Attitudes toward aging : a study of middle aged women in Gallatin County, Montana
by Ann Ohlfest Johnson

A thesis submitted in partial fulfillment of the requirements for the degree of Doctor of Education
Montana State University
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Abstract:
This study was conducted to determine if a difference in attitudes toward aging existed among middle aged women whose mother or mother-in-law varied in functional status. Data was collected August 1993 through October 1993 via a mail survey. All participants were residents of Gallatin County, Montana; all respondents were 40 to 59 years of age. The degree of functional independence of the elder mother/mother-in-law was established according to their service need: independent, recipient of community health services, or a resident in a long term care facility. A measure of the middle aged daughter/daughter-in-law's attitudes towards personal anxiety of aging, the aging of one's peers, and the aged as a group was measured by the Aging Opinion Survey (Kafer, 1981). Additionally independent variables of education, income, and self-rated health of the middle aged women were studied.

Significant differences were found regarding caregivers' education level and attitude scores on all of the three scales of the Aging Opinion Survey. College educated caregivers had more positive attitudes than caregivers with high school or less education. Analysis of variance revealed interactions between income and caregiver groups on the attitude toward the aging of peers and attitude toward the aged as a group. Significant differences were identified among those caregivers rating their health status as good and those who rated their health status as fair on attitude toward personal anxiety, the aging of peers, and the aged as a group.

. Caregivers who rated their health as good had a more positive attitude than caregivers who rated their health as fair.

ATTITUDES TOWARD AGING: A STUDY OF MIDDLE AGED WOMEN IN GALLATIN COUNTY, MONTANA

by

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A thesis submitted in partial fulfillment
of the requirements for the degree

of

Doctor of Education

MONTANA STATE UNIVERSITY
Bozeman, Montana

April 1994

D378
J63

APPROVAL

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This thesis has been read by each member of the graduate committee and has been found to be satisfactory regarding content, English usage, format, citations, bibliographic style, and consistency, and is ready for submission to the College of Graduate Studies.

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Date 4-15-94

ACKNOWLEDGEMENTS

I wish to extend sincere appreciation to Dr. Gloria A. Gregg, my committee chairperson and thesis advisor, for her years of guidance and support. I am also grateful for the contributions and encouragement of my committee: Dr. Robert Fellenz, Dr. Richard Horswill, Dr. Dale Olson, Dr. Robert Carson, and Dr. Reed Howald. Thanks also to Dr. Don Robson, Dr. Lee Hamilton, and Dr. Wayne Larson who also were committee members during the course of my graduate study. Thank you to Gary A. Refsland who taught gerontology as an applied science.

Special thanks is extended to the caregivers and the service providers of Gallatin County who made this study possible.

Deepest gratitude is expressed to Maxx Johnson and Kenneth and Marguerite Ohlfest for their diverse assistance and emotional support.

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ABSTRACT

This study was conducted to determine if a difference in attitudes toward aging existed among middle aged women whose mother or mother-in-law varied in functional status. Data was collected August 1993 through October 1993 via a mail survey. All participants were residents of Gallatin County, Montana; all respondents were 40 to 59 years of age. The degree of functional independence of the elder mother/mother-in-law was established according to their service need: independent, recipient of community health services, or a resident in a long term care facility. A measure of the middle aged daughter/daughter-in-law's attitudes towards personal anxiety of aging, the aging of one's peers, and the aged as a group was measured by the Aging Opinion Survey (Kafer, 1981). Additionally independent variables of education, income, and self-rated health of the middle aged women were studied.

Significant differences were found regarding caregivers' education level and attitude scores on all of the three scales of the Aging Opinion Survey. College educated caregivers had more positive attitudes than caregivers with high school or less education. Analysis of variance revealed interactions between income and caregiver groups on the attitude toward the aging of peers and attitude toward the aged as a group. Significant differences were identified among those caregivers rating their health status as good and those who rated their health status as fair on attitude toward personal anxiety, the aging of peers, and the aged as a group. Caregivers who rated their health as good had a more positive attitude than caregivers who rated their health as fair.

CHAPTER 1

INTRODUCTION

Introduction

More people than ever before are growing old and the consequences are far reaching. By the year 2000, persons aged 65 and over are expected to represent 13% of the population, and the percentage may climb to 21.2% by 2030 (American Association of Retired Persons [AARP], 1991). As this elderly cohort increases, the emotional, physical and financial consequences will have an impact on American society that is unprecedented.

In past years gerontology, the study of the aging process, has increased its attention to the individual's mental and physical changes and to society's policies and resources. Underlying all facets of the aging process is the effect of attitude. Attitude affects self-concept, interpersonal interaction, and governmental policy formation (Kafer, Rakowski, Lachman, & Hickey, 1980). "The key in the problems of aging is not natural resources or the know how of the medical and behavioral sciences. It is a fundamental change in attitude" (Bevan, 1972, p. 4052).

Attitude research, which began over fifty years ago, has been sustained by the conviction that attitudes are an important, influential feature of the

socio-cultural environment (Hendricks & Hendricks, 1977; Wingard, Heath, & Himelstein, 1982). The role of members of any group depends to a large extent on the social attitudes others hold toward them at a given time (Austin, 1983). Attitudes of others, as well as one's own attitudes toward aging, influence the way the elderly are treated in society (Murphy-Russell, Die, & Walker, 1986) as well as the way one ages individually (Glass & Knott, 1982).

While attitude research abounds with contradictions, gerontologists agree that the aged hold a devalued position in our society (Glass & Knott, 1982). Numerous research efforts have been conducted that document this trend (Harris and Associates, 1975; Kogan & Shelton, 1962a, 1962b; McTavish, 1971; Sadowski, 1978; Tuckman & Lorge, 1953a). Hendricks and Hendricks (1977) state the negative image of an old person has become a national prejudice because of our culture's emphasis on productivity. Butler (1975) coined the word "ageism" which depicts the stigmatizing effect of society's attitudes toward the elderly.

In general, attitudes toward older persons are negative and often older persons internalize these negative social perceptions (Myers, 1991). Individuals who call themselves old, act older. Their self descriptions become personal prophecies. People often underestimate their capacities which creates a downward cycle of function (Furstenberg, 1989). Younger people who have negative attitudes toward aging may avoid information which would assist them to plan responsibly for their own future (Kremer, 1988).

Attitudes may restrict or disempower the individual and, by extension, his society. In order to improve the quality of life of both ourselves and our older citizens, it is imperative that attention be given to the sources of negative images in societal dynamics. Such information may lead to the development of intervention strategies to improve the future of our aging society.

Problem Statement

The problem of this research was to determine if the attitudes toward aging of the middle aged women living in Gallatin County, Montana, differed according to the functional status of their elderly female relative. Specific attitudes examined were attitudes toward one's own aging, the aging of one's peers and toward the aged as a group. The level of education, income and self-rated health status were the variables used to determine if a difference existed between caregivers' attitudes.

Need for the Study

As people age, they are more likely to suffer chronic illness and decreased functional ability (Rakowski, Barber, & Seelbach, 1983). The size of this impaired population increases with age. According to a study done by Seccombe and Ishii-Kuntz (1991) only 8% of people in the 65-74 year age group need help from another person in at least one activity of daily living. Of the people requiring help

with the activities of daily living, 22% are between the ages of 75-84 and 54% are over the age of 85.

As the elderly cohort becomes more dependent, research shows the burden falls on the family (Kosberg & Cairl, 1986; Malonebeach & Zarit, 1991; Mindel, 1979; Silliman & Sternberg, 1988). The caregivers are children, primarily women, with more than half between the ages of 40 and 59 (Smith & Bengston, 1979; Stone, Cafferata, & Sangl, 1987; York & Calsyn, 1977) Over 40% of people in their late 50's have at least one parent still alive (AARP, 1984). The caregiving experience becomes a significant contact with the aged person and the nature of this contact may influence attitudes toward the elderly as well as attitudes toward one's own aging process (McKeachie & Doyle, 1960; Naus, 1973; Regan & Fazio, 1977).

The importance of attitude is far reaching. The middle aged have special significance in the impact of attitudes (Glass & Knott, 1982). One of their developmental tasks is to deal with their own aging (Havighurst, 1972). The middle aged determine the services and the resources available for meeting the needs of the current elderly population, and influence their own children as they develop and begin forming attitudes toward aging (Bader, 1980; Green, 1981; McTavish, 1971). Therefore, the "sandwich generation" (Dobson & Dobson, 1985), which refers to the burden of caretaking for aging parents and growing children at the same time, also becomes the pivotal generation in determining the consequences on the aging of the population as a whole.

In attitude studies little attention has been paid specifically to the middle aged (Glass & Knott, 1982). In caregiving studies, minimal attention has been paid specifically to the dyad of female recipients of care and their caregivers (Brody, 1981; Fengler & Goodrich, 1979). There has been little research relating to the effects of parental health on one's attitudes toward aging as a process (Johnson, 1978; Rakowski, Barber, & Seelbach, 1983; Tuckman & Lorge, 1958). This study does not answer questions of how middle aged women will behave in their own aging process, but it does propose a starting point by inquiring if there are attitudinal differences among women who interact with functional elders versus women who have dependent elders.

General Questions to Be Answered

This study was designed to answer the following questions about caregivers who have a dependent relative in nursing homes, a dependent relative living in the community and an independent relative:

1. Is there a difference of the caregivers' attitudes toward personal anxiety of aging, the aging of peers, and the aged as a group according to their education level?

2. Is there a difference of the caregivers' attitudes toward personal anxiety of aging, the aging of peers, and the aged as a group according to their income level?

3. Is there a difference of the caregivers' attitudes toward personal anxiety of aging, the aging of peers, and the aged as a group according to their self-rated health status?

General Procedures

This study compared the attitudes toward personal aging, aging of one's peers, and the social value of the aged as a group held by middle aged women living in Gallatin County. These women were assigned to one of three caregiver groups according to the functional status of their elderly relative. The functional status of the caregiver's elderly mother or mother-in-law was an aged dependent relative living in a nursing facility, an aged relative living independently in the community receiving home health care, or an aged relative living in the community without agency assistance. Three demographic variables of the caregiver were studied: education, income and self-rated health status.

All licensed nursing homes and home health agencies located in Gallatin County participated in the study. The independent elders were volunteers in the Gallatin County Retired Senior Volunteer Program. Each agency, with the exception of Gallatin County Nursing Home, contacted the daughter or daughter-in-law of their clients prior to the mail survey and asked them to participate in the study. Data was collected from all agencies through a mail survey, using the total design method developed by Dillman (1978). The Aging Opinion Survey (Kafer, 1981), a multi-dimensional self report attitude survey, and a supplemental questionnaire were used to collect the data required.

Limitations

The study's design limited participation to women residing in Gallatin County and was not a random sample. The lack of ethnic diversity in Gallatin County was a limitation of this study and the population does not reflect distinctions between urban populations or rural populations. Caregivers experiencing the greatest amount of stress may not have had the time or energy to participate. Other confounding factors were the historical relationship between parent and caregiver, the extent of the support system available to the dyad and its ameliorating effect, or the possibility of other elderly contacts that were more influential on the caregiver's attitudes toward the aging process or the aged.

The design of the study necessitated that the caregiver's relative have a relationship to a community service agency. Therefore, this study is not representative of all women caregivers in Gallatin County.

Definition of Terms

Activity of Daily Living: Refers to personal care such as bathing, feeding, dressing.

Attitude: A hypothetical construct representing an enduring organization of motivational, perceptual and cognitive processes with respect to some aspect of the individual's world (Scott, 1968).

Caregivers: Women who provide support for the older adult through direct service or have the responsibility for supervision of hired services. The caregiver is

identified as a primary caretaker through a minimum contact of monthly interaction, verified by the supplemental questionnaire, and by interview with agency personnel. The caregiver is the daughter or daughter-in-law of an elder in a nursing home, an elder receiving home health care or an elder registered as a volunteer. The women are residents of Gallatin county.

Dependent: The functionally impaired elderly women who receives assistance from community agencies or from a long term care facility.

Functional Health Status: Ability of the older person to perform activities of daily living or instrumental activities of daily living to the degree of meeting criteria of eligibility of the community health agencies or institutional placement which is established by federal funding sources.

Home Health Agency: A community based organization that provides support services in activities of daily living, or instrumental activities of daily living and may included skilled nursing care. For the purpose of this study, such agencies are eligible for medicaid, medicare or Title III funds.

Independent: The elderly women who does not receive assistance from community agencies or from a long term care facility.

Instrumental Activities of Daily Living: Refers to activities inside and outside the home. For example, housework, meal preparation, shopping and transportation.

Middle Age: Middle age, for the purpose of this study, is defined as the period between 40 to 59 years of age.

Nursing Facility: A residential care facility that is licensed to provide intermediate or skilled care as defined by medicare and medicaid reimbursement policies.

Opinion: Conceived as a verbal manifestation of an attitude. Opinion is essentially an evaluation or prediction concerning the object (Kafer, 1981; Scott, 1968).

Stereotype: A consensual belief concerning expected behavior and attributes about some social group or category (Kafer, 1981).

