Aging: An Overview for Mental Health Counselors

By: Jane E. Myers

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Abstract:
Aloha' health counseling with older persons is an emerging specialty, stimulated by changing demographics and dramatic increases in the numbers of older persons during this century. Because mast mental health counselors can expect to encounter older persons and their families with increasing frequency, an understanding of normative developmental issues and transitions is imperative. In addition, the "social breakdown syndrome" provides a useful model for implementing mental health interventions in later life. Similarities and differences in counseling older persons are discussed, with an emphasis on the importance of recognizing countertransference reactions on the part of the mental health counselor when working with older clients A brief review of outcome research reflects a need for all practitioners to evaluate outcomes when using the techniques discussed in this issue in counseling with older persons.

Abstract:
Mental health counselors differ in their beliefs about aging and older persons. For some, aging is seen as *apart of* the life span, while for others aging is seen as *apart from* the rest of the life span. Although the Preponderance of evidence suggests that the needs of older persons differ in degree, rather than in type, from the needs of younger persons (see Myers, 1989a), there remains a tendency to place older persons in a special category for treatment (Schlossberg, 1990). "Imagine a scale extending from the extreme discontinuous position that older people are clinically unique and require entirely different treatment than other age groups to the extreme continuous position that they require and benefit from the same treatment considerations and techniques . . . clinical progress may have been limited by an overemphasis on discontinuity" (Gatz, Popkin, Pino, & VandenBos, 1985, p. 755).

The development of this special issue may seem to argue implicitly for the discontinuity perspective. Such is not the case. Each of the techniques discussed in the articles that follow can be applied in mental health counseling with persons of any age. What is important in gerontological mental health counseling is an understanding of the unique aspects of work with older persons that may affect the success of helping interventions. Some modifications of basic techniques may be required because of the unique life circumstances of older individuals, These modifications are discussed in the articles in this issue, and case examples are included to make the applications more readily understood in clinical treatment.

This introductory article is intended to provide a foundation for understanding the continuum of mental health counseling possibilities with older persons, including the perspective of continuity as well as discontinuity. Definitions of terms used in the articles that follow are discussed. Normative developmental issues and transitions common in later life are reviewed as a basis for understanding the needs of older clients. The relationship between aging and mental health is considered, and a model is presented to assist mental health counselors in understanding and affecting this relationship. Similarities and differences in mental health counseling with older and younger persons are discussed, followed by a brief review of research and training needs in gerontological counseling. This article concludes with an overview of the remaining articles that appear in this special issue.

WHO ARE "OLDER PERSONS"?

A basic difficulty in understanding older persons results from lack of clear definitions. What is meant by "old," chronologically, depends on who is asked to answer the question. For example, the federal definition of an "older worker" is a person over age 40. One can join the American Association of Retired Persons at age 50, become eligible for services under the Older Americans Act at age 60, and retire at age 70 if working as a college professor. Neugarten (1976) provided a major distinction within the older population when she distinguished the young-old (ages 60-74) from the old-old (ages 75+). Increasingly, the definition that is gaining most acceptance is a functional one, as the predominant characteristic of the older population seems to be its great diversity. It seems that what the 25.5 million "older persons" in America hold most in common is their chronological age range, and little else.

It seems that people grow old in very different ways (Neugarten, 1982), so that as people grow older, they become more like themselves and less like anyone else. Within this context of individual variability, however, certain demographic characteristics of the older population may be important for mental health counselors in achieving an understanding of the context of aging in our society. The demography of aging has changed dramatically in this century, and particularly in the last 50 years. Whereas the average life expectancy was a mere 47 years in 1900, by the year 2000 it is expected to approach or exceed age 90. The fastest-growing segment of the population includes persons over the age of 85, who also happen to be those with the greatest number of physical and mental health problems (Brotman, 1982).

Differential life expectancies result in an older population that is predominantly female and primarily Caucasian. Older women tend to be widowed, living alone, and with incomes at or near the poverty level (American Association of Retired Persons, 1987). Because women outlive men and also tend to marry older men, data from the 1980 census indicate that women can expect to live alone, as widows, for an average of 25 years (Special Committee on Aging, 1983). Older men who become widowed can expect to remarry, and those who become ill tend to be cared for within family environments. Older women, in contrast, are much more likely to end their lives in a long-term care facility. Older minorities, especially those who are female, tend to be the poorest, to be the least healthy, and to have access to fewer resources than older Persons who are Caucasian (Brotman, 1982).

