Mar 23rd, 1:45 PM - 3:00 PM

“Listen Carefully:” A Study of Ageist Stereotypes and Undergraduates’ Desire to Work with Elders

Genevieve Ilg
Providence College

Follow this and additional works at: http://digitalcommons.providence.edu/auchs
Part of the Health Policy Commons, and the Policy Design, Analysis, and Evaluation Commons

http://digitalcommons.providence.edu/auchs/2013/panelc2/2

This Event is brought to you for free and open access by the Conferences & Events at DigitalCommons@Providence. It has been accepted for inclusion in Annual Undergraduate Conference on Health and Society by an authorized administrator of DigitalCommons@Providence. For more information, please contact mcaprio1@providence.edu, hposey@providence.edu.
“Listen Carefully:”

A Study of Ageist Stereotypes and Undergraduates’ Desire to Work with Elders

Genevieve Marie Ilg

Providence College

“Listen Carefully:” A Study of Ageist Stereotypes and Undergraduates’ Desire to Work with Elders identifies and assesses how prior experience with elders and ageist stereotypes informs the degree to which undergraduates are inclined (or disinclined) to consider geriatrics as a potential career. Current literature indicates a lack of interest among social workers and other allied-health professionals in working with this demographic. Here, the “generation gap” not only pertains to the differences between younger people and their elders, but to the gap between the aging population’s increasing demand of need and how many individuals plan to serve the elderly. For this study, participants were required to prioritize a set of 27 statements in order from least to most significant in influencing their desire to work with elders (Q methodology). A factor analysis of the data generated two groups of participants. Group 1 was significantly (p < .01) more willing to work with elders, which was associated with their rejection of negative stereotypes and their indication of having prior experience working with elders. Group 2 was significantly less willing to work with the elders (p < .01), put significantly (p < .05) more emphasis on deficits of old age, and reported not having as much experience working with the elderly. The data suggest that exposure to actual work with elders and debunking false, negative stereotypes about the elderly are key in attracting professionals to work in geriatrics. Funding for incentive and awareness programs should be provided to encourage more people to work in geriatrics.
“A test of a people is how it behaves toward the old. It is easy to love children. Even tyrants and dictators make a point of being fond of children. But the affection and care for the old, the incurable, and the helpless are the true gold mines of a culture.”

-Abraham J. Heschel, The Insecurity of Freedom, 1959

We all age while watching our loved ones and friends do the same. Yet, Heschel’s observation indicates individuals often fail to care for the elderly. Professionally, as a result of the dramatic growth of the older population, an increasing number of social workers and allied health professionals will work with older adults and/or issues that concern the aging population during their careers. Yet, studies indicate a lack of interest among social workers and other professionals in joining the field of geriatric practice. Here, the “generation gap” not only pertains to the differences between younger people and their elders, but to the gap between the aging population’s increasing demand of need and how many individuals plan to serve the elderly.

A belief that working with elders is depressing, paired with a lack of opportunities for students to take courses in gerontology, were significant factors in predicting employment in aging-related jobs (Cummings & Alder, 2007, p. 11). At Providence College, for example, the only course offered in geriatrics is the “Psychology of Aging.” Cummings and Alder’s article discusses what is considered common knowledge within the field of social work: many professionals elect not to work with the elderly. I am concerned with why. I will be the first to admit that my interest in working with the elders is deeply rooted in my personal experiences with the aging population. So, it is plausible to say other professionals may feel inclined to work in a particular area of social work that personally attracts them because of their personal experience with the demographic
or the scenario at hand. However, I have not found any research that explores this specifically. To have extensive research on each social worker’s motives for working in the field is probably too broad to be explored adequately. My research study taps into individuals’ perceptions of elders and how they understand the demographic in order to learn if these individuals desire to work with them.

To get a better understanding of the number of younger adults working in geriatrics, I called a few assisted living facilities in the Providence area, such as Capitol Ridge, EPOCH, and Laurelmead, and conducted an informal interview with employees. I asked the same three questions (See Appendix A), and the answers were consistent for all of the facilities I interviewed. “Students from Brown volunteer with [EPOCH East Side], but there is such a shortage of help in geriatrics that their services are not enough,” said a respondent from EPOCH. Most of the information I solicited was confidential, because it included employment information. However, each facility did say that they do not receive much help from young adults and few are within the age group of 18-24 apply for work.

