An Examination of the Perceived Educational Needs of Residents in Continuing Care Retirement Communities

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(ABSTRACT)

As the mean age of the population continues to rise, increasing attention is being given to how and where the elderly will live. Since health of this age group varies considerably, living arrangements which offer a full spectrum of services and attend to a continuum of needs have arisen over the past few decades. Called Continuing Care Retirement Communities (CCRCs), these places offer three levels of living: individual apartments, assisted living and the nursing center. Residents can move freely among these three levels as the need arises.

While the educational needs of the elderly have been discussed theoretically and explored in a variety of practical contexts, no research to the author's knowledge has investigated the context of CCRCs and the population within. This study filled that gap in the literature. Framed by the seminal research of McClusky which identified five categories of educational needs of the elderly (coping, expressive, contributing, influencing and transcending), the purpose of this study was to investigate the educational needs of the residents as perceived by residents and to determine if selected demographic variables differentiated among responses; a corollary aim was to learn more about the residents' learning formats used, and current satisfaction as well as future interest in educational activities.

Results of a questionnaire distributed to residents of two not-for-profit CCRCs in northern Virginia served as a data base, with a response rate of 68% for residents. The questionnaire, designed by the researcher, was validated through multiple iterations by content and process experts and piloted with a CCRC not in the study. Data were appropriately coded and analyzed using SPSS. Confidentiality of the respondents was maintained at all times.

The results indicated that residents were highly educated, financially secure, and in good health. Ages range from 67 to 100 years old. Both current participation as well as future interest in educational activities was high, but only a few demographic variables seemed to differentiate responses. Educational activities dealing with coping and transcending needs seemed to take priority, involvement in self-directed learning activities was high, and when involved in programmatically organized and structured activities, the format of small groups preferred. These findings could be significant for any practical intervention implication. Implication for future research include inquiry into this growing special population; for example, the why and how of their self-directed learning projects.

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DEDICATION

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CHAPTER ONE

INTRODUCTION

Life expectancy is increasing in the United States (AARP, 1993). According to Sterns and Sterns (1995), people are living longer in good health and are retiring earlier. During the 1900s there were 3.2 million people in the United States who were 65 years of age and older, constituting about 4% of the total population. In 1996 the number of people 65 years of age and older increased to 33.9 million (AARP, 1997). It is anticipated that by the year 2000, there will be 34.7 million older adults, and by 2030 the number of people in the United States over the age of 65 will increase to 69.4 million or 21% of the population (AARP, 1997). The Ababy boom≅ of the past decades will become the Asenior boom≅ of the next century.

Today's older adults, 65 and older, are experiencing more physical, social, psychological and economic changes than did their ancestors (Deedy, 1984; Peterson 1983). These changes affect the status of the older adults in society. Rather than viewing advanced age as the beginning of the end of life, many are using this time for personal enrichment through travel and education and also for making contributions to their families and to society by sharing with young people the benefits of their experiences. Examples of active elderly can be seen throughout the popular culture, in current books, magazines, newspapers, and on television.

At the same time, the relationship between work and retirement is changing (Cox, 1988; Sterns & Sterns, 1995). It was not until recently that Americans became concerned about retirement and retirement benefits. The United States, in its developing years, was in a large part an agrarian society, where most individuals lived, worked and retired on the farm among their families. As the country grew into an industrial nation, people moved off the farms and into the cities. One of the results of this movement was that people did not necessarily have a support structure at home to care for elderly family members, and the burden of this responsibility started to shift from the family to the employer. As an answer to this need, Apensions and mandatory retirement came into being≅ (Riker and Myers, 1990, p.6). Besides providing a kind of safety net for workers, the pension and retirement system benefitted the employer as well by keeping the

older, more experienced worker active and on the job. APensions were used as incentives for experienced workers to remain at their jobs. The longer they worked, the greater would be their retirement.≅ (Riker and Myers, 1990, p.6).

During the 1930s, when people were hired, they asked few questions about retirement. They knew they were eligible for retirement at the age of 65 and would be receiving Social Security benefits thanks to the Social Security legislation that was passed in 1935 (Riker and Myers, 1990; Bass, 1995). Now, in the 1990s when Americans are hired, a company's retirement options are often considered a crucial part of the compensation package. This change in attitude toward retirement benefits apparently is prompted by the decline in the average age of retirement (Pyron & Manion, 1970; Parnes, 1981) and a loss of confidence that the Social Security system can provide enough income for a comfortable retirement. According to Riker and Myers (1990), people are living longer and in better health; they enjoy a better standard of living; retirement is no longer mandatory at a set age; they continue to participate in a range of activities during their retirement; and they have a commonality of interest with other retirees. Moreover, according to Riley (1993), when people retire they are involved in a multitude of activities simultaneously.

People who retire earlier and in better health have more time for participation in a variety of leisure activities. One of these activities is education. Education plays an important role in helping both the general population and the older adult understand the changes that are occurring not only in the individual, but also in society and in the world.

But education for the older adult, according to Manheimer et al. (1995), Arequires a different rationale and set of justifications from that of education at other times of life≅ (p.xv). Older adults are obviously no longer interested in education related to work place. They are interested in education related to their specific needs, be they financial, social, spiritual. According to Riker and Myers (1990), people need to consider the importance of education when planning for retirement. They need to become educated, A...for leisure in which individuals learn positive points of view toward leisure and the necessary skills to participate in appropriate activities≅ (p.15).

In 1986, the American Association of Retired Persons reported in several national surveys on the educational activities of older adults. The surveys indicated that in 1981, the older

American population participated in educational endeavors in greater proportions than ever before. This shows that education is valued not only by children and by workers for its utility or as a means to an end, but also by those not traditionally considered targets of educational efforts -- those approaching the end of their lives.

Education for leisure should begin early if one is to enjoy the benefits of retirement to the fullest. This education is not necessarily formal, but often is informal, as discussion groups held in a variety of settings, such as in religious organization centers, museums, community centers, senior citizen centers, libraries, retirement communities, or even sparked by watching PBS on television. This education often revolves around a few major themes -- financial, health care options, travel, history, etc. Not only are older Americans starting to seek out educational opportunities that meet their needs, but today's average older adult has had more education before retirement than any of his predecessors. ABetween 1970 and 1995, the percentage who had completed high school rose from 28% to 64%≅ (AARP, 1997, p.12). In 1970, the United States census indicated that the median of formal education for those 65 years old was 8.6 years (U.S. Special Senate Committee on Aging, 1984), and in 1990 this grew to 12.2 years (U.S. Bureau of Census, 1990).

This nationwide increase is even sharper in Northern Virginia as the educational attainment in 1980 was 11.8 years (Public Use, 1980), and in 1986 the median educational achievement of those 65 years and older was 14.4 years (Report of the Aging Task Force, November 1986). Looking at this another way, the results of a 1984 Fairfax County survey of its senior citizens for the Board of Supervisors indicated that a substantial proportion had at least some post high school education (see Table 1).

Table 1

Level of Formal Education Completed by
Fairfax County Residents over 65

Age	1-3 years of college	college completed	post graduate
65-69	15%	13%	18%
70-74	21%	13%	17%
75-+	11%	5%	16%

Source: based on data reported in Assessing the well-being of the Fairfax elderly, 1984

This growth in number of years of formal education has shown that with each succeeding generation, more and more older people will have more formal schooling. And this trend is likely to continue.

It has also been shown that as educational attainment increases, participation in educational programs increases as well (Anderson & Darkenwald, 1979). One reason for this, according to Cross (1981) and others, is that the primary indicator for participation in education is prior participation. The more education people have, the more likely they will seek more educational opportunities. According to Darkenwald (1988), Atomorrow's elderly will have traveled to more places, will have read more books and magazines, will have met more people, will have lived longer, and will be part of a more powerful 'elderculture' than previous cohorts in the history of the world≅ (December 1987-January 1988, p.7). White (1988) has predicted that the Anext generation of older adults will be more mobile, healthier, more politically astute and better educated than those of today≅ (p.2). ASimilarly, our present-day leisure class of retirees might be looking around for models of excellence in dealing with adult children and their kids, managing estates (big or small), volunteering for good causes, exercising leadership (such as

serving in one of the numerous state senior legislatures), keeping fit, and wondering what makes for a good death≅ (Manheimer et al., 1995, p.xv).

At the same time, there has been an increase in participation in continuing education by older adults. Manheimer et al. (1995) found that the older adult participating in educational pursuits was found in non-credit, continuing education. These citizens are now broadening their participation by involvement in educational programs sponsored by the community, by institutions of higher education, by volunteer groups, and by organizations of older adult themselves. One of the most noticeable developments has been Elderhostel programs. Elderhostel provides inexpensive short term (usually one to two weeks) academic residential programs for older adults, Awho want to continue to expand their horizons and to develop new interests and enthusiasms≅ at educational institutions around the world (Elderhostel, 1990, p.2). From its inception in 1975 with 2000 attendees, to over 250,000 attendees in 1997, Elderhostel is addressing the educational needs of older adults by offering courses in areas particularly relevant to retired persons, such as Cultural and Social Mecca of the Old West; Chi Gong for Energy Building and Healing Flexibility; Spring Migrating Maine Birds; The Americanization of America; Bucks County Artist; Pearl Buck and Artist Colony; The Mysteries of Ancient Egypt, etc. (Elderhostel, 1998).

Likewise, the American Association of Retired Persons believes that to attract the older learners, courses must be relevant to their circumstances and their goals (1986). AARP provides guidance and instruction through its magazine and seminar programs in areas such as health, changes in the law, upcoming bills being passed through Congress, and travel.

But it is not only associations that are focusing renewed attention on the elderly. Builders and real-estate developers have tapped into the senior market and have been delivering housing specifically designed with the elderly in mind. Retirement communities which were little more than single-level tract housing during the 1960s and 1970s are now being designed to suit the residents' physical, social and psychological needs. These communities build residences with wider halls, bathrooms have extra safety features, lawn maintenance, entrances are wheelchair friendly, etc.

In addition, some retirement communities are starting to address the educational needs of older people. These communities are providing some educational programs under the auspices of the recreational director. Some developments have a central clubhouse where residents can enjoy structured activities, such as bridge, dancing, exercise, arts and crafts; some have restaurants, pools, golf courses, etc.

Continuing Care Retirement Communities

There is a wide variety in the types of retirement communities, which, according to Riker and Myers (1990), include residential communities, assisted-living communities, co-operative housing communities, continuing care retirement communities, and nursing homes. One of the new and exciting retirement communities that is gaining popularity is the Continuing Care Retirement Community (CCRC), also called Life Care Retirement Communities. These retirement communities offer a range of services to the residents, allowing older adults to lead an independent life for as long as they are able, after which they have the option of moving into the community nursing home facility.

Continuing care retirement communities are unique in that they provide housing, meals, health care, social and recreational activities to the residents, based on the individual's physical and social needs. These facilities are also addressing the needs of older persons to maintain their financial security and personal dignity. According to Hearnden (1983):

> Continuing care communities are an attempt to meet the diverse and changing needs of retired people as they age, without the necessity of their having to move away from familiar faces and surroundings if and when they are unable to maintain their independence. Such communities of course also provide opportunities for elderly people to mix with others of similar age, and to participate in social, educational and leisure activities provided by the sponsors or organized by the residents themselves (p.2).

During the 1960s, continuing care retirement communities came on the scene and have increasingly become a more appealing option for elder care. No longer were these facilities caring only for the poor who had no family to take care of them, they started to appeal to the upper middle class and the upper income elderly who wanted to enjoy retirement, free from the concerns of home-owning and secure in the knowledge that health-care support was readily available. Starting in the 1960s, there has been a surge in the number of such communities (Long-term, 1984). According to a report from the American Association of Homes for the Aged (1987), CCRCs have increased from 150 in 1964 to over 1,200 in 1998 (Continuing Care Accreditation, 1997). This dramatic increase in the number of CCRCs is attributed to the Asociological advantage of independent living without the burdens of ownership, and the economic or insurance advantage of relatively fixed fees regardless of the level of services received≅ (Continuing-Care, 1980, p.888).

Once the province of religious organizations or other charity institutions, retirement communities have now come to the attention of mainstream business. For-profit organizations such as insurance companies, hotels, hospitals, and nursing homes have now started developing Continuing Care Retirement Communities. As early as 1986 Marriott Corporation announced its intention to build four CCRCs in the United States. By 1998, in Northern Virginia alone, Marriott had built two of the four CCRCs it had planned in Virginia (American Association of Homes and Services for the Aging and the Continuing Care Accreditation Commission, 1997).

With the residents of CCRCs having more time to participate in a variety of activities, continuing education will play a vital role in assisting the residents to lead a fuller life. The increase in educational attainment of older adults seen in the general population appears to be even more dramatic for residents of CCRCs. One study reported that in two CCRCs, 76% of the residents were college graduates, with only 1% having less than a high school education (Tell, Cohen, Larson, Batten, 1987).

Given that the average amount of formal education in each decade is increasing, and that a strong correlation exists between participation in educational programs and level of formal education (Anderson & Darkenwald, 1979), one might expect an increase in the number of older adults participating in educational programs. This increase should be even greater for CCRC

residents. Given their higher educational levels, their continued educational needs should be greater than those of the general older adult population. It is essential to empirically document the specific educational needs of this subpopulation of older adults.

Educational Needs

There has been some research only in the last few decades on the educational needs of the older adult population in the United States (Londoner 1978, Marcus 1978, Courtenay et al. 1983, Peterson 1983, Long & Zoller-Hodges 1995, and Sterns and Sterns 1995).

Courtenay et al. (1983) looked at needs of uneducated adults living in Georgia. Ludman and Newman (1986) looked at needs of residents in Adult Day Care facilities. Brady (1983) and Long & Zoller-Hodges (1995) looked at the needs of participants of Elderhostel programs. White (1988) looked at the educational preferences of residents in selected retirement communities. However, the educational needs of residents in Continuing Care Retirement Facilities does not appear to have been addressed in the literature.

Howard McClusky, the noted writer and educator on gerontology, in the 1971 White House Conference on Aging, addressed the importance of education to the elderly when he emphasized the Apositive nature of education and the potential that every person, regardless of age, has≅ (Peterson, 1983, p.27). He further assured us that when Awe turn to education we find a more optimistic domain≅ (McClusky, 1973, p.60) thereby improving their overall well-being.

McClusky then proceeded to use this statement as a basis for his Atheory of margin≅, which has been defined as follows: Aolder people are constantly engaged in a struggle to maintain the margin of energy and the power they have enjoyed in earlier years≅ (McClusky, 1971, p.1). He believed that education would play an important part in achieving this outcome. Education will Aassist them (the older adult) in creating margins of power for the attainment and maintenance of well-being and continuing growth toward self-fulfillment≅ (McClusky, 1971, p.2).

McClusky (1974), drawing from Erickson's developmental psychology and Maslow's motivational theory, offered a categorization of educational needs for the older adult. McClusky

strongly asserted that addressing the educational needs of the older adults could enhance their life situation.

