 .9653	12 Items: .9001 .8590	11 Items: .9648 .9699	6 Items: .9283 .9535

Table 6

Administration of the Health Assessment Instrument

The average time to administer the instrument was about 60 minutes. It took about 20 minutes to introduce the researcher, explain the study and build rapport, 30 minutes for the individuals to complete the questionnaire and 10 minutes to terminate the session.

EVALUATION OF ENGLISH EXPRESSION

Using an Oral Language Expression Rating Scale, the coordinator twice measured the seniors' ability to speak English — before the programme (T_1) and after its completion (T_2). In addition, the coordinator kept an individual journal of reflection of her perceptions of the seniors' activities and ability to express their thoughts during the programme sessions. Entries into the journals started on the first week of the programme so that the recorded data offered baseline data. These weekly journals were kept for the next 12 weeks of the programme to record the progress of individual senior's ability to speak English and his or her group interaction.

Development of Oral Language Expression Rating Scale

Several reading and language inventories were developed by Bader, (1993). Her inventories of oral language and writing performance were modified and a rating

scale was developed for data collection of the participants' basic oral expressive skills (Appendix J).

Structured observations can be recorded in a number of ways other than through the use of category systems and checklists. The major alternative is to use a rating scale. Observational methods are more vulnerable to human perceptual errors than any other data collection method. If persons are to become good "instruments" for measuring observational data, then they must be trained to observe in such a way that accuracy is maximized and biases are minimized. The training of the observer is a very important phase in the preparation of a study. The coordinator of the present study familiarized herself with the aims of this study and the nature of the behaviours to be observed and the rating scale. A training session was arranged to discuss and clarify any ambiguities of the rating scale. During the practice session, the comparability of the observer and investigator was assessed twice.

The investigator and the coordinator, each observed and independently rated oral skills performance of five male and five female immigrant adults at their first "English As A Second Language" class. The raw scores were tabulated (see Tables 7, 8, 9 and 10). There was 100% agreement between the investigator and the coordinator for both times on the following items:- use of compound sentence, sentence length, grammar and explanation, description and exploring, and articulation (T_1). The agreement for the other items ranged between 90% to 60%.

Some of the measurement process can be controlled to some degree, but it must be recognized that scores obtained from most measuring instruments are fallible. Errors of measurement are problematic because they represent an unknown

quantity and also because they are variable. Many factors contribute to errors of measurement. Among the most common are the following:- situational contaminants, response set biases, transitory personal factors, administration variations, instrument clarity and instrument format. The internal Chance correction was estimated by using Cohen's Kappa. Kappa was 1.0 in the following items for both pre and post test measures between the observers (coordinator and the investigator):- use of compound sentence, sentence length, grammar and explanation, description and exploring, and articulation in time one. In the pretest, Kappa for the other items was .40 or greater except for item "use of verb", where $K=.09$ with 60% agreement. Although Kappa was low (.40) in 4 of the items (T_1), there was 70% agreement between two observers. In the post test, Kappa ranged between .80 to .60 with 90% to 80% agreement. Kappa was low (.21) in the item "use of verb", however, the agreement was 70%. Although Kappa was low in some of the items (T_1 and T_2), that is the observers could not distinguish between "poor" and "fair", but in fact they were able to distinguish between two broad categories, "poor to fair" and "good to excellent". Unfortunately no subjects studied had "good to excellent" oral language skills.

**RAW SCORE OF FIVE ITEMS AND KAPPA BY COORDINATOR AND
INVESTIGATOR (T₁)**

ABBREVIATION:

Articulation=R
Vocabulary Development=VO
Use of verbs=VER
Investigator=In

Fluency=FL
Use of simple sentence=SIM
Coordinator=Co

Subject	R (Score)		FL (Score)		VO (Score)		SIM (Score)		VER (Score)	
	Co.	In.	Co.	In.	Co.	In.	Co.	In.	Co.	In.
1	1	1	1	1	1	1	1	1	1	1
2	1	1	1	1	1	1	1	1	1	1
3	1	1	1	1	1	1	1	1	1	1
4	1	1	1	1	1	1	1	1	1	1
5	1	1	2	1	2	1	2	1	2	1
6	2	2	2	2	2	2	2	2	2	2
7	2	2	2	2	2	2	2	2	2	1
8	1	1	1	2	1	1	1	2	2	1
9	2	2	1	2	1	2	1	2	1	1
10	2	2	2	2	1	2	2	2	1	2
KAPPA	1.0		.4		.4		.4		.09	
AGREEMENT	100%		70%		70%		70%		60%	

Table 7

**RAW SCORE OF FOUR ITEMS AND KAPPA BY COORDINATOR AND
INVESTIGATOR (T₁)**

ABBREVIATION:

Use of compound sentence=COM
Sentence length=SEN
Coordinator=Co

Grammar=GRA
Explaining, describing, exploring=EXP
Investigator=In

Subject	COM		SEN		GRA		EXP	
	Co.	In.	Co.	In.	Co.	In.	Co.	In.
1	1	1	1	1	1	1	1	1
2	1	1	1	1	1	1	1	1
3	1	1	1	1	1	1	1	1
4	1	1	1	1	1	1	1	1
5	1	1	1	1	1	1	1	1
6	1	1	1	1	1	1	1	1
7	1	1	1	1	1	1	1	1
8	1	1	1	1	1	1	1	1
9	1	1	1	1	1	1	1	1
10	1	1	1	1	1	1	1	1
KAPPA	1.0		1.0		1.0		1.0	
AGREEMENT	100%		100%		100%		100%	

Table 8

**RAW SCORE ON FIVE ITEMS AND KAPPA BY COORDINATOR AND
INVESTIGATOR (T₂)**

ABBREVIATION:

Articulation=R
Vocabulary Development=VO
Use of verbs=VER
Investigator=In

Fluency=FL
Use of simple sentence=SIM
Coordinator=Co

Subject	R		FL		VO		SIM		VER	
	Co.	In.	Co.	In.	Co.	In.	Co.	In.	Co.	In.
1	1	1	1	1	1	1	1	1	1	1
2	1	1	1	1	1	1	1	1	1	1
3	1	1	1	1	1	1	1	1	1	1
4	1	1	1	1	1	1	1	1	1	1
5	1	1	2	1	1	1	2	2	1	1
6	2	2	2	2	2	2	2	1	2	1
7	1	2	2	2	1	2	2	2	1	1
8	1	1	1	2	1	1	1	2	2	1
9	2	2	2	2	1	2	2	2	1	2
10	2	2	2	2	1	1	2	2	2	2
KAPPA	.8		.6		.6		.6		.21	
AGREEMENT	90%		80%		80%		80%		70%	

Table 9

**RAW SCORE ON FOUR ITEMS AND KAPPA BY COORDINATOR AND
INVESTIGATOR (T₂)**

ABBREVIATION:

Use of compound sentence=COM

Sentence length=SEN

Coordinator=Co

Grammar=GRA

Explaining, describing, exploring=EXP

Investigator=In

Subject	COM		SEN		GRA		EXP	
	Co.	In.	Co.	In.	Co.	In.	Co.	In.
1	1	1	1	1	1	1	1	1
2	1	1	1	1	1	1	1	1
3	1	1	1	1	1	1	1	1
4	1	1	1	1	1	1	1	1
5	1	1	1	1	1	1	1	1
6	1	1	1	1	1	1	1	1
7	1	1	1	1	1	1	1	1
8	1	1	1	1	1	1	1	1
9	1	1	1	1	1	1	1	1
10	1	1	1	1	1	1	1	1
KAPPA	1.0		1.0		1.0		1.0	
AGREEMENT	100%		100%		100%		100%	

Table 10

**RAW SCORE ON FIVE ITEMS AND KAPPA BY COORDINATOR
(T₁) AND T₂**

ABBREVIATION:

Articulation=R
Vocabulary Development=VO
Use of verbs=VER
Investigator=In

Fluency=FL
Use of simple sentence=SIM
Coordinator=Co

Subject	R		FL		VO		SIM		VER	
	T ₁	T ₂	T ₁	T ₂	T ₁	T ₂	T ₁	T ₂	T ₁	T ₂
1	1	1	1	1	1	1	1	1	1	1
2	1	1	1	1	1	1	1	1	1	1
3	1	1	1	1	1	1	1	1	1	1
4	1	1	1	1	1	1	1	1	1	1
5	1	1	2	2	2	1	2	2	2	1
6	2	2	2	2	2	2	2	2	1	1
7	1	1	2	2	2	1	2	2	2	2
8	1	1	1	1	1	1	1	1	1	1
9	2	2	2	1	1	1	1	2	1	2
10	2	2	2	2	1	1	2	2	2	2
KAPPA	1.0		.8		.6		.8		.6	
AGREEMENT	100%		90%		80%		90%		70%	

Table 11

**RAW SCORE ON FOUR ITEMS AND KAPPA BY COORDINATOR
(T₁) AND T₂**

ABBREVIATION:

Use of compound sentence=COM

Sentence length=SEN

Coordinator=Co

Grammar=GRA

Explaining, describing, exploring=EXP

Investigator=In

Subject	COM		SEN		GRA		EXP	
	T ₁	T ₂	T ₁	T ₂	T ₁	T ₂	T ₁	T ₂
1	1	1	1	1	1	1	1	1
2	1	1	1	1	1	1	1	1
3	1	1	1	1	1	1	1	1
4	1	1	1	1	1	1	1	1
5	1	1	1	1	1	1	1	1
6	1	1	1	1	1	1	1	1
7	1	1	1	1	1	1	1	1
8	1	1	1	1	1	1	1	1
9	1	1	1	1	1	1	1	1
10	1	1	1	1	1	1	1	1
KAPPA	1.0		1.0		1.0		1.0	
AGREEMENT	100%		100%		100%		100%	

Table 12

Kappa was also calculated between the scores of each item (T_1 and T_2) given by the coordinator (Tables 11 and 12). Kappa ranged between 1.00 to .80 except for the items "vocabulary" (.41) and "use of verb" (.52). The agreement ranged between 100% to 80% for all the items. Based on Kappa and agreement scores, it could be stated that the coordinator, as an independent observer was able to distinguish the difference between "poor" and "fair".

The rating scale was also compared by mean score. Though there were some differences in individual item scoring, the mean score of each item given by both of them for a total of 10 senior sample had a very little difference, mean score each item was calculated from a score of the ten senior sample. On the second day, seniors' oral skills were independently recorded by the investigator and the coordinator using the same rating scale. It was expected that no change of mean score in each item for the seniors would occur. Again, it was found that there was very little change of mean score on item "Articulation" and "Fluency" (difference of .10 to .20), but there was no change of mean score difference for other items (Table 13).

MEAN SCORE BY COORDINATOR AND INVESTIGATOR:T₁-T₂

Items	Coordinator		Investigator	
	Mean T ₁	Mean T ₂	Mean T ₁	Mean T ₂
Articulation	1.30	1.40	1.20	1.30
Fluency	1.40	1.50	1.50	1.50
Vocabulary Development	1.30	1.40	1.10	1.40
Use of simple sentence	1.40	1.50	1.50	1.60
Use of Verb	1.40	1.20	1.20	1.20
Use of compound sentence	1.00	1.00	1.00	1.00
Sentence length	1.00	1.00	1.00	1.00
Grammar	1.00	1.00	1.00	1.00
Explaining, describing, exploring	1.00	1.00	1.00	1.00

Table 13**Coordinator's Journal**

The coordinator recorded her weekly observations on the participants' oral English expression and team work. A total of nine observation records were entered in the journal by the coordinator. After the post test the investigator received the journal from the coordinator.

ETHICAL CONSIDERATION

To fulfil the ethical commitment, the information given to the participants was clear and non-threatening. (Appendix K). The data collection process was kept informal, but anonymity and confidentiality of responses were assured to all participants. The participants were free to join the study or to decline involvement at any stage of data collection. It was made clear to them that if they withdrew from the study, they still had the right to access any available educational, social, and recreational services. The proposal was submitted and received approval from the Ethics Committees of Michigan State University and McMaster University (Appendices L and M).

DATA COLLECTION

Rapport building was one of the most important components of the study. A main consideration of the project investigator and coordinator was to develop an attitude which would assist the participant to express him/herself freely. To develop rapport with the participants, the investigator explained the content and process of the educational program with the help of an interpreter.

The first session (four hours) was devoted to rapport building and explanation of the study and educational process. The students were asked to complete the instrument at the beginning of the second session (T_1). The next nine sessions were used for the self-supportive educational programme (Table 14).

If the participant was unable to read Chinese, the coordinator read each item for him/her and also provided assistance in recording the response. Care was taken to ensure that no suggestions were given to the participants by the coordinator.

SCHEDULE FOR EDUCATIONAL INTERVENTION

1 week	1 week	9 weeks	1 week
Rapport Building	Baseline Data (T ₁)	Educational Program	Final Evaluation and Data Collection (T ₂)

Table 14

The twelfth, and final session was spent with no predetermined agenda. It was an open information-sharing session for the learners and was facilitated by the coordinator and investigator. The participants were occupied with their thoughts and emotions of ending the session. The investigator and participants decided to wait for two days and came back for a two hour session for responding to the instrument a second time (Table 14).

CHAPTER IV

RESULTS AND DATA ANALYSIS

*"I shall ride the storm,
Tame the waves,
Slay the sharks.
I shall drive away the enemy
To save our people.
I shan't be content
With the customary fate of women
To bow their heads as concubines"
(Vietnamese Peasant Woman, 300 A.D., Source unknown).*

DEMOGRAPHIC CHARACTERISTICS

Twenty-seven seniors completed the educational programme. Of the 27 seniors 19 were men, eight were female. The demographic profile questions indicated respondents were: male 73% and female 27% (Appendix N), married 73% (Appendix O) and widower 27% (Appendix O), a low income earner — under \$500.00 per month (65%) (Appendix P) 31% earned \$1000.00 per month and only 4% earned \$ 1500.00 or over per month (Appendix P). Sixty-nine percent indicated that their monthly income was not sufficient to live comfortably (Appendix Q). The age categories were as follows: 60 to 69 years of age (52%), 70-79 (32%) and 50-59 (12%), only 4% were 80 or over (Appendix R). Forty-six percent had obtained an elementary school education, 31% received secondary school education, 12% attended junior college and 12% had attended college (Appendix S). Forty-six percent self-identify as of Chinese origin and 38% self-identify as Cantonese, for a total of 84% South East Asian origin. Sixteen percent of seniors are either from

Vietnamese (12%) or Malaysian origin (4%), who are also of South East Asian origin (Appendix T).