Again, there is little research exploring why this is so. I hypothesize that individuals are discouraged from working with elders, in part, because of their conceptions of the people who are considered “elderly” or “older persons.” Therefore, the study I designed is not intended to deduce why professionals – namely social workers and allied health professionals – do not work with the aging population. Rather, I explored how people perceive the aging population by assessing the negative and positive stereotypes people associate with the demographic.

Ageist stereotypes came to my attention after I started noticing certain marketing techniques. Greeting-card and novelty companies call them “Over the Hill” products:
50th birthday coffin gift boxes featuring prune juice and anti-aging soap; “Old Coot” and “Old Biddy” bobblehead dolls; birthday cards mocking the mobility, intellect, and sex drive of the no-longer-young. Below is an example of a birthday card, illustrated by Daniel Collin of The Humor Company that I purchased at Newbury Comics at the Providence Place Mall. Inside of the card it reads, “Listen Carefully. Happy Birthday.”

My initial interest in researching aging stereotypes began when I worked on a qualitative study in the spring of 2012 at a small Catholic liberal arts college in the northeast about the students of the Department of Social Work on their perceptions of and
experiences with elders, as well as their potential interests in working with them in clinical practice. In the study, “Perspectives of Gerontological Social Work Among Undergraduate Students at Providence College,” the research group found that out of 25 students interviewed, only three expressed an interest in working with the demographic after graduation, and all three of them had extensive experience working with elders (Ilg, Casale, & Marcarelli, 2012). Coupled with an alarming lack of interest in working with elders is that rate at which the demands of them are growing.

Americans face the financial, economic, and political consequences that the baby boom caused, and the United States is struggling to adequately prepare for the needs of this quickly increasing population at the rate it is increasing today. Knickmen and Snell (2002) reviewed economic and demographic data as well as simulations of projected socioeconomic and demographic patterns in the year 2030 and “found the basis of an intense review of the challenges related to caring for seniors need to be faced by society” (p. 850-851). To compliment Knickmen’s and Snell’s study, I studied a condensed list of current statistics from the Administration on Aging (2010). The older population (65+) numbered 39.6 million in 2009, which was an increase of 4.3 million or 12.5% since 1999. The population 65 and over increased from 35 million in 2000 to 40 million in 2010 (a 15% increase) and then to 55 million in 2020 (a 36% increase for that decade). Elders tend to require a certain amount of assistance with age, and as the statistics show, the aging population is rapidly increasing.

This study can be considered an expansion of the one I conducted in the spring of 2012 but is quantitative in design. It describes undergraduate students at a small Catholic liberal arts college in the northeast on their understandings of the aging population to see
if their desire to work with the elderly were conditioned by particular stereotypes about the demographic. The goal is that by identifying what specific stereotypes and how frequently they are identified within this research group will allow for more research into stereotyping and provide an avenue for targeted advocacy that curtails the lack of professional interest in working with elders.

**Literature Review**

There is a breadth of information regarding the topic of ageist stereotypes. However, there is no literature concerning the identification and ranking of specific ageist stereotypes among a specific population. Therefore, this study can contribute to the existing research and support the studies mentioned throughout this paper. The best way to categorize the research is by grouping the published literature by psychosocial aspects of aging, stereotypes, and working in gerontology.

**Psychosocial aspects of aging**

Human aging consists of the physiological changes that take place in the human body leading to senescence, the decline of biological functions and of the ability to adapt to metabolic stress. In humans, the physiological developments are normally accompanied by psychological and behavioral changes. Other changes occur as a result of social and economic factors (Gusmano & Rodwin, 2006, p. 2). Like other generalized words, “aging” is difficult to define with specificity. However, gerontologists describe it as the process by which a healthy individual of any species gradually deteriorates into one that is frail, one whose bodily capacities diminish to make these individuals more vulnerable and ultimate lead them to disease and death (Nuland, 2007, p. 27).
Understanding the role of psychosocial factors in late life requires a high-altitude view of human development of people and the ways in which they respond to life changes. Many psychosocial elements play a key role in the development of aging individuals. Depression and disillusionment are two obvious obstacles. Michael Gusmano and Victor Rodwin, co-directors of the World Cities Project at the International Longevity Center in New York City, agreed to hold an interview with me regarding this topic.

