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Effects of Training and Contact on Decreasing Ageism in Mental Health Professionals

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An Abstract Presented to the Faculty of the Graduate School
of Lindenwood College in Partial Fulfillment of the
Requirements for the Degree of
Master of Art
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Abstract

Advances in research on attitudes towards older adults can productively be applied to the problem of professional ageism. In this study a group of 50 mental health professionals ranging in age from 19-65 with 21 being male and 29 being female responded to a questionnaire entitled Aging Opinion Survey. This survey requested the subjects' opinions concerning three topics: stereotypic decrement, personal anxiety towards aging, and social value of the elderly. This was matched with their level of training in gerontology and contact with this population. In general, subjects with higher levels of contact and training had a more positive opinion of older adults. Therefore education about normal life span development and attention to how the public climate affects service delivery is recommended.

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Dedication

To Bernie and Carol Nachtmann, my parents, whose love and support made me believe in myself even when I didn't want to.

To Ruth Wilhelm, my grandmother, who taught me to set my standards high and never settle for less.

To all my friends and family, who put up with all the trials and tribulations it took me to get this far.

Thanks to all of you, I couldn't have made it without you!

Acknowledments

I would like to thank the staff of the Independence Center for participating in this study.

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Chapter One

Introduction

Background

Gatz and Pearson (1988) report that, "ageism is a term used to describe a societal pattern of widely held devaluate attitudes and stereotypes about aging and elderly people" (p.184). Like racism and sexism, ageism may breed social avoidance, segregation, hostility, discrimination in practice and policy, as well as the belief that the elderly are a drain on society (Hummert, Garstka, Shaner, & Strahm, 1994). Societal attitudes and beliefs about aging can have a profound effect on how people view themselves and others who are aging (Ford & Sbordone, 1980). These negative stereotypes about aging are still quite prevalent (Bytheway, 1995).

Unfortunately, ageism can also affect the choices people are presented with and the decisions they make about those choices. On a positive note, Reker, Peacock, and Wong (1987) indicated that if an individual believes that some of the "inevitable deterioration" of aging is preventable, they are likely to be more active in their own self-care (p. 44). Hillerband and Shaw (1990) indicated that if health care providers believe that older adults are valuable, equal members of society, then this belief should support the geriatric community thought the aging process. Therefore this level of support should be reflected in professional training and service provision. Consequently, confronting ageism by enhancing positive beliefs

about aging is an essential element of health promotion training and programming (Ebersole & Hess, 1990).

Gatz and Parson (1988); Rohan, Berkman, Walker, and Holmes (1994); as well as Knight (1988) agreed that mental health providers, such as psychiatrists, therapists, and social workers are not immune to these stereotypes. Misconceptions of the older adult's skills, abilities, and potential for rehabilitation combined with 'gerontophobia', or a fear of aging may create a form of ageism (Rohan et al., 1994). These misconceptions may contribute to the elderly receiving poor or inappropriate mental and physical health care, due to misdiagnosis (Knight, 1988). As a result, sensitivity both to aging issues and the effect of personal and societal biases are critically important to all health care providers (Gatz & Pearson, 1988).

A review of the literature on attitudes towards disabled persons reinforces the previous suggestion that older people are neglected by psychosocial rehabilitation professionals, such as case managers, therapists, and social workers (Dunn, 1989). Paradoxically, older individuals experience impairments that psychosocial rehabilitation specialists historically have addressed (Bozarth, 1981). Although being old cannot be equated with being impaired or disabled, there is direct correlation between incidence of impairments and advancing age (Blake, 1981).

Research Questions

The significant increase in the proportion of the total population over 65 years of age has occurred in this century, and nearly parallels the development of mental health rehabilitation services (Blake, 1981). This raises several questions. Why have psychosocial rehabilitation specialists neglected older adults in research, teaching, and practice? Have these professionals widely internalized negative general stereotypes of older adults? Does the preoccupation of this profession with vocational services and the cost benefit orientation toward client selection conveniently eliminate older persons from the rehabilitation caseload (Bozarth, 1981; Dunn, 1981)? Does the profession hold the view that older disabled persons cannot be helped? It is appropriate for psychosocial rehabilitation specialists to examine their attitudes and values towards older people in general and those with mental disabilities in particular. The following study will provide a small sample of these professionals an opportunity to do so through the completion of the Aging Opinion Survey (AOS).

Purpose

The purpose of this study is to examine the relationship between AOS scores and both the level of contact with the geriatric population and training in gerontology in mental health professionals. Mental health professionals from a social service agency were selected to participate in this study.

The overall intent of the following research is to alert mental health professionals to the negative effects of ageism. It also promotes a decrease in their level of ageism through increased training in gerontology and contact.

Primary Hypotheses

The primary null hypotheses examined in this study are as follows:

1. There is no significant relationship between mental health professionals' AOS scores and level of training in gerontology.
2. There is no significant relationship between mental health professionals' AOS scores and level of contact with the geriatric population.

Secondary Hypotheses

In addition, three secondary hypotheses were examined as follows:

1. There is no significant relationship between mental health professionals' Stereotypic Age Decrement score (Ster) on the AOS and level of training in gerontology.
2. There is no significant relationship between mental health professionals' Personal Anxiety towards Aging score (Anx) on the AOS and level of training in gerontology.
3. There is no significant relationship between mental health professionals' Social Value of the Elderly score (Scl Val) on the AOS and level of training in gerontology.

Chapter Two

Literature Review

Many elderly individuals are caught in a downward spiral of dependency due to the multiple health problems often associated with the aging process (Gatz & Pearson, 1988). The societal reaction to this problem is usually aimed merely at making their lives easier, which contributes to client dependency (Kohler, 1990). With the increasing geriatric population, this country cannot possibly provide them all with acute care. It is essential to explore and create alternatives for this vast generation of individuals (Czaja, Weber, & Nair, 1993).

Baltes and Barton (1990) determined that psychological problems in older adults can go untreated for a number of reasons.

1). Psychological disorders can be difficult to diagnosis in this population, because it camouflaged by physical symptoms. These symptoms may be misdiagnosed and disregarded as part of the normal aging process.

2). Older adults are often more reluctant to seek assistance with mental health problems, due to an attached stigma to such help or lack of knowledge about what type of help is available (Hillerband & Shaw, 1990).