HEALTH ASSESSMENT QUESTIONNAIRE RESULTS

The Health Assessment Questionnaire was administered prior to the educational programme (T₁), and 13 weeks later, immediately after the programme (T₂).

The four clusters of items in Part II of the survey were health, happiness, self-confidence and loneliness (Table 4).

In the **health** cluster, items were asked both positively and negatively. On the positive side, the mean scores increased from 2.63 to 6.96 or 164.64% (Maximum score=10, increase of percentage = $\frac{x-y}{y} \times 100$) [Appendix U]. On the negatively phrased items the mean scores decreased from 31.15 to 18.27, representing a decrease in score of 41.35% (Maximum score=35, decrease of percentage = $\frac{x-y}{x} \times 100$) [Appendix V].

For the positively phrased items in the **happiness** cluster, there was a definite increase in the happiness level from a mean score of 32.889 to a score of 50.630, an increase of 53.94% (Maximum score=60) [Appendix W]. On the one item which was negatively phrased the mean score decreased from 3.19 to a mean score of 2.65 (Maximum score=5), representing decrease in score of 1.69%.

The **self-confidence** cluster also contains both positively and negatively phrased items. The score for the positive items (maximum score=15) recorded prior to the

educational programme was 7.424 and a post-educational programme score of 10.154 (an increase of 36.77%) [Appendix X]. For the negatively phrased items with a maximum score of 55, the mean scores decreased from 52.630 to 27.077 (48.55%) [Appendix Y].

For the **loneliness** cluster, the positively phrased items recorded a pre-educational programme score of 5.519 and a post-educational programme score of 12.852, of a maximum score of 15. This is an increase of 132.89% (Appendix Z). On the items phrased negatively, the respondents recorded a pre-educational programme score of 28.889 and a post-educational programme score of 13.815, a maximum score of 30. This demonstrated a decrease in negatively phrased responses of 52.17% (Appendix A1).

The data were tested for significance using paired t-tests in the health cluster, happiness cluster, self-confidence cluster and loneliness cluster. Health (positive and negative items) ($t_{25} = -16.65$ and 16.54 , respectively, and $p < 0.001$ for both), happiness (positive items) ($t_{25} = -19.53$, $p < 0.001$) and for negative items $t_{25} = 2.67$ ($p < 0.01$), self-confidence (positive and negative items) ($t_{25} = -11.75$ and 31.51 , respectively, and $p < 0.001$ for both), and loneliness (positive and negative items) ($t_{25} = -19.61$ and 31.65 , respectively, and $p < 0.001$ for both), were statistically significant (Table 15).

On the pre-test low self-esteem and perception of poor health clusters, high scores were registered for the "negative" items, and low scores in the "positive" items. The positive feelings of the seniors increased from 48.333 (mean) to 80.346 (mean) [out of a maximum of 100] on the scale. This was an increase of 66.23% (Appendix

B1). The negative feelings of the seniors fell from 115.33 (mean) to 62.385 (mean) (out of a maximum of 125) on the scale. This represented a drop of 46% (Appendix C1) [Table 16]. Since one of the seniors did not complete all questionnaire items, the Mean score was calculated based on 26 seniors instead of 27 seniors. The rationale for excluding the score of the twenty seventh senior was because it was necessary to use equal size groups for comparing the mean score before and after the educational programme.

With the maximum possible positive score to be 100, it was found that the females were generally more satisfied than the males (scores of 53.6 and 46.1, respectively) before the programme (T_1). After the programme (T_2), these scores were 85.143 and 78.579, respectively (Appendix D1). It was also found that before the programme, females had more negative feelings than males (scores of 123 and 112.11) respectively. However, after the educational programme, the females' negative feelings dropped more than those of the males to levels of 63.429 and 62, respectively (Appendix E1 and F1) [Table 17].

For the marital status group, it was found that a married senior was more likely to be satisfied than a widower before the educational programme period, with scores of 51.25 and 40, respectively. The difference in scores decreased after the educational programme, with the married seniors recording a satisfied score of 81, while the widower seniors recorded 78.61.

POSITIVE AND NEGATIVE ITEMS CLUSTERS :-**HEALTH, HAPPINESS, SELF-CONFIDENCE AND LONELINESS**

ITEMS	PAIR-T TEST	P-VALUE
Health		
Positive Items (n=2)	$t_{25} = -16.64$	$p < 0.001$
Negative Items (n=7)	$t_{25} = 16.54$	$p < 0.001$
Happiness		
Positive Items (n=12)	$t_{25} = -19.53$	$p < 0.001$
Negative Item (n=1)	$t_{25} = 2.67$	$p < 0.01$
Self-confidence		
Positive (n=3)	$t_{25} = -11.75$	$p < 0.001$
Negative (n=11)	$t_{25} = 31.51$	$p < 0.001$
Loneliness		
Positive (n=3)	$t_{25} = -19.61$	$p < 0.001$
Negative (n=6)	$t_{25} = 31.65$	$p < 0.001$

Table 15

**T₁-T₂ SUM AND MEAN SCORES OF SATISFACTION AND
DISSATISFACTION USING ALL FOUR CLUSTER ITEMS**

POSITIVE FEELINGS: (Satisfaction)	No. of seniors	Sum	Mean
T₁	26	1257	48.333
T₂	26	2089	80.346
NEGATIVE FEELINGS: (Dissatisfaction)			
T₁	26	2999	115.33
T₂	26	1622	62.385

Table 16

During the educational programme period, the widowers gained an average of 8.76 more than the married seniors.

It was found that the seniors with only elementary school education were the most satisfied, recording a pre-test score of 53.385. This was well above those in the other education levels on the pre-test; the seniors with junior high school education, secondary and college education recorded scores of 40, 44.75, and 44.33 respectively. That profile changed, after the educational programme. The elementary-educated then recorded a post-test score of 83.917, the junior high-educated recorded 73.662, the secondary-educated recorded 79.625, and the college-educated recorded 74.667.

T₁ - T₂ TOTAL AND MEAN SCORE (POSITIVE ITEMS OF FOUR CLUSTERS)

VARIABLES	BEFORE PROGRAMME SATISFACTION		AFTER PROGRAMME SATISFACTION	
	Total Score	Mean Score	Total Score	Mean Score
Gender				
Male	876	46.11	1493.02	78.58
Female	378	54.00	595.98	85.14
Marital Status				
Married	974	51.25	1539.00	81.00
Widower	280	40.00	549.99	78.61
Education				
Elementary	640	53.39	1007.40	83.92
Junior High	120	40.00	221.01	73.67
Secondary	358	44.75	637.04	79.63
College	132.99	44.33	224.01	74.67
Age				
50-59	120.99	40.33	240	80.33
60-69	686.98	49.07	1063.01	81.77
70-79	403.04	50.38	629.04	78.63
Over 79	46.00	46.00	74.00	74.00

Table 17

The seniors found to be most content before the programme were between the ages of 70 to 79. They recorded a pre- programme score of 50.375. Scores recorded by the other groups were: 40.33 recorded by the 50 to 59 age group, 49.07 recorded by the 60 to 69 age group, and 46 recorded by the 80 and over age group. After the educational programme, the 60 to 69 age group was found to be the most content, with a score of 81.76, then the 50 to 59 age group was next with 80.33, followed by the 70 to 79 age group with 78.625, and finally, the 80 and over group, with a score of 74.

ORAL EXPRESSION RATING SCALE RESULTS

The participants' language capability was rated using the Oral Language Expression Scale. The questionnaire was completed by the coordinator before the English Language Programme (T₁), and after the end of the English Language Programme (T₂). The variables for the Oral Language Expression Questionnaire included: Articulation; Fluency; Vocabulary Development; Use of Simple Sentences; Use of Verbs; Use of Compound Sentences; Sentence Length; Grammar; and Explaining, Describing, Exploring Ideas and Thoughts.

These variables provided a means by which to determine which, if any, aspects of language seemed to be influenced by the educational programme.

A bar graph (Appendix G1) was drawn in order to show the differences in language ability from pre to post test. The graph plot was based on the mean value of the answers of the questionnaire on that particular variable at the pre test (T₁)

phase, and subsequently, was paired on the graphic presentation with its corresponding value for the post test (T_2). This method was used for each item to provide a graphic representation of the possible influence of the English language programme on the aspects of language. The sample was divided into male and female groups. There were 19 male and eight female subjects. The separate male and female scores were calculated in order to find a relation between the results for male and female subjects (Appendices H1 and I1).

The overall objective was to find which variable (aspect of language) presented the most "positive" change, in terms of the highest statistical significance. For **articulation** it was noted that the difference in means between T_1 and T_2 was 0.4077 (i.e. T_1 mean was less than T_2 mean by 0.4077). The **Fluency** variables had a mean difference of 0.2226; **Vocabulary Development** had a mean difference of 0.4448. The mean differences of other variables were as follows: **Use of Compound Sentences** (mean difference = 0.0000), **Sentence Length** (mean difference = 0.0000), **Use of Simple Sentences** (mean difference = 0.0741), **Use of Verbs** (mean difference = 0.1115), **Grammar** (mean difference = 0.0741). The variables **Explaining**, **Describing**, **Exploring** had a mean difference of 0.0000 (Table 18).

The differences in the scores can be seen in the graphic presentation (Table 19). Large differences in the means for the values at T_1 and T_2 can be seen. Slight differences in such means as indicated on the graphic presentation are also apparent. As for the graphic presentations (Appendices H1 and I1), one could examine these graphs and look for any significant differences in the mean differences of each variable for these graphs.

**TOTAL SCORE AND MEAN SCORE OF NINE ITEMS BY COORDINATOR
(T₁) AND T₂**

ABBREVIATION:

Articulation=AR
Vocabulary Development=VO
Use of Verbs=VER
Grammar=GRA
Use of compound sentence=COM
Explaining, describing, exploring=EXP

Fluency=FL
Use of simple sentence=SIM
Sentence length=SEN

Items	Total Score T₁	Mean Score T₁	Total Score T₂	Mean Score T₂	Mean Difference
AR	37	1.379	48	1.777	.4077
FL	38	1.407	44	1.629	.2226
VO	37	1.370	49	1.814	.4448
SIM	33	1.222	35	1.296	.0741
VER	38	1.407	41	1.518	.1115
SEN	34	1.259	34	1.259	.0000
GRA	37	1.370	39	1.444	.0744
COM	32	1.185	32	1.185	.0000
EXP	33	1.222	33	1.222	.0000

Table 18

**TOTAL SCORE AND MEAN SCORE OF ALL NINE ITEMS BY GENDER
BY COORDINATOR**

ABBREVIATION:

Articulation=AR
 Vocabulary Development=VO
 Use of Verbs=VER
 Grammar=GRA
 Use of compound sentence=COM
 Explaining, describing, exploring=EXP

Fluency=FL
 Use of simple sentence=SIM
 Sentence length=SEN

Items	Total Score T ₁		Mean Score T ₁		Total Score T ₂		Mean Score T ₂	
	Male	Female	Male	Female	Male	Female	Male	Female
AR	28	9	1.4799	1.1250	40	8	2.1053	1.0000
FL	29	9	1.5263	1.1250	32	12	1.6842	1.5000
VO	29	8	1.5263	1.0000	38	11	2.0000	1.3750
SIM	25	8	1.3158	1.0000	27	8	1.4211	1.0000
VER	30	8	1.5789	1.0000	33	8	1.7368	1.0000
SEN	26	8	1.3684	1.0000	26	8	1.3684	1.0000
GRA	29	8	1.5263	1.0000	31	8	1.6316	1.0000
COM	25	8	1.3158	1.0000	29	8	1.6111	1.0000
EXP	25	8	1.3158	1.0000	29	8	1.6111	1.0000

Table 19

NARRATIVE ANALYSIS OF THE JOURNAL

The narrative analysis of English as a second language was also based on the programme coordinator's weekly journal. Before the programme, only a few men from the group of participants used English consistently. These men used very little English, mostly of monosyllables with nonverbal gesture (e.g. "I bathroom", "I eat"). None of the seniors could read or write the English alphabet. After the completion of the programme, all of the men could express simple ideas by using multiple words, but were unable to use properly formulated sentences. All of the men were able to write their name and the date. Only 46% of the women could write their name and the date. Seventy six percent of the women could express their thoughts by using few words, and more nonverbal gestures. They used single words, mostly nouns (e.g. dog, bathroom, house). Verbs and pronouns were not usually used by either gender. "Thank you", "Welcome", "Good Afternoon", "Goodbye", "See you" were frequently used.

Before the programme, nodding and smiling were expressed as acceptance of opinion or ideas discussed in the group. By the end of the programme, "yes", "good", "O.K.", "No" were added with the nodding of head and a smile, to express their agreement or disagreements of the group's views. Men were more vocal than women and were less hesitant to express their ideas in English. Twenty percent of the men were able to formulate a single sentence (e.g. "I go vacation", "It is very cold", "I am happy"). The programme coordinator established the rule that no conversation would take place in Chinese during the English session. Initially, women

were quiet during the first two sessions. They preferred to communicate in Chinese, which was not encouraged by the coordinator. On the third session, as the participatory activities began, women started to use simple English words. Use of English increased as both men and women felt more comfortable within the group. They accepted each other when mistakes were made by a group member. Peer support and encouragement were noticeable within the group. By the sixth week, more different words were used. Most of the men started to formulate sentence with verbs (eg. "It is fun", "I teach you"). All sessions were flexible and conversation in English was encouraged by the investigator and the coordinator. Once the seniors felt more comfortable with each other, and were better able to express their thoughts and feelings in English, it appeared that they realized that they had some control over the topic (content of the session), group activity and interaction process related to the programme. They became less conscious about their mistakes in learning English. They were more interested in communication and interaction with others.

