

AN INVESTIGATION OF THE EFFECTS OF A SIMULATION-
GAMING TRAINING PROGRAM UPON HEALTH CARE
PERSONNEL IN A NURSING HOME

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GRACE MAUREEN CHAISSON
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This is to certify that the

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AN INVESTIGATION OF THE EFFECTS OF
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UPON HEALTH CARE PERSONNEL IN A NURSING HOME

presented by

GRACE MAUREEN CHAISSON

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Major professor

Date June 24, 1975



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ABSTRACT

AN INVESTIGATION OF THE EFFECTS OF A SIMULATION- GAMING TRAINING PROGRAM UPON HEALTH CARE PERSONNEL IN A NURSING HOME

By

Grace Maureen Chaisson

The purpose of this study was twofold. It attempted to measure the effects of a six-hour inservice training program upon the staff of a nursing home. Second, it investigated the relationship between certain demographic and personal characteristics of individuals and their attitude toward the aged, as measured by a Likert-type questionnaire.

Forty subjects were selected at random from the nursing home staff and divided into an experimental group (20) and a control group (20). The members of the experimental group participated in a training program in which the simulation game "Life-Cycle" was used; this game incorporates the teaching modes of simulation-gaming, videotape feedback, and role-playing. The control group received no training but did receive the same pretest and posttest batteries designed to measure attitude changes.

Several different types of measurement instruments were used to collect data for testing ten hypotheses. The ATOP Scale was used as a pretest and posttest measure of attitudes toward the aged. The Hogan Empathy Scale was used as a pretest for the purpose of testing

the construct validity of the ATOP Scale. Additional posttests were administered. The first one was a subjective evaluation of the training program by the members of the experimental group only. The second one was a posttest questionnaire developed by the writer and administered to all subjects. It was an open-ended, projective-type test that was completed in response to a critical incident stimulus film.

An analysis of the data obtained from the pretests and posttests of the subjects produced supporting evidence for five out of the ten hypotheses. There was one significant effect of the training program; it concerned the emotional response of the subjects to an old man in a critical incident stimulus film. The experimental group reported significantly more positive emotional responses to a simulated old man in distress than did the control group.

A test of the reliability of the ATOP Scale as a measure of attitude on this group of subjects indicated that, in a test-retest situation, this was a reasonably reliable test. A reliability coefficient of .65 for the experimental group and .51 for the control group was obtained, which was significant at the .01 level.

A test of the construct validity of the ATOP Scale was performed by correlating the results of the ATOP with the results obtained from the administration of the Hogan Empathy Scale. The correlation of the scores of the subjects on both tests was very low and was not significantly different from zero.

A significant relationship was found between attitude scores and the existence among staff of a satisfying personal relationship with an elderly person outside of the nursing home ($r = +.46$). This

relationship was significant at the .004 level of confidence, with an F of 9.42.

A significant negative relationship was found to exist between the number of days a staff member worked per week and his attitude toward the aged ($r = -.33$). In other words, the more days the staff member worked per week, the less favorable was his attitude toward the elderly. This correlation was significant at the .05 level of confidence.

A significant positive relationship was found to exist between the formal educational background of a staff member and his attitude toward the aged ($r = .47$). In other words, those staff members with more schooling had a better attitude toward the aged than those staff members with fewer years of schooling. This correlation was significant at the .005 level of confidence.

The majority of the subjects in both groups (38 out of 40) demonstrated a remarkable sensitivity to the feelings expressed by an old man in a critical incident stimulus film. However, this population of subjects was clearly unable to translate that apparent sensitivity to an old person into responses that were helpful and/or therapeutic. Quite the contrary, the self-reported responses of the sample population to the old man in the film were rated by three independent judges as generally nontherapeutic (72 to 92 percent).

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A DISSERTATION

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To my loving and patient husband, Wayne,
and to my precious children,
Monique and Paul

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CHAPTER I

INTRODUCTION

Nursing homes are a relatively new mode of providing care for older patients in this country. They evolved in the late 1930's as a replacement of the old almshouse or "poor house." When federal legislation prohibited people from receiving social security if they lived in government-supported institutions, private nursing homes emerged. Originally, these homes were set up to provide little more than custodial care.

It seems that, "in recent years Federal Housing Authority mortgages have encouraged improved buildings but buildings are changing more rapidly than attitudes or level of knowledge of people providing care."¹ The level of knowledge of staff in nursing homes is woefully inadequate. Staff are usually uninformed about geriatric rehabilitation. Many assume that depression is a usual emotional state for elderly people. Whitehead noted that,

Nurses tend to be preoccupied with the physical care of the elderly because they enjoy and feel comfortable with this type of nursing service. They are often unaware or insensitive to their patient's emotional needs, due to one-sided physically biased instruction in the past.²

¹F. H. Frankel and E. Clark, "Mental Health Consultation and Education in Nursing Homes," Journal of American Geriatrics Society 17 (1969): 360-365.

²Anthony Whitehead, In the Service of Old Age (Baltimore, Maryland: Penguin Books, 1970).

In addition to the inadequate preparation of staff, many of these long-term care facilities have difficulties in organizing their social system. "Communication, lines of authority, and personality clashes are areas that give rise to many problems that hamper the delivery of good care."³

Education--Attitudes

Elderly people 65 and over constituted 4.1 percent of our population in 1900, are now 10.3 percent of the population, and will soon be 15 percent.⁴ This shift in the proportion of our population comprising the geriatric group is accompanied by increasing demands for services for the aged.

Education of Health Personnel in Geriatrics

In the face of the impending demands for service, health professions educators seem to be burying their heads in the sand as if they were hoping that, by so doing, both the aged and their problems would disappear. To be precise, Alexander reported that there is not a single university or medical school chair of geriatric medicine, nor any related chair in psychiatry in the country. Furthermore, he stated that less than 3 percent of the National Institute of Mental Health funds is spent on geriatric problems.⁵

³Frankel and Clark, op. cit., p. 363.

⁴Shanal Alexander, "Getting Old in Kids' Country," Newsweek, November 1974, p. 124.

⁵Ibid.

Attitudes of Health
Personnel Toward the Aged

Even as the number of elderly climbs rapidly, few graduating nurses show any interest in geriatric care. An American Hospital Association survey of 11,000 senior nursing students about to graduate from 388 hospital schools of nursing indicated that less than 1 percent chose geriatrics as a field of practice. In the survey results, geriatrics ranked sixteenth among 22 specialties available to graduate nurses. Barbara Bloom, the director of the Association's career division, said that most students' career choices are stimulated by what they learn in school.⁶

Doctors and nurses look upon geriatrics and psycho-geriatrics as uninteresting and unrewarding, preferring to deal with younger patients. In fact, they may even find geriatrics depressing. The above-mentioned American Hospital Association survey of nursing graduates showed a disproportionate number of students seeking jobs in obstetrics at a time when the nation's birth rate has dropped to zero.⁷ Obstetrics has always been associated with cheerful and optimistic working conditions.

In a study of the attitudes of nursing personnel toward aged, dying patients, Franks found that 65 percent of those nurses observed

⁶"Elderly Increasing, But Few Nurses Head for Geriatrics Field," Chicago Tribune, November 16, 1974, p. 3.

⁷Ibid.

appeared to have negative attitudes toward aged, dying patients.⁸ Another study, by Barrow, of physicians' attitudes toward aging and the aging process revealed that over half of the physicians expected aged patients to be uncooperative and frustrating to deal with.⁹

That physicians and other health professionals have absorbed negative stereotypes about the aged was also reported in a study by Coe based on tape-recorded discussions held with small groups of physicians, dentists, physical therapists, nurses, and social workers. He found that health professionals view aged patients as rigid, unadaptable, and slow to respond to treatment.¹⁰

The effect of these stereotypic, negative attitudes toward the elderly on the care of the aged is manifold. It is difficult, if not impossible, for professionals to meet the expectations of the aged patient if the above stereotypes are strongly held. "Practitioners will have developed a negative 'set' about older patients even before seeing a particular aged patient."¹¹ Coe's conclusion was that ". . . Stereotypes must be modified before therapists (or other helping agents) will be able to deal effectively with the health problems of

⁸Margaret Laura Franks, "Social Factors and the Attitudes of Nursing Personnel Toward Aged, Dying Patients," Master's Abstracts, Ann Arbor, Michigan, No. M-2756, p. 129.

⁹Georgia May Barrow, "Physicians' Attitudes Toward Aging and the Aging Process," Dissertation Abstracts International, Ann Arbor, Michigan, No. 71-27316, p. 141.

¹⁰Rodney M. Coe, "Professional Stereotypes Hamper Treatment of Aged," Geriatric Focus 15 (September 15, 1966): 1-3.

¹¹*Ibid.*, p. 2.

the aged, and before aged patients will be able to regain confidence in medical treatment."¹²

Gaps in the knowledge of young people about old age are prevalent because of the separation of the young from the old in our society. These gaps are largely filled in by media presentations. The media operate in a society in which youthfulness is the valued state of being, in which wrinkles, grey hair, lack of zip, and irregularity must be eradicated along with spotty glassware, grimy sinks, and dirty floors. This type of presentation of the elderly by the media has resulted in negative stereotypes, among young and old alike, toward aging and the aged.

An analysis of articles from a leading midwestern newspaper concerning aging was undertaken by MacDonald to compare the view of aging projected to the paper's 288,000 readers today as compared to ten years ago. A detailed content analysis revealed that there has been a significant increase in the number of articles on aging, although midwestern readers still get a rather outdated, patronizing, and negative view of aging from the news media.¹³

Women in our society are especially vulnerable to negative attitudes toward the aging process. A study based on 2,741 characters in prime-time network television drama sampled between 1969 and 1971 showed that elderly comprised less than 5 percent of both sexes, about

¹¹Ibid., p. 2.

¹²Ibid.

¹³Roderick MacDonald, "Content Analysis of Perceptions of Aging as Represented by the News Media," Gerontologist, Part II, 1973, p. 103.

half of their share of the real population. Whereas most males in prime-time drama failed because they were evil, females failed just as they aged. The female characters actually failed more often than they succeeded.¹⁴ Aging in prime-time drama is thus associated with increasing evil, failure, and unhappiness, especially for females.

Negative stereotypes that infect the American mentality and contribute to dissuade professionals from working in geriatrics are not supported by the research data, such as the Hess study mentioned above. In fact, there are usually greater differences within a group of older people than there are among the young. In other words, standard deviations tend to increase with age.¹⁵

Health Manpower Shortage in Geriatrics

For those professionals who are concerned with their status in the medical community, there is little incentive to elect a career in geriatrics. Chronic care of the elderly is accorded little status in medical circles. Instead, medical education attaches prestige to acute care and research.¹⁶

If health professionals continue to avoid geriatrics as a career choice, and the shortage of personnel caring for the elderly

¹⁴Beth B. Hess, "Stereotypes of the Aged," Journal of Communication 24 (1974): 76-85.

¹⁵David Schoenfield, "Translations in Gerontology--From Lab to Life," American Psychologist, November 1974, pp. 796-801.

¹⁶E. Clark, "Improving Post-Hospital Care for Chronically Ill Elderly Patients," Social Work 14 (January 1969): 796.

continues as it is or becomes worse, there is a greater danger of patient care deteriorating. "Overburdened staff lose heart, some leave, making the burden heavier and finally only the basic physical needs of the patient can be catered to," warned Whitehead.¹⁷

Clark voiced the opinion of many when he commented, "One of the major social-medical problems of our day is the low quality of care provided by society to the chronically ill elderly persons . . . and 3/4 of the population over 65 have some chronic condition."¹⁸

Those overburdened staff who are left behind to carry the load of caring for their elderly patients struggle on a daily basis to meet the overwhelming demands of a needy population. They live with the daily frustration of knowing that the task is too great to accomplish with inadequate manpower and insufficient rewards. But they settle for "good enough" while recognizing that "good enough" is better than nothing. Despite their struggle to do the best job that is humanly possible within the constraints of inadequate staff and inadequate time, they are seldom recognized and appreciated for their efforts. Instead they are criticized by the society at large for not providing the high-quality care that that same society is unwilling to pay for. Society has been unwilling to provide the level of reimbursement to nursing homes that would allow them the leeway to increase staffing patterns and offer in-service education opportunities for the purpose of improving the knowledge and competencies of the service providers.

¹⁷Whitehead, op. cit., p. 24.

¹⁸Clark, op. cit., p. 63.

Society's devaluation of the efforts of nursing home personnel causes staff to become discouraged. One can hardly persevere in a job when the criticisms and frustrations soon begin to outweigh the rewards and satisfactions.

Transience of Nursing Home Staff

For many of the reasons mentioned above, there is a large turnover of personnel in nursing homes. This high turnover rate among staff creates further tensions for the patients, who must daily adjust to new personnel. Also, the new personnel are unable to be emotionally supportive of the residents because they are absorbed in their own struggle to become oriented and contributing members of the staff. Adjustment to the nursing home setting is oftentimes even more difficult for transient staff than it is for the residents and, in the battle to cope, the staff can offer little if any emotional support to the patients. "The U.S. Labor Department estimates some 30,000 vacancies, with a 60 percent turnover rate for nursing home personnel."¹⁹

American Funding Priorities

The American society, by its financial priority setting, has only planned for the patient to receive custodial care. Reimbursement rates from insurance companies and public welfare cover only such care. With this limited funding it is clearly impossible for

¹⁹U.S., Department of Health, Education and Welfare, The Practitioner and the Elderly, vol. III: Working With Older People, Public Health Service Publication No. 1459 (Washington, D.C.: Government Printing Office, 1966).

nursing homes to offer in-service training programs aimed at improving care. Nor do low salary scales attract or motivate well-qualified practitioners. The unwillingness of society to pay the bill perpetuates the inadequacy of nursing homes. Clearly, then, there is a crying need for money, which brings with it prestige and incentive, to be funneled into the preparation and remuneration of geriatric service workers, to improve care of elderly patients.

In conclusion, studies cited in the preceding discussion indicated that negative stereotypic attitudes toward the elderly are prevalent among health care professionals. As explained above, these attitudes contribute to the following problems in providing care to the aged:

1. rejection of geriatrics as a career choice by health care workers
2. low morale of those professionals who work in long-term institutions
3. decreased effectiveness of service providers who are hampered by their own attitudes
4. communication blocks between the young and the old, which prevent the formation of relationships that are satisfying to both parties
5. low self-esteem of the elderly because of society's and their own rejection of the old

Statement of the Problem

From the preceding discussion, it is concluded that there is a need to improve attitudes toward and interaction with the elderly

among health care providers. It is necessary to help these people move toward a greater acceptance of their own aging process. In other words, it is necessary to design a training program that would have as its target the attitudes of helping agents toward their own old age and then toward the aged as a group.

The need for training health care workers in gerontology is great, and so is the need for evaluating the effectiveness of such training. "This is a fit-area for scientific inquiry even as we proceed to undertake training."²⁰

Society needs training programs to improve the quality of care of the elderly. Those programs must be subjected to intensified assessment.

Purpose of Study

If such improvements in the preparation of service providers are made, in conjunction with increased funding to support these improvements, then perhaps there will be less reluctance on the part of professionals and paraprofessionals to enter this area of service where the need is great.

The purpose of this study is to implement a social-simulation game as a teaching strategy with nursing home staff and to evaluate its effectiveness in improving the following:

1. attitudes toward the elderly
2. sensitivity to the needs of the elderly

²⁰Ibid., p. 12.

3. emotional responses to the elderly
4. therapeutic responses to the elderly

In addition, the study will collect and analyze demographic data to replicate other studies that have related attitudes toward the elderly with characteristics of individuals such as age, education, job experience, and relationship with elderly friends and/or relatives.

Theory

How does one bring about an exchange of emotionally based prejudices for more realistic and accepting attitudes? How does one empathize with the elderly from an experimental awareness, before one has himself grown old? In other words, how can one appreciate what it is like to be old before he gets there? Is there a better method of training providers of care to the elderly that will help them to become more understanding of what it is like to be an older person residing in a nursing home? Can one create a learning environment that allows the participant to become more sensitive to the emotional needs of the elderly by experiencing the role of the elderly in a simulation of reality? What effect will the method of social simulation have on the student? Will it affect his attitude toward the elderly? Will it help him improve his methods of communicating with the elderly; and will he feel more comfortable and secure in resolving problem situations with "difficult" patients after the training experiences?

The investigator designed a social simulation game entitled "Life-Cycle," whose effect on health care providers in a nursing home will be studied. The game provides the staff with an opportunity to

"put-on" or role-play the part of an older self. After playing the role in one's own imaginary old age, it is hoped that the players will come to perceive themselves as not very different from those old people who before had seemed so strange. It is hoped that they will begin to see the old person in a new light, not as a member of an alien "other group," but as a person akin to themselves who simply has more longevity in the world. It is hoped, with these new insights, the game players will develop a new understanding, a relaxed acceptance, and a moving toward rather than away from the elderly.

The attitudes of health care personnel toward the elderly can greatly affect their response to the emotional and psychological needs of the elderly. Decisions made about the care of the patient are influenced by the staff member's perception of and attitude toward the importance of a particular need. A negative attitude can act as a barrier to even seeing the needs of the elderly person. Instead, it may result in judgmental, rejecting responses to the aged. On the other hand, a positive attitude toward the old patient can foster a greater understanding of the position of the elderly in a long-term care institution.

A simulation game was selected as a teaching mode in this study, to offer the health care worker an opportunity to experience the feelings and reaction of an old person through a process of role reversal in a simulated world. The rationale for this approach is that, once having acted as an old person and experiencing his needs, the staff member will be better able to tune in on the needs of the elderly in similar situations. The hope is that staff members would

move from the position of responding to the words of the patient in distress, toward a response to the more basic needs of the patient that are often hidden behind his words. That is, by replacing negative, rejecting attitudes toward the elderly with more accepting attitudes, the staff would experience a greater rapport with their patients, resulting in improved communication and greater satisfaction for both parties.

Another teaching element that is utilized in the game, "Life-Cycle," is videotape feedback, or stimulated mutual recall. The reason for its use in the training program to be investigated in this study is based upon its reported effectiveness in encouraging a more democratic and equalitarian relationship between participating parties. Supposedly, the technique has been helpful in decreasing the intellectualization of the subject, allowing him to understand his own reacting self and the other party in an interaction.

The training program under investigation was designed to force a reevaluation and subsequent modification of attitudes toward the elderly that act as barriers to the delivery of service.

The main hypothesis of the study is that negative attitudes of health care personnel toward the elderly are in part related to training in geriatrics, which, until recently, has been nonexistent and is still considered inadequate.

It is proposed that training in geriatrics is necessary for changing some of these attitudes. This study concerns an investigation of one particular type of training program to determine if it is

effective in accomplishing the end of changed attitudes toward and improved relationships with the elderly.

Hypotheses

An attempt will be made to cause a significant, positive change in the attitude of a sample population of workers in a nursing home toward the aged in general, and the elderly patients in the home in particular. Additionally, the training program will endeavor to alter significantly the patterns of staff-patient communication toward a more therapeutic mode. Other correlates that might also influence the attitudes of the sample population toward the aged will be investigated. The following hypotheses will be tested:

- H₁: The ATOP scale, in the test-retest situation on this particular group of subjects, will be reliable.
- H₂: As a test of construct validity of the ATOP scale, that is, as a test that it measures what it purports to measure, the ATOP will correlate significantly with the Hogan Empathy Scale.
- H₃: After a six-hour social simulation training program, the experimental group will show a significantly more positive attitude index, as measured by ATOP, than the attitude index of the control group.
- H₄: The emotional responses of the experimental group to a simulated elderly person on videotape (stimulus tape) will differ significantly from the emotional responses of the control group (positive emotional responses of the experimental group will be significantly greater than the positive responses of the control group), as measured by the Davitz classification scheme.
- H₅: On the stimulus film test the experimental group will demonstrate a significantly greater sensitivity to the feelings expressed by the elderly man on the film than the control group, as measured by a content analysis of self-reported emotional responses of the subjects.

- H₆: On the stimulus film test the experimental group will demonstrate a significantly greater number of therapeutic responses to a simulated elderly person on videotape than the control group, as measured by the independent ratings of judges, using specific criterion measures.
- H₇: On the stimulus film test the type of physical intervention chosen by the experimental group in assisting a simulated elderly person on videotape will differ from the type of intervention chosen by the control group, as measured by a post-facto analysis of the self-reported interventions of the subjects.
- H₈: The experimental group will evaluate the educational experience as satisfying and successful in helping them to gain insights into what it is like to be old, what it is like to be an old patient in a nursing home, how they interact with patients, and how they could interact with patients in difficult situations.
- H₉: The attitudes toward the aged of those subjects who report a regular, satisfying relationship with an elderly person or relative outside of the nursing home will be significantly more positive than the attitudes of those who report having no such relationship with elderly persons.
- H₁₀: A significant correlation will exist between the demographic variables of age, job category, employment status, and education and the dependent variable of attitude toward the aged, as measured by the ATOP scale.

Definitions of Terms

To clarify the intended meaning of important words that are used in this study, definitions are given below.

Attitude--the sum total of man's inclinations and feelings, prejudice or bias, preconceived notions, ideas, fears, threats, and confictions about any specific topic.²¹

²¹L. L. Thurstone, "Attitudes Can Be Measured," American Journal of Sociology 33 (1928): 531.

Empathy--the ability to put one's self in the other person's position, establish rapport, and anticipate feelings, reactions, and behaviors.²²

Social Simulation Game--a game in which certain social processes are explicitly mirrored in the structure and functioning of the game. By its very definition, it is concerned principally with part of an individual's environment that consists of other people, groups, and organizations.²³

Stimulated Mutual Recall--a process that involves the video-taping of role players during their interactions with subsequent playback of the film for the purpose of stimulating recall of the details of the interaction so that they can be analyzed for learning purposes. Recall sessions are conducted by an "interrogator" who helps the actors examine the underlying dynamics of their interaction with each other.²⁴

Health Care Worker--within the context of this study, it refers to any person who is employed in a setting where health care is provided to persons in need of such care. This includes both professionally trained workers, such as nurses and doctors, and others who have had no professional and/or formal preparation for the work they

²²B. J. Speroff, "Empathy and Role Reversal as Factors in Industrial Harmony," Journal of Social Psychology 37 (1953): 117.

²³Sarane S. Boocock and E. O. Schild, Simulation Games in Learning (California: Sage Publications, 1968), p. 30.

²⁴Norman Kagan, "Attitudes Toward Old People: The Examination of a Scale and an Examination of Correlates," Journal of Abnormal Social Psychology 62 (1969): 365.

are doing in a health care setting, such as aides, maintenance men, and kitchen help.

Emotional Response--a descriptive statement given by a subject in an effort to explain his emotional reaction to a critical incident.²⁵

Limitations

The training program was designed to have some impact upon several additional problems. However, it is not the object of this study to measure the effects of the program on the following problems:

1. promote progression from authoritarian to more democratic communication structure
2. increase group cohesiveness among staff members
3. increase communication among staff, between staff and patients, and between the staff of different levels in the system
4. increase group rather than individual problem solving
5. improve problem-solving skills.

²⁵Joel Davitz, The Language of Emotion (New York: Academic Press, 1969), p. 14.