CHAPTER 2

REVIEW OF LITERATURE

Introduction

A review of literature in the following areas provides a foundation for the attitude study of middle aged women who are caregivers. A psychological perspective of attitude construct and it's relationship to behavior provides an understanding of the impact of experience on attitude formation. The current gerontological knowledge of attitudes toward the aged and the issue of stereotypes reveals the pervasive negative view of the aged. The significance of middle age as a developmental process dealing with the consequences of individual aging and as caregivers who direct the services and quality of life for the aged, cannot be underestimated.

Attitude Construct and Relationship to Behavior

Most writers suggest that attitude is composed of three components: cognitive, affective, and behavioral, that is, a predisposition to action (Glass & Knott, 1982). Attitude, according to Youmans (1977), refers to a complex of knowledge, beliefs, notions, convictions and values by which a person expresses

ways of looking at things and situations. In discussing attitudes, Halloran (1967, p. 14) states, "Attitudes are not innate, they are learned, they develop and they are organized by experience." From the literature, there appears to be three primary ways that attitudes can be formed or changed (1) through interaction with others, (2) through direct experience with attitude objects, and (3) through more knowledge. Authors believe attitudes can be learned and they can be changed (Glass & Knott, 1982; McKeachie & Doyle, 1966). Changes in the cognitive component related to aging have been studied with mixed results. Cognitive attitude studies focus on participation in workshops, classes and support groups which provide information on aging (Glass & Trent, 1980; Tuckman & Lorge, 1953a).

Attitudes can be formed and changed through an affective component. Knox (1977, p. 364) states, "Attitudes reflect internal and external influences, and they shift over time as the individual interacts with the environment." Attitude is related to self concept and locus of control (Myers, 1991). Research reports there is a definite conflict between negative attitudes toward the aged as group and a positive response tendency toward a personalized older person (Weinberger & Millham, 1975), suggesting the influence of affect. When emotions are involved, the attitude expression may be filtered. The individual's past experiences and sentiments are evoked to become the dominant attitudinal determents (Taylor, 1981).

The study by Kafer et al. (1980) relates attitude to behavior. The authors state that unfortunately the presumed associations between attitudes and behavior have proven difficult to document. Attitudes measured by a reliable and valid scale may in fact have minimal associations with behavioral indices. When attitudes are equated with behavior, the researcher is faced with multiple explanations given for apparently similar action by several individuals. When attitudes are defined independently of behavior, the ability of attitude scales to predict specific behavioral events is suspect.

However, other authors state direct experience has been shown to be an important mediation factor in the predictability of behavior through attitude measures (Zanna, Olson, & Fazio, 1978). Researchers have found that attitudes formed as a consequence of direct experience are better predictors of behavior than attitudes formed through indirect experience. These attitudes are held with greater confidence and are defined more clearly (Murphy-Russell, Die, & Walker, 1986). Fazio, Zanna, and Cooper (1978) suggest a crucial information processing difference may also exist between direct and indirect experience. As direct experience, or action, relates to aging, Knox (1977) thinks self-reported quality of contact with the general elderly may be a powerful determinant of one's views of them. Therefore, the interaction of middle aged females as caregivers with their parents may contribute to a difference in their attitudes toward aging.

Attitude Studies Related to Gerontology

Other factors, beside the three components of attitude formation, influence attitude. McTavish (1971) suggests that researchers study attitudes on multiple levels including the consideration of differences in respondent's socio-cultural context, comparison of alternative measurement approaches, and recognition of the multidimensional character of attitudes toward the aged. An awareness of the multidimensional nature of attitudes toward aging has grown in recent literature (Kafer, 1981).

Bennett and Eckman (1973, p. 243) in their review of the literature on attitudes in gerontology classify these studies according to five types of content.

a. Attitude toward aging which consist of evaluation of the process of aging.
b. Attitude toward aging which are evaluations by any age group of the aged as a group.
c. Morale and life satisfaction which are attitude reflections and evaluations of one's surroundings and one's life circumstances.
d. Self image which is an attitude toward or evaluation of oneself.
e. Conformity and rigidity which are viewed as personality and or behavior traits of a more enduring form than attitudes. Conformity is related to one's willingness to accept others evaluation or opinions as one's own. Rigidity is the inability or unwillingness to change one's attitudes.

The first four categories of Bennett and Eckman's 1973 classification system are evaluations of group and process orientations. The fifth is intensity and strength of feeling (Kafer, 1981).

Since the first study on attitudes was done in 1944 (Palmore, 1982), hundreds of research projects have been undertaken. In spite of the volume of

work, agreement on attitudes toward the elderly is unclear. Many studies report that respondents view the aged and the special problems they have negatively. Several articles have summarized this literature (Bader, 1980; Kogan, 1979; Palmore, 1982; Schonfield, 1982).

One of the first studies investigating attitudes was conducted by Tuckman and Lorge in 1953. The results from this study of graduate students indicated that there was considerable acceptance of negative stereotypes of old people. This group response indicates that old age is looked upon as a period characterized by economic insecurity, poor health, loneliness, resistance to change, and failing physical and mental powers. Other studies since have reported negative views toward aging of college students (Hickey, Hickey, & Kalish, 1968; Kluge, Mansbach, & Johnson, 1984; Weinberger & Millham, 1975). Studies of other age groups, including children (Hickey et al., 1968) and adults in general (Harris and Associates, 1981) concur with this predominantly negative attitude. Martel (1968) studied magazine fiction of the United States between 1890-1955 and reported evidence supporting the declining status of mature middle aged and older people.

Tringo (1970) investigated the preference hierarchies for various groups termed disability groups and found that a rank order existed. People with physical disabilities were most accepted. Sensory related disabilities were second. Old age was eleventh, followed by those with spinal cord or brain injuries. The last of the 21 groups was convicts and persons with mental disorders. Negative reports emerge from social and health professionals who are likely to work directly with

elderly clients in fields such as nursing (Campbell, 1971), social work (Mutchler, 1971), medicine (Lieff, 1982), and psychology (Ray, McKinney, & Ford, 1987).

Collette-Pratt (1976) suggests three possible explanations for negative attitudes. They may originate from the life satisfaction research that equates continuing social relationships, financial security and good health to positive life satisfaction. The elderly are thought to have low social economic status, poor health, and be lonely. Another explanation is that the elderly are devalued because of the lack of opportunity to reflect the American values of productivity, achievement and independence (Clark, 1967). A third possible explanation is the age stratification that divides American society and fosters stereotypes and misinformation about the elderly in younger people (Riley, 1968).

Discrepancies found among attitude studies have been noted by several authors (Bennett & Eckman, 1973; McTavish, 1971). These authors conclude that evidence for the existence of negative or otherwise stereotypical perceptions of the elderly and of old age is equivocal at best (Wingard, Heath, & Himelstein, 1982). Schonfield (1982) has challenged the validity of the negative attitudes and labeled the assumption as a social myth. Austin (1985) found the elderly are being viewed more positively at least in comparison to others toward whom negative attitudes are traditionally held.

Stereotypes

Taylor (1981) has suggested that stereotyping is a process that essentially represents a form of categorizing social stimuli into groups whose members are perceived to share some common attribute. Within this context, any physical or social cue can provide a sufficient basis for categorizing people (Wingard, Heath, & Himelstein, 1982). When one utilizes a cognitive structure formed from misconceptions and stereotypes when dealing with individuals, one shapes the person's capabilities, choices and level of activities (Furstenberg, 1989).

In our culture, with its emphasis on youth, stereotypes about aging are generally negative. Tuckman and Lorge (1953b) postulate that these cultural expectations encourage the formation of misconceptions and stereotypes of old age. Many of these stereotypes have no biological, sociological or psychological evidence to support them (Seccombe & Ishii-Kuntz, 1991). Harris and Associates (1981) concluded that the reality of old age is very different from the negative perception held by the general public.

Research shows that attitudes toward aging on the part of widely different groups, high school students to institutionalized aged, show considerable agreement with the misconceptions and stereotypes about old people and the older worker (Tuckman & Lorge, 1958). Palmore (1977) documents the extent of misconceptions through his Facts on Aging quiz. Kluge, Mansbach, and Johnson (1984) found that both undergraduates and aged share misconceptions about

aging. Elected public officials share such sentiments. A content analysis of congressional documents indicated that two thirds of statements and speeches contained at least some stereotype of elderly persons and 82.5% of these misconceptions were negative in nature (Lubomudrov, 1987).

Significance of the Middle Aged

In 1890, the average life span was 47 years (Myers, 1991). In the year 2000, people can expect to live into their eighties, nearly twice as long. Although the ages from 35 to 55 are often considered the prime of life, the literature states that these years precipitate new developmental tasks. Some of those developmental tasks are to confront the young and old within oneself (Levinson, 1978), to plan for the inevitability of one's own aging (Havighurst, 1972), and to adjust to aging parents (Dobson & Dobson, 1985).

Eisdorfer (1977) has discussed the similarities between changes in later adulthood and those occurring in adolescence. However, Riley, Foner, Hess and Toby (1969) point out the focus of adolescence is increased status, whereas the movement of middle aged adults is toward decreased status (Dobson & Dobson, 1985). Dobson and Dobson also found middle aged adults are becoming aware of their own mortality which heightens the sense of running out of time. Youmans (1977, p. 177) states, "It appears old age characteristics may set in during later middle age and remain fairly constant into later age." Knox (1977) cites aging as an appropriate topic for persons concerned with middle life transition. In terms of

adult development, the middle years would seem an optimum time to address attitudes toward aging and the aged.

Although there has been little research conducted expressly to measure the attitude of the middle aged, existing studies show that their attitudes reflect the negative trend presented by the population as a whole (Kalish & Johnson, 1970; Tuckman & Lorge, 1953a, 1958). Collette-Pratt (1976) found middle aged subjects, age 30-59, were most negative toward social isolation and financial insecurity compared to older and younger groups. The same study also found in that in middle age, negative attitudes toward death were the best predictor of the devaluation of old age. Kogan (1961b) found that the most problems associated with aging were held by middle aged adults when compared with the young and the old. Seccombe and Ishii-Kuntz (1991) state the middle aged experience trepidation and anxiety about the aging process. However, Glass and Knott (1982) determined that middle aged adults held slightly positive attitudes toward aged.

The attitudes of the middle aged take on increased importance when one considers that this age group is found in positions of influence and decision making. Neugarten (1968) observes society is oriented toward youth but it is controlled by the middle-aged. The middle aged control the policies and programs on which many older adults find themselves dependent. They also impact future public welfare as they influence the formation of attitudes of the young (Harris and Associates, 1975). The attitudes the middle age impart to the young are most

likely the attitudes by which those same middle aged will be judged when they move into the aged population themselves (Glass & Knott, 1982).

Caregivers

Middle aged adults, after seeing their children reach financial and emotional independence, are often needed by their parents. In 1983, Baumhaover referred to middle aged adults faced with raising children and caring for aging parents as the sandwich generation (Dobson & Dobson, 1985). Though the myth of neglectful and uncaring children has persisted (Shanas, 1979), researchers continue to find that strong and pervasive norms of family responsibility to the elderly exist, and those norms are exhibited in actual caregiver behavior.

Caregivers of the elderly were identified by Soldo and Myllyluoma (1983) as being members of the adult child generation, predominately middle aged, with approximately eight of ten being women. Much previous research has established the role of daughters as the primary helpers to the disabled old (Brody, 1981; Shanas, 1979). Daughters are three times more likely to share their household with a dependent parent (Brody & Schoonover, 1986). Studies suggest that there is consistency in the experience of daughters and daughter-in-laws caring for elderly relatives (Cattanach & Tebes, 1991).

The informal support network, consisting of the family and females in particular, rather than the formal system provides the bulk of long term heath and social care. Demographic trends indicate that it is unreasonable to assume

families can deal with all of the age related problems of parents, but it is generally agreed that institutionalization represents a last resort in providing for aged family members.

The elderly and their families often hold negative attitudes toward nursing facility placement (Shanas, 1979). The Smith and Bengston (1979) study does not uphold the notion of the literature that negative attitudes prevail, rather the families of nursing home patients expressed positive attitudes about aging. Rakowski (1983) found that the caregiving experience was not related to attitudes, although ratings of parental health and self-health did show associations.

Variables Related to Attitudes of Aging

Relationships between attitudes toward aging and the aged and several classes of variables have been examined in past research. However, the relationship of these attitudes and variables have been reported with mixed results. Skoglund (1977) according to Kafer (1981) explains this diversity of findings due to methodological shortcomings as well as societal changes in values. A study of the literature suggests that certain personal and situational variables might be related to attitudes toward older persons. These variables are age, race, gender, geographic location, contact with the elderly, health status, education, and socio-economic status, dependence of the parent, and religion (Glass & Knott, 1982).

For the purpose of this study, the design controls several significant variables. Age is narrowly defined, including only those caregivers who are

between the ages of 40 to 59. Most studies utilize age as a variable when comparing groups of children, college age persons or the elderly (Kogan & Shelton, 1962a; Kogan & Wallach, 1961; Tuckman & Lorge, 1953b).

Gender is not a relevant variable as the participants all are female. However, no clear relationship has been found for gender difference and attitudes. Kogan (1961a) found no association between attitudes and gender; Tuckman and Lorge (1958) found women to have a somewhat more negative view of the elderly; while Skoglund (1977) in Kafer (1981) found women to have slightly more favorable attitudes toward the elderly.