ANECDOTAL NOTES

The following anecdotes were recorded by the coordinator:

♦ Anecdote I:

One evening the coordinator was invited to dinner by the seniors at the home of one senior. The host lived with three unmarried children in their forties who joined the seniors for dinner on their arrival home from work. While the coordinator was talking to one of the daughters of the host senior in the kitchen after the meal,

the phone rang. Automatically, the coordinator stopped her conversation, pointing out to the daughter that the phone was ringing. In her previous experience elderly members of their community never answer the phone because it was never for them, always for the children or grandchildren. Besides, the seniors felt inhibited to pick up the phone as they were unable to speak in English.

"Oh," the daughter said with a wave of her hand, "it will be for my mother, anyway". The coordinator asked the daughter with some surprise if her mother had a lot of friends.

"Oh, yes," she said, "since she started going to the seniors educational programme".

♦ **Anecdote II:**

Just after the completion of the educational programme the coordinator was in Chinatown in Toronto, Ontario. She met an old friend who had sponsored his father some five years ago. In the meantime, he had married and moved to Toronto. During the conversation the friend told her:

"I have asked my father to move to Toronto and live with me, but he will not leave Hamilton. He says it is more fun in Hamilton, I have lots of friends and they are old like me".

♦ **Anecdote III:**

The last day of the educational programme the seniors asked the coordinator if they could continue the weekly gathering among themselves. As days went by, the number of seniors who participated grew from 30 to 40. There has been a marked increase in contact among the seniors outside of the weekly meetings. For example, dinners in the restaurants and homes have been held to mark special events in

people's lives and simply to get together and enjoy each other's company. Events like weddings, birth and birthday parties in the extended families have become occasions when the grandparents would invite a number of their friends. In the past, it was unusual for the seniors to have friends of their own in the new country-Canada. On one occasion, where a family was not well-versed in cultural customs and the proper way of doing things, members of the seniors took on the role of cultural experts in planning and carrying out of the traditional Chinese wedding ceremonies. Most of all they have developed a self support group and started to take care of each other rather than depending on their children.

When the seniors were asked "what did you gain most from this educational programme", mostly men and few women responded that they have created their roles as experts among the younger generation on maintaining cultural rituals and customs for the Canadian of South East Asian origin. They have begun to develop a self support group independent of Provincial and Federal Government funding. They have started an exercise programme for seniors, and started to take care of each other rather than depending only on their children.

CHAPTER V

SUMMARY, ANALYSIS OF FINDINGS, CONCLUSIONS, RECOMMENDATIONS AND REFLECTIONS

*"I laugh when I hear that the fish in the water is thirsty.
You don't grasp the fact that what is most alive of all is
inside your own house; and so you walk from one holy city
to the next with a confused look!
Kabir will tell you the truth: go wherever you like, to
Calcutta, or Tibet;
if you can't find where your soul is hidden, for you the
world will never be real!" (Kabir) [Unknown Source].*

SUMMARY

Educational and Health care policies in Canada are based on the principle of universal accessibility. With this principle everyone has an equal right to access and receive educational and health services regardless of age and ethnicity.

In spite of being part of the mainstream (dominant group), a large number of seniors suffer from ageism and have difficulty in accessing available services. Seniors from non-European backgrounds are confronted with double barriers: ageism and racism. Those seniors who are from non-European culture and non-English speaking are more vulnerable than any group of seniors.

This study was aimed at exploring the effectiveness of a culturally sensitive, self-directed and self-supported educational programme for the selected population. The purpose of the programme was to increase self-confidence and alleviate social

isolation among a selected group of senior, South-East Asian immigrants by providing a self-directed, self-supportive educational programme.

In this study a descriptive design employed: the independent variables include the subjects' gender, age, ethnic origin, marital status, language, education, income, financial status. The dependent variables were perception of health, self-confidence and loneliness, and ability to speak English.

Participants included 27 seven seniors. They are all located in Hamilton, Ontario, and they immigrated from Vietnam within the last five years. All spoke Chinese and resided in apartment buildings in downtown Hamilton. Two questionnaires were developed and tested for face and content validity and reliability for this study. The health assessment questionnaire was developed to measure the perception of health, self-confidence, happiness and loneliness. Bader's (1993) oral language expression rating scale was modified to measure the seniors' ability to speak English. In addition, a weekly journal was kept to record the progress of individual seniors' ability to speak English and their group interaction.

The demographic profile questions indicated respondents were: male 73%, married 73%, a low income earner - under \$500.00/ month 65%, and Chinese origin 100%. Forty six percent of seniors had obtained an elementary school education (46%).

The results of the study were tested by using paired t-test to compare changes in health, happiness, self-confidence and loneliness before and after the educational program. Health (positive and negative statements) ($t_{25} = -16.65$ and 16.54 , respectively, and $p < 0.001$ for both), happiness (positive statement) ($t_{25} = -19.53$, p

< 0.001), self- confidence (positive and negative statements) ($t_{25} = - 11.75$ and 31.51 , respectively, and $p < 0.001$ for both), and loneliness (positive and negative statements) ($t_{25} = - 19.61$ and 31.65 , respectively, and $p < 0.001$ for both), were statistically significant.

ANALYSIS OF STUDY QUESTIONS

According to Beckingham, Dugus (1993), seniors face social problems such as low self-esteem and social isolation. Stephenson in his study, found that the Vietnamese and Chinese appeared to have some of the "symptoms associated with depression, insomnia, sorrow, loss of appetite" (Stephenson, 1992, p. 4). He further stated that the majority of the Vietnamese reported being very sad and many had difficulty sleeping. Insomnia was highly associated with recent arrival and increasing age.

Generally, at the beginning of the educational programme of this study, the Vietnamese seniors reflected some of the most basic findings in the literature as mentioned in Chapter 1, such as: lower self-esteem, perception of own health status and high social isolation and loneliness. The following summarized statements are based on the study findings and organized around the study questions.

What is the demographic background of the study population?

The demographic profile questions indicated respondents were: male (75%), married (73%). The only income for many of them was the Canada pension plan (\$500.00/ month). Fifty five percent of the seniors were from 60 to 69 age group and

46% of them had obtained an elementary school education. All of them were from Chinese origin.

What is the prevalence of perception of poor health among the selected participants?

In this study, there were four items of demographic data that were found to be of statistical significance. These items were age, gender, education and marital status. In general, the breakdown of these items determined that the poor health was still quite prevalent. Specifically, when analyzed by marital status, the widowers were generally dissatisfied more than the married seniors. One can say that this is not surprising, as the widowers would feel more stress with the loss of their wife. By gender group, the males were dissatisfied more often than the females. One could speculate as to whether this would remain true if the male widowers didn't come into play. The additional stress placed upon these particular males might statistically make the entire group more dissatisfied and have poorer perception of health than the female group.

Generally, on the date (pre-educational) of this study, the Vietnamese seniors reflected some of the most basic findings in the literature: [After the Door Has Been Opened (1988), Majumdar (1990), Beckingham & DuGar (1993), Masi (1988), Hamilton-Wentworth District Health Council (1990), Graham (1988), The National Advisory Council on Aging (1993)] lower self-esteem, perception of own health status and high social isolation and loneliness.

Beckingham and DuGas (1993) stated many Canadian seniors face social problems, such as low self-confidence and low self-esteem which may lead to

depression and loneliness. It has been established by various studies (Pham, 1986; Buchwald, Spero, Manson, Norman, Dinges, Ellen, Keane, Msph, 1993; Lin, Ihle, Tazuma, 1985; Lin, Carter, Kleinman, 1985; Lin, Tazuma, Masuda, 1979; David, 1970; Kojak, 1974; Fried, 1964; Reusch, Jacobson, Loeb, 1948) that due to extreme difficulties in adapting to a new socio-cultural environment, mental health problems (depression, anxiety, and low self esteem) of the South East Asian population in North America is one of the challenges for the health care professional. Therefore it could be said that the findings of this investigator are similar to the findings of other researchers in the Canadian senior and particularly in the South East Asian senior population.

By education, the subgroup having only elementary school education was the most satisfied, well above the other subgroups. This might be due to the fact that since that subgroup has only elementary school education, they might have lower expectations from life in general, so they were more content in that regard. Finally, by age group, it was found that the 60 to 69 age group seniors were most dissatisfied about their health status.

Overall, the pattern that emerges is the prevalence of poor health and is evident when one looks at the individual correlations between the groups and subgroups, and how different circumstances contribute to this health state.

What is the prevalence of happiness, low self-confidence and loneliness among these selected participants? (Study Questions 3, 4 and 5)

The perception of low self-confidence and loneliness was quite prevalent in the sample. By examining the scores before the educational programme, the seniors

were scoring high on the negative statements related to self-confidence and loneliness, and low on the positive statements on self-confidence and loneliness. The seniors were scoring close to the maximum negative score in almost every cluster, particularly in the loneliness cluster, where the total score on the negatively-asked items was 28.889 out of a maximum 30. It was evident that there was a prevalence of perception of loneliness among the seniors.

What is the difference of pre and post test measures of English speaking ability for the selected participants who have received the culturally sensitive self-directed educational programme? (Study Question No. 6)

It was originally thought that the seniors would have great difficulty in gaining English language expression skills, since some of whom illiterate in their own language. However, a desire to learn, with the hope of gaining better access to social, health and recreational services may have motivated the seniors to learn English quickly. In this way, the desire to learn gained in strength.

Some observations could be drawn from the analysis. Males and females responded differently to the language programme. **Vocabulary Development** was significantly improved for both, but the female participants had a significant improvement in **fluency**, whereas the male participants seemed to have a significant improvement in **articulation**. It was quite possible that the male participants were more susceptible to the language programme, since there were slight to large changes in values of almost all the variables, whereas most of the variable values for the females remained quite consistent (Appendices H1, I1, and J1). Overall, the language programme might appear to have a positive impact on the participants.

Based on anecdote reports, it also appears that the language programme had an impact on the participants. Most of the variable values (as indicated on Appendix H1) underwent at least a small (perhaps insignificant) change. One could conclude that the language programme was successfully implemented. As one of the 82 year old seniors said " I couldn't write my name in Chinese, but now I can write my name in English".

What are the differences in pre and post test measures of perceptions related to health, feeling of happiness, self confidence, and loneliness for those selected participants who have received the culturally sensitive self-directed self-supported educational programme? (Study Question No. 7)

Overall, a significant increase in positive feelings (in respond to positive cluster items) was shown, as well as a similar decrease in negative feelings (in respond to negative items) was found. To examine the reasons for these findings, one may consider that there could be a positive effect of the educational programme on the seniors towards their positive perception of health status, feelings of happiness, increased self-confidence and less loneliness.

It is difficult to isolate the feeling of happiness, since the other feelings such as loneliness can be related to happiness. For example, if a senior is less lonely, he or she may be happier. The same can be said about the other two "clusters" (self-confidence and health status) when related to feelings of happiness. For the loneliness "cluster", a large decrease was seen in the lonely feeling scores, while the "not-lonely" scores rose in a similar manner. The senior sample felt more "belonging", and perhaps a sense of pride to belong to their senior group. This

"feeling of belonging" sense among the seniors may have provided them with a feeling of comfort to share their thoughts and needs to each other. This, in effect, dissipated the loneliness, and perhaps created new friendships. The self-confidence variable showed a similar effect from less confidence to more confidence. The self-confidence level of the seniors rose considerably, while the insecurity level (negative self-confidence question responses) dropped. It may be said that after the educational programme the seniors felt assured that they actually had a place in life, that they really do belong to something, that they are capable to give some knowledge (customs and rituals) to their younger generation. This assurance may have brought a feeling of self-confidence among the seniors and they felt eager to think about the fact that they are cared for, that they have their own identity. Finally, the perception of health, like happiness, may simply be a general result. It is known that less stress is beneficial to one's health. The diminishing of the negative feelings such as less self-confidence or loneliness, caused stress to decrease, and thus, health improved. Some effects of this are the gaining in appetite of the senior sample and more restfulness.

To **conclude**, it could be said that the perception of poor health might have been effected by a lack of self-confidence, feeling of loneliness and a needed sense of belonging, which is a sense that all immigrants (as well as all persons), need the most. After the educational programme, it has been noticed that the seniors identified less feeling of isolation and loneliness, and perception of better health.

CONCLUSIONS

The influence of modernization affects the lifestyle of every individual, especially in a country such as Canada, having a large immigrant population, with diverse culture and origins. Culture, education and health are inter-related. According to Borremans (1978), there are many different concepts of *health*, that is, as many as there are cultures and sub-cultures. It is an error of modern civilization to assume that there is only one concept of health - a universal health which is given in the form of health services and imposed on *all* people. Hence, the first step of any health service should be an understanding of the health culture of the society by the health professionals.

Peoples' health needs depend on their health culture, perception of health, religion, socio-economic condition, and most of all, their education and attitude towards life. Therefore, it can be said that to improve the health of an individual, it is necessary that people determine their own needs and health professionals understand the individual's needs and priorities.

In Canada, approximately 10.7% of the population are seniors, many of which are from a diverse population and belong to minority populations. The majority of seniors from minority populations have little education and ability to communicate in English or French. It can not be denied that ethnic seniors face multiple barriers in accessing culturally sensitive health services in Canada (Canadian Government Publishing Centre, 1984; After the Door Has Been Opened, 1988; Naidoo, 1989; Head, 1989; Ralph, 1989).

It has been established by various studies (Pham, 1986; Buchwald, Manson, Dinges, Keane, Kinzie, 1993; Lin, Ihle, Tazuma, 1985; Lin, Carter, Kleinman, 1985; Lin, Tazuma, Masuda, 1979) that mental health problems of the South East Asian population in North America is one of the challenges for the health care professional. Extreme difficulties in adapting to a new socio-cultural environment have long been recognized (David, 1970; Kojak, 1974; Fried, 1964). Mental health problems such as depression, anxiety, and low self esteem have been observed to be more prevalent in immigrants (Nguyen, 1982; Eyton, Neuwirth, 1984; Tyhurst, 1951).