CHAPTER II

REVIEW OF THE LITERATURE

Several areas relevant to the hypotheses that are to be investigated in this study are reviewed in this chapter as they appear in the literature. Since the primary focus of the study is on the attitudes toward the elderly among health care workers, and educational efforts to improve those attitudes, studies related to both are presented. Since simulation-games and stimulated mutual recall or videotape feedback are the principal methods used in the training program under investigation, reports of their effectiveness are reviewed. Finally, since additional hypotheses have been formulated that relate to other personal and demographic characteristics that might influence attitudes toward the aged among health care workers, other investigations into this phenomenon also appear.

Attitudes Toward the Aged Among Health Care Personnel

The concept of attitude has been widely researched and written about in the literature. In reviewing the concept, Allport concluded that "Attitudes are never directly observed, but, unless they are admitted, through influence, as real and substantial ingredients of human nature, it becomes impossible for the consistency of any

individual behavior or for the stability of any society."¹ Earlier, he had written that "An attitude characteristically provokes behavior that is acquisitive or avertive, favorable or unfavorable, affirmative or negative toward that object or class of objects with which it is related."²

In later writing, Allport stated that "one always has an attitude toward something or someone and the attitude is usually identifiable as either positive or negative."³

According to Drobda, an attitude is a mental disposition of the human individual to act for or against a definite object.⁴

Sherif and others found that "attitudes prevalent among individuals in various groups are derived from the value sets and special concerns of their groups."⁵ Health care workers have attitudes about or directed toward any thing or person connected with their job. Their attitudes may be positive or negative or somewhere in between those two poles.

That there do exist negative attitudes toward the aged among health care workers has been reported in three instances in recent

¹Gordon Allport, Personality: A Psychological Interpretation (New York: H. Holt, 1937), p. 78.

²Ibid., p. 819.

³Gordon Allport, Pattern and Growth in Personality (New York: Holt, Rinehart and Winston, 1961), p. 347.

⁴D. D. Drobda, "The Nature of Attitude," Journal of Social Psychology 4 (1933): 445.

⁵Carolyn W. Sherif, Mazafer Sherif, and R. E. Nebergall, Attitude and Attitude Change (Philadelphia: W. B. Saunders, 1965), p. 11.

literature. In a study of the attitudes of persons working in the field of aging, Silless examined 54 subjects by means of a semantic differential to determine their beliefs about the aged. Preliminary analysis using mean scores revealed that subjects held attitudes indicating the aged to be of less value, less potent, less active, and less understandable than youth or adult groups. Results also indicated that even persons working directly with the elderly held more negative attitudes toward them than toward either youths or adults, and that these attitudes followed the negative stereotypes of the general public, as demonstrated in previous studies.⁶

In a study of the attitudes of undergraduate students concerning geriatric patients, Mills surveyed 188 undergraduate occupational therapy students. The results of the study indicated that most of the students did not plan to work with the aged and showed a general weakness in geriatric knowledge. Indications were that their general unwillingness to become a part of geriatric service was caused by their negative attitudes toward the elderly.⁷

In a book about the life and work of William Posner, a Jewish social worker who devoted his life to a crusade for more recognition of the problems and value of the old, his views of social work with the aged were presented. Posner felt the cause of the distress of aging is found fundamentally in each individual's attitudes toward the

⁶S. Silless and C. L. Estes, "Perceptions of the Aged, Adults and Youth; The Attitudes of Persons Working in the Field of Aging," Gerontologist 13 (1973): 82.

⁷Jane Mills, "Attitudes of Undergraduate Students Concerning Geriatric Patients," American Journal of Occupational Therapy 26 (1972): 203.

old around him and toward his own aged years. Fearful, condescending, or indifferent attitudes are prevalent in the helping professions, he felt, as well as in the broader society.⁸

Training of Health Personnel in Geriatrics

A wide variety of teaching modes described in the literature have been used in training health professionals in the care of the elderly. None of the techniques reported has included simulation. Teaching modes that have been used and reported about are:

- Lectures, discussions, conferences, panel discussions
- Grand rounds presentation of cases on closed-circuit TV
- Written materials
- Sociodrama or role-playing
- Demonstration and ward experience
- Exchange program experience at other institutions
- Demonstrations on closed-circuit TV (therapy, interviews)
- Patient interview with follow-up discussion
- Living with patients for a day
- Keeping a diary of experiences
- Weekly informal doctor-nurse conferences
- Field trips

Of all the varying approaches described above in training health care workers in geriatrics, only four included the results of an effort to evaluate the impact of the teaching program. Three reported positive outcomes and the other reported negative results.

The first study was an evaluation of an eight-week inservice training program for psychiatric aides. Observer raters were used for four months before the program and during the program. An aide behavior rating scale was developed and tested. The results indicated

⁸Mary Buckley, The Aged Are People Too: About William Posner and Social Work With the Old (New York: Kennikat Press, 1972), p. 119.



that aide behavior improved with the introduction of informal, group-centered meetings on the ward.⁹

The second study investigated the effects of selected learning experiences on the attitudes of nursing students toward the aged. Associate degree nursing students were given questionnaires before and after participating in a course. During the program 55 subjects experienced a program structured to modify and change stereotyped attitudes held by students toward old people. The program included 45 hours of gerontology focused on intensive contact and planned experiences with essentially healthy aged in a variety of settings. A statistically significant positive change in attitude toward the aged and increased preferences for working with them after graduation resulted from the training intervention.¹⁰

The third study was an evaluation of a 15-hour prototype course taught to community college students using a multi-disciplinary approach intended to illustrate the interrelationships among the biological, psychological, and social components and variables in aging while also introducing related aspects of economics and community service. The attitudes of the subjects toward the aged were measured by a Likert-type scale; the Kogan Old People Scale. The subjects were grouped into three classes by total scores: low, medium, and high.

⁹Robert Ellsworth, Arthur Bryant, and Grace Butler, "Psychiatric Aide Inservice Training: An Experimental Approach," Nursing Research 9 (Winter 1960): 12-16.

¹⁰Barbara H. Steinbaum, "Effects of Selected Learning Experiences on the Attitudes of Nursing Students Toward the Aged," Gerontologist 13 (1973): 103.

The most significant change in attitude was in the high group, where more than twice the number of students had positive attitudes after taking the course than before. The investigator recommended that future courses of this nature include twice the number of hours in training, or 30 hours, than was included in this prototype course.

The final study to be reported had negative findings. It was designed to examine the attitude change of medical students who were exposed to a social medicine course focusing on the elderly. An experimental group of 91 and a control group of 89 freshmen medical students were exposed to lectures on social medicine, but only the first group dealt with the problems of aging. The results of questionnaires indicated little attitude change in any of the first-year medical students toward the elderly.¹¹ This study supported the idea that didactic presentation of data about the elderly is insufficient to effect attitudinal changes toward the aged.

Simulation as a Teaching Technique

None of the training programs reported above used social-simulation gaming as a teaching technique. In addition, a survey of curricular innovation in undergraduate nursing education, as reported by 102 deans of schools of nursing in the United States, revealed that 48 of the 226 innovations reported were in teaching methods. Of all

¹¹ Domenic V. Cicchetti and others, "Effects of a Social Medicine Course on the Attitudes of Medical Students Toward the Elderly: A Controlled Study," Journal of Gerontology 28 (1973): 370-373.

those innovations, none was in the area of simulation as a teaching technique.¹²

In the area of inservice training, one program reported in the literature that used a simulation game as part of the training was a pilot program designed for preparing administrators and sponsored by the Western Interstate Commission on Higher Education (WICHE). There was no systematic effort to measure the impact of this training endeavor.

The need for research on the effect of simulation learning has been repeatedly mentioned in the literature. There are conflicting reports about the usefulness of simulation as a teaching technique. Those who extol the advantages of simulation-gaming as a teaching technique attribute the following characteristics to this teaching mode:

1. Accelerates role-playing over a concentrated period of time
2. Allows feedback to the imaginary or fictitious staff member--less of an attack on person and more on performance and role-playing (sugar-coated feedback, easier to swallow)
3. Player can camouflage his identity in a role and then receive feedback for the characterization, which is a replication of his own interpersonal tendencies in dealing with others.

¹²Shke Ketefian, "Trends in Curricular Innovations in Nursing Education," International Nursing Review 21 (1974): 139.

¹³I. Levy, J. Tuckman, and A. J. Abrams, Attitudes of Junior and Senior High School Students Toward Aging, Annual Report of the New York State Joint Legislative Committee on Problems of the Aging, 1954, pp. 97-103.

4. All of the above characteristics of simulation-gaming free the participants to give honest feedback to each other because they all play the game of perpetuating the make-believe yet very real behavior of the actors.

Gordon, in Games for Growth, stated several reasons for the lack of evaluation in the field of simulation-gaming:

1. relative newness of the technique
2. consequent lack of time for data collection and the development of systematic evaluation procedures
3. difficulty in establishing experimental controls
4. nonexistence of appropriate measuring instruments¹⁴

In a Report on Education Research, the following was reported about simulation games:

1. The types of media used in the exercise have an impact on participant performance. If the simulation includes the use of both audio and visual media, the performance of participants improves compared to that when only one type of medium is used or none at all.
2. By participating in simulation exercises, players may develop more empathy for the roles they are assuming and the complexities of the environment with which they are dealing.
3. Repeated use of the exercises seems to improve the decision-making strategies of the participants.

¹⁴Alice Kaplan Gordon, Games for Growth (California: Science Research Associates, 1970), pp. 150-151.

4. Participants appear to develop a better understanding of the system dynamics and respect for the complex interplay of variables in a social system.

5. Simulation games affect the attitudes of students who play. In general, "a simulation game can be expected to increase the player's level of tolerance, approval or empathy for the real-life person whose role the player takes in the game." Emotional arousal during a game (as indicated by fluctuation in the heart rate) is related to changes in attitude, and the emotional arousal of one participant in a game is contagious--if one student gets excited, others will, too.¹⁵

The scattered evidence available on the effects of games and simulation games in socialization and in the classroom indicates that at least a few of the far-reaching hypotheses about the effects of games might have some validity.¹⁶

From the perspective of the sociology of learning, games have been suggested to have characteristics that are especially facilitative of learning, such as their ability to focus attention, their requirement for action rather than merely passive observation, their abstraction of simply elements from the complex confusion of reality, and the intrinsic rewards they hold for mastery. "By the combination of

¹⁵"Researchers Probe Reactions to Simulation Games," Report on Education Research (Washington, D.C.: Capital Publications, Inc., January 19, 1972), p. 4.

¹⁶M. Inbar, "The Differential Impact of a Game Simulation Disaster," American Behavior Scientist 10 (1966): 59.

these properties that games provide, they show remarkable consequences as devices for learning," reported Boocock and Schild.¹⁷

Defense of games culminates in the work of John Dewey, who examined their functions for society in general and the educational system in particular. He claimed that play and games not only fill a basic human need for make-believe activity, but also provide "fresh and deeper meanings to the usual activities of life."¹⁸

The student's active involvement in his own learning process, as opposed to "teaching by pouring it in, learning by passive absorption," was at the core of Dewey's pedagogical philosophy. In fact, the major difference between work and play, as he saw it, is that play is its own end, whereas work has ulterior ends and rewards external to itself, which would indicate an educational advantage of the former over the latter, at least in terms of motivation.

As Moreno pointed out, one advantage of role play in games over real-life experience is their relative safety.¹⁹ Subjects can test out alternative decisions, can analyze the consequences of their actions with a certain detachment, and can make mistakes without having to pay the real-life consequences.²⁰ In fact, for many, role-playing and the subsequent feelings of familiarity and empathy they

¹⁷Boocock and Schild, loc cit.

¹⁸John Dewey, Democracy and Education (New York: MacMillan, 1928), p. 152.

¹⁹J. L. Moreno, Who Shall Survive? (New York: Beacon House, 1953), p. 53.

²⁰Boocock and Schild, op. cit., p. 59.

gain with respect to their roles are the most rewarding aspects of the game experience.²¹

There is a difference between simulation gaming and straight role-playing. Less withdrawal is expected in the game situation. It may, of course, be that the game itself evokes more intense participation because it is "fun," hence more intrinsically attractive than the conventional classroom activity. But Boocock and Schild insisted that even students who initially find the game no more appealing than the conventional activity should withdraw less in the game, because they would be drawn into the situation by the other players.

Early research on social studies games did not produce startling findings. Cherryholmes' review of six studies concluded: "Simulation does produce more student motivation and interest compared to other teaching techniques, but there are not consistent or significant differences in learning, retention, critical thinking, or attitude change."²²

Inbar showed that two game variables--the number of game players and the individual administrator--have a considerable impact upon the amount of interest and learning generated within the game.²³

In short, much has been attributed to simulation games in regard to their effectiveness as a teaching mode, but there is little

²¹ Ibid., chapter 6.

²² C. H. Cherryholmes, "Some Current Research on Effectiveness of Educational Simulations: Implications for Alternative Strategies," American Behavioral Scientist, 1966, p. 6.

²³ M. Inbar, "The Differential Impact of a Game Simulation Disaster," American Behavioral Scientist 10 (1966): 18.

research evidence to support these claims. "The state of the art requires that simple hypotheses be tested, because for too long, speculations have accumulated without adequate supportive empirical work."²⁴ Although published reports of the implementation and investigation of the effects of simulation learning are scanty, several doctoral studies have been addressed to this problem. Some of these studies are reviewed below.

Eliot Bean studied effects of simulation games in modifying the attitudes of prospective teachers toward blacks. The study took white teacher trainees and placed them in interactive situations with blacks. After the interaction the role players received feedback from the group members. Within the game the players worked on interactions that were specifically designed to get at racial issues. Trained raters and a questionnaire were used to collect data on the effect of the simulation. All of the null hypotheses that related to attitude change failed to be rejected. It was concluded that simulation games as developed in that study did not affect prejudice. The reason for the negative findings was that a measuring device used was not sensitive enough or that changes were of such a nature that they would only occur over a long period of time.²⁵

The only investigation of simulation techniques applied to nursing education was the study by Shirley Steels. She studied the

²⁴Ibid., p. 60.

²⁵Eliot Bean, "An Attempt to Modify Prejudicial Attitudes Toward Blacks in Prospective Teachers by Use of Simulation Games" (Ph.D. dissertation, University of Southern California, 1972), Dissertation Abstracts, 33/04-A, p. 1503.

effects of simulation techniques with teachers in the area of child health nursing. The simulation was composed of videotapes of children ages three to eight in play and of role-taking by participants for the evaluation of various role positions. Twenty volunteer faculty from community colleges participated in the study. Results were significant at the .05 level, indicating that improved attitudes after training were also related to improvement in nursing care planning.²⁶

A role-play simulation was evaluated in the study by Peter Diulus. He attempted to analyze the elements of learning that are involved in role-play simulation games. Evaluation of two groups' playing of a role-play simulation game of the urban school in crisis indicated that students experienced dynamic processes of typical urban school and community and they practiced behaviors in a safe context. This study was called "action research," and does not appear to have used statistical analysis of data for the purpose of drawing conclusions. The investigator reported "evidence of significant skill development in interpersonal communication, negotiation, decision making, and problem solving."²⁷

Another study explored the effectiveness of simulation in changing regular classroom teachers' attitudes toward the integration of exceptional children into the regular classroom. The groups were

²⁶Shirley May Steele, "Investigation of Simulation Techniques with Teachers in the Area of Child Health Nursing" (Ph.D. dissertation, Ohio State University, 1973), *Dissertation Abstracts*, 34/02A, p. 672.

²⁷Peter Diulus, "Design, Use, Evaluation and Implications for Educational Theory of a Role Play Simulation Game of the Urban School in Crisis" (Ph.D. dissertation, University of Pittsburgh, 1972), *Dissertation Abstracts*, 33/12A, p. 6787.

comprised of regular classroom teachers enrolled in a course entitled "Education of Exceptional Children," at Michigan State University. The treatment group experienced a simulation of hearing impairment as part of a three-day presentation on the acoustically impaired child. Both groups were given the Classroom Integration Inventory as pre- and posttests. The analysis of the data showed a significant improvement in acceptance of the exceptional children after exposure to the simulation experience.²⁸

Stimulated Mutual Recall

Stimulated Mutual Recall has been incorporated as a teaching technique in the game design. This process involves the videotaping of role players during their interactions, with subsequent playback of the film for the purpose of stimulating learning. Dr. Norman Kagan, who has used this technique for over ten years in the training of therapists and physicians, described the purposes of the technique as follows:

In 1962 my colleagues and I observed that stimulated recall by means of videotape could enable people to understand themselves better, to recognize their impact on others and to realize the impact of others on them, and could allow people an unusual opportunity to try out new interpersonal modes of relating and responding.²⁹

²⁸Vincent Palacino, "A Comparative Study of the Effectiveness of Simulation in Changing Regular Classroom Teachers' Attitudes Toward the Integration of Exceptional Children Into the Regular Classroom" (Ph.D. dissertation, Michigan State University, 1973), Dissertation Abstracts, 34/06A, p. 2318.

²⁹Norman Kagan, "Attitudes Toward Old People: The Examination of a Scale and an Examination of Correlates," Journal of Abnormal Social Psychology 62 (1961): 1.

Originally, the "data" that were accumulated by Kagan attesting to the value of this technique were in the form of statements by the participants that were "fantastic."³⁰

Later research data from well-designed studies report the effects of more than just the process of Stimulated Mutual Recall. There are investigations into the effectiveness of the Interpersonal Process Recall method of training helping agents, which incorporates more than just Stimulated Mutual Recall in its methodology. Interpersonal Process Recall (IPR) is a term coined by Kagan for the basic process of reviewing a videotape with a person trained in the recall technique. Since the simulation game used in this study does not require the game manager to be trained in Kagan's recall technique, it cannot properly be called IPR.

Nevertheless, it might be useful to review some of the reported effects of IPR as a technique, since it is similar to Stimulated Mutual Recall. Efforts of Kagan and associates to determine the real vs. the imagined effects of IPR as a training tool have left us with results that are supportive of the value of this teaching paradigm. For example:

1. When the model was used in conjunction with a graduate practicum with a total of ten hours over an eight-week period, there were large, significant differences in counseling skills between the groups in favor of IPR, as rated by independent judges.³¹

³⁰Ibid., p. 3.

³¹Ibid., p. 10.



2. A study that compared the IPR model with a traditional seminar approach to a pre-practicum course revealed significant differences in favor of the IPR model in respect to interview behavior after 15 hours of training.³²

3. Dendy provided a 38-hour program to undergraduate students over a six-month period. Among his findings were significant improvement in interviewing skills, significant growth on an affective sensitivity scale, and no loss of skills during the three-month no-training period. Dendy suggested that, "One of the most important findings of this study was that R.A.'s were taught to function on certain dimensions of helping relationships at levels no different from that of experienced professional counselors at or near the Ph.D. level." However, in evaluating this study, one needs to consider that the participants were carefully selected and not a random grouping.³³

4. Archer also studied the IPR model in training undergraduates as paraprofessional leaders in interpersonal communications skills training. Measures of affective sensitivity and self-actualization were used to collect data. In addition, a subjective questionnaire was given to the students so they could rate the training experience. Results of the subjective questionnaire indicated that

³²J. D. Spivak and N. Kagan, "Laboratory to Classroom, The Practical Application of IPR in a Master's Level Pre-Practicum Counselor Education Program," Counselor Education and Supervision, September 1972, p. 23.

³³R. F. Dendy, "A Model for the Training of Undergraduate Residence Hall Assistants as Paraprofessional Counselors Using Videotape Techniques and Interpersonal Process Recall (IPR)" (Ph.D. dissertation, Michigan State University, 1971), Dissertation Abstracts, 32/09A, p. 4940.

93 percent of the students felt they had improved their interpersonal communication skills to some degree. Conclusions from the results of the research were that undergraduates as paraprofessionals could train other undergraduates to have more effective interpersonal skills using the IPR model.³⁴

5. Heiserman compared the effectiveness of the IPR model and cognitive-classroom teaching methods in training juvenile court workers in interpersonal communication skills. Data on the performance of the subjects pre-, mid-, and post-training were gathered from the rating of audiotapes by three independent judges. The results indicated that the IPR model was not more effective in teaching discrimination and communication skills.³⁵

Videotape Feedback

Videotape feedback as a process similar to stimulated mutual recall has been used extensively in therapy with clients. Alger reported that playback is particularly valuable in clarifying communication problems and feelings meant to be conveyed at the time of the original session, but which did not come through to the person to whom

³⁴James Archer, "Undergraduates as Paraprofessional Leaders in Interpersonal Communication Skills Training Groups Using an Integrated IPR (Interpersonal Process Recall) Videotape Feedback/Affect Simulation Training Model" (Ph.D. dissertation, Michigan State University, 1971), Dissertation Abstracts, 23/09A, p. 4932.

³⁵Mary Heiserman, "The Effect of Experiential-Videotape Training Procedures Compared to Cognitive Classroom Teaching Methods on the Interpersonal Communication Skills of Juvenile Court Case-workers" (Ph.D. dissertation, Michigan State University, 1971), Dissertation Abstracts, 32/09A, p. 4949.



they were addressed.³⁶ He further concluded that feelings that were once considered unacceptable are often accepted by the patient through playback, that is, through seeing how they come across. The result is less intellectualization on the patient's part.

On the other hand, Bahnson found that the effects of videotape feedback differ according to differing characteristics of the subjects.

The effect of audio-visual self-confrontations depends upon the subject's developmental level and ego defenses, and varies from non-therapeutic disintegration of perceived self and body barriers, to therapeutic and integrative incorporation of central aspects of self (insight) in patients with sufficient ego strength.³⁷

Although he did not label it Stimulated Mutual Recall, Hogan reported on the use of videotape feedback as a technique in group psychotherapy. His description of the use of the videotape is identical to its use in the stimulation game in the present study.

During the playback, any member of the group can stop the tape at any point in order to comment on his own reactions, or any discrepancies he sees between the way he appears and the way he felt at the time of the original recording, or on the behavior of any of the other members as he sees it. (In that way the reactions of the groups are integrated into the learning situation, providing valuable feedback and fostering further interaction among the members.)³⁸

³⁶I. Alger and P. Hogan, "The Impact of Videotape Recording on Involvement in Group Therapy," Journal of Psychoanalysis Groups 2 (1967): 50-57.

³⁷Claus Bahne Bahnson, "Body and Self Images Associated With Audio-Visual Self-Confrontation," Journal of Nervous and Mental Disease 148 (1969): 262-280.

³⁸Peter Hogan, M.D., and Ian Alger, M.D., "The Impact of Videotape Recording on Insight in Group Psychotherapy," International Journal of Group Psychotherapy 19 (April 1969): 158-164.

Although they were not supported with hard data, Hogan saw the following advantages of the above-described process:

1. Participants gain an awareness of their behavior, which previously alluded them.
2. General lack of defensiveness--people seem fascinated to learn how they appeared to others.
3. Motivation to change is increased.
4. Desire to change is experienced as coming from himself as a result of his own observations and conclusions rather than being imposed upon him by some outside authority.³⁹

None of the above studies of Stimulated Mutual Recall nor of videotape feedback looked at any influence such processes might have on attitudes and/or stereotypes. That is the concern of the present study.