We met at Mr. Gusmano’s office at Columbia University, where he is the Assistant Professor of Health Policy and Management, in the summer of 2012. He said the foundation of changes in thought and behavior of elders are rooted in their sense of vulnerability and social isolation. “For the few who want to dedicate their careers to geriatrics, they must understand the people they will be working with,” he said.

Social isolation refers to living without companionship, social support, or social connectedness. It is the absence of having a significant other to trust in a time of crisis. It is related to poorer health-related quality of life, levels of satisfaction, well-being, and community involvement (National Research Council, 1992). Gusmano and Rodwin (2006), said, “Socially isolated older persons are difficult to find. Like other vulnerable older persons, they tend to be invisible…World cities like New York face an unprecedented challenge: how to meet the needs of a population that lives longer, has a declining birthrate, and is generally healthier.” Like race and gender, age is one of the automatic dimensions on which we categorize others (Bousfield & Hutchinson, 2010, p. 451), yet categorization and labels often stereotype groups of people.
Stereotypes

A stereotype is a simplified and standardized conception or image invested with special meaning and held in common by members of a group. People of all ages can hold stereotypes about the aging. “As soon as individuals perceive someone as old, they tend to assume knowledge of their competencies, beliefs, and abilities across different areas” (Bousfield & Hutchinson, 2010, p. 451). Benne and Gaines (2010, p. 437) found that four basic characteristics of self-stereotypes are identified: “(a) stereotypes can be negative or positive; (b) stereotypes have significant power, particularly if they are self-relevant; (c) stereotypes can be operative without awareness and influence physical and cognitive outcomes; and (d) negative stereotypes can be countered by positive priming.”

Research shows that there are many different stereotypical views of elders (Bousfield & Hutchinson, 2010, p. 451); attitudes depend on which stereotype – positive or negative – is salient. “While multiple stereotypes exist, an overarching stereotype about older people has also been identified across different cultures – a benevolent yet dismissive combination of warmth and incompetence, with elderly people seen as ‘doddering but dear’ ”(Bousfield & Hutchinson, 2010, p. 452). However, there are many negative stereotypes about elders that contradict this finding like those of severe impairment: “being fragile, senile, dependent on family, and incapable of handling a job” (Bousfield & Hutchinson, 2010, p. 452). One study confirmed the existence of independent domain-specific age stereotypes, providing evidence for a multi-faceted and complex view of old age and aging. “‘Old persons’ were evaluated differently in various life domains and age thresholds because ascriptions of being old differed between domains” (Kornadt & Rothermund, 2011, p. 550).
Stereotypes about the elderly are varied and complex, but negative stereotypes often lead to ageist attitudes. Ageism includes “negative attitudes or behaviors towards an individual solely based on that person’s age.” Ageism may be the most commonly experienced form of discrimination (Bousfield & Hutchinson, 2010, p. 451). However, it is not generally regarded as serious, certainly not in comparison to racism or prejudice on the grounds of religion or disability. It can be directed towards the young as well as the old. One way it affects both parties could be that ageism discourages young adults from working with older persons.

**Working in gerontology**

Many young adults do not work with the elderly, and I suspect that individuals are discouraged from working with the elderly because of various stereotypes that have conditioned their thinking. As stated previously, this subsection could be its own area of research alone; the intent of having such a section is to merely provide background on the rationale for my topic. When researching this topic and planning this study, I was interested in learning more about the nature of gerontological social work because of my career interests at the time. However, the lack of interest in working with geriatrics is not specific to the field of social work (although it is very easy to include allied-health professionals into the conversation). Therefore, I selected social work as the area of professionalism to hone in on for this study because to research all professions that interact with elders is too broad. Again, however, this problem is contained within the field of social work.

According to Cummings & Adler (2007, p. 11), the rapidly growing aging population highlights the need for social workers trained in gerontological practice. Their
study examined recent social work graduates’ perceptions of aging-related jobs. Their analysis revealed that “[attaining] aging-related skills, believing that working with older adults is depressing, and having taken an undergraduate gerontology class were significant in predicting employment in aging-related jobs.” Many schools of social work, however, lack faculty with expertise in gerontological issues (Olson, 2007, p. 986).