According to Barsky (1979), "somatization" is more common among those who are less educated, of lower socio-economic status, and among ethnic groups that discourage the direct expression of emotional distress. Culture shapes the perception and expression of distress (Lin, Ihle, Tazuma, 1985). Kleinman (1982) found that Chinese patients express depression and other psychological problems using somatic idioms: for example, "*I have a headache.*" rather than "*I am sad.*"

An independent investigation (Lin, Ihle, Tazuma, 1985) among Vietnamese refugees indicated a high prevalence of depression (approximately 50%). Therefore, findings in this study have re-established the mental health problems of the South East Asian population who are from low socio-economic backgrounds, and have low education.

Several investigators (Phem, 1986; Lin, Ihle, Tazuma, 1985; Lin, Carter, Kleinman, 1985; Lin, Tazuma, Masuda, 1979) found that a culturally sensitive educational programme improves physical and mental health, increases self-confidence and motivation to explore various resources and decrease loneliness and

isolation. In this study, the seniors showed the improvement in their health after the educational training and also increased their self-confidence. Based on the anecdote notes, it appears the seniors have begun to access their own community group members.

RECOMMENDATIONS

One of the major implications of this study was the need to gather baseline health data for the seniors from the minority population in Canada. The focus of such research should be on the socio-culture patterns, educational backgrounds, religions, attitudes towards the aging process, structure of the specific community, perception of those in the community regarding their health problems, their responses to resolving health problems, exploration of local community resources and their "leaders" position in respect to traditional versus modern health care and the willingness to be involved in the mainstream health care system.

Health beliefs and practices of the minority senior population need to be explored through vigorous research. Educators and health professionals should have more knowledge of their clients' and learners' beliefs and practices in order to develop a community-oriented education and health care systems.

Development and training of local community members will assist in reducing the cost of educational and health care and increase senior benefits. Therefore, seniors and community leaders should be given short courses so that they can assist the community to participate in the development and implementation of the educational programmes for the seniors. Through such programmes, the ethnic seniors can examine their lifestyle and their own needs in order to become independent citizens.

On the basis of the findings, the following recommendations are made:

- A similar study could be conducted on a larger sample of South East

Asian seniors at local, regional, provincial and federal level.

- **Comparative study could be conducted between:**
 - recent immigrants and citizens from the South East Asian population
 - high and low socio-economic groups
 - those with higher formal educational background and those with little or no formal education.
 - those settled in rural and those settled in urban areas
- **A study could be done to compare the opinion of educators and health care providers on their knowledge, skills and attitudes related to culturally sensitive practice.**
- **Longitudinal follow-up study could be done on the effectiveness of the culture-sensitive educational programmes.**
- **A similar study could be done with the South East Asian younger generation in educating them to understand that their parents have adopted to the Canadian life style by increasing their self-confidence and decreasing feeling of loneliness.**
- **A similar study could be done with seniors from other visible minority groups.**

REFLECTIONS

In this study, all educational sessions were based on experiential method. This study has shown that the participatory research method is effective with ethno-

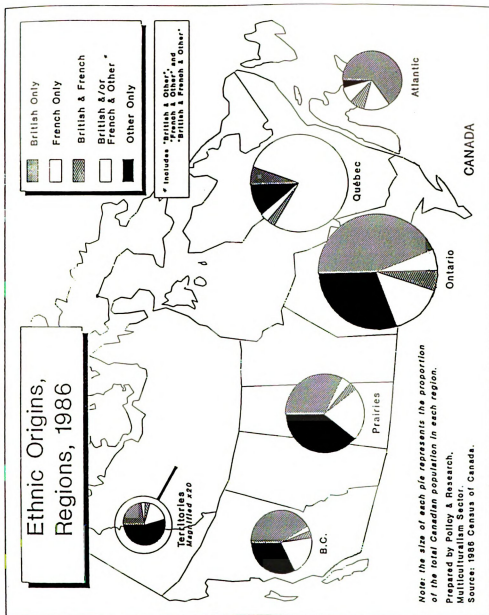
cultural groups who are usually not accustomed to such techniques.

As the study progressed the investigator started to notice that seniors were becoming independent and were getting comfortable to express their opinions. They were negotiating with the coordinator related to the class agenda and social activities with their sons and daughters. They started to plan social activities with their peers during the week ends. The investigator noticed that their children were not comfortable with their parents' feeling of independence. Some of the seniors also expressed that they were experiencing family stress due to such changes.

It was also evident that family pressure did not stop these seniors. By the end of the programme they started to meet every week by themselves. They rented a room in the neighbourhood. They recruited more seniors as their self-help group continue to grow. They invited guest speakers from the community to learn more about the social and health care resources and Canadian policies related to job opportunities. To be part of the Hamilton Wentworth community, they started to attend the community meetings at the local City Hall.

As they were becoming more adopted to the Canadian life style, they started to realize that their children have not accepted this change which has caused some family conflicts. The children have expressed that their parents have become too "Canadianized and independent." The seniors felt "we don't want to be burden to our children". It was clear to the investigator that the children needed an educational programme to change their own beliefs and behaviour to acknowledge their parents' change of life style for maintaining the "harmony" of their extended family life.

APPENDICES

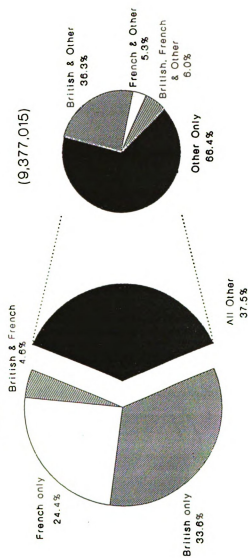


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Department of Multiculturalism and Citizenship, 11/19/92

Appendix A

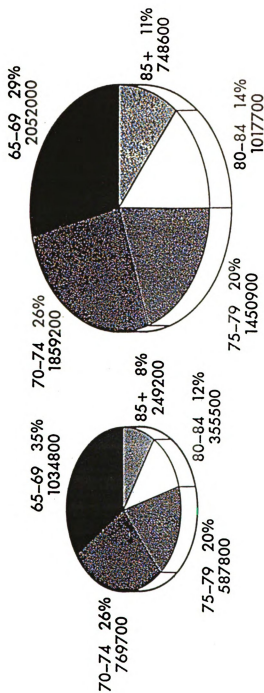
Ethnic Origins, Canada, 1986

Total Population
(25,022,005)



Prepared by: Policy & Research,
Multiculturalism Sector.
Source: Census of Canada, 1986

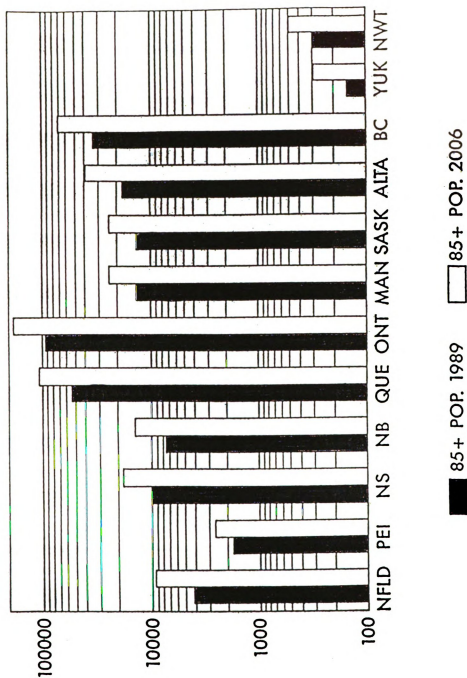
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Mid-range projections

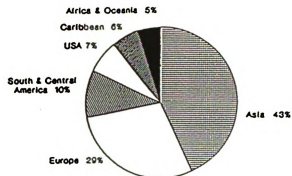
Source: Stat. Can. Cat 91-520, from Health and Welfare Canada: Report on Home Care, 1990, Ottawa: Minister of Supply and Services Canada

p. 7

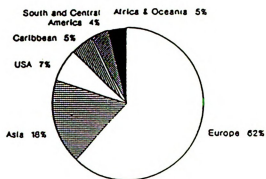


Source: Stat. Can. Cat 91-520, from Health and Welfare Canada: Report on Home Care, 1990, Ottawa: Minister of Supply and Services Canada
p. x

Immigrant Population by Place of Birth, Canada, 1986



Persons Entering From 1981-1986

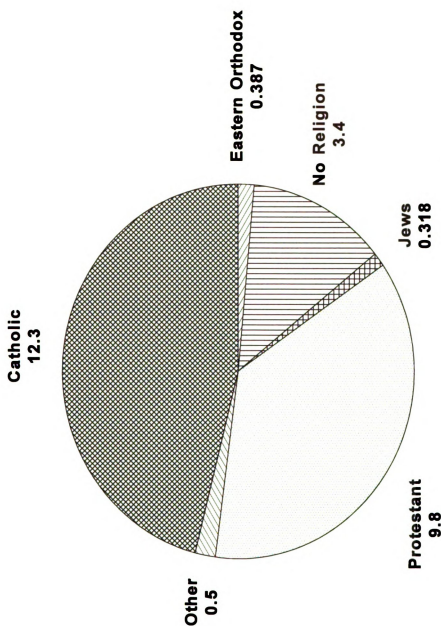


All Persons Born Outside Canada, 1986

Prepared by Policy & Research,
Multiculturalism Sector.
Source: 1986 Census of Canada.

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Department of Multiculturalism and Citizenship, 11/19/92

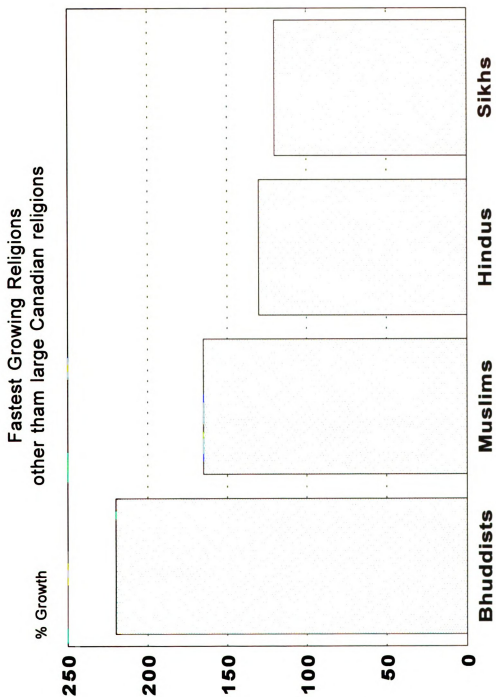
Appendix E



Sources: Globe & Mail, Toronto, dated June 2, 1993 and
Statistics Canada

Religion in Canada

Numbers in Millions



Sources: Globe & Mail, Toronto, June 2, 1993
and Statistics Canada

**Demographic Data:
Health Assessment Questionnaire**

1. ☐ **Male** ☐ **Female**

2. **Age** ☐ 50-59
☐ 60-69
☐ 70-79
☐ Over

3. **Ethnic Origin**

4. **Marital Status**

☐ Single ☐ Married
☐ Divorced ☐ Separated
☐ Widowed/Widower

5. **Language**

6. Education

- ☐ Elementary School
- ☐ Junior High School
- ☐ Secondary School
- ☐ College
- ☐ University

7. Family Income

- ☐ 500/month
- ☐ 100/month
- ☐ 1500/month
- ☐ 2000/month
- ☐ Over/month

**8. Household
(Occupants)**

- ☐ Self
- ☐ Spouse
- ☐ No. of sons
- ☐ No. of daughters
- ☐ No. of grandchildren
- ☐ No. of friends

9. Financial Status

- ☐ Not sufficient
- ☐ Sufficient
- ☐ More than sufficient

**Health Assessment Questionnaire
With Positive and Negative Items**

**1 = Never
2 = Seldom
3 = Usually
4 = Often
5 = Always**

I am content with my life at the present time

1 2 3 4 5

I am happy in my home

1 2 3 4 5

I am happy with my family

1 2 3 4 5

Life is hard for me

1 2 3 4 5

I feel that life is worth living

1 2 3 4 5

My life is full of things that interest me

1 2 3 4 5

I still enjoy doing things I used to do

1 2 3 4 5

I look forward to coming events

1 2 3 4 5

I have as much energy as I had last year

1 2 3 4 5

I can sit and feel comfortable and relaxed

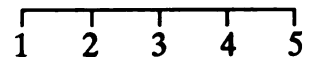
1 2 3 4 5

I can laugh at the funny things in life

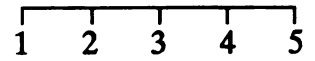
1 2 3 4 5

Appendix I

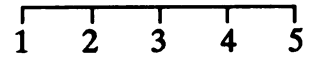
I have someone that I trust and confide in



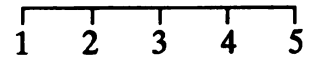
I am as happy now as when I was younger



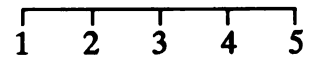
I have enough friends



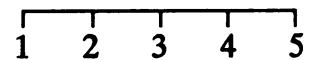
I see my friends as often as I want to



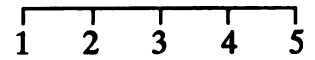
I feel lonely



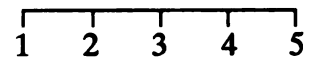
I feel bored, there is nothing to do



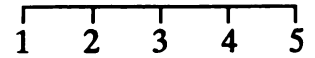
I have many things to be sad about



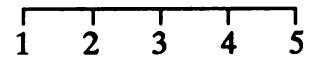
I feel happy and cheerful



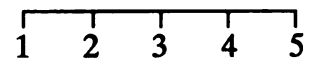
I feel useless



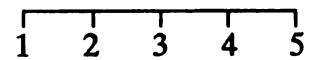
I am too old to do anything



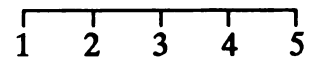
When I am with people I still feel lonesome



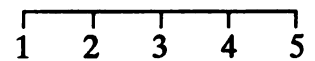
Little things bother me



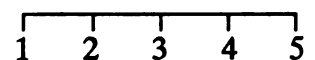
I get angry at things that are not important