Over 80% of all older persons live independently in their own homes in the community. Only 5% reside in long-term care settings, and 10-15% are largely homebound because of physical and/or emotional illness (Special Committee on Aging, 1983). Although 86% of older persons report experiencing one or more chronic physical impairments that limit their activities of daily living (Brotman, 1982), most are able to cope and function independently. When care is needed, more than 80% of such care is provided by family members (Shanas, 1980). Parent care has recently been defined as a normative family stress (Brody, 1985). Further, today it is possible to spend more time caring for aging parents than raising children to adulthood (Johnson, 1987). The implications of this trend are significant and beyond the scope of the present discussion (see Myers, 1989b, for more information).

People today live three fourths of their lives as adults and one fourth or even one third as older persons. In some parts of the country (e.g., the "sunbelt") older people make up extremely large proportions of the population and are more likely to be encountered by mental health counselors, As the population as a whole ages, it is increasingly likely that *all* mental health practitioners will encounter older persons and their families as clients. The following section presents normative developmental information that can form a basis for understanding the issues faced by older clients.

DEVELOPMENTAL ISSUES IN LATER LIFE

Development in later life can be viewed from at least two perspectives: developmental sequences and life transitions. The developmental perspective assumes a unidirectional, stepwise progression of events. Certain tasks must be mastered for successful development. The positive theme here is that development occurs and can be fostered throughout the life span. Older persons are not viewed as static, rigid, or poor prospects for

therapeutic change. However, existing developmental theories seem inadequate to explain the complexities of later life. Some examples of developmental theories may serve to illustrate this point.

Gerontologists, those who study older persons, have devoted much attention to the study of successful aging. Those who age successfully tend to have a strong sense of life satisfaction, high self-esteem, and positive morale. Persons who do not age successfully experience depression and low self-esteem. Among the theories that attempt to explain this difference is Erikson's (1963) psychosocial theory of life-span development. Erikson posited the crisis of ego integrity versus despair as central to late-life development. Older persons who achieve a sense of ego integrity are able to look back on their lives with a sense. of satisfaction, acknowledging that they are basically happy with the decisions they have made and the life they have lived. Older persons who look back with regret, realizing that it is now too late to make significant changes, may experience a sense of despair and overwhelming depression. The process of life review, discussed in later articles in this issue (see Waters, Crose), seems to be central to the search for integrity. Reminiscence occurs naturally in later life. Mental health counselors can use this natural tendency to reflect on life experiences as a basis for interventions. The advantage of using memories as a therapeutic technique, as described by Sweeney in his article on early recollections, is that mental health counselors can help older persons reframe past events in a positive, ego-integrity-enhancing manner.

Another widely accepted developmental theory is that of Havighurst (1972), who proposed a series of developmental tasks that must be learned if persons are to age successfully. These include adjusting to the loss of a spouse, adjusting to retirement and reduced income, adjusting to declining physical strength and health, establishing an explicit affiliation with one's age group, meeting social and civic obligations, and establishing satisfactory living arrangements. Clark and Anderson (in Troll, 1982) modified Havighurst's model, listing five adaptive tasks for later life: recognition of aging and definition of one's instrumental limitations, redefinition of physical and social life space, substitution of alternative sources of need satisfaction, reassessment of criteria for self-evaluation, and reintegration of values and life goals.

As the life span has increased, the need to update and revise existing developmental theories has become increasingly apparent. Research on the search for integrity, for example, now indicates that this developmental crisis is resolved in the sixties and seventies. Given that people live 20-30 years beyond this time, some explanation of later developmental tasks is needed. One such explanation, provided by Riker and Myers (1990), proposes a series of tasks for each decade of later life (continuing beyond age 100) based on career, family, leisure, intimacy, and inner-life needs. Additional theories are needed to help explain the extreme variability found in all studies of older persons.

TRANSITIONS IN LATER ADULTHOOD

One difficulty with most developmental theories, as noted by Gatz et al. (1985), is that they tend to focus on aging as a time of loss. An alternative view is that aging is a time of both positive and negative transitions and transformations. Mental health counselors will approach .older clients differently if they choose the latter perspective as a foundation for understanding later life.

Schlossberg (1984) explained transitions as events or non-events resulting in stress and the need for adaptation. Transitions are influenced by the older person's perception of the transition, his or her personal characteristics, and the characteristics of the environment. Transitions may be anticipated, such as occurs with retirement at a particular age, or nonanticipated, such as occurs with an unplanned, forced retirement. They may consist of chronic hassles, such as an unhappy marital relationship that continues over time and emotionally immobilizes one of the partners, or they may be nonevents, such as the transition to grandparenthood that did not occur because one's children did not marry or chose not to have children. Whatever the source of the transition, it is likely to be a process that occurs over time, is accompanied by a variety of confusing and conflicting emotions, and is an opportunity for growth as well as a time of potential or actual crisis.