In short, the lack of professionals – particularly younger ones – who work in gerontological social work is associated with what is called professional commitment (occupational commitment): “a psychological link between a person and his or her occupation that is based on an affective reaction to their occupation” (Simons, Bonifas, & Gammonley, 2011, p.184). However, there is little knowledge of the factors affecting it among licensed clinical social workers. One study’s data found a positive relationship between the years of experience working in geriatrics and the commitment to continue working in the field. “Compared with social workers with 16 or more years working with older adults and their caregivers, the odds that social workers with zero to five years of experience would have high commitment decrease by a factor of 0.239 (p <.05), or 76 percent” (Simons, Bonifas, & Gammonley, 2011, p.188). As a result, I submit that researching the stereotypes individuals associate with the elderly will likely provide insight into the rationale as to why individuals are not pursuing work in geriatrics. Therefore, more research could be done to help target the trajectory of the early stages of a licensed social worker’s career.

**Methodology**

For this study, I used the Q methodology. It contains a heterogeneous set of items (called a Q sample) and is drawn from the concourse. A group of respondents (P set) is
instructed to rank order (Q sort) the Q sample along a standardized continuum according to a specific condition of instruction. Participants do this according to their own likes and dislikes according to their own psychological significance. The resulting Q sorts are submitted to correlation and factor analysis. Interpreted results are factors of “operant subjectivity” (Donner, 2001, p. 24).

The method requires participants to prioritize a set of 20 to 50 elements or statements in order from least to most desirable. Although the root of the Q is the prioritization of elements, one of its strengths is that the pattern that drives the weighting of a particular statement or concept versus another does not need to be known in advance. Furthermore, each person uses his or her own subjective criteria to evaluate the relative attractiveness of each element. Participants’ logic (perspective) is their own; but since the researcher is asking the same question, using the same elements, to be placed in the same format, the researcher can compare these subjective perspectives with more rigor than normal qualitative methods would allow (Donner, 2001, p. 24). The statements to be ranked, as well as the sorting table are in Appendix B.

I was awarded an Undergraduate Research Grant by the institution at which I conducted this study to fund the research materials needed for administering the survey and to compensate the participants. This institution’s Institutional Review Board also approved me to conduct it after passing the “Social and Behavioral Research Investigator’s” course.

Participants

I solicited undergraduate students from a small Catholic liberal arts college in the Northeast to conduct the study. In order to recruit participants, I used the “accidental
sampling” technique, via in-person conversations, announcements at organization meetings, and email exchanges. Appropriate administrators to recruit students in this way gave me permission to pursue recruiting students. Accidental sampling (sometimes known as grab, convenience, or opportunity sampling) is a type of non-probability sampling, which involves the sample being drawn from that part of the population, which is close to hand. That is, a population is selected because it is readily available and convenient (Donner, 2001, p. 27). At this institution, I drew from organizations and departments where I knew the student leaders and faculty members well enough to ask them to help in conducting this study. The students were provided with a Statement of Purpose stating that participating in this study secured their confidentiality and anonymity (Appendix C).

**Data Gathering**

For each of the administrations, I gathered my materials and my compensation to present my survey to the groups. I conducted six administrations from the middle of October through the middle of November. I read to the students the instructions for filling out the scorecard, and each administration took about 30 minutes. When explaining what to do, I segmented the administration into two parts: the first required students to read through each of the 27 statement cards and create two piles for the cards: statements that had the least significant impact on their decision to work with elders and statements that had the most significant impact on their decision to work with elders. Then, students were instructed to select the two statements out of the “most significant” pile that they felt had the most significant impact on their decision and wrote the number of the card in the two boxes under the +3 column. The students were instructed to then select the two
statements from the “least significant” pile that had the least amount of impact on their decision to work with the elders and wrote the number of those cards in the two boxes under the “-3” column. The participants were instructed to continue filling in the columns in an alternating fashion (from -2, 2, -1, 1, to 0) until they completely filled out the scoring card. During each administration, a couple students had questions that were easily clarified. Afterwards, the participants were compensated with food (usually pizza).