I worry so much I can't sleep properly



I get sudden feelings of panic



I get upset easily with other people

1 2 3 4 5

I feel afraid

1 2 3 4 5

I have difficulty deciding what to do

1 2 3 4 5

I worry about possible misfortunes happening

1 2 3 4 5

I feel that no one understands me

1 2 3 4 5

Life becomes more difficult as I get older

1 2 3 4 5

I am capable of taking part in activities

1 2 3 4 5

I feel self confident

1 2 3 4 5

I feel I am in good health

1 2 3 4 5

I tire easily

1 2 3 4 5

My physical disabilities limit my activities

1 2 3 4 5

My eyesight limits my activities

1 2 3 4 5

My hearing limits my activities

1 2 3 4 5

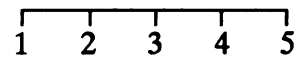
I am troubled by my headaches

1 2 3 4 5

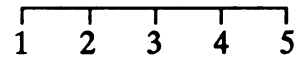
I am troubled by shortness of breath

1 2 3 4 5

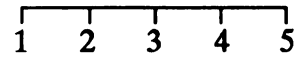
I am troubled by my heart pounding



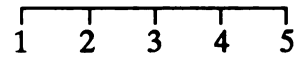
I have a good appetite



I wake up fresh and rested



My sleep is restless and distributed



Oral Language Expression Rating Scale

1 = Poor
2 = Fair
3 = Moderate
4 = Good
5 = Excellent

1. Articulation

1 2 3 4 5



Observer's Comments:

2. Fluency

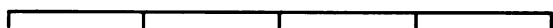
1 2 3 4 5



Observer's Comments:

3. Vocabulary Development

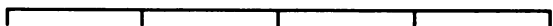
1 2 3 4 5



Observer's Comments:

4. Use of simple sentences

1 2 3 4 5



Observer's Comments:

5. Use of Verbs

1	2	3	4	5

Observer's Comments:

6. Use of compound sentences

1	2	3	4	5

Observer's Comments:

7. Sentence Length

1	2	3	4	5

Observer's Comments:

8. Grammar

1	2	3	4	5

Observer's Comments:

9. Explaining, describing, exploring

1	2	3	4	5

Observer's Comments:

Consent Form

Participation Consent Form (South East Asian Clients)

I, _____ hereby consent to participate in the study on "**The Effectiveness of a Culturally Sensitive Educational Programme on Self-Perception of Physical and Mental Health and Self-Confidence in Minority Group Seniors**". I am aware of the details of the study as explained to me by Basanti Majumdar.

I will be asked to complete questionnaires twice asking about me.

I understand that I may withdraw from the study at any point even after giving consent and I understand that this can be done without penalty.

I understand that all information supplied by me will be confidential and my name will not be identified on the data collection sheet nor in the study report.

I understand that my response will not in any way have an impact on the care I have been or will be receiving in and my accessibility to health care and social service systems.

I understand that I will be asked to attend a three hour educational programme every Saturday or Sunday for twelve weeks. There will be various topics for discussions and one of the topics will be English as a second language.

I also understand that there will be various activities such as field trips. I may withdraw from these activities at any point.

I will keep a copy of the consent form as a reminder. If I have any questions, I may call Basanti Majumdar at McMaster University, PHONE: (905) 525-9140, ext. 22726.

Signature _____

Date _____

Code Number _____

Appendix K

MICHIGAN STATE
UNIVERSITY

March 16, 1994

TO: Basanti Majumdar
P.O. Box 126
Waterdown, Ontario
L0R 2H0
Canada

RE: IRB #: 94-038
TITLE: THE EFFECTIVENESS OF A CULTURALLY SENSITIVE EDUCATIONAL
PROGRAMME ON SELF-PERCEPTION OF PHYSICAL AND MENTAL
HEALTH AND SELF-CONFIDENCE IN MINORITY GROUP SENIORS
REVISION REQUESTED: N/A
CATEGORY: 1-A,B,C
APPROVAL DATE: March 7, 1994

The University Committee on Research Involving Human Subjects' (UCRIHS) review of this project is complete. I am pleased to advise that the rights and welfare of the human subjects appear to be adequately protected and methods to obtain informed consent are appropriate. Therefore, the UCRIHS approved this project including any revision listed above.

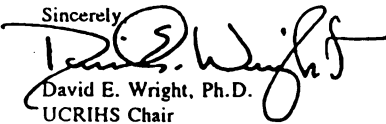
Renewal: UCRIHS approval is valid for one calendar year, beginning with the approval date shown above. Investigators planning to continue a project beyond one year must use the green renewal form (enclosed with the original approval letter or when a project is renewed) to seek updated certification. There is a maximum of four such expedited renewals possible. Investigators wishing to continue a project beyond that time need to submit it again for complete review.

Revisions: UCRIHS must review any changes in procedures involving human subjects, prior to initiation of the change. If this is done at the time of renewal, please use the green renewal form. To revise an approved protocol at any other time during the year, send your written request to the UCRIHS Chair, requesting revised approval and referencing the project's IRB # and title. Include in your request a description of the change and any revised instruments, consent forms or advertisements that are applicable.

**Problems/
Changes:** Should either of the following arise during the course of the work, investigators must notify UCRIHS promptly: (1) problems (unexpected side effects, complaints, etc.) involving human subjects or (2) changes in the research environment or new information indicating greater risk to the human subjects than existed when the protocol was previously reviewed and approved.

If we can be of any future help, please do not hesitate to contact us at (517) 355-2180 or FAX (517) 336-1171.

Sincerely


David E. Wright, Ph.D.
UCRIHS Chair

DEW:pjm

MSU is an affirmative action,
equal opportunity institution

✓ cc: Dr. James E. Snoddy

Appendix L



McMASTER UNIVERSITY
faculty of health sciences

1200 MAIN STREET WEST, HAMILTON, ONTARIO L8N 3Z5

Fax No.: 521-0048

DATE: February 8, 1994

TO: B. Majumdar

FROM: D. Rosenbloom, Pharm.D.
Chair, Research Advisory Group (Ethics Board)

This is to confirm that your project "Effectiveness of a culturally sensitive educational programme on self-perception of physical and mental health and self-confidence in minority group seniors" Project #94-09 was reviewed by the Research Advisory Group on January 26, 1994 and approved.

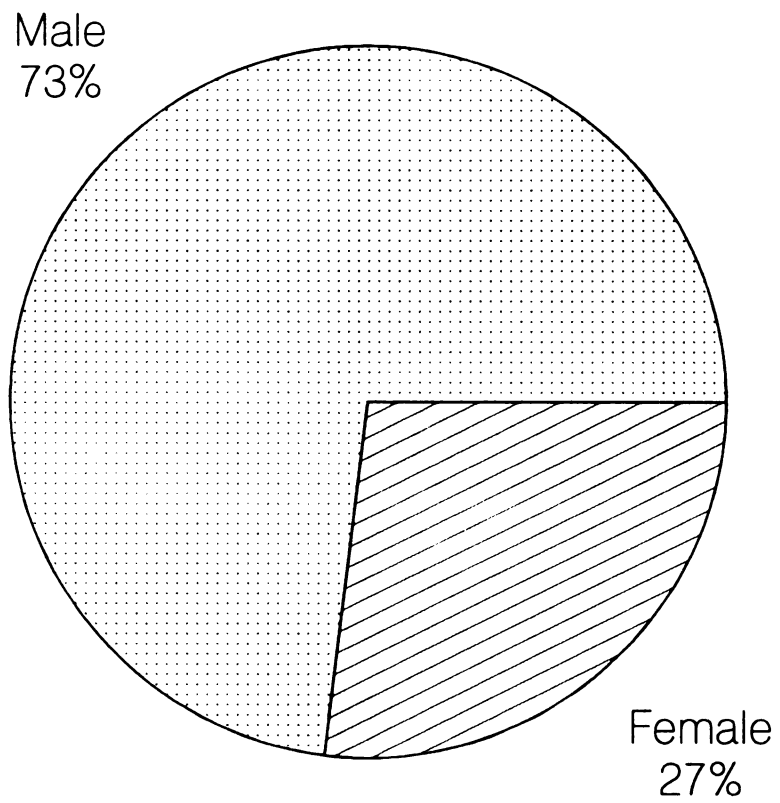
Please note that it is the responsibility of the researcher to ensure that evidence of consent is inserted in the patient's health record. In the case of invasive or otherwise risky research, the researcher might consider the advisability of keeping personal copies.