Geriatric Population

Basically aging is the ability to adapt to reduced physical and mental abilities by utilizing cognitive strategies designed to maintain

a sense of control over life events (Heckhausen & Schulz, 1993). The old adage 'the cure is worst then the disease' is often the fact when the prescribed medical regimen for an older adults' chronic illness further erodes the individual's functional independence and perceived quality of life (Aasen, 1986). The geriatric population has reported a preference for treatment and care that promote independence for as long as possible (Kohler, 1988). This desire for independence refers to an individual's ability to live in their own homes and maintain control over their own lives (Tinetti & Powel, 1993).

Schulz, Heckhausen, and Locher (1991) determined that functional disability can be characterized on a number of dimensions including an inability to care for self, a cognitive impairment, and problem behaviors. Schulz and Williamson (1993) concurred that behavioral and physical disabling conditions may significantly affect the social life of the client and the caregiver. It was further stated that the level of independence was effected by the nature of the illness, time since onset, prognosis, and the pain associated with the disability (Power & Craven, 1983).

Another factor affecting independence is the perceived natural history and stage of illness the client is in (Beck, Heacock, & Mercer, 1991). It seems likely that the level of independence in the elderly will be greatly affected by their level of hope (Sculz & Williamson, 1993). Biegel, Sales, and Schulz (1991) reported that

the personality variables promoting independence were perceived control and optimism. For instance all other things being equal individuals who felt they could control important outcomes in their lives or were more optimistic about the future, reported lower levels of depression.

There is strong evidence to suggest that a sense of well-being is in large part determined by a person's belief systems (Gatz & Pearson, 1988). Although a system involves a number of beliefs, two are seen as crucial: belief about control and belief about self-esteem (Beck, 1991). Although discussed separately, they are notably interrelated.

A sense of control is the belief that certain actions lead to certain results (Bandura, 1977, 1982). This belief influences how an event is assessed and handled (Aasen, 1987). This is an important concept when considering the aging process because this sense of control can often be compromised in older adults (Czaja, Weber, & Nair, 1993). If the elderly view physical and mental deterioration as uncontrollable, the perceived lack of control is likely to reduce coping mechanisms (Rodin & Langer, 1989). Clark (1988) determined that a sense of helplessness in older adults has been shown to decrease responsiveness, motivation, and self-esteem as well as to increase illness, fatality rates, and memory problems. Unfortunately, research has shown that increased contact with the

helping professionals can reinforce a sense of helplessness (Power & Craven, 1983).

Self-esteem is a basic feeling of self-worth and a belief that one is fundamentally a person of value (Beck, 1991). In Maddox and Atchley (1987) review of the literature on self-esteem and older adults, it was suggested that the same factors that predict self-esteem in younger adults applied to older adults: (a) measure of personal achievement, (b) success in interpersonal relationships, and (c) meaningful leisure activities. However, correlates of self-esteem that were unique to older adults were health status and attitudes towards aging.

Purpose and meaning in life influence self-esteem (Clark, 1988). For the elderly, this component is related to whether growing older is viewed as a time for continued contribution, goal setting, and purpose (Hummert, Garstka, Shaner, & Strahm, 1994). A perceived meaningless existence can lead to anxiety, depression, hopelessness, and physical decline, whereas meaning and purpose in life are associated with positive mental and physical health (Reker, Peacock, & Wong, 1987). Although meaning in life changes with each developmental phase, the need to be challenged and valued remains the same (Troll, 1989).

If aging is seen only in terms of the negative aspects of growing old and not as another stage of development, self-esteem can be seriously compromised (Botwinck, 1984). Knox (1986)

studied several behaviors commonly seen as characteristics of the elderly. The young and middle-aged participants primarily saw older adults as involved in nonsocial behavior and passive activities, attributing them to negative personal characteristics rather then positive characteristics. It was also found that all respondents, including the older ones, appeared to have a stereotype of the elderly that included the idea of senility. Ninety percent of older adults respondents believed that there was a strong possibility that they would become senile. However, medical estimates indicate that only 4% of people over 65 years of age suffer from a severeform of senility, and only another 10% suffer from a milder version (Reed, 1989).

Mental Health Professionals

Traditionally, aging has been viewed as a continual process of decline (Bytheway, 1995). Unfortunately, this type of stereotyping may result in systematic discrimination that devalues senior citizens and frequently denies them equality (Butler, 1987). These societal attitudes can affect not only how older adults are perceived but also how they view themselves (Repper, Brooker, & Repper, 1995).

Blake (1981) and Dunn (1989) both discovered that mental health professionals, by virtue of their training and work, are familiar with the prejudice and stigmatization of other groups deemed "abnormal" by society. However, these professionals often have negative attitudes towards older adults (Dunn, 1989). Like the

disabled, older adults are chronic victims of stigmatization (Blake, 1981). It affects virtually every aspect of their lives and the services they receive (Bozarth, 1981).

Gatz and Pearson (1998) further stated that although global negative attitudes towards aging may not exist in the health care field, specific biases may. Part of the responsibility for health care professionals' biases belongs to the educational institutions. Santos and VandenBos (1982) pointed out that few graduate programs in the social sciences offered training in gerontology. Whitbourne and Hulicka (1990) analyzed 139 psychology textbooks written over 40 years for evidence of ageism. It was determined that aging issues received little attention even in later editions. Aging issues seemed to address problems rather then successes and described older adults as suffering from multiple deficits and handicaps that were attributed entirely to the aging process. The texts also infrequently mentioned intellectual plasticity, the difference between normal aging and disease process, and manners in which individuals can compensate for the losses associated with aging. These researchers concluded that the texts exposed students to a narrow and permanently fixed view of the aging process.

Hillerband and Shaw (1990) discovered that geriatric clients were under serviced at community mental health centers, private practitioners, and in nursing homes. One of the long-standing explanations for such under service is that the ageism of service

providers keeps geriatric clients from seeking mental health treatment (Butler & Lewis, 1982) and discourages professional from serving aged individuals (Santos & Vandenbos, 1982). Attitudes of mental health professional toward the aged were initially illustrated by Kastebaum (1964) with the term 'reluctant therapist'.

Knight (1988) pointed out that healthcare professionals define physical disease and psychological difficulties according to the way they typically present in 20-40 year old individuals. Diagnosis and treatment of the geriatric population generally have received only minimal attention (Knight, 1988). Behavior that would warrant further investigation in a younger person may not be investigated in an elderly person (Gatz & Pearson, 1988). Older adults are also more likely to receive less long-term therapy and to be institutionalized for the same symptoms that would be treated more aggressively in a younger person (Rodin & Langer, 1980).