Data Analysis

After collecting the data, I manually entered it into the PQ Method software I downloaded. PQMethod is a statistical program tailored to the requirements of Q studies. Specifically, it allows someone to easily enter data (Q-Sorts) the way they are collected, i.e. as “piles” of statement numbers. It computes intercorrelations among Q-Sorts, which are then factor-analyzed with the Centroid or, alternatively, PCA method. Resulting factors can be rotated either analytically (Varimax), or judgmentally with the help of two-dimensional plots. Finally, after selecting the relevant factors and “flagging” the entries that define the factors, the analysis step produces an extensive report with a variety of tables on factor loadings, statement factor scores, discriminating statements for each of the factors as well as consensus statements across factors, etc. The original FORTRAN program, QMethod, was developed by John Atkinson at Kent State University in 1992 for mainframe platforms and released to the Public Domain (Schmolck, 2011 p. 1). Once I gathered the printouts of the data, I analyzed them with Dr. Michael Hayes of the Department of Social Work at Providence College. We analyzed the data in a 2-factor analysis (which generated two groups from the total number of participants).
Findings

Below is the table of the 2-factor analysis for the data collected. All of the statements shown distinguish the two factors at a statistically significant level (p < .05). All elements marked with an asterisk (*) are statistically significant at the (p < .01) level. Both the factors’ Q-sort (Q-SV) and the Z-Score (Z-SCR) are shown. Students prioritized the statements from the +3 column (most significant) and the -3 column (least significant) when considering them in regards to their desires to work with elders (Q-SV numbers).

<table>
<thead>
<tr>
<th>Statement</th>
<th>Q-SV</th>
<th>Z-SCR, Group 1</th>
<th>Q-SV</th>
<th>Z-SCR, Group 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>#14 witnessed relative care for dependent elderly</td>
<td>3</td>
<td>1.94*</td>
<td>1</td>
<td>0.15</td>
</tr>
<tr>
<td>#15 helped care for dependent elderly relatives</td>
<td>3</td>
<td>1.74*</td>
<td>0</td>
<td>-0.032</td>
</tr>
<tr>
<td>#16 visited relative(s) in nursing homes</td>
<td>2</td>
<td>1.61*</td>
<td>0</td>
<td>0.08</td>
</tr>
<tr>
<td>#24 have volunteered/worked with elderly b/c of past exposure</td>
<td>2</td>
<td>1.17*</td>
<td>0</td>
<td>-0.12</td>
</tr>
<tr>
<td>#23 have volunteered/worked with the elderly</td>
<td>2</td>
<td>1.13</td>
<td>2</td>
<td>1.47</td>
</tr>
<tr>
<td>#22 would like to work or volunteer with the elderly</td>
<td>1</td>
<td>0.99*</td>
<td>1</td>
<td>0.59</td>
</tr>
<tr>
<td>#17 had a loved one with Alzheimer's</td>
<td>1</td>
<td>0.58*</td>
<td>-1</td>
<td>-0.53</td>
</tr>
<tr>
<td>#3 tend to be isolated/lonely</td>
<td>1</td>
<td>0.42*</td>
<td>3</td>
<td>1.62</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>#12 are more likely to have chronic illnesses</td>
<td>0</td>
<td>0.07*</td>
<td>3</td>
<td>2.37</td>
</tr>
<tr>
<td>#18 took courses in geriatrics</td>
<td>0</td>
<td>-0.06*</td>
<td>-2</td>
<td>-1.09</td>
</tr>
<tr>
<td>#8 more likely to be weaker</td>
<td>0</td>
<td>-0.21*</td>
<td>1</td>
<td>1.13</td>
</tr>
<tr>
<td>#10 are more likely to be weak and frail</td>
<td>0</td>
<td>-0.22*</td>
<td>2</td>
<td>1.55</td>
</tr>
<tr>
<td>#5 tend to have low SES status</td>
<td>0</td>
<td>-0.25</td>
<td>0</td>
<td>0.03</td>
</tr>
<tr>
<td>#20 not exposed to issues concerning the elderly</td>
<td>0</td>
<td>-0.30</td>
<td>-1</td>
<td>-0.63</td>
</tr>
<tr>
<td>#27 would not like to work with the elderly</td>
<td>0</td>
<td>-0.40*</td>
<td>-3</td>
<td>-1.40</td>
</tr>
<tr>
<td>#21 never volunteered/worked with the elderly</td>
<td>-1</td>
<td>-0.44*</td>
<td>-2</td>
<td>-1.02</td>
</tr>
<tr>
<td>#19 offered but declined to take courses in geriatrics</td>
<td>-1</td>
<td>-0.55*</td>
<td>-3</td>
<td>-1.34</td>
</tr>
<tr>
<td>#9 are more likely hard of hearing</td>
<td>-1</td>
<td>-0.84*</td>
<td>0</td>
<td>-0.14</td>
</tr>
<tr>
<td>#2 tend to be unable to adapt to change</td>
<td>-2</td>
<td>-0.92*</td>
<td>1</td>
<td>0.26</td>
</tr>
<tr>
<td>#4 tend not to be effective in the workforce</td>
<td>-2</td>
<td>-1.12*</td>
<td>0</td>
<td>-0.34</td>
</tr>
<tr>
<td>#1 tend to be mentally slow or dull</td>
<td>-2</td>
<td>-1.20*</td>
<td>0</td>
<td>-0.32</td>
</tr>
<tr>
<td>#6 tend to have no interest in/capacity for sex</td>
<td>-3</td>
<td>-1.31*</td>
<td>-1</td>
<td>-0.073</td>
</tr>
<tr>
<td>#7 tend to be cranky</td>
<td>-3</td>
<td>-1.83*</td>
<td>-1</td>
<td>-1.01</td>
</tr>
</tbody>
</table>
In the above table, the Q-SV numbers highlighted in yellow represent the participants of Group 1. In Group 1, participants rejected the statements about false, negative stereotypes by placing these statements in the -1, -2, and, -3 columns of the scoring sheet and thereby indicating that these statements had the least significant impact on their decision to work with the elderly. Furthermore, the participants of this group indicated having exposure to geriatrics, had previously worked or volunteered in geriatrics, and would like to continue working with elders by placing these statements in the 1, 2, and 3 columns of the scoring sheet thereby indicating that these statements had the most significant impact on their decision to work with the elderly. This illustrates an association between participants’ exposure to working with elders and their rejection of negative stereotypes, perhaps because people who have worked in geriatrics have a better understanding of the demographic. Exposure to working with elders and the rejection of false stereotypes about elders are in turn associated with significantly greater willingness to work with elders on a volunteer or professional basis. Conversely, the participants in Group 2 of the same factor analysis had significantly more emphasis on deficits and false negative stereotypes, did not take courses in geriatrics, and had significantly less exposure to working with elders. This was associated with their significantly lesser interest in working with elders on volunteer or professional bases.