D. Rosenbloom, Pharm.D.
Chair 

Appendix M

Gender

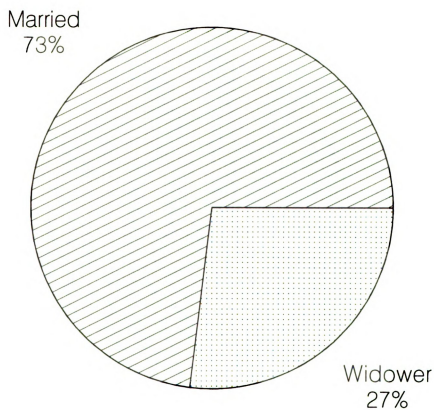
% of respondents



Appendix N

Marital Status

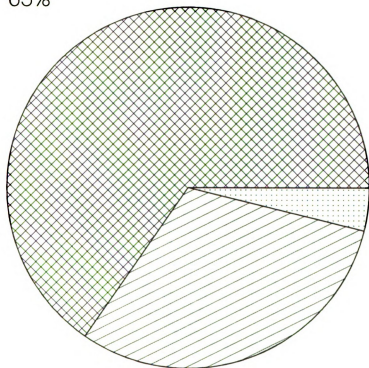
% of respondents



Monthly Income

% of respondents

\$500 / month
65%



\$1500 / month
4%

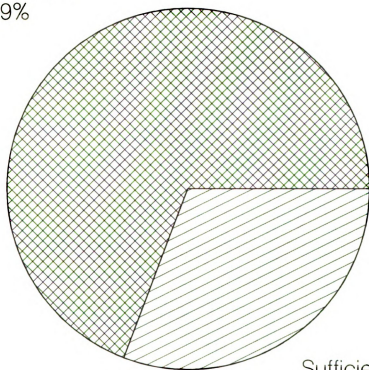
\$1000 / month
31%

Appendix P

Financial Status

% of respondents

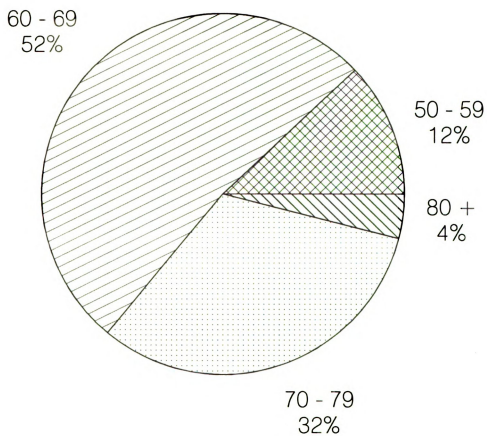
Not Sufficient
69%



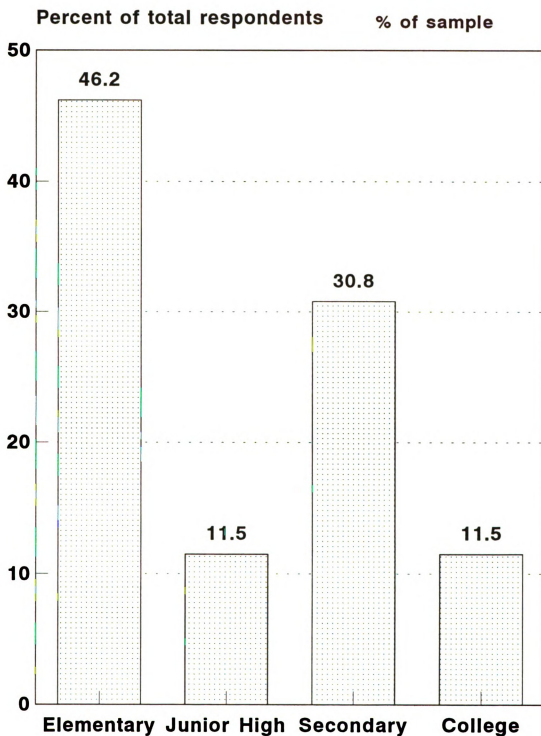
Sufficient
31%

Age

% of respondents



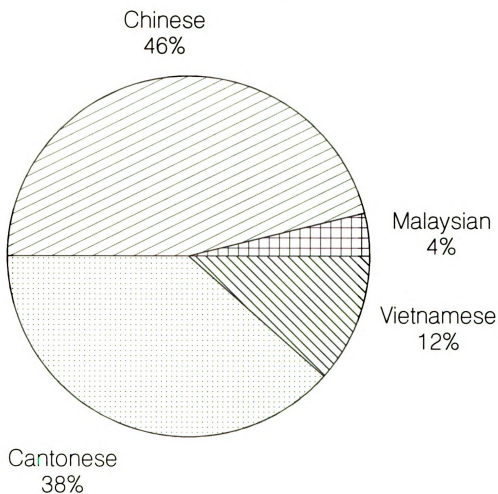
Education

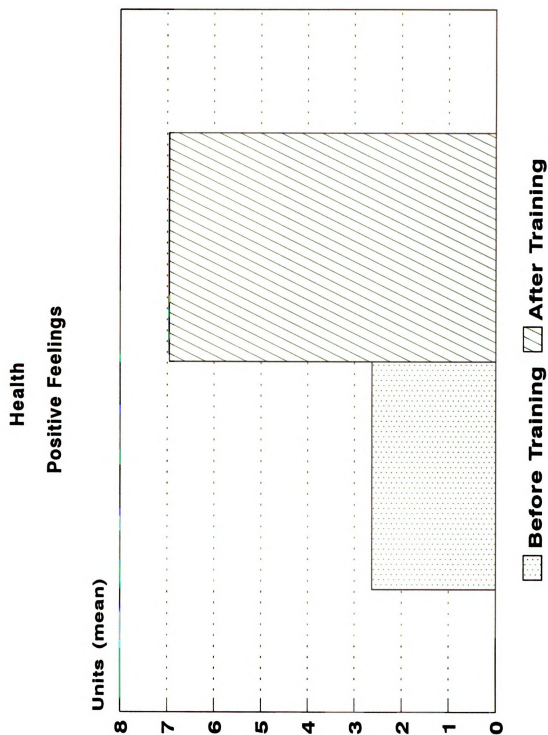


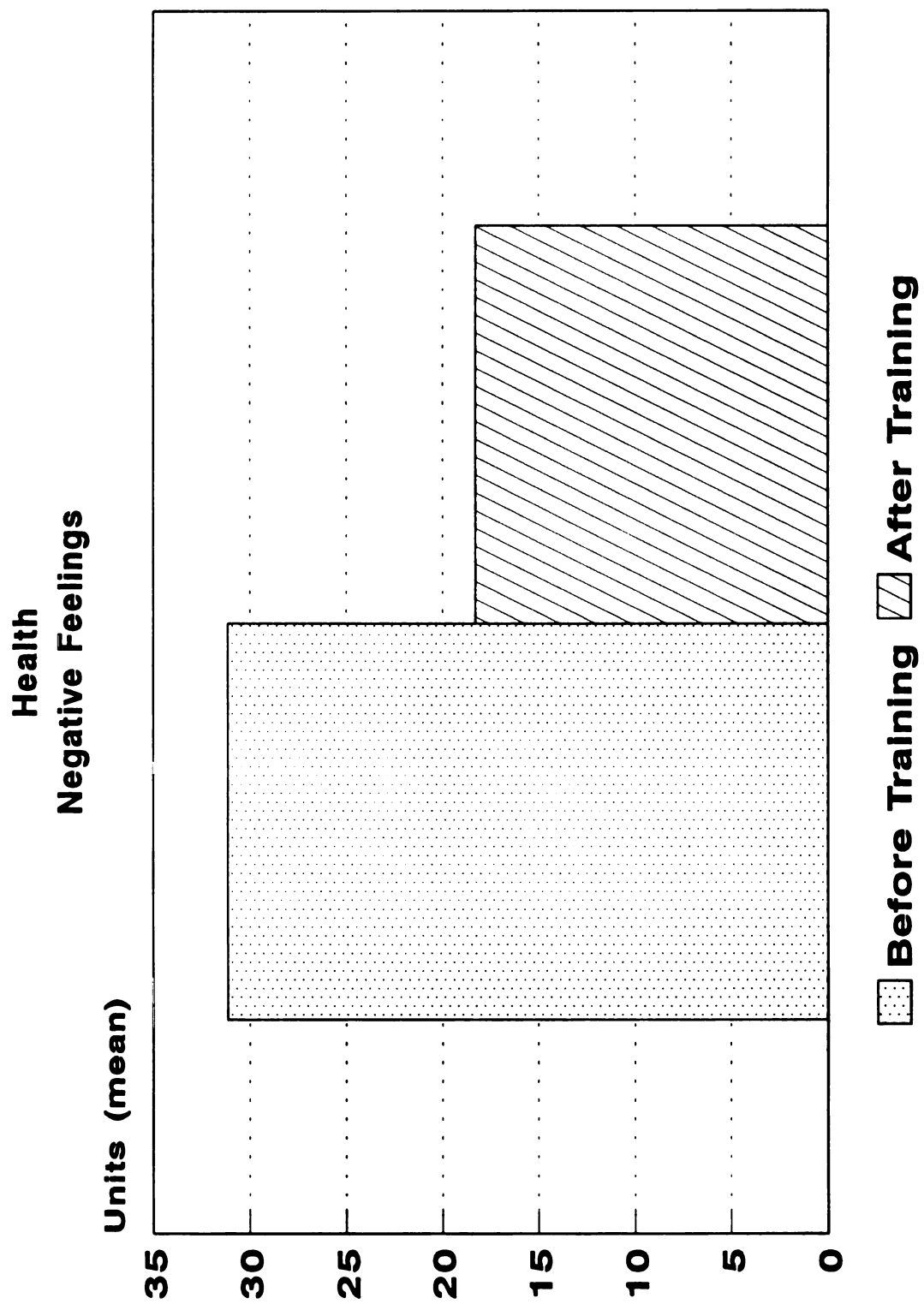
Appendix S

Ethnic Origin