The design of this study defines the level of dependence of the parent and geographic location of the caregiver. Contact with the elderly is addressed through the criteria defining the caregiver. The literature on contact is again ambiguous. Two studies, Drake (1957) and Chappell (1977), indicate that contact with the elderly is not significantly related to attitude. However, the majority of research finds that increased contact with the elderly results in slightly more positive attitudes (Porter & O'Connor, 1978; Olejnik & LaRue, 1981). This study does not address race or religion because the population of Gallatin County is predominantly white and protestant (U.S. Census, 1991).

The remaining variables of interest as suggested by the literature are income, caregiver health status, and education. Tentative relationships have been found between low social class and stereotyped views of the elderly (Hickey et al., 1968; Rosencranz & McNevin, 1969). This relationship has generally been

negative in character. Health status, when rated as poor, has been found to adversely affect attitudes toward aging (Johnson, 1978). Higher income has been correlated with positive attitudes (Harris and Associates, 1975) while educational levels have had mixed results (Holtzman & Beck, 1979).

CHAPTER 3

PROCEDURES

Introduction

This research queried if a difference existed among middle-aged women of Gallatin County, Montana in their attitudes toward personal aging, aging of peers, and toward the aged as a group based on the functional health status of their mother or mother-in-law. A secondary purpose was to determine if education, income and self-rated health status of these middle aged women made a difference in their attitudes.

The caregivers, that is the middle-aged daughters/daughters-in-law, were assigned group membership according to the location of their mother or mother-in-law who might reside in a nursing home, live in the community and receive home health care, or live without assistance in the community. The caregiver's attitudes were assessed using a multidimensional tool, the Aging Opinion Survey (Kafer, 1981). The variables of education, income status, and self-rated health status were gathered with a supplemental questionnaire.

The procedures for this study are presented in this chapter as follows:

(1) population description,

(2) methods of data collection,

(3) organization of data,

(4) statistical hypotheses,

(5) analysis of data, and

(6) precautions taken for accuracy.

Population Description

The state of Montana has 132,000 citizens over the age of 65 (U.S. Census, 1990). Pioneers on the Frontier of Life (Refsland & Straub, 1990) report 9.5% of older Montanans living in the community are receiving some type of supported living and 8% of Montanans over 65 are residing in nursing facilities. Gallatin County has 4,489 people over the age of 65 (U.S. Census, 1990) and 8% are residing in nursing facilities. Gallatin County is representative of the state in the distribution of its aged population and represents the more urban counties such as Lewis and Clark, Silverbow, Missoula, and Yellowstone in available community services that support the dependent elderly.

The dyad studied was the middle-aged daughter or daughter-in-law as caregiver and mother or mother-in-law as the recipient. Middle aged was defined as the years between 40 to 59 because many government programs qualify persons for senior services at the age of 60. The middle aged caregiver assists in the supportive care of the parent either through activities of daily living or

instrumental activities of daily living. The caregiver support might be direct services or purchased.

The mother or mother-in-law was 60 years or older, and her degree of dependency was initially identified by her place of residence. She could be a resident of a nursing home, live in the community and receive home health services, or live in the community and belong to the Gallatin County Retired Senior Volunteer Program (RSVP). Additional verification of this functional status was checked in the supplemental portion of the questionnaire. The caregiver was asked to rate the functional level of her parent as independent (needs no assistance), semi-dependent (needs assistance weekly), and dependent (needs assistance daily). Dependent relatives, that is the functionally impaired elderly woman, were either residing in a nursing facility or receiving home care through community agencies. Eligibility for either nursing home placement or home health care mandates a physician referral.

The three Gallatin County medicare/medicaid licensed nursing facilities, Bozeman Care Center, Mountain View Care Center, and Gallatin County Nursing Home participated in the study. The identified nursing home population was 85 elderly women who had a daughter/daughter-in-law living in Gallatin County. Of the 85 caregivers polled, 74 responses (87%) were received, with 48 caregivers between the ages of 40 and 59. Twenty-six caregivers were out of the middle age range.

The dependent elderly in the community were enrolled with a Gallatin County licensed home health agency. These agencies were Bozeman Deaconess Home Care, Gallatin Home Care, Gallatin County Health Department, and Case Management Services. The number of elderly women who had a daughter/daughter-in-law was 39. The number of respondents was 33 (84.6%); 28 were middle aged as defined by this study.

The independent relative was identified through the RSVP. The Director and Staff of RSVP further verified that the seniors polled were not residents of a long term care facility and were known to be independent in activities of daily living. Fifty-eight volunteers reported having daughters/daughter-in-laws living in Gallatin County and 49 caregivers responded (84.5%). There were 32 daughters/ daughters-in-law identified as middle aged women in the age range 40 to 59.

Methods of Data Collection

The researcher met with the administrators, nursing directors and social service personnel of each nursing home; with the directors and staff of the home health agencies; and with the Director and Volunteer Coordinator of the Gallatin County Retired Senior Volunteer Program to discuss the purpose of the study, the proposed methodology, and to identify the specific needs for implementing the survey. This interview identified which method of data collection would meet the confidentiality criteria of the agencies.

The agencies chose to survey all female recipients as it was difficult to identify only caregivers who were middle aged. The Bozeman Care Center, Mountain View Care Center, Bozeman Deaconess Home Care, Case Management Services, Gallatin County Health Department, Gallatin Home Care contacted the potential caregivers by phone to ask for their participation. The Gallatin County RSVP program contacted their female volunteers requesting permission to contact their relative. All agencies, with the exception of the Gallatin Home Care and Gallatin County RSVP, held the caregiver's name in confidence and, under the supervision of this researcher, implemented the mail survey. The researcher was provided caregiver names from the Gallatin Home Care and Gallatin RSVP and conducted those mail surveys directly.

The mail survey was implemented according to the total design method developed by Dillman (1978). The participating agencies introduced the researcher and purpose of the research in a personalized cover letter on agency letterhead. This cover letter provided an explanation of the study, the dependence of success on the respondent's participation, an explanation of the identification number used for coding purposes, an assurance of confidentiality, and the phone number of the researcher for questions. Included in the first mailing was the questionnaire and a stamped return envelope.

The initial mailing was followed up exactly one week later by a postcard thanking people in advance for returning the questionnaire, while reminding those who had not, to please do so. Three weeks later a second letter and a replacement

questionnaire was sent only to non-respondents. After seven weeks, the last attempt was made to contact non-respondents. In these instances the participating agency, or researcher, contacted the caregiver by phone or in person to ensure the recipient had an opportunity to respond, to address any personal concerns, or to assist in the completion of the instrument.

Instrumentation

The Aging Opinion Survey (Kafer, 1981; Kafer et al., 1980) was employed to measure the attitudes toward aging. A copy of the instrument is located in Appendix A. It is a self-report instrument that is estimated to take between 15 and 20 minutes to complete. The Aging Opinion Survey is comprised of three 15-item scales: (a) Personal Anxiety About Aging, which is concerned with attitudes toward one's own aging (alpha reliability = .68); (b) Stereotypic Age Decrement, which measures the perceived aging of friends and same aged peers (alpha reliability = .81); and (c) Social Value of the Elderly, which is concerned with opinions toward the elderly as a general-other group (alpha reliability = .76). Responses to each statement are marked on a five-point, Likert-type scale ("Strongly Agree" to "Strongly Disagree"). Some statements are phrased positively and others negatively to control for response bias. Each factor covers attitudes in a variety of content domains. These domains are the anticipated health status of the respondent, knowledge of the facts of the aging process, perceptions of dependence on others of the elderly, and sociability which reflects the value of the

aged as a group and activity level of the elderly. Lower scores, below the "uncertain" or "neutral" score of 46, tend to indicate a less favorable outlook. Those scoring 60 and above would have a more positive attitude.

Construct validity, that is, analysis of the convergent and discriminant validity of the Aging Opinion Survey was conducted by Kafer in the context of a multitrait-multimethod matrix formed by the correlations of the three Aging Opinion Survey subscales to subscales formed from the Tuckman-Lorge Questionnaire, the positive and negative scales of the Attitudes toward Old People scale which measures trait anxiety, and the Marlowe-Crowne social desirability instrument. The analysis of factor structure involved fitting various configurations of trait and method factors to the multitrait-multimethod correlation matrix. Three factors in all the multiple-factor solutions were interpretable as representing decline due to the aging process, anxiety toward aging, and evaluation of the elderly as a group, thus providing support for the hypothesized structural properties of the scales comprising the Aging Opinion Survey. Kafer's study shows substantial evidence supporting the validity and interpretation of the Aging Opinion Survey. The amount and configuration of variance revealed in attitudes toward aging identified by the Aging Opinion Survey is consistent with the outcomes of previous research.

Further application of the Aging Opinion Survey was conducted by Kafer and Delaney (1988) as a cross validation of the survey instrument using an American sample (n = 367) and a comparable Canadian sample (n = 120). The

authors reported qualitative differences in the factor structure; the American sample closely fitting the previous research while the Canadian sample revealed qualitative differences. The authors conclude that the two samples were not comparable, possibly due to the culture differences in attitudes toward aging including a difference in the health care systems which may affect the anticipated consequences of aging.

A study of 74 young adults examined the relationship of parental health status and attitudes toward aging using the Aging Opinion Survey (Rakowski, Barber, & Seelbach, 1983). Their results showed unfavorable parental health was associated with greater anxiety toward personal aging and a less positive view of friend's and peer's aging. The responses on the three Aging Opinion Survey subscales did not differ significantly from those obtained in the larger study by Kafer.

Riddick (1985) used the subscale personal anxiety toward aging of the Aging Opinion Survey to study the impact of an inservice educational program, concluding that the educational program made no significant difference and personal anxiety toward aging remained high. Katz (1990) used the Aging Opinion Survey in her study of personality trait correlates of attitudes toward older people. The study used Pearson correlation coefficients consisting of the three Aging Opinion Survey subscales and the Cattell 16 Personality Factors Test, finding 29 of 48 correlations to be significant. Katz concludes there are constellations of personality traits related to attitudes.

For this study, in addition to the Aging Opinion Survey, a multi-choice questionnaire was developed to collect demographic variables from the caregiver including education, income, and self-rated health status (see Appendix B). The information collected also assisted the researcher in verifying the dependence of the relative, frequency of interaction between caregiver and relative, and the age of the respondent. The inclusion of an open ended question provided the respondent an opportunity to voice any concerns about the responsibility of caregiving or feelings regarding their own aging process. These comments are located in Appendix C.

Organization of Data

The data is organized according to caregiver membership in three groups, reflecting the functional status of their elder female relative. These three groups are elders living in medicare/medicaid licensed nursing homes, elders living in the community with assistance from medicare/medicaid licensed home health agencies and elders who live in the community with no agency support system. The descriptive data of these groups is given first, including the overall means of the scores on the Aging Opinion Survey. The analysis of variance examining the interaction and main effects regarding group membership, education, income, and self-rated health with the scores of the Aging Opinion Survey are presented.

Analysis of Data

The design of this study used the scores of the Aging Opinion Survey as its dependent variable. These scores measure the caregiver's attitude toward their personal anxiety of aging, the aging of their peers, and their attitude toward the aged as a group. The independent variables in the study design were caregiver group membership (according to the functional status of their relative) and the caregiver's education, income, and self-rated health status.

Statistical tests employed were a two-way analysis of variance to examine interactions between the independent variables of group membership, education, income, and self-rated health with the Aging Opinion Survey subscores as the dependent variables. When interactions were present, they were checked for ordinal versus disordinal interaction. Where no interactions occurred, the main effects were examined to identify if a statistically significant difference existed.

The assumption of equal variances and a normally distributed population were handled by relying on the robust nature of the F-test (Ferguson, 1981). However, caution must be used in inferring to other populations due to the small number of respondents in this study and the non-random selection of the sample.

All of the dependent data were raw scores on the Aging Opinion Survey instrument. Table 1 summarizes the variables studied.

Table 1. Summary of Variables for Analysis.

Independent	Dependent
Caregiver group x education	AOS scores
Caregiver group x income	AOS scores
Caregiver group x self-rated health	AOS scores

In selecting the level of significance, which is the probability defining how rare or unlikely the data may occur before rejecting the null hypothesis, the consequences of making a TYPE I error (rejecting a true null) or a TYPE II error (retaining a false null) must be determined. In this study, a consequence of making a TYPE I error would indicate there was a difference in attitudes on aging in the three groups studied, when there actually was no difference. A TYPE I error might lead to the creation of educational materials and support resources developed for the caregivers; this effort may be translated into cost and time expended by providers.

A TYPE II error would result in the researcher believing there were no differences among the three groups of women, when in fact there were differences of attitude. This error would have a more serious consequence as the research may discourage further inquiry into the relationships and needs of caregivers. Because attitude is an important element in the aging process, a disservice to the population by not recognizing attitude differences would be a result of a TYPE II

error. Therefore, the level of significance to control for a TYPE II error was set at .05.

Statistical Hypotheses

To answer the general questions asked by the study, the following sets of hypotheses were developed and tested by nine two-way analysis of variance procedures.

(1) Is there a difference of the caregivers' attitudes by group membership toward personal anxiety of aging, the aging of peers, and the aged as a group according to their education level?

Variables: Education x Caregiver Group with Dependent Variable Personal Anxiety of Aging

H_0: There is no interaction between the independent variables education and caregiver groups on the dependent variable attitude toward personal anxiety of aging.