In a study of age bias, Hillerbrand and Shaw (1990) found that compared to younger patients, geriatric patients were less likely to be referred for psychiatric consultation. The study also found that the suicidal ideation and past psychiatric history evaluations were not as complete for older patients. Even though the suicide rate for the elderly population is 50% higher than for younger populations (Maddox & Atchley, 1987).

It is important to consider other factors related with illness that play a role in the response of older adults and their caregivers

(Clark, 1988). For instance, caregivers frequently provide custodial care because they believe the situation will not improve but only get increasingly worse (Burton & Spall, 1981). In actuality excess functional disabilities can often be attributed to the environment created by the caregiver (Booth, 1986). An individual's activities of daily living (ADLs) may even deteriorate more quickly than the disease warrants because the caregiver does not allow or encourage the individuals to perform their ADLs to the individual's potential (Beck, Heacock, & Mercer, 1991).

Researchers argue that when others believe that an older person's range of physical and cognitive abilities is narrowing, there is a tendency to restrict individual freedom even further (Clark, 1989). These restrictions can lead to the reinforcement of dependency by the helping professions and to symptom management rather than health promotion (Knight, 1988). This behavior may best be conceptualized as "disabling support" versus "enabling support" (Rowe & Kahn, 1987).

Schaie (1988) further criticized mental health professionals by stating that the majority of past psychological research had ageism undertones. A number of methodological mistakes were listed including: (a) failing to operationlize the concept of the aging variable as a homogenous group of individuals over 60 years old, (b) the lack of reasonable effect size in age comparison, (c) confounding findings with age changes, (d) the utilization of apparatus normed

for young adults, and (e) no consideration for the range of individual differences that results in overlapping distributions. It was concluded that to avoid being accused of inadvertently supporting ageist biases, researchers in psychology need to address the above concerns and be as sensitive to these issues as they would be to issues of race and gender.

Research

It has been established through research that psychological well-being also plays a significant role in the preservation of physical and mental health (Zantura, Maxwell, Reich, 1989). However, it has only recently been recognized that many of the variables associated with well-being in older adults are linked to intervention (Rowe & Kahn, 1987). In the review of the literature, Clark (1988) indicated that a lack of social support increased fatality rates and decreased treatment regimen compliance. As an example, he cited studies showing that moving from familiar surroundings to a nursing home or institution increased mortality rates. A longitudinal study in Sweden revealed that death rates increased by 48% for men and 26% for women within the first three months after losing a spouse (Svanborg, 1990). Other risk factors of older adults include: stress of managing on a fixed income, elder abuse, isolation, perceived health limitations, and ageism (Gilhooly, Sweeting, Whittick, & McKee, 1994).

Beck, et al. (1991) ascertained that case studies, clinical experience, and research studies suggest that external forces may influence the functional abilities of the geriatric population. It was determined that effective behavioral techniques for rehabilitation included calm and friendly communication, proper action initiation, prompts, reinforcement, verbal instructions, modeling, practice, and positive reinforcement. The following studies employed these various techniques.

One study exemplifies the impact of the two approaches. Avorn and Langer (1982) divided residents in a nursing home into three groups and gave them jigsaw puzzles to complete. One group was actively assisted by the staff to complete the puzzle (helped group), one was encouraged but only received minimal assistance (encouraged group), and one was left to complete the puzzle on their own (control group). All three groups were tested before and after puzzle assembly on ability to complete the task and self confidence rating. The "helped" group's performance deteriorated posttest and they rated the task as more difficult, compared with the "encouraged" group, who improved their performance and felt more confidant in their abilities. Even the "control" group increased their speed of performance slightly. Therefore, it may be that the expectation of disability becomes disabling in and of itself. It could be argued that what has been termed helpless behavior in the geriatric population is

actually an active attempt to cope with a system that reinforces adherence to stereotypes and dependent behavior.

Alford (1985) revealed that a holistic approach to care supported and enhanced this population's ability to manage chronic disease. It allowed them to maintain the highest level of functioning possible, while promoting self-responsibility for their own health and well-being. By meeting the holistic needs of the geriatric population, independence is promoted and reliance on acute care is decreased (Kohler, 1990). The desire to maintain independence is a key factor in contributing to their perceived self-esteem and life satisfaction (Aasen, 1987; Power & Crave, 1983; Ryden, 1983).

Providing older adults with the opportunity to increase perceived control over the environment leads to improved memory, alertness, activity, and physical health, as well as decreased morbidity and mortality (Schulz, 1991). In one noteworthy study, alterations that increased residents' control over the environment in a nursing home demonstrated that even small changes can have a profound effect (Rodin & Langer, 1989). When the researchers returned 18 months after the intervention, they found that the experimental group (with increased control) had a 48% increase in subjective happiness; were increasingly active, alert, and social, perhaps most surprisingly, had a 50% lower mortality rate than the control group.

Sandman, Norberg, Adolfson, Axelson, and Hedley (1986) explored the notion that excess disability does not directly correlate with the degree of cognitive impairment. These excess disabilities were thought to be primarily attributed to the caregiver. Therefore this group of individual created a qualitative method that described how nursing home caregivers decreased excess disability in three Alzheimer's patients by initiating action and communicating in calm and empathetic manner.

After reviewing these finding Beck,et al. (1991) further investigated this topic through the creation of an environment where caregiver's actions promoted independent behavior with subjects in the home and nursing home setting. This involved the identification of caregiver's actions that had the potential to promote independent behavior. Then the caregiver's behavioral strategies were assessed in the home setting and appropriate behavior was modeled. This study resulted in four out of five subjects showing a decreased need for caregiver assistance and an increased ability to dress more independently. It also revealed the important role the caregiver had in the elderly individual's maintenance of ADL independence.

Another factor in North American culture is that employability is often viewed as a primary measure of one's ability to make a meaningful contribution to society and as a source of self-identity and self-worth (Moody, 1988). Botwinck (1984) found that although age was not an important factor in the evaluation of work

competence, older age was given as one of the reasons for poor applicant quality if the person was not hired. When a younger applicant was not hired, lack of effort or inability was given as the reason.

Bodily's survey (1991) of inactive nurses determined that many of the respondents cited their age as the sole reason for not working. Hummert et al. (1994) concurred that negative stereotyping in society can lead to viewing older adults as less valuable members of society. The older adults that adopt these aging myths may see decline as inevitable and become more passive members of society (Reker et al, 1987). Unfortunately, when older adults act according to these stereotypes, societal misconceptions about the aging process are reinforced (Butler & Lewis, 1982).

