Journal of Counseling Psychology
1988, Vol. 35, No. 1, 81-86

0022-0167/88/$00.75

Efficacy of Elderly and Adolescent Volunteer Counselors in a Nursing Home Setting

Joseph Nagel
Family Guidance Services of Orange
Orange, Virginia

Peter Cimbolic
Catholic University

Margie Newlin
University of Virginia

Reliance on the use of volunteers and lay paraprofessionals in human services delivery has increased with the rising demand and shortage of professional providers. We examined the effects of a volunteer training program on depression levels of nursing home residents. The Zung Self-Rating Depression Scale (SDS) was used to identify 60 moderately depressed residents. A total of 20 volunteer counselors (10 elderly, 10 adolescent) were trained in empathic listening, and 20 volunteer counselors (10 elderly, 10 adolescent) were only given information regarding the aging process. Counselors and nursing home residents met twice a week for 5 weeks. Zung SDS posttest results showed that residents who received a volunteer counselor significantly improved ($p < .01$) in level of depression, compared with a no-volunteer control group. The empathy-trained counselors were not significantly more effective than the group given information only. Age of volunteer counselors was found not to be a significant variable.

Whether the reasons be (a) resistance of older people to seek help and of therapists to provide it, (b) limitations of trained personnel and available programs, or (c) financial and transportation problems, it is evident that older people receive a disproportionately small share of psychotherapeutic services. Despite the tremendous growth of mental health services, older people seem to have been largely overlooked by the system (Kahn, 1975). This is unfortunate because it has been demonstrated that older individuals can unquestionably benefit from therapeutic encounters that encourage them to mobilize their inner resources and regain a sense of belonging (Knight, 1978/1979; Willner, 1978; Yesavage & Karasu, 1982).

Meeting the growing needs of the elderly can be attempted by either increasing the number of mental health personnel or changing the traditional manner of psychotherapeutic intervention. A growing trend has been to use nonprofessionals, trained and supervised by professionals, as psychotherapeutic agents, in order to contain cost. In this way, larger numbers of people in need may be reached in a more efficient and cost effective manner (Christensen, Miller, & Munoz, 1978). The efficacy of this approach and results of treatment outcome have been reviewed by several investigators (Balch & Solomon, 1976; Brown, 1974; Karlsruher, 1974). Although they were critical of various methodological flaws, they concluded that the evidence generally supports the view that nonprofessional personnel can function as effective counselors and contribute to client improvement (Brown, 1974).

Only recently have investigators turned their focus to elderly persons as both providers and recipients of paraprofessional counseling. Much of the reported work is methodologically flawed and unsystematic, but, nevertheless, it offers a foundation from which to hypothesize. Several projects have been reported that substantiate (a) the important role the elderly can play in extending services to those who need them and (b) the beneficial return this may have on the provider (Arch, 1978; Hirschowitz, 1973; Matefy, 1978).

The seemingly obvious place to explore the potential usefulness of elderly paraprofessionals is with other, less well-adjusted, older people. Surprisingly, only a few such projects have been undertaken, although the results reported have been positive. Elderly persons' capacity to learn effective communication skills and empathic responding was demonstrated by Becker and Zarit (1978) and Isquick (1981). Compared with no-treatment control subjects, the seniors who participated in the skills training programs significantly improved in the therapeutic core conditions of empathy and warmth (Truax & Mitchell, 1971) and manifested these at levels sufficient for therapeutic effectiveness.

Waters, Fink, and White (1976) developed a peer counseling program that trained the elderly volunteers to lead personal growth groups. Following the Carkhuff (1972) model, trainers were taught, among other things, the principles of nonverbal communication, attending to content and feelings, and reflective listening, and a successful treatment outcome was reported.

Researchers agree that elderly people are able to learn facilitative skills and use them effectively with their peers. Substantial improvement in self-esteem and self-understanding and in establishing warm relationships with others was reported for both clients and peer helpers. In addition, Bond (1982) found volunteerism to be positively correlated with life satisfaction among the elderly.