Transition approaches focus on adult roles, routines, assumptions about self, and relationships (Schlossberg, 1990). Thus, a specific, concrete focus is provided as a basis for mental health interventions. Older persons can be encouraged to talk about how the transition has affected or will affect their life and roles. Coping skills can be taught to deal with the transitions either before (preferably) or after they have occurred. Decision-making skills can also be emphasized during transition times.

Transitions commonly experienced by older persons include widowhood, divorce, job loss as a result of retirement, change in physical health and energy, and grandparenthood. Many of these transitions are experienced as negative, unhappy events. Counseling techniques that employ strategies for coping with loss will be important, as well as those that emphasize crisis intervention. Whatever strategies are used, mental health counselors should understand the relationship between aging and mental health and how that relationship might help or hinder the counseling process.

MENTAL HEALTH AND AGING

Mental health concerns tend to increase with advancing age (Butler & Lewis, 1982). These include needs for preventive mental health care as well as needs for assistance with significant problem areas. It has been estimated that at least 25% (and perhaps as many as 65%) of all older persons experience treatable mental health problems (Kramer, Taube, & Redick, 1975). The problems of these 7 million older persons range from mild impairments to those that are severe and entail loss of functioning.

Unfortunately, existing mental health services for older persons have not met the demand for care. Older persons make up over 12% of the population but only 6% of the caseload of community mental health centers and 2% of the caseload of private practitioners (Flemming, Rickards, Santos, & West, 1986). Older persons who are homebound have little access to mental health services, and those residing in long-term care settings almost never receive mental health treatment (Roybal, 1988).

Although older persons are underrepresented in outpatient care, they are overrepresented in inpatient mental health populations. More than 60% of public mental hospital beds are occupied by persons over age 65. More than half of these persons received no psychiatric care prior to their admission, making the mental hospital admission their first contact with the mental health system (Special Committee on Aging, 1)83). Preventive care or early intervention could likely prevent or postpone such hospitalizations.

The reasons for underservice of mental health care to older persons have been studied and several possible answers proposed. Older persons themselves tend not to seek mental health care for their problems but, rather, seek care from their primary physicians. In part this is due to the lack of a vocabulary for emotional issues in today's older persons. From another perspective, those who are older today hold strong values of Independence in resolving personal problems, as evidenced by cliches such as "You don't air your dirty laundry in public." It is also true that today's older persons were raised in a time when mental health services Were available only to those with the most severe impairments, and the resulting negative stigma on receiving such services is great.

Additional barriers to service exist among mental health care providers. These barriers include lack of sufficient training to meet the needs of older persons (Myers & Blake, 1984), bias against older clients (Butler & Lewis, 1982), and third-party payment policies and other systemic factors that prohibit providers from accepting older persons as clients (Knight, 1986). Cohen (1977) suggested that therapists may be reluctant to work with older clients because of unrecognized negative countertransference reactions, in that older clients may stimulate the therapist's fears of personal aging or the aging and death of parents. He further suggested that older clients may be perceived as rigid and unwilling or unable to change. The few years they may have remaining Can serve as a disincentive to the therapist who feels that his or her time is being "wasted."

Mental health counselors are subject to the same negative perceptions arid stereotypes of older persons that are common in our society. Myths such as "Old people are all sick, poor, angry, sad, lonely tend to discourage counselors from working with older clients. Gatz and Pearson (1988) reviewed studies of attitudes toward older

people and concluded that global negative attitudes may not be as prevalent as once thought but that specific biases still interfere with service to older clients. Misperceptions of organic brain syndromes, including prevalence as well as manifestations, tend to discourage mental health providers from active involvement with many older persons. The interaction of negative societal perceptions and the emotional functioning of older persons is explained in the social breakdown model discussed below.

THE SOCIAL BREAKDOWN SYNDROME

Kuypers and Bengtson (1973) proposed the "social breakdown syndrome" as an explanation of the psychological impact of aging and loss of functional ability among older persons. According to this model, as persons age, they become more vulnerable to societal perceptions and social definitions. The functionalist perspective, which implies that persons have value only when they are active workers, leaves persons at risk when they retire from active work or social involvements. Perceptions of older persons as less capable because of their reduced involvements or advancing age are communicated explicitly, through prejudicial statements such as "Act your age!" or "You can't do that at *your* age!" Such perceptions are also communicated implicitly through media, which advertise the pre-eminent values of a youth-oriented society. Older persons tend to internalize these negative perceptions, resulting in self-perceptions as less capable.