Several doctoral studies have been conducted on other effects of videotape feedback in education. A few of these studies have been selected for a brief review here because they relate in some way to the present study. They are as follows:

Elbert investigated the effects of videotape feedback upon participants in sensitivity training, specifically to determine changes in self-concept, self-actualization, and interpersonal relations. Two groups of twelve subjects were randomly selected from volunteers. Before the 30-hour training period, each subject completed the Personal Orientation Inventory and the Tennessee Self-Concept Scale; the Fundamental Interpersonal Relations Orientation

³⁹Ibid.

scale was given both before and after training. All three null hypotheses were supported by the findings; no significant difference was found, on the basis of the posttest results. Further, videotape feedback as employed in this study was not effective in producing interpersonal orientation changes in sensitivity training.⁴⁰

In Durand's study the purpose was to devise an "outreach" counseling program to meet student interpersonal needs by training helpers in listening behavior using videotape replay techniques. Two groups of twelve subjects were randomly selected from volunteers. Members of the control group met in parallel interpersonal situations but were not exposed to videotape replay, as the other group was. The findings, based on a pretest-posttest comparison, indicated that the experimental group had significantly improved its ability to discriminate "affect," whereas the control group had not. In conclusion, this study demonstrated that it is possible to teach "naive" subjects listening behavior with videotape replay techniques in a relatively short period of time.⁴¹

Using role-play and critique methodology, a study by Stroh measured the effect on learning caused by self-confrontation by means of videotape replay compared to audiotape replay. The audiotape recording was used to aid recall during the critique. Twenty-five

⁴⁰Eugene Elbert, "Changes in Self-Concept, Self-Actualization and Interpersonal Relations as a Result of Video Feedback in Sensitivity Training" (Ph.D. dissertation, East Texas State University, 1969), Dissertation Abstracts, 30/12A, p. 5233.

⁴¹Henry Durand, "Teaching Listening Behavior: A Videotape Technique for the Improvement of Affective Discrimination" (Ph.D. dissertation, University of Pittsburgh, 1971), Dissertation Abstracts, 32/09A, p. 4942.

experienced industrial salesmen were randomly assigned to two groups: a 12-man control group and a 13-man experimental group. It was found that videotape feedback improved scores significantly in two areas: reducing the number of interruptions and appropriate sharing of the conversation. Conversely, feedback limited to audiotape improved scores in four areas over the experimental group scores. The control group was able, through progressive performances, to achieve approximately the same overall score improvement as the experimental group in the areas measured.⁴²

Role-Playing or Role-Reversal

Role-playing is also incorporated into "Life-Cycle" as a teaching strategy. Sometimes a participant acts in his normal social role of nurse, aide, housekeeper, etc., and in this case simple role-playing is used. Other times in the game he may be put into a role that is not his natural role in real life, such as playing the part of a senior citizen. In the latter case the teaching technique would more properly be termed "role-reversal."

Role-reversal is a technique that has been utilized repeatedly in therapy with adults for the purpose of sensitizing the individual to the feelings and motivations of an antagonist. For instance, the technique has been effectively incorporated into marital therapy for the purpose of increasing the understanding of both parties toward

⁴²Thomas Frederick Stroh, "Videotape Feedback in the Development of Listening Skills by Industrial Salesmen" (Ph.D. dissertation, Columbia University, 1968), Dissertation Abstracts, 30/03A, p. 1085.

each other. There are no reports in the literature of role-reversal being used as a technique to sensitize people to the experience of being old, as is done in the training program under investigation.

In respect to role-playing, Kerlinger commented that:

It has been the experience of role players that they say things they would rarely say under ordinary circumstances. They "come out" with things that surprise even themselves. The method, in other words, tends to bring out motives, needs, and attitudes that are below the surface.⁴³

Byrne also noted his observations of the perceived advantages of role-playing as a teaching technique, especially in training physicians. He wrote:

The introduction of role-playing into a situation adds a further dimension to the possible teaching value. "Role-playing is a technique unfamiliar to most trainees. In fact it does not require so much acting in a physical sense, it requires the feeling for the part of the patient. Role-playing makes each reflect more with care on what it means to be a doctor and, above all, a patient. It was Checkov, himself a doctor, who said that he would spend a substantial portion of his time in their training to make medical students realize what it was like to be a patient. . . ."⁴⁴

This is exactly the intent of the simulation game to be used in training health care workers in this study.

In a search of Dissertation Abstracts, only one study was located that investigated the effects of role-playing. It specifically examined the effects of role-playing on the racial attitudes of white suburban fourth and sixth grade students toward blacks. The researcher used a questionnaire of the semantic differential type as

⁴³Fred N. Kerlinger, Foundations of Behavioral Research (2nd ed.; New York: Holt, Rinehart and Winston, 1973), p. 199.

⁴⁴P. S. Byrne and B. E. Long, Learning to Care (London: Churchill Livingstone, 1973), p. 83.

well as an open-ended questionnaire that dealt with interracial social dilemmas. There were 504 experimental and control group subjects. Even with such a large number of subjects, no significant differences were found, and it was concluded that role-playing does not affect the racial attitudes of white suburban fourth and sixth graders.⁴⁵

Effect of Other Variables on Attitude Toward the Aged

An additional area of investigation in this study is the influence of demographic variables and other personal characteristics of the subjects upon their attitudes toward the aged. Previous studies in this vein are few and contradictory. An attempt is made either to confirm or to replicate the findings of the following studies in this area.

A study of the influence of age on the attitude of the individual toward aging indicated that these attitudes are less affected by age than by some other factor, such as isolation, inactivity, and institutionalization.⁴⁶

Quite the opposite results were reported in a study that indicated more negative attitudes toward the aged on the part of older subjects and those who have fewer years of education.⁴⁷

⁴⁵Diulus, loc. cit.

⁴⁶Ruth Bennett and Judith Eckman, Attitudes Toward Aging: A Critical Examination of Recent Literature and Implications for Future Research (Washington, D.C.: American Psychological Association, 1973), pp. 575-597.

⁴⁷J. Thorson, K. Hancock, and L. Whatley, "Attitudes Toward the Aged as a Function of Age and Education," Gerontologist 13 (1973): 82.

Another study by Tuckman concluded that individuals who have had more direct contact with a variety of old people tend to be somewhat less negative in their attitudes toward aging than those whose acquaintance is more limited and constrained.

A more recent study found that age appeared to be highly related to attitude scores. Older students in the study tended to have more positive attitudes toward old people. Another finding of the study was that those subjects who reported pleasurable memories of their grandparents had higher positive reactions to old people than those with unpleasurable or neutral memories.⁴⁸

⁴⁸J. Tuckman, "The Effect of Institutionalization on Attitudes Toward Old People," Journal of Abnormal and Social Psychiatry 47 (1952): 337-344.

CHAPTER III

DESIGN OF THE STUDY

This chapter provides a detailed description of the design of the study, the population from which the sample was chosen, the nature of the sample, and the methodology used in gathering the data.

Subjects

The population from which the sample of subjects was chosen consisted of 40 personnel employed by the Martin Luther Holt Home in Holt, Michigan, during the month of April, 1975. The population was chosen from a community nursing home rather than from students in the health professions because the investigator felt they would be more representative of the majority of workers in the field who care for the aged on a daily basis. In consideration of their need for special training in communication skills and their frequent interpersonal contact with elderly patients in a nursing home, they were considered to be appropriate representatives to use to evaluate the effects of the training program.

The subjects for the experiment were selected at random by the Director of Nursing of the home. The process involved picking names out of a hat from a pool of the names of all employees in the institution. The only employees who were excluded from the selection process were those who could not participate in the training program because

of personal commitments that made them unavailable during the hours planned for the training program. Ten names were removed from the pool of 45 subjects for this reason, leaving 35 names in the pool, from which 20 were again selected randomly for participation in the training program. The experimental group members who were chosen in this fashion were all part of the nursing staff, that is, registered nurses, licensed practical nurses, and nurses aides.

The control group consisted of 20 additional staff members who were present at the total staff meeting at which the pretest was administered. They were assigned to the control group in the order in which they appeared for the meeting. Since the control group members were randomly interspersed with the experimental group subjects upon arrival at the meeting, they were essentially a randomly selected population.

The random sampling technique was used to equate the two groups on a variety of uncontrolled variables so that differences on several dependent variables, i.e., measures of attitudes, could be attributed to the manipulated independent variable.

No more than five subjects from the experimental group could participate in the training program at one time because of the necessity of having sufficient staff coverage on the wards at all times. For this reason, the training program was given in two sessions, on two consecutive weeks, with two groups. That is, two groups of five subjects each were trained the first week (April 14-18) and two groups of five subjects each were trained the second week (April 21-25). A representation of the total design is presented in Appendix A.

It would have been preferable for all training groups to begin and end on the same day. However, it was not possible for all those subjects to be away from their patients at the same time because of the need for continuous patient care by a portion of the experimental group at all times. Fairweather stressed the importance of all subsystems in an experiment being activated and terminated at the same time: "Fluctuations in economic and political climates, as well as attitude changes among the citizens, will influence the conditions present at any given moment."¹ However, in a consultation interview, he recognized that experiments performed in community settings must be amenable to changes in the research design to accommodate the real-life needs of the host institutions. Since this was a field experiment, there was less control over the scheduling and staffing of the training program than there might have been in an academic setting or under laboratory conditions.

Three subjects had to be eliminated from the experimental group. One subject eliminated herself by not showing up for the training program. She was, therefore, assigned to the control group since she had not been exposed to the training intervention but had filled out the pre-questionnaire. The other two subjects were eliminated from the study after missing the last session of the training program. Since these two subjects had been exposed to a portion of the treatment program, they were eliminated from the study entirely.

¹George W. Fairweather, Methods for Experimental Social Innovation (New York: John Wiley and Sons, 1968), p. 104.

ProcedurePretest

All 40 subjects were assembled in one room at a time normally scheduled for monthly in-service meetings, on April 11, 1975. The staff members were not informed beforehand that they would be asked to complete a questionnaire during the meeting time. When the meeting convened, the administrator announced that a training program would be given over the next two weeks and that 20 members of the staff had been chosen at random to participate in the training. The training program was explained as an educational program in Communication and Problem-Solving Skills. No mention was made of its possible effects upon attitudes toward the aged. The administrator indicated his support and positive endorsement of the program.

It was decided not to announce the names of the experimental group participants until after the questionnaire was administered. This was a joint decision on the part of the nursing home administration staff and the researcher, to avoid a reaction on the part of the control group of a sense of nonparticipation and lack of interest in completing the questionnaires. This concern about potential disinterest on the part of the control group proved to be well-founded when seven members of this group failed to appear for the final staff meeting and posttest at the completion of the training program, as compared to a 100 percent attendance of the experimental group at the same meeting.

Posttest

The posttest was a repetition of the ATOP scale and an open-ended questionnaire given in conjunction with a critical-incident stimulus film (see page 57 for an explanation). These tests were administered to all subjects on April 29, when they were gathered in a meeting room at the nursing home before a staff meeting. Members of the experimental group completed a subjective questionnaire at the end of the last training session (see page 55).

Description of Subjects

The sample was composed of 39 females and one male. The marital status of the group is presented in Table 1. Over half of the subjects were married, and the remainder were either divorced and widowed (20 percent) or single (27.5 percent). Their age distribution is illustrated in Figure 1. The majority of subjects (over 50 percent) were in the 18-25 age bracket; the mean age was 34.9 years. It can be noted from the figure that the age distribution of the subjects would have ended at age 65, were it not for one unusual subject who was employed as an aide at the age of 74.

TABLE 1
MARITAL STATUS OF SUBJECTS

Married	52.5%
Divorced and widowed	20.0%
Single	27.5%

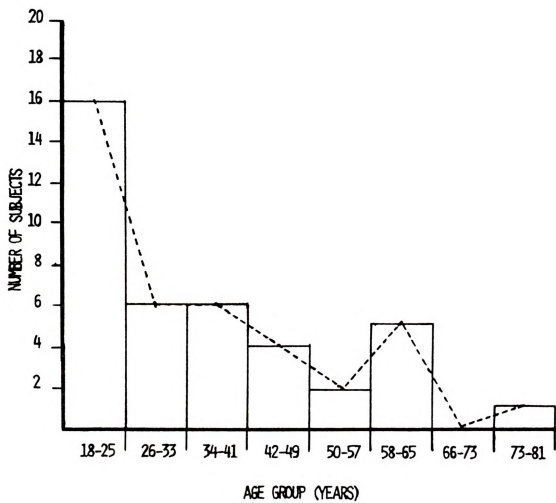


Figure 1. Age distribution of subjects.

The overall educational background of the subjects is presented in Table 2. The greatest percentage fell into the high school education group, with the remainder of the subjects evenly divided between elementary school and college preparation. Those subjects who were members of the nursing staff were 77.5 percent aides and 7.5 percent licensed nurses (R.N. and L.P.N.). The other job categories represented in the sample were dietary (2), laundry (2), housekeeping (1), and janitor (1).

TABLE 2
EDUCATIONAL BACKGROUND OF SUBJECTS

Elementary school	20%
High school	60%
College	20%

The nursing home job experience of the subjects ranged from two weeks to 15 years. A differentiation was made between job experience in the Holt Home and experience in other homes (see Table 3); the percentage distribution of the job experience is also presented. The distribution of the group in terms of their job experience in this particular home is presented in Figure 2. When only the job experience at the Martin Luther Holt Home is considered, 40 percent had been employed for less than a year.

In Table 4, 87 percent of the subjects reported receiving no formal training in the field of geriatrics, exclusive of in-service

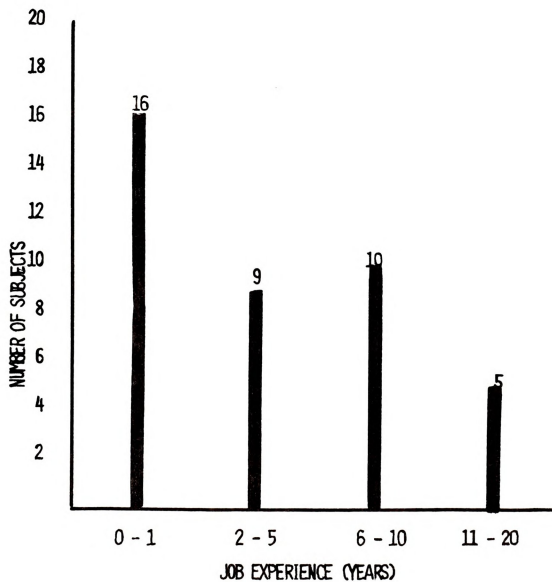


Figure 2. Subjects' job experience in the Martin Luther Holt Home.

TABLE 3
WORK EXPERIENCE OF SUBJECTS IN GERIATRICS

Martin Luther Holt Home

1 year or less	40%
2-5 years	22%
5-10 years	25%
11-15 years	13%

In other homes

1 year or less	80.0%
2-5 years	17.5%
6 years	2.5%

TABLE 4
SUBJECTS' EDUCATION IN GERIATRICS

No formal academic preparation	87.5%
In-service in other nursing homes	12.5%

training programs that had been attended at other nursing homes by 12.5 percent of the population. All staff members employed at the Holt Home attended monthly in-service training meetings, which were not calculated in the 12.5 percent allocation to in-service preparation.

The number of days the subjects worked each week varied from five to one. Fifty-seven and one-half percent were full-time employees

(five days/week); the remainder were part-time employees (less than five days/week). See Table 5.

TABLE 5
EMPLOYMENT STATUS OF SUBJECTS

Full time (five days per week)	57.5%
Less than full time	42.5%
4 days per week	27.5%
3 days per week	10.0%
1 day per week	5.0%

Measures

Four questionnaires were used to obtain data on the sample group. They were comprised of two rating scales, the Hogan Empathy Scale and the Attitude Toward Old Persons Scale (ATOP), a subjective evaluation of the training program experience, and an open-ended questionnaire in response to a stimulus film. Each of these instruments is explained in detail below.

The Hogan Empathy Scale

The Hogan Empathy Scale is more a measure of personality type than it is a detector of short-term changes in empathic abilities as a result of an in-service training experience. For this reason it was given as a pretest only, to determine its correlation with the ATOP scale as an additional test of the construct validity of ATOP. It is a forced-choice, true-false scale consisting of 64

items. Thirty-nine of these items are found in the California Psychological Inventory and 17 items are found in the group form or booklet version of the Minnesota Multiphasic Personality Inventory. The remaining eight items come from an experimental testing form used at and developed by the Institute of Personality Assessment and Research, University of California, Berkeley. Hogan reported extensive research on the construction and empirical validation of this scale.² The empathy criterion of the highly empathic person, developed by Hogan, resulted in a composite with an estimated reliability of 0.94. The True/False Empathy Scale developed correlated an average of 0.62 with the criterion. Test-retest scores produced a reliability coefficient of 0.84. The empathic individual measured by this scale has been defined as having the following characteristics:

1. socially perceptive of a wide range of interpersonal cues
2. aware of his own perception of others
3. adept at social facilitation techniques
4. insightful into his own and others' motivations and behaviors
5. able to see self as separate from others
6. sensitive to current feelings and able to communicate this understanding verbally
7. able to describe feelings in fuller, richer manner

²R. Hogan, "Development of an Empathy Scale," Journal of Consulting and Clinical Psychology 33 (1969): 307-316.

Attitude Toward Old
Persons Scale (ATOP)

This scale was used as both a pretest and posttest measure of attitudes toward the aged among the sample population, and as a measure of attitude change as a result of manipulation of an independent variable--the in-service training program. It was also used to determine the relationship between several demographic variables and attitudes toward the aged. Finally, the researcher hypothesized that those subjects who have had or are still having a satisfying personal relationship with an elderly relative and/or friend will have a more positive attitude toward the elderly; that is, a positive relationship was predicted. The ATOP Scale was used as a measure of the influence of these relationships upon attitudes toward the elderly.

The ATOP Scale is a Likert-type scale consisting of 18 items, of which 11 express negative attitudes toward the aged and 7 express favorable attitudes toward the aged. The items are rated in terms of a five-point scale ranging from strongly agree to strongly disagree. High scores (above 54) are interpreted to reflect favorable attitudes toward the old, whereas low scores (below 54) represent negative or prejudicial attitudes toward old persons. The scale has been employed to determine changes in self and interpersonal attitudes as the result of remotivation techniques used on elderly persons in nursing homes.

The ATOP was validated on only one sample of 88 undergraduate college students. Using this sample, an internal consistency reliability estimate of .86 was obtained based on Flanagan's formula.

Considering that only 18 items comprise the scale, this reliability coefficient is somewhat encouraging. The mean score for this group of college students was 66.2, with a standard deviation of 12.1.

Eisler, who developed the ATOP scale, suggested that it would be premature to assume that a full evaluation of the potential of the ATOP has been made. The scale has been used in only one study and, although its reliability coefficient appears adequate to its purposes, there is a need for replication. Further indices of the stability of the test need to be obtained to supplement the internal consistency data already present. A more complete evaluation of the scale would entail its administration to samples other than college students, as was done in the present study. A further measure of the scale's reliability was done in this study by determining the correlation between the pre- and posttest scores of the control group.

More evidence is needed to support the construct validity of the scale. In this study the scale was correlated with the Hogan Empathy Scale, the hypothesis being that those persons who are highly empathic will be more likely to have a strongly positive attitude toward the aged than those who are not highly empathic.

Despite the cited limitations of ATOP, the summated rating scale (of which this is a type) seems to be the most useful measure of attitudes in behavioral research.³ A summated rating scale is a set of attitude items, all of which are considered of approximately equal "attitude value," and to each of which subjects respond with degrees

³Kerlinger, op. cit., p. 499.

of agreement or disagreement (intensity). The scores of the items of such a scale are summed, or summed and averaged, to yield an individual's attitude score. As in all attitude scales, the purpose of the summated rating scale is to place an individual somewhere on an agreement continuum concerning the attitude in question.

The main advantage of this type of attitude measure is that greater variance results.

The variance of summated rating scales, unfortunately, often seems to contain response-set variance. Individuals have differential tendencies to use certain types of responses. This response variance confounds the attitude (and personality trait) variance.⁴

Despite the need for further validation of the ATOP Scale, it was chosen as a measurement instrument because it appeared to be the best measure of attitudes toward aging found in a review of the literature.

Subjective Evaluation of Training Program by Participants

Upon completion of the training experience, a questionnaire consisting of eight forced-choice, fixed-alternative response items and three open-ended questions was administered to those who participated in the training program. The purpose for administering this questionnaire was to determine the subjects' personal evaluation of the learning experience in terms of learner satisfaction and self-reported impact of the training program. This questionnaire was administered in an effort to catch any self-reported effects of the training program that would not otherwise be detected by the other measurement

⁴Ibid., p. 496.

instruments to be utilized. A copy of this evaluation form is contained in Appendix P.

The fixed-alternative item questionnaire has both advantages and disadvantages. It achieves greater uniformity of measurement and thus greater reliability by forcing the respondent to answer in a way that fits the previously determined response categories. The major disadvantage is the superficiality of such questionnaires; without probes they do not ordinarily get beneath the response surface. However, "they can be used to good purpose if they are judiciously written and mixed with open items,"⁵ as was done in this evaluation questionnaire.

The open-ended questions were used to supplement the forced-choice responses in an effort to get beneath the response surface.

Such questions have many advantages:

Open-end questions are flexible; they have possibilities of depth; they enable the interviewer to clear up misunderstanding (through probing); they enable the interviewer to ascertain a respondent's lack of knowledge, to detect ambiguity, to encourage cooperation and achieve rapport, and to make better estimates of the respondent's true intentions, beliefs, and attitudes.⁶

In summary, a form for evaluating the impact of the training program was completed by each participant. In addition to forced-choice items, the form included open-ended questions intended to alleviate any superficiality or ambiguity that might have resulted from the forced-choice items.

⁵Ibid., p. 483.

⁶Ibid., p. 484.

Use of Critical Incident
Stimulus Film With Open-
Ended Response Questions

A critical incident stimulus film was created, using a professional actor to dramatize an emotion-packed, confrontative situation to the subjects. The three-minute videotape presented the actor in the role of an elderly patient in a nursing home, speaking directly to the audience about a situation that was very distressing to him. (A copy of the actor's monologue is contained in Appendix F.)

The film, with an accompanying questionnaire, was presented after the subjects had completed the ATOP posttest scale. The administration of ATOP before the stimulus film in the posttest situation was an intentional precaution to prevent a reaction effect of the emotion-packed film upon ATOP test results.

This film-questionnaire technique was field tested on two volunteer subjects. During the field test, the volunteers were asked to respond to two separate stimulus films. According to the reports of the testees in the trial run, the manner and form in which they responded to the second videotaped critical incident was very much influenced by the viewing of the first videotape segment. In other words, their written responses to the second film clip tended to be essentially a repetition of their initial responses to the first filmstrip. They also reported that their judgment and observation of the second filming was "set" by an awareness of the questions they would be asked in relation to the film, an awareness that resulted from responding to the same questions about the first filmstrip. Because of this reported response-set and test-retest interference, it was



decided to use only one critical incident film as a stimulus in the posttest.