H_1: There is interaction between the independent variables education and caregiver groups on the dependent variable attitude toward personal anxiety of aging.

H_0: There is no statistically significant difference between the independent variable education and the attitude toward personal anxiety of aging.

H_1: There is a statistically significant difference between the independent variable education and the attitude toward personal anxiety of aging.

H_0: There is no statistically significant difference between caregiver groups and the attitude toward personal anxiety of aging.

H_1: There is a statistically significant difference between caregiver groups and the attitude toward personal anxiety of aging.

Variables: Education x Caregiver Group with Dependent Variable Aging of Peers

H_0: There is no interaction between the independent variables education and caregiver groups on the dependent variable attitude toward the aging of peers.

H_1: There is interaction between the independent variables education and caregiver groups on the dependent variable attitude toward the aging of peers.

H_0: There is no statistically significant difference between the independent variable education and attitude toward the aging of peers.

H_1: There is a statistically significant difference between the independent variable education and attitude toward the aging of peers.

H_0: There is no statistically significant difference between caregiver groups and attitude toward the aging of peers.

H_1: There is a statistically significant difference between caregiver groups and attitude toward the aging of peers.

Variables: Education x Caregiver Group with Dependent Variable Aged as a Group

H_0: There is no interaction between the independent variables education and caregiver groups on the dependent variable attitude toward the aged as a group.

H_1: There is an interaction between the independent variables education and caregiver groups on the dependent variable attitude toward the aged as a group.

H_0: There is no statistically significant difference between the independent variable education and attitude toward the aged as a group.

H_1: There is a statistically significant difference between the independent variable education and attitude toward the aged as a group.

H_0: There is no statistically significant difference between caregiver groups and attitude toward the aged as a group.

H_1: There is a statistically significant difference between caregiver groups and attitude toward the aged as a group.

(2) Is there a difference in caregivers' attitudes by group membership toward personal anxiety of aging, the aging of peers, and the aged as a group according to their income level?

Variables: Income x Caregiver Group with Dependent Variable Personal Anxiety of Aging

H_0: There is no interaction between the independent variables income and caregiver groups on the dependent variable attitude toward personal anxiety of aging.

H_1: There is an interaction between the independent variables income and caregiver groups on the dependent variable attitude toward personal anxiety of aging.

H_0: There is no statistically significant difference between the independent variable income and attitude toward personal anxiety of aging.

H_1: There is a statistically significant difference between the independent variable income and attitude toward personal anxiety of aging.

H_0: There is no statistically significant difference between caregiver groups and attitude toward personal anxiety of aging.

H_1: There is a statistically significant difference between caregiver groups and attitude toward personal anxiety of aging.

Variables: Income x Caregiver Group with Dependent Variable Aging of Peers

H_0: There is no interaction between the independent variables income and caregiver groups on the dependent variable attitude toward the aging of peers.

H_1: There is an interaction between the independent variables income and caregiver groups on the dependent variable attitude toward the aging of peers.

H_0: There is no statistically significant difference between the independent variable income and attitude toward the aging of peers.

H_1: There is a statistically significant difference between the independent variable income and attitude toward the aging of peers.

H_0: There is no statistically significant difference between caregiver groups and attitude toward the aging of peers.

H_1: There is a statistically significant difference between caregiver groups and attitude toward the aging of peers.

Variables: Income x Caregiver Group with Dependent Variable Aged as a Group

H_0: There is no interaction between the independent variables income and caregiver groups on the dependent variable attitude toward the aged as a group.

H_1: There is an interaction between the independent variables income and caregiver groups on the dependent variable attitude toward the aged as a group.

H_0: There is no statistically significant difference between the independent variable income and attitude toward the aged as a group.

H_1: There is a statistically significant difference between the independent variable income and attitude toward the aged as a group.

H_0: There is no statistically significant difference between caregiver groups and attitude toward the aged as a group.

H_1: There is a statistically significant difference between caregiver groups and attitude toward the aged as a group.

(3) Is there a difference of the caregivers' attitudes by group membership toward personal anxiety of aging, the aging of peers, and the aged as a group according to their self-rated health status?

Variables: Self-Rated Health Status x Caregiver Group with Dependent Variable Personal Anxiety of Aging

H_0: There is no interaction between the independent variables self-rated health and caregiver groups on the dependent variable attitude toward personal anxiety of aging.

H_1: There is an interaction between the independent variables self-rated health and caregiver groups on the dependent variable attitude toward personal anxiety of aging.

H_0: There is no statistically significant difference between the independent variable self-rated health and attitude toward personal anxiety of aging.

H_1: There is a statistically significant difference between the independent variable self-rated health and attitude toward personal anxiety of aging.

H_0: There is no statistically significant difference between caregiver groups and attitude toward personal anxiety of aging.

H_1: There is a statistically significant difference between caregiver groups and attitude toward personal anxiety of aging.

Variables: Self-Rated Health x Caregiver Group with Dependent Variable Aging of Peers

H_0: There is no interaction between the independent variables self-rated health and caregiver groups on the dependent variable attitude toward the aging of peers.

H_1: There is an interaction between the independent variables self-rated health and caregiver groups on the dependent variable attitude toward the aging of peers.

H_0: There is no statistically significant difference between the independent variable self-rated health and attitude toward the aging of peers.

H_1: There is a statistically significant difference between the independent variable self-rated health and attitude toward the aging of peers.

H_0: There is no statistically significant difference between caregiver groups and attitude toward the aging of peers.

H_1: There is a statistically significant difference between caregiver groups and attitude toward the aging of peers.

Variables: Self-Rated Health x Caregiver Group with Dependent Variable Aged as a Group

H_0: There is no interaction between the independent variables self-rated health and caregiver groups on the dependent variable attitude toward the aged as a group.

H_1: There is an interaction between the independent variables self-rated health and caregiver groups on the dependent variable attitude toward the aged as a group.

H_0: There is no statistically significant difference between the independent variable self-rated health and attitude toward the aged as a group.

H_1: There is a statistically significant difference between the independent variable self-rated health and attitude toward the aged as a group.

H_0: There is no statistically significant difference between caregiver groups and attitude toward the aged as a group.

H_1: There is a statistically significant difference between caregiver groups and attitude toward the aged as a group.

Precautions Taken for Accuracy

The questionnaires were hand scored and checked twice for accuracy. All incomplete data sets (six) were deleted. A VAX/VMS computer located at Montana State University was used to analyze the statistical procedures. The data was placed into a computer file and the computer printout of the raw data was checked against the original data. SPSS software was used. The statistical analysis of the data is presented in Chapter 4.

CHAPTER 4

ANALYSIS OF DATA

Introduction

The data reported in this chapter are presented as follows:

(1) descriptive summary of the caregiver respondents in Gallatin County,

(2) descriptions of the caregivers as divided into three groups reflecting the functional status of the elder,

(3) findings of analysis of variance regarding the independent variables of education, income, self-rated health and group membership on the scores of the Aging Opinion Survey.

The data reported are organized by the variables education, income, and self-rated health. These variables are listed according to Aging Opinion Survey sections that measure attitude toward personal anxiety of aging, attitude toward the aging of one's peers, and attitude toward the aged as a group. Each research question is answered with the appropriate statistical hypothesis. The level of significance was set at alpha = .05.

Middle Aged Women Caregivers in Gallatin County

In July, 1993, service agencies in Gallatin County identified 182 women caregivers. The mail survey, implemented from August through September, generated a response rate of 156 or 86%. Of these 156 women, 108 were between the ages of 40-59 which was the age range identified in this study as middle aged. The supplemental questionnaire provided a profile of the majority of these middle aged women as being high school graduates (95%) and employed (76%). Their elderly mother or mother-in-law was likely to be widowed (71%); however 25% were still married and 11% were divorced. The caregivers reported visiting their mother on a daily (36%) or weekly basis (59%). More than half of the respondents (64%) had been caregivers for over six months. Twenty-eight percent of the caregivers had sole responsibility for the care of their relative. See Table 2 for a summary of the demographic information.

Scoring instructions of the Aging Opinion Survey state that a mean score of 46 or below suggests an attitude on the negative side. Conversely, scores above 46 indicate a more positive attitude. A summary of the mean scores for the caregivers is located in Table 3.

Table 2. Summary of Frequency Responses to Demographic Questions.

Question	Response	Percent of Responses
Length of caregiving responsibility	Less than one month	5
	Less than six months	60
	Over six months	35
Caregiver shares responsibility	Yes	73
	No	27
Frequency of caregiver visits	Monthly or less frequently	5
	Weekly	59
	Daily	36
Marital status of elderly women	Married	23
	Divorced or separated	10
	Widowed	66
	Other	1
Employment status of caregiver	Employed outside the home	70
	Unemployed	4
	Retired	6
	Homemakers	20
Education level of caregiver	Did not finish high school	5
	Graduated from high school	56
	Graduated from college	39
Self-rated health status of caregiver	Good	74
	Fair	26
Household income of caregiver	Under 20,000	18
	Between 20,001 and 45,000	54
	Over 45,001	24
	Note: Five non-responses	

Table 3. Summary of Mean Scores on the Aging Opinion Survey.

AOS Scales	Nursing Home Caregivers	Home Health Caregivers	Independent Caregivers	Mean
Personal anxiety	58.59	55.93	55.44	56.66
Aging of peers	47.50	48.00	49.75	48.42
Aged as a group	45.00	44.25	44.41	44.56
Mean AOS	50.37	49.40	49.87	49.88

Description of the Three Groups of Caregivers

Caregivers of Nursing Home Residents

The three medicare/medicaid licensed nursing facilities in Gallatin County identified 85 women caregivers as survey participants. The 86% response rate of this group revealed that 25 were over the age of 60 and 48 were in the catchment group of middle age. Four caregivers were under the age of 40. Therefore, 48 caregivers are female, middle aged, and are caregivers to mothers/mothers-in-law residing in nursing homes in Gallatin County. The mean for the total score on the Aging Opinion Survey for this group was 50.37.

Caregivers of Home Health Care Recipients

The four medicare/medicaid licensed home health agencies in Gallatin County participated in this study. Unfortunately, this provider group population is small due to two reasons. First is the duplication of clients served under both the

Gallatin Home Care program and the Case Management Services and second is the reduction in case load of the Gallatin County Health Department in anticipation of ending their medicare participation the end of September 1993. Therefore, 39 possible caregivers were identified, with a return of 33 respondents (85%). Of these respondents, 5 were over the age of 60 leaving 28 middle aged, female caregivers whose mothers or mothers-in-law reside in the community and receive supportive health care from a home health agency. The mean for this group of caregivers on the total Aging Opinion Survey was 49.40.

Caregivers of Independent Relatives

The Gallatin County Retired Senior Volunteer Program has 321 volunteers, of which 286 are women. The RSVP staff wrote the women and requested their permission to contact their relative if they had a daughter or daughter-in-law living in Gallatin County. Of the 183 responses, 122 reported they had no daughter/daughter-in-law living in Gallatin County. The remaining 58 women provided their relatives names and addresses. Of the 58 caregivers contacted, 49 caregivers (84%) returned the survey. Of these respondents, six were over the age of 60 and eleven were younger than 40. This resulted in 32 middle aged women caregivers of elders living independently in the community. The mean for this group of caregivers on the Aging Opinion Survey was 49.87.

Analysis of Variance for Caregivers

The analysis of variance considered the dependent variables of attitude toward personal anxiety of aging, attitude toward the aging of one's peers and attitude toward the aged as a group and the independent variables of caregiver group membership, education, income and self-rated health. No interaction was found for the independent variables education and group membership on any of the three dependent variables. Significant differences were found between caregivers who had a high school education or less and those who had a college education on personal anxiety of aging ($p = .035$), the aging of peers ($p = .010$), and the attitude toward the aged as a group ($p = .048$). Caregivers who had a college education had more positive attitudes than those who were high school graduates.

Two interactions were found in the independent variables income and group membership with the dependent variables attitude toward the aging of peers ($p = .021$) and the attitude toward the aged as a group ($p = .038$). No interaction or significant difference was found in the variables income and group membership and personal anxiety toward aging.

No interaction was found for the independent variables self-rated health and group membership on any of the three dependent variables. However, significant differences were identified between caregivers who rated their health as good and caregivers who rated their health as fair on personal anxiety of aging ($p = .043$), the aging of peers ($p = .026$), and the attitude toward the aged as a

group (p = .002). Caregivers who rated their health good had more positive attitudes than those who rated their health as fair. No significant differences existed between caregiver groups and the three dependent variables.

Results

This section reports the results of the analysis of variance for each hypothesis tested.

Education

Due to only 5 persons reporting not graduating from high school, the data was collapsed into two categories, either a high school graduate or less (n = 66) or a college educated person (n = 42).

Table 4. Analysis of Variance for Education x Caregiver Group with Dependent Variable Personal Anxiety of Aging.

Source	DF	Sum of Squares	Mean Square	F value	P
Education	1	189.411	189.411	4.574	.035*
Caregiver Group	2	179.877	89.939	2.172	.119
Interaction	2	187.924	93.962	2.269	.109
Error	102	4223.939	41.411		

H_0: There is no interaction between the independent variables education and caregiver groups on the dependent variable attitude toward personal anxiety of aging.