% of respondents

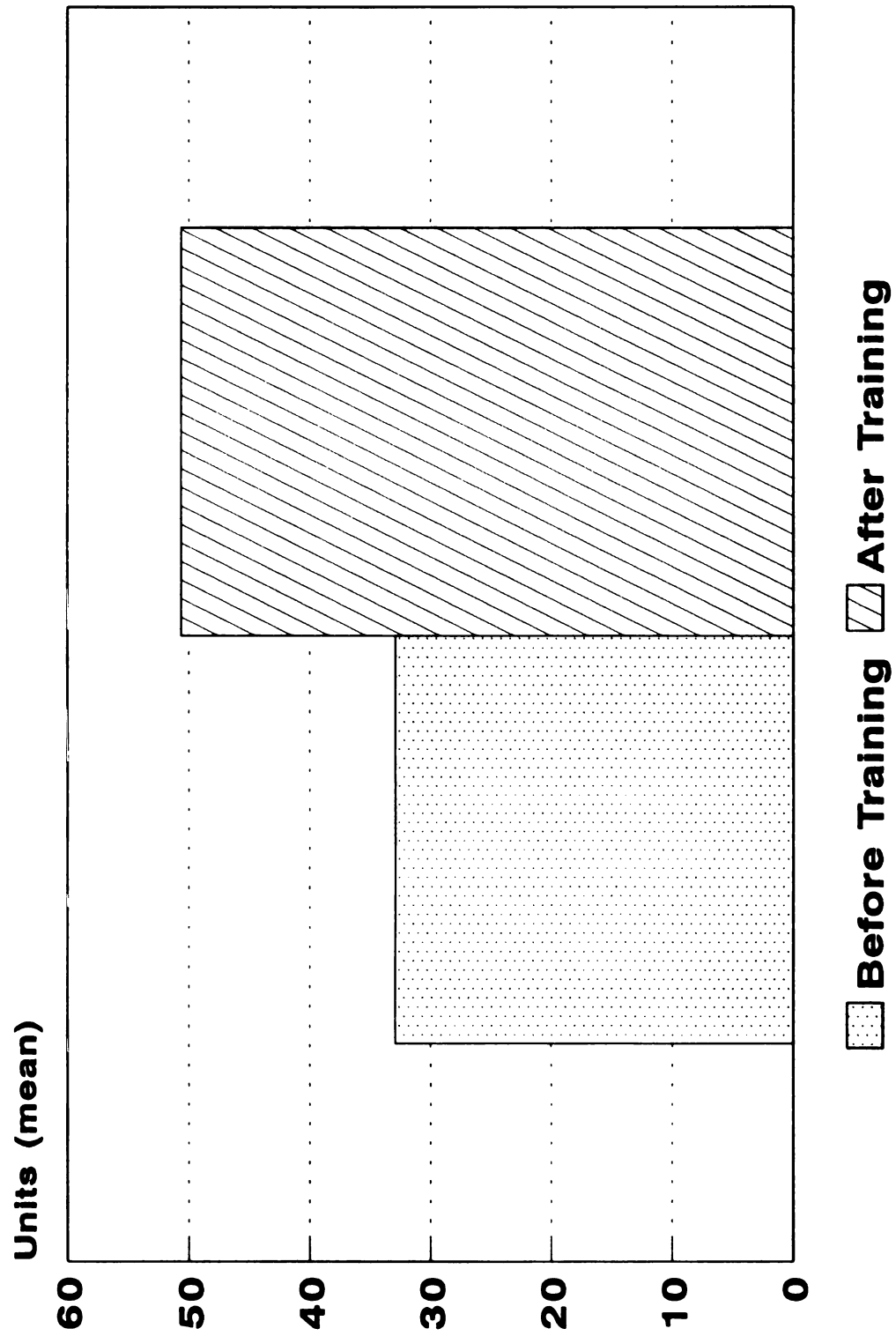






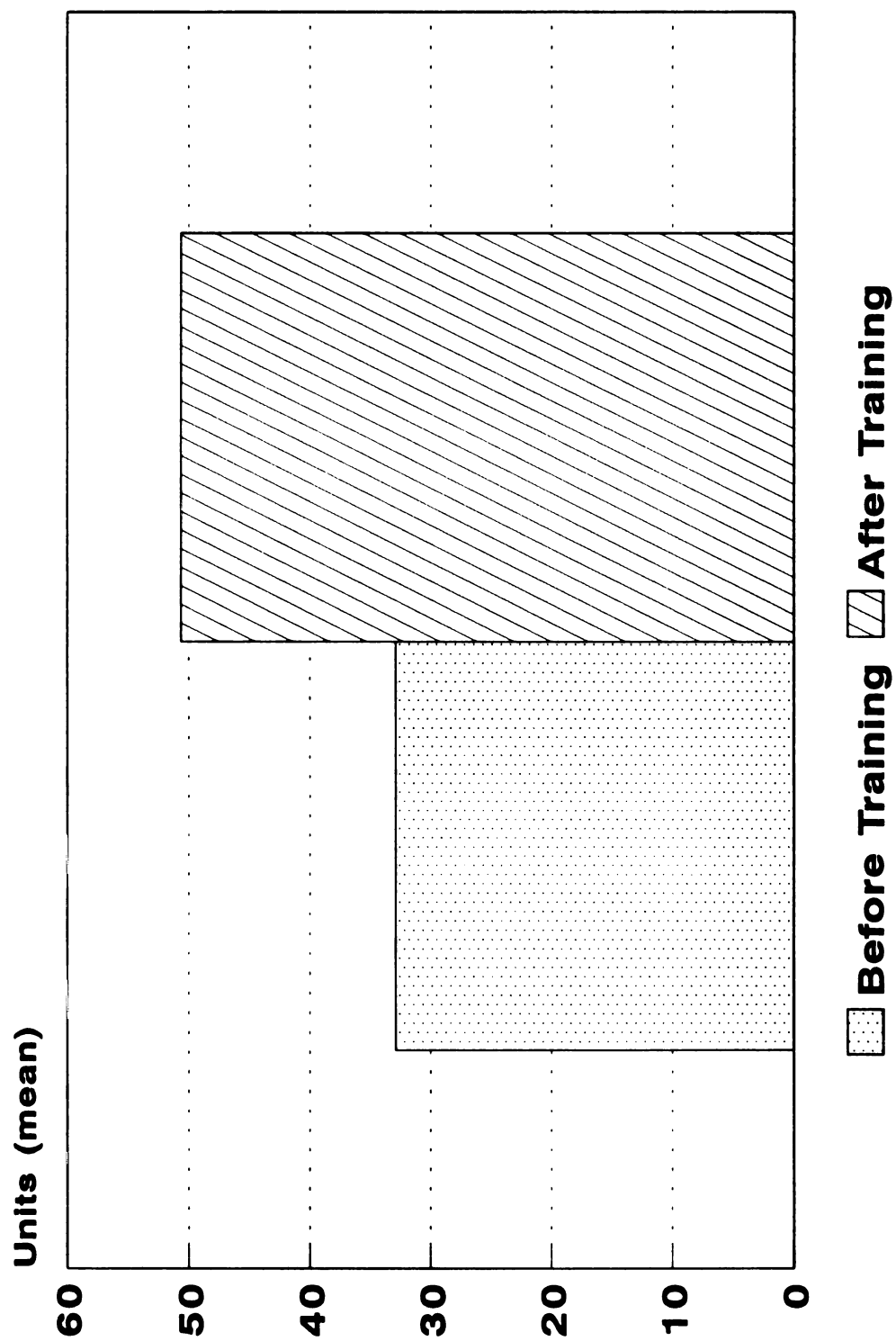
Appendix V

Happier Feelings

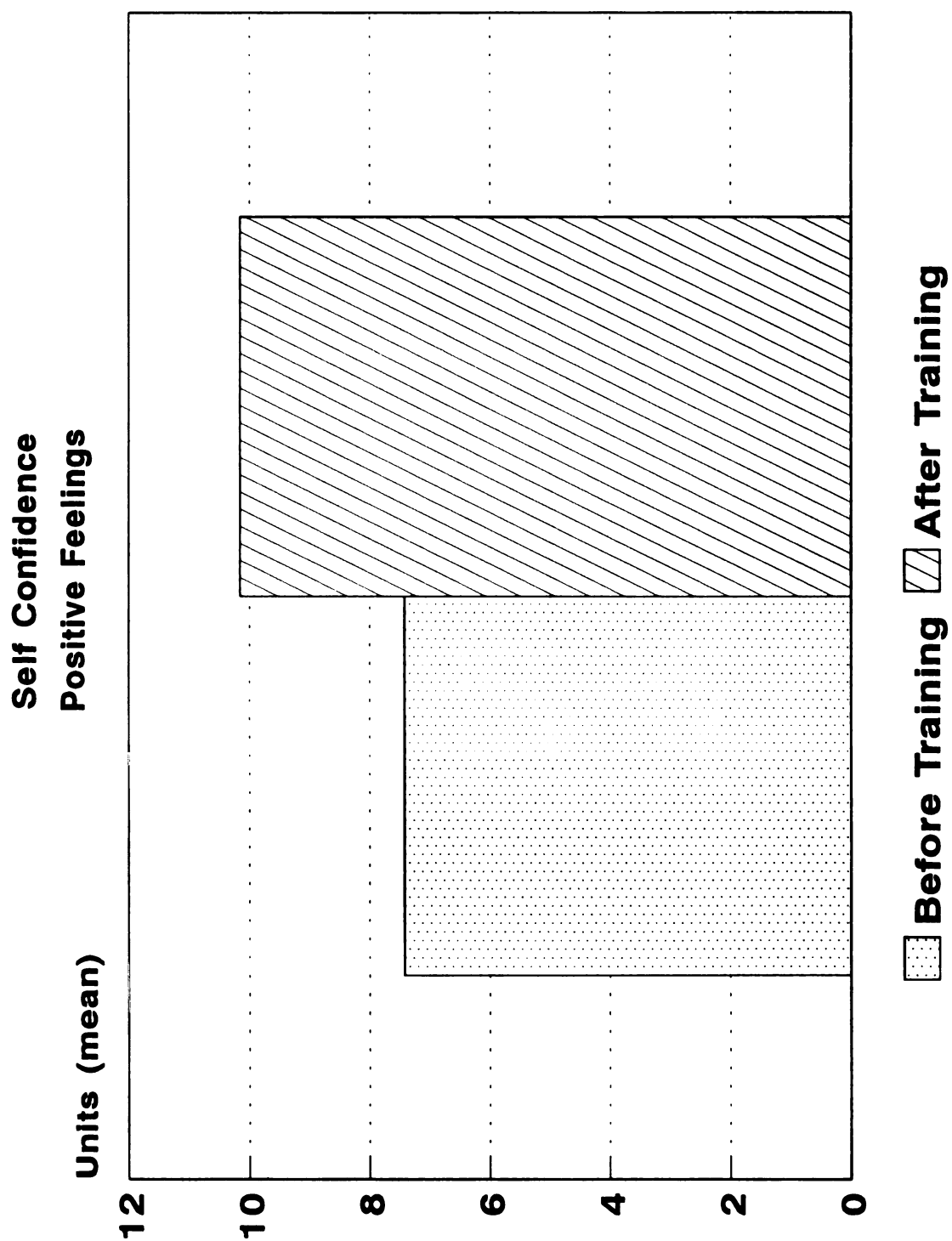


Appendix W

Happier Feelings

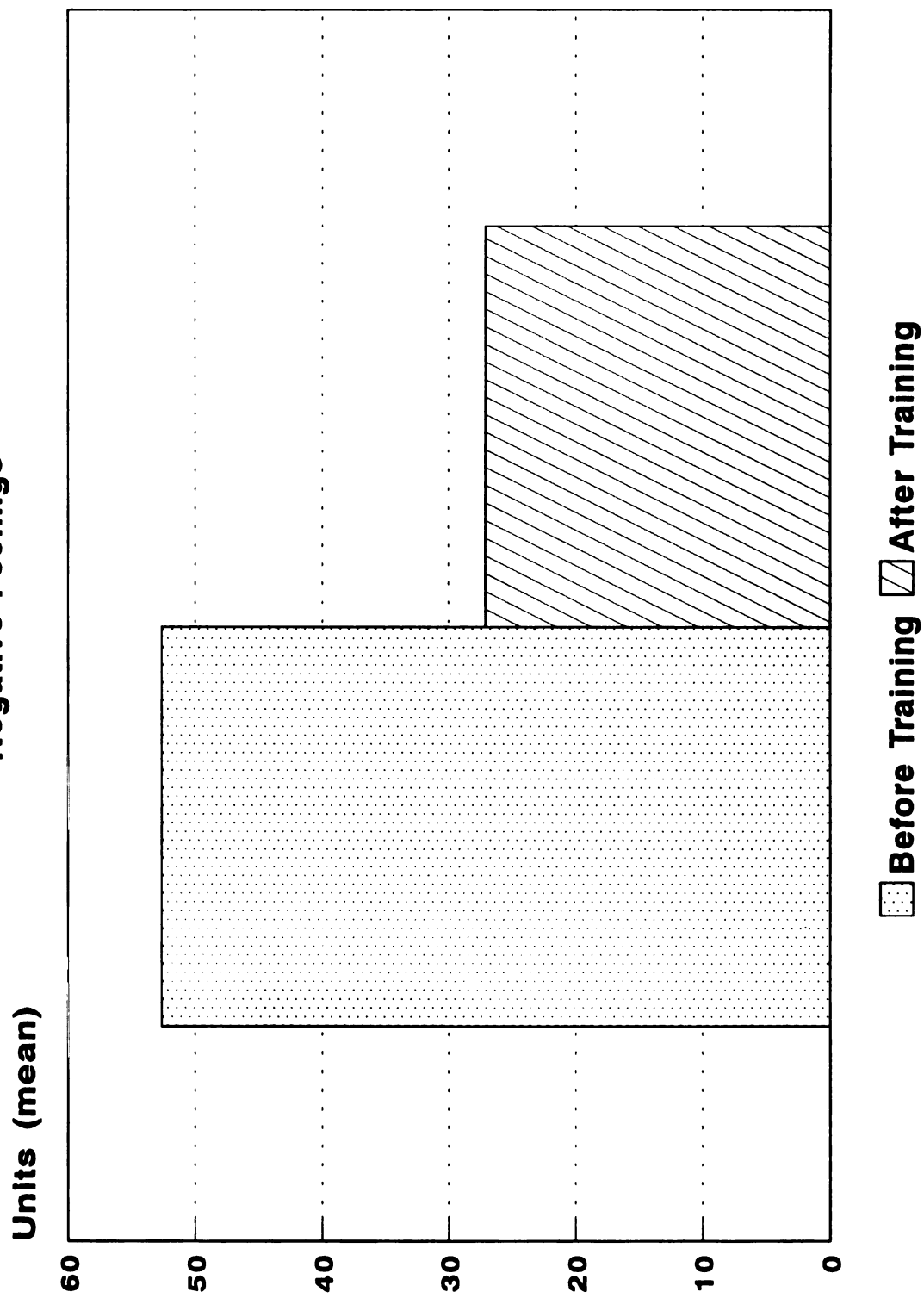


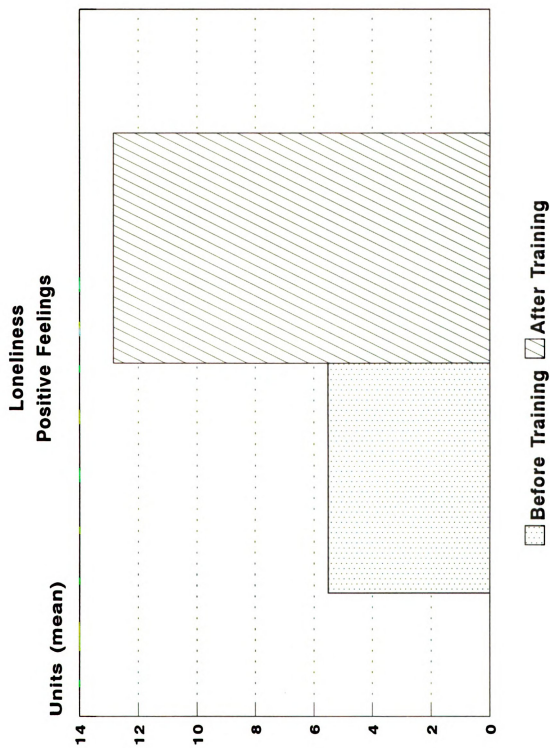
Appendix W



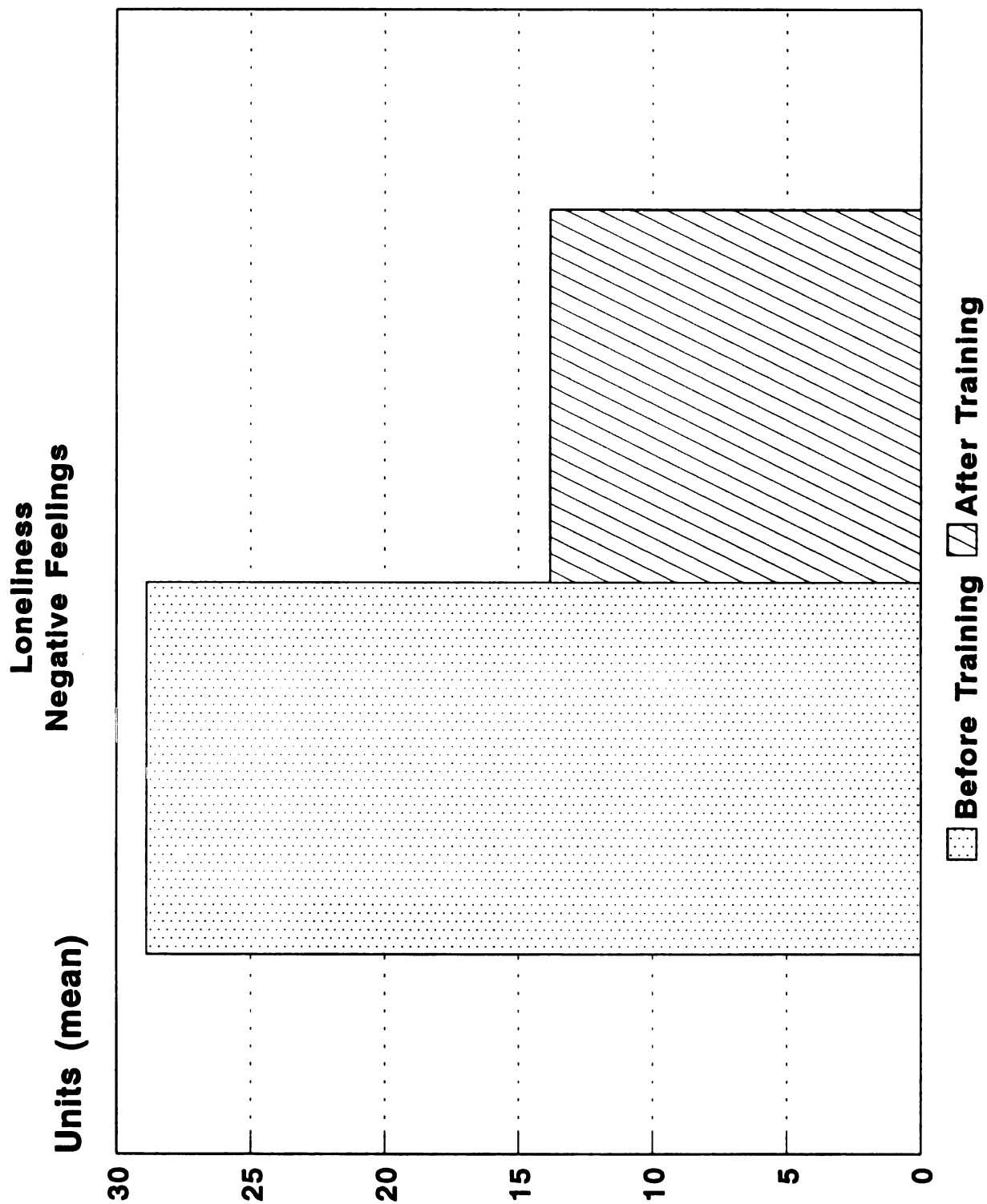
Appendix X

Self Confidence
Negative Feelings



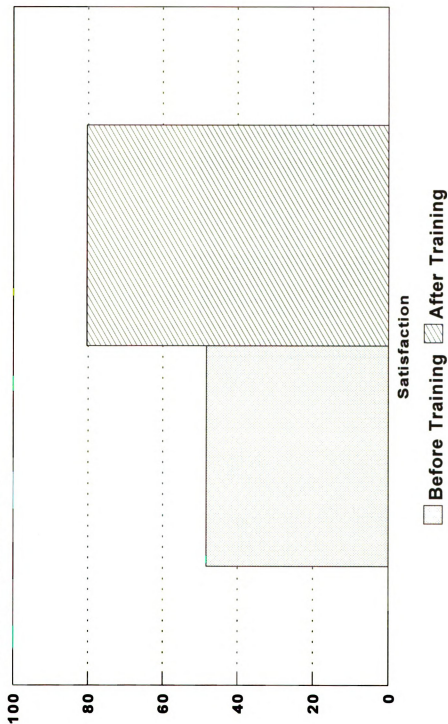


Appendix Z

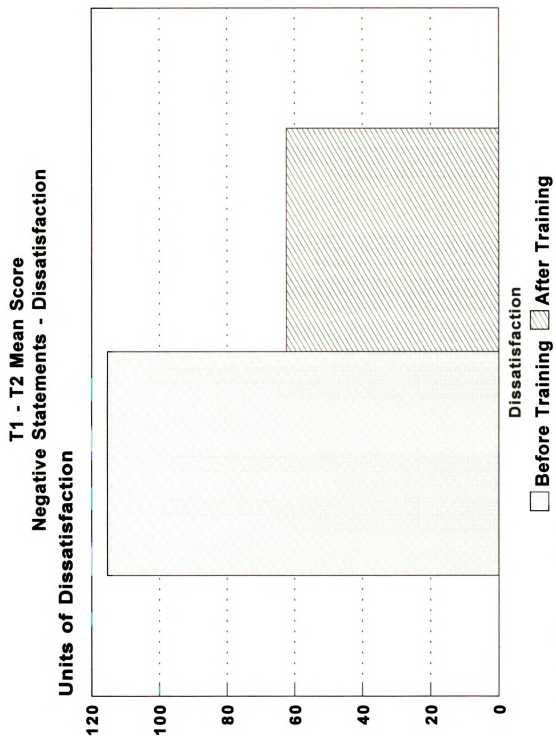


Appendix A1

T1 - T2 Mean Score
Positive Statements - Satisfaction
Units of Satisfaction



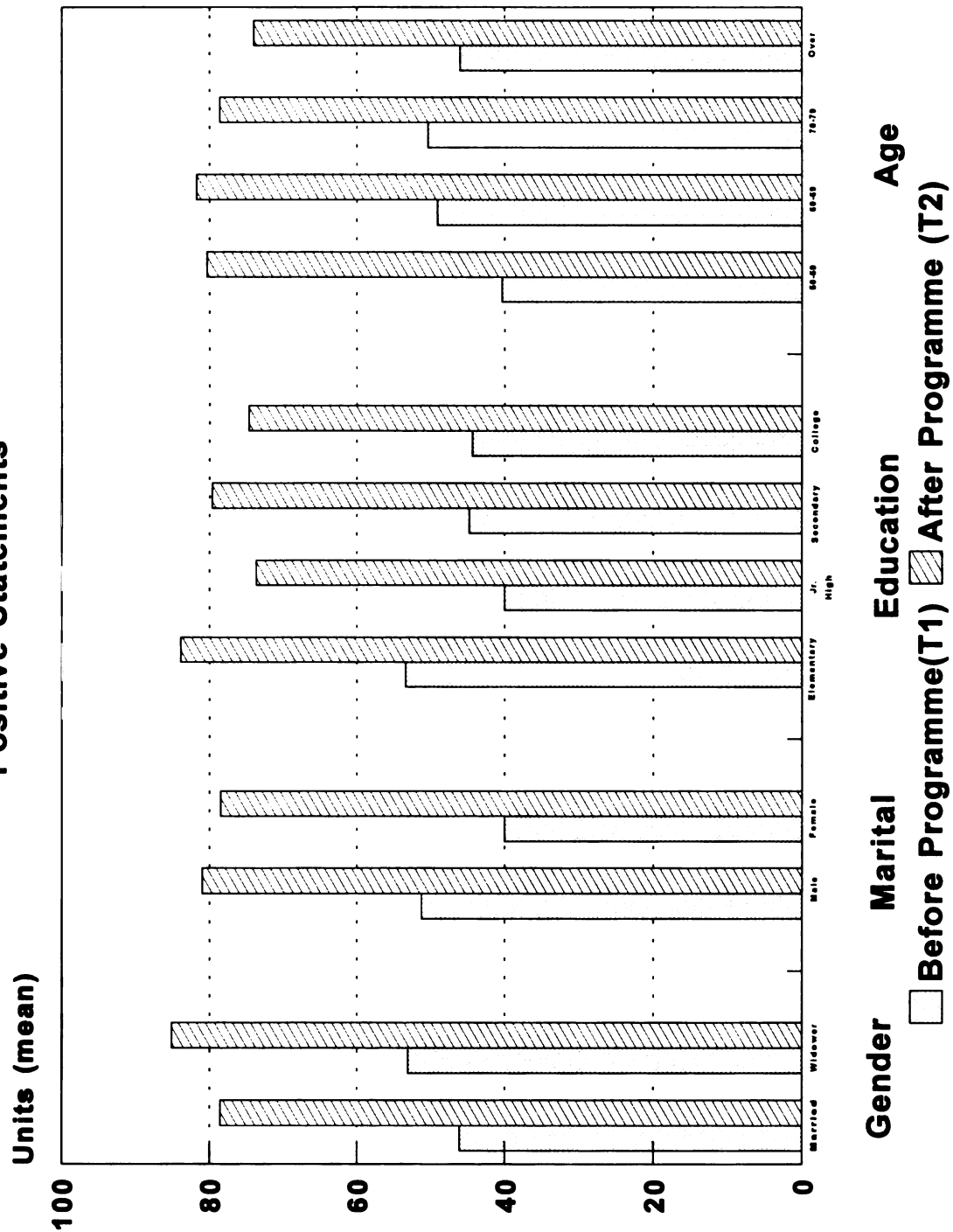
Paired T test: significant ($t_{25} = 27.9, p < 0.001$)