In this test, the participants were asked to respond to a person speaking directly on videotape as they would respond if they were alone in a room with him. They were encouraged to put themselves mentally into the situation and to react freely and spontaneously to the speaker as they would in a comparable event in real life. (A copy of the directions given to the participants and the questions they answered is given in Appendix E.)

The writer was unable to find reports of previous attempts at this method of data collection in the literature reviewed. Kagan and associates, who investigated the influence of IPR training on interviewer behavior, used independent judge-rated scores of interviewer behavior as a measure of therapeutic response modes on the part of the interviewer.⁷

This type of testing technique is similar in some respects to projective tests. In a projective test a subject is presented with some unstructured, ambiguous content material in the form of a design, pictures, or objects. He is then asked to organize the subject matter into some comprehensible whole that has specific meaning for him. In the case of projective tests the interpretation of content comes from the subject, depending upon his subjective response to the material.

In the testing technique of eliciting responses to a critical incident stimulus film, the subject is presented well-structured,

⁷Norman Kagan and others, Studies in Human Interaction: Interpersonal Process Recall Stimulated by Videotape (East Lansing, Mich.: Educational Publications Service, 1967), p. 7.

well-defined content material in the form of a videotape. The testee is then asked to respond to the videotape spontaneously, as though he were in the situation in real life, and to record his responses on paper. In this technique no interpretation of content is required of the subject. He is merely asked to respond to a provocative stimulus.

A common characteristic of projective methods and stimulus films is their relative lack of objectivity, in the sense that it is much easier for different observers to come to different conclusions about the responses of the same persons. Although different observers can score the same data quite differently, a serious weakness from the perspective of objectivity, this is a strength from the projection perspective.

Therapeutic and nontherapeutic response modes.--In this study, three judges rated the verbal responses of the subjects as reported by them in writing on the questionnaire form. They first rated the communicated response on a global basis by judging its overall therapeutic effectiveness, using their professional judgment as professional counselors. The raters were a psychologist-caseworker, a family nurse practitioner, and the researcher, who is a clinical specialist in psychiatric-mental health nursing. The identities of the subjects and their identification with either the experimental or the control group were unknown to the raters, to prevent any biased judgments in favor of individuals and/or groups.



After a global rating on a scale from one to three (three being the most therapeutic response), the raters then evaluated the types of response modes used by the subject. They used the rating form that had been used by Kagan et al. in judging interviewer behavior.⁸ Following Kagan, they rated the responses using the following four nominal, dichotomous variables: exploratory vs. nonexploratory, affective vs. cognitive, listening vs. nonlistening, and honest labeling vs. distorting. (A copy of the rating form and definitions are contained in Appendix I.)

Emotional response.--Subjects' responses to open-ended questions about their emotional experience in response to the stimulus films were analyzed and classified using Davitz's methodology. Subjects were asked how they felt in the simulated situation with the elderly patient; their responses to this question were categorized according to the structure of defining emotional experience developed by Davitz. This structure is useful in that it brings together a number of apparently diverse lines of speculation, and provides a framework within which complex emotional phenomena can be described. From a content analysis of descriptions of emotional experiences, Davitz identified 12 clusters, such that items in each cluster show similar patterns of presence and absence in definitions of 50 emotions. On the basis of a structural analysis of emotional meaning, a way of classifying emotions at various levels of specificity was developed.

⁸Ibid., p. 8.

The four dimensions of emotional meaning used in Davitz's model are Activation, Relatedness, Hedonic Tone, and Competence.⁹

The dimensions that were used to analyze the emotional response of the participants to the videotaped situation were limited in this study to Relatedness, Hedonic Tone, and Competence. A list of possible subject responses that are expressive of emotional-state clusters of Relatedness, Hedonic Tone, and Competence is given in Appendix J.

Since many of the participants in the study had had limited experience in expressing themselves on paper, a descriptor list was provided for them. The list contained a randomized listing of all of those phrases describing emotional responses that are presented in the above-mentioned clustered list. The participants were given the option of either checking off their emotional responses to the speaker on the descriptor list or of choosing their own words to describe their emotional response. In cases in which the subject elected to describe his feeling response in his own words, the responses were fit into the same cluster classification scheme by using the dictionary of emotional meanings that Davitz provided in his book. This dictionary attempts to fit most commonly used emotionally descriptive words into the above clustering pattern. In the end, by using either the descriptor checklist or the dictionary to analyze written responses, it

⁹Joel Davitz, The Language of Emotion (New York: Academic Press, 1969). This source contains a thorough presentation of the cluster analytic technique.

was possible to categorize all the emotional responses of the subjects into the dimensions of Relatedness, Hedonic Tone, and Competence.

Action taken.--The participants were asked what they would do in the situation portrayed on film. This question attempted to elicit data that would reflect the physical activity of the subject in response to the speaker, as opposed to his emotional response, which was analyzed by the above-described technique. An ex-post-facto data coding process was used when the responses to this question were obtained, since it was difficult to predict all of the possible alternatives that the subjects might choose for a response to this question.

The subjective scoring methods described above do need further empirical testing because of the very long inferential leaps involved. Their proposed validity is based on the assumption that the participants would respond to a videotaped critical incident stimulus film in a manner reflective of how they might respond to the same situation in real life.

Projective tests have a large element of subjectivity of interpretation. In this study an attempt was made to objectify the results of the projective tests by the following methods. First, a well-researched and validated classification tool developed by Davitz was used to quantify the emotional responses of the participants. Second, a test of inter-rater reliability was made on the judgments of the three raters in an attempt to "objectify the subjective." Third, a well-defined criterion structure for rating the types of

response modes was used by the raters in an effort to arrive at an agreement between the judges on the scoring and interpretation of the data. Fourth, the projective measures were not the only instruments used in this study. There was potential for their further validation by correlating the results of the projective tests with the results of the other standardized and objective tests used.

Design

This study used an experimental design, designated by Campbell and Stanley as Design 4.¹⁰ It took this form:¹¹

Experimental Group -- R O₁ X O₂

Control Group -- R O₁ O₂

A schematic outline of the design is presented in Appendix A.

Internal Validity

This design controls for all of the seven rival hypotheses described by Campbell and Stanley, that is, history, maturation, testing, instrumentation, regression, selection, mortality and interaction of selection and maturation.

Design 4 calls for simultaneity of experimental and control sessions. Such conditions were approximated in this study. Since the experimental group itself was divided into four separate units, which received training at different time periods, one could hypothesize that this might cause differences between subgroups in the

¹⁰Donald T. Campbell and Julian Stanley, Experimental and Quasi-Experimental Designs for Research (Chicago: Rand McNally, 1963), p. 14.

¹¹R = randomization; O = observation; X = intervention.

experimental group. However, randomization of subjects to each of these subgroups served to control for subgroup differences. The fact that the experimenter or trainer was the same for each of these subgroups also helped to control for variances among experimental subgroups. The problem of intrasession history was more controlled than if the trainers had been different people, because the trainer was the same for each experimental subgroup.

Since the subjects responded to a fixed paper and pencil instrument, the instrumentation factor was more controlled than it would have been if the subjects had been interviewed or observers used. A further precaution to control for instrumentation effect in the analysis of responses by judges was to present randomized stacks of responses to the judges, with subject and group identity hidden, so they could make unbiased ratings.

A possible rival hypothesis in the study would be that the invitation to participate in the training program would in itself be sufficient to create differences between the experimental and control groups. Campbell and Stanley suggested that one possible way to gain some control over this confounding variable would be to share the pretest results with the uninvited group as well.¹² This action was taken at the time of the meeting for the final posttest. At that time all subjects were presented with a thorough analysis of the demographic data obtained during the pretest session.

¹²Campbell and Stanley, loc. cit.



In conclusion, the main effects, those factors that might affect internal validity or the resulting scores, seemed to be adequately controlled in this design.

External Validity

The threats to external validity, those factors that can be called interaction effects, involving the independent variable and some other variable, constituted a serious problem in this design. The problem of having pretested groups is that the attitudes of the subjects could be changed by the pretest. For this reason, any significant changes in attitudes toward the elderly as a result of a training experience in this study can only be generalized to a similar pretested population. However, since the stimulus film and the accompanying questionnaire were used as a posttest measure only, any significant data from this analysis could be considered to be more representative of the universal population of individuals who were not pretested.

The ATOP Scale, which was used as a pretest, may sensitize the audience to attitude issues by focusing their attention on the same, and thereby increase the educational effect of the training program on attitudes. However, since the pretest was not concerned with communication, sensitivity, and therapeutic communication modes, it was anticipated that the ATOP would not have an effect upon these elements as they are measured in the posttest by means of the stimulus film and questionnaire.

Overall, because of the use of a pretest, results can only be partially and cautiously generalized to other populations. To increase the external validity of this study, it would require replication in other settings and among other populations that had not been pretested.

Because the testing program and the training program are both highly unusual occurrences in this setting, one could expect some reactive arrangements. The "on-stage," "up-for-inspection" behavior of the subjects may seriously influence their responses to the testing instruments. However, any "on-stage" variances that might be a result of testing ought to be equally present in both groups, since they took the same tests at the same time. But "on-stage" factors that are a result of differential treatment cannot be avoided in this design. Nevertheless, Campbell and Stanley commented, "Where such reactive arrangements are unavoidable, internally valid experiments of this type should by all means be continued."¹³

In conclusion, Design 4, or the pretest-posttest control group design, provides control for all of the seven rival hypotheses to internal validity. Its representativeness or external validity is questionable, and any generalization to an untested population should be made on those dependent variables that were tested with a posttest instrument only.

A final threat to external validity in this design is the selection factor. The Holt Nursing Home was one out of five approached

¹³Ibid., p. 20.

by the writer to participate in the study. Three nursing homes did not demonstrate sufficient interest in the research program to proceed to the interview stage. They received introductory letters with follow-up telephone calls. Two of these homes had insufficient staffing to supply an adequate number of subjects for the study. The third was clearly not interested in participating. A fourth home, which pursued the research possibility to the interview stage, refused to participate in the study because of a fear of adverse publicity just before a millage election that would determine its future existence. An additional reason for the refusal of the fourth home was that it was already receiving similar services in the form of training and consultation from the area mental health center staff. The nursing home where the study was conducted was, in a sense, self-selected in that it was the only home of adequate size that did not refuse to participate in the study.

In summary, two out of five nursing homes refused to participate and two others had insufficient staff members for conducting a study of this size. Consequently, the selection factor had an interaction effect in this study and ought to delimit further the generalizability of the results.

Description of Field Setting for Study

The Martin Luther Holt Home is a private, nonprofit nursing home situated in a suburb of Lansing. It has an in-patient population of approximately 100 patients. It was originally owned by the administrator, who recently sold the home to a local church. He

still manages the day-to-day affairs of the home, lives on the premises, and takes a deep personal interest in the patients and the quality of service rendered by the staff. In a sense, this is an unusual and rather ideal type of nursing home.

Description of the Independent Variable: A Social
Simulation Game, "Life-Cycle"

The First Phase--Warm-Up
and Discussion, Pre-Game

The experimental group participated in the training program using the instructional social-simulation game entitled "Life-Cycle." The control group was not exposed to this training experience.

The first two hours of the training program were devoted to promoting relaxation and sharing of thoughts and feelings among group members. This purpose was accomplished by using two warm-up social interaction exercises and viewing a 20-minute filmstrip and recording about old age.

In the first social interaction exercise, the group members were asked to communicate some positive feedback to one of the other group members. They did this in pairs for five minutes. When they had shared this complimentary information with their partner, they were then requested to introduce their partner to the group leader and other members of the group. The exercise thereby served to increase the confidence of the participants by recognizing their positive attributes. With such recognition, the participants usually felt more confident about becoming involved with group interaction later on. The exercise also served to bring the group members closer to each



other by revealing more about the individuals in a short period of time than would usually be revealed in a normal social situation. Concluding comments after this exercise usually referred to the difficulty most people experience in complimenting each other, even though such positive feedback can be important in boosting the morale of both nursing home staff and patients. In other words, by observing the benefits to be derived from sincerely complimenting one's co-workers and patients, the participants were encouraged to do more of the same on the job.

The second exercise was designed to promote an experimental awareness among the participants of what a patient might experience if he knew death was imminent and would have to dispose of some very precious possession. The participants were asked to imagine that they had only a limited time to live. Given that situation, they were asked to think about something very precious to them. Considering the personalities and attributes of the other group members, with whom they were now more familiar after the first exercise, they were asked to pick out one member of the group to whom they would prefer to give this precious item. Having selected a valued item and a group member to bestow it upon, they were then requested to share this information with the rest of the group, being sure to explain why they decided to give that particular item to that particular person.

Discussion among group members after this exercise usually focused around how much thought and personal sentiment is involved in giving away or bequeathing one's most prized possessions. This usually led to a commentary upon the devaluation of a patient's personal

possessions that usually occurs in the institutionalized setting of a nursing home. What usually resulted from this discussion was a greater appreciation on the part of the participants of the importance of items of sentimental value to their owners that may, on the surface, appear insignificant to others. Each individual, in explaining the reason why he chose a particular person as the recipient of his gift, provided more information to the group about both himself and the recipient, thereby promoting more group cohesiveness.

After these warm-up exercises were completed, the group viewed the film, How Would You Like to Be Old?¹⁴ They were informed that group discussion would follow the viewing, at which time they would be asked to share some of their observations and comments about the content of the film. In this way, the film served as a stimulus for group discussion about issues relating to old age and institution-alization of the elderly and its effects upon the individual. Group members viewed the film in seating arrangements that encouraged dis-course immediately upon completion of the film. The intent in care-fully planning the seating arrangement was to help capture emotional responses to the film that might otherwise be lost during any inter-vening distracting period of rearranging chairs between the end of the film and the beginning of group discussion.

The trainer in the group discussion acted in the role of a facilitator of communication. He intervened in the discussion only when necessary, to prevent the group from wandering into areas of

¹⁴How Would You Like to Be Old? (Pleasantville, New York: Guidance Associates, 1973).

nonproductive chatter. Otherwise, he encouraged group sharing and learning by reflecting group and individual insights, offering feedback and providing some form of summarization and closure to the discussion. It is, of course, advantageous if the group leader is experienced in this role. A skilled group leader can create an atmosphere of openness and support that allows for the verbalization of conflicts and concerns that are worthy of group discussion. During this process of contemplating and reacting to the film, it was hoped that the participants would begin a process of identification with the elderly by being encouraged to project themselves into the roles of the elderly actors in the script. Later this process of identification was further intensified when the participants actually played the roles of patients in the simulation game that followed.

The Second Phase--A Simulation Game, "Life-Cycle"

The rules of "Life-Cycle" are contained in Appendix N. The game is played on a game board that is essentially a tool to stimulate role-playing of difficult interpersonal situations involving patients in an institutional environment. The situations that are acted out in the game were carefully designed to reflect fairly common conflict situations that are apt to be dealt with in the real work-a-day world. Striving for a close approximation of real-life situations was an intentional effort to foster the relevance of the learning experience. It was hoped, by closely approximating reality in these situational encounters, the transfer of learning to real life would be increased.

The senior citizen residents made their moves on a game board after throwing dice. Since there is no goal or end point on the game board, there is no implication that one is striving for some completion point in travels along the board. Instead, the game is circular in design, allowing for summation or continuation when desired by the game manager (teacher). As one falls on a titled space, the interaction begins with the party whose name is written thereon. Participants who are not playing on the board, as senior citizens, are given the roles of significant others in the life of the senior citizen, such as nurse, physician, family, etc. These others then play opposite the senior citizen in role enactments. Depending upon the situation, either the senior citizen or the other player takes the role of protagonist.

The players are given sufficient time to contemplate their parts, which they create in their imagination around the skeleton of a description that is given to them on cards. Both the senior citizen and his co-actor are supplied with cards that present them with a typically difficult encounter and their attitudes toward the same. They are thereby encouraged to assume the identity of the character whose part they will play. When the parties have mentally "gotten into" their roles, they so indicate to the game manager, who then acts as recorder and timer. The game manager records the interaction on videotape and limits the players to approximately three to five minutes of acting out the situation.

When role-play ceases, the game manager then acts in the inquirer role. He asks the following two questions of the senior

citizen: "How do you feel now, after that interaction?" It is important to recognize that the answers to these questions are not always the same. For example, the doctor may have had to share an unpleasant diagnosis with the patient that results in the patient feeling terrible. At the same time the patient may feel that the doctor handled well that difficult situation, answering all of her questions, etc.

To better identify one's own feelings in answer to the game manager's question, "How do you feel?" the senior citizen can use the prop of two "feel wheels." One feel wheel is entitled "I Feel Good"; on it are descriptions of a variety of good feelings. The other feel wheel is entitled "I Feel Bad," and lists words that describe negative feelings. (See Appendix K.) If the "patient" is having a difficult time pinpointing the feeling with which he is left after playing out the interaction, he can use the feel wheel to search out the word that most accurately describes his feeling at that time. In effect, what the "patient" does in answering these questions is to give his partner some very direct and immediate feedback on the effectiveness of his response to the patient.

The post-game analysis is the most impactful portion of the learning package, if conducted properly. Directions for this portion of the game are contained in the game rules in Appendix N.

Norman Kagan, who used Stimulated Mutual Recall for over ten years in training therapists and physicians, stated the theory behind this learning mode:

People need to be helped to come face to face with their most feared interpersonal nightmares. If these can be experienced from a position of maximum safety and security it is possible for

people to learn to deal with and overcome such fears. Film stimulation seems to offer this security by permitting people to talk about and gradually come to both experience and label the kinds of stress which ordinarily would evoke too much anxiety to permit acknowledgement, awareness and understanding. Stimulation enables people to enter what would otherwise be overwhelming experiences without becoming overwhelmed. A great deal of control and mastery can come through such a combination of experience followed by cognitive analysis. Videotape feedback of one's reactivity to experienced simulated threat seems to give people an opportunity to look at some of the most frightening of interpersonal potentials but from a secure position so that the "nightmare" can be experienced but also examined and understood. One also learns that others may share some of their nightmares, thus reducing feelings of aloneness and shame.¹⁵

Each three-minute interaction during the game can usually provide material for 20 to 30 minutes of group learning in the post-game analysis period. In essence, then, the game serves as a medium to access material that will be used for milking out observations and insights that foster an increased understanding of oneself and the actors, be they patients or significant others, as they act out a scene from real life. The intention is that the participants will transfer these personal insights to real-life situations, where they will prove useful in improving communication and relationships with elderly institutionalized patients and their families. In this safe, simulated environment the participants are encouraged to offer feedback to the role-player that is directed at that "patient" or that "nurse" or that "family member," but does not directly attack the personhood of the actor playing the role. The feedback is fashioned more as a critique of the part played by that actor than of the actor himself. Because of the decreased threat of such indirect feedback, participants usually feel freer to be honest and critical as well as

complimentary in a manner that is conducive to the learning of both parties.

Summary

This research was done in a pretest-posttest design. It was an experimental field study conducted in a nursing home in Michigan. The subjects were 40 staff members of the nursing home, who were randomly selected and assigned to two groups, the experimental and control groups. Members of the experimental group participated in a training program in which the game "Life-Cycle" was used, which incorporated the teaching modes of simulation-gaming, videotape feedback, and role-playing. The control group received no training.

Several tests were used before and after training to collect the data for analysis. A demographic questionnaire was administered to all the subjects during the pretest period. The ATOP Scale, an attitude scale that measures attitudes toward the aged, was used as both a pretest and a posttest to measure the influence of the training program on the attitudes of the subjects toward old people. The Hogan Empathy Scale was used as a pretest for the purpose of testing the construct validity of the ATOP Scale. Two posttests were administered in addition to the ATOP Scale. The first one was a subjective evaluation of the training experience in a true-false, forced-choice format, with three additional open-ended questions. Only participants in the training program completed this posttest. The second posttest was an open-ended questionnaire in response to a critical incident stimulus film.

CHAPTER IV

ANALYSIS OF RESULTS

The study was a pretest-posttest field experiment. Several different types of measurement instruments were used to collect data. The Attitudes Toward Old Persons Scale, a Likert-type attitude scale that measures attitudes toward the aged, was used as a pretest and posttest to measure the effect of the experimental training program upon the attitudes of the experimental group subjects toward the aged. The Hogan Empathy Scale was only used as a pretest, for the specific purpose of testing the construct validity of the ATOP Scale. The Hogan Empathy Scale was used as a criterion measure of construct validity because it has been well validated and it measures the construct of empathy, which was judged to be a construct similar to that of attitude toward the aging.

Two additional posttests were administered. The first questionnaire was a true-false, seven-item subjective evaluation of the training program by the members of the experimental group. The second posttest was an open-ended test completed by all of the subjects in response to a critical incident stimulus film. The open-ended questionnaire was used to elicit data about the emotional reactions of the subjects to the film and their perceptions of helpful verbal and physical reactions to the simulated patient. These data were then

used to analyze the effects of the experimental training program on the subjects.

The following hypotheses were tested in the study:

- H₁: The ATOP scale, in the test-retest situation on this particular group of subjects, will be reliable.
- H₂: As a test of construct validity of the ATOP scale, that is, as a test that it measures what it purports to measure, the ATOP will correlate significantly with the Hogan Empathy Scale.
- H₃: After a six-hour social simulation training program, the experimental group will show a significantly more positive attitude index, as measured by ATOP, than the attitude index of the control group.
- H₄: The emotional responses of the experimental group to a simulated elderly person on videotape (stimulus tape) will differ significantly from the emotional responses of the control group (positive emotional responses of the experimental group will be significantly greater than the positive responses of the control group), as measured by the Davitz classification scheme.
- H₅: On the stimulus film test the experimental group will demonstrate a significantly greater sensitivity to the feelings expressed by the elderly man on the film than the control group, as measured by a content analysis of self-reported emotional responses of the subjects.
- H₆: On the stimulus film test the experimental group will demonstrate a significantly greater number of therapeutic responses to a simulated elderly person on videotape than the control group, as measured by the independent ratings of judges, using specific criterion measures.
- H₇: On the stimulus film test the type of physical intervention chosen by the experimental group in assisting a simulated elderly person on videotape will differ from the type of intervention chosen by the control group, as measured by a post-facto analysis of the self-reported interventions of the subjects.
- H₈: The experimental group will evaluate the educational experience as satisfying and successful in helping them to gain insights into what it is like to be old, what it is like to be an old patient in a nursing home, how they interact with patients, and how they could interact with patients in difficult situations.

- H₉: The attitudes toward the aged of those subjects who report a regular, satisfying relationship with an elderly person or relative outside of the nursing home will be significantly more positive than the attitudes of those who report having no such relationship with elderly persons.
- H₁₀: A significant correlation will exist between the demographic variables of age, job category, employment status, and education and the dependent variable of attitude toward the aged, as measured by the ATOP scale.

In the following section, data are presented on each of the hypotheses tested in this study.

Reliability of the ATOP Scale

- H₁: The ATOP scale, in the test-retest situation on this particular group of subjects, will be reliable.