The social breakdown syndrome may be graphically depicted as a downward spiral that eventually results in death. As older persons internalize negative societal perceptions, they come to view themselves as having less self-efficacy, leading to decreased attempts to master and control their environment. As they appear to have less control, additional negative societal inputs verify their perceptions, and so the negative spiral continues. Persons may live most of their adult years with a highly internal locus of control, only to experience an increasingly external locus when faced with the events and losses of later life over which they have no control.

Mental health counselors can use the social breakdown model as the basis for "social reconstruction" with older persons. Typically, both environmental and social/psychological inputs are needed to allow older persons to live independently and to foster a sense of environmental and personal mastery. Continued encouragement is needed as part of a multifaceted treatment approach to slow, stop, or even reverse the effects of social breakdown. Both breakdown and reconstruction are processes that occur over time, typically late in life when resources are diminished and needs have escalated. Sensitivity to these processes can be valuable for mental health counselors as part of early intervention efforts, efforts that may be more successful when based on an understanding of similarities and differences in counseling with older and younger persons.

SIMILARITIES AND DIFFERENCES IN COUNSELING OLDER AND YOUNGER PERSONS

There are many more similarities in counseling with older persons and younger persons than there are differences. The entire repertoire of a mental health counselor's knowledge and skills will be required, including facilitative listening and responding, caring confrontation, questioning, and so forth. Older persons are similar to younger persons in their need for support and challenge, respect, expectation for growth, self-understanding and acceptance, decision making, and action (Waters, 1984).

In addition, mental health counselors working with older clients will need to have specialized knowledge of the general needs of older people, developmental issues in later life, and late-life transitions (Glass & Grant, 1983). Skills for facilitating coping with loss and bereavement are important. Mental health counselors must also be Prepared to listen in spite of lengthy and sometimes rambling conversation, attend to nonverbal communication, and be sensitive to environmental distractions (O'Brien, Johnson, &. Miller, 1979). The lack of a Vocabulary for feelings may inhibit in-depth exploration, resulting in the need to teach older clients to recognize and label their emotions and internal experiences.

The establishment of trust may take longer with older than younge$_r$ clients and may require a focus on tangible, social-service-type needs before mental health interventions can be effective (Waters, 1984, 1990). Mental health counselors may need to make a conscious effort to learn about older clients' experiences and values. One of the major differences in counseling with older persons, in fact, is that they have such a wealth of experiences

and coping skills from which to draw in responding to the circumstances of later life. Counselors will need to avoid making assumptions and instead listen carefully to learn about the coping resources possessed by a particular client.

It is important to recall that older persons tend not to seek mental health services or to accept them readily when they are available. Mental health counselors may even need to call what they do something else, such as personal growth enhancement or life review discussions, in order to encourage older clients to participate. Even so, many areas of the clients' lives may remain "too personal" to discuss. This should not be treated as resistance but, rather, as a reluctance to participate. Robison, Smaby, and Donovan (1989) suggest using influencing strategies to promote a reciprocal relationship with older clients, which will result in greater receptivity to mental health interventions. These include appropriate self-disclosure at a nonintimate level, advising clients on less threatening concerns than those in the area of mental health, using reflective listening to build trust while moving at the client's pace, minimizing direct confrontations, and adopting the client's communication style to facilitate understanding and interaction. Other strategies, such as using titles (e.g., Mr., Mrs.), will result in a greater rapport and the establishment of trust with older clients.

Another area of difference in mental health counseling with older persons is the greater possibility of countertransference that exists, In contrast to typical models of transference, in which the client is the subject of most concern, in working with older persons the mental health counselor may be most "at risk." Older clients can stimulate the counselor's recollections of parents, grandparents, and other older persons important in the life of the counselor. Lack of awareness of such responses can interfere with effective interventions in both positive and negative directions. When such reactions occur, consultation with a clinical or peer supervisor may be necessary. If the mental health counselor is unable to resolve his or her countertransference reaction, referral to another therapist is essential. Countertransference reactions are one of many areas in which further research with older clients is needed. Other areas are discussed in the following section.