Policies

Subtle ageism may be partly to blame for the deficits in service delivery to the population of older adults (Bytheway, 1995). In Kimmel's (1988) review of the effects of ageism on public policy, he stated that 45% of the US community mental health centers reported having no specific programs for senior citizens and that 41% did not have any clinical staff members trained to deliver geriatric services. Roybal (1988) called for an expansion of the federal response to mental health and aging. He pointed out that even though the elderly make up 12% of the US population, only 6% of people served by mental health centers are older Americans.

As a result of the negative effects of ageism on service delivery a new policy of refocusing mental health services was developed by the 1994 Mental Health Nursing Review (Haight, Christ, & Dias, 1994). This policy has concurred with the previously stated fact that ageism lies beneath the surface of mental health services. Butterworth (1988) highlighted the fact that working with older people has historically been regarded negatively by mental health professionals and has even been seen as a punishment in many mental hospitals. Moreover, 'working with the geros' was not seen as attractive by many ambitious newly qualified mental health professionals. It was either seen as a poor career move or as evidence that they could not really cope with other, supposedly more challenging areas; for example, those with an acute and psychotherapeutic focus. This ageism may manifest at a personal level with low expectations of an individual's ability or at a societal level with negative attitudes creating laws and institutions that adversely affect older adults (Bytheway, 1995).

Repper et al. (1995) determined that there were three main problems with the new policy for older adults. The first is that the policy defined people with serious and enduring mental health problems in terms that exclude older people. This policy gives people with functional disorders a privileged position and fails to address the needs of people with organic mental disorders. This is an important group that includes those with long-term and

devastating illnesses that predominantly affect older adults, such as Alzheimer and Parkinson's disease. In this way, the policy does nothing to help older adults.

The second problem is that the policy fails to acknowledge demographic and epidemiological studies that highlight the number of older adults who are mentally ill (Repper et al., 1995). Studies clearly show that, at a time when the number of older adults in our society is increasing, the prevalence of moderate to severe dementia among people between 75 and 79 years of age is 8%, while among those aged over 80 years it soars to nearly 18% (Gilhouly & Brooking, 1994).

Finally, White (1990) points out that this policy ignores the fact that caring for older adults is a traditional part of the work of mental health professionals, although perhaps done somewhat reluctantly. This continues to be the case, with many mental health professionals in hospitals and in the community working specifically with this population (Bandura, 1982).

Another policy was developed by the American Psychological Association and the American Psychological Society who cosponsored a report by Adler in 1993 entitled *Vitality for Life: Psychological Research for Productive Aging*. This report recognized that senior citizens have been poorly represented in research and funding priorities. It lists four priorities in the area of aging which included: (a) learning how to best maximize senior

citizens' productivity at work, (b) developing mental health assessment and treatment strategies to enhance vitality, (c) learning how to change older people's health behavior, and (d) increasing research on how to optimize the functioning of those over 75 years old. The report's sponsors used the report to demonstrate to Congress the importance of providing more funding to agencies that support behavioral science research on aging.

Ethical Implications

The ethical implication of dealing with the elderly population included the issue of informed consent. The American Psychological Association (APA) - section 4.02 and the American Counseling Association (ACA) - section B8 both stated that it is professionally necessary to a.) provide information to the client involving the intervention, b.) assess the client's capacity to consent, c.) insure the client voluntarily consent, and d.) appropriately document a, b, and c (Corey, Corey, & Callanan, 1993; Herlihy & Golden, 1990). These codes advocate the client's right to make an educated decision on their manner of treatment.

Levine and Lawlor (1991) determined that the aging process may be accompanied by memory loss and confusion. Since a cognitively impaired individual may not have the capacity to fully understand the implications of their decision, they may not be aware of the fact that they have consented to the intervention. It was further stated that some elderly individuals may lack the competency

to make or communicate responsible decisions due to their insufficient understanding or capacity. In such a case a power of attorney would carry out their previously stated wishes.

Another ethical issue encountered by counselors dealing with the aging, involved the ethical codes APA - section D and ACA - section B1 (Corey et al., 1993; Herlihy & Golden, 1990). The counselor's primary obligation is to respect the integrity and promote the personal welfare of each client.

A supplementary ethical code involved the American Association of Marriage and Family Therapy (AAMFT) - section 1.1, APA - sections 1.10 and 1.13, and ACA - section A10 (Corey et al., 1993; Herlihy & Golden, 1990). These codes addressed the issues of nondiscrimination and the avoidance of personal issues. Both of these issues create a barrier, which prevents the counselor from providing a safe and therapeutic environment for the client (Corey et al., 1993; Herlihy & Golden, 1990; Meier & Davis, 1993; Peterson & Nisenholz, 1991). Kastenbaum (1963) exposed that the elderly are the population avoided most by therapists and health-care workers. This avoidance was attributed to fear of diminished status by working with a low-status group, and to their anxiety surrounding their own issues of aging. It can also be associated with the value judgment that a client nearer to death does not deserve as much of a time investment. Such ageism is responsible for further isolating a lonely population (Levine & Lawlor, 1991).

Chapter Three

Method

Participants

Fifty social service professionals: social workers, case managers, and counselors voluntarily participated in this study. The age range of participants was from 19 to 65 years old with an average age of 37.8. There were 21 men and 29 women that comprised this study of 50 professionals. Among these participants 24 had at least two courses in gerontology while the other 26 had little to no training in gerontology. All participants were employed at a community based agency, which served the mentally ill population of St. Louis, Missouri. These voluntary participants did not receive any type of monetary compensation for their participation and were treated in accordance with the "Ethical Principles of Psychologists and Code of Conduct" from the American Psychological Association in 1997.

Apparatus

A questionnaire entitled the Aging Opinion Survey (AOS) with three 15-item scales was administered (Appendix A). This questionnaire was utilized to assess the participants' attitude towards the elderly and the aging process. The AOS was developed during the Gerontology Manpower Project, a Community Education-Community Service program. The AOS was chosen primarily

because of its' roots as a component in a basic aging course, to assess attitude change as a result of education in Gerontology.

In the past the AOS has been effective in the evaluation of training in correlation with attitudinal changes in practitioners/volunteers. The AOS has also been utilized in continuing education settings to stimulate interaction and self-awareness and self-esteem in group discussions.