A correlation of the pretest and posttest scores of both groups is presented in Table 6. With 13 observations in the experimental group, an r of .65 was significant at the .01 level. With 22 observations in the control group, an r of .51 was significant at the .01 level. These data on significance level were derived from the statistical table of coefficient of correlation. Therefore, the null hypothesis that the ATOP would not be a reliable test on this particular group of subjects in the test-retest situation was rejected. The test is at best marginally reliable since the r 's are significant but low for reliability.

Validity of the ATOP Scale

- H₂: As a test of construct validity of the ATOP scale, that is, as a test that it measures what it purports to measure, the ATOP will correlate significantly with the Hogan Empathy Scale.

A correlation test of the subjects' scores on the ATOP and the Hogan Empathy Scale resulted in a correlation coefficient of .14, which

was not significant. The null hypothesis of no correlation between the ATOP Scale and the Hogan Empathy Scale failed to be rejected.

TABLE 6
CORRELATION OF ATOP PRETEST AND POSTTEST RESULTS

Group	Number of Observations	r
Experimental	13	.65 ^a
Control	22	.51 ^a

^aSignificant at the .01 level.

Affecting Attitudes Toward Old People

H₃: After a six-hour social simulation training program, the experimental group will show a significantly more positive attitude index, as measured by ATOP, than the attitude index of the control group.

The ATOP Scale was administered as a pretest and posttest to both groups. The analysis of variance of pretest scores of both groups is presented in Table 7. The F test of the between-group variance was 4.72, which was significant at the .03 level, with the control group showing a higher attitude index than the experimental group.

An analysis of posttest scores is presented in Table 8. The results indicated that the two groups continued to have essentially the same between-group variance after the training program period, producing an F of 3.57, which was significant at the .02 level.

TABLE 7

AN ANALYSIS OF VARIANCE OF MEAN PRETEST SCORES OF
EXPERIMENTAL AND CONTROL GROUP ON ATOP SCALE

Source of Variation	Sum of Squares	Mean Square	df	F
Between groups	360.527	360.527	1	4.72 ^a
Within groups	2748.840	76.356	36	

^aSignificant at .03 level.

TABLE 8

ANALYSIS OF VARIANCE OF MEAN POSTTEST SCORES OF
EXPERIMENTAL AND CONTROL GROUP ON ATOP SCALE

Source of Variation	Sum of Squares	Mean Square	df	F
Between groups	716.802	712.802	1	5.37 ^a
Within groups	3731.864	133.280	28	

^aSignificant at .02 level.

Missing observations Experimental = 3
 Control = 7

Since the data revealed there was no significant increase in the positive attitude index of the experimental group following the training program and in comparison with the control group, the null hypothesis failed to be rejected.

Since pretest scores of the two groups were as different as the posttest scores, an analysis of variance of the gain scores from

pretest to posttest was done for the two groups. The results of this analysis are presented in Table 9.

TABLE 9
ANALYSIS OF VARIANCE OF GAIN SCORES OF BOTH GROUPS ON ATOP

Source of Variation	Sum of Squares	Mean Square	df	F
Between groups	182.775	182.775	1	1.89
Within groups	2600.673	96.321	27	

Missing observations Experimental = 3
 Control = 8

Gain scores of both groups were not significantly different. This, then, presented further evidence that there would be no significant change in the pretest to posttest scores, both within and between groups. Therefore, any change in ATOP scores cannot be related to the training program statistically, and Hypothesis 3 was rejected.

In summary, an analysis of variance of the ATOP posttest scores alone did reveal a significant difference between the two groups. However, when this difference was compared to an analysis of variance of the pretest scores, the posttest difference was essentially the same as the pretest between-group variance. An analysis of variance of the gain scores of the two groups was not significant; therefore Hypothesis 3 was not confirmed. The training program did not seem to affect ATOP scores.

Emotional Response to Critical
Incident Stimulus Film

- H₄: The emotional responses of the experimental group to a simulated elderly person on videotape (stimulus tape) will differ significantly from the emotional responses of the control group (positive emotional responses of the experimental group will be significantly greater than the positive responses of the control group), as measured by the Davitz classification scheme.

In the open-ended questionnaire given to the subjects after they viewed a videotape of an elderly man in distress who was speaking directly to them, the subjects were asked to relate how they felt in this situation. They were given the choice of using a checklist of descriptive phrases of emotional states (derived from Davitz's classification scheme) or of answering the question in their own words on paper. The responses of those who used the checklist were easily classified into emotional-state clusters. (A list of the phrases and categories in which they belong is contained in Appendix J.) The answers of those who chose to respond in their own words were placed into emotional-state categories with the assistance of the Davitz dictionary of emotional meaning. A frequency check was performed on the responses falling into each category; this is shown in Table 10.

A two-cell chi-square test was computed by hand on the positive and negative emotional reactions of the experimental and control groups. The results of the chi-square test (4.67), with 1 degree of freedom, were significant at the .05 level of confidence. Consequently, these data supported the hypothesis that the training program promoted a positive emotional reaction in the experimental group, as compared to the control group, when confronted with an old person in distress.

The experimental group had more moving toward, comfort (positive) reactions as opposed to the moving away, discomfort, incompetence, and inadequacy (negative) reactions after the training program than they had before the training program. The hypothesis was accepted.

TABLE 10
EMOTIONAL RESPONSES OF SUBJECTS TO
CRITICAL INCIDENT FILM

Emotional Reactions		Group		Total
Type	Cluster	Experimental	Control	
POSITIVE	Moving Toward	15	13	28
	Comfort	-	1	1
	Total	15	14	29
NEGATIVE	Moving Away	1	9	10
	Discomfort	3	9	12
	Incompetence	4	9	13
	Inadequacy	4	6	10
	Total	12	33	45
TOTAL		27	47	74

N = 34

E = 20

C = 14

Chi-square = 4.67, 1 degree of freedom, significant at .05.

Therapeutic Response Modes to Critical
Incident Stimulus Film

- H₅: On the stimulus film test the experimental group will demonstrate a significantly greater sensitivity to the feelings expressed by the elderly man on the film than the control group, as measured by a content analysis of self-reported emotional responses of the subjects.

In the open-ended questionnaire that was given to the subjects after viewing the critical incident stimulus film, the subjects were asked to relate, in quotes, what they would say to this person in such a situation. Three independent judges were used to rate both the quality and the type of response-mode selected by the subjects. The raters were an experienced psychologist-therapist, a family nurse practitioner, and the researcher, who is a clinical specialist in psychiatric-mental health nursing. Ebel's Reliability of Raters Test was calculated by computer at Michigan State University, using a program Ebel developed specifically for this purpose.¹ The results showed an inter-rater reliability of .99.

The first step in judging the responses consisted of a global rating by the experienced therapist-raters of the overall therapeutic effectiveness of the self-reported verbal response of each subject to the film. A final score for each subject was obtained from the three independent ratings by equating a majority score of the judges with a final score for each subject. In other words, two out of three ratings in a "low" quality of response category would be equated with a final quality of response score of "low." Using this technique for arriving

¹Robert L. Ebel, "Estimation of the Reliability of Ratings," Principles of Educational and Psychological Measurement (Chicago, Illinois: Rand McNally, 1969), pp. 116-132.

at a final rating of each subject presented no difficulties because a majority score existed for every subject; that is, two out of three had to agree.

Table 11 presents the tabulation and chi-square of the judges' final ratings of the quality of the subjects' responses. This analysis produced no significant difference between the experimental and control groups in this category of judgment.

TABLE 11
RATINGS OF QUALITY OF THERAPEUTIC RESPONSE
OF SUBJECTS TO STIMULUS FILM

Quality of Response	Group				Total	
	Experimental		Control			
High	0	0 %	1	7.1%	1	4.3%
Medium	4	44.4	4	28.6	8	34.8
Low	5	55.6	9	64.3	14	60.9
Total	9	100.0	14	100.0	23	100.0

N = 34

Missing observations = 11

Chi-square = 1.10, 2 degrees of freedom, not significant

The next rating the judges performed was to label the types of responses given by the subjects. A copy of the rating form used by the judges is contained in Appendix I. This rating form was first developed by Kagan and his associates to assess the performance of counselor-trainees. It consists of a classification of four types of

responses, each with dichotomous variable-descriptors. The four areas and dichotomous descriptors in each are as follows:

1. affective-cognitive
2. exploratory-nonexploratory
3. listening-nonlistening
4. honest labeling-distorting

Again, the majority score of the raters in each of the four above areas was listed as the final score for each subject in that area. Tables 12 through 15 present tabulations of the ratings and the chi-square of the data, which produced no significant differences in any of the four areas of response-types.

TABLE 12
RATINGS OF AFFECTIVE VS. COGNITIVE RESPONSES
OF SUBJECTS TO STIMULUS FILM

Responses	Group				Total	
	Experimental		Control			
Affective	3	33.3%	2	14.3%	5	21.7%
Cognitive	6	66.7	12	85.7	18	78.3
Total	9	100.0	14	100.0	23	100.0

N = 34

Chi-square = .31, 1 degree of freedom, not significant

TABLE 13

RATINGS OF EXPLORATORY VS. NONEXPLORATORY RESPONSES
OF SUBJECTS TO STIMULUS FILM

Responses	Group				Total	
	Experimental		Control			
Exploratory	3	33.3%	3	21.4%	6	26.1%
Nonexploratory	6	66.7	11	78.6	17	73.9
Total	9	100.0	14	100.0	23	100.0

N = 34

Chi-square = .02, 1 degree of freedom, not significant

TABLE 14

RATINGS OF LISTENING VS. NONLISTENING
RESPONSES OF SUBJECTS TO STIMULUS FILM

Responses	Group				Total	
	Experimental		Control			
Listening	3	33.3%	3	21.4%	6	26.1%
Nonlistening	6	66.7	11	78.6	17	73.9
Total	9	100.0	14	100.0	23	100.0

N = 34

Chi-square = .02, 1 degree of freedom, not significant

TABLE 15
RATINGS OF HONEST LABELING VS. DISTORTING
RESPONSES OF SUBJECTS TO STIMULUS FILM

Responses	Group				Total	
	Experimental		Control			
Honest labeling	1	33.3%	0	0 %	1	7.1%
Distorting	2	66.7	11	100.0	13	92.9
Total	3	100.0	11	100.0	14	100.0

N = 34

As a result of this data analysis, the hypothesis that there would be a significant difference between the therapeutic responses of the experimental and control groups was not supported.

Looking at the response modes of the population as a whole in all four areas, as presented in Tables 12 through 15, we see that in all categories this population of subjects produced a low level of therapeutic response to an elderly person in distress. The highest percentage of therapeutic responses reached by the whole population in any one category was 26 percent. In other words, from 74 to 92 percent of all the response-modes in each category used by the subjects could be classified as nontherapeutic.

Sensitivity of Subjects to the Old Person in
Critical Incident Stimulus Film

- H₆: On the stimulus film test the experimental group will demonstrate a significantly greater number of therapeutic responses to a simulated elderly person on videotape than the control group, as measured by the independent ratings of judges, using specific criterion measures.

During the posttest the subjects were asked to describe the feelings that were being experienced by the simulated elderly person as he spoke to them on videotape. The responses of the subjects were then separated into two categories--those that demonstrated a sensitivity to the feelings of the actor and those that were clearly judgmental or rejecting of both the actor and the feelings he expressed. A frequency count was made of all the responses falling into these two categories. As presented in Table 16, an overwhelming majority of the subjects in both groups indicated by their responses to this question that they were aware of the feelings being expressed by the "patient." Only three responses fell into the category of judging, rejecting the patient. All three of these rejecting responses were made by members of the control group. With the kind of data where the gross difference between groups is minimal, "statistical tests are hardly necessary"² and, therefore, were not performed.

The data presented a picture of the sensitivity of the whole population to a "patient" in distress, a sensitivity that was prevalent in the majority (84 percent) of responses. However, there was no clear differentiation between groups with respect to sensitivity to the patient. Therefore, the hypothesis that there would be a

²Kerlinger, op. cit., p. 199.

difference between the experimental and control groups in their sensitivity to a simulated elderly person in distress, as portrayed on videotape, was not supported.

TABLE 16
SUMMARY OF PERCEPTION OF PATIENT'S FEELINGS
IN STIMULUS FILM AS REPORTED BY SUBJECTS

Category of Response	Group		Total
	Experimental	Control	
Sensitive to patient's feelings	12	14	26
Judging, rejecting of patient	0	3	3
No response	2	0	2
Total	14	17	31

Intervention Activity in Response to
Critical Incident Stimulus Film

- H₇: On the stimulus film test the type of physical intervention chosen by the experimental group in assisting a simulated elderly person on videotape will differ from the type of intervention chosen by the control group, as measured by a post-facto analysis of the self-reported interventions of the subjects.

In the posttest, open-ended questionnaire, the subjects were asked what they would do, in response to the elderly person who was portrayed to them on videotape. This question concerned what physical, interventionist type of action the subjects would take to assist

the old man in his situation. The responses to this open-ended question were subjected to post-facto coding. From an analysis of the replies, four general categories of self-reported action in response to the "patient" emerged. They were: (1) communicate with the patient's family directly, (2) get the patient interested in other things, (3) attend to the patient's emotional needs, and (4) initiate physical contact with the patient.

The replies of the subjects were coded into the above four categories; Table 17 presents the results of a frequency and percentage count on the data as well as a chi-square test for significance. The data differences between the two groups were not significant; the chi-square was 3.11, with 21 observations and 3 degrees of freedom. The subject population as a whole did not appear to prefer any one method of intervening in the situation. As a result of an analysis of the data obtained in response to this posttest, open-ended question, the hypothesis that there would be a difference between the two groups in the action they would take to assist an elderly man in distress was not supported.

Happiness Data on Instructional Experience

- H₀: The experimental group will evaluate the educational experience as satisfying and successful in helping them to gain insights into what it is like to be old, what it is like to be an old patient in a nursing home, how they interact with patients, and how they could interact with patients in difficult situations.

TABLE 17
SUMMARY OF ACTIONS TAKEN AS REPORTED BY
SUBJECTS IN RESPONSE TO STIMULUS FILM

Action Taken	Group				Total	
	Experimental		Control			
Physical contact with patient	4	50.0%	2	15.4%	6	28.6%
Attend to patient's emotional needs	2	25.0	4	30.8	6	28.6
Get patient interested in other things	1	12.5	3	23.1	4	19.0
Communicate with patient's family	4	50.0	2	15.4	6	28.6
Total	11	100.0	11	100.0	22	100.0

Immediately upon completion of each training program, the participants were asked to complete a true-false, forced-answer type of questionnaire of eight items relating to the training program experience. Table 18 presents a list of the questions, with the frequency and percentage count of the responses. There was a 75 percent or higher agreement of the subjects on each item of program evaluation in the questionnaire. On four items there was 100 percent agreement among the participants that the program was a total success. Those four areas were: (1) The training program was a pleasant experience for me. (2) I would recommend that this training program be offered to staff of other nursing homes. (3) I have learned more about old people and about how they feel in certain situations. (4) I wish that

we could have more group discussion about patient management problems like we did in these sessions. An evaluation of the data on satisfaction with the educational experience, as reported by the experimental group, revealed that over 75 percent of all the subjects were pleased with the learning outcomes of the program.

TABLE 18
TRUE-FALSE EVALUATION OF TRAINING PROGRAM
BY EXPERIMENTAL GROUP

Statement	Frequency	Percent
The training program was a pleasant experience for me	16	100.0%
I would recommend this training program to the staff of other nursing homes	16	100.0
I feel that I learned more about myself and how I interact with patients as a result of participating in this training program	13	81.0
I have learned more about old people and how they feel in certain situations	16	100.0
I have a better understanding of what it is like to be a patient in a nursing home	14	87.6
I wish that we could have more group discussion about patient management problems like we did in these sessions.	16	100.0
I have learned new ways of working through difficult situations with old residents	12	75.0

Three additional items on the training program evaluation questionnaire were open-ended. In answer to the question, "What did you like most about the training program?" the experimental group most frequently gave the following responses: the film, trying out the role of an old person, discussions, the chance to express ourselves, and the game itself.

The next open-ended question was: "What did you like least about the training program?" The following responses were obtained: we didn't work hard enough as a group (1), or the training program was too short (3).

The last question had to do with the helpful things the participants felt they had learned in the training. Their answers to this question and a frequency count on the number of times the same response was given are presented in Table 19.

TABLE 19

SUMMARY OF THE HELPFUL THINGS LEARNED IN THE
TRAINING PROGRAM, AS REPORTED BY THE SUBJECTS

Statement	Frequency
Be more understanding of old people	8
How to communicate with patients	3
How to be honest in learning situations	4
How the aide handles a problem is important	3
What I will be like when I get old	3
Getting to know my co-workers better	2
How other people react to an old person	1

N = 16

The three open-ended questions in the evaluation form provided a "catch-all" for those outcomes of the learning experience that were noted by the participants themselves but were not incorporated into the true-false list compiled by the researcher. The comments about the training program that were supplied by the subjects covered the following areas, which had been left uncovered in the true-false questionnaire:

1. How to be honest in the learning situation (4 responses)
2. How the aide handles a problem is important (3 responses)
3. What I will be like when I get old (3 responses)
4. Getting to know my co-workers better (2 responses)
5. How other people react to an old person (1 response)

With the above supporting data, the hypothesis that the experimental group will evaluate the educational experience as satisfying and successful in the areas listed above was supported.

Influence of Relationship With Old Person on Attitude Toward Aged

- H₉: The attitudes toward the aged of those subjects who report a regular, satisfying relationship with an elderly person or relative outside of the nursing home will be significantly more positive than the attitudes of those who report having no such relationship with elderly persons.

In the pretest questionnaire, all subjects were asked if they related on a regular basis with an old person outside of the nursing home. In response, 26 reported they did have such a relationship; 13 said they did not. All those reporting the existence of a relationship with an old person described the relationship as "satisfying." Using the data in response to these questions, the subjects were

separated into two categories--those who did have a satisfying relationship with an old person and those who did not report any relationship with an old person.

An analysis of variance was performed using the ATOP scores as a dependent variable. Table 20 presents the results of that analysis. There was a significant difference between the attitude scores of those who did have a relationship with an elderly person outside of the nursing home and those who did not have such a relationship. The F test was 9.42, which was significant at the .004 level.

The hypothesis that there would be a relationship between the subject's relationship vs. no-relationship status and his attitude toward old people, as measured by ATOP, was supported.

TABLE 20
ANALYSIS OF VARIANCE OF RELATIONSHIP WITH ELDERLY
PERSON AND ATTITUDE TOWARD THE AGED

Source of Variation	Sum of Squares	Mean Square	df	F	Sig.
Between groups	643.245	643.245	1	9.42	.004
Within groups	2387.727	68.22	35		

N = 40

Correlation of Demographic Variables
and the ATOP Scores

- H₁₀: A significant correlation will exist between the demographic variables of age, job category, employment status, and education and the dependent variable of attitude toward the aged, as measured by the ATOP scale.

A least squares regression analysis of the demographic variables and the ATOP scores as the dependent variable was performed to measure the strength of these relationships. The results indicated that the variables of employment status and formal education had the highest correlation with the ATOP scores. As shown in Table 21, a significant negative relationship ($-.33$), at the .05 level, was found between the variable of employment status and attitude scores on the ATOP scale. A significant positive correlation ($+.47$), at the .005 level, was found between the variable of formal education and attitude score as measured by the ATOP scale.

The null hypothesis that there would be no significant relationship between ATOP scores and any of the demographic variables of age, job category, employment status, and education was rejected in part.

TABLE 21
LEAST SQUARES REGRESSION ANALYSIS OF
DEMOGRAPHIC VARIABLES AND ATOP SCORES

Demographic Variable	ATOP Scores			
	Regression Coef.	r	df	Sig.
Employment Status (number of days worked per week)	-3.36	-.33	2	.05
Education (elementary to college)	6.53	+.47		.005

Summary

Ten hypotheses were tested in this study. Five of them were supported by the data analyzed in the study. The training program did not seem to have any effect upon the attitudes of the subjects toward the aged, nor did it affect the way they communicated with an old man who was presented to them in a critical incident stimulus film. Although 84 percent of the subjects in both groups demonstrated a keen sensitivity to the feelings expressed by the old man on videotape during the posttest session, only 6 percent of the subjects were able to respond to the "patient" in a therapeutic manner. There was no clear differentiation between groups in the type of action the subjects chose as a suitable way to assist the old man.

The training program did have a significant influence on the emotional reactions of the subjects to the critical incident stimulus film. The experimental group showed significantly (.05 level) more positive as opposed to negative reactions to the old man than did the control group. It appears that the training program had some effect on the emotional response of the subjects to old people in distress by making them more accepting and tolerant than the control group.

The ATOP Scale was tested for reliability and showed a marginal reliability at the .01 level for this group of subjects (control group $r = .51$; experimental group $r = .65$). When correlated with the Hogan Empathy Scale, the ATOP Scale did not appear to be a valid test of the construct of attitude toward the aged, as related to the construct of empathy.

Over 75 percent of the participants in the training program rated the learning experience as satisfying in the areas of learning how to interact with patients in difficult situations and learning what it is like to be an old person in a nursing home. The participants expressed total agreement in recommending that the training program be offered to the staffs of other nursing homes and in the judgment that they had learned more about old people and how they feel in certain situations.

A significant positive relationship was found between those subjects who reported having a regular, satisfying relationship with an elderly person outside of the nursing home and their attitude toward the aged. Those who had a good relationship with an elderly person had an attitude index significantly (at the .004 level) higher than those who had no such relationship.

A significant positive correlation was found (+.47) between the variables of formal education and attitudes toward the aged. Those subjects with more years of formal schooling had a significantly (.005) higher attitude index than those subjects with fewer years of schooling.

A significant negative correlation (-.33) was found to exist between the variables of days worked per week and attitudes toward the aged. The more days an employee worked per week, the less favorable his attitude toward the aged on the ATOP Scale.

CHAPTER V

SUMMARY AND CONCLUSIONS

The purpose of this study was twofold. It attempted to measure the effects of a six-hour inservice training program upon the staff of a nursing home. Second, it investigated the relationship between certain demographic and personal characteristics of individuals and their attitude toward the aged, as measured by a Likert-type questionnaire.

Forty subjects were selected at random from the nursing home staff and divided into an experimental group (20) and a control group (20). The members of the experimental group participated in a training program in which the simulation game "Life-Cycle" was used; this game incorporates the teaching modes of simulation-gaming, videotape feedback, and role-playing. The control group received no training but did receive the same pretest and posttest batteries designed to measure attitude changes.

Several different types of measurement instruments were used to collect data for testing ten hypotheses. The ATOP Scale was used as a pretest and posttest measure of attitudes toward the aged. The Hogan Empathy Scale was used as a pretest for the purpose of testing the construct validity of the ATOP Scale. Additional posttests were administered. The first one was a subjective evaluation of the training program by the members of the experimental group only. The second

one was a posttest questionnaire developed by the writer and administered to all subjects. It was an open-ended, projective-type test that was completed in response to a critical incident stimulus film.

An analysis of the data obtained from the pretests and posttests of the subjects produced supporting evidence for five out of the ten hypotheses. There was one significant effect of the training program; it concerned the emotional response of the subjects to an old man in a critical incident stimulus film. The experimental group reported significantly more positive emotional responses to a simulated old man in distress than did the control group.