RESEARCH AND TRAINING IN GERONTOLOGICAL COUNSELING

The specialty of gerontological counseling is relatively new, having emerged only since 1975. In that year, only 6% of counselor preparation programs offered even an elective course to train counselors to work with older persons. Today approximately one third of counselor education programs offer such course work or a specialty in gerontological counseling. A directory of these programs is provided in a recent publication available through the American Association for Counseling and Development (Myers, 1989a). The increase in course work has been stimulated by changing demographics and sheer increases in the numbers of older persons, and it has been made possible by a dramatic increase in our knowledge base in regard to gerontological mental health concerns. That knowledge base, though growing, remains limited in scope.

Wellman and McCormack (1982) completed an extensive review of outcome research in individual and group counseling with older persons. They noted that the common methodological problems of sampling errors and lack of controls have distorted the results in most studies. In particular, the use of readily available samples has biased gerontological research toward studies of institutionalized populations, which are largely *not* representative of the older population as a whole.

In their review, Wellman and McCormack (1982) classified outcome research in one of four areas. They noted that most studies have focused on the success of traditional, one-to-one counseling with older clients. Although results are generally favorable, there is little evidence of the differential effectiveness of selected techniques with either younger or older individuals. There is some indication, however, that cognitive and behavioral techniques are more effective with older persons experiencing depression. Group interventions have been proposed by many authors as having great potential utility with older clients. A thorough review of available studies indicates a need for evaluation of the differential effectiveness of group interventions. Environmental factors, including characteristics of group members, have been found to influence therapeutic outcomes. Paraprofessional and peer counseling is another area that has been widely recommended for use with older persons, and yet there is little available evidence for the effectiveness of these approaches. Most support is

anecdotal in nature. The last area studied by Wellman and McCormack, that of programmatic research, led them to question the efficacy of current programs designed to meet the needs of older persons. In the absence of controlled studies, the utility of different programmatic approaches remains questionable.

More recently, Smyer and Intrieri (1990) summarized available outcome studies and suggested that mental health counseling with older persons requires an understanding of aging, counseling, and evaluation. They encourage practitioners to include a focus on evaluation in all of their efforts, placing the responsibility for accountability in the hands of mental health counselors. It is up to each practitioner to use his or her skills and techniques with older clients with full consideration of whether the treatment programs work and, if so, under what circumstances and conditions and with what types of clients. The articles included in this special issue are intended to provide practicing mental health counselors with a suitable knowledge base for action with a broad spectrum of older clients. The challenge is to find what fits—for yourself as well as for each of the older clients you may serve.

OVERVIEW OF SPECIAL ISSUE

This special issue, "Techniques for Counseling Older Persons," is divided into four major areas. Articles in each area explain the theoretical basis of a particular technique and its use with older clients. Clinical examples are provided to assist the reader in understanding the application of the concepts presented.

The first section, "Using Memories in Counseling Older Persons," includes three articles. The first describes and provides examples of the use of the Adlerian technique of Early Recollections (Sweeney) in mental health counseling with older clients. The second article describes the use of life review (Waters) techniques, one of the major techniques that historically have been used in counseling with older people. Crose's article concludes this section with a description of the use of Gestalt techniques with life review.

The second section, "Techniques for Individual and Family Counseling," includes four articles that provide guidelines for mental health counselors in working with the broad array of concerns presented by older clients and their families. The first article discusses the use of bibliotherapy (Hynes & Wed!) in interactive mental health counseling. The second presents a model for crisis theory and management (Duffy & Iscoe) with older clients. The third describes the application of Lazarus's multimodal approach (Weikel) in dealing with older clients. The final article in this section reviews the adaptation and use of genograms (Erlanger) in mental health counseling with older clients and their families.

The third section, "Techniques for Special Concerns," includes three articles that address concerns of special populations of older persons. The first provides concrete suggestions for modifying mental health counseling to meet the needs of hearing-impaired older persons (Hittner & Bornstein). The second reviews current trends in sexuality and aging (Capuzzi & Friel) and offers guidelines for mental health counseling interventions. The final article discusses mental health counseling and older problem drinkers (Blake).

The final section of this issue, "Coping With Cognitive impairment," includes two articles to assist mental health counselors in dealing with older persons experiencing cognitive impairments and with their families. The first provides an overview of dementia (Hinkle) with suggestions for differential diagnosis of dementia and depression. The second reviews strategies for assessment and cognitive screening (Agresti) of older clients.

Taken together or separately, the articles in this issue are intended to provide a foundation for mental health counseling with older persons and their families. Further research on the application of these techniques with subgroups of older persons is needed. All the authors would appreciate feedback from practitioners about the helpfulness of the techniques and the successful applications of each in working with older clients. In addition, mental health counselors are encouraged to initiate evaluative research to determine the effectiveness of each technique in meeting the mental health needs of older persons and their families.

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