**Limitations**

The research study I conducted faced two limitations: breadth of previous literature and longitudinal restraints. When researching the topic, I found many articles pertaining to the three subsections of the literature review. However, I did not find any articles assessing stereotypes of elders using Q methodology, suggesting the pursuit of
my study. Furthermore, as a result of the time constraints and of the location of the independent study in which I conducted the research, the sample came from a small Catholic liberal arts school in the northeast. Therefore, the sample group is not particularly diverse.

Furthermore, there is another important fact that needs to be analyzed: the determining age of “old.” For the purposes of this study, I considered “old age” to begin at age 65. Our country’s Medicare program is a health insurance program for people age 65 or older, although certain people younger than age 65 can qualify for Medicare, as well including those who have disabilities, permanent kidney failure, or amyotrophic lateral sclerosis (Lou Gehrig’s disease). It is imperative to keep in mind that due to each person’s different physiological changes and medical history, the point at which a person feels “old” can be earlier or later than the 65-year-old marker. Aside from defining a decline in health related to aging as senescence, defining what being old is and how it feels (in a standardized way) is nearly impossible. The literature suggests that a new definition of healthy ageing needs to be created, while taking into the account that there are various definitions of the term used in practice for different professions and different disciplines (Hansen-Kyle, 2005, p. 52). “No number can define us as middle-aged, or elderly, or the oldest person. We can be defined only by what we have become” (Nuland, 2007, p. 15). Therefore, with a lack of a unified definition of the demographic at hand, treating those in it will continue to be challenging because professionals are unable to clearly specific their population.
Summary and Implications

The research above contributes to the existing literature because stereotypical perceptions of elders in relation to peoples’ desire to work with the demographic have not been previously studied using Q methodology. With the data I provided, I submit that there should be funding for awareness programs to debunk negative stereotypes that hold (as evident in Group 2 of the analysis) and funding for incentive programs to encourage people to work with elders as to better influence their desire to continue working with elders, as supported by the analysis of Group 1. There is not much funding pumped into programs concerning elders outside of Medicare at this point. Although there are political pushes to cut some funding for Medicare and/or raise the age of eligibility, the reasons for this exceed the scope of the paper. I submit that a better understanding of elders and the process of aging would be helpful in fairly distributing money and services to elders across the nation.