A test of the reliability of the ATOP Scale as a measure of attitude on this group of subjects indicated that, in a test-retest situation, this was a reasonably reliable test. A reliability coefficient of .65 for the experimental group and .51 for the control group was obtained, which was significant at the .01 level.

A test of the construct validity of the ATOP Scale was performed by correlating the results of the ATOP with the results obtained from the administration of the Hogan Empathy Scale. The correlation of the scores of the subjects on both tests was very low and was not significantly different from zero.

A significant relationship was found between attitude scores and the existence among staff of a satisfying personal relationship with an elderly person outside of the nursing home ($r = +.46$). This relationship was significant at the .004 level of confidence, with an F of 9.42.

A significant negative relationship was found to exist between the number of days a staff member worked per week and his attitude toward the aged ($r = -.33$). In other words, the more days the staff member worked per week, the less favorable was his attitude toward the elderly. This correlation was significant at the .05 level of confidence.

A significant positive relationship was found to exist between the formal educational background of a staff member and his attitude toward the aged ($r = .47$). In other words, those staff members with more schooling had a better attitude toward the aged than those staff members with fewer years of schooling. This correlation was significant at the .005 level of confidence.

The majority of the subjects in both groups (38 out of 40) demonstrated a remarkable sensitivity to the feelings expressed by an old man in a critical incident stimulus film. However, this population of subjects was clearly unable to translate that apparent sensitivity to an old person into responses that were helpful and/or therapeutic. Quite the contrary, the self-reported responses of the sample population to the old man in the film were rated by three independent judges as generally nontherapeutic (72 to 92 percent).

Discussion

Given the design and measurements instruments used in this study, in four out of the five areas tested it was not possible to demonstrate any significant change in the subjects as a result of their participation in the training program. However, there was a

significant difference in the emotional reaction of the experimental group after the training program when they were confronted with a simulated elderly man in distress on videotape. The experimental group demonstrated a significantly more positive, accepting attitude toward the old man than did the control group (at the .05 level).

Some observations about the research study may offer some plausible explanations for the results that were found. These observations suggest future directions for similar training programs and their evaluation.

Establishing a Control Group

As pointed out in Chapter II, Gordon accounted for the lack of evaluation in the field of simulation-gaming by pointing out (1) the difficulty in establishing controls and (2) the nonexistence of appropriate measuring instruments.¹ The results of this study support her conclusions.

The control group was a no-treatment group and, in contrast to their peers in the experimental group, control group members seemed to feel that they were being neglected and deprived of a "special" experience. As was pointed out in Chapter III, the feeling of non-involvement of the control group was clearly demonstrated when seven members of that group failed to appear for the posttest, as compared with a 100 percent attendance from the experimental group at the final evaluation session. The lack of interest on the part of the control group resulted in less than enthusiastic cooperation and many missing

¹Gordon, loc. cit.

observations in the posttest data. If a positive improvement in the performance of the experimental group on the posttest measures had been seen, one could justifiably have argued that outcome was a result of the Hawthorne effect that was built into the experiment by the very nature of the treatment/no-treatment design. However, such was not the case in this study, since the final data did not reveal significant differences between the two groups.

An alternate design that would eliminate the Hawthorne effect is difficult to find in the research of simulation-gaming. Any other treatment given to the control group in an effort to equalize the special treatment effect between the groups would still be less than adequate because of the exciting and innovative nature of simulation, videotape feedback, and role-playing aspects of the instructional program. Any other teaching medium, by comparison, when given to the control group would seem less than appealing when compared with the "different" experience of the experimental group. For this reason the administrator of the nursing home refused to expose the control group to any other form of treatment. He was so convinced that the simulation-gaming experience was preferable to lecture or any other traditional format, that he felt anything else offered to his staff would be second best and hence a poor investment. Furthermore, because of the marked contrast between a simulation-gaming experience that included videotaping and any other form of learning experience, it would have been clear to all parties which was the experimental group, and the Hawthorne effect might still be present.

One possible solution to this dilemma might be to create a design that matches subjects from two similar institutions, offering the gaming experience in one institution and an alternative treatment in the other institution. The advantage of this approach would be that the participating parties would not be aware of the different treatment being given to their counterparts in another locale.

Were such a design to be implemented, another distinct advantage would accrue that would alleviate a problem inherent in this study; namely, both groups would be able to be exposed to the treatments within the same time frame. The number of subjects required from each institution would be fewer, thereby permitting the program to be given in each nursing home only once rather than having to be given repeatedly for different subgroups at four different time intervals, as was done in this study. A "one-shot" effort at putting on the training program would offer more control over the many extraneous variables introduced during repetition of the training at different times.

Nonexistence of Appropriate Measuring Instruments

It was difficult to find an instrument that could measure the intangible construct of attitude toward the aged. As it was, the ATOP Scale was used, even though it had been inadequately researched and required further validation during the conduct of the experiment on this sample population. The results tended to support the reliability of the scale in the test-retest situation, but did not support its construct validity by correlation with the Hogan Empathy Scale.

The Hogan Empathy Scale was used as a criterion measure because it was felt that empathy would be closely related with attitudes toward the aged. In addition, the Hogan Empathy Scale had been better validated and was assumed to be a more reliable instrument against which to validate the ATOP Scale. Because of the apparent lack of validity of the ATOP Scale, it is difficult to have the same confidence in the results as would be possible with a more adequately validated instrument.

Another possible explanation for the negative findings is that the ATOP Scale was not a sensitive enough instrument. It is quite possible that an attitude change did occur in the subjects but the instrument was not sensitive enough to reveal a difference.

In conclusion, considering the two reasons cited by Gordon for the lack of adequate research in simulation-gaming, it seems to the writer that a potential solution to both problems cited would be to move away from experimental designs and toward research that is less intrusive. That is, incorporating the measures of outcome into the simulation gaming experience itself would eliminate the need for attaching other tests as measures that in themselves become new and confounding variables. It is preferable to use tests (or other measures) that are already part of the learning process and therefore anticipated without special reactions from the subjects. For example, in this study it might have been possible to use the videotapes that were part of the gaming experience itself as a measure of progress in learning. They could have been preserved for subsequent content analysis and/or rating by judges. The advantage of these types of

unobtrusive measures is that the testing itself does not become a new variable in the design.

Increased Tolerance

There was a statistically significant difference in the reactions of the two groups to the stimulus film. Significantly more moving away, negative emotional reactions were expressed by the control group than by the experimental group. This could be interpreted as a greater degree of tolerance to the old man in the situation on the part of experimental group members, who were less "turned off" or motivated to move away from him. Considered as a demonstration of tolerance on the part of the experimental group, these results would lend some support to the findings of Palacino that simulation does affect the tolerance level of the individual to the other party.² Tolerance is perhaps a lower level of response than empathy, the difference between the two being the degree of acceptance of another individual. With more exposure to a simulation game that increases tolerance, perhaps the subjects could advance to a higher degree of acceptance and perhaps even empathy.

Time in Training

As pointed out in Chapter II, all the reviewed studies with significant findings exposed the subjects to a minimum of 15 hours of training. Considering this fact, the six-hour training program used in this study was probably insufficient to achieve the desired

²Palacino, loc. cit.

results. Attitudes that have developed over an individual's lifetime of exposure to different experiences can probably not be radically altered in a few hours of classroom experience, no matter how intensive that experience may be. In the case of this study, it was not possible to extend the length of time in training because of the expense of the project to the nursing home administration. When all participants had to be paid time and a half for attending the training sessions, each hour invested in a repetition of similar experiences would have meant a costly and unsupportable expense to the administration. Although it was decided to implement this research in a community setting, it might be beneficial to replicate the study in a setting where time invested is not such a costly issue. If this were possible, the variable of time in training could be extended to see if a lengthened exposure to the training program would result in a shift in degree of acceptance of the aged from tolerance to empathy.

Focus of Future Training Programs

The sample population in this study indicated by their responses to the stimulus film that they were very aware of the feelings conveyed by the actor. However, they were unable to translate this sensitivity into verbal, therapeutic responses. Therefore, it is suggested that future training programs in interpersonal relations with similar populations ought to focus on helping the subjects learn how to translate their perceptions of feeling tone into helpful responses. Psychology research has produced some rules of thumb for therapists to help them respond in therapeutic ways to their clients.

These rules of thumb, or techniques of responding therapeutically, can be taught to nonprofessionals as Dendy demonstrated in his research.³ Therefore, considering the apparent need for training in therapeutic response modes, future training programs with similar populations ought to focus more on this cognitive area. In the training program used in this study, learning therapeutic response modes was an incidental learning objective rather than a primary one. It is suggested that future programs ought to reverse the priority of learning objectives so that the teaching of therapeutic response modes becomes a primary objective rather than an incidental one. After preliminary introduction to therapeutic response modes, the subjects could put the new knowledge into practice within the gaming situation. By rehearsing the newly learned form of responding in the game, "Life-Cycle," the subjects would have the opportunity to evaluate their effectiveness in feedback sessions and, hopefully, to internalize these newly acquired communication skills.

Relationship With Elderly Persons

This study replicated the finding of Tuckman--that relationships with old relatives and friends have a definite influence on the attitudes of the individual toward the aged in general.⁴ From these results it is not possible to generalize that all individuals would benefit from association with the elderly in terms of their attitude toward the aged, because (1) this was a pretested population (from

³Dendy, loc. cit.

⁴Tuckman, loc. cit.

which conclusions about an untested population cannot be drawn) and (2) no data were available on those who had unsatisfying relationships with elderly people. In this study no subjects fell into the latter category.

Generalizations about hiring practices in nursing homes in favor of recruiting applicants who have had or are still having satisfying relationships with old persons probably cannot be drawn from this study. On the other hand, if such associations are beneficial to the young in terms of helping them accept their own old age and the old age of another, then we need to reverse the present trend in our society of segregating the generations. Instead we should foster the integration of young and old to promote a healthy acceptance and respect for the aged. However, another consideration as a result of this study is that exclusive, prolonged contact with sick, institutionalized elderly people tends to have a negative effect on one's attitude toward the aged. Young people need to have a well-balanced contact with both sick and healthy aged so that they can have an accurate perception of old age in general.

In the subjective evaluation questionnaire of the training program, the subjects agreed unanimously that they learned more about old people and about how they feel in certain situations as a result of the training experience. Although the results were not significant using the measuring instruments of this study, this testimony on the part of the experimental group indicated that the program, at least from their perspective, was successful in achieving its major goal--helping the subjects to understand better what it is like to be old.

Education and Attitude Toward the Aged

The statement of the problem in this study revolved around the lack of geriatrics training of health care personnel and the effect of this lack of training upon the delivery of quality care in nursing homes. There is a need to try more educational programs in geriatrics and to assess carefully the outcomes of such programs. This study did implement such a training program and evaluated its impact. Also, it sought to replicate the findings of other studies that were able to relate certain demographic characteristics of individuals and their attitudes toward the aged. In an endeavor to correlate attitudes toward the aged with demographic characteristics in this study, a significant relationship between attitudes of subjects and their formal educational preparation was found. In other words, there existed a strong positive relationship between the formal education of the subjects and their attitude toward the elderly, with the college-prepared subjects demonstrating more positive attitudes toward the aged than the less-well-educated subjects. In the future, training programs of this type ought to be designed for those with a limited educational background, to improve their attitudes toward the aged.

Employment Status

A new finding in this study was that those employees who spent more time per week in the nursing home setting seemed to have more negative attitudes toward the aged than those who worked fewer days per week. Consider this finding with the observation that prior training programs that were successful in altering the attitude of

workers toward the aged took place in a community setting with essentially healthy aged.⁵ One explanation might be that the sick, institutionalized aged generate negative attitudes toward the aged in others. It could be hypothesized that when the experience of the health care worker is limited to his experiences in the nursing home setting and is not counterbalanced with more positive experiences with healthy aged in the community, then it appears that negative attitudes are developed. For this reason, it seems that future programs in geriatrics must incorporate experiences with healthy, independent elderly people. This training program, as it was designed, had an exclusive emphasis upon the institutionalized and problem patient. Perhaps, the program should include a picture of the healthy, active senior citizen in the community to foster a more positive attitude toward the aging among subjects.

In conclusion, research in the area of simulation-gaming has been hampered by the difficulty in establishing controls and by the nonexistence of appropriate measuring instruments. Despite those handicaps, which were present in this study, it was possible to show that the training program using the game "Life-Cycle" in conjunction with videotape feedback had a significant effect upon the emotional responses of the subjects to a simulated old man in emotional distress. After the training program the experimental group was significantly more accepting and tolerant of the old "patient" than was the control group. It has been suggested that with additional time in training

⁵Ellsworth, loc. cit; Steinbaum, loc. cit.

beyond the six hours used in this study, subjects might advance to a higher level of tolerance or empathy. Besides increases in the hours of training, future programs need to cater to the less-well-educated staff member. There seems to be a need for cognitive content on therapeutic response modes in future training programs. And, finally, both inside the classroom and outside of the classroom, staff members need to experience contact with healthy old people in the community, as well as the sick, institutionalized elderly patient, to develop a positive attitude about aging.

Recommendations

From the preceding discussion, a number of recommendations for future direction in the training of health care personnel in geriatrics have emerged. They are listed below:

1. In the future, studies of the effect of simulation-gaming that use the two-group, experimental design ought to draw the experimental and control groups from two separate but similar institutions to avoid a possible Hawthorne effect influencing the outcomes.
2. More research is needed in the development of a scale with demonstrated reliability and validity for the measurement of attitudes toward the aged.
3. Future studies of the effects of simulation-gaming as a teaching technique ought to use unobtrusive measures that are built into the gaming experience as a nonreactive part of the learning process.



4. More research is needed on the influence of the variable of time in training upon the altering of attitudes toward and relationships with the elderly among health care personnel.

5. Future programs in interpersonal relations with similar populations ought to focus on the teaching of therapeutic response modes as a primary learning objective.

6. Based upon the recommendations of the participants in the training program, the teaching game, "Life-Cycle," ought to continue to be used as a training program for personnel in nursing homes. In addition, this program should focus on teaching therapeutic response modes as a primary learning objective, and should include an emphasis on the healthy adult aged in the community.

7. Future programs in geriatrics ought to focus their training efforts on those nursing home staff members with a limited educational background, to remediate their gaps in knowledge of geriatrics and improve their attitudes toward the aged.

8. In the future, training programs that aim at altering attitudes toward the aged among health care personnel ought to include a heavy emphasis on the healthy adult aged in the community setting.

APPENDICES

APPENDIX A

SCHEMATIC OUTLINE OF EXPERIMENTAL DESIGN

APPENDIX A
SCHEMATIC OUTLINE OF EXPERIMENTAL DESIGN

PRETEST	TREATMENT		POSTTEST
Week I	Week II	Week III	Week IV
ALL SUBJECTS	TREATMENT GROUP		ALL SUBJECTS
1. Attitude Toward Old Persons Scale (ATOP) 2. Hogan Empathy Scale 3. Demographic Questionnaire	Group A	No treatment	1. Attitude Toward Old Persons Scale (ATOP) 2. Rating of Training Experience 3. Stimulus Film with Open-Ended Questionnaire
	Group B	Group C	
	No Treatment	Group D	
	CONTROL GROUP		
	No treatment		



APPENDIX B

DEMOGRAPHIC QUESTIONNAIRE

APPENDIX B

DEMOGRAPHIC QUESTIONNAIRE

AFTER YOU HAVE READ AND SIGNED THIS PAGE, DETACH IT FROM THE QUESTIONNAIRE TO FOLLOW AND RETURN IT TO THE TRAINER.

This is a questionnaire that is being given to you for the purpose of determining the effectiveness of a training program that will be given at this nursing home.

Your name will not be attached to the forms. In other words, your answers will remain anonymous and confidential.

The completed questionnaires will not be revealed at any time to the administration of the nursing home; therefore, your answers will in no way jeopardize your job or position within the nursing home. The information from the questions will be summarized and presented to the staff of the nursing home as group data, not individualized results.

In consideration of the confidentiality of your answers and for the sake of an accurate assessment, I would ask you please to be as honest as possible in your replies to the questions.

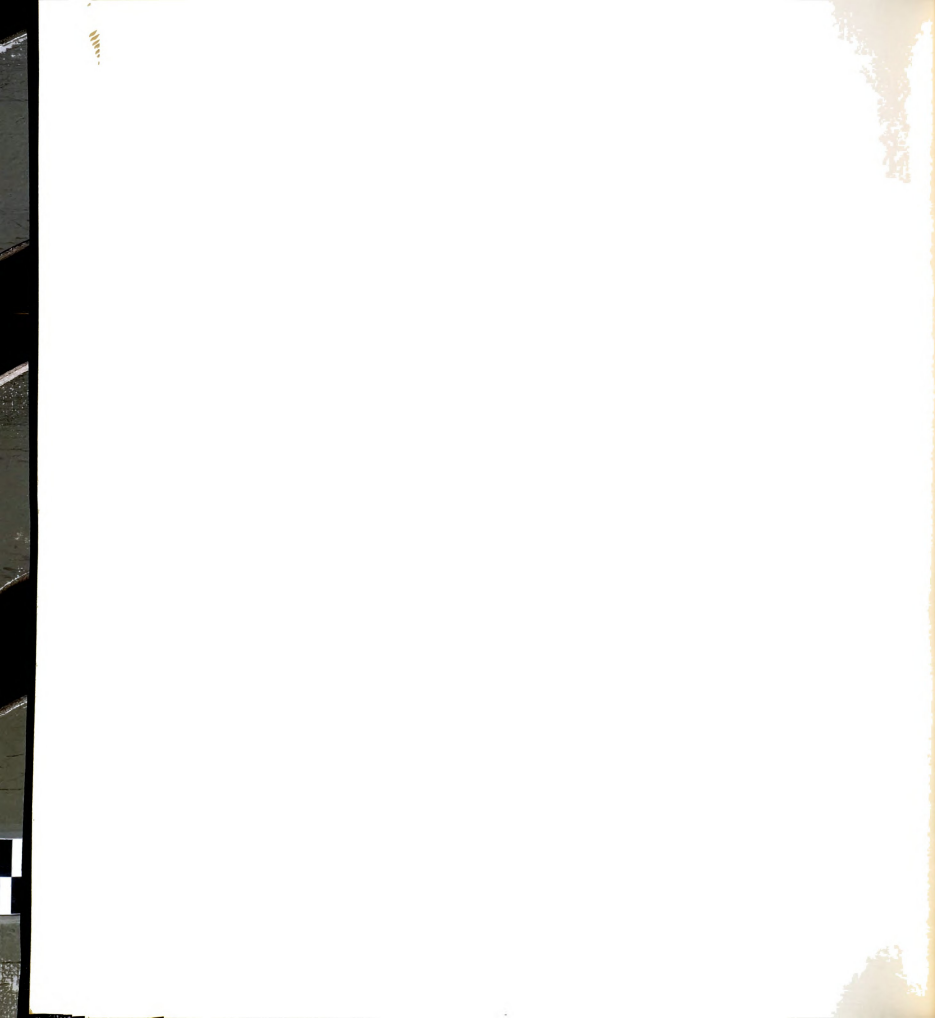
I _____, understand that the information that I give in this questionnaire will remain anonymous and confidential. I have read the above explanation of the questionnaire and I understand its purpose.

Signed _____ Participant

G. Maureen Chaisson, M.S.N.

Will you please now take a minute to stop and think of some code name to use and then write this in the blank provided in the top right-hand corner of this page. (Example: "fish," "slam," "1489," etc.)

This code name will serve to identify your questionnaire to you alone. You will be asked to write it again on the questionnaire that you will answer at the end of the training program at the end of April. Therefore, be sure to select a sign that you will not forget in one month. To help you remember, you have been supplied with a blank index card. You may use this to record your code name and take it with you should you so choose.



1. Code identification_____

2. Age_____

3. Sex ___Male ___Female

4. Marital Status ___Single
 ___Married
 ___Divorced
 ___Widowed

5. Education--Please fill in the number of years completed:

 ___Elementary
 ___High school
 ___College
 Degree____
 ___Professional school
 ___R.N.
 ___A.D.N.
 ___L.P.N.
 ___Other
 Please describe_____

6. How long have you worked in a job of caring for the elderly?

___months

or

___years

7. How long have you worked in this nursing home?

___months

or

___years

8. How would you describe the level of job satisfaction that you experience in your present employment in this nursing home?
(Check the place on the scale that best reflects your feeling.)

Very Satisfying	_____	Dissatisfying
	1 2 3 4 5	
Burdensome	_____	Enjoyable
	1 2 3 4 5	
Too Demanding	_____	Challenging
	1 2 3 4 5	
Uplifting	_____	Depressing
	1 2 3 4 5	
Unpleasant	_____	Pleasant
	1 2 3 4 5	
Easy	_____	Difficult
	1 2 3 4 5	

9. What would you say are the most dissatisfying or unpleasant aspects of your job? Please list them in order from most dissatisfying or unpleasant to the least.
- 1.
 - 2.
 - 3.
 - 4.
 - 5.
10. What would you say are the most satisfying or pleasant aspects of your job? Please list them in order from the most satisfying or pleasant to the least.
- 1.
 - 2.
 - 3.
 - 4.
 - 5.

11. Have you worked in another nursing home? ☐ Yes
☐ No

If yes, how long did you work there? ☐ Months
☐ Years

12. Outside of the inservice training programs that you have attended in this nursing home, what other special training have you received in caring for the elderly? Please estimate.

☐ number of inservice sessions

☐ number of one-day workshops (training program away from nursing home)

☐ academic courses. Please list:

☐ other preparation. Please list:

13. How are you employed now? ☐ 5 days
☐ 4 days
☐ 3 days
☐ 2 days

14. What is the title of your job?

☐ Charge nurse	☐ Housekeeping
☐ Staff nurse	☐ Janitorial
☐ Aide	☐ Maintenance
☐ Dietary	☐ Office
☐ Laundry	

15. a) Do you now or have you ever lived with a family member or other close friend or relation who was over 65 years old?

☐ Yes
☐ No



b) Their relationship to you:

☐ sister or brother ☐ grandparent ☐ other
☐ in-law ☐ parent
☐ friend ☐ aunt or uncle

c) How old were they when you lived with them?

☐ 65-75 ☐ 75-85 ☐ 85-95 ☐ older

d) If you answered "yes" to the above question (a), please check the quality of your relationship with that person.

Very satisfying _____ Very Dissatisfying
 1 2 3 4 5

16. a) Outside of your job situation do you or have you in the past associated with someone over 65 years on a regular basis?

☐ Yes ☐ No

b) How often? _____

c) Their relationship to you:

☐ sister or brother ☐ grandparent
☐ in-law ☐ parent
☐ friend ☐ aunt or uncle
☐ other

d) If you answered "yes" to the above question (a), please check the quality of your relationship with that person.

Very satisfying _____ Very dissatisfying
 1 2 3 4 5

APPENDIX C

ATOP PRETEST



APPENDIX C

ATOP PRETEST

Read each statement and put a check in the box that most appropriately identifies your response to the statement.

Example: Eggs are best to eat when they are soft cooked.