Decision: Retain the null hypothesis at the alpha = .05 level. There was no interaction between education and caregiver group on the attitude toward personal anxiety of aging (F = 2.27, p = .11). The college educated caregivers of independent women had the higher mean of 60.00.

H_0: There is no statistically significant difference between the independent variable education and the attitude toward personal anxiety of aging.

Decision: Reject the null hypothesis at the alpha = .05 level. There was a statistically significant difference between the independent variable education and the attitude toward personal anxiety of aging (F = 4.57, p = .04).

H_0: There is no statistically significant difference between caregiver groups and the attitude toward personal anxiety of aging.

Decision: Retain the null hypothesis at the alpha = .05 level. There was no statistically significant difference between caregiver groups and the attitude toward personal anxiety of aging (F = 2.17, p = .12).

Table 5. Analysis of Variance for Education x Caregiver Group with Dependent Variable Aging of Peers.

Source	DF	Sum of Squares	Mean Square	F value	P
Education	1	441.252	441.252	6.901	.010*
Caregiver Group	2	143.433	71.717	1.122	.330
Interaction	2	163.633	81.817	1.280	.283
Error	102	4311.721	42.271		

H_0: There is no interaction between the independent variables education and caregiver groups on the dependent variable attitude toward the aging of peers.

Decision: Retain the null hypothesis at the alpha = .05 level. There was no interaction between the independent variables education and caregiver groups on the attitude toward the aging of peers ($F = 1.28$, $p = .28$). The college educated caregivers of women receiving home health had the higher mean of 53.00.

H_0: There is no statistically significant difference between the independent variable education and attitude toward the aging of peers.

Decision: Reject the null hypothesis at the alpha = .05 level. There is a statistically significant difference between the independent variable education and attitude toward the aging of peers ($F = 6.901$, $p = .01$).

H_0: There is no statistically significant difference between caregiver groups and attitude toward the aging of peers.

Decision: Retain the null hypothesis at the alpha = .05 level. There was no statistically significant difference between caregiver groups and attitude toward the aging of peers ($F = 1.12$, $p = .33$).

Table 6. Analysis of Variance for Education x Caregiver Group with Dependent Variable Aged as a Group.

Source	DF	Sum of Squares	Mean Square	F value	P
Education	1	236.669	236.669	4.015	.048*
Caregiver Group	2	28.944	14.472	.246	.783
Interaction	2	199.158	00.579	1.689	.190
Error	102	6012.155	58.943		

H_0: There is no interaction between the independent variables education and caregiver groups on the dependent variable attitude toward the aged as a group.

Decision: Retain the null hypothesis at the alpha = .05 level. There was no interaction between the independent variables education and caregiver groups on the dependent variable attitude toward the aged as a group ($F = 1.69$, $p = .19$). The college educated caregivers of home health recipients had the higher mean of 48.55.

H_0: There is no statistically significant difference between the independent variable education and attitude toward the aged as a group.

Decision: Reject the null hypothesis at the alpha = .05 level. There is a statistically significant difference between the independent variable education and attitude toward the aged as a group ($F = 4.02$, $p = .048$).

H_0: There is no statistically significant difference between caregiver groups and attitude toward the aged as a group.

Decision: Retain the null hypothesis at the alpha = .05 level. There was no statistically significant difference between caregiver groups and attitude toward the aged as a group (F = .25, p = .78).

Income

Table 7. Analysis of Variance for Income x Caregiver Group with Dependent Variable Personal Anxiety of Aging.

Source	DF	Sum of Squares	Mean Square	F value	P
Income	2	94.447	47.224	1.080	.344
Caregiver Group	2	192.805	96.403	2.204	.116
Interaction	4	261.037	65.259	1.492	.211
Error	94	4111.948	43.744		

H_0: There is no interaction between the independent variables income and caregiver groups on the dependent variable attitude toward personal anxiety of aging.

Decision: Retain the null hypothesis at alpha = .05 level. There was no interaction between the independent variables income and caregiver groups on the dependent variable attitude toward personal anxiety of aging (F = 1.49, p = .21). The middle income (20,001-45,000) caregivers to nursing home residents had the highest mean of 61.73.

H_0: There is no statistically significant difference between the independent variable income and attitude toward personal anxiety of aging.

Decision: Retain the null hypothesis at the alpha = .05 level. There was no statistically significant difference between the independent variable income and attitude toward personal anxiety of aging (F = 1.08, p = .34).

H_0: There is no statistically significant difference between caregiver groups and attitude toward personal anxiety of aging.

Decision: Retain the null hypothesis at the alpha = .05 level. There was no statistically significant difference between caregiver groups and attitudes toward personal anxiety of aging (F = 2.20, p = .12).

Table 8. Analysis of Variance for Income x Caregiver Group with Dependent Variable Aging of Peers.

Source	DF	Sum of Squares	Mean Square	F value	P
Income	2	251.214	125.607	1.813	.133
Caregiver Group	2	191.573	95.787	1.488	.231
Interaction	4	786.565	196.641	3.054	.021*
Error	94	6051.965	64.383		

H_0: There is no interaction between the independent variables income and caregiver groups on the dependent variable attitude toward the aging of peers.

Decision: Reject the null hypothesis at the alpha = .05 level. There was an interaction between the independent variables income and caregiver groups on the dependent variable attitude toward the aging of peers (F = 3.05, p = .02). The interaction was disordinal with low income caregivers of independent women

having the greater mean of 52.60 and high income caregivers of independent women having a mean of 45.89.

Table 9. Interaction for Income x Caregiver Group with Dependent Variable Aging of Peers.

Income	Nursing Home	Home Health	Independent
< 20,000	41.27	46.67	52.60
20,001-45,000	48.04	47.63	52.56
> 45,001	53.33	48.63	45.89

H_0: There is no statistically significant difference between the independent variable income and attitude toward the aging of peers.

Decision: Due to the existence of interaction between income and caregiver groups, it cannot be determined if there was a significant difference between income levels and attitude toward the aging of peers.

H_0: There is no statistically significant difference between caregiver groups and attitude toward the aging of peers.

Decision: Due to the existence of interaction between income and caregiver groups, it cannot be determined if a significant difference existed between caregiver groups and attitude toward the aging of peers.

Table 10. Analysis of Variance for Income x Caregiver Group with Dependent Variable Aged as a Group.

Source	DF	Sum of Squares	Mean Square	F value	P
Income	2	229.877	27.037	2.036	.136
Caregiver Group	2	54.073	27.037	.479	.621
Interaction	4	598.542	149.635	2.651	.038*
Error	94	5306.076	56.448		

H_0: There is no interaction between the independent variables income and caregiver groups on the dependent variable attitude toward the aged as a group.

Decision: Reject the null hypothesis at the alpha = .05 level. There was interaction between the independent variable income and caregiver group on the attitude toward the aged as a group ($F = 2.65$, $p = .04$). The interaction was disordinal with low income caregivers of independent women having the greater mean of 49.40 and high income caregivers of independent women mean of 44.00.

Table 11. Interaction for Income x Caregiver Group with Dependent Variable Aged as a Group.

Income	Nursing Home	Home Health	Independent
< 20,000	39.27	39.67	49.40
20,001-45,000	45.67	46.38	45.94
> 45,001	49.33	41.50	44.00

H_0: There is no statistically significant difference between the independent variable income and caregiver group on attitude toward the aged as a group.

Decision: Due to the interaction between income and caregiver it cannot be determined if there was a statistically significant difference between income and caregiver group on attitude toward the aged as a group.

H_0: There is no statistically significant difference between caregiver groups and attitude toward the aged as a group.

Decision: Due to the interaction between income and caregiver group, it cannot be determined if there was a statistically significant difference between caregiver groups and attitude toward the aged as a group.

Self-Rated Health

Due to no respondents reporting poor health, the data is collapsed into ratings of good health (n = 80) or fair health (n = 28).

Table 12. Analysis of Variance for Self-Rated Health x Caregiver Group with Dependent Variable Personal Anxiety of Aging.

Source	DF	Sum of Squares	Mean Square	F value	P
Health	1	174.630	174.630	4.193	.043*
Caregiver Group	2	157.013	78.506	1.885	.157
Interaction	2	178.666	89.333	2.145	.122
Error	102	4247.978	41.647		

H_0: There is no interaction between the independent variables self-rated health and caregiver groups on the dependent variable attitude toward personal anxiety of aging.

Decision: Retain the null hypothesis at the alpha = .05 level. There was no interaction between the independent variables self-rated health and caregiver groups on attitude toward personal anxiety of aging ($F = 2.15$, $p = .12$). The caregivers who rated their health good had a mean of 58.79.

H_0: There is no statistically significant difference between the independent variable self-rated health and attitude toward personal anxiety of aging.

Decision: Reject the null hypothesis at alpha = .05. There was a statistical difference between self-rated health and attitude toward personal anxiety of aging ($F = 4.19$, $p = .04$). Those caregivers who rated their health good had a mean of 58.30 versus those who rated their health fair, whose mean was 55.43.

H_0: There is no statistically significant difference between caregiver groups and attitude toward personal anxiety of aging.

Decision: Retain the null hypothesis at alpha = .05 level. There was no statistically significant difference between caregiver groups and attitude toward personal anxiety of aging ($F = 1.88$, $p = .16$).

Table 13. Analysis of Variance for Self-Rated Health x Caregiver Group with Dependent Variable Aging of Peers.

Source	DF	Sum of Squares	Mean Square	F value	P
Health	1	336.759	336.759	5.114	.026*
Caregiver Group	2	117.598	58.799	.893	.413
Interaction	2	73.808	36.904	.560	.573
Error	102	6716.308	65.846		

H_0: There is no interaction between the independent variables self-rated health and caregiver groups on the dependent variable attitude toward the aging of peers.

Decision: Retain the null hypothesis at the alpha = .05 level. There was no interaction between the independent variables self-rated health and caregiver group on attitude toward the aging of peers (F = .56, p = .57). The caregivers of independent women had the highest mean of 50.69.

H_0: There is no statistically significant difference between the independent variable self-rated health and attitude toward the aging of peers.

Decision: Reject the null hypothesis at the .05 level. There was a statistically significant difference between self-rated health and attitude toward the aging of peers (F = 5.11, p = .03). Caregivers who rated their health good had a mean of 49.75 and those who rated their health fair had a mean of 45.21.

H_0: There is no statistically significant difference between caregiver groups and attitude toward the aging of peers.

Decision: Retain the null hypothesis at the alpha = .05 level. There was no statistically significant difference between caregiver groups and attitude toward the aging of peers (F = .89, p = .41).

Table 14. Analysis of Variance for Self-Rated Health x Caregiver Group with Dependent Variable Aged as a Group.

Source	DF	Sum of Squares	Mean Square	F value	P
Health	1	555.171	555.171	9.787	.002*
Caregiver Group	2	2.605	1.302	.023	.977
Interaction	2	106.970	53.485	.943	.393
Error	102	5785.841	56.724		

H_0: There is no interaction between the independent variables self-rated health and caregiver groups on the dependent variable attitude toward the aged as a group.

Decision: Retain the null hypothesis at the alpha = .05 level. There was no interaction between self-rated health and caregiver groups on attitude toward the aged as a group (F = .94, p = .39).

H_0: There is no statistically significant difference between the independent variable self-rated health and attitude toward the aged as a group.

Decision: Reject the null hypothesis at the alpha = .05 level. There was a statistically significant difference between the independent variable self-rated health and attitude toward the aged as a group (F = 9.79, p = .00). Caregivers

who rated their health as good have a greater mean of 46.49 and those who rated their health fair to poor have a mean of 41.14.

H_0: There is no statistically significant difference between caregiver groups and attitude toward the aged as a group.

Decision: Retain the null hypothesis at alpha = .05 level. There was no statistically significant difference between caregiver groups and attitude toward the aged as a group ($F = .02$, $p = .98$).

CHAPTER 5

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

Summary

This study, conducted from August, 1993, to October, 1993, investigated the differences between three groups of women caregivers and their attitudes toward aging as measured by the Aging Opinion Survey. The caregivers' group membership was assigned according to the functional status of their elderly mother/mother-in-law. All 108 caregivers were between the ages of 40-59 and residents of Gallatin County. The variables of education, income, and self-rated health were also examined to determine their impact on the caregivers' attitudes toward aging. An analysis of variance was used to test the variables for interaction and significant differences at the alpha = .05 level.

The dependent variables were the scores on the Aging Opinion Survey: attitude toward personal anxiety of aging, attitude toward the aging of one's peers, and attitude toward the aged as a group. The independent variables were group membership, education, income, and self-rated health of the caregivers.

This study found no interactions between education level, caregiver groups, and the scores of the Aging Opinion Survey. Significant differences were found to

exist between caregivers whose education was high school or less and caregivers who had a college education, with the college educated caregiver having a more positive attitude on all Aging Opinion Survey subscores. Interactions were found between income, caregiver group, and attitude toward aging of peers and the aged as a group. Significant differences were found between caregivers who rated their health good versus those who rated their health fair on all scores of the Aging Opinion Survey.

The literature notes that weak or negligible correlations between demographic variables and attitudes are the norm (Bader, 1980; McTavish, 1971). Therefore, both support and dissension may be found in the literature to substantiate the findings of this study.