Among the educational needs (1971), McClusky originally identified four categories: (a) coping needs, the needs for skills or information that helps people survive and deal with the changes that are occurring in themselves and in society, (b) expressive needs, the needs older adults have to find a way, physically and psychologically, to participate in an activity for its own sake and not necessarily to achieve a goal, (c) contributive needs, in which the older adult has an altruistic need to help other people and desires information or services to help them meet that need, and (d) influencing needs, the needs of the older adult to find a mechanism so that he or she can have some influence on society. To aid the older adult in creating and maintaining well-being and continued growth toward self-fulfillment, McClusky subsequently expanded his categories of needs to include a fifth category, the transcendence need (McClusky, n.d.), in which the older adult tries to understand the meaning of life. The elderly often desire a kind of metaphysical education to help them answer the increasingly relevant questions about purpose of their existence as their lives draw to a close.

The educational needs based on McClusky's Atheory of margin≅: the coping need, the expressive need, the contributing need, the influencing need, and the transcendence need served as a basis for this research.

This paper takes a practical and realistic look at educational needs of older adults. This topic has relevance for me in my functioning and experience as a nurse. In planning the care for patients, I use Maslow's articulation of needs which provides a framework for determining prioritization of the care given. McClusky similarly categorizes the educational needs, going from the basic -- the need to be able to survive -- to the more complex -- the need to achieve a sense of growth, self-fulfillment, and self-transcendence. The needs are humanistic and workable; at the same time they are specific and applicable, with categories that are realistic and understandable to the older adult. The application of McClusky's educational needs can contribute substantially to the development and the contentment of the older person and can assist the person in coping with problems of aging. For these reasons, McClusky's educational

needs (coping, expressive, influencing, contributing and transcendence) served as the foundation for this research.

Problem Statement

The number of older adults in America is changing drastically. In 1996, people 65 years or older numbered 33.9 million or 12.8% of the U.S. population. Put another way, they represented about one in every eight Americans (AARP, 1997). These older adults are in better health and are better educated than ever before in American history.

With the establishment of the National Conferences on Aging, the White House Conferences of Aging and the Older American Act, both the citizenship and the legislature have become more conscious about the problems of senior citizens. One of these problems is the educational needs of the older adult.

Educational opportunities specifically designed for the older adult were slow in developing. Most of the opportunities were Aan extension of other community-based adult education programs≅ (Peterson, 1985, p.10). As programs developed for older adults, research done by McClusky (1971), Hiemstra (1973), Londoner (1978), and Green and Enderline (1980) identified the educational needs of this population.

Within this older adult population, there is an emerging group of people who live in a specific type of retirement community called Continuing Care Retirement Communities. The older adults in the CCRCs are healthier and have a higher educational attainment than the general older adult population at large (Tell, et al., 1987). However, there appears to be no research regarding the educational needs of this particular group of people. How important to CCRC residents are educational needs that embody McClusky's five categories?

Purpose of the Study

The primary purpose of this study was to estimate the importance of McClusky's five categories of educational needs as perceived by the residents of Continuing Care Retirement Communities. Also investigated was the relationship between selected demographic variables (gender, marital status, educational attainment and health) and perceived needs. Additionally, different learning formats the residents used were identified, as well as their perception of how well their educational needs were being met, and their interest in future activities.

Research Questions

This inquiry will be guided by the following questions:

1. How important are educational activities within each of McClusky's five categories of educational needs to the residents of Continuing Care Retirement Communities?
2. What are the relationships between selected demographic characteristics of the residents (gender, marital status, educational attainment, and health) and their perceived educational needs?
3. What learning formats are most frequently used by the residents?
4. To what extent are CCRC residents satisfied with the educational activities in which they participated?
5. To what extent are CCRC residents interested in participating in various educational activities in the future?

Definition of Terms

Continuing Care Retirement Communities. Retirement communities are institutions Aoffering a contract based on an entrance fee. In the contract, the CCRC agrees to provide facilities for independent living and various health services to an individual who is eligible to remain in the CCRC for the balance of his or her life≅ (American Association of Homes for Aging, 1987, p.6). The CCRCs have three types of ownership: private, corporate, and religiously owned.

Northern Virginia. This area is defined to include the counties of Fairfax, Arlington, and the cities of Alexandria and Fairfax City.

Educational attainment. The number of years of formal education a person has completed.

Older adult. A person 65 years of age or older who is able to live independently.

Live independently. The ability of the older adult to make decisions and to care for his/her activities of daily living.

Activities of daily living. Those activities a person Ausually performs in the course of a normal day, such as eating, dressing, bathing, brushing of teeth or grooming≅. (Potter and Perry, 1985, p.188).

Educational activity. Activities in which individuals seek to increase their knowledge.

Facility. The Continuing Care Retirement Community.

Needs. Implies Athe existence of a desirable condition requiring the operation of certain factors for its attainment≅ (McClusky, n.d., p.331).

Educational needs. Implies in older adult Aa, survival; more than mere adequacy is needed for health. A minimal level of income is needed...while substantially more is required for the maintenance of self-respect, and the freedom to choose those options which lead to personal growth≅ (McClusky, n.d., p.331). As defined by McClusky for the purposes of this study, the educational needs include the coping needs, the expressive needs, the contributive needs, the influencing needs, and the transcendence needs (McClusky, 1971).

> Coping Needs. Those needs which must be met by older adults to help them survive in society, to help them deal with societal changes. It simply means Athat a minimal ability to read, write and compute must be attained before a person can take part in the satisfaction of needs...the need to educate for a minimum of economic self-sufficiency≅ (McClusky, n.d., p.332).
>
> Expressive Needs. The needs that are Abased on the premise that people have a need to engage in activities for the sake of the activity

itself and not always to achieve some goal to which the activity has only an instrumental relationship≅ (McClusky, n.d., p.334).

Contributive Needs. The needs that older people have Ato give...to contribute something acceptable to others and the community, blending the need to be useful and to be wanted≅ (McClusky, n.d., p.334).

Influencing Needs. The desire of older people in later life to Aexert far greater influence on the circumstances of their living and the world about them than they are apparently and customarily able to do≅ (McClusky, n.d., p.335). Influencing needs implies that the older adult may become a change agent.

Transcendence Needs. The desire of the older person to Aarise above and beyond the limitations of declining physical powers and of diminishing life expectancy≅ (McClusky, n.d., p.337).

Previous involvement in continuing education. Attendance at any continuing education programs (educational programs, conferences, individual courses, seminars, workshops, or self-directed learning activities) during the past year.

Continuing education. AThe process, more structured than unstructured, which provides learning opportunities for adults≅ (Langerman & Smith, 1979, p.7). This can also include self-directed learning.

Significance

There have been many studies looking at older adults' educational needs in different context: in the general population, in adult day care centers, in institutions of higher education, and in retirement communities. None, however, focused on the Continuing Care Retirement Communities. This study may be used as a foundation for educational programs that will be developed for residents in Continuing Care Retirement Communities.

CCRCs are among the fastest growing group of retirement communities in the United States. These residents are unique as they have a higher educational attainment then the general older adult population. According to the literature, there appears to be no research looking at the education needs of this specific group of people. This study looks at the educational needs of the specific group of older adults who live in the CCRCs.

It is hoped that this study will add to the growing body of knowledge about older adults and their educational needs. Further, it is hoped that programs will be developed to satisfy the educational needs of the residents in the CCRCs.

Delimitation

The results of this study and any implications which can be drawn from it are restricted to the following:

The study was limited to the residents of two not-for-profit Continuing Care Retirement Communities in Northern Virginia.

Summary

Chapter 1 formulated the problem of why the educational needs of residents in Continuing Care Retirement Communities should be studied. Chapter 2 provides the literature review. Chapter 3 covers the methods used. Chapter 4 reports the results of the data analysis and findings related to the research questions. Chapter 5 provides a summary of the research, conclusions, and recommendations.

CHAPTER TWO

REVIEW OF LITERATURE

This chapter provides a framework for the study of perceived educational needs of residents in Continuing Care Retirement Communities. This framework was developed by addressing the following six areas: population trends, concept of needs, typologies of educational needs of older adults, focus on McClusky, derivation and application of his theory, and studies within specific institutional contexts.

Population Trends

Americans are slowly realizing that the country is in the midst of a demographic revolution that will sooner or later affect each one of us and our institutions. Each one of us is aging; that is inevitable. The phenomenon of an aging society, however, is different. This phenomenon has been caused by two separate and simultaneous developments. First, the rapid acceleration in the population of older people, who are living longer and healthier lives, and the decline in the birth rate. Second, changes in Social Security program requirements, which allow people to receive benefits at an earlier age. These two developments have contributed to the growing numbers of elderly in the population.

Since 1900, life expectancy has increased by twenty-eight years from forty-seven years to seventy-five years. At the beginning of the twentieth century, there were approximately three million Americans who were considered elderly. Thirty years later, the older population had nearly doubled. In the 1920s there were approximately 4.9 million people over the age of 65, in the 1940s there were 9.0 million people, in the 1960s there were 16.7 million people and in the 1980s there were 25.7 million people, and in 1996 there were 33.9 million people in the United States who were 65 years of age and older (AARP, 1997).

It is not only the growth in the population of elderly that is fueling this change in society, but also the rate of that growth. Put another way, Asince 1900, the percentage of Americans 65

and older has more than tripled (4.1% in 1900 to 12.8% in 1996), and the number has increased nearly eleven times (from 3.1 million to 33.9 million)≅ (AARP, 1997, p.1). Even fifteen years ago, a report by the United States Senate Special Committee on Aging (1983) noted that Athe older population has been increasing at a far more rapid rate than the rest of the population for most of the century. For instance, in the decades of the 60's and 70's the sixty-five plus population grew twice as fast as the rest of the population≅ (p.4). A more recent statistic shows that by the year 2000, the number of people over 65 years of age is expected to represent 13% of the population. That figure may climb to 69.4 million people or 20% of the population by 2030 (AARP, 1997). The Census Bureau's prediction for that same year shows a population structure for the United States as an almost perfect triangle up to the age of 70. As we extend the application of present medical knowledge regarding prevention, diagnosis and treatment of major illness to more of the general population, life expectancies will increase. A 1990 study by Siegel and Taeuber (1990) predicted that by the year 2050, life expectancy will be 100 years as compared to today's 75 years.

This increase has affected the metropolitan Washington, D.C. area. Although recent statistics are not available, the growth trend in the area is still apparent. According to the 1985 Metropolitan Washington Council of Governments report, the number of people 65 or older in the Washington area alone was expected to increase 54 percent from the census of 1985 to the census of 1990. In Fairfax County, Virginia, the Area Agency on Aging reported in 1984 that the number of anticipated elderly should be between 64,000 and 76,000 in 1985 and by 1990 should be between 85,000 to 100,000 as compared to fewer than 50,000 in 1980 (Assessing the Well-being, 1984, p.112). However, these anticipated figures in Fairfax county did not hold true. According to a report presented to the Board of Supervisors by the Fairfax Area Commission on Aging in 1994 there were 26,989 citizens over the age of 65 in 1980, 53,544 in 1990, and it is anticipated that there would be 74,479 adults over the age of 65 in 2000 (Profile, 1994).

Another way to look at this phenomenon is to track the number of years a person spends in retirement. In 1900 only 3% of a person's life remained after his retirement. By 1975 Neugarten estimated that the number of years a person would live after retirement would increase

from 13 years in 1975 to 25-28 years by the year 2000. Similarly, in the 1980s, the retirees were expected to spend one-fifth of their lives in retirement (Aging America, 1986).

Because people are living longer and healthier lives, it is no surprise that Americans are beginning to plan for their retirements. One part of the planning may include a broad range of retirement options such as travel, beginning new recreational activities, initiating a career change, changing living arrangements, or continuing education.

As the older adult aged, they lived through a variety of similar experiences. During the 1930s and 1940s, these citizens lived through a depression, World War II, and an atomic bomb. During the 1950's, they lived through the Korean police action, the cold war, and the threat of World War III starting.

During the 1960s and 1970s, the social scene in the United States was in uproar. There were intense and widespread protests, violence, attacks on established institutions and social disorganization with the Civil Rights movement. Citizens, instead of supporting the country in a war started protesting, with burning the American flag, over our involvement in Vietnam. In the early 1960s they heard President Kennedy tell Americans, AAsk not what your country can do for you, ask what you can do for your country≅ (1961). It was a time in which Americans were beginning to look at social reforms. During this same period they saw a man walk on the moon. It was a time in which they saw a President assassinated. Following President Johnson taking office, the AGreat Society≅ programs made changes in education, and our citizens became concerned with the problems of aging, and with human rights.

In the 1970s Americans saw a gasoline shortage, the Watergate hearings culminating with the resignation of the President, the Three Mile Island nuclear generator accident and anti-nuclear demonstrations. During the same decade our embassy in Teheran was attacked and hostages taken and then released.

In the 1980s, the Acold war≅ ended, the Berlin wall came down, an American President visited China, international terrorism increased, and the Challenger exploded.

In the 1990s, terrorism increased, and the world saw an up-to-the-minute account of hostilities during Desert Storm. At the same time, we saw the decrease in unemployment, consolidations of businesses, and the starting of new businesses.

Simultaneously, Americans again became concerned with the problems of the older adults. As the older population increased and as science lengthened their lives, citizens became concerned with the welfare of this group. Congress responded by building on the Social Security Act of 1935 and passing the Older American Act, Title XX, reformed Older Americans Act and the Higher Education Act of 1965 and 1972.

For all their similarities, the elderly should not be treated as a homogeneous group. Although today's older Americans have all lived through the same national events, their differing backgrounds and attitudes affect their interpretation of those events. People's cultures, families and finances enrich and complicate their experiences, so that even people who stood side by side watching President Kennedy's funeral will experience the event differently. Similarly, financial, health, and social circumstances among the elderly vary widely.

This older age group is a heterogeneous group that has a wide range of ages and characteristics. In fact, the shift in numbers, age distribution, sex composition, health status, mental status, and economic characteristics is considerable. Among these groups, according to Jacobs and Ventura-Merkel, are Aindividuals with different needs, attitudes, values, cultural and educational backgrounds≅ (1984, p.1).

Needs

This older age group, though a heterogeneous group, has a wide range of needs. There are many interpretations of the word needs. Maslow (1954) discussed a hierarchy of needs, going from the need to satisfy the basic physiological drives to the psychological needs of self-actualization and self-transcendence. He categorized the different levels as basic, the need for physiological and survival goals; safety, the need for security, protection and orderliness; belongingness, the need to feel accepted and appreciated; ego-status, the need to gain status, ambition and the desire to excel; and self-actualization, the need for personal growth, and a desire for self-fulfillment. Prior to his death, he was augmenting his hierarchy to include self-transcendence. McClusky's typology of educational needs of the older adult employed Maslow's hierarchy of needs as a conceptual framework, as discussed later in the chapter.

Archambault (1957) suggested that the term needs can be used in describing a demonstrable deficiency of individuals in relation to their environment. Even the economist John Kenneth Galbraith (1958) stated that a need pointed to a lack of something or somebody that requires relief or fulfillment.

When working with older adults, Komisar (1961) suggested that according to continuing education practitioners, a need is something essential for the learner.