Strongly Agree		Neutral		Strongly Disagree
1	2	3	4	5

PLEASE ANSWER EVERY QUESTION. Please mark your answer on the accompanying scoring sheets.

-
1. It would probably be better if most old people lived in residential units with people of their own age.

Strongly Agree		Neutral		Strongly Disagree
1	2	3	4	5

2. Most old people are really no different from anybody else: they're as easy to understand as younger people.

Strongly Agree		Neutral		Strongly Disagree
1	2	3	4	5

3. Most old people get set in their ways and are unable to change.

Strongly Agree		Neutral		Strongly Disagree
1	2	3	4	5

4. Most old people would prefer to quit work as soon as their pensions allow them to.

Strongly Agree		Neutral		Strongly Disagree
1	2	3	4	5



5. Most old people can generally be counted on to maintain a clean, attractive home.

Strongly Agree		Neutral		Strongly Disagree
1	2	3	4	5

6. Old people have too much power in business and politics.

Strongly Agree		Neutral		Strongly Disagree
1	2	3	4	5

7. Most old people do things to make one feel ill at ease.

Strongly Agree		Neutral		Strongly Disagree
1	2	3	4	5

8. Most old people bore others by their insistence on talking about the "good old days."

Strongly Agree		Neutral		Strongly Disagree
1	2	3	4	5

9. Most old people spend too much time prying into the affairs of others and giving unsought advice.

Strongly Agree		Neutral		Strongly Disagree
1	2	3	4	5

10. When you think about it, old people have the same faults as anybody else.

Strongly Agree		Neutral		Strongly Disagree
1	2	3	4	5

11. Most old people seem to be interested in their personal appearance.

Strongly Agree		Neutral		Strongly Disagree
1	2	3	4	5

12. Most old people are cheerful, agreeable, and good humored.

Strongly Agree		Neutral		Strongly Disagree
1	2	3	4	5



13. Most old people are constantly complaining about the behavior of the younger generation.

Strongly Agree		Neutral		Strongly Disagree
1	2	3	4	5

14. Most old people make excessive demands for love and reassurance.

Strongly Agree		Neutral		Strongly Disagree
1	2	3	4	5

15. Most old people would prefer to continue working just as long as they possibly can.

Strongly Agree		Neutral		Strongly Disagree
1	2	3	4	5

16. Most old people are very relaxing to be with.

Strongly Agree		Neutral		Strongly Disagree
1	2	3	4	5

17. Most old people are very dependent upon others.

Strongly Agree		Neutral		Strongly Disagree
1	2	3	4	5

18. Most old people would prefer living with relatives over living alone.

Strongly Agree		Neutral		Strongly Disagree
1	2	3	4	5

19. Most old people are hard of learning.

Strongly Agree		Neutral		Strongly Disagree
1	2	3	4	5

20. Most old people prefer not to associate with young people.

Strongly Agree		Neutral		Strongly Disagree
1	2	3	4	5

21. Most old people are very interesting to talk to.

Strongly Agree		Neutral		Strongly Disagree
1	2	3	4	5

22. Most old people complain a great deal.

Strongly Agree		Neutral	Strongly Disagree
1	2	3	4 5

23. Most old people wish that they were young.

Strongly Agree		Neutral	Strongly Disagree
1	2	3	4 5

24. Most old people have lost their need for a sexual outlet.

Strongly Agree		Neutral	Strongly Disagree
1	2	3	4 5

25. Most old people prefer to associate with other old people of the same sex.

Strongly Agree		Neutral	Strongly Disagree
1	2	3	4 5

26. I suspect that when I get old, I will be quite a different person from how I am now.

Strongly Agree		Neutral	Strongly Disagree
1	2	3	4 5

27. Most old people are alike; that is, the differences between them as individuals are very small.

Strongly Agree		Neutral	Strongly Disagree
1	2	3	4 5

28. We become more alike as we grow older.

Strongly Agree		Neutral	Strongly Disagree
1	2	3	4 5

29. Most old people live in a daily fear of dying.

Strongly Agree		Neutral	Strongly Disagree
1	2	3	4 5

30. Most old people need to be forced to take an interest in something for their own good.

Strongly Agree		Neutral	Strongly Disagree
1	2	3	4 5

31. As people grow older they tend to lose interest in the world around them.

Strongly Agree		Neutral		Strongly Disagree
1	2	3	4	5

32. It is better not to say anything to an old person that will make him/her cry, even if it is true.

Strongly Agree		Neutral		Strongly Disagree
1	2	3	4	5

33. Old people need a lot of cheering up and reassurance from staff.

Strongly Agree		Neutral		Strongly Disagree
1	2	3	4	5

34. All elderly residents of nursing homes should be informed of their medical condition.

Strongly Agree		Neutral		Strongly Disagree
1	2	3	4	5

35. Residents should participate in the planning of their medical treatment.

Strongly Agree		Neutral		Strongly Disagree
1	2	3	4	5

36. Residents should be encouraged to verbalize their complaints about treatment or services.

Strongly Agree		Neutral		Strongly Disagree
1	2	3	4	5

37. As people get older they are less concerned about their privacy.

Strongly Agree		Neutral		Strongly Disagree
1	2	3	4	5

38. For practical reasons residents must limit their retention of personal belongings to absolute essentials.

Strongly Agree		Neutral		Strongly Disagree
1	2	3	4	5



APPENDIX D

HOGAN EMPATHY SCALE



APPENDIX D

HOGAN EMPATHY SCALE

1. I enjoy social gatherings just to be with people.
2. The only interesting part of the newspaper is the "funnies."
3. I looked up to my father as an ideal man.
4. A person needs to "show off" a little now and then.
5. Our thinking would be a lot better off if we would just forget about words like "probably," "approximately," and "perhaps."
6. I have a very strong desire to be a success in the world.
7. When in a group of people I usually do what the others want rather than make suggestions.
8. I liked Alice in Wonderland by Lewis Carroll.
9. I usually go to the movies more than once a week.
10. Some people exaggerate their troubles in order to get sympathy.
11. People can pretty easily change me even though I thought my mind was already made up on a subject.
12. I often feel that I made a wrong choice in my occupation.
13. I am very slow in making up my mind.
14. I always follow the rule: business before pleasure.
15. Several times a week I feel as if something dreadful is about to happen.
16. There's no use in doing things for people; you only find that you get it in the neck in the long run.
17. I would like to be a journalist.
18. A person who doesn't vote is not a good citizen.

19. I think I would like the work of a building contractor.
20. I have had very peculiar and strange experiences.
21. My daily life is full of things that keep me interested.
22. When a person "pads" his income tax report so as to get out of some of his taxes, it is just as bad as stealing money from the government.
23. In most ways the poor man is better off than the rich man.
24. I always like to keep my things neat and tidy and in good order.
25. Clever, sarcastic people make me feel very uncomfortable.
26. It's a good thing to know people in the right places so you can get traffic tags, and such things, taken care of.
27. It makes me feel like a failure when I hear of the success of someone I know well.
28. I think I would like the work of a dress designer.
29. I am often said to be hotheaded.
30. I gossip a little at times.
31. I doubt whether I would make a good leader.
32. I tend to be on my guard with people who are somewhat more friendly than I had expected.
33. Usually I would prefer to work with women.
34. There are a few people who just cannot be trusted.
35. I become quite irritated when I see someone spit on the sidewalk.
36. When I was going to school I played hooky quite often.
37. I have very few years compared to my friends.
38. It is hard for me to start a conversation with strangers.
39. I must admit that I enjoy playing practical jokes on people.

40. I like mechanics magazines.
41. I have a good appetite.
42. I wake up fresh and rested most mornings.
43. I think I would like the work of a librarian.
44. I am easily awakened by noise.
45. I like to read newspaper articles on crime.
46. My hands and feet are usually warm enough.
47. My daily life is full of things that keep me interested.
48. I am about as able to work as I ever was.
49. There seems to be a lump in my throat much of the time.
50. A person should try to understand his dreams and be guided by
or take warning from them.
51. I enjoy a detective or mystery story.
52. I work under a great deal of tension.
53. I have diarrhea once a month or more.
54. Once in a while I think of things too bad to talk about.
55. I am sure I get a raw deal from life.
56. My father was a good man.
57. I frequently undertake more than I can accomplish.
58. I enjoy the company of strong-willed people.
59. Disobedience to the government is never justified.
60. It is the duty of a citizen to support his country, right or
wrong.
61. I have seen some things so sad that I almost felt like crying.



62. I have a pretty clear idea of what I would try to impart to my students if I were a teacher.
63. As a rule I have little difficulty in "putting myself into other people's shoes."
64. I am usually rather short-tempered with people who come around and bother me with foolish questions.

APPENDIX E

DIRECTIONS FOR CRITICAL INCIDENT

STIMULUS FILM

APPENDIX E

DIRECTIONS FOR CRITICAL INCIDENT
STIMULUS FILM

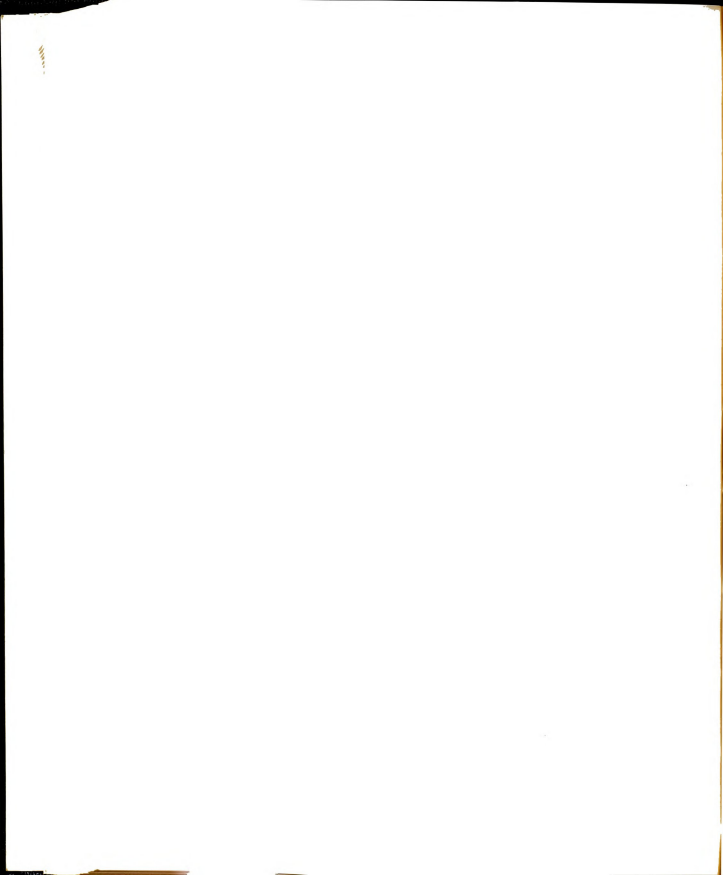
You are about to view two short segments of a videotape. In the videotape you will see an elderly person who is talking directly to you. You are asked to concentrate on the tape, imagining yourself to be alone in a room with this person. Although it is clear that this is a simulation of reality, you are urged to become a participant, rather than just an uninvolved observer. In other words, try to put yourself into the situation and react freely and spontaneously to the speaker as you would in a comparable event in real life.

After viewing the videotape wait until you receive a signal from the test administrator before proceeding to answer questions about the tape. There is one question on each page. Do not turn the page to proceed to the next question until you are given another signal from the test administrator. There will be 4 questions with 3 minutes allowed for answering each question.

PLEASE--DO NOT turn pages of the questionnaire until you are given a signal to do so.

APPENDIX F

MONOLOGUE OF CRITICAL INCIDENT STIMULUS FILM



APPENDIX F

MONOLOGUE OF CRITICAL INCIDENT STIMULUS FILM

Where the hell is he? You know God-damn well he said that he would be here for me in one or two weeks. Now it's been a month. Hasn't it? Nurse you saw those letters . . . two God-damn letters. That's all! (Sniffing, muffled crying) You can't just write somebody letters, you got to talk to them. Oh, it's easy for them to write me letters, isn't it? Isn't that right, nurse? They write me letters easy. Isn't that right? Oh no, you can't talk back to a letter. You can't argue with a letter. Tell me that they wouldn't leave me here, not with all these other people (looks around him at other imaginary people in the nursing home). They got nothing to live for. I've got a family. We did all right when we were here in Michigan living together. He said that he'd take me to California with him. Why the hell didn't he take me? Why am I here? (More crying) It's no good. I'm not like a cow! You can't send me out to pasture! He wouldn't betray me . . . not my Tommy. He'll come back. He said I'd go to California with him, didn't he? You heard him. Then where the hell is he! I don't like these other people here. They're too old. (Sobbing) I don't want to be old. (More sobbing) Call him. I want to call him. Will someone get a telephone?

APPENDIX G

OPEN-ENDED QUESTIONNAIRE

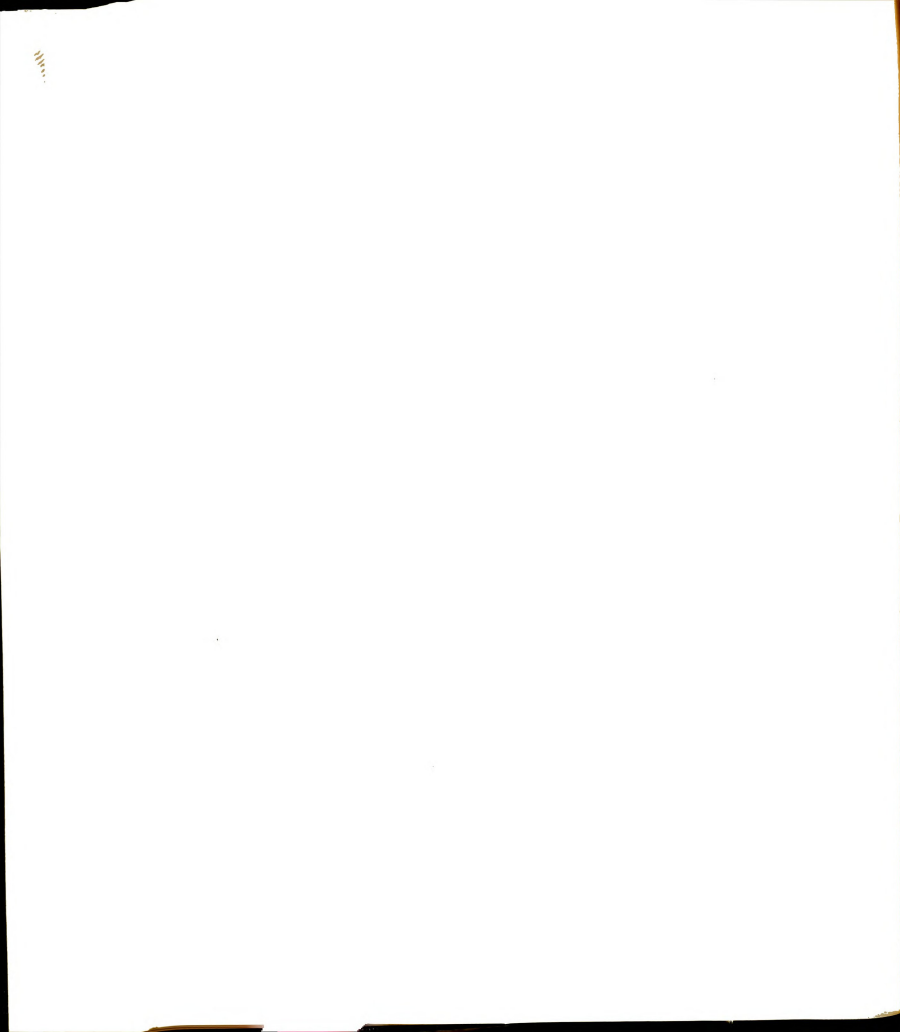
APPENDIX G

OPEN-ENDED QUESTIONNAIRE

1. How did you feel when the speaker was talking to you in the videotape?
In other words, what emotions did you feel in viewing the tape as you imagined the person to be speaking directly to you?

(In order to help you describe your reactions a list of descriptor words is provided from which you may choose the word or words that best describe your reactions. Your answer need not be limited to only those descriptors listed. You may use words from this list or others of your own choice.)

WAIT FOR SIGNAL BEFORE TURNING PAGE.



2. How did you perceive that the speaker was feeling in this situation as portrayed on tape? (Again you may use the descriptor list if it is helpful to you in finding words to explain the feelings presented by the speaker.)

WAIT FOR THE SIGNAL BEFORE TURNING PAGE.

3. What would you say to the person presented in this situation? How would you respond to him/her in words? (Use direct quotations of the exact response that you would make.)



4. In addition to what you would say, can you think of anything that you would do in this situation? If so, please describe what you would do.

APPENDIX H

DESCRIPTOR LIST



APPENDIX H

DESCRIPTOR LIST

This is a list of descriptions of different reactions to this situation. If any of the phrases listed here describe your feelings in this situation, please put an "X" in front of the phrase.

- ___ I want to help, protect, please this person.
- ___ I would like to get away from this situation.
- ___ I feel safe and secure.
- ___ A sense that I have no control over the situation.
- ___ I want to touch, hold, be close physically to the other person.
- ___ I get mad at myself for my feelings or thoughts.
- ___ I'm loose, relaxed.
- ___ I feel as if I'm under a heavy burden.
- ___ I want to say something nasty, something that will hurt someone.
- ___ There's a desire to give of myself to this person.
- ___ I want to strike out, explode, but I hold back, control myself.
- ___ There's a sense of not knowing where to go, what to do.
- ___ I begin to think about what I can do to change the situation.
- ___ I want to make this person happy.
- ___ There is a sense of regret.
- ___ My heart seems to ache.
- ___ There's a sense of complete understanding of this person.
- ___ I don't feel close to this person.
- ___ I am peaceful, tranquil, quiet.
- ___ There's a lump in my throat.



- ___ There's a sense of weakness.
- ___ I want to be tender and gentle with another person.
- ___ I don't like being with this person.
- ___ A sense of well-being.
- ___ There's a heaviness in my chest.
- ___ A sense that I have no control over the situation.
- ___ I want to be comforted, helped by someone.
- ___ I would like to shake this person.

APPENDIX I

GLOSSARY OF RESPONSE MODE TERMS
AND RATING FORM

APPENDIX I

GLOSSARY OF RESPONSE MODE TERMS AND RATING FORM

Affective--Responses that "tune in" on the feeling tone expressed by the speaker. They indicate that the listener is aware of how the speaker is feeling.

Cognitive--Responses that indicate the listener is attentive to the content of the words spoken, rather than to the feelings behind the words.

Listening--Responses that indicate the listener is listening to what the other person really means and how he is feeling. They indicate that the listener has accurately caught what the speaker really means and what he is really experiencing and feeling.

Nonlistening--Responses that indicate the listener has not accurately received the communication the speaker intended. Nonlistening responses usually result when the person's problem arouses strong feelings in the listener or when the listener identifies strongly with the feelings of the speaker and then becomes confused about the differences between his own feelings and those of the speaker.

Honest-labeling--Responses that involve the introduction or exploration of unspoken speaker feelings by the listener. Such an attempt on the part of the listener to go one step beyond what the speaker has communicated and to communicate further for him, involves risk-taking--the risk being that the listener may be wrong in his assumption. In honest labeling the listener tries to find words to



express the characteristics of the gut-level emotions that the speaker may not be able to express in words.

Distorting--Responses that somehow alter the message that the speaker intended to convey. They are often the result of the listener projecting his own reactions to the situation upon the speaker and then responding to the speaker as though his own gut reactions actually were owned by and originated from the speaker. Distorting responses tend to confuse and misdirect communication.

Definitions for the above terms were compiled by the researcher from several different sources, including Kagan and Williams (1971).



APPENDIX J

DEFINITIONS OF EMOTIONAL STATES

APPENDIX J

DEFINITIONS OF EMOTIONAL STATES

CLUSTER 4: MOVING TOWARD

I want to help, protect, please this person
There's a sense of complete understanding of this person
I want to touch, hold, be close physically to the other person
I want to be tender and gentle with another person
I want to make this person happy
There's a desire to give myself to this person

CLUSTER 5: MOVING AWAY

I would like to get away from this situation
I don't like being with this person
I don't feel close to this person

CLUSTER 7: COMFORT

A sense of well-being
I am peaceful, tranquil, quiet
I'm loose, relaxed
I feel safe and secure

CLUSTER 8: DISCOMFORT

There's a lump in my throat
My heart seems to ache
There's a heaviness in my chest
I feel as if I'm under a heavy burden

CLUSTER 11: INCOMPETENCE:DISSATISFACTION

I get mad at myself for my feelings or thoughts
I begin to think about what I can do to change the situation
There is a sense of regret
There's a sense of weakness

CLUSTER 12: INADEQUACY

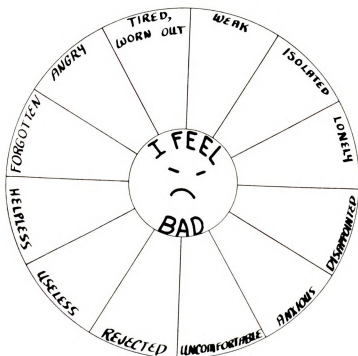
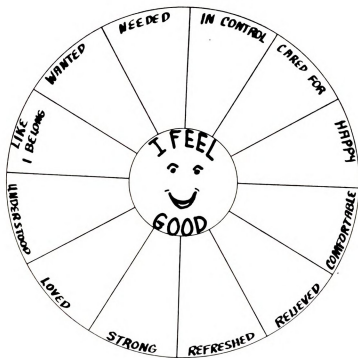
There's a sense of not knowing where to go, what to do
A sense that I have no control over the situation
I want to be comforted, helped by someone

APPENDIX K

FEEL WHEELS

APPENDIX K

FEEL WHEELS





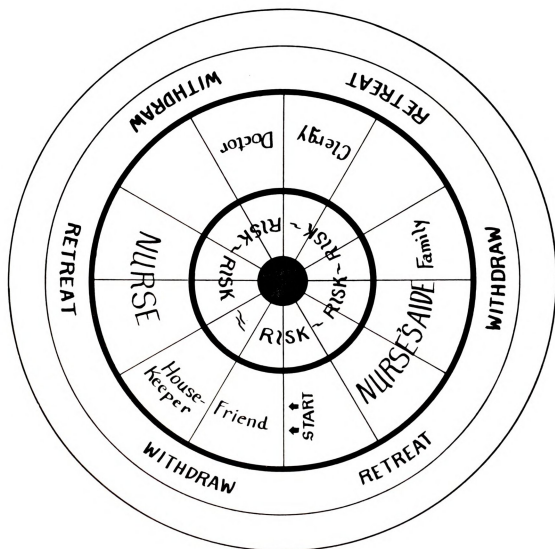
APPENDIX L

REPRODUCTION OF GAME BOARD

OF "LIFE-CYCLE"

APPENDIX L

REPRODUCTION OF GAME BOARD OF "LIFE-CYCLE"



LIFE CYCLE

A SOCIAL SIMULATION GAME.