Adolescents may be another source of potential helpers that has been ignored. Can adolescent volunteers function as facilitative agents to the elderly? Reviews of relevant studies—

Correspondence concerning this article should be addressed to Joseph Nagel, Family Guidance Services of Orange, 358 Madison Road, Orange, Virginia 22960.

again, studies poorly controlled and methodologically flawed (Scott & Warner, 1974)—suggest that adolescents possess such potential (Anderson, 1976). The underlying principle that provides the rationale for using nonprofessional personnel is that many lay people possess some of the personal characteristics necessary for effective counseling. The consensus of those who have worked with adolescents in this regard is that they satisfy the core conditions (Rogers, 1957, 1975) and can translate them into practice. Common practice has been to train and supervise adolescents to work with peers. However, there is no reason to expect that they could not be equally helpful to the elderly. Simply stated, establishment of a facilitative relationship based on genuine concern, warmth, and empathic understanding is fundamentally therapeutic across chronological barriers.

Investigators agree that, by far, the most common psychiatric conditions encountered in old age are affective disorders, especially depression (Fassler & Gaviria, 1978; Hale, 1982). This appears to be equally true of the elderly in psychiatric facilities and those in the community at large (Blazer, 1982; Feigenbaum, 1970). The relation between depression and advancing years has been demonstrated in numerous surveys (Brink, 1977). Most notably observed by those who work with the elderly is a pervasive and persistent theme of loss (Brink, 1979), as well as cognitive attributions of hopelessness (Fry, 1984).

Depressive symptomatology found in the elderly may largely resemble that observed in the general adult population. Symptoms can vary from mild to severe, and include feelings of hopelessness, anxiety, self-deprecation, and hypochondriacal preoccupations, at one end of the spectrum, and severe obsessive ideation, feelings of depersonalization, nihilistic delusions, and suicidal ideations at the other end of the spectrum. Physiological concomitants include disturbances in bodily cycles, such as sleep, appetite, bowel functions, and diurnal mood shifts. There are also associated behavioral disturbances, and depression may be manifested by isolation, withdrawal, or apathy, or by compulsive, agitated, or hostile behavior (Brink, 1977; Hirschfeld & Klerman, 1979).

The process of diagnosis entails ruling out true dementia, as well as distinguishing the presence of depression among a host of somatic complaints. The assessment instruments used in this study were chosen for their efficacy in this regard.

We attempted to assess the effectiveness of elderly and adolescent volunteers comparably trained in helping skills in working with elderly clients. The counselor skill selected for training was *empathy*. Considerable debate centering around the construct of empathy and its measurement has prevailed for some time (Barret-Lennard, 1981; Gladstein, 1977, 1983). However, there is substantial evidence establishing its significance in therapy (Patterson, 1984) and its construct validity (Conklin & Hunt, 1975). The dependent measure of interest in this study was *depression in the elderly*. This was selected primarily because of its reported prevalence in the elderly population and because reliable and valid assessment instruments are currently available.

The hypotheses being tested in this study are as follows:

1. Depressed patients who receive volunteer counseling will improve in level of depression compared with depressed patients who do not have a volunteer counselor.
2. Elderly and adolescent volunteers will be equally effective.
3. Volunteers trained in empathic listening skills will be more effective than will attention–placebo volunteer counselors.

Method

Subjects

Subjects were 60 nursing home residents (44 women, 16 men); 20 subjects were in each of two treatment groups, and 20 subjects were in a no-treatment control group. Subjects ranged from 64 to 86 years of age, with a mean of 74 years. Patients' names were provided by nursing home staff familiar with the diagnostic criteria and were screened and evaluated to determine their appropriateness for inclusion in the study. Each resident was given the Mental Status Questionnaire (MSQ) and the Simultaneous Bilateral Physical Stimulation Test as measures of organic brain syndrome (Yesavage, 1979). Patients whose score on these measures fell in the moderate to severe range of neurological impairment were eliminated from further investigation. In addition, residents presenting with overt psychotic symptomatology (i.e., presence of hallucinations, delusions, or manifest thought disorder) were ruled out and referred for more appropriate interventions. Eligible patients were then given the Zung Self-Rating Depression Scale (SDS; Zung, 1965) to measure their level of depression. Subjects whose SDS raw score fell in the 40 to 61 range were included in the study, inasmuch as this range represents mild to moderate depression (Zung, 1967). Subjects whose SDS raw score was 62 or greater (severe to most extremely depressed) were referred to mental health staff for further treatment. Eligible nursing home residents were asked to participate in a mental health program. Those in the treatment groups agreed to meet with a volunteer "companion." The no-treatment control group agreed to participate in an "evaluation" program for research purposes.