A few years later, Atwood and Ellis (1971) discussed a need in relation to a deficiency which detracts from the well-being of a person. They further described five needs an individual may have as including the basic needs, which are the basic biological and psychological requirements a human being has; the real needs, which are the deficiencies people, groups or institutions have in relation to the environment; the felt needs, the desires that are considered necessary for a person; the educational needs, the conclusion that through education, a person can gain a more desirable condition; and the symptomatic needs, which are the needs that a person feels are genuine.

Taking a different approach, Bradshaw (1974) looked at needs from a societal perspective rather than an individual perspective. He looked at needs in relation to what was going on in society. He categorized needs into four areas: felt needs or wants; expressed needs, needs which become demands to which society responds; normative needs, differences between reality and standards that have been established by professionals; and comparative needs, comparing those people who receive the service with those with similar characteristics who do not receive the service.

Monette's (1977) analysis yielded four categories of needs. They included basic human needs, the drives in which human beings seek gratification; felt and expressed needs, which can best be described as interests; normative needs, the gap between what is desirable and what actually exists; and comparative needs, comparing the services which two different groups receive.

Scrivan and Roth (1978), on the other hand, suggested that a need is a gap which is between an actual and a satisfactory situation. Pennington (1981) also discussed need as a gap. However, he stated that a need was a Agap between a current set of circumstances and some

chanted or desired set of circumstances≅ (p.2). In 1985, Wlodkowski defined a need as Aa condition experienced by the individual as an internal force that leads the person to move in the direction of a goal≅ (p.47).

McClusky (1974) took a realistic and practical approach in defining need. He defined need as Athe existence of a desirable condition requiring the operation of certain factors for its attainment≅ (p.331).

There appears to be no clear definition of the term need. There are as many definitions as there are people who would like to define a need. When trying to define educational needs of the aging, the same holds true. We are also dealing with a range of definitions for educational needs.

As there appears such variety of meaning to the term need, why then do we use it? Defining needs provides a place to start. It is a process of clarifying the goals, establishing the priorities of people. Needs assist in laying the groundwork for educational needs. Educational needs help in planning programs for this population.

Educational Needs

Donahue (1955), one of the first people to identify the educational needs of the older adult, provided both a theoretical and practical description of educational programs in his book Education for Later Maturity. In this book he reviewed 14 agencies (public schools, colleges, university extension, agricultural extension, correspondences, libraries, state agencies, federal agencies, employment agencies, institution, business and industry, government and unions) that provided education for older adults.

However, when looking at educational needs of older adults, we must also look at motivation. Motivation will give clues to the needs of older adults. Houle (1961) discussed that educational needs of older adults are based on motivation. He classified needs as goal-oriented, activity-oriented and learning-oriented. A need is goal-oriented when a person has clear objectives for his accomplishments. A need is activity-oriented when the activity itself fulfills the need, such as meeting people, and a need is learning-oriented when the person wants to achieve personal growth and enlightenment, and learn for the sake of learning.

Havighurst (1964) looked at educational needs through educational opportunities. He described two types of educational opportunities that can influence a need: instrumental and expressive. Instrumental opportunities are those in which the goal goes beyond the act of learning itself; it is an acquired skill, Aa kind of investment of time and energy in the expectation for future gain≅ (p.207-208). Whereas expressive opportunities are those in which a person learns for the sake of learning, because learning is an enjoyable act and a source of gratification. AExpressive education is a kind of consumption of time and energy for gain≅ (p.207-208).

Older adults may combine these two types of educational opportunities, which can be related to McClusky's educational needs. Havighurst's instrumental education can to be compared to McClusky's coping, contributing and influencing needs. Likewise, Havighurst's expressive education can be related to McClusky's expressive and transcending needs.

Hiemstra (1972, 1973) examined the educational preferences of older adults in relation to expressive and instrumental needs. Hiemstra (1975) discovered that in the older adults he sampled, most preferred instrumental over expressive needs.

Later, Birren and Woodruff (1973) discussed the need for lifelong education that enables a person to adjust in society. They found three reasons for older adults to have educational needs or interests: alleviation of deprivation, enrichment, and prevention. Alleviation of deprivation referred to older adults who were deprived of an education early in their lives and who were interested in an opportunity for education later in their lives. The second category, enrichment, refers to a senior citizen's desire for lifelong learning opportunities. The enrichment category is similar to Maslow's and Moody's self-actualization category and Havighurst's expressive needs category. The third category, prevention, refers to the way in which the older adult might prepare for later life through education.

Morstain and Smart (1974) list six motivational categories that give some insights into educational needs. They include social relationships, a desire of older people to interact with others or to make friends; external expectations, the pressure from others to participate in educational activities; social welfare, a desire to better the community or to serve others through education; professional advancement, a wish to improve occupational performance; escape or

stimulation, a desire to get away from boring routines and find intellectual stimulation; and finally, cognitive interest, learning for the sake of learning.

Ventura and Worthy (1982) indicated older adults participated in educational programs because they had a need to learn. They found that 34% of the participants took courses which provided a sense of meaning, a sense of control, or the ability to cope.

Moody (1976) approached educational needs from the perspective of the motivation of older adults. He offered four categories: (a) rejection, how society avoids and represses the needs of older adults; (b) social service, in which the population Arequires social services and that government bureaucracies and specialized professions can best provide these services≅ (p.5); (c) participation, which is described as participation by older adults in programs that are politically motivated (in this category, the older adults are kept politically motivated so that they can affect legislative changes); and (d) self-actualization, in which the older adults gain an insight and self-understanding.

Londoner (1978) supported Havighurst's distinction of educational needs as either Ainstrumental≅ or Aexpressive≅. However, in 1990, Londoner reexamined the instrumental and expressive needs. He felt that though ≅the actual learning activity is neither instrumental or expressive; the intent of the client makes the activity either instrumental or expressive≅ (p.104).

Taking a different approach, Green and Enderline (1980) found that educational needs varied according to the socioeconomic class. They found the middle class seeking more Aexpressive activities≅, while the lower socioeconomic groups sought coping activities.

Peterson in 1983 in his book made the distinction between educational needs (what the experts believe older adults should have) and educational wants (the preferences of the older adult). Peterson stated that when educational programs are developed, educational wants of older adults must be ascertained before consideration is given to their needs.

Lowy & O'Connor (1986) examined the Elderhostel approach. They found that Elderhostel used a liberal arts curriculum preselected by the institution's administration and that most of the courses were identified as expressive needs.

However, it was Havighurst (1964) who looked at educational needs through educational opportunities that was closely identified with McClusky's five categories of educational needs.

Havighurst's (1976) instrumental opportunities can be related to McClusky's (1974) coping, contributing, and influencing needs. Whereas, Havighurst's (1964) expressive opportunities best met McClusky's (1974) expressive and transcendence needs (Lowy & O'Connor, 1986, p.145-147).

McClusky

Among the variety of theories of adult education and education of the older adult, there appears to be only one theory, which I feel is the most comprehensive, directly addressing the learning needs of the older adult. Howard McClusky, known in the field of education for the older adults, is best known for his presentation at the White House Conference on Aging in 1971. At that conference McClusky presented his Atheory of margin≅:

> Older people are constantly engaged in a struggle to maintain the margin of energy and power they have enjoyed in earlier years... 'Margin' is a function of the relationship of 'load' to 'power'. By 'load' we mean the self and social demands made on a person in order for him to maintain a minimal level of autonomy. By 'power' the resources, abilities, possessions, positions, allies, etc. which a person can command to cope with load... We can control margin by modifying either load or power... It is this margin that confers autonomy on the individual, gives him an opportunity to exercise a range of options, and enables him to reinvest his psychological capital in growth and development (p.329-330).

McClusky's Atheory of margin≅ attempted to show the struggle older adults faced in order to maintain a minimum level of autonomy. McClusky theorized that older adults Afaced a disruption in their sense of autonomy because their load≅ (responsibilities, expenses, illnesses) increases and their power (energy, income, etc.) decreases. He felt that educational experiences would help older adults decrease their load and increase their power.

For older adults to achieve this level of autonomy, McClusky identified five educational needs. Ranking in order, they include the need to cope, the need to express oneself, the need to contribute, the need to influence and the need to transcend.

Coping need is placed first in the order of importance as Maslow (1986) placed survival and security in the hierarchy of human needs. The coping need includes basic skills as reading and writing, how to manage legal, financial and family affairs, and how to be self-sufficient.

The expressive need, placed second in importance, includes any activity carried out for its own sake -- learning for the pure joy of learning. The expressive need includes participation in programs such as art and music, studying the humanities, and learning languages.

The third need, the contributive need, is the need which encourages older adults to contribution to society. As older adults age, they lose their friends and family, their hearing and eyesight, their mobility and sense of usefulness. To overcome this they need to feel valuable. One of the ways to feel valuable is to contribute something of themselves. This can be accomplished by volunteering in different programs as an ombudsman, becoming adoptive grandparents, working with school age children in the schools.

The fourth category is the influencing need. Often older people are not heard or they are ignored. Older adults need to be heard, they want to make a difference, and to do so they need to develop political skills. Benoit (1982) showed how nursing home residents successfully lobbied for legislative reforms with regard to their privacy and security, as well as how the Gray Panthers lobbied for various reforms.

The final and last category of educational needs is the transcendence need, the need or desire for continuous fulfillment and personal and transpersonal growth. It is a time to focus attention on members of the family, friends, and associates whom they may leave behind. It is a time to look at the legacy they are leaving behind.

Fisher (1986) using McClusky's educational needs of older residents in Milwaukee County, found that most of the participants responded most favorably to courses which favored expressive needs followed by coping, influencing and contributing, and there were no courses that could fit the transcendence need. White (1988) looked at McClusky's educational needs for residents in retirement communities and categorized these as either an expressive or instrumental

activity as distinguished by Havighurst, who found that the residents preferred a combination of instrumental and expressive activities. At this point in time, there appears to be no research looking at the educational needs of the residents in the CCRCs, and this study attempts to fulfill this gap.

CHAPTER THREE

METHOD

The primary purpose of the study was to investigate the perceived importance of the five categories of educational needs, identified by McClusky, for residents in Continuing Care Retirement Communities (CCRCs). Also investigated was the relationship between selected demographics and the perceived importance of the needs. Additionally, this study was designed to identify the learning formats used by the residents, the extent to which current educational needs are being met, and future interest in educational activities. This inquiry was executed by surveying all the residents of two selected Continuing Care Retirement Communities in Northern Virginia by distributing a questionnaire first at an ice cream party and then distributing the questionnaires in mailboxes of the people who did not attend the ice cream party. The questionnaire is found in Appendix A.

The focus of this chapter is on the method: the subjects and how they were selected, the procedure, the instrument, and an explanation of how the data were analyzed. Babbie (1973), Carmines and Zeller (1979), Fowler (1984), Isaac and Michael (1981), Kerlinger (1973), and Rubinson and Neutens (1987)were the sources of information for this chapter. The selection of a survey research design allowed the researcher to identify specific educational needs of residents in CCRCs with possible application to CCRCs in large metropolitan areas in the United States. This was achieved by surveying the residents of the two Continuing Care Retirement Communities in Northern Virginia by means of the questionnaire found in Appendix A.

Population and Sample

There are eight CCRCs in Northern Virginia: five non-profit, two are owned independently, three of which are owned by religious communities, and three are for-profit facilities owned by a large corporation for a specific population of retired military officers and their spouses. While the CCRCs differ physically, all are representative of a specific type of

planned retirement community consisting of three levels: independent living, assisted living, and health care center.

One of the major research tasks was to identify which Continuing Care Retirement Community to study. To accomplish this task, various agencies were contacted by phone to identify the CCRCs. Agencies contacted included the Agency on Aging at the state and local level, the American Association of Retired Persons, the American Association for Homes for the Aged, Continuing Care Accreditation Commission, and the telephone directory. A total of eight Continuing Care Retirement Communities were identified with one additional facility under construction in Northern Virginia. After the identification of the eight facilities, contact was made with the administrators, either by phone or in person, to ascertain their willingness to participate in the survey. Of the eight identified, only three CCRCs were willing to participate. The other five CCRCs declined to participate because of previous involvement in surveys or not being interested. The three CCRCs consisted of two not-for-profit, and one religious not-for-profit. The target population consisted of 673 residents. The breakdown within each of the three facilities is 160, and 213 residents respectfully in not-for-profit, and 300 residents of a religious not-for-profit CCRC.

The first facility Community A was established more than 25 years ago in 1972. This facility is accredited by the Continuing Care Accreditation Commission. According to the facility brochure, the CCRC recognizes the changing physical, social, spiritual and financial needs of its residents. Affiliated with a foundation, Community A provides a safe, caring environment. Also in the brochure Dr. Arthur Fleming, who was chairman of the 1971 White House Conference on Aging and later the Commissioner on Aging in 1973, is quoted as saying, AThere is a feeling about (the facility) that is apparent to residents and visitors alike -- a kind of happiness and bright physical surroundings and this pointed up by attractive, wide corridors and inviting 'sit-down' areas all over the building≅ (1998 brochure for facility unnamed to preserve anonymity). The brochure also notes that the facility Ahelps make the seniors' lives easier and more enjoyable by providing services to them≅ (Home is where the Heart is, p.1) as if it were their home.

The facility provides services that enhance the residents while enabling them to remain active and independent for as long as they are able, after which they can move to assisted living and if needed to the health care part of the facility.

ACommunity A≅ is made up of apartments which are bright and roomy. Entrance fees depend upon the contract the individual or couple signs and can range from $78,500 to $349,900. Factors that enter into the initial cost are preference for (a) studio apartment or a two bedroom deluxe apartment; and (b) modified contract or an extensive contract. The monthly fees range from around $1500 to $3400, depending upon the size of the apartment, the contract signed, and their living arrangements as a couple or single. These monthly fees include heating, air conditioning, electricity and water, and two meals provided on a daily basis served in the dining room of the facility.

The second facility, ACommunity B≅, was established in 1980. This facility is also accredited by the Continuing Care Accreditation Commission. It is a private, not-for-profit community committed for the long term to provide high-quality services in a supportive environment. This facility is in the heart of Fairfax County, and features a variety of services and facilities designed to meet the needs of the senior community. Within this caring framework, the residents in independent living, assisted living, and the health care center enjoy choice, independence and dignity. This facility offers a continuum of care. One of its greatest assets is the variety of occupations, professions, cultures, religions, nationalities and interests of its residents. Many of the residents participate in activities such as gardening, choir, Tai Chi, bridge, going to the theater, shops, museums and local points of interest.

ACommunity B≅ also has a variety of apartments ranging from a one bedroom/one bath unit to a two bedroom/two bath unit. ACommunity B's≅ entrance fee again is dependent on the type of plan the individual chooses. In ACommunity B≅, there are two plans: one that is refundable and the other that is non-refundable. The entrance fees for the refundable plan range from $249,500 to $588,800 depending on the apartment size and the applicant's living arrangement as an individual or a couple. The non-refundable plan ranges from $116,500 to $274,000. Both plans have a monthly fee which includes electricity, heat, air conditioning, and water. Also, two meals are provided on a daily basis in their dining room. The monthly fee is

dependent on the contract the individual signs. In both the refundable and non-refundable plan the cost ranges from $1750 to $2800 a month, again dependent on the size of the apartment and the status of the resident as a single client or a couple.