The three 15-item dependent variable scales provide the following representation:

Scale 1 - Stereotypic Age Decrement focuses primarily on the negative changes related with the aging process of their peers (Coefficient Alpha = 0.78).

Scale 2 - Personal Anxiety Toward Aging primarily illuminates an individual's level of fear related to the aging process (Coefficient Alpha = 0.47).

Scale 3 - Social Value of the Elderly primarily illuminates an individual's interpersonal relations with this population as well as a view of this group's societal contribution (Coefficient Alpha = 0.65).

Examination of the items comprising scale one, stereotypic age decrement, reveals several content areas (e.g., work, physical appearance, health) but a homogeneity in implying a stereotyped view of the aging processes of friends and peers. These age related changes are often seen as being decremental. The positively worded statements (6, 23, 29) indicate a similarly pessimistic view with

reverse scoring. In the present scoring scheme, lower scores indicate endorsement of the stereotypic view of aging as a decrement process.

Inspection of statements contained in scale two, the Personal Anxiety toward Aging Scale, also produced a broad range of topics that included finances, mobility, friends, family and relationships. The statements with two exceptions (items 7 and 27) have clear personal reference. Responses reflect anxiety, fear, or dread concerning the participant's aging process. In this scoring system, a low score indicates a higher level of anxiety towards aging. This view was supported by the correlation of scale two of Spielberg, Gorsuch, and Lushene (1970), which measured trait anxiety.

The third scale entitled Social Value of the Elderly focused on topics such as: residential segregation, social responsibility, public policy, and knowledge. The statements are primarily targeted for older adults as a social group, without familiarity of the items composing scale one. The majority of the items in this scale emphasize the value of the contribution to society that the elderly are capable of making. Lower scores on this particular scale indicate a lower perceived social value of the elderly. There was a strong correlational link between this scale and the Attitudes toward Old Persons questionnaire by Kogan (1961).

Design

The design for this study incorporated the coefficient alpha which is determined by an internal consistency measure of reliability

based upon a function of the item-total correlation. Coefficient alpha may be interpreted as the expected correlation between the given scale and an alternative form of the scale with an equal number of items. The square root of the coefficient alpha is the expected correlation of the scale with errorless true scores (Howell, 1992). The reliability of the AOS is comparable to that of other attitude scales of equal length (Kogan, 1961 & 1979).

Analyses of variance were achieved through the subdivision of data into four dimensions of interest acquired through the general information cover page on the survey (Appendix B). These four independent variables include each participant's sex (gender), age, level of contact with the elderly, and training/education in gerontology. The subdimensions of each variable were as follows:

Sex: 2 (female) or 1 (male)

Age: participant's years of life.

Level of contact:

1(very little contact with the elderly population) thru

9 (very much contact with the elderly population)

Training in Gerontology:

1 (at least two courses in geronotological studies.) or

2 (no geronotological training)

These variables represented two different types of measurement, sex was a nominal variable based on status. In contrast age, training, and

level of contact were ordinal variables based on values of measurement.

The purpose of this study is to examine the relationship between AOS scores and the level of contact with the geriatric population as well as training in gerontology in mental health professionals. Mental health professionals from a social service agency were selected to participate in this study. A correlational and chi-square analyses were conducted to determine relationship between the independent variables (sex, level of contact, age, and training in gerontology) and the dependent variables (stereotypic age decrement, personal anxiety towards aging, and social value of the elderly).

Primary Hypotheses

The primary null hypotheses examined in this study are as follows:

1. There is no significant relationship between mental health professionals' AOS scores and level of training in gerontology.
2. There is no significant relationship between mental health professionals' AOS scores and level of contact with the geriatric population.

Secondary Hypotheses

In addition three secondary null hypotheses were examined as follows:

1. There is no significant relationship between mental health professionals' Stereotypic Age Decrement score (Ster) on the AOS and level of training in gerontology.
2. There is no significant relationship between mental health professionals' Personal Anxiety towards Aging score (Anx) on the AOS and level of training in gerontology.
3. There is no significant relationship between mental health professionals' Social Value of the Elderly score (Scl Val) on the AOS and level of training in gerontology.

Procedure

The AOS was administered on an individual basis. Each participant was provided with a single copy of the AOS with a general information sheet and a set of written instructions. The general information sheet requested the participant to identify their age, gender, training in gerontology, and frequency of contact with the elderly to determine independent variables (Appendix B).

Each participant completed the test independently in a time span of approximately 15-20 minutes. At the end of the testing process, the purpose of the study was explained to each participant. A score for each of the three AOS scales: Stereotypic Age Decrement, Personal Anxiety toward Aging, and Social Value of the Elderly, was obtained by summing item scores across the 15-items. Reverse scoring was utilized to maintain logical consistency and direction of the scale.

Chapter Four

Results

The results of this study rejected both the primary and secondary null hypotheses, which reinforced the initial purpose preposed by the research questions.

Table 1

Descriptive Statistics

Variable	Mean	Std Dev	Min.	Max.
Age	37.80	10.02	19.00	65.00
Sex	1.58	0.50	1.00	2.00
Educ	1.52	0.50	1.00	2.00
Cont	5.64	2.11	1.00	9.00
Ster	51.36	9.15	31.00	68.00
Anx	46.06	7.64	29.00	60.00
Scl Val	57.10	8.03	33.00	72.00

The raw data of the AOS was subdivided according to four dimensions of independent variables: sex, age, training in gerontology (Educ), and level of contact with elderly (Cont). These results were matched with the three dependent variables of the AOS,

which were stereotypic age decrement (Ster), personal anxiety towards aging (Anx), and social values of the elderly (Scl Val). The analysis of variance is displayed in the descriptive statistics (df=48) in table 1, which note the mean, standard deviation (Std Dev), range (Minimum-Maximum), and the number of subjects (N). Table 1 depicts a visual distribution of measurement for both the independent and dependent variables.

Null hypotheses were not challenged by this distribution of data.

Table 2

Percentiles Ranking of AOS Scores

Percentile	Scale A	Scale B	Scale C
25	44	40	51
50	50	46	57
75	59	53	65
99	68	60	72
Mean:	51.34	46.06	57.100
Std. Dev.:	9.158	7.638	8.026
Range:	31-68	29-60	33-72
Mean Difference:	1.42	0.12	0.99

Population percentiles corresponding to obtained scores are presented above in Table 2. Participants rating in below the in 25th percentile and below have a tendency towards more negative views of the aging process in association with each dependent variable. In contrast participants rating in the 75th percentile and above have a tendency towards a more positive attitude towards the aging process in accordance with each dependent variable. The representation of the scales depicting the dependent variables are as following: Scale A measures Stereotypic Age Decrement (Ster), Scale B measures Personal Anxiety Toward Aging (Anx), and Scale C measures Social Value of the Elderly (Scl Val). The mean of each of these scales is compared to Kogan (1961) results, which results in a calculated mean difference. The low mean difference indicates that this study has a significant relationship with Kogan's (1961) results.