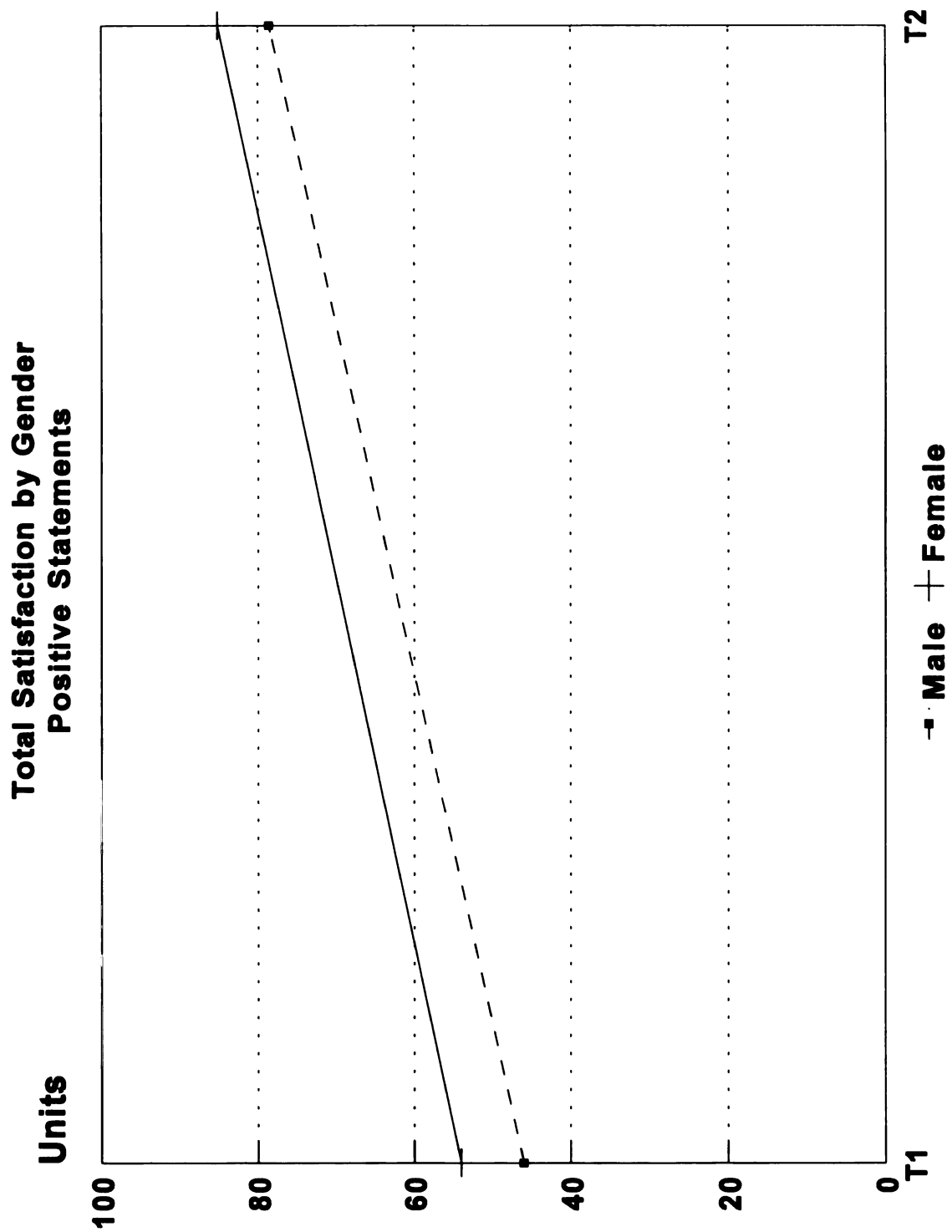


Paired T test: significant ($t_{25} = 28.54$, $p < 0.001$)

Appendix C1

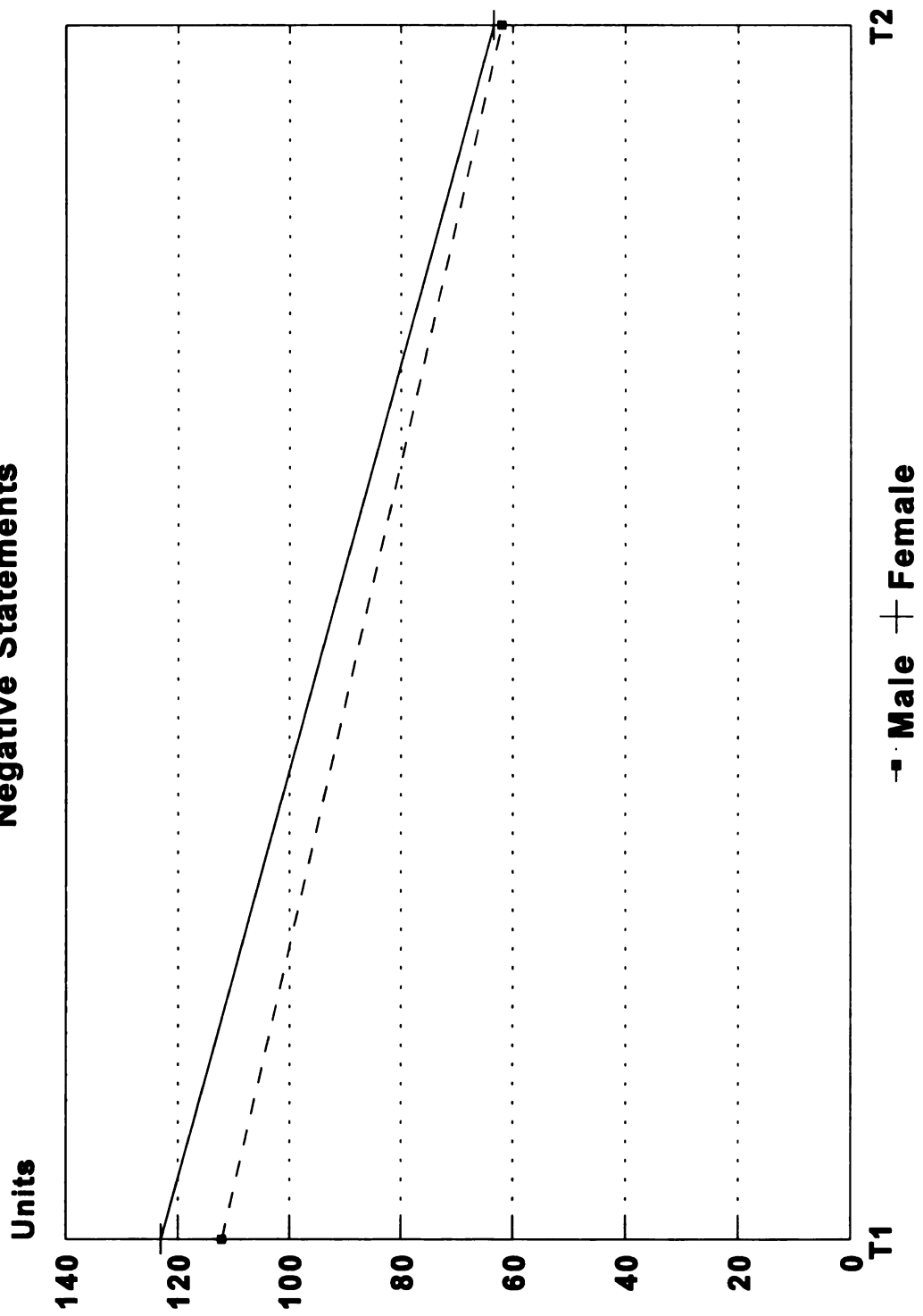
T1 - T2 Mean Score Positive Statements





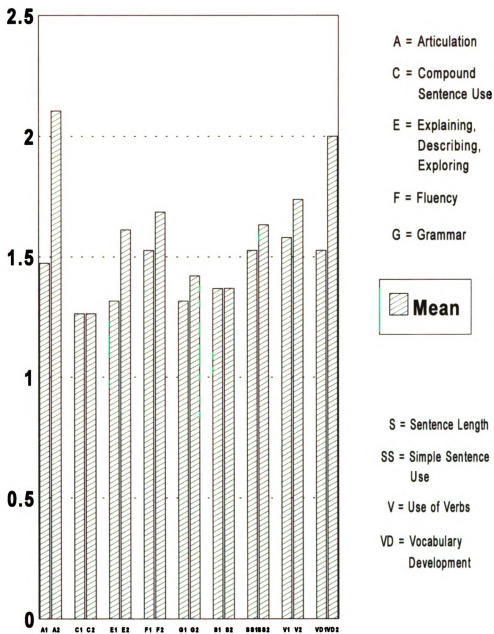
Appendix E1

**Total Dissatisfaction by Gender
Negative Statements**



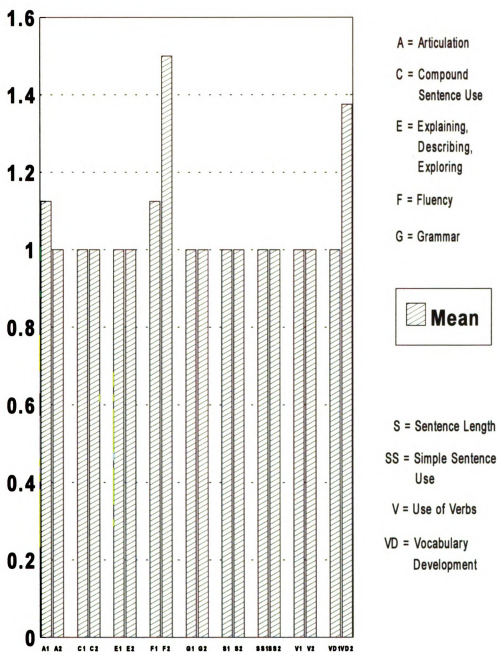
Appendix F1

Summary Comparison Chart (Male)
(T1 - T2)



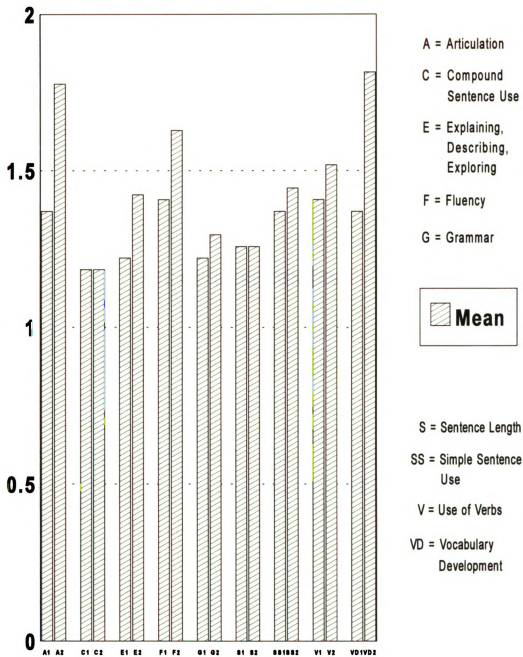
Appendix G1

Summary Comparison Chart (Female)
(T1 - T2)



Appendix H1

Summary Comparison Chart
(T1 - T2)



Appendix I1

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LIST OF REFERENCES

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