The third facility, ACommunity C≅, was established in 1955 as a non-profit charitable Virginia corporation It derives its mission from the Episcopal Diocese of Virginia. Its officers, staff and trustees are committed to providing retirement housing in Northern Virginia. This facility is also accredited by the Continuing Care Accreditation Commission.

ACommunity C≅ is located very close to a large shopping center which contains restaurants, theater, clothing stores and churches. This facility is unique in that it also has guest rooms for visitors of the residents if they wish to stay a while. The facility has an art and craft center, woodworking shop, library, auditorium, exercise rooms, nature and fitness trails and a computer lab.

Information provided by the facility indicates that entrance fees range from $38,000 to $429,500 depending upon the size of the apartment or the type plan selected by the client. The apartments range from a studio apartment to a five-room suite. Three plans are available ranging from the standard plan, with entrance fees from $76,000 to $277,000 and monthly fees between $1533 to $3012; the modified plan, with an entrance fee between $38,000 to $138,000 and monthly fees between $2156 to $5262; and finally the 50% refundable plan with entrance fees ranging between $118,000 and $429,500 with monthly fees the same as the standard plan of $1533 to $3012. These monthly fees include two meals per day in the facility dining room, and water, heat, air conditioning and electricity. Unfortunately, due to logistical difficulties, data from this facility were not received in time for inclusion in the study.

The survey respondents were self-selected in that the respondents chose whether or not to participate in the survey. To avoid the appearance of favoritism, the questionnaire was distributed to all the residents of the three selected CCRCs.

Instrument

The instrument was a questionnaire designed by the researcher and reviewed for validity by three experts in the field of gerontology. It was pilot tested with residents in a CCRC not involved in this research. This facility had ongoing educational programs in conjunction with a community college.

The questionnaire was divided into two parts. The first part documented the educational needs of the residents, learning formats used and current satisfaction, as well as future interests in educational activities, as perceived by the residents themselves.

The second part, the demographic section, was designed to gather information on the characteristics of the residents (age, gender, marital status, education, length of stay at the facility, previous involvement in educational offerings, and perceived health and mobility).

The first draft was developed based on the literature review of educational needs of older adults. In addition, specific questions were written based on McClusky's educational needs of coping, expressing, influencing, contributing, and transcending. The questionnaire was reviewed both by academic advisors and by colleagues who work with senior citizens.

Revisions resulted in a second draft reviewed by nurses working in the field of gerontology who were doing advanced studies in the field. Verbal and written comments were used to refine the questionnaire and to refocus different items.

A further revision of the questionnaire was presented to two educators in the field of gerontology. Additional modifications were made on the questionnaire based on the assessment that it was hard for residents to read in spots and was concluded to be too long.

A subsequent revision was made and at this time an expert in the field of educational gerontology from Texas reviewed and commented on the questionnaire. Her comments were that it was still too long and to stop trying to put everything in it.

After another revision, the questionnaire was piloted with residents at a CCRC which was not participating in the research. Their comments included the following: use yellow paper, make the print larger, shorten the questionnaire to two or three pages, and put the stem in front of each of the questions on the first page.

With the above comments and modifications, a questionnaire was finalized and approved by the chair and the researcher on the committee (see Appendix A).

The questionnaire was easily identified by the yellow color. Yellow paper was used at the recommendation of the residents in the pilot study.

Procedure

Initially, a dialogue was held either over the phone or in person with each of the three administrators of the Continuing Care Retirement Communities. Following this, a meeting was held with the administrator or his representative to discuss the purpose of the research and method of distribution for the questionnaire. During these meetings, an ice cream party was offered to be held to encourage participation by the residents in the survey. Two of the CCRCs agreed for the researcher to give the ice cream party and the third decided it was not necessary. This latter facility (Community C) was the one in which the data were not received in a timely manner for inclusion in the study.

A follow-up letter was sent to each administrator, verifying permission to conduct the survey in each facility (see Appendix B). After receiving permission from each administrator, the survey was announced in each facility's newsletter and in their daily announcements.

At the first two facilities, the ice cream party was given. When the residents first arrived, they were asked to sign an attendance register to ensure that the questionnaire would not be given to the same person twice. The attendance list was given to the activity directors who then returned a list of the apartment numbers of those people who did not attend the party. That night and the following night an envelope with a pencil and questionnaire was provided to those residents who did not attend the ice cream party.

Stapled in front of the questionnaire was a letter explaining who I was, what I was trying to do, that the questionnaire would be coded to maintain their confidentially, and where and when to return the questionnaire. The letter also informed the residents that if they had difficulty reading or understanding the questionnaire, I or someone else would be available to help them read the questionnaire.

Signs were placed at the entrance of the facility the day of the ice cream party. An attractively decorated box for the returned questionnaires was also placed in a visible and accessible spot near the reception desk at the entrance of the facility.

Each questionnaire was coded and placed in a closed envelope with a pencil. The pencil was included to facilitate the respondent's completion of the questionnaire. The envelope was coded to identify the apartment in which the respondent lived. Two days after the prescribed date, the questionnaire was collected. It was decided that because of their age, I would allow two extra days for the return of the questionnaire.

After collecting the questionnaires, another questionnaire was sent to the non-respondents based on their coded apartment numbers. The same distribution procedure was again instituted with the exception that the residents were asked to return the unfilled questionnaire to the collection box in the lobby if they did not want to respond.

Data Analysis

All the data generated from the questionnaire were designed to be coded, keyed into a computer and stored for analysis. Each questionnaire was reviewed for completeness. If a respondent failed to answer an item, that item was treated as missing data.

Data gathered from the questionnaire were analyzed using the SPSS/PC. Each demographic item and educational need item was assigned a numerical code. All the data collected were coded and placed in a data file. The data were sorted and placed into appropriate categories. The analysis encompassed frequency distributions and percentages. Chi square was used, however as there were too many empty cells in specific demographics (gender,educational attainment, marital status, and health) several categories were collapsed. The responses that were related to each item were summarized to determine the significant findings related to each question. A summary was designed and developed to address each research question.

Open-ended comments to the questionnaire gave the residents the opportunity to discuss areas not addressed in the questionnaire or to elaborate on their responses. No one, however, contributed to this section.

A Likert scale was used Ato increase the variation in the possible scores≅ (Bailey, 1982, p.365). The scoring ranged from very important (4) to not important (1) when asking about the educational needs based on McClusky's categories. When asking about participation in different programs, extent of satisfaction and interest in participation in the future, the Likert scale ranged from not at all (0) to frequently (3) with a N/A for not applicable. This approach facilitated both response and analysis.

Ethical Considerations

Because the respondents were disclosing personal information, all disclosures were kept confidential. The recommendation of Helmstadter (1970) was followed, i.e., the person conducting the research treated all respondents as the person conducting the research would wish to be treated if the roles were reversed. The purpose of the study had been clearly outlined in the cover letter to both the administrator and to the participants. The letter also offered to share the results of the questionnaire with both the administrators and the respondents if they so requested. This included information on either their own individual CCRC or that of the total community. Information on the other CCRC, however, was not shared. In addition, all the data gathered will be accessible only to the myself and dissertation advisors.

To protect the confidentiality of the respondents, the instrument was coded only for the purpose of follow-up. The respondents' names were not on the questionnaire. Completion of the questionnaire was on a voluntary basis.

Summary

This chapter described the method used in this study which included the selection of the subjects and agencies used, the data collection procedure, the development of the instrument, and the method of data analysis.

CHAPTER FOUR

RESEARCH FINDINGS AND DISCUSSION

The findings of this study are presented in two sections. Section one provides a profile of the 254 respondents to the survey questionnaires. The second section presents responses to the research questions addressed by the study.

Profile of Residents

Residents' Response Rate

Three hundred seventy-three questionnaires were given to the residents of two selected Continuing Care Retirement Communities (CCRCs) with 254 questionnaires returned. The overall residents' response rate of 68% consisted of 74% from ACommunity A≅ and 63% from ACommunity B≅ (see Table 2).

Table 2

Response Rate of Residents to Questionnaire at Each Site

	Distributed		Completed		% Completed
Community A	160		119		74%
Community B	213		135		63%
TOTAL	373		254		68%

Demographic Profile

Demographic data were collected in four areas: age, educational attainment, marital status, and how the residents perceived their health. The reader is referred to Table 3 for the discussion which follows.

Out of the total 254, there were 89 males (35%) and 165 females (64.9%). In ACommunity A≅ there were 40 male residents (33.6%) and 79 female residents (66.4%); in ACommunity B≅ there were 49 male residents (36.3%) and 86 female residents (63.7%). In both the total group of respondents as well as in each community, women outnumbered the men.

In looking at educational attainment, there was a wide range of educational levels in relation to the total respondents, 68% having a bachelor's degree and above and 32% having an associate's degree or below. With regard to ACommunity A≅, 70% of the residents had their bachelor's degree or higher. In ACommunity B≅, 66% of the residents had a bachelor's degree or higher. Both communities appear similar with over two-thirds of the respondents having a bachelor's degree and above.

Only 20% of the respondents were currently married. The percent of married residents was slightly lower in Community A (16%) and slightly higher in Community B (24%). It should also be noted that all married residents who responded were living with their spouse. For the purpose of further analysis, all others were considered single, even if separated, divorced, or widowed, as they are not living with their spouse.

Residents perceived themselves as quite healthy. In the total group 58% perceived themselves in good health with an additional 20% indicating excellent health. Consequently over three fourth of the group (78%) saw themselves as quite healthy. The trend was similar in both communities AA≅ and AB≅.

In ACommunity A≅ the residents ranged from 73-101 years old, with the largest number born in 1910. The mode for this group, consequently, was 88 years old. Median age was 86, and the average age was 85.5 (see Appendix C).

In ACommunity B≅ the residents ranged from 69 years old, born in 1929, to 92 years old, born in 1906. The largest number (13) were born in 1911. The mode for this group,

consequently, was 87 years old. The mean and median age were 82. One can see the consistency when considering the total sample: mode=87, mean and median=84.

Residents have been living in their own apartments in the CCRCs from less than one year to 20 years. Overall, over half (54%) lived there for three years or less. This constituted a larger population of residents in ACommunity A≅ (63%) and a lower one in ACommunity B≅ (47%) (see Appendix C). The modal number of years of residency in both communities was three years.

Table 3

Profile of Residents

	Total Residents N= 254		Community A N= 119		Community B N= 135	
	F	%	F	%	F	%
SEX						
Males	89	35.04	40	33.6	49	36.3
Females	165	64.96	79	66.4	86	63.7
EDUCATIONAL ATTAINMENT						
< 12 years	1	.4	1	.8		
High school	36	14.23	22	18.6	14	10.4
Vocational/ Technical	10	3.95	6	5.1	4	3.0
Certificate	1	.4	1	.8	--	--
Associate	33	13.04	5	4.2	28	20.7
Bachelor	89	35.18	45	38.1	44	32.6
Master	68	26.88	26	22.0	42	31.1
Doctorate	7	2.77	5	4.2	2	1.5
Other	8	3.16	7	5.9	1	.7
Missing	1		1		--	--
MARITAL STATUS						
Single	34	13.39	16	13.4	18	13.3
Married	52	20.47	19	16.0	33	24.4
Separated	3	1.18	--	--	3	2.2
Divorced	33	12.99	12	10.1	21	15.6
Widowed	132	51.97	72	60.5	60	44.4
HEALTH						
Excellent	50	19.76	17	14.4	33	24.4
Good	147	58.10	70	59.3	77	57.0
Fair	45	17.79	22	18.6	23	17.0
Poor	11	4.35	9	7.6	2	1.5
Missing	1		1		--	--

Table 3 (continued)

Profile of Residents

	Total Residents N= 219	Community A N= 105	Community B N= 114
AGE			
Range:	69-101	73-101	69-92
Mean:	83.9	85.5	82.4
Median:	84	86	82
Mode:	87	88	87

	Total Residents N= 249	Community A N= 115	Community B N= 134	
NUMBER OF YEARS LIVING IN FACILITY				
Range:	<1 year-20 years	<1 year-20 years	<1 year-14 years	Mean:
Median:	3	3	4	
Mode:	3	3	3	

While some residents had lived in Community A for up to 20 years, no one in Community B lived there for more than 14 years. When this was discussed with the administrators, they stated that either the residents went to the assisted living section, the health care section or had died.

It becomes obvious that the women outnumber the men, the age of the residents ranges from 69 to 101 years old, their educational attainment is consistently high with over 68% having a bachelors degree or above, most feel that their health is either good or excellent, over three times as many so called single residents are living in the CCRCs as married, and that approximately half the residents have lived in their CCRC for less than three years. The variations between Communities A and B were negligible.

Responses to Research Questions

The research questions will be addressed under this heading. The first section deals with research question #1, which examines the importance of elements of the five categories of need (coping, expressive, influencing, contributing, and transcending) as perceived by the residents. In addition, research question #2 attempted to discern if a relationship existed between selected demographic variables (gender, educational attainment, health of the person and marital status) and responses to question #1. The second section deals with research question #3 regarding the types of learning formats used by the residents, and with questions #4 and #5, which deal with the residents' perceived satisfaction with current involvement and interest in future involvement with educational activities.

Importance of Different Types of Needs

Question #1: How important are each of McClusky's five categories of educational needs as perceived by the residents?

McClusky (1971) theorized that older adults Afaced a disruption in their sense of autonomy because their load≅ (responsibilities, expenses, illnesses) Aincreases and their power (energy, income, etc.) decreases≅ (p.329-330), and that addressing these needs would enhance their lives. Among the educational needs McClusky identified are the coping need, the expressive need, the contributing need, the influencing need, and the transcendence need. The reader is referred to Table 4 for the inspection of educational needs as perceived by the residents in Communities AA & B≅. A comparison of the two Communities indicated that the pattern of responses to the questionnaire were similar. Hence, data from Communities A and B were collapsed to give a more realistic picture of how the residents perceived their educational needs. The interested reader may wish to refer to the questionnaire completed by the residents (see Appendix A). The discussion, and data collection on which it is based, is framed by McClusky's five needs.