Null hypotheses were not challenge by this analysis of data.

Table 3

Pearson Correlation of Training

Variable	Ster	Anx	SclVal	AOS
Educ	-0.7941	-0.7653	-0.7235	-0.767

Table 3 depicts the correlation between level of training in gerontology and the AOS scores. Each subcategory of the AOS was calculated as well as the overall AOS score. The results of this analysis denote a significant relationship between level of training and ageism as measured by the AOS.

Table 4

Chi-Square Analyses of Training

Variable	Chi-Square	DF	Sign.	Cell Freq.
Educ	0.080	1	0.777	<5

In addition, table 4 reinforces the determination of a significant relationship as well as a significant difference between AOS scores and level of training.

As a result of these analyses of data, the primary null hypothesis (1) was rejected. There was a significant relationship between mental health professionals' AOS scores and level of training in gerontology.

Table 5

Pearson Correlation of Contact

Variable	Ster	Anx	SclVal	AOS
Cont	0.5396	0.4871	0.5923	0.539

Table 5 depicts the correlation between level of contact with the elderly and the AOS scores. Each subcategory of the AOS was calculated as well as the overall AOS score. The results of this analysis denote a significant relationship between level of contact and ageism as measured by the AOS.

Table 6

Chi-Square Analyses of Contact

Variable	Chi-Square	DF	Sign.	Cell Freq.
Cont	13.720	8	0.089	<5

In addition, table 6 reinforces the determination of a significant relationship as well as a significant difference between AOS scores and level of contact.

As a result of these analyses of data, the primary null hypothesis (2) was rejected. There was a significant relationship between mental health professionals' AOS scores and level of contact with the geriatric population.

Table 7

T-test and Equality of Variance for Independent Samples of Training in Gerontology (EDUC) as a Function of Stereotypic Age Decrement

Variable	N	Mean	SD	SE
Training	24	58.8333	4.797	0.979
No Training	26	44.4615	6.313	1.238
T-value		9.01		
Mean Difference		14.3718		
DF		48		
SE of Difference		1.596		
2-Tail Significance		0.000		

AOS raw scores of the Stereotypic Age Decrement Scale were converted into t-scores and measured for equality of variance by Levine's Test for independent samples of training in gerontology (F=

2.314, P=0.135, mean difference=14.3718). Table 7 depicts an analysis of data through the number of cases (N), the mean, the standard deviation (SD), the standard error of the mean (SE), and the mean difference. The discrimination in the means or mean difference associated with training implies a significant relational difference.

In addition, to these findings the results of the Pearson Correlation between training (EDUC) and Stereotypic Age Decrement (-0.7941) reinforces the determination that a significant relationship exists.

As a result of these analyses the secondary null hypothesis (1) was rejected. There was a significant relationship between mental health professionals' Stereotypic Age Decrement score (Ster) on the AOS and level of training in gerontology.

Table 8

T-test and Equality of Variance for Independent Samples of Training in Gerontology (EDUC) as a Function of Personal Anxiety Towards Aging

Variable	N	Mean	SD	SE
Training	24	52.0833	5.641	1.151
No Training	26	40.5000	4.254	0.834
T-value		8.24		
Mean Difference		11.5833		
DF		48		
SE of Difference		1.406		
2-Tail Significance		0.000		

AOS raw scores of the Personal Anxiety towards Aging Scale were converted into t-scores and measured for equality of variance by Levine's Test for independent samples of training in gerontology (F= 3.325, P=0.074, mean difference=11.5833). Table 8 depicts an analysis of data through the number of cases (N), the mean, the standard deviation (SD), the standard error of the mean (SE), and the mean difference. The discrimination in the means or mean

difference associated with training implies a significant relational difference.

In addition, to these findings the results of the Pearson Correlation between training and Personal Anxiety towards Aging (-0.7653) reinforced that a significant relationship exists.

As a result of these analyses the secondary null hypothesis (2) was rejected. There was a significant relationship between mental health professionals' Personal Anxiety towards Aging score (Anx) on the AOS and level of training in gerontology.

Table 9

T-test and Equality of Variance for Independent Samples of Training in Gerontology (EDUC) as a Function of Social Value of the Elderly

Variable	N	Mean	SD	SE
Training	24	63.0833	5.315	1.085
No Training	26	51.5769	5.846	1.146
T-value		7.26		
Mean Difference		11.5064		
DF		48		
SE of Difference		1.585		
2-Tail Significance		0.000		

AOS raw scores of the Social Value of the Elderly Scale were converted into t-scores and measured for equality of variance by Levine's Test for independent samples of training in gerontology (F= 0.495, P=0.485, mean difference=11.5064). Table 9 depicts an analysis of data through the number of cases (N), the mean, the standard deviation (SD), the standard error of the mean (SE), and the mean difference. The discrimination in the means or mean

difference associated with training implies a significant relational difference.

In addition, to these findings the results of the Pearson Correlation between training and Social Value of the Elderly (-0.7235) reinforced that a significant relationship exists.

As a result of these analyses the secondary null hypothesis (3) was rejected. There was a significant relationship between mental health professionals' Social Value of the Elderly score (Scl Val) on the AOS and level of training in gerontology.

Chapter 5

Discussion

Hypotheses

In review, the purpose of this study was to examine the relationship between AOS scores and the level of contact with the geriatric population as well as training in gerontology in mental health professionals. Mental health professionals from a social service agency were selected to participate in this study. Correctional and chi-square analyses were conducted to determine relationship between the independent variables (sex, level of contact, age, and training in gerontology) and the dependent variables (stereotypic age decrement, personal anxiety towards aging, and social value of the elderly).

The results of the null hypotheses examined in this study are as follows:

Primary Hypotheses

1. There was a significant relationship between mental health professionals' AOS scores and level of training in gerontology.
2. There was a significant relationship between mental health professionals' AOS scores and level of contact with the geriatric population.