Resident social interaction in a small rural nursing home is frequent. Therefore, the danger of confounding results vis-à-vis differential contact with community volunteers presented a problem. Consequently, the no-treatment control patients were selected from a different nursing home than those who were assigned a volunteer. This facility served residents of similar demographic background as those in the treatment conditions. The original program format called for all of the eligible patients to be served in one nursing home by volunteers from one county. Unfortunately, low volunteer turnout necessitated that an alternate site be found to reach criteria. Table 1 shows the proportion of nursing home patients who were screened and their disposition in terms of qualifying for inclusion in the study.

Volunteer Counselors

Volunteer counselors were recruited from each of two populations. The adolescent group ($n = 20$) was composed of 11 male adolescents

Table 1
Outcome of Screening Procedures in Three Nursing Homes

Nursing home	No. beds	No. of patients			
		Screened	Qualified	Failed MSQ	Not depressed
1	120	79	34	26	19
2	32	10	6	3	1
3	150	30	20	3	7

Note. Subject qualifies if Mental Status Questionnaire (MSQ) is passed and Zung Self-Rating Depression Scale raw score ≥ 40 ≤ 62.

and 9 female adolescents, whose ages ranged from 14 to 18 years (M age = 15.0 years). They were local middle and high school students who were generally either in an educational tract designed for the helping professions (e.g., nurses' aides) or college bound. The older volunteers (n = 20) were 18 women and 2 men, recruited generally, from senior citizen organizations. Their ages ranged from 60 to 74 years (M = 67.1 years), and the majority had some high school education (M = 10.4 years). Although many of the volunteers had previous experience doing volunteer work, none had any previous specialized training in counseling or communication skills. Promotional methods to gain volunteer interest included local radio and newspaper announcements and presentations in local schools, churches, youth groups, adult service organizations (e.g., Rotary Club), senior organizations, and senior nutrition sites.

Procedure

Volunteer training conditions. Volunteer counselors were assigned to one of two conditions. A counseling skills training group consisted of 10 older volunteers (OS group) and 10 younger (YS group) volunteers. A second group of 10 older (OE) and 10 younger (YE) volunteers participated in educational seminars on the issues of the elderly. This group was designed to function as a credible placebo control group. Trainers were mental health clinic staff randomly assigned to one of the training conditions.

Counseling skills training group. The OS and YS volunteers participated in a 2-day workshop held on consecutive Saturdays, for 6 hr each day. The training program was adapted from *Gerontology Practitioner Training Manual: Communication Skills in the Gerontological Environment* (Greenberg, Fatula, Hameister, & Hickey, 1976), a program modeled on Carkhuff's (1969) curriculum for lay counselors designed for the geriatric population. Two components were stressed: One involved the learning and practicing of the counseling skills defined as *accurate empathy*; the other stressed the basic process of aging, to free the counselors from stereotypic and mythical thinking about the behavior and needs of older persons. The program was designed to provide both didactic and experiential learning in the fundamental components of facilitative human relations. Particular emphasis was placed on effectively communicating empathy toward others. The training paradigm primarily consisted of triad and dyad exercises specifically designed to teach reflective listening and its derivatives.

Education on aging group. The other 20 volunteers also participated in Saturday workshops for a comparable period of time. These workshops, however, kept their focus almost entirely on the process of dispelling the myths and stereotypes about the elderly. Didactic material on the aging process, effects of loss, and the special needs associated with growing old were examined. Group discussions centered around values clarification and expression of feelings generated by their own experiences with growing older. Written material and film presentations reinforcing the dignity and potential of the aged were presented and discussed. These group discussions and didactic materials were designed to impart an accurate understanding of the difficulties associated with growing old. Also, they allowed participants to become more aware of their own values and attitudes regarding the elderly. They did not, however, involve direct training or practice in the communication of empathic responses and other counseling skills. Apart from the modeling inevitably presented by the trainers themselves, no specific experience in empathic responding was provided.

Recruitment. The names of 30 adolescents and 20 senior citizens were randomly assigned to each of the two training conditions, prior to the start of the first volunteer workshop. On the day of the first session, 7 of the 15 adolescents and 6 of the 10 seniors appeared; only 2 adolescents and 4 senior volunteers completed the program. Subsequent attempts at retaining volunteers proved equally disappointing. The high attrition rate forced a departure from the original design: Rather than the planned procedure of running two large workshops, each composed of 10 younger and 10 older randomly assigned volunteers, a series of small workshops were run until the criterion number of younger and older volunteers was attained. Thus, a total of five workshops (2 skills, 3 education) were presented.