Conclusions

Education

No interaction was found between the variables education level, caregiver group membership and the scores on the Aging Opinion Survey. Significant differences were found between caregivers who had a high school education or less and those who had a college education on all of the three scales of the Aging Opinion Survey. Riddick (1985) in her study of geriatric recreational service providers differs from this finding. Employing the revised adaptation of Kafer et al. (1980) Social Value of the Elderly (the aged as a group portion of the Aging Opinion Survey), educational background was not found to be significantly

associated with an individual's attitude toward the value of elders in our society. Gillis (1973) also found that educational level was not significantly associated with the attitudes held by practicing nurses toward the elderly. Other studies report that formal education is positively associated with attitudes toward old people (Holtzman, Toewe, & Beck, 1979). Katz (1990), employing the Aging Opinion Survey in a study of personality correlates of attitudes toward old people, found that education, although the participants all had some post secondary education, was found to relate significantly to personal anxiety toward aging ($r = .22$, $p < .01$) and the aged as a group ($r = .44$, $p < .01$). People with more education held more positive attitudes toward older people on both personal anxiety toward aging and the aged as a group. Kahana and Kiyak (1983) suggest that education level, although among the most commonly studied factor, has also been among the variables yielding the most inconsistent data in studies of gerontological knowledge and attitudes.

The researcher concludes that education is an important element of attitude toward aging. The caregivers' scores as measured by the Aging Opinion Survey support this conclusion, and the voluntary comments in the open ended question underscore the need for accurate information regarding the aging process. Specifically, the myths of aging are operational in the Gallatin County community. Two of Palmore's (1977) Facts on Aging questions are directly contested. The myth of senility as an inevitable part of aging and affecting the majority of elderly is reflected by a caregiver of a nursing home recipient: "Most

elderly get forgetful and repeat themselves, and if we accept this, we can be happy for them instead of frustrated." Palmore also mentions the myth that most old people are set in their ways and unable to change. This misconception is echoed by a caregiver of an independent person: ". . . my concern is that the generation I'm acquainted with is very headstrong and not open to new ideas or progress."

Other educational needs are identified in comments indicating a lack of awareness of existing services and the difficulty in negotiating a fragmented aging service network. A caregiver of a home health client comments: "I think it would be nice if there were something between independent living and a nursing home--help with meals, medication, laundry, etc." These services do exist in Gallatin County and caregivers need to be educated in the language of eligibility and how to access existing programs.

Therefore, a conclusion of this researcher is that information regarding normal aging patterns and intervention strategies to assist the dependent elderly, including available community services, is not accessible to all caregivers in Gallatin County. Also, considering the response rate of 86% in this study, the caregivers in Gallatin County are interested in issues of aging.

Income

No interaction or significant difference was found with income, group membership and the personal anxiety of aging on the Aging Opinion Survey. The middle income (20,001-45,000) caregivers to nursing home residents had the

highest mean of 61.73. This score is interpreted as being a positive attitude toward one's personal aging.

An interaction was found between income and caregiver groups on attitude toward the aging of peers. Low income caregivers of independent women have a higher mean than the high income caregivers of independent women. Due to the existence of interaction between income and caregiver groups, it cannot be determined in this study, using these statistics, if there is a significant difference between income levels and attitude toward the aging of peers or caregiver groups and the attitude toward peers.

A second interaction was found between income and caregiver groups on the attitude toward the aged as a group. Low income caregivers of independent women have a higher mean than the high income caregivers of independent women. Due to the interaction between income and caregiver it cannot be determined if there is a statistically significant difference between income and caregiver group on attitude toward the aged as a group.

Tentative relationships have been stated between low social class and stereotyped views of the elderly (Hickey et al., 1968; Rosencranz & McNevin, 1969). The majority of researchers found that the higher the socioeconomic status, the more positive the attitudes toward the elderly (Neugarten & Peterson, 1957; Ivester & King, 1977). Wingard, Heath, and Himelstein (1982) found a correlation among attitudes and income where higher incomes denote more positive attitudes. However, the authors qualify their findings as the participants were predominantly

young and from affluent families. One study (Thorson, 1975) found a correlation between socioeconomic status and attitudes. Although the Gallatin County study does not reveal differences between caregiver groups and income level, the presence of two interactions in the income variable warrants further investigation. It may be concluded that income is a variable which should be included in future studies of attitudes toward aging.

Self-Rated Health

No interaction was found between self-rated health and group membership on any of the three Aging Opinion Survey scores. However, significant differences were identified between caregivers who rated their health as good and caregivers who rated their health as fair on all three dependent variables. Caregivers who rated their health as good had more positive attitudes than caregivers who rated their health as fair on all three Aging Opinion Survey subscores.

The literature supports the findings that a better health status reflects a more positive attitude toward aging. Tuckman and Lorge (1958) found attitudes toward the elderly were found to be influenced by perceived health status among the young. Johnson (1978) found that perceptions of poor parental health appeared to adversely affect ratings of the quality of the parent-child relationship by simultaneously producing less favorable attitudes toward aging. A study by Rakowski et al. (1983) support the conclusion of Johnson. Their study, which also used the Aging Opinion Survey, reports that college students' rating their health

less than excellent was associated with less positive views of peers' aging and a slightly more negative view of personal aging than students rating their health excellent. The findings of the Gallatin County study related to health status agree with Rakowski et al. where caregivers who rated their health as good, compared to caregivers whose self-rated health was fair, have a positive view of personal aging. The Rakowski et al. study did not find a relationship between self-rated health and the aged as a group. The findings of the Gallatin County study differ as a fair health rating did indicate a more negative view of the aged. In a multi-generational study of attitudinal predictors of devaluation of old age, Collette-Pratt's (1976) most consistent finding was that a negative attitude toward poor health was a predictor of higher devaluations of old age; its influence greatest for the young, next highest for the elderly, and least for the middle aged (ages 30-59). She concluded negative attitudes toward poor health significantly contributed to devaluation of old age for all groups.

The importance of self-rated health in reference to attitudes toward aging indicates the existence of a myth of aging, the inevitable failure of health. Furstenberg (1989, p. 274) summarizes the impact of this association:

> Illness forms a central component of any model of aging. Even for people in relatively good health, growing older heightens awareness of the imminence of frailty. Fears of future illness and frailty are a cause of fear, especially for women, a far larger proportion of whom face old age without a spouse. Persons need education regarding the normal aging process so they can view health issues in a continuum, not as a forecaster of the inevitable.

The lack of correct information about the aging process contributes to the stereotype of aging as a season of decline. Indicators of serious health problems such as memory loss or mobility may be accepted rather than addressed as health issues.

The caregivers of Gallatin County are in jeopardy of positive aging if information regarding aging and disease process is not enhanced. Further, 122 RSVP volunteers, who do not have the potential support of a daughter or daughter-in-law in Gallatin County, are entering the aging milieu in a community where resources are difficult to access.

Recommendations

The "ultimate utility of attitude research" lies with the assumption, according to Kafer et al. (1980, p. 320), that this type of research "provides a basis for interventions designed to improve the conditions of aging and older adults." All information gathered from the participants must be considered when the consequences of the numbers of persons aging is considered. Therefore, recommendations are based not only on the statistical findings of the study, but on the insights provided by the spontaneous comments of 60 caregivers, some falling out of the middle age range, on the open question of the survey. See Appendix C for unedited comments.

Action

The response rate of 86% to the Aging Opinion Survey indicates strong interest among Gallatin County's middle aged women in issues of aging. The comments shared by the caregivers identifies a lack of awareness of resources that could impact not only their own aging, but their ability to support the elderly in the community. The community of Gallatin County cannot afford to delay in increasing its efforts to better prepare residents for the impact of the aging process.

This researcher recommends that outreach to the middle aged through community education be intensified not only by agencies in the Aging Service Network but by nontraditional sources such as civic clubs, churches, and banks. The role of each agency can address the needs of the middle aged in their personal aging process as well as providing the resources needed to train them as advocates for the elderly. Organizations may be interested in topics such as myths of aging, opportunities for seniors to remain active in the community, estate planning, living wills, information on medicare and other service programs. The organizations can include speakers in their programs, sponsor workshops, or coordinate their service projects with local senior centers in an effort to broaden their membership's exposure to important information.

Positive public images of the elderly should dominate the media, reflecting the majority of older persons. Opportunities to interact with healthy seniors should be increased through employment or volunteer opportunities. Youth

organizations and civic clubs can join with senior centers, RSVP, ACTION and other senior organizations to work together on community projects.

Montana should redesign the existing fragmented service delivery system by developing a "one stop shop" which coordinates community services and the referral process. One caregiver clearly identifies Montana's state aging network problem: ". . . hopefully, there is an agency to contact that can help me in all areas, an informational service. I know my time will be valuable taking care of a parent so I will need to learn these things without getting the run around." No such service exists in any Montana community. Part of this service delivery problem lies in the historic nature of the funding of programs under the Older American Act, the funding of Medicare and Medicaid, the separate entities of Social Security, housing assistance, food commodities and, lastly, the division of eligibility according to age, medical diagnosis and other distal criteria. Created separately, the time has come for evolution to a single point of access.

Positive health practices should be reinforced in community life, especially emphasizing that middle age is not too late to change bad habits. With the middle aged population living longer and the most expensive health care cost phase of the life span ahead, personal responsibility for healthy aging should be encouraged. This information should, at a minimum, address nutrition, exercise, recreation, avocations and opportunities for learning to promote continuing good mental health. Equally important, older persons suffering from a decline of health should

be encouraged to pursue medical attention and remain aggressive in their own positive health behavior.

Further Study

This study provided a format for inquiry of attitudinal differences among middle aged women who are part of what has been called the sandwich generation. The high response rate affirms that issues of personal aging and the aging of society are timely and potent issues. It is recommended that a similar study of attitudes of middle aged women and their relationship as caregivers to the older population be replicated. Refinement of the demographic questions regarding income, prior experience with elderly, and caregiver burden would enhance the research. The study should be conducted on a larger population, perhaps one reflecting more ethnic diversity. The finding of differences in education and self-rated health status is interesting in its implications of attitude and behavior relationships.

Because women are not only the traditional caregivers of the family, but also will be the majority of elders, it is essential that further research be conducted to assess their attitudes. Study of the informational exchange between professionals of the aging service delivery network and the daughters of clients should be undertaken to identify potential educational outreach opportunities. Issues of caregiver burden underlie the survey; a longitudinal study of these same women could reveal a pattern of attitude formation.

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APPENDICES

APPENDIX A

AGING OPINION SURVEY

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 numbers labeled as follows:

1) Strongly Agree	2) Mildly Agree	3) Uncertain	4) Mildly Disagree	5) Strongly Disagree

You are to indicate the degree to which you agree or disagree with each statement by circling the appropriate number. 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.

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

1) Strongly Agree	2) Mildly Agree	3) Uncertain	4) Mildly Disagree	5) Strongly Disagree

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

1) Strongly Agree	2) Mildly Agree	3) Uncertain	4) Mildly Disagree	5) Strongly Disagree

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

1) Strongly Agree	2) Mildly Agree	3) Uncertain	4) Mildly Disagree	5) Strongly Disagree

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

1) Strongly Agree 2) Mildly Agree 3) Uncertain 4) Mildly Disagree 5) Strongly Disagree

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

1) Strongly Agree 2) Mildly Agree 3) Uncertain 4) Mildly Disagree 5) Strongly Disagree

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

1) Strongly Agree 2) Mildly Agree 3) Uncertain 4) Mildly Disagree 5) Strongly Disagree

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

1) Strongly Agree 2) Mildly Agree 3) Uncertain 4) Mildly Disagree 5) Strongly Disagree

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

1) Strongly Agree 2) Mildly Agree 3) Uncertain 4) Mildly Disagree 5) Strongly Disagree

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

1) Strongly Agree 2) Mildly Agree 3) Uncertain 4) Mildly Disagree 5) Strongly Disagree

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

1) Strongly Agree 2) Mildly Agree 3) Uncertain 4) Mildly Disagree 5) Strongly Disagree

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

1) Strongly Agree 2) Mildly Agree 3) Uncertain 4) Mildly Disagree 5) Strongly Disagree

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

1) Strongly Agree 2) Mildly Agree 3) Uncertain 4) Mildly Disagree 5) Strongly Disagree

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

1) Strongly Agree 2) Mildly Agree 3) Uncertain 4) Mildly Disagree 5) Strongly Disagree

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

1) Strongly Agree 2) Mildly Agree 3) Uncertain 4) Mildly Disagree 5) Strongly Disagree

Q-15 I have become more content with the years.

1) Strongly Agree 2) Mildly Agree 3) Uncertain 4) Mildly Disagree 5) Strongly Disagree

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

1) Strongly Agree 2) Mildly Agree 3) Uncertain 4) Mildly Disagree 5) Strongly Disagree

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

1) Strongly Agree 2) Mildly Agree 3) Uncertain 4) Mildly Disagree 5) Strongly Disagree

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

1) Strongly Agree 2) Mildly Agree 3) Uncertain 4) Mildly Disagree 5) Strongly Disagree

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

1) Strongly Agree 2) Mildly Agree 3) Uncertain 4) Mildly Disagree 5) Strongly Disagree

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

1) Strongly Agree 2) Mildly Agree 3) Uncertain 4) Mildly Disagree 5) Strongly Disagree

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

1) Strongly Agree 2) Mildly Agree 3) Uncertain 4) Mildly Disagree 5) Strongly Disagree

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

1) Strongly Agree 2) Mildly Agree 3) Uncertain 4) Mildly Disagree 5) Strongly Disagree

Q-23 People my age can learn new things easily.