Table 4

<u>Educational Needs as Perceived by the Residents</u>

1 = NOT IMPORTANT
2 = MODERATE IMPORTANT
3 = SOMEWHAT IMPORTANT
4 = VERY IMPORTANT

		1	2	3	4
1.	Activities which help the residents **COPE** with situations relating to:				
	Age	11.75%	12.65%	38.15%	37.45%
	Health				
	Financial Status	5.5%	11.05%	36.7%	46.75%
	COPING SUM [A] 8.2767 Sd 2.2753	26.95%	32.95%	27.15%	13.0%
2.	Activities in which the resident can participate for **FUN** or **TO EXPRESS** yourself relating to:				
	Different types of music, e.g., classical, big bands, rock and roll	21.9%	21.0%	30.85%	26.25%
	Washington's night life or activities	55.6%	33.3%	9.4%	1.75%
	Virginia's history, e.g., battles, its presidents, soldiers and statesmen	24.6%	28.15%	24.4%	22.8%
	EXPRESSIVE SUM [A] 6.4859 Sd 2.1981				
3.	Activities in which the resident learns to become more effective in **INFLUENCING** events which affect your life, such as:				
	How to make your opinions count	23.05%	30.45%	28.85%	17.65%
	Social, moral, ethical and legal issues affecting the community	21.75%	29.7%	31.85%	16.7%
	How to get your point across effectively	25.6%	31.7%	28.75%	13.95%
	INFLUENCING SUM [A] 6.9641 Sd 2.6927				
4.	Activities which help the resident **CONTRIBUTE** to the well-being of others, such as:				
	How to assist others who have some type of handicap, e.g., communicating with a deaf person	30.1%	25.0%	25.8%	19.15%
	First aid, lifesaving or CPR	45.0%	35.45%	13.6%	5.96%
	How to share your knowledge, experiences and talents with others	19.2%	30.50%	32.35%	17.95%
	CONTRIBUTING SUM [A] 6.4382 Sd 2.3696				
5.	Activities which help the resident focus on (deal with) **RISING ABOVE AND GOING BEYOND** your own individual life, such as:				
	God, Buddha, AllahBa comparative look at religion	20.1%	22.65%	32.04%	25.18%
	Is there still something I want to do or leave as a legacy	11.75%	16.4%	41.5%	30.35%
	Seeking better understanding of Wisdom of the ages	15.55%	22.75%	35.5%	26.2%
	TRANSCENDENCE SUM [A] 8.0794 Sd 2.5471				

[A] Sums range from 3 to 12 for each set of three items.

COPING NEEDS. Coping needs are those needs that help the older adults survive and deal with changes that are occurring in their lives.

As is evident in Table 4, educational activities which help a resident cope would be ranked in order from most important to least important as follows: health, age, financial status. Specifically, 83% of the residents considered health as either very important or somewhat important; and 76% of the residents considered aging as either very or somewhat important. In contrast only 40% considered finance as very or somewhat important. Over a quarter (27%)considered financial status as not important at all. When considering the entrance fee and monthly fees paid by the residents at these CCRCs, it seems evident that this sample of residents is not among the needy elderly in monetary terms and consequently may be able to divert their attention to more than survival needs.

EXPRESSIVE NEEDS. Expressive needs are those needs in which older adults participate for fun. They may not have a goal, they do it just for their own pleasure and enjoyment, for expanding their knowledge. With regard to this need, the total sample had no strong opinion. Based on percentages indicating importance, learning or expanding their knowledge about different types of music was first, followed by learning about Virginia's history. Learning about Washington's night life was not viewed as important.

As far as having fun and/or expressing themselves, this is not a group who would be drawn to Washington's night life or activities. An overwhelming 89% consider it either not important (55.6%) or moderately important (33.3%). Conversely, activities dealing with different types of music was seen as important by the majority of residents (57%). Slightly less (47%) felt that learning about Virginia's history was very or somewhat important. For this group of residents, expressive needs on an overall basis do not seem to have a high priority when compared to the coping needs.

INFLUENCING NEEDS. The third category, influencing needs, are those needs relevant to finding a mechanism which can be used to influence society. This can be done by various means, for example learning how to get their point across, expressing their opinion about an issue, or making their opinion count can affect their lives and the community around them.

As seen in Table 4, residents were very diverse in their opinion about the importance of educational activities that will help them become more effective in influencing events that affect their lives.

Specifically, less than half felt that the following three aspects of influencing needs were either somewhat or very important:

(1) issues (social, moral, ethical and legal) affecting the community (49%),

(2) making your opinion count (47%), and

(3) getting your point across (43%).

CONTRIBUTING NEEDS. Contributing needs are those needs which an older person has to help others and a desire to share their knowledge with others.

As one can derive from Table 4, sharing one's knowledge and experience with others took top ranking with 50% of the residents considering it very important or somewhat important. This was followed closely by the need to learn how to assist others with handicaps, where 45% of the residents considered it either very important or somewhat important.

At the other end of the spectrum, however, 30% considered assisting the handicap as not important and another 25% as only moderately important.

Finally, first aid, lifesaving and CPR were low on the list of needs, with only 19% rating it as very important or somewhat important. Almost one half (45%) felt it was not important, and another 35% felt it was only moderately important.

TRANSCENDENCE NEEDS. Transcendence needs are those needs that usually only an older adult can succeed in having. It is the need for relevance and purpose of existence in one's life as it draws to a close. When the residents were asked to look at transcendence, they were asked to view it as rising above or beyond themselves. This is a time in their lives when they have to face losses of work, social roles, health, and possibly the loss of a loved one. This category emphasizes a replacement of the real losses and of finding new resources within one's self to restore the person's sense of purpose and meaning.

According to response percentages, from 57% to 72% of the residents felt the three transcendence categories were either somewhat or very important. Specifically:

(1) 72% felt this way for leaving a legacy

(2) 62% for seeking a better understanding of wisdom of the ages, and

(3) 57% felt a need for looking at comparative religions.

Based on the averages of summated scores for each set of three items, a pattern clearly emerges. The Coping and Transcendence needs are the most important with means= 8.3 and 8.1 on a scale from 3 to 12. On this scale, a 9 is comparable to a 3= somewhat important and a 6 is comparable to a 2= moderately important on the original Likert scale. On average, the other three needs were seen as relatively moderate ones (Influencing= 7.0; Expressive= 6.5; and Contributing= 6.4). These findings are consistent with those of White (1988) who suggested that coping and transcendence needs rank higher than the other needs; and, as Hansen (1988) stated, McClusky Astrongly supported his first and final levels (coping and transcendence), but did not give much attention to the middle levels≅ (p.8).

Question #2: What is the relationship between selected demographic characteristics of the residents (gender, marital status, formal educational attainment and health) and their perceived educational needs?

Table 5 contains the Chi-square and p-values for all the combinations of the dichotomized demographic variables and specific elements in McClusky's five categories of educational needs. As can be seen, only seven of the 60 Chi-squares were significant, using a .05 significance level. However, even in those cases, the strengths of the relationships were extremely weak, with no correlation reaching .3, and most being even lower.

The general consistency in the patterns of responses across levels of each demographic variable may be seen in the contingency tables in Appendix D. Inspection of these tables shows that, even in the few cases where significance did occur, the patterns do not differ very much. Therefore, the overall conclusion is that responses to educational needs do not differ based on differences in residents' gender, educational attainment, marital status, or health.

A few relatively minor differences will be highlighted. Under expressive needs, activities related to Washington's night life were seen as either very or somewhat important by less than 3% of the residents with AA or lower educational levels, but by a quarter of those with BS or higher degrees.

First aid, lifesaving, or CPR type of activities that help contribute to the well being of others was deemed as somewhat or very important by 37% of the married individuals, but only by 15% of residents who were single, divorced, or widowed.

Although the overall responses indicated that the legacy category of transcendent needs was seen as important, a greater percentage of males felt that it was not important (19%) than did females (8%).

Four responses were slightly related to the health of the respondents. Those in good health were almost evenly divided in their opinions on learning about how to influence events by making their opinions count, while those in poor health were concentrated in the middle two response categories, seeing this as somewhat or moderately important. The contributing need of sharing your experiences and knowledge was seen as very important by 20% of those in good health, but only 8% of those in poor health. For the transcendence needs of leaving a legacy and seeking a better understanding of wisdom, there was a slight tendency for those in good health to see these areas as more important then for those in poor health.

Table 5

Relationship Between Demographic Variables and Perceived Needs

	GENDER[A]		EDUCATIONAL[B] ATTAINMENT		MARITAL[C] STATUS		HEALTH[D]	
	X^2	P	X^2	P	X^2	P	X^2	P
COPING								
Age	3.21	.361	.709	.871	1.103	.776	2.329	.507
Health	1.47	.214	2.831	. 418	4.483	.214	5.819	.121
Financial	.751	.861	1.382	. 710	2.356	.502	5.124	.163
EXPRESSIVE								
Music	4.38	.223	2.575	.462	2.480	.479	2.685	.443
Night Life	6.03	.110	8.416	.038	6.389	.094	4.881	.181
History	4.662	.193	.194	. 979	6.126	.106	1.915	.590
INFLUENCING								
Opinions	2.216	.529	2.904	.407	.889	.828	7.957	.047
Issues	1.234	.745	3.414	.332	2.321	.508	4.110	.250
Point Across	3.155	.368	3.060	.382	2.647	.449	..330	.954
CONTRIBUTING								
Assist Others	5.31	.151	1.98	.58	6.612	.085	.966	.809
First Aid	1.16	.763	1.12	.71	13.404	.004	7.180	.066
Share Knowledge	5.61	.132	5.185	.159	2.468	.481	8.100	.044
TRANSCENDENCE								
Religion	.671	.880	1.347	.718	2.435	.487	3.660	.301
Legacy	8.48	.037	1.858	.602	1.032	.794	11.463	.009
Wisdom	2.448	.483	2.553	.446	5.045	.169	20.505	.000

A= Education 1=Associate and below; 2= BS and above

B= Marital Status 1=Married; 2=Other- single, separated, divorced, widowed

C= Gender 1=Males; 2= Females

D= Health Good= Excellent and good; Poor= fair and poor

Past and Future Educational Involvement

Typical Learning Formats

Question #3: What learning formats are most frequently used by the residents?

In looking at the participation in educational endeavors during the last year, the respondents identified the extent to which they participated in five specific areas or types of programs. These included educational programs, conferences, individual courses, seminars or workshops, and finally self-directed learning. Each will be discussed below. The reader is referred to Table 6 which accompanies the narrative data from Communities A and B which are combined. The percentages were combined because there were no significant differences between the two communities.

Table 6

Learning Format Used by the Residents

	0= NOT AT ALL 1= SOMETIMES 2= OCCASIONALLY 3= FREQUENTLY N/A= NOT APPLICABLE				
	0	1	2	3	N/A
DURING THE PAST YEAR, TO WHAT EXTENT HAVE YOU PARTICIPATED IN ANY OF THE FOLLOWING:					
EDUCATIONAL PROGRAMS	14 %	14.85%	30.55 %	40.6 %	
CONFERENCES	59.95%	18.65%	14.95%	6.5 %	
INDIVIDUAL COURSES	32 %	22 %	33.7%	12.3 %	
SEMINARS OR WORKSHOPS	61.4%	18.45%	11.1%	9.05%	
SELF-DIRECTED LEARNING ACTIVITY (such as doing things on your own)	7.8%	17.15%	36.6%	38.45%	

For the most part the residents in both communities frequently participated in educational programs and self-directed learning and tended not to participate in conferences and seminars. Most of the residents tended at least occasionally to participate in individual courses.

It would appear that this group of senior citizens would prefer learning about things on their own or in small groups rather than larger groups.

Satisfaction with Educational Involvement

Question #4: To what extent are CCRC residents satisfied with the educational activities in which they participated?

As can be seen from Table 7, 41% of the residents stated that their needs were occasionally satisfied, plus an additional 22% were frequently satisfied.

When talking to the residents in the different facilities, they talked about participating in programs at the Smithsonian, attending Elderhostel, participating in courses at the Community College, at AARP, watching the History channel on TV, participating in programs for senior citizens in the county, and a variety of other programs. It appears that CCRC residents participate in a variety of educational activities. For whatever they do participate in, most residents felt their educational interests were being satisfied.

Table 7

Perceived Present Satisfaction
Of Residents' Educational Activities

PLEASE CIRCLE THE NUMBER THAT MATCHES TO YOUR SITUATION	0= NOT AT ALL 1= SOMETIMES 2= OCCASIONALLY 3= FREQUENTLY N/A= NOT APPLICABLE 0	1	2	3	N/A
To what extent have such activities satisfied your needs? *	2.7%	13.3%	40.9%	21.8%	

*Missing data

Future Educational Participation

Question #5: To what extent are CCRC residents interested in participating in various educational activities in the future?

With regard to participation in activities for the future, 63% of the residents stated that they would either occasionally (34%) or frequently (29%) participate in some type of programs in the future (see Table 8). This was a fairly educated set of residents, and so both their past participation and expectation of future participation is reasonable.

Table 8

Perceived Future Interest
Of Residents' Educational Activities

PLEASE CIRCLE THE NUMBER THAT MATCHES YOUR SITUATION	0= NOT AT ALL 1= SOMETIMES 2= OCCASIONALLY 3= FREQUENTLY N/A= NOT APPLICABLE 0	1	2	3	N/A
To what extent would you be interested in Participating in such activities in the Future? *	3.7%	12.2%	34%	28.8%	

*Missing data

CHAPTER 5

SUMMARY, IMPLICATIONS AND RECOMMENDATIONS

Summary

People are living longer. In fact, the Aold≅ (defined as-people over the age of 85) currently constitute the most rapidly growing segment of the population. As the mean age of the population continues to rise, increasing attention is being given to how and where they live. Because, among other reasons, the state of health of the elderly varies considerably, living arrangements which offer a full spectrum of services and attend to a continuum of needs have arisen and evolved over the past several decades. Called Continuous Care Facilities or Continuous Care Retirement Communities (CCRCs), these places offer residents their own apartment, and the freedom to move back and forth as the need arises to assisted living facilities and to nursing care facilities.

Very often, as seen in the sample for this study, the individuals who utilize CCRCs have a higher educational level than the average population. Because research has consistently demonstrated that those with higher educational levels tend to participate in educational activities well into older age, this population clearly represents a need and a challenge for adult education.

While educational needs of the elderly have been discussed theoretically and explored in practice in a variety of contexts, no research to the author's knowledge had tended to the context of CCRCs and the population within. This study was undertaken to fill that gap in the literature. The main purpose of this study was to document the importance of exemplary elements of the five categories of educational needs -- as identified by McClusky -- for the residents of CCRCs.

In relation to the importance of the five categories of needs, there appears to be two main groupings. The most important set, for the residents, contains the coping and the transcendence needs, while the less important set contains the expressive, influencing and contributing needs. This appears consistent with White (1988) and Hanson (1988) who stated that McClusky gave more attention to the coping and transcendence areas.

Regarding coping needs, the residents indicated that health was the most important consideration, followed by age and lastly financial status. This seems reasonable because, when talking to the residents, they appeared to be concerned about their health and wanted to stay healthy or as healthy as they were. When questioning why financial status was considered by the residents as the least important educational need under coping, consideration should be given to the significant entrance costs and the high monthly fees charged in these CCRCs. One can therefore conclude that these residents are financially secure. For transcendence needs, which emphasizes a replacement of loss and finding new resources, the residents felt that leaving a legacy was most important, followed by seeking a better understanding of wisdom and, finally, looking at comparative religions.

The next category, influencing needs, did not appear to be very important, with less than half the residents feeling that the subcategories under this need were either somewhat or very important. In relation to expressive needs, over 50% of the residents felt that learning about different types of music was more important than learning about Virginia's history; not very many residents were drawn to Washington's night life. Finally, contributing needs also did not appear to be very important to the residents. Specifically, approximately 80% of the residents felt that first aid was not or only moderately important. Another 55% considered learning how to assist the handicapped as not important, and 19% considered sharing information as not important.