Empathy pretest. Prior to the workshops, a pretest of counselor's level of empathic skills was administered. Two videotapes were made, showing, respectively, a 65-year-old woman and a 17-year-old female adolescent, who each read five statements that were high in affective content. Videotaped instructions directed the subjects to respond to each statement on the tape as they would to a client. One half of the subjects in each group viewed the older woman's tape before training and the younger client's tape after the 2-day workshop. The order of the tapes was reversed for the other subjects. No time limit was required in responding, and the responses were tape recorded. The tapes were then blind-rated by two mental health therapists who had been trained in the rating of the therapeutic conditions of the Carkhuff Scale for Empathic Understanding in Interpersonal Processes (Carkhuff, 1969). This scale has five levels, of which the third level is regarded as the minimum necessary for a therapeutic encounter.

Empathy posttest. After completion of each workshop, all of the participants were again rated on the Carkhuff empathy scale. Subjects were then randomly assigned to their nursing home resident counselee.

To ensure that both older and younger counseling skill-trained subjects were equally proficient using communication skills, a minimum criterion level of empathic responding (3.0) was imposed.

Treatment period. Having reached their respective criteria, counselors from both the skills training and education groups met with their nursing home resident for 1 hr, two times per week, for 5 weeks. Education group counselors spent this time period engaged in various recreational and social activities with their counselee and generally maintained a companionship role. The skill-trained counselors endeavored to use their communication skills to facilitate expression of emotional concerns by their clients and to establish a therapeutic alliance.

In addition, all "counselors" attended a group supervision session for 1 hr per week. Education group supervision sessions were structured to reinforce didactic material and to allow discussion of reactions to their counseling experiences. These groups were designed primarily to foster group cohesiveness and a mutually reinforcing support system.

The weekly supervision sessions attended by the skills-training group focused primarily on continued training in facilitative responding. Role-play exercises, derived from experiences encountered with their counselee, reinforced their learning. Group members were also encouraged to express their own feelings regarding their experiences and to function as a support group.

Treatment outcome. After the 5-week counseling period for both the treatment group and education-only group, the nursing home residents were posttested using the Zung SDS. The no-treatment control group was simply retested after 5 weeks without intervention beyond their regularly delivered services. Pretest and posttest protocols were administered by the same mental health professionals who knew the subject's treatment condition (volunteer vs. no-volunteer). The Zung (1965) SDS is a self-report instrument, and all efforts were made to reduce the influence of experimenter bias effects.

Results

Given the numerous logistical problems in the implementation of this program, a series of test analyses were performed to determine whether the assumptions of comparability be-

tween volunteer counselor conditions or between nursing home resident conditions were violated. Furthermore, a workshop rating form was completed by every volunteer at the end of each training session, asking them to rate their level of interest, as well as the quality and degree of applicability of material learned. All of these analyses showed no differences between groups and are available on request from the first author. Hence, it was possible to combine subject depression scores and counselor empathy responses for statistical analysis.

Tests of interrater reliability of empathic responses resulted in a Pearson r of .84 for pretest and .93 for posttest of all of the volunteers ($N = 40$, $p < .001$). To test for differences in empathy among the various age and training variables, a 2 × 2 × 2 (Adolescent vs. Older × Education vs. Skills × Pretest vs. Posttest) split-plot analysis of variance (ANOVA) with repeated measures was performed. There were no differences between the four groups at pretest, $F(3, 36) = 0.76$, $p > .05$. Significant main effects were found for training, $F(1, 36) = 9.35$, $p < .004$, and time, $F(1, 36) = 110.95$, $p < .001$, but the age variable was found not to be significant, $F(1, 36) = 0.35$, $p > .05$. Furthermore, a significant Training × Time interaction was found, $F(1, 36) = 70.05$, $p < .001$. That is, the empathy posttest scores for both the adolescent and older skills group conditions were significantly higher than were the posttest scores of the education-only group (see Table 2).

The main conclusion to be drawn from these analyses was that, as anticipated, the empathy training did have the desired outcome on the counselor trainees. Namely, it demonstrated that this training was equally suited to both the adolescent and senior volunteer groups.

Treatment Outcome

A 3 × 2 split-plot ANOVA with repeated measures was performed using the pre- and posttest measures of the Zung (1965) SDS. This analysis found significant main effects for type of training, $F(2, 57) = 5.33$, $p < .01$, and time, $F(1, 57) = 38.7$, $p < .001$, and a significant Training × Time interaction, $F(2, 57) = 5.61$, $p < .01$.