Secondary Hypotheses

1. There was a significant relationship between mental health professionals' Stereotypic Age Decrement score (Ster) on the AOS and level of training in gerontology.
2. There was a significant relationship between mental health professionals' Personal Anxiety towards Aging score (Anx) on the AOS and level of training in gerontology.
3. There was a significant relationship between mental health professionals' Social Value of the Elderly score (Scl Val) on the AOS and level of training in gerontology.

These results revealed a supportive conclusion with the previous hypotheses as well as a confirmation of the literature review with a range of 36 years of research. A significant correlation exists between ageism with regard to stereotypes, anxiety, and social values of the aging to education in gerontology as well as contact with the aging population. In essence, the more contact with and knowledge of the geriatric population the less ageist an individual was on average. The other variable that included age and gender had no significant effect on an individual level of ageism.

The overall intent of the following research was to alert mental health professionals to the negative effects of ageism the elderly population. It also was to promote a decrease in their level of ageism through increased training in gerontology and contact. Finally, educating mental health professionals about normal aging,

minimizing stereotypes, and attending to factors beyond professional ageism. These adjustments should improve mental health professionals' ability to help.

Limitations

There were some shortcomings resulting from the nature of the research. The statistical results of this research are questionable due to the small sample, ex post facto experiment, lack of exploration of a racial variable, pre-established groups with low professional contact with the geriatric population, as well as the subjective nature of only one researcher analyzing the results. In the future it would be beneficial to increase the sample size, identify race as a variable, and expand the sample to encompass various types of healthcare agencies. In addition, performing the AOS as a pre and post test would further verify and expand the alternative hypothesis that training and contact decreases ageism.

The results were further limited by subjectively interpreted data, therefore the direction of these associations is subject to some speculation. The use of reverse scoring was utilized to decrease bias attributable to immediate relationship problems or transient mood states of the participant. However, other problems inherent in such data may persist. In any analysis of the social problems confronting ageism, it is important to separate over generalized stereotypes from actual injustice inflicted on the aging population.

Therapeutic Implications

There are a number of implications for professionals working with the geriatric population, which include responsibility, training, research, and confronting ageism. Roybal (1988) stated that the first concern is individual professional responsibility. Because ageism can be quite subtle, service providers need to continually examine their own attitudes toward aging and older adults. Bodily (1991) determined that healthcare professionals need to focus on the causes of functional impairments, even impairments that occur more frequently among older adults.

Professionals can also combat ageism through types of programs offered and the way these programs are developed. Services providers need to actively involve older adults in identifying what programs are needed and in designing, implementing, and managing the programs (Wilson, Patterson, & Alford, 1989). Moody (1988) encouraged programs to be designed to target misconceptions about aging and more directly in elderly individuals themselves. These programs would encourage them to examine how aging myths may be affecting their behavior and promote behavioral change. Knight (1988) added that these programs could have three components: (a) direct challenge of aging myths, (b) skill-developing practice, (c) a supportive environment for testing the new behavior. The advantages of this approach on participants include the promotion of new methods of responding, increased awareness of

the manifestation of aging myths in society, as well as an increased of insight surrounding the subtle effects they may have on their own responses to aging and sense of well-being (Rowe & Kahn, 1987).

The second concern is professional training. Exposure to the elderly population and to aging issues has been shown to reduce ageism (Gatz & Pearson, 1988). Height, Christ, and Datz (1994) found that educational institutions in the health care and social sciences are beginning to establish departments with subspecialties in gerontology, particularly at the graduate level. These same institutions should include aging issues in their continuing education programs, allowing working professionals to keep up to date on the geronotological literature and new trends in the field.

Schaie (1988) criticized researchers and professional for their lack of awareness of relevant work and research in the existing aging literature. Therefore the third area of improvement is in research. More research needs to be conducted on issues such as work and aging, individual differences in age-related change in behavior and performance, the magnitude of age changes and age differences, how to enhance health behaviors, and how to optimize the functioning of extreme elderly (Schaie, 1988). Researchers need to be educated about the biases that may be influencing their own research. A majority of the current aging literature can be dismissed because of these biases (Knight, 1988).

Finally, professionals working with the geriatric population have an obligation to make a concerted effort to confront ageism in society as a whole. Older individuals' failure to make health changes may often be the result of the barriers society creates to block successful change (Blake, 1981). The stereotypes of aging explored in this thesis may prevent the elderly from initiating change or may defeat them before they start. Much can be learned from other groups, such as the women and gay movements, about how to raise awareness of stereotyping and unfair practices, including concerted lobbying efforts to change governmental policies at all levels (Repper et al., 1995). Service providers must actively target stereotypical beliefs in themselves, their professional organization, and their communities to bring about lasting change (Rohan et al., 1994).

Models

Once the professional population has created a stable foundation by increasing knowledge and contact, they may be more effective at serving the geriatric population utilizing these various techniques (Butterworth, 1988). Hazard and Kemp's (1983) caregiver-directed "health promotion and wellness" model of service delivery is one approach currently being used in an effort to delay, promote independence, and minimize ageism in older adults. Such wellness centers can identify those at risk for disease, promote self-care techniques, and assess the need for referrals for other health care services (Wilson, Alford, & Peterson, 1989).

Kohler (1988) developed a model to promote potential independence called Shared Control. This is an interactive model involving the client and caregiver entering into a partnership for the purpose of increased independence and autonomy in the decision making process. The purpose of the model is to maximize client commitment and involvement in achieving the desired outcome of independence. Each stage of this model is adapted to the client's level of energy, supportive services, motivation, and dependency. Throughout this model the caregiver acted as an advocate, guide, and partner rather then a dictator.

Ebersole and Hess (1990) explored a nursing model of care which focused on the opinion that wellness should emphasize functional potential rather then functional limitations. It also recognized the interdependence in all areas of human functioning not only the physical aspect. In addition this model was found to advocate personal growth through acquiring of independence.

These models offer techniques to promote independence in a non-ageist through assisting older adults meet their own needs. Wilson et al. (1989) illuminated the fact that the provision of such health-related services is often necessary for an older adult to remain in an independent living situation. Each model provided present healthcare services with a method of supplying more effective care in a cost effective manner while advocating increased self-esteem and life satisfaction (Kohler, 1988).

Future Goals

The promotion of independence in the geriatric population enhanced their life satisfaction. Although my literature research extends back until 1961, this information is only currently beginning to surface in settings for the aging. Although these results seem simple and easily attainable, there are many barriers to the implementation of these models. The process is highly sensitive and easily disrupted by inconsistency. Healthcare providers should continually challenge themselves and their geriatric clients to strive towards their potential for success. This topic was a significant investigation aimed at educating current and future mental health professionals of the potential of the human mind. It encourages caregivers to focus on an individual's strengths rather then their limitation. This allows them to maximize their level of productivity in the remaining time allotted to them.