1) Strongly Agree 2) Mildly Agree 3) Uncertain 4) Mildly Disagree 5) Strongly Disagree

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

1) Strongly Agree 2) Mildly Agree 3) Uncertain 4) Mildly Disagree 5) Strongly Disagree

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

1) Strongly Agree 2) Mildly Agree 3) Uncertain 4) Mildly Disagree 5) Strongly Disagree

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

1) Strongly Agree 2) Mildly Agree 3) Uncertain 4) Mildly Disagree 5) Strongly Disagree

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

1) Strongly Agree 2) Mildly Agree 3) Uncertain 4) Mildly Disagree 5) Strongly Disagree

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

1) Strongly Agree 2) Mildly Agree 3) Uncertain 4) Mildly Disagree 5) Strongly Disagree

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

1) Strongly Agree 2) Mildly Agree 3) Uncertain 4) Mildly Disagree 5) Strongly Disagree

Q-30 I never think about dying.

1) Strongly Agree 2) Mildly Agree 3) Uncertain 4) Mildly Disagree 5) Strongly Disagree

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

1) Strongly Agree 2) Mildly Agree 3) Uncertain 4) Mildly Disagree 5) Strongly Disagree

Q-32 Most elderly prefer to live in senior citizen apartment buildings.

1) Strongly Agree 2) Mildly Agree 3) Uncertain 4) Mildly Disagree 5) Strongly Disagree

Q-33 I fear that when I'm older all my friends will be gone.

1) Strongly Agree 2) Mildly Agree 3) Uncertain 4) Mildly Disagree 5) Strongly Disagree

Q-34 The thought of outliving my spouse frightens me.

1) Strongly Agree 2) Mildly Agree 3) Uncertain 4) Mildly Disagree 5) Strongly Disagree

Q-35 Financial dependence on my children in old age is one of my greatest fears.

1) Strongly Agree 2) Mildly Agree 3) Uncertain 4) Mildly Disagree 5) Strongly Disagree

Q-36 I would prefer to always live in an area where people my age predominate.

1) Strongly Agree 2) Mildly Agree 3) Uncertain 4) Mildly Disagree 5) Strongly Disagree

Q-37 The social status of my fiends and people my age is decreasing.

1) Strongly Agree 2) Mildly Agree 3) Uncertain 4) Mildly Disagree 5) Strongly Disagree

Q-38 People I know seem to sit around the house a lot more than they use to.

1) Strongly Agree 2) Mildly Agree 3) Uncertain 4) Mildly Disagree 5) Strongly Disagree

Q-39 Based on the people I know, you can't teach an old dog new tricks.

1) Strongly Agree 2) Mildly Agree 3) Uncertain 4) Mildly Disagree 5) Strongly Disagree

Q-40 I know I'll enjoy sexual relations no matter how old I am.

1) Strongly Agree 2) Mildly Agree 3) Uncertain 4) Mildly Disagree 5) Strongly Disagree

Q-41 The older I become, the more anxious I am about the future.

1) Strongly Agree 2) Mildly Agree 3) Uncertain 4) Mildly Disagree 5) Strongly Disagree

Q-42 The elderly shouldn't be expected to do more for society after they retire.

1) Strongly Agree 2) Mildly Agree 3) Uncertain 4) Mildly Disagree 5) Strongly Disagree

Q-43 Neighborhoods where the elderly predominate often become run down.

1) Strongly Agree 2) Mildly Agree 3) Uncertain 4) Mildly Disagree 5) Strongly Disagree

Q-44 You can keep the joys of grandparenthood, I rather be young.

1) Strongly Agree 2) Mildly Agree 3) Uncertain 4) Mildly Disagree 5) Strongly Disagree

Q-45 I would always want to live in a neighborhood where there was a variety of age groups.

1) Strongly Agree 2) Mildly Agree 3) Uncertain 4) Mildly Disagree 5) Strongly Disagree

Table 15. Questions Comprising the Three Content Scales of the Aging Opinion Survey.

Personal Anxiety Toward Aging	
* Item No.	Statement
7.	It's best to forget that we're getting older every day.
10.	The older I get the more I worry about money matters.
11.	I always dreaded the day I would look in the mirror and see gray hairs.
(-) 15.	I have become more content with the years.
20.	I dread the day when I can no longer get around on my own.
22.	The older I become the more I worry about my health.
(-) 26.	I am sure I will always have plenty of friends to talk to.
27.	Most older people seem to need a lot of extra sleep to have enough energy for everyday chores.
(-) 30.	I never think about dying.
33.	I fear that when I'm older all my friends will be gone.
34.	The thought of outliving my spouse frightens me.
35.	Financial dependence on my children in old age is one of my greatest fears.
(-) 40.	I know I'll enjoy sexual relations no matter how old I am.
41.	The older I become, the more anxious I am about the future.
44.	You can keep the joys of grandparenthood, I'd rather be young.

* Minus signs (-) indicate reversal of scoring when determining scale score.

Table 15. Continued.

	Stereotypic Age Decrement Aging of Peers
* Item No.	Statement
3.	I don't think some of my friends can hear quite as well as they use to.
(-) 6.	My friends are just as interested in sex as they ever were.
9.	So many people I know grow less content as the years go by.
12.	My friends never look as good as they used to anymore.
13.	My friends aren't nearly as changeable as when they were younger.
16.	The older my friends get the less interest they seem to have in interacting with others.
19.	More and more people I know are becoming observers rather than participants.
21.	People my age seem to worry unnecessarily about their health.
(-) 23.	People my age can learn new things easily.
24.	I see the years creeping up on my friends.
(-) 29.	My friends make sure they get plenty of exercise.
31.	It's sad to say, but my friends just can't turn out the like they use to.
37.	The social status of my friends and people my age is decreasing.
38.	People I know seem to sit around the house a lot more than they use to.
39.	Based on the people I know, you can't teach an old dog new tricks.

Table 15. Continued.

Social Value of the Elderly	
* Item No.	Statement
1.	After retirement one should not have much influence in public policy making.
2.	Most people I know feel that the elderly deserve a great deal of admiration.
(-) 4.	The elderly have wealth of knowledge and experience that is not sufficiently utilized.
(-) 5.	Community organizations would function more smoothly if older persons were included on their governing boards.
8.	Youthful enthusiasm and fresh ideas should count for more in today's world that the outdated notions of the older generation.
14.	The older my friends get the less respect they have for privacy of others.
(-) 17.	The elderly are one of our great undeveloped natural resources.
18.	Older people usually interfere with their adult children's child rearing practices.
25.	Older people are more or less a burden for the young.
(-) 28.	Society would benefit if the elderly had more say in government.
32.	Most elderly prefer to live in senior citizen apartment buildings.
36.	I would prefer to always live in areas where people my age predominate.
42.	The elderly shouldn't be expected to do more for society after they retire.
43.	Neighborhoods where the elderly predominate often become run down.
(-) 45.	I would always want to live in a neighborhood where there was a variety of age groups.

APPENDIX B

DEMOGRAPHIC QUESTIONS

This section of the survey was designed to assist the researcher in the verification of the functional status of the elder, to solicit information regarding education, income and self-rated health, and to aid in the interpretation of the responses on the Aging Opinion Survey. Frequency data from the 108 middle aged caregivers is reported below each question. The * denotes information was used for verification purposes only and therefore not coded. The open comment section at the end of this portion is reported in Appendix C.

Finally, we would like to ask some questions about yourself to help interpret the study results. The word "relative" refers to either your mother or your mother-in-law; with whomever you may have a caregiver's relationship. Please circle the number of the most appropriate answer.

*Q-46 Does your relative, in managing their life,
1) NEED NO ASSISTANCE
2) NEED SOME ASSISTANCE DURING THE MONTH
3) NEED ASSISTANCE DAILY

Q-47 If your relative is not independent, how long have you been a caregiver?
1) LESS THAN ONE MONTH
2) LESS THAN SIX MONTHS
3) OVER SIX MONTHS

Q-48 Do you share your caregiving duties with someone else?
1) YES
2) NO
3) MY RELATIVE IS INDEPENDENT

*Q-49 Where does your relative live?
1) LIVES WITHOUT ASSISTANCE IN THE COMMUNITY
2) LIVES WITH ASSISTANCE IN THE COMMUNITY
3) LIVES IN A NURSING HOME

Q-50 How frequently do you see your relative?
1) MONTHLY OR LESS FREQUENTLY
2) WEEKLY
3) DAILY

Q-51 What is the marital status of your relative?
1) MARRIED
2) DIVORCED OR SEPARATED
3) WIDOWED
4) OTHER

Q-52 Are you presently:
1) EMPLOYED OUTSIDE THE HOME
2) UNEMPLOYED
3) RETIRED
4) CONSIDER YOUR PRIMARY EMPLOYMENT HOMEMAKING

Q-53 How long did you attend school?
1) DID NOT FINISH HIGH SCHOOL
2) GRADUATED FROM HIGH SCHOOL
3) GRADUATED FROM COLLEGE

Q-54 How do you rate your health over the past year?
1) GOOD
2) FAIR
3) POOR

*Q-55 What is your present age? _____

Q-56 What is your approximate household income?
1) UNDER 20,000
2) BETWEEN 20,001 AND 45,000
3) OVER 45,001

*Q-57 How many people live in your household, including you? _____

*Q-58 Have you had a stronger relationship with an older person (over 60 years old) than your relationship with the person for whom you are providing care?
1) YES
2) NO
3) NOT A CAREGIVER

If yes, what relationship to you was that person?

_____

How would you rate that person's health during your relationship?
1) GOOD
2) FAIR
3) POOR

_____

Is there anything else you would like to tell us about your opinions on aging or your experience as a caregiver? If so, please use this space for that purpose.

See Appendix C.

APPENDIX C

COMMENTS FROM CAREGIVERS IN GALLATIN COUNTY

The supplemental questionnaire closed with the following invitation: 'Is there anything else you would like to tell us about your opinions on aging or your experience as a caregiver?

Comments from 60 respondents, ages 31 to 77, provide a personal perspective of issues that may be broadly grouped as service delivery problems, caregiving experiences, the personal aging process, and the aged as a group. The comments are unedited except to protect privacy. The age of the respondent and the caregiver group that they belonged to is given.

Service Delivery Issues

Age 54
Nursing Home
Better care for elderly so they can live at home longer.

Age 61
Home Health
Since my mother has been in home care I feel very deeply about the importance of the program, it allows one to stay in their own home with familiar surroundings and keep their dignity, also providing services which some of us are unable to perform. Also the relationship between the person receiving home care and relatives is not as strained.

Age 59
Nursing Home
As people age and find it necessary to move into nursing home living it is very sad to see the resident deprived of so much of their normal type of living that they have had in the past. The resident suddenly finds herself in a totally different type of living condition, with most of the time poor and tasteless meals. I think it totally unfair to overnight tell someone who has smoked for 50 some years that this is no longer allowed. Rather traumatic to the system. I also feel it is very unappetizing to eat with the patients that no longer have their faculties and have to be spoon fed. The patient who is still sharp about their wits soon degenerates when having to associate day after day with the others.

Age 56
Nursing Home
Its a real puzzle how to communicate with people who have Alzheimer's. I wish we could develop a wider range of activities for adults in nursing homes such as more physical exercise. And why can't we try a greater emphasis on healthier eating in nursing homes? Its wonderful to see older adults with a zest for life--such an inspiration for us all. Why not promote and encourage people who keep trying and why not recognize accomplishments and the surmounting of most difficult situations? Yes, nursing homes are improving and we are learning a lot about aging better.

Age 52
Nursing Home
I believe this community needs more options available for day care centers for the elderly while caregivers have to work.

Age 38
Home Health
The home health care aid available has been invaluable to me. I see a need for more availability for companion type aid to the elderly in the home setting but I have also seen an overwhelming need for more companions (possibly volunteers) inside the nursing homes. Thank-you!

Age 41
Independent
I have not yet been a caregiver for my mother. However, I was an in home caregiver for my husband's grandfather (age 96) for two months until his death, in our home. I believe there should be more support for the caregiver on an emotional level as well as physical and financial.

Age 62
Independent
One day I will be a caregiver-I will want to know all I can know about facilities, help organizations, entitlement and etc. without doing a lot of research. So hopefully there is an agency to contact that can help me in all areas-an informational service "if you will." I know that my time will be valuable taking care of a parent or parents, so I will need to learn these things without getting the run around.

Age 46
Independent
We need more education on "parenting our parents" and how to prepare for these role changes. One of the biggest burdens for us was trying to get our father to put

his affairs in good legal order, which we were unable to do. Middle aged folks need to be prepared ahead of time for these issues through seminars, classes, pamphlets, doctors, etc. so living trusts, living wills, and estate planning in general is seen as an option now rather than when you are too ill or incapacitated to think straight. We can do more in our community to meet such needs.

Age 48
Home Health
I think it would be nice if there were something between independent living and a nursing home--help with meals, medication, laundry, etc.

Age 44
Home Health
I believe many people are not aware of services in the community and struggle needlessly, not knowing how to access these resources.