There appears to be no appreciable difference in the relationship between the demographic variables and the perceived needs. It is worthy to note that four perceived needs were slightly related to health. Those in good health were almost evenly divided regarding their opinion on learning about how to influence events by making their opinion count. However, those whose health was poor were concentrated in the middle two response categories, considering the influencing of events as either somewhat or moderately important. The contributing needs of sharing experiences and knowledge was considered very important by 20% of those in good health, but only 8% of those in poor health considered this as very important. Regarding transcendence, 56% of those in poor health felt it was somewhat or very important, while 76% of those in good health felt it was important to know about leaving a legacy. In the

other subcategory under transcendence, only 52% of the residents who were in good health felt it was important to understand the wisdom of the ages, while only 15% of those in poor health felt it was important. Does this show that those in poor health were not concerned about transcendence needs because their concerns were more about their health? Such a conclusion cannot be reached because the relationship between these two variables was very weak.

During the past year, the vast majority of the residents of these CCRCs had participated in various educational programs and/or self-directed learning experience and many had participated in individual courses. In contrast, they did not tend to go to conferences, seminars, or workshops. Regardless of what they participated in, they were satisfied with learning activities to at least some degree, with less than 3% being not satisfied at all. Likewise, most would participate in such activities in the future, with less than 4% saying that they were not likely to do so.

Implications and Recommendations

Because residents varied in their responses about their needs, it would be useful for staff to encourage residents to take an active role in communicating their preferences to management. To implement this recommendation, the CCRC might establish a board of resident directors, or have residents vote for representatives from within their population to the governing body of the CCRC. Communications between these resident-selected representatives and the resident population could take place through periodic meetings and newsletter publications. Resident participation in the educational program planning effort undoubtably would result in the selection of learning activities that are preferred by the residents.

From this study a conclusion can be drawn that there is a market for future education for the older adults. However, as in any market, educational offerings must meet the needs of the consumer. One way this can occur is involvement by the residents themselves in the selection of educational offerings. We know that they want information about health as a result of this study. But more than that, there seems to be a need for a more holistic health movement, encompassing both mind and body, when looking at the coping and transcendence needs. Their request seems to

say, Ateach me about the now of my body so that I can tell the tale of where it has taken me and I can leave a legacy to those behind≅.

Future Research

Future research issues as a result of this limited study would include an examination concerning why a majority of residents responded that they had participated in educational programs and self-directed learning. Was this because these were the main formats available at that time, or was it the format they would choose? Are there any other formats that the residents would have preferred to use, or do they just go to programs not caring what format is used? Along the same trend, how would the residents of CCRCs plan and implement their self-directed learning? What resources are available to them?

In this study, satisfaction with educational programs was addressed only in general terms. It would be interesting to identify the satisfaction in each specific educational endeavor (educational programs, conferences, courses, workshops and self-directed learning), not just asking it as a whole group of activities. Also, future research could look at previous (before entering the facility) and present participation in educational endeavors including: looking at the frequency of participation in programs, how well their interests in the various educational endeavors were satisfied, where they participated in the various educational programs, what type of programs would they like regarding the specific activity, and how available are the various programs to the residents. Additionally, research covering how the various programs are being presented to the residents, how available transportation is to various locations, and how this affects residents' participation. Also, how are the various programs being advertised, and is the staff encouraging participation in all programs or just very specific ones. Are the residents themselves involved in assessing and planning the various programs. Further, what resources, both human and material, are available to the residents?

Also, as CCRCs are increasing not just in the Northern Virginia area but also throughout the country, do the staff of these facilities see educational needs for their residents as important, or do they just feel they need to keep them occupied with bridge and arts and craft? Does the

staff realize that as educational attainment increases, so does participation? What is the role of the staff in the planning of programs?

It would be interesting to examine how educational activities are viewed by the not-for-profit, for profit, large corporations administrated, and religious organization administrated CCRCs. As the CCRCs are increasing, is there a difference between those CCRCs in metropolitan areas and those in rural areas and how they view educational needs? Is there a difference in those that are accredited by the national accreditation agency and those that are not and how they view educational needs? Is there a difference in the demographics of the different types of CCRCs and their relationship with educational needs?

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APPENDIX A

PERCEIVED EDUCATIONAL NEEDS

Dear Resident,

I am a doctoral student at Virginia Polytechnic Institute and State University at the Northern Virginia Graduate Center and a nurse. I am interested in the educational needs of residents of the Continuing Care Retirement Communities in Northern Virginia and need your assistance.

There have been many surveys done identifying educational needs of senior citizens. However, there has been no research done for residents in Continuing Care Retirement Communities. May I respectfully ask you to complete the enclosed questionnaire in order that we might find ways to better serve people in Continuing Care Retirement Communities. It should only take a few minutes of your time to complete.

The questionnaire has been sent to all the residents and professional staff of your facility. It is numbered to help me keep track of your responses. Your answers will be strictly confidential and no individual answers will be reported.

Please complete this questionnaire and return it to the marked box in the lobby area by Monday, May 4th. I will be at your facility on Tuesday, May 5th to answer any questions you may have about the study. If you want to talk about the questionnaire you can contact me at xxx-xxxx.

After the results of the study has been tabulated, I will be happy to share the results of the entire questionnaire with you individually or as a group.

Thank you for your time in completing the questionnaire. Your assistance is of great value in helping me identify the educational needs of residents of Continuing Care Retirement Communities.

Sincerely,

Florence Smoczynski, M.S.N., R.N.

CODE ______

PERCEIVED EDUCATIONAL NEEDS

HOW IMPORTANT IS LEARNING OR EXPANDING YOUR KNOWLEDGE IN RELATION TO EACH OF THE FOLLOWING TOPICS?

1 = NOT IMPORTANT
2 = MODERATE IMPORTANT
3= SOMEWHAT IMPORTANT
4 = VERY IMPORTANT

Please circle the number that matches your need.

1.	Engage in activities which help you **COPE** with situations relating to:	4	3	2	1
	∃ Age	4	3	2	1
	∃ Health	4	3	2	1
	∃ Financial Status	4	3	2	1
	∃ Others ____________________				
2.	Engage in activities in which you can participate for **FUN** or **TO EXPRESS** yourself relating to:				
	∃ Different types of music, e.g., classical, big bands, rock and roll	4	3	2	1
	∃ Washington's night life or activities	4	3	2	1
	∃ Virginia's history, e.g., battles, its presidents, soldiers and statesmen	4	3	2	1
	∃ Others ____________________	4	3	2	1
3.	Activities in which you learn to become more effective in **INFLUENCING** events which affect your life, such as:				
	∃ How to make your opinions count	4	3	2	1
	∃ Social, moral, ethical and legal issues affecting the community	4	3	2	1
	∃ How to get your point across effectively	4	3	2	1
	∃ Others ____________________	4	3	2	1
4.	Activities which help you **CONTRIBUTE** to the well-being of others, such as:				
	∃ How to assist others who have some type of handicap, e.g., communicating with a deaf person	4	3	2	1
	∃ First aid, lifesaving or CPR	4	3	2	1
	∃ How to share your knowledge, experiences and talents with others	4	3	2	1
	∃ Others ____________________	4	3	2	1
5.	Activities which help you focus on (deal with) **RISING ABOVE AND GOING BEYOND** your own individual life, such as:				
	∃ God, Buddha, AllahBa comparative look at religion	4	3	2	1
	∃ Is there still something I want to do or leave as a legacy	4	3	2	1
	∃ Seeking better understanding of Wisdom of the ages	4	3	2	1
	∃ Others ____________________	4	3	2	1

PLEASE FEEL FREE TO WRITE ADDITIONAL COMMENTS ON THE REVERSE PAGE

PLEASE CIRCLE THE NUMBER THAT MATCHES TO YOUR SITUATION WHERE:	0 = NOT AT ALL 1 = SOMETIMES 2 = OCCASIONALLY 3 = FREQUENTLY N/A = NOT AT ALL			
	0	1	2	3	N/A
DURING THE PAST YEAR, TO WHAT EXTENT HAVE YOU PARTICIPATED IN THE ANY OF THE FOLLOWING:					
EDUCATIONAL PROGRAMS	0	1	2	3	N/A
CONFERENCES	0	1	2	3	N/A
INDIVIDUAL COURSES	0	1	2	3	N/A
SEMINARS OR WORKSHOPS	0	1	2	3	N/A
SELF-DIRECTED LEARNING ACTIVITY (such as doing things on your own)	0	1	2	3	N/A
TO WHAT EXTENT HAVE SUCH ACTIVITIES SATISFIED YOUR NEEDS?	0	1	2	3	N/A
TO WHAT EXTENT WOULD YOU BE INTERESTED IN PARTICIPATING IN SUCH ACTIVITIES IN THE FUTURE?	0	1	2	3	N/A

IS THERE ANYTHING ELSE YOU WOULD LIKE TO SAY ABOUT YOUR EDUCATIONAL NEEDS?

____

____

____

____

DEMOGRAPHIC INFORMATION

PLEASE CIRCLE THE NUMBER OR
FILL IN THE BLANKS WHERE APPROPRIATE

WHAT IS YOUR GENDER?
1. Male
2. Female

WHAT IS YOUR STATUS?
1. Single
2. Married
3. Separated
4. Divorced
5. Widowed

WHAT IS THE HIGHEST LEVEL OF SCHOOLING YOU HAVE COMPLETED?
1. Under 12th Grade
2. High School
3. Vocational or Technical School
4. Certificate
5. Associate Degree
6. Bachelor's Degree
7. Master's Degree
8. Doctoral Degree
9. Other

In what year were you born? ____________

How many years have you lived or worked in this facility? ____________

How do you typically travel when going out?
1. Drive myself
2. Passenger in a Car
3. Take a Bus or Taxi
4. FasTran
5. Walk
6. Wheelchair/Walker
7. With Someone Else
8. Unable to go out

How do you perceive your health?
1. Excellent
2. Good
3. Fair
4. Poor

Thank you for taking the time to complete this questionnaire

APPENDIX B

LETTER TO ADMINISTRATOR

7876 Godolphin Drive
Springfield, VA 22153

Dear Administrator,

I enjoyed speaking to you recently concerning my research study on identifying the educational needs of residents in Continuing Care Retirement Communities. I appreciate your assistance in helping me complete this project.

Enclosed are copies of the questionnaire. The questionnaire is yellow colored and coded for the resident, and salmon color and coded for members of the professional staff.

As we discussed at our meeting, I would like to have an Ice Cream party for the residents to encourage them to participate in completing the questionnaire. Would you please announce in either your weekly newsletter or during the daily announcements that I will be in your facility to distribute this questionnaire at an Ice Cream party to be held on the date we agreed.

For the residents who do not attend the Ice Cream party, I would appreciate it if you could distribute the questionnaires in their mailboxes.

Again, thank you for your assistance and the assistance of your staff in helping me complete my study of the Educational Needs of Residents of Continuing Care Retirement Communities.

Sincerely,

Florence I. Smoczynski, M.S.N., R.N.

APPENDIX C

PROFILE OF RESIDENTS YEARS BORN

	Total Residents N= 214		Community A N= 105		Community B N= 114	
	F	%	F	%	F	%
AGE						
1897 (101)	1	.5	1	1.0	--	--
1898 (100)	1	.5	1	1.0	--	--
1904 (94)	3	1.4	3	2.9	--	--
1905 (93)	3	1.4	3	2.9	--	--
1906 (92)	10	4.6	7	6.7	3	2.6
1907 (91)	7	3.2	5	4.8	2	1.8
1908 (90)	3	1.4	3	2.9	--	--
1909 (89)	8	3.7	2	1.9	6	5.3
1910 (88)	19	8.7	13	12.4	6	5.3
1911 (87)	22	10.0	9	8.6	13	11.4
1912 (86)	9	4.1	6	5.7	3	2.6
1913 (85)	15	6.8	7	6.7	8	7.0
1914 (84)	15	6.8	8	7.6	7	6.1
1915 (83)	11	5.0	4	3.8	7	6.1
1916 (82)	13	5.9	6	5.7	7	6.1
1917 (81)	18	8.2	9	8.6	9	7.9
1918 (80)	17	7.8	7	6.7	10	8.8
1919 (79)	13	5.9	5	4.8	8	7.0
1920 (78)	11	5.0	2	1.9	9	7.9
1921 (77)	6	2.7	--	--	6	5.3
1922 (76)	2	.9	--	--	2	1.8
1923 (75)	7	3.2	1	1.0	6	5.3
1924 (74)	1	.4	1	1.0	--	--
1925 (73)	2	.9	2	1.9	--	--
1928 (70)	1	.4	--	--	1	.9
1929 (69)	1	.4	--	--	1	.9
Missing data	35		14		21	

APPENDIX C

PROFILE OF RESIDENTS LIVING IN FACILITY

	Total Residents N= 254		Community A N= 119		Community B N= 135	
	F	%	F	%	F	%
LIVING IN FACILITY						
< 1 year	31	12.2	21	17.6	10	7.4
1 year	22	8.7	10	8.4	12	8.8
< 2 years	9	3.5	5	4.2	4	2.9
2 years	29	11.4	17	14.3	12	8.8
< 3 years	3	1.2	2	1.7	1	.7
3 years	44	17.3	20	16.8	24	17.7
< 4 years	3	1.1	2	1.7	1	.7
4 years	33	13.0	13	11.3	20	14.8
< 5 years	3	1.2	2	1.7	1	.7
5 years	13	5.1	2	1.7	11	8.1
< 6 years	3	1.2	--	--	3	2.2
6 years	10	4.0	1	.8	9	6.6
7 years	14	5.5	5	4.2	9	6.6
< 8 years	1	.4	--	--	1	.7
8 years	5	2.0	2	1.7	3	2.2
< 9 years	2	.8	--	--	2	1.5
9 years	5	2.0	--	--	5	3.7
10 years	6	2.4	3	2.5	3	2.2
11 years	5	2.0	5	4.2	--	--
< 12 years	2	.8	--	--	2	1.5
12 years	3	1.2	3	2.5	--	--
14 years	3	1.2	1	.8	2	1.5
15 years	2	.8	2	1.7	--	--
16 years	1	1.4	1	.8	--	--
18 years	1	.4	1	.8	--	--
20 years	1	.4	1	.8	--	--

APPENDIX D

CONTINGENCY TABLES

Coping: Age

RESIDENTS RESPONDING TO AGE

	TOTAL RESIDENTS N=249			COMMUNITY A N=116	COMMUNITY B N=133
IMPORTANT	FREQUENCY	PERCENT		PERCENT	PERCENT
NOT	28	11.75%		19.0%	4.5%
MODERATE	32	12.65%		10.3%	15.0%
SOMEWHAT	96	38.15%		31.9%	44.4%
VERY	93	37.45%		38.8%	36.1%
MISSING	5			3	2

RESIDENTS RESPONDING BY GENDER TO AGE
N=249

IMPORTANT	MALES (N=87)	FEMALES (N=162)
NOT	12.6%	10.5%
MODERATE	10.3%	14.2%
SOMEWHAT	44.8%	35.2%
VERY	32.2%	40.1%

Pearson Chi Square= 3.207; p= .361

RESIDENTS RESPONDING BY SCHOOLING TO AGE
N=241

IMPORTANT	AA DEGREE and BELOW (N=79)	BS DEGREE and ABOVE (N=162)
NOT	11.4%	9.9%
MODERATE	11.4%	13.6%
SOMEWHAT	36.7%	40.1%
VERY	40.5%	36.4%