APPENDIX M

OUTLINE OF TRAINING PROGRAM

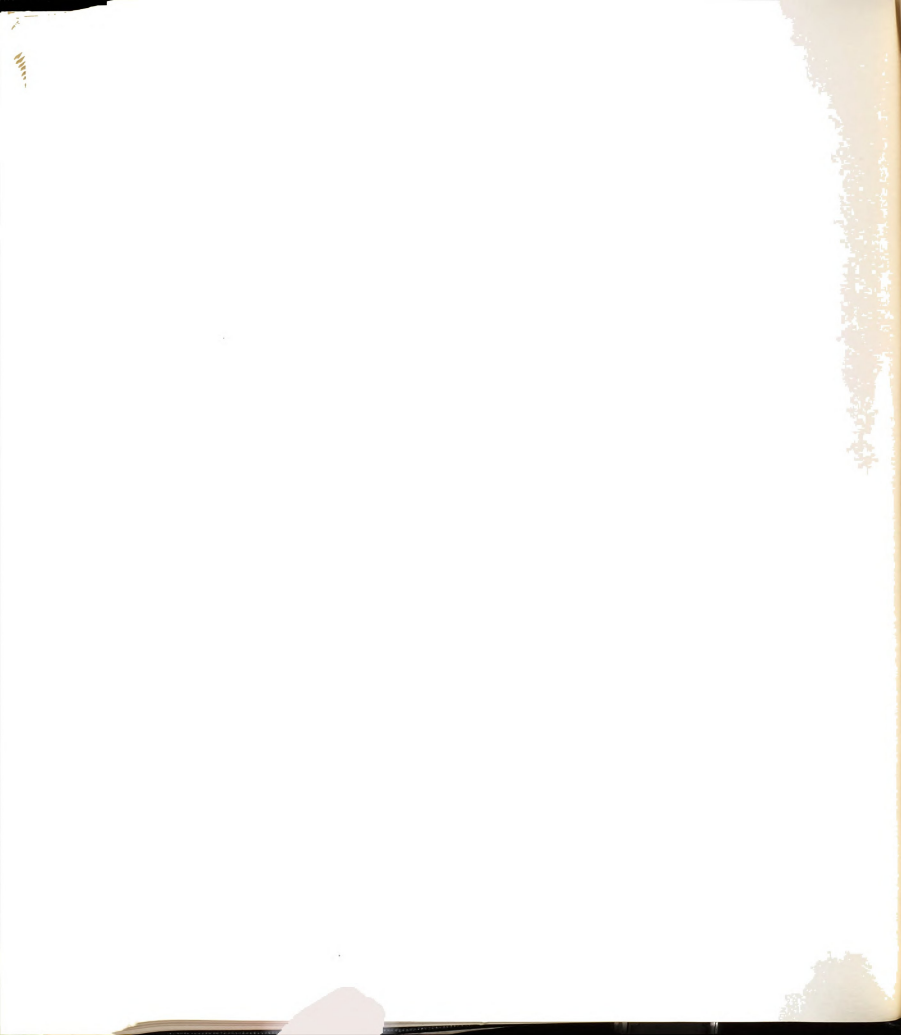


APPENDIX M

OUTLINE OF TRAINING PROGRAM

Time	Phases	Goals	Strategy	Advantages
PHASE 1--3 HOURS	PREREQUISITES	Promote system-wide impact Promote progression from authoritarian to more democratic communication structure Begin introducing all levels of staff into decision-making process	Insist on full participation of all house staff Insist on all levels of staff playing game together	
	INTRODUCTION & WARM-UP	Increase communication Increase group cohesiveness Decrease anxiety Promote identification with position of institutionalized elderly Stimulation of realization of common problems of elderly	Games Films and discussion	
	GAME-PLAYING	Increase empathy with lot of elderly by experiencing role of old patient Provide concrete, honest feedback on interpersonal effectiveness, by means of symbolic tokens Stimulate discussion of reality of death by use of symbolic snake eyes, and suicide circle	Simulation game	Less threatening than reality Allows for discussion and resolution of conflicts generated High level of involvement of all participants
PHASE 11--4 HOURS				

PHASE III-- INDEF. TIME	Game-manager models role of accepting, active listener Provide opportunity for practicing different modes of interacting with patients Increase awareness of one's impact upon elderly patient Learn to counter hostile reactions Learn to deal with dissension more effectively Learn to plan strategies Learn to resolve an impasse Increase personal awareness Increase self-analysis and critique Increase insights Increase motivation to improve Increase understanding of system dynamics Increase open communication Increase group problem solving Provide opportunity for personal catharsis Allow for airing of grievances Stimulate team goal setting	Modeling Role-playing Peer feedback Conflict resolution Stimulated mutual recall Debriefing	Allows for trying out roles in safe, make-believe world Allows for less-threatening critique of "actor" rather than person Forces action on common and difficult situations Accelerates process of personal awareness Less-threatening mode of direct confrontation Peer instruction "Client" feedback rather than supervisor's
PHASE II--4 HOURS (Cont'd)	Game-manager models role of accepting, active listener Provide opportunity for practicing different modes of interacting with patients Increase awareness of one's impact upon elderly patient Learn to counter hostile reactions Learn to deal with dissension more effectively Learn to plan strategies Learn to resolve an impasse Increase personal awareness Increase self-analysis and critique Increase insights Increase motivation to improve Increase understanding of system dynamics Increase open communication Increase group problem solving Provide opportunity for personal catharsis Allow for airing of grievances Stimulate team goal setting	Modeling Role-playing Peer feedback Conflict resolution Stimulated mutual recall Debriefing	Allows for trying out roles in safe, make-believe world Allows for less-threatening critique of "actor" rather than person Forces action on common and difficult situations Accelerates process of personal awareness Less-threatening mode of direct confrontation Peer instruction "Client" feedback rather than supervisor's



APPENDIX N

RULES OF THE GAME, "LIFE-CYCLE"



APPENDIX N

RULES OF THE GAME, "LIFE-CYCLE"

A. Objectives of the Game

One of the main purposes of this game is to illustrate and dispel some of the common myths about old age. It provides the opportunity for participants to identify and explore their own feelings about old age of others and of themselves. By stimulating role-playing between participants in a non-threatening atmosphere, it provides the opportunity for the clarification of roles, of the possibilities and limitations of service to the elderly. Through the use of concurrent videotaping of role-plays and subsequent stimulated recall through videotape playback, the players can help each other to increase their awareness of the emotional dimensions that affect behavior. It is hoped that through a process of peer instruction they can increase their ability to assess individual situational conflicts, to understand their underlying dimensions and to be able to know and review together various alternative approaches toward resolution.

B. Gaming Atmosphere

There are no winners or losers in this game. The goal of the game is to facilitate learning, not to stimulate competition. While the gaming atmosphere makes learning more fun, the game is not designed primarily for diversion, but rather for learning.

Each player has his own personal view of aging and of each situation in which he finds himself based upon his own personal background and value system. Therefore, each will bring his own perspective and set of values into the analysis of the situational interactions. Neither game-manager nor any one individual player is represented as the holder of the truth or the correct answers. As in the real world, there is no one omniscient individual in any conflict situation. Rather, the game will provide the players with honest, helpful feedback from the protagonist that can prove to be formative in handling future similar situations in the real world. In addition, the players will have the opportunity to "try-on" and then analyze with peer assistance the differing response modes in a situation, thereby enabling them to sort out the most therapeutic and helpful response mode for carrying over into the real world. The game manager is not to be presented nor to act as the teacher in any way. Rather he or she plays a facilitative, reflective and supportive role to the players. Instead of "injecting" learning, his/her role ought to be draw out, learning from the players by encouraging them to teach each other by means of the techniques built into the game model, that is, peer feedback, reward system, post-game analysis.



C. Players

The game is designed for 5 to 10 players. The players are divided into two teams of equal numbers, who sit on opposite sides of a playing table from each other. The teams are designated as (I) senior citizens and (II) significant others (aide, nurse, physician, family, etc.). Only the senior citizen players roll the dice and move their men along the game board. The significant others stand by to play the roles of protagonist in difficult situational encounters with the senior citizen.

D. To Begin Playing

The "senior citizens" take turns in throwing the dice and moving along the game board the number of spaces dictated by the dice. They must begin at start and move their men along the white path of the circular board.

If they land on a blank space they have two choices:

1. They are relieved of having to play a role or
2. they can elect to advance into the inner circle, to get closer to someone by taking a risk.

If they decide to move into the "risk" circle they will be given "risk" situational cards that set them up in a role play with another character that is difficult to enact but may provide the opportunity for getting closer to another human being, if the confrontation is successful.

If they land on a titled space, they have three choices:

1. They can play an interaction with the player whose name is written on the square.
2. They can elect to play a more difficult encounter with the same party by moving into the inner circle or "risk" circle.
3. They can read the situation designed for their role-play and then elect to withdraw from an interplay. If they do this, they move into the "withdraw" circle and incur a white "cop-out" token from the game manager as a penalty.

At any time during the course of the game a player may decide to withdraw from the game completely. He may do this on his turn by moving his man into the outer limits or "death" circle, which is otherwise known as suicide.

If a player throws a snake eyes or double one on the dice, he is automatically dead through forces out of his control and he must



withdraw from the rest of the game by moving his man to the outer, "death" circle.

E. Instructions for Role-Playing

The game manager will provide cards to both of the role-players. On the cards are described each role-player's position and perspective in a situation to be acted out with the other party. When the players are ready to begin the role play, they will notify the game manager. The game manager will time the interaction, which he will limit to from 3 to 5 minutes, not as a punitive measure but merely to allow for a larger number and variety of interactions. The game manager will either tape-record or videotape the interaction (depending upon the equipment available). Videotaping is preferable.

The players are asked to "put-on" the roles designed and described for them on the cards in as realistic a manner as possible. If they are to be a grouchy, despondent old man, then they are asked to give an honest reproduction of that role. For it is only by so doing, by presenting as faithful a representation of character types in the role-playing situation, that real learning is facilitated for all parties.

F. Using the Feel Wheel

When the interaction is completed, the game manager will direct two distinct questions to the "senior citizen."

The first question he/she will ask is, "How do you feel now after that encounter?" The "senior citizen" at this point may use the feel wheels to assist him in finding the appropriate label for the feeling that he is left with. He can choose from feelings listed in the "I Feel Good" wheel or those listed in the "I Feel Bad" wheel.

If he communicates a feeling from the "I Feel Good" wheel, both parties are awarded a blue chip token by the game manager (a symbolic representation of a satisfying encounter). If the "senior citizen" communicates a feeling from the "I Feel Bad" wheel, both parties are awarded a red chip token by the game manager (a symbolic representation of an unsatisfying encounter).

When the interaction played was from the "risk" circle, the chip rewards are doubled for each player, either red or blue, according to the adjudged quality of the interaction.

The second question that the game manager will direct toward the "senior citizen" after the role-play will be, "How do you feel your partner handled that situation with you?" If the response to this question is positive, the game manager will award both parties another blue chip (2 blue chips if on the risk space). If the response to this question indicates a negative reaction, both parties will be awarded another red chip by the game manager (2 red chips if on the risk space).



G. Using Distrust Tokens

For the purposes of this game, white playing chips are otherwise known as distrust tokens or "cop-out" tokens. A distrust token may be awarded to any role-player by any other participant in the game at any point during the role-play. It is a concrete way of indicating to the recipient that his role-play is not coming across as sincere, that something about the way that he is playing the part makes another feel that the player is not being completely honest and straightforward.

H. Post-Game Analysis

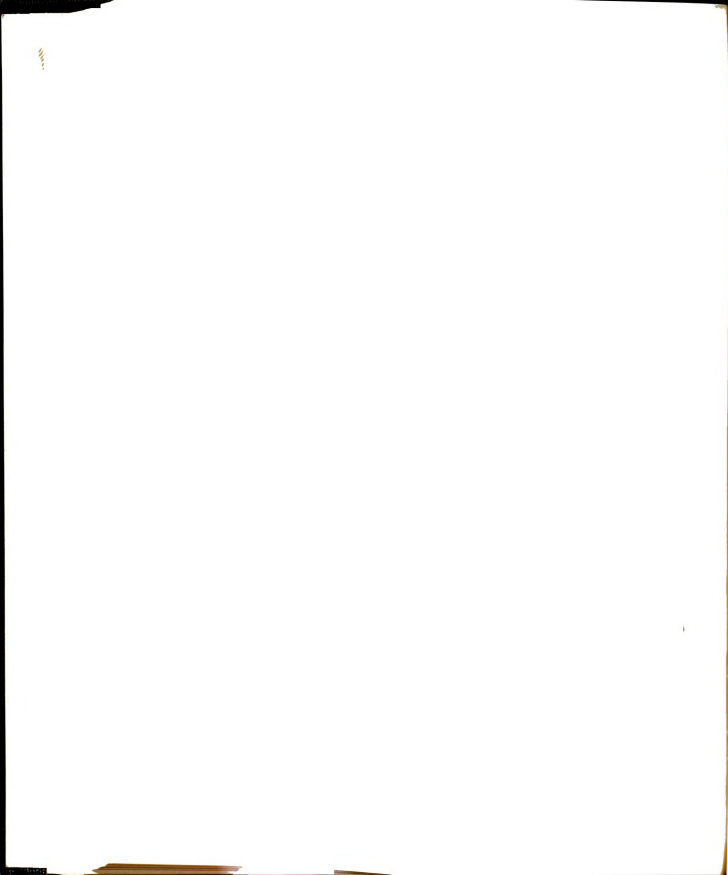
Group discussion of role-plays is reserved for the post-game analysis period. It is suggested that after three role-plays have been recorded on tape that the game be interrupted for analysis. If the analysis session is conducted well by the game manager, it is here that most of the learning takes place.

During the post-game analysis the role-players and observers are encouraged to be as candid as possible in their comments in order to provide the feedback that is essential for learning and growth. The debriefing session provides an opportunity for all participants to share or compare ideas, techniques, and reactions. To the extent that the critique is looked on merely as a chance to participate in a bull session about the play, the effectiveness of the entire effort is in jeopardy. The focal point of the critique discussion ought to be: "Were we to relive this experience, in what way would our actions be different?"

I. The Role of the Game Manager

The game manager is very crucial to the success or failure of the game as a teaching tool. He is to assist the players to relive and talk about the interactions with special emphasis on covert processes. His task in the post-game analysis phase becomes that of a clinical interrogator or "inquirer." If he assumes a respectful, noncritical set with the players, the recall and self-analysis ought to be intensified.

It is the game manager's responsibility to direct attention to the most critical and meaningful portions of the play. He must also gently redirect the focus onto the essential issues when they tend to get sidetracked into nonproductive speculation. He encourages the players to focus on the subtle, often complex, nonverbalized messages that they were sending during the interplay and to reveal these to the group for analysis. If this is done successfully, the players ought to increase their sensitivity and awareness of each other as players and also as individuals.



J. Length of Game

The game board plays can be resumed at any time and continued as time permits in order to provide taped feedback for class analysis. The game can be played numerous times with different actors in different situations and the variations of interplay will provide an endless supply of material for group discussion and learning.



APPENDIX O

SITUATIONS FOR ROLE-PLAYING USED
IN GAME, "LIFE-CYCLE"



APPENDIX O

SITUATIONS FOR ROLE-PLAYING USED IN GAME, "LIFE-CYCLE"

Situation 1

Senior Citizen

You are visited by the clergyman today. You think someone called him because you are dying. You feel very nervous wondering what his real reason is for visiting you.

Clergy

You just drop by to say "hi" to those patients in the facility who are part of your denomination. You walk into one of the rooms and this patient doesn't appear very happy to see you. You wonder why and what to do about that.

Situation 2

Senior Citizen

You have been admitted to the nursing home after a prolonged illness in the local general hospital. You are sure that it is only a matter of weeks now before you will be on the road to recovery, once you have regained your strength. The minister has come to visit you at the request of your family.

Clergy

You have been informed by the doctor that his patient has about three weeks to live. She has inoperable cancer but does not know it. The doctor has asked you to visit with the patient and say the necessary prayers as well as to offer to her consolation at this hour of need. You feel that you can not hide the truth of her real condition from her as revealed to you by her doctor, but at the same time you are very up-tight because this information has not been shared outright with the patient by her doctor.



Situation 3Senior Citizen

Your family has given you some excuse about not inviting you to their home for Thanksgiving. You are very disappointed and resentful. You feel like you must talk to them more about this and you do. You have a hard time understanding why you can't be with them. You feel they owe this to you and you are determined to get your way.

Family Member

The Thanksgiving holiday is coming up. You want to enjoy this day with your wife and children. You don't look forward to having your father with you, who has had a stroke. He is in a wheel chair, drools at the mouth when he eats, needs considerable help in eating, must wear a bib--generally a burden and unpleasant sight at the dinner table.

You plan to visit him two days before Thanksgiving and must, at that time, explain to him why he can't come home with you to celebrate the holiday.

Situation 4Senior Citizen

You have been a patient at the facility for about three months and you still have not adjusted to time schedules that demand you to provide the aide with a urine specimen for an S and A test. You hate institutional living and feel that the staff completely disregards some of your needs in the name of efficiency. Today you are especially irritable since you did not rest well because of the noise in your room from a roommate whose condition has worsened. The aide wakes you just when you are falling asleep. You decide to discuss this annoying situation with her. She wants another urine specimen from you just when you want to sleep.

Aide

Before the end of your shift your duty is to take all of the urines for S and A. You got a late start because one of the patients turned bad and required a lot of your attention. You are now very tired and anxious to get done so that you can go home. You are trying to get this job done in record time and this senior citizen holds you up to talk to you. You try to get a urine for S and A from her as quickly as possible.



Situation 5Senior Citizen

You are very angry because your daughter called and left a message with the nurse on the floor, instead of talking directly to you. Her message was that she has a cold and will be unable to visit you today. You feel that this is just an excuse, a "cop-out." You are upset about her excuse and also about not communicating to you directly. Now you decide to call her up and tell her so yourself.

Daughter

You have been visiting your mother faithfully at the Home on a regular basis. Today you felt like taking a break from that obligation and called to tell the nurse that you had a cold and would be unable to visit your mother. You asked her to pass that message on to your mother. You felt that doing it in this manner would save you the hassle of having to explain your absence in detail directly to your mother. It was an easy way out for you. You are not really happy about your finding excuses and now your mother is going to call you to talk about the situation with you.

Situation 6Senior Citizen

Your daughter is coming to visit you today. You know that your physical condition is deteriorating since you feel weaker and are in more pain each day. Although no one has told you so directly, you can tell by their reactions to you and the protective way that they communicate with you that you may, in fact, never get well again.

Daughter

You are aware of your mother's fear of cancer. You know that she has cancer, that it is progressing and is terminal in nature. The social workers has offered to talk about this with you. You refused. You must visit your mother today.



Situation 7Patient

You are a married woman of 40 years of age. You are bedridden with multiple sclerosis. Since you are paralyzed in all four extremities, you demand a lot of nursing care. The nurses have become so well organized and systematic in their morning care of you that you often feel like a sack of potatoes that is pushed, pulled, cleaned and treated, without having any control sometimes of what is done to you. Sometimes you feel like just that--a thing, rather than a person. This feeling is especially acute when two aides who give you your morning care talk to each other as they care for you, just as though you were not there. You decide to complain to the chief nurse about this behavior of the aides, when they relate to each other and not to you as they care for you.

Nurse

You have been given a message that one of the patients would like to talk with you. She has been very irritable and you have a suspicion that she is unhappy about something. She is a 40 year old lady who is a paraplegic as a result of her disease of multiple sclerosis. She is a difficult patient for you to relate to since you can't even begin to imagine what it must be like for her to be stricken with such a depressing and fatal disease. You especially feel bad for her because she has such lovely children and such a young and pleasant husband.

Situation 8Senior Citizen

You are very confused and frightened. You are somewhat aware that you are in an unfamiliar location. It scares you and you would like to get back to your home where you feel safe and secure because you know people and places. Each time you set out to find your safe home you get lost and one of the ladies comes to take you back to that strange place.

Aide

You have a patient who is continuing his behavior of wandering off the ward and getting lost in other sections of the facility. You are really upset about the situation. When you try to move the patient by touching her or when you attempt to restrain her she becomes physically combative and more resistant. Medicating her is not an alternative. She consistently appears frightened and you try now to deal with her anxiety by talking with her.



Situation 9Senior Citizen

You have only been in the Home for about two weeks. You were admitted here after having a leg amputation at a local hospital. Until the present you have been a very independent and active man. You are a former manager of a large chain of furniture stores until your retirement four years ago. You are very conscious of making a favorable impression on people, and one thing that you have never done and cannot condone is swearing. It makes you angry when you hear other people swearing in public. You feel that it is very discourteous and insulting. Especially is this objectionable when done by females. You have been annoyed by loud talk, laughter, and swearing in the Home hallways. It seems to be a regular group of nurses who do this. Besides upsetting you, they keep you awake. You decide to talk about the problem with one of the night crew that you have come to be quite fond of.

Aide

This patient was a new admission to the Home about two weeks ago after he had an amputation at a local hospital. He seems to be a very pleasant white-haired gentleman. He just turned on his light and you go to see what he needs.

Situation 10Senior Citizen

You are an 83 year old widow who has been a resident in the home for the past two years. You are troubled by persistent and annoying low-back pain. You were a school teacher for most of your life and became very used to telling others what to do and making decisions for them. You follow this same pattern in the home, of not asking but telling the staff what to do for you because you feel that this is the only way that you will get things done. You are very lonely and often frightened in this place. Hospitals always did scare you and you know that you will be here until you die. You hate to be left alone and often try to keep the nurses with you longer by finding things for them to do for you. One of the reasons why you are so lonely is that your roommate is deaf and, therefore, not a companion to you. And since you are not very mobile, you are unable to get about the home to seek out others for companionship.

Aide

Today you have been assigned to take care of a patient who is very unpopular in the home. The main reason for her unpopularity is that she is extremely demanding. The minute that you go near her she sets you to doing numerous, and sometimes unnecessary, chores, like pouring her a glass of water, checking for the location of her wheelchair, finding out who will pour the coffee at dinnertime, etc. You try to please her and follow her directions, but her demands are endless and often you try to avoid them by avoiding contact with her. She often treats you like a child or chorewoman and you resent that. You must go check on her now.



APPENDIX P

EVALUATION OF TRAINING PROGRAM

APPENDIX P

EVALUATION OF TRAINING PROGRAM

Thank you for your participation in this training program. At this time I would appreciate receiving your comments about the learning experience.

Please answer true or false to the following questions by putting a "T" or "F" in the blank. If you agree with the statement write "T." If you disagree write "F." Example: T I like cats for pets.

- 1. The training program was a pleasant experience for me.
- 2. I would recommend this training program to the staff of other nursing homes.
- 3. I feel that I learned more about myself and how I interact with patients as a result of participating in this training program.
- 4. I have learned more about old people and about how they feel in certain situations.
- 5. I have learned new ways of working through difficult situations with old residents.
- 6. I have a better understanding of what it is like to be a patient in a nursing home.
- 7. I wish that we could have more group discussion about patient management problems like we did in these sessions.
- 8. I am glad the training is over. I did not like it.
- 9. What I liked most about the training program was:
- 10. What I liked least about the training program was:
- 11. The most helpful things that I learned in the training program were:



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