Age 48
Independent
I think there should be more done for aging seniors. My mom pays so much on prescriptions, and medicare doesn't help and I think they should. She lives on very little during the month. Also they should give better things at the food program during the month. One can only use so much rice and corn meal. She uses all so much but they could furnish better items.

Caregiver Experiences

Age 65
Nursing Home
I am still working. My answers might have been different if I were not. Nothing my husband and I have ever done was as difficult as caring for mom for 18 months. We could get "sitters" for her in the daytime (so we were able to go to work) but we had no help in the pm's or at night. We went out together, during that time, only once. We alternated nights sleeping so one of us could be available to help mom during the many times she got up. We were terribly sleep deprived by the end of 18 months.

1) adult day care centers should have hours which match usual work hours (i.e. 7 to 6 pm).
2) help should be available to relieve families during all "shifts" (even for private pay families)
3) there should be tax deductions for "sitters" and/or nursing home care.

My greatest concern is that one of us may end up being dependent on our children the way mom was on us--the rest home saved our lives. Thanks.

Age 43
Nursing Home
When caring for my mother in law, it would have meant a lot to us if we could have had some assistance-didn't seem to qualify for any at that time. Went through quite a few "sitters"; her odd behavior frightened several of them. She needed constant supervision, would "take" things, and misplace things frequently, wandered; not an ideal person to take shopping or with for appointments but frequently had to. Very few breaks from caregiving. Very frustrating! Our friends and acquaintances were nervous around her because of odd, unpredictable behaviors. Lost a lot of "friends." No relatives live nearby. So very little help from the usual sources. Funds limited, had been working before she came to live with us upon the death of her husband could not work outside or in the home as she required full time supervision and that limited funds to hire assistance. It was hard on the family, but at the time was what she needed most, family around her, caring for her. We don't regret it and we all came through for the better. Note: my mother (65 yrs) also cares for her mother (85 years).

Age 69
Home Health
I think the biggest problem a caregiver has is the over dependency that the person he or she is taking care of develops. It seems to me this leads to child-like behavior on the part of this person and more emphasis should be placed on this problem than on the effects of the situation on the caregivers. In a family situation where children and parents were involved this would be a real problem and the older person might not realize how they were contributing to it; they should not take advantage of their position (as feeling they deserved more respect and consideration than others) but, nevertheless, they do.

Age 61
Home Health
The person to whom I am a caregiver is not what I consider average. In my social life I know many people in their 80's who are active, productive people. They give to society through volunteer work. My mother-in-law has never been active; never worked out of the home, raised only two children, never did any charity work nor did she join any clubs or lodges. Each "elderly" are as different as each child or young adult and it seems that they end their lives as they lived it.

Age 56
Nursing Home
It takes an awfully lot of energy and patience, and can be very depressing. Especially when the older person does not seem to appreciate your help or try to do much of anything to help herself.

Age 70
Nursing Home
My parents passed away 10 years ago but before that I helped them both very much. In their own home and, also they lived with us until my father passed away and later my mother lived in a care center but I visited her every week and gave her a lot of love. However I do not expect as much from my children as my parents did from me. We have a very active life and hope to live in our own home for a long time yet.

Age 46
Nursing Home
My husband and I cared for my mother seven and a half years before she moved to the rest home. It is demanding of your time and energy. Very draining on the caregiver. I am so thankful mother is in the rest home. I still give care, taking her out twice a week and talking on the phone almost every day. I hope I never have to be in her position. It is so important to keep active and involved and not to be become isolated.

Age 60
Nursing Home
My relative is a resident at the rest home. I was the primary caregiver for approx 12 months before she came to live at the rest home. Those were probably the most frustrating, yet satisfying months of my life!

Age 59
Nursing Home
We are grateful to receive the help we are getting from the rest home with my mother. She has had multiple health problems for many years and we've done our best to help her, my mother-in-law who is also nearing 90 years old, an elderly aunt and an uncle while all the rest of the family backed away and found excuses why they couldn't help. We are supplementing our retirement income by trucking coast to coast as relief. We are attempting to keep a home here because of our mothers, so our income varies depending on how much we can stand to truck. Its a demanding stressful job. My husband had to retire per Dr's. orders due to stress. We try to be in Bozeman as much as possible because it means so much to our moms and when we're on the road we call both of them a couple times a week. My dad died when I was 9 and my husband's dad died when he was 2 so our moms had a rough go. We appreciate their efforts raising us and want to do right by them. Again, many thanks to the rest home and home health care and all the wonderful people who are helping during a difficult time for us.

Age 54
Nursing Home
Exhausting! But also rewarding! Very difficult at times trying to juggle a career, own family and parents!

Age 45
Independent
A lot of my time is spent being a sounding board. Just being there seems to help them in venting their feelings. Just knowing you are within reach of the phone seems to give comfort. It takes a lot of patience sometimes when they get worked up over little things or things that don't matter. In my case my mother drags up the past (negative) when she is down. Even with all of this I will never put my parents in a home-they seem to lose too much will to live--I saw this in my Grandfather. He just gave up and died.

Age 35
Independent
As a caregiver (house and expense provider) it was difficult to watch a person who was vital choose to be much less at home, initially. As time passed her life became more full..to the point of a marriage taking place. The 2 years we provided space and financial security were difficult at times but rewarding too. Grandchildren had a chance to get to know a grandmother who had lived far away before. It was worth it to see someone's health and self worth improve so much...however it's nice to have some privacy again!

Age 43
Independent
On caregiving: I wish that some days I would be more patient and loving. I just think what would I do if that person dies, and I know I would be very lonely. I hope that when I get older I will have lots of energy. I want to be able to play with my grandchildren and be involved with children in general. I am trying to keep healthy now. I wish there were programs for the elderly that would include exercising and strengthening with weights. I think it would help them a lot. Too sedentary.

Age 65
Nursing Home
My mother is a very dominating person and finds it difficult to give up her independence. She is not spiteful. Her health for her age is very good. I have guilt feelings for not keeping her in my home, but my husband and I get along much better now that she is in a nursing home. She thinks he is wonderful and he helps me with her when we take her out but we like our freedom. I think this

County needs a level of care where people who can be mostly independent could have moderate supervision with medication, shopping, and have meals supplied for less money than we have to pay for nursing home.

Age 54
Nursing Home
When my parent's health failed I brought them from Washington to Montana to live with me. The experience was gratifying and difficult. Gratifying because by nature I am a caregiver and I enjoyed giving to them, caring for them, and being closer to them than I had been in years. Difficult because of the hard work, lack of family time, frustrations over health problems. Because of health problems I eventually felt I was not able to provide adequate care myself. Our family decided a nursing home situation would be best.

Age 41
Independent
My husband I both feel that the aging of my parents will be looked after by us. It is not even a question. Of course if they need constant medical attention that we are not capable of providing we will look to the medical community for support.

Age 37
Independent
I've had more experience in caregiving to grandparents. During that time I found it much easier and more gratifying to deal with the older person that was willing to use technology hearing aides, electric wheelchairs, bath lifts, etc. to help herself as much a possible. Another one was into denial of her infirmities and would make no changes in her life to make her life and the lives of people around her better, which was very hard to deal with.

Age 33
Independent
I'm not sure I could be considered a "caregiver" I just help out once in a while like taking her shopping (she can't drive) and occasionally with household duties. I also think that the elderly have a lot to give and offer to people of all ages.

Personal Aging Issues

Age 42
Independent
When I was younger (teens & 20's) I actually feared aging. Now that I am middle-aged and have three teenagers I laugh at my previous fears. I honestly never felt truly comfortable with myself as an individual until I was at least 35! I now look

forward to aging, and to achieving self-assurance and dignity that I observe in the elderly whom I admire. I think the saddest aspect of aging would be for those who have not cultured family values and friends and eventually find themselves alone. By focusing on bringing up a very strong family I hope to avoid that. I believe strongly that many women in my generation who put career before family will live to regret their choices! Kids who know they were not a priority leave home, and never really look back. I have met them as adults and they consider their parents as burdens, someone to "contend" with.

Age 62
Nursing Home
Old age attitudes seem to depend on middle age/young attitudes and don't change but are magnified and may be somewhat causal. Health and attitude are all in enjoyment of life and reciprocal in relationships. Rest homes are a horror to visit. I hope I can commit suicide before I lose "me."

Age 50
Nursing Home
My biggest fear is to lose my mind. Would rather have cancer and be able to think straight.

Age 64
Independent
The fears that all savings, all finances will be gobbled up with the first serious sickness even though we have insurance, medicare and supplementary health care, not the devastation of but the finances of, are a constant threat to peace of mind.

Age 55
Independent
Many of the questions were difficult to answer correctly with the choice of answers. They seemed to be questions that were for elderly people to answer regarding their friends. I am 55 and do not feel elderly nor do my friends. We also agree we feel different than 10 years or so ago. Some are retired but most work full time or at lease part time and are very active.

The Aged as a Group

Age 52
Home Health
I feel that it is "very" important for the elderly to stay in their own homes and run their own lives as much as possible.

Age 34
Independent
I have two RSVP volunteers working in my office, both are over 70 years old. They are the best volunteers I have, they are dependable and always willing to learn something new. Working outside of the home makes them feel wanted and needed. It gives them something to get out of bed in the morning for. They take great pride in their work. They have great ideas on how to run the office more efficiently because of their life experiences. I have great respect for older people. They have seen a lot in their life and we would all be better off slowing down a bit and listening to them. They provide comfort and support in a way that no one young can. I don't fear growing old, but I fear how some younger people treat them.

Age 54
Nursing Home
I feel that it is difficult to evaluate people only on the basis of their age. People of the same age may vary greatly in their physical and mental acuity. A person's usefulness in areas of government and policy making may vary a great deal because of other factors such as physical and mental health and past experience and education. Each must be evaluated as an individual. An elderly person may not be able to produce physically like a younger person but they may have developed other qualities that suit them for a different type of work as they age. Both have something valuable to contribute and each has its unique place.

Age 38
Independent
I feel that the problems of aging have a lot to do with societies promotion on looking young, being young etc. Everyone is entitled to go through every phase of life with appreciation and dignity. We need to value the opinions and experience of our older generations, then perhaps we would discontinue to make the same historical mistakes.

Age 77
Home Health
People should remain active members of society for as long as possible. Contacts with other people and a feeling of belonging and self-worth and that someone cares are very important.

Age 42
Independent
I think as a society we have far too little interaction with older people. They need support and friendship and we can learn so much from them.

Age 31
Independent
Even though I strongly feel like elderly can and should contribute to the community I am leery of the elderly with whom I've been associated. Projects, etc. of interest to them would greatly benefit the community as well as the elderly-we need more volunteers. But my concern is that the generation I'm acquainted with is very headstrong and not open to new ideas or progress. As a result, my survey may be biased because of that.

Age 58
Nursing Home
Personality, background and leadership qualities have much more to do with smoothly operating boards than age. Age doesn't guarantee the above qualities. Being realistic about age can lead to activities that extend ones productive years. Denial only leads to sore muscles and gross embarrassments. The elderly have one of the most effective lobbies in the country in the AARP. God help the younger generation if they get any more powerful! Its my opinion that one's outlook on life is only magnified as one gets older--barring personality altering disease. A negative person gets more negative-a positive person, while not liking the limitations he puts upon one, can still see the good in life and has a calmness and peace about them. After retirement one has more time to give to others and those people whom I know that do that seem to be happier than those who only focus on themselves.

Age 66
Nursing Home
I do think older people can learn new ways of life and technology but they must be given confidence and encouraged to go back to school. Every neighborhood should have exercise classes for seniors and these should be compulsory, like grade school. Due to our transient society, families no longer are close to each other. It's often difficult to ascertain change in an older parent. I do not advise the generations living together under one roof. Its too much of strain emotionally. I do think older people should keep up with the thoughts of the new generation, and not become lodged in their beliefs. This contributes to their stodginess. They should develop a routine in their 50's to contribute to their own old age by positive attitudes, support groups and activity. Once you sit down you're a "goner."

Age 59
Nursing Home
I feel that is a national tragedy that there is no value placed on the experience and wisdom of the "elder-women" in our youth oriented society-resulting in so many going back to being child-like so that they will have the "attention" they crave. It is a sad substitute for respect. If your life has no purpose-you are lost.

Age 62
Nursing Home
All people, no matter what the age, need love, touching and attention. Most people that I know are better as they grow older. Of course there are a few old grouches (who were probably young grouches!) Most older people are pretty sharp and still contribute to society.

Age 49
Nursing Home
I think its important to love elderly people (really everyone) the way they are. Don't worry what others will think of them. Most elderly get forgetful and repeat themselves and if we accept this, we can be happy for them instead of frustrated.

Age 68
Nursing Home
As an old RN, I resent the numbers of elderly being kept alive by extraneous measures. They should be kept pain free at all times. So what if they become addicted? I strongly believe in euthanasia! I personally would not assist anyone, however, I might offer suggestions. When the dollars are added up on what is spent to keep elderly people (and hopeless others) alive, our nation would be shocked, if that is possible at this point in time. We have fears for the future of our country and therefore our children and grandchildren.

Age 49
Home Health
I think that old people think the world owes them a living, senior citizen's discounts etc. They feel that because they've lived so many years everyone should bow down.

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