Future goals of this topic include implementing independence promotion methods into the elderly population's living environment. This includes private homes, social service agencies, hospitals, retirement apartment, and nursing homes. These methods should be implemented by a health care provider with knowledge of and frequent contact the geriatric population to maintain consistency in behavior.

In conclusion, particular attention should be given to various forms of exploitation, oppression, discrimination, and victimization

with which the elderly must contend. Notions for reduction of ageism, including those resulting from my research, are often influenced by the theoretical and ideological perspectives of the observer. At one time or another most people are agents of oppression just as they are on occasion subjects of oppression. The aged are no exception in this respect and for this reason we will want to consider the evidence concerning the extent to which the elderly are, themselves, agents of oppression and exploitation should be considered.

Appendix A

Aging Opinion Survey (AOS)

Kogan

pages a-f

AGING OPINION SURVEY

On the following pages, you will find a number of statements expressing opinions with which you may or may not agree. Following each statement are five spaces labeled as follows:

Strongly agree	Mildly agree	Uncertain	Mildly disagree	Strongly disagree

You are to indicate the degree to which you agree or disagree with each statement by checking the appropriate space. Avoid choosing the uncertain response where possible.

Please consider each statement carefully, but do not spend too much time on any one statement. Do not skip any item, even if it seems like it doesn't apply to you. There are no right or wrong answers--the only correct responses are those that are true for you.

1. After retirement one should not have much influence in public policy making.

Strongly agree	Mildly agree	Uncertain	Mildly disagree	Strongly disagree

2. Most people I know feel that the elderly deserve a great deal of admiration.

Strongly agree	Mildly agree	Uncertain	Mildly disagree	Strongly disagree

3. I don't think some of my friends can hear quite as well as they use to.

Strongly agree	Mildly agree	Uncertain	Mildly disagree	Strongly disagree

4. The elderly have a wealth of knowledge and experience that is not sufficiently utilized.

Strongly agree	Mildly agree	Uncertain	Mildly disagree	Strongly disagree

5. Community organizations would function more smoothly if older persons were included on their governing boards.

Strongly agree	Mildly agree	Uncertain	Mildly disagree	Strongly disagree

6. My friends are just as interested in sex as they ever were.

Strongly agree	Mildly agree	Uncertain	Mildly disagree	Strongly disagree

7. It's best to forget that we're getting older every day.

Strongly agree	Mildly agree	Uncertain	Mildly disagree	Strongly disagree

8. Youthful enthusiasm and fresh ideas should count for more in today's world than the outdated notions of the older generation.

Strongly agree	Mildly agree	Uncertain	Mildly disagree	Strongly disagree

9. So many people I know grow less content as the years go by.

Strongly agree	Mildly agree	Uncertain	Mildly disagree	Strongly disagree

10. The older I get the more I worry about money matters.

Strongly agree	Mildly agree	Uncertain	Mildly disagree	Strongly disagree

11. I always dreaded the day I would look in the mirror and see gray hairs.

Strongly agree	Mildly agree	Uncertain	Mildly disagree	Strongly disagree

12. My friends never look as good as they used to anymore.

Strongly agree	Mildly agree	Uncertain	Mildly disagree	Strongly disagree

13. My friends aren't nearly as changeable as when they were younger.

Strongly agree	Mildly agree	Uncertain	Mildly disagree	Strongly disagree

14. The older my friends get the less respect they have for the privacy of others.

Strongly agree	Mildly agree	Uncertain	Mildly disagree	Strongly disagree

15. I have become more content with the years.

Strongly agree	Mildly agree	Uncertain	Mildly disagree	Strongly disagree

16. The older my friends get the less interest they seem to have in interacting with others.

Strongly agree	Mildly agree	Uncertain	Mildly disagree	Strongly disagree

17. The elderly are one of our great undeveloped natural resources.

Strongly agree	Mildly agree	Uncertain	Mildly disagree	Strongly disagree

18. Old people usually interfere with their adult children's child rearing practices.

Strongly agree	Mildly agree	Uncertain	Mildly disagree	Strongly disagree

19. More and more people I know are becoming observers rather than participants.

Strongly agree	Mildly agree	Uncertain	Mildly disagree	Strongly disagree

20. I dread the day when I can no longer get around on my own.

Strongly agree	Mildly agree	Uncertain	Mildly disagree	Strongly disagree

21. People my age seem to worry unnecessarily about their health.

Strongly agree	Mildly agree	Uncertain	Mildly disagree	Strongly disagree

22. The older I become the more I worry about my health.

Strongly agree	Mildly agree	Uncertain	Mildly disagree	Strongly disagree

23. People my age can learn new things easily.

Strongly agree	Mildly agree	Uncertain	Mildly disagree	Strongly disagree

24. I see the years creeping up on my friends.

Strongly agree	Mildly agree	Uncertain	Mildly disagree	Strongly disagree

25. Older people are more or less a burden for the young.

Strongly agree	Mildly agree	Uncertain	Mildly disagree	Strongly disagree

26. I am sure I will always have plenty of friends to talk to.

Strongly agree	Mildly agree	Uncertain	Mildly disagree	Strongly disagree

27. Most older people seem to need a lot of extra sleep to have enough energy for everyday chores.

Strongly agree	Mildly agree	Uncertain	Mildly disagree	Strongly disagree

28. Society would benefit if the elderly had more say in government.

Strongly agree	Mildly agree	Uncertain	Mildly disagree	Strongly disagree

29. My friends make sure they get plenty of exercise.

Strongly agree	Mildly agree	Uncertain	Mildly disagree	Strongly disagree

30. I never think about dying.

Strongly agree	Mildly agree	Uncertain	Mildly disagree	Strongly disagree

31. It's sad to say, but my friends just can't turn out the work like they use to.

Strongly agree	Mildly agree	Uncertain	Mildly disagree	Strongly disagree

Appendix B

General Information

Date: _____

Age: _____

Sex: _____

Training in gerontology (study of the elderly):

No: _____

Yes: _____

If yes, please list the name of each course or training session:

_____

_____

_____

_____

_____

_____

Please rate your level (frequency) of contact eith the elderly population from 1 (very little) to 9 (very much):_____

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