Pearson Chi Square= .709; p= .871

RESIDENTS RESPONDING BY MARITAL STATUS TO AGE
N=249

IMPORTANT	SINGLE (N=198)	MARRIED (N=51)
NOT	11.1%	11.8%
MODERATE	13.1%	11.8%
SOMEWHAT	39.9%	33.3%
VERY	35.9%	43.1%

Pearson Chi Square= 1.103; p= .776

RESIDENTS RESPONDING BY THEIR HEALTH TO AGE
N=248

IMPORTANT	GOOD (N=193)	POOR (N=55)
NOT	10.4%	14.5%
MODERATE	13.0%	12.7%
SOMEWHAT	37.3%	43.6%
VERY	39.4%	29.1%

Pearson Chi Square= 2.329; p= .507

Coping: Health

RESIDENTS RESPONDING TO HEALTH

	TOTAL RESIDENTS N=248			COMMUNITY A N=116	COMMUNITY B N=132
IMPORTANT	FREQUENCY	PERCENT		PERCENT	PERCENT
NOT	13	5.5%		9.5%	1.5%
MODERATE	28	11.05%		6.9%	15.2%
SOMEWHAT	92	36.7%		31.0%	42.4%
VERY	115	46.75%		52.6%	40.9%
MISSING	6			3	3

RESIDENTS RESPONDING BY GENDER TO HEALTH
N=248

IMPORTANT	MALES (N=87)	FEMALES (N=161)
NOT	5.7%	5.0%
MODERATE	8.0%	13.0%
SOMEWHAT	39.1%	36.0%
VERY	47.1%	46.0%

Pearson Chi Square= 1.473; p= .688

<u>RESIDENTS RESPONDING BY SCHOOLING TO HEALTH</u>
N=240

IMPORTANT	AA DEGREE and BELOW (N=79)	BS DEGREE and ABOVE (N=161)
NOT	3.8%	5.6%
MODERATE	7.6%	13.7%
SOMEWHAT	36.7%	37.3%
VERY	51.9%	43.5%

Pearson Chi Square= 2.831; p= .418

<u>RESIDENTS RESPONDING BY MARITAL STATUS TO AGE</u>
N=248

IMPORTANT	SINGLE (N=197)	MARRIED (N=51)
NOT	5.1%	5.9%
MODERATE	12.2%	7.8%
SOMEWHAT	39.6%	27.5%
VERY	43.1%	58.8%

Pearson Chi Square= 4.483; p= .214

<u>RESIDENTS RESPONDING BY THEIR HEALTH TO HEALTH</u>
N=247

IMPORTANT	GOOD (N=192)	POOR (N=55)
NOT	4.2%	9.1%
MODERATE	13.5%	3.6%
SOMEWHAT	37.0%	38.2%
VERY	45.3%	49.1%

Pearson Chi Square= 5.819; p= .121

Coping: Financial

RESIDENTS RESPONDING TO FINANCIAL

	TOTAL RESIDENTS N=237			COMMUNITY A N=108	COMMUNITY B N=129
IMPORTANT	FREQUENCY	PERCENT		PERCENT	PERCENT
NOT	63	26.95%		30.6%	23.3%
MODERATE	79	32.95%		28.7%	37.2%
SOMEWHAT	64	27.15%		28.7%	25.6%
VERY	31	13.0%		12.0%	14.0%
MISSING	17			11	6

RESIDENTS RESPONDING BY GENDER TO FINANCIAL
N=237

IMPORTANT	MALES (N=86)	FEMALES (N=151)
NOT	29.9%	25.2%
MODERATE	32.6%	33.8%
SOMEWHAT	24.4%	28.5%
VERY	14.0%	12.6%

Pearson Chi Square= .751; p= .861

RESIDENTS RESPONDING BY SCHOOLING TO FINANCIAL
N=229

IMPORTANT	AA DEGREE and BELOW (N=75)	BS DEGREE and ABOVE (N=154)
NOT	28.0%	25.3%
MODERATE	29.3%	35.1%
SOMEWHAT	26.7%	27.9%
VERY	16.0%	11.7%

Pearson Chi Square= 1.382; p= .710

RESIDENTS RESPONDING BY MARITAL STATUS TO FINANCIAL
N=237

IMPORTANT	SINGLE (N=188)	MARRIED (N=49)
NOT	25.0%	32.7%
MODERATE	35.1%	26.5%
SOMEWHAT	27.7%	24.5%
VERY	12.2%	16.3%

Pearson Chi Square= 2.356; p= .502

RESIDENTS RESPONDING BY THEIR HEALTH TO FINANCIAL
N=236

IMPORTANT	GOOD (N=184)	POOR (N=52)
NOT	26.6%	26.9%
MODERATE	36.4%	21.2%
SOMEWHAT	25.0%	34.6%
VERY	12.0%	17.3%

Pearson Chi Square= 5.124; p= .163

Expressive: Music

RESIDENTS RESPONDING TO MUSIC

	TOTAL RESIDENTS N=248			COMMUNITY A N=116	COMMUNITY B N=132
IMPORTANT	FREQUENCY	PERCENT		PERCENT	PERCENT
NOT	54	21.9%		23.3%	20.5%
MODERATE	53	21.0%		14.7%	27.3%
SOMEWHAT	77	30.85%		28.4%	33.3%
VERY	64	26.25%		33.6%	18.9%
MISSING	6			3	3

RESIDENTS RESPONDING BY GENDER TO MUSIC
N=248

IMPORTANT	MALES (N=87)	FEMALES (N=161)
NOT	23.0%	21.1%
MODERATE	21.8%	21.1%
SOMEWHAT	36.8%	28.0%
VERY	18.4%	29.8%

Pearson Chi Square= 4.379; p= .223

RESIDENTS RESPONDING BY SCHOOLING TO MUSIC
N=240

IMPORTANT	AA DEGREE and BELOW (N=78)	BS DEGREE and ABOVE (N=162)
NOT	28.2%	19.1%
MODERATE	19.2%	21.0%
SOMEWHAT	28.2%	33.3%
VERY	24.45%	26.5%

Pearson Chi Square= 2.575; p= .462

RESIDENTS RESPONDING BY MARITAL STATUS TO MUSIC
N=248

IMPORTANT	SINGLE (N=197)	MARRIED (N=51)
NOT	21.8%	21.6%
MODERATE	22.8%	15.7%
SOMEWHAT	28.9%	39.2%
VERY	26.4%	23.5%

Pearson Chi Square= 2.480; p= .479

RESIDENTS RESPONDING BY THEIR HEALTH TO MUSIC
N=247

IMPORTANT	GOOD (N=193)	POOR (N=54)
NOT	21.8%	22.2%
MODERATE	21.8%	20.4%
SOMEWHAT	29.0%	38.9%
VERY	27.5%	18.5%

Pearson Chi Square= 2.685; p= .443

Expressive: Night Life

RESIDENTS RESPONDING TO NIGHT LIFE

	TOTAL RESIDENTS N=241			COMMUNITY A N=111	COMMUNITY B N=130
IMPORTANT	FREQUENCY	PERCENT		PERCENT	PERCENT
NOT	134	55.6%		55.0%	56.2%
MODERATE	81	33.3%		29.7%	36.9%
SOMEWHAT	22	9.4%		12.6%	6.2%
VERY	4	1.75%		2.7%	.8%
MISSING	13			8	5

RESIDENTS RESPONDING BY GENDER TO NIGHT LIFE
N=241

IMPORTANT	MALES (N=86)	FEMALES (N=155)
NOT	48.8%	59.4%
MODERATE	41.9%	29.0%
SOMEWHAT	9.3%	9.0%
VERY	0%	2.6%

Pearson Chi Square= 6.032; p= .110

RESIDENTS RESPONDING BY SCHOOLING TO NIGHT LIFE
N=233

IMPORTANT	AA DEGREE and BELOW (N=75)	BS DEGREE and ABOVE (N=158)
NOT	62.7%	51.9%
MODERATE	34.7%	33.5%
SOMEWHAT	1.3%	12.7%
VERY	1.3%	1.9%

Pearson Chi Square= 8.416; df= 3, p= .038
Kendall's tau-b= .129; p= .029

RESIDENTS RESPONDING BY MARITAL STATUS TO NIGHT LIFE
N=241

IMPORTANT	SINGLE (N=190)	MARRIED (N=51)
NOT	54.2%	60.8%
MODERATE	36.3%	23.5%
SOMEWHAT	7.4%	15.7%
VERY	2.1%	0%

Pearson Chi Square= 6.389; p= .044

RESIDENTS RESPONDING BY THEIR HEALTH TO NIGHT LIFE
N=240

IMPORTANT	GOOD (N=188)	POOR (N=52)
NOT	53.7%	63.5%
MODERATE	35.1%	28.8%
SOMEWHAT	10.1%	3.8%
VERY	1.1%	3.8%

Pearson Chi Square= 4.881; p= .181

Expressive: History

RESIDENTS RESPONDING TO HISTORY

	TOTAL RESIDENTS N=241			COMMUNITY A N=113	COMMUNITY B N=128
IMPORTANT	FREQUENCY	PERCENT		PERCENT	PERCENT
NOT	59	24.65%		27.4%	21.9%
MODERATE	69	28.15%		20.4%	35.9%
SOMEWHAT	59	24.4%		23.0%	25.8%
VERY	54	22.8%		29.2%	16.4%
MISSING	13			6	7

RESIDENTS RESPONDING BY GENDER TO HISTORY
N=241

IMPORTANT	MALES (N=86)	FEMALES (N=155)
NOT	26.7%	23.2%
MODERATE	33.7%	25.8%
SOMEWHAT	24.4%	24.5%
VERY	15.1%	26.5%

Pearson Chi Square= 4.662; p= .198

RESIDENTS RESPONDING BY SCHOOLING TO HISTORY
N=233

IMPORTANT	AA DEGREE and BELOW (N=75)	BS DEGREE and ABOVE (N=158)
NOT	25.3%	22.8%
MODERATE	29.3%	29.7%
SOMEWHAT	24.0%	25.3%
VERY	21.3%	22.2%

Pearson Chi Square= .194; p= .979

RESIDENTS RESPONDING BY MARITAL STATUS TO HISTORY
N=241

IMPORTANT	SINGLE (N=190)	MARRIED (N=51)
NOT	23.7%	27.5%
MODERATE	32.1%	15.7%
SOMEWHAT	22.1%	33.3%
VERY	22.1%	23.5%

Pearson Chi Square= 6.126; p= .106

RESIDENTS RESPONDING BY THEIR HEALTH TO HISTORY
N=241

IMPORTANT	GOOD (N=189)	POOR (N=52)
NOT	24.3%	26.9%
MODERATE	29.1%	26.9%
SOMEWHAT	22.8%	30.8%
VERY	23.8%	17.3%

Pearson Chi Square= 1.915; p= .590

Influencing: Opinions

RESIDENTS RESPONDING TO OPINIONS

	TOTAL RESIDENTS N=246			COMMUNITY A N=115	COMMUNITY B N=131
IMPORTANT	FREQUENCY	PERCENT		PERCENT	PERCENT
NOT	57	23.05%		20.9%	25.2%
MODERATE	76	30.45%		24.3%	36.6%
SOMEWHAT	70	28.85%		34.8%	22.9%
VERY	43	17.65%		20.0%	15.3%
MISSING	8			4	4

RESIDENTS RESPONDING BY GENDER TO OPINIONS
N=246

IMPORTANT	MALES (N=87)	FEMALES (N=159)
NOT	26.7%	20.8%
MODERATE	31.0%	30.8%
SOMEWHAT	27.6%	28.9%
VERY	13.8%	19.5%

Pearson Chi Square= 2.216; p= .529

RESIDENTS RESPONDING BY SCHOOLING TO OPINIONS
N=239

IMPORTANT	AA DEGREE and BELOW (N=78)	BS DEGREE and ABOVE (N=161)
NOT	26.9%	20.0%
MODERATE	34.6%	29.8%
SOMEWHAT	23.1%	31.7%
VERY	15.4%	18.0%

Pearson Chi Square= 2.908; p= .407

RESIDENTS RESPONDING BY MARITAL STATUS TO OPINIONS
N=246

IMPORTANT	SINGLE (N=195)	MARRIED (N=51)
NOT	23.1%	23.5%
MODERATE	31.8%	27.5%
SOMEWHAT	28.7%	27.5%
VERY	16.4%	21.6%

Pearson Chi Square= .889; p= .828

RESIDENTS RESPONDING BY THEIR HEALTH TO OPINIONS
N=245

IMPORTANT	GOOD (N=192)	POOR (N=53)
NOT	23.4%	22.6%
MODERATE	28.1%	41.5%
SOMEWHAT	27.6%	30.2%
VERY	20.8%	5.7%

Pearson Chi Square= 7.957; p= -.047
Kendall's tau-b= -.094; p= .074

Influencing: Issues

RESIDENTS RESPONDING TO ISSUES

	TOTAL RESIDENTS N=245			COMMUNITY A N=112	COMMUNITY B N=133
IMPORTANT	FREQUENCY	PERCENT		PERCENT	PERCENT
NOT	53	21.75%		23.2%	20.3%
MODERATE	74	29.7%		24.1%	35.3%
SOMEWHAT	77	31.85%		36.6%	27.1%
VERY	41	16.7%		16.1%	17.3%
MISSING	9			7	2

RESIDENTS RESPONDING BY GENDER TO ISSUES
N=245

IMPORTANT	MALES (N=87)	FEMALES (N=158)
NOT	20.7%	22.2%
MODERATE	34.5%	27.8%
SOMEWHAT	29.9%	32.3%
VERY	14.9%	17.7%

Pearson Chi Square= 1.234; p= .745

RESIDENTS RESPONDING BY SCHOOLING TO ISSUES
N=238

IMPORTANT	AA DEGREE and BELOW (N=77)	BS DEGREE and ABOVE (N=161)
NOT	28.6%	18.6%
MODERATE	29.9%	31.1%
SOMEWHAT	28.6%	32.3%
VERY	13.0%	18.0%

Pearson Chi Square= 3.414; p= .332

RESIDENTS RESPONDING BY MARITAL STATUS TO ISSUES
N=245

IMPORTANT	SINGLE (N=194)	MARRIED (N=51)
NOT	21.1%	23.5%
MODERATE	32.5%	21.6%
SOMEWHAT	30.4%	35.3%
VERY	16.0%	19.6%

Pearson Chi Square= 2.321; p= .508

RESIDENTS RESPONDING BY THEIR HEALTH TO ISSUES
N=244

IMPORTANT	GOOD (N=192)	POOR (N=52)
NOT	21.4%	23.1%
MODERATE	30.2%	30.8%
SOMEWHAT	29.7%	38.5%
VERY	18.8%	7.7%

Pearson Chi Square= 4.110; p= 2.50

Influencing: Point Across

RESIDENTS RESPONDING TO GETTING POINT ACROSS

	TOTAL RESIDENTS N=243			COMMUNITY A N=114	COMMUNITY B N=129
IMPORTANT	FREQUENCY	PERCENT		PERCENT	PERCENT
NOT	62	25.6%		27.2%	24.0%
MODERATE	78	31.7%		25.4%	38.0%
SOMEWHAT	69	28.75%		34.2%	23.3%
VERY	34	13.95%		13.2%	14.7%
MISSING	11			5	6