A series of comparison tests were then conducted that analyzed the nature and direction of significance of the various treatment conditions. A total of nine tests were performed. Although they may be evaluated for significance at the nominal alpha level (one-tailed), in order to control for inflation of alpha, one takes .05/9 = .0055 as the significance level for the family of tests. Table 3 presents the various comparisons and their outcomes.

This body of tests indicates that residents who were seen by volunteer counselors from both the skills group and the education group improved on depression scores from pretest to posttest. This was not true for the no-treatment control group.

None of the groups differed at pretest. At posttest, the empathy-trained counselor's group and the education group both differed from the control group significantly. However, these two groups did not differ significantly from one another at posttest.

A 2 × 2 × 2 (Adolescent vs. Elderly × Skills vs. Education × Pre vs. Post) split-plot ANOVA was performed on the two treatment groups. A significant main effect was found for time, $F(1, 36) = 60.03$, $p < .001$, but neither type of training, $F(1, 36) = 0.53$, or age of counselor, $F(1, 36) = 2.54$, were found to be significant. Furthermore, there were no interaction effects found, $F(1, 36) = 0.71$, $p > .05$. Collapsing the age groups across treatment modalities in a 2 × 2 ANOVA indicated that there were no significant differences in counseling effectiveness as a function of age, $F(1, 36) = 2.98$, $p > .05$.

Table 2
Comparison of Pretest and Posttest Empathy Ratings as a Function of Counselor Age and Training Model

Condition	Empathy			
	M pretest	*SD*	*M* posttest	*SD*
Skills[a]				
Younger	2.037	0.57	3.512	0.35
Older	2.139	0.57	3.425	0.32
Education[b]				
Younger	2.152	0.48	2.290	0.46
Older	2.307	0.53	2.485	0.63

Note. $n = 10$ in each group.
[a] Empathy-skills-trained group. [b] Information-only group.

Discussion

Despite the procedural difficulties, one unambiguous conclusion may be drawn from this study: Volunteer "counselors," whether elderly or adolescent, are demonstrably effective therapeutic agents in helping to improve depression in the elderly. The alpha level chosen for statistical significance was set at a conservative level, and so the results are convincing. Compared with no-treatment control subjects, nursing home residents who received regular visits from a volunteer counselor showed significantly less depression. It was demonstrated that volunteers in a helping relationship can provide the catalyst for therapeutic change. It was also shown that both elderly and adolescent counselors are comparable in helping skills and in therapeutic outcomes.

The finding that adolescents could serve as effective change agents with clients much their senior is heartening. Although the attrition rate was particularly high, those who completed the program proved their mettle. Although it is probable that the residents responded differently in their interactions with younger versus older volunteers, the outcome was similar. Younger volunteers bring a vitality and optimism to their mission that is infectious. Anecdotal evidence from the residents and nursing home staff supported the impression that the presence of youth helped to create a more vibrant atmosphere.

Because no differences were found between the empathy-skills-trained group and the education-only group, some questions emerge in regard to the role of empathy. However, a problem of interpretation of these results arises out of the ambiguity of the role of the counselor education group as an *attention–placebo*. The education group emerged from their 12-hr workshop series perceiving themselves as equally pre-

Table 3
Comparison of Pretest and Posttest Mean Depression Scores as a Function of Treatment Condition

Comparison on Zung Self-Rating Depression Scale	*M*	*SD*	*M*	*SD*	*t*(57)	*p* (two-tailed)
Skills[a] pre vs. skills post	45.60	4.77	39.80	6.62	5.8166	.001
Education[b] pre vs. education post	46.05	3.65	42.20	4.26	3.8610	.001
Control pre vs. control post	49.60	6.97	48.50	6.20	1.1031	.30
Skills pre vs. educ pre	45.60	4.77	46.05	3.65	−0.2080	.20
Skills pre vs. control pre	45.60	4.77	49.60	6.97	−1.8527	.10
Education pre vs. control pre	45.05	3.65	49.60	6.97	−1.6443	.20
Skills post vs. education post	39.80	6.62	42.20	4.26	−1.1116	.30
Skills post vs. control post	39.80	6.62	48.50	6.20	−4.0296	.001
Education post vs. control post	42.20	4.26	48.50	6.20	−2.9180	.01