RESIDENTS RESPONDING BY GENDER TO GETTING POINT ACROSS
N=243

IMPORTANT	MALES (N=84)	FEMALES (N=159)
NOT	28.6%	23.9%
MODERATE	29.8%	33.3%
SOMEWHAT	32.1%	26.4%
VERY	9.5%	16.4%

Pearson Chi Square= 3.155; p= .368

RESIDENTS RESPONDING BY SCHOOLING TO GETTING POINT ACROSS
N=236

IMPORTANT	AA DEGREE and BELOW (N=78)	BS DEGREE and ABOVE (N=158)
NOT	29.5%	22.8%
MODERATE	35.9%	31.0%
SOMEWHAT	24.4%	31.0%
VERY	10.3%	15.2%

Pearson Chi Square= 3.060; p= .382

RESIDENTS RESPONDING BY MARITAL STATUS TO GETTING POINT ACROSS
N=243

IMPORTANT	SINGLE (N=194)	MARRIED (N=49)
NOT	23.7%	32.7%
MODERATE	34.0%	24.5%
SOMEWHAT	28.9%	26.5%
VERY	13.4%	16.3%

Pearson Chi Square= 2.647; p= .449

RESIDENTS RESPONDING BY THEIR HEALTH TO GETTING POINT ACROSS
N=243

IMPORTANT	GOOD (N=189)	POOR (N=54)
NOT	24.9%	27.8%
MODERATE	32.3%	31.5%
SOMEWHAT	29.1%	25.9%
VERY	13.8%	14.8%

Pearson Chi Square= .330; p= .954

Contributing: Assisting Others

RESIDENTS RESPONDING TO ASSISTING OTHERS

	TOTAL RESIDENTS N=245			COMMUNITY A N=116	COMMUNITY B N=129
IMPORTANT	FREQUENCY	PERCENT		PERCENT	PERCENT
NOT	74	30.0%		26.7%	33.3%
MODERATE	62	25.0%		19.8%	30.2%
SOMEWHAT	63	25.8%		27.6%	24.0%
VERY	46	19.15%		25.9%	12.4%
MISSING	9			3	6

RESIDENTS RESPONDING BY GENDER TO ASSISTING OTHERS
N=245

IMPORTANT	MALES (N=86)	FEMALES (N=159)
NOT	33.7%	28.3%
MODERATE	31.4%	22.0%
SOMEWHAT	20.9%	28.3%
VERY	14.0%	21.4%

Pearson Chi Square= 5.305; p= .151

RESIDENTS RESPONDING BY SCHOOLING TO ASSISTING OTHERS
N=238

IMPORTANT	AA DEGREE and BELOW (N=78)	BS DEGREE and ABOVE (N=160)
NOT	33.3%	28.8%
MODERATE	21.8%	26.9%
SOMEWHAT	23.1%	27.5%
VERY	21.8%	16.9%

Pearson Chi Square= 1.981; p= .576

RESIDENTS RESPONDING BY MARITAL STATUS TO ASSISTING OTHERS
N=245

IMPORTANT	SINGLE (N=196)	MARRIED (N=49)
NOT	30.6%	28.6%
MODERATE	27.6%	16.3%
SOMEWHAT	26.0%	24.5%
VERY	15.8%	30.6%

Pearson Chi Square= 6.612; p= .085

RESIDENTS RESPONDING BY THEIR HEALTH TO ASSISTING OTHERS
N=244

IMPORTANT	GOOD (N=190)	POOR (N=54)
NOT	30.0%	31.5%
MODERATE	26.8%	20.4%
SOMEWHAT	25.3%	27.8%
VERY	17.9%	20.4%

Pearson Chi Square= .966; p= .809

Contributing: First Aid

RESIDENTS RESPONDING TO FIRST AID

	TOTAL RESIDENTS N=243			COMMUNITY A N=114	COMMUNITY B N=129
IMPORTANT	FREQUENCY	PERCENT		PERCENT	PERCENT
NOT	110	45.0%		41.2%	48.8%
MODERATE	86	35.45%		36.8%	34.1%
SOMEWHAT	33	13.6%		13.2%	14.0%
VERY	14	5.95%		8.8%	3.1%
MISSING	11			5	6

RESIDENTS RESPONDING BY GENDER TO FIRST AID
N=243

IMPORTANT	MALES (N=84)	FEMALES (N=159)
NOT	46.4%	44.7%
MODERATE	35.7%	35.2%
SOMEWHAT	14.3%	13.2%
VERY	3.6%	6.9%

Pearson Chi Square= 1.158; p= .763

RESIDENTS RESPONDING BY SCHOOLING TO FIRST AID
N=236

IMPORTANT	AA DEGREE and BELOW (N=79)	BS DEGREE and ABOVE (N=157)
NOT	48.1%	45.2%
MODERATE	30.4%	36.9%
SOMEWHAT	15.2%	12.7%
VERY	6.3%	5.1%

Pearson Chi Square= 1.124; p= .771

RESIDENTS RESPONDING BY MARITAL STATUS TO FIRST AID
N=243

IMPORTANT	SINGLE (N=194)	MARRIED (N=49)
NOT	46.9%	38.8%
MODERATE	38.1%	24.5%
SOMEWHAT	9.8%	28.6%
VERY	5.2%	8.2%

Pearson Chi Square= 13.404; df= 3, p= .004
Kendall's tau-b= .126; p= .057

RESIDENTS RESPONDING BY THEIR HEALTH TO FIRST AID
N=242

IMPORTANT	GOOD (N=188)	POOR (N=54)
NOT	43.1%	53.7%
MODERATE	39.4%	22.2%
SOMEWHAT	11.7%	20.4%
VERY	5.9%	3.7%

Pearson Chi Square= 7.180; p= .066

Contributing: Experience

RESIDENTS RESPONDING TO EXPERIENCE

IMPORTANT	TOTAL RESIDENTS N=245 FREQUENCY	PERCENT		COMMUNITY A N=114 PERCENT	COMMUNITY B N=131 PERCENT
NOT	47	19.2%		19.3%	19.1%
MODERATE	76	30.5%		22.8%	38.2%
SOMEWHAT	79	32.35%		34.2%	30.5%
VERY	43	17.95%		23.7%	12.2%
MISSING	9			5	4

RESIDENTS RESPONDING BY GENDER TO EXPERIENCE
N=245

IMPORTANT	MALES (N=88)	FEMALES (N=157)
NOT	25.0%	15.9%
MODERATE	33.0%	29.9%
SOMEWHAT	23.9%	36.9%
VERY	18.2%	17.2%

Pearson Chi Square= 5.610; p= .132

RESIDENTS RESPONDING BY SCHOOLING TO EXPERIENCE
N=237

IMPORTANT	AA DEGREE and BELOW (N=77)	BS DEGREE and ABOVE (N=160)
NOT	23.4%	17.5%
MODERATE	33.8%	30.6%
SOMEWHAT	22.1%	36.3%
VERY	20.8%	15.6%

Pearson Chi Square= 5.185; p= .159

RESIDENTS RESPONDING BY MARITAL STATUS TO EXPERIENCE
N=245

IMPORTANT	SINGLE (N=194)	MARRIED (N=51)
NOT	18.6%	21.6%
MODERATE	31.4%	29.4%
SOMEWHAT	34.0%	25.5%
VERY	16.0%	23.5%

Pearson Chi Square= 2.468; p= .481

RESIDENTS RESPONDING BY THEIR HEALTH TO EXPERIENCE
N=244

IMPORTANT	GOOD (N=191)	POOR (N=53)
NOT	16.2%	30.2%
MODERATE	31.9%	28.3%
SOMEWHAT	31.9%	34.0%
VERY	19.9%	7.5%

Pearson Chi Square= 8.100; p= .044
Kendall's tau-b= -.134; p= .020

Transcendence: Religion

RESIDENTS RESPONDING TO RELIGION

	TOTAL RESIDENTS N=243			COMMUNITY A N=112	COMMUNITY B N=131
IMPORTANT	FREQUENCY	PERCENT		PERCENT	PERCENT
NOT	47	20.1%		29.5%	10.7%
MODERATE	55	22.65%		23.2%	22.1%
SOMEWHAT	80	32.05%		21.4%	42.7%
VERY	61	25.15%		25.9%	24.4%
MISSING	11			7	4

RESIDENTS RESPONDING BY GENDER TO RELIGION
N=243

IMPORTANT	MALES (N=86)	FEMALES (N=157)
NOT	19.8%	19.1%
MODERATE	23.3%	22.3%
SOMEWHAT	34.9%	31.8%
VERY	22.1%	26.8%

Pearson Chi Square= .671; p= .880

RESIDENTS RESPONDING BY SCHOOLING TO RELIGION
N=235

IMPORTANT	AA DEGREE and BELOW (N=77)	BS DEGREE and ABOVE (N=158)
NOT	22.1%	19.0%
MODERATE	18.2%	24.7%
SOMEWHAT	35.1%	32.3%
VERY	24.7%	24.1%

Pearson Chi Square= 1.347; p= .718

RESIDENTS RESPONDING BY MARITAL STATUS TO RELIGION
N=243

IMPORTANT	SINGLE (N=192)	MARRIED (N=51)
NOT	20.8%	13.7%
MODERATE	23.48%	19.6%
SOMEWHAT	32.3%	35.3%
VERY	23.4%	31.4%

Pearson Chi Square= 2.435; p= .478

RESIDENTS RESPONDING BY THEIR HEALTH TO RELIGION
N=242

IMPORTANT	GOOD (N=189)	POOR (N=53)
NOT	17.5%	26.4%
MODERATE	21.2%	26.4%
SOMEWHAT	34.9%	26.4%
VERY	26.5%	20.8%

Pearson Chi Square= 3.660; p= .301

Transcendence: Legacy

RESIDENTS RESPONDING TO LEGACY

	TOTAL RESIDENTS N=246			COMMUNITY A N=114	COMMUNITY B N=132
IMPORTANT	FREQUENCY	PERCENT		PERCENT	PERCENT
NOT	28	11.75%		16.7%	6.8%
MODERATE	40	16.4%		18.4%	14.4%
SOMEWHAT	103	41.5%		36.0%	47.0%
VERY	75	30.35%		28.9%	31.8%
MISSING	8			5	3

RESIDENTS RESPONDING BY GENDER TO LEGACY
N=246

IMPORTANT	MALES (N=86)	FEMALES (N=160)
NOT	18.6%	7.5%
MODERATE	17.4%	15.6%
SOMEWHAT	40.7%	42.5%
VERY	23.3%	34.4%

Pearson Chi Square= 8.485; df= 3, p= .037
Kendall's tau-b= .151; p= -.011

RESIDENTS RESPONDING BY SCHOOLING TO LEGACY
N=238

IMPORTANT	AA DEGREE and BELOW (N=78)	BS DEGREE and ABOVE (N=160)
NOT	9.0%	12.5%
MODERATE	17.9%	15.6%
SOMEWHAT	46.2%	39.4%
VERY	26.9%	32.5%

Pearson Chi Square= 1.858; p= .602

RESIDENTS RESPONDING BY MARITAL STATUS TO LEGACY
N=246

IMPORTANT	SINGLE (N=195)	MARRIED (N=51)
NOT	11.8%	9.8%
MODERATE	15.9%	17.6%
SOMEWHAT	43.1%	37.3%
VERY	29.2%	35.3%

Pearson Chi Square= 1.032; p= .794

RESIDENTS RESPONDING BY THEIR HEALTH TO LEGACY
N=245

IMPORTANT	GOOD (N=190)	POOR (N=55)
NOT	10.5%	14.5%
MODERATE	12.6%	29.1%
SOMEWHAT	42.6%	38.2%
VERY	34.2%	18.2%

Pearson Chi Square= 11.463; df= 3, p= .009
Kendall's tau-b= -.174; p= .003

Transcendence: Wisdom

RESIDENTS RESPONDING TO WISDOM

	TOTAL RESIDENTS N=247			COMMUNITY A N=115	COMMUNITY B N=132
IMPORTANT	FREQUENCY	PERCENT		PERCENT	PERCENT
NOT	37	15.55%		23.5%	7.6%
MODERATE	55	22.75%		29.6%	15.9%
SOMEWHAT	89	35.5%		27.8%	43.2%
VERY	66	26.2%		19.1%	33.3%
MISSING	7			4	3

RESIDENTS RESPONDING BY GENDER TO WISDOM
N=247

IMPORTANT	MALES (N=86)	FEMALES (N=161)
NOT	17.4%	13.7%
MODERATE	23.3%	21.7%
SOMEWHAT	38.4%	34.8%
VERY	20.9%	29.8%

Pearson Chi Square= 2.448; p= .485

RESIDENTS RESPONDING BY SCHOOLING TO WISDOM
N=240

IMPORTANT	AA DEGREE and BELOW (N=70)	BS DEGREE and ABOVE (N=161)
NOT	15.2%	14.3%
MODERATE	21.5%	21.7%
SOMEWHAT	41.8%	33.5%
VERY	21.5%	30.4%

Pearson Chi Square= 2.553; p= .466

RESIDENTS RESPONDING BY MARITAL STATUS TO WISDOM
N=2476

IMPORTANT	SINGLE (N=197)	MARRIED (N=50)
NOT	12.7%	24.0%
MODERATE	23.4%	18.0%
SOMEWHAT	35.5%	38.0%
VERY	28.4%	20.0%

Pearson Chi Square= 5.045; p= .169

RESIDENTS RESPONDING BY THEIR HEALTH TO WISDOM
N=247

IMPORTANT	GOOD (N=193)	POOR (N=54)
NOT	28.9%	8.1%
MODERATE	43.0%	12.0%
SOMEWHAT	69.5%	19.5%
VERY	52.6%	14.4%

Pearson Chi Square= 20.505; df= 3, p= .000
Kendall's tau-b= -.257; p= .000

VITA

Florence I. Smoczynski was born in Mt. Vernon, New York, and received her Bachelor of Science in Nursing Degree from Villanova University, Villanova, Pennsylvania. She received a Master of Science in Nursing Degree from The Catholic University of America in Washington, D.C.

Her professional experience includes six years of clinical experience, three years of health care administration, and twenty-seven years as a nursing educator. After graduating from Villanova University, she entered the U.S. Navy Nurse Corps for three years. She taught at Our Lady of Lourdes School of Nursing in Camden, New Jersey, and Marymount University in Arlington, Virginia.

For the past twenty years, she has been adjunct faculty at George Mason University, College of Nursing and Health Science, and the same time was on the faculty at Northern Virginia Community College for five years. She has been a Director of Nursing for a large nursing home in Arlington, Virginia.

She has been a member of the American Nurses Association and the Virginia Nurses Association for the past twenty-five years, the American Association of Adult and Continuing Education for twelve years, and the National Council on Aging for five years. She is a charter member of Sigma Theta Tau, Eta Alpha, the national honor society of nursing, and Phi Delta Kappa, a professional fraternity in education. She has received the Distinguished Service Award from the Virginia Nurses Association and the Alumni Medal for Outstanding Service from Villanova University. She was in Who's Who in American Nursing in 1990.