Note. Pre = pretest; post = posttest.
[a] Empathy-skills-trained group. [b] Information-only group.

pared and enthusiastic about their role as counselors as did the skills group volunteers. They also received direct factual information designed to increase their knowledge and appreciation of the aging process. Although it is an improvement over previous designs (Gormally & Hill, 1974), the present study must still be qualified on two counts: (a) Without a truly innocuous attention–placebo group, it cannot be ascertained whether the clinical gains obtained were not simply a function of time spent with another person; and (b) because there were, in effect, two treatment groups, the design did not control for trainer effects; that is, differential results obtained in one group may have been due to superior trainers rather than to a superior training paradigm.

To account for these factors, the design would have had to include a third no-training placebo group and then several workshops would have had to be run, systematically counterbalancing the trainers across treatment modes. This procedure was hardly practical.

The inherent nature of this project challenged a number of popular preconceptions and community values. In one stroke it asked (a) senior citizens and adolescents to work side-by-side; (b) seniors and teens to openly explore their feelings regarding aging, death, and affective disturbance; (c) seniors and adolescents to make an emotional investment in a depressed, aged patient; and (d) seniors and adolescents to overcome the stigma associated with a mental health agency and a nursing home.

Several lessons learned from this study have implications for future research, as well as for future community volunteer programs. The design included features that incorporated the suggestions of critical reviews of paraprofessional training models. The dependent measure used to determine the effectiveness of the training program was taken of the patient rather than the counselor. Also, this study included a placebo counselor group whose motivation and expectations were measurably equivalent, in order to control for nonspecific counselor effects.

Significant barriers to establishing an effective volunteer counselor program must be overcome in a rural area. However, if they are overcome, this study confirms the fact that volunteers are a viable treatment alternative. The implications are that such a program could expand the quantity, quality, and modalities of services available to the elderly. If administrative costs permit, we suggest using volunteers in a home visitation counseling program. Such a program would offset the reluctance on the part of the elderly to seek mental health services. This form of community outreach program could serve a primary prevention function by targeting loneliness issues that arise in advance of depressive symptomatology.

References

Anderson, R., (1976). Peer facilitation: History and issues. *Elementary School Guidance and Counseling, 11*, 16–25.

Arch, S. D. (1978). Older adults as home visitors modeling parenting for troubled families. *Child Welfare, 57*, 601–605.

Balch, P., & Solomon, R. (1976). The training of paraprofessionals as behavior modifiers: A review. *American Journal of Community Psychology, 4*, 167–179.

Barrett-Lennard, G. T. (1981). The empathy cycle: Refinement of a nuclear concept. *Journal of Counseling Psychology, 28*, 91–100.

Becker, F., & Zarit, S. H. (1978). Training older adults as peer counselors. *Educational Gerontology, 3*, 241–250.

Blazer, D. (1982). The epidemiology of late life depression. *Journal of the American Geriatric Society, 30*, 587–592.

Bond, J. (1982). Volunteerism and life satisfaction among older adults. *Canadian Counselor, 16*, 168–172.

Brink, T. L. (1977). Depression in the aged: Dynamics and treatment. *Journal of the National Medical Association, 69*, 891–893.

Brink, T. L. (1979). *Geriatric psychotherapy.* New York: Human Sciences Press.

Brown, W. (1974). Effectiveness of paraprofessionals: The evidence. *Personnel & Guidance Journal, 53*, 257–263.

Carkhuff, R. R. (1969). *Helping and human relations: A primer for lay and professional helpers* (Vol. 1). New York: Holt, Rinehart, & Winston.

Carkhuff, R. R. (1972). *The art of helping.* Amherst, MA: Human Resources Development Press.

Christensen, A., Miller, M. R., & Munoz, R. F. (1978). Paraprofessionals, partners, peers, paraphernalia, and print. Expanding mental health service delivery. *Professional Psychology, 9,* 249–270.

Conklin, R. C., & Hunt, A. S. (1975). An investigation of the validity of empathy measures. *Counselor Education and Supervision, 15,* 119–127.

Fassler, J. B., & Gaviria, M. (1978). Depression in old age. *Journal of the American Geriatrics Society, 26,* 471–475.

Feigenbaum, E. M. (1970). *A geriatric psychiatric outpatient project.* San Francisco: Langley Porter Neuropsychiatric Institute.

Fry, P. S. (1984). Development of a geriatric scale of hopelessness: Implications for counseling and intervention with the depressed elderly. *Journal of Counseling Psychology, 31,* 322–331.

Gladstein, G. A. (1977). Empathy and counseling outcome: An empirical and conceptual review. *The Counseling Psychologist, 6*(4), 70–79.

Gladstein, G. A. (1983). Understanding empathy: Integrating counseling, development, and social psychology perspectives. *Journal of Counseling Psychology, 30,* 467–482.

Gormally, J., & Hill, C. E. (1974). Guidelines for research on Carkhuff's training model. *Journal of Counseling Psychology, 21,* 539–547.

Greenberg, L., Fatula, B., Hameister, D. R., & Hickey, T. (1976). *Gerontology practitioner training manual: Communication skills in the gerontological environment.* State College: Pennsylvania State University.

Hale, W. D. (1982). Correlates of depression in the elderly: Sex differences and similarities, *Journal of Clinical Psychology, 38,* 253–257.

Hirschfeld, R. M. A., & Klerman, G. (1979). Treatment of depression in the elderly. *Geriatrics, 34*(10), 51–57.

Hirschowitz, R. G. (1973). Foster Grandparents Program: Preventive intervention with the elderly poor. *Hospital and Community Psychiatry, 24,* 558–559.

Isquick, M. F. (1981). Training older people in empathy: Effects on empathy, attitudes, and self-exploration. *International Journal of Aging and Human Development, 13,* 1–14.

Kahn, R. L. (1975). The mental health system and the future aged. *The Gerontologist, 15,* 24–31.

Karlsruher, A. E. (1974). The nonprofessional as a psychotherapeutic agent: A review of the empirical evidence pertaining to his effectiveness. *American Journal of Community Psychology, 2,* 61–77.

Knight, B. (1978/1979). Psychotherapy and behavior change with the non-institutionalized aged. *International Journal of Aging and Human Development, 9,* 221–236.

Matefy, Robert E. (1978). Evaluation of a remediation program using senior citizens as psychoeducational agents. *Community Mental Health Journal, 14,* 327–336.

Patterson, C. H. (1984). Empathy, warmth and genuineness: A review of reviews. *Psychotherapy, 21,* 431–438.

Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology, 21,* 95–103.

Rogers, C. R. (1975). An unappreciated way of being. *The Counseling Psychologist, 5*(2), 2–10.

Scott, S., & Warner, R. (1974). Peer counseling. *Personnel & Guidance Journal, 53,* 228–231.

Truax, C. B., & Mitchell, K. M. (1971). Research on certain therapist interpersonal skills in relation to process and outcome. In A. E. Bergin & S. L. Garfield (Eds.) *Handbook of psychotherapy and behavior change* (pp. 299–344). New York: Wiley.

Waters, E., Fink, S., & White, B. (1976). Peer group counseling for older people. *Educational Gerontology, 1,* 157–170.

Willner, M. (1978). Individual psychotherapy with the depressed elderly outpatient: An overview. *Journal of the American Geriatrics Society, 26,* 231–235.

Yesavage, J. (1979). Dementia: Differential diagnosis and treatment. *Geriatrics, 34*(9), 51–59.

Yesavage, J. A., & Karasu, T. B. (1982). Psychotherapy with elderly patients. *American Journal of Psychotherapy, 36,* 41–55.

Zung, W. W. K. (1965). A self-rating depression scale. *Archives of General Psychiatry, 12,* 63–70.

Zung, W. W. K. (1967). Depression in the normal aged. *Psychosomatics, 8,* 287–292.

Received August 29, 1986
Revision received February 17, 1987
Accepted February 17, 1987 ■

Call for Nominations for *JEP: Learning, Memory, and Cognition*

The Publications and Communications Board has opened nominations for the editorship of the *Journal of Experimental Psychology: Learning, Memory, and Cognition* for the years 1990–1995. Henry L. Roediger III is the incumbent editor. Candidates must be members of APA and should be available to start receiving manuscripts in early 1989 to prepare for issues published in 1990. Please note that the P&C Board encourages more participation by women and ethnic minority men and women in the publication process and would particularly welcome such nominees. To nominate candidates, prepare a statement of one page or less in support of each candidate. Submit nominations no later than April 4, 1988, to

Gary M. Olson
Department of Psychology
University of Michigan
330 Packard Road
Ann Arbor, Michigan 48104.