Social workers are not the only professionals affected by the lack of information available about elders. “There is a well-documented critical need for an expanded and adequately trained interdisciplinary workforce from medicine, nursing, social work, and allied health fields that can provide person-centered care to our rapidly aging population (Simons, Bonifas, & Gammonley, 2011, p.183). These professionals require knowledge about the demographic, and yet, the aging process and its effects seem to be a mystery. This is the next direction I would take my research. I have answered the questions regarding what people have come to learn about the aging population through stereotypes. The next fundamental concept that needs to be explored more thoroughly is what people perceive the aging process to be.
All humans die. However, while each of us knows they shall die someday, few of us can escape wishing we could delay the process. As I researched, I learned that not only are people unaware of the needs of the aging, but they are mystified by the process itself. 

Aging (and more so death) seem to be a phenomenon of human nature that intrigues people perhaps because of its ambiguity – aging, as with death, is a unique experience for each person who experiences it. Perhaps the intrigue lies in the fear embedded in one’s understanding of aging as a process or the diseases affiliated with “old age.” Others may fear death altogether and wish to prolong the inevitable. Many understand “old age” (just based on the chronology of a standard life) to be the step that precedes death. Researchers themselves are inconsistent with their understanding of it: the words “aging” and its process, as well as with “death with dignity” hold different definitions for doctors, nurses, therapists, and social workers.

Throughout time, people have tried to grapple with one’s ultimate, perhaps untimely, end. This could be a result of people’s ignorance, apathy, or fear about the process of aging – which is just as emotional, mental, and spiritual, as it is physiological. Perhaps, this is more of a topic for biomedical ethics and not clinical practice. Heschel argued that society had little regard for elders. Consistent with this, others have written about the aging process and the effects of it. In the words of American poet, Ogden Nash:

\[
\begin{align*}
\text{People expect old men to die,} \\
\text{They do not really mourn old men.} \\
\text{Old men are different. People look} \\
\text{At them with eyes that wonder when…} \\
\text{People watch with unshocked eyes;} \\
\text{But the old men know when and old man dies.}
\end{align*}
\]
Nash’s poem reminds us that old persons may not be understood better than anyone but themselves. Society’s attempt to understand elders and the aging process as a natural phenomenon may lead to stereotyping, false presumptions, and inaccurate information concerning the demographic. This, however, does not mean that people should avoid working in geriatrics. Rather, this is an opportunity for social workers, allied-health professionals, and other individuals to learn more about gerontological fields and avoid stereotyping. Yet, there is still more research to be done and this begs the question: should the aging process be something feared or a celebration of the transition into the next stage of the lifespan?
Appendix A

Facility Name: ________________________________

Name of Person Interviewed: ________________________________

Contact Number: ________________________________

1. Please explain the response you have received, if any, from young adults (ages 18 - 24) to volunteer with the elderly?

2. How many young adults (ages 18-24) are employed at your facility?

3. (Depending on your answers to the previous questions), Why do you think there is either little or much interaction between the young and the old?
Appendix B

Below is the list of statements I will ask the participants to categorize from strongly disagree to strongly agree, as well as an image of a general Q-Sort template.

A. **Stereotypes (7 statements)**
   The elderly tend to be mentally slower or duller than younger adults.
   The elderly tend to be unable to adapt to change.
   The elderly tend to be socially isolated and lonely.
   The elderly tend to be less effective in the workforce than younger adults.
   The elderly tend to have a low socioeconomic status.
   The elderly tend to have little interest or capacity for sexual relations.
   The elderly tend to be cranky.

B. **Psychosocial Aspects of Aging (6 statements)**
   The elderly are more likely to be physically weaker than adults younger than them.
   The elderly are more likely hard of hearing than younger adults.
   The elderly are more likely to be weak and frail than younger adults.
   The elderly are more likely to be mature than middle-aged and young adults.
   The elderly often have chronic illnesses such as arthritis, dementia, and osteoporosis.
   The elderly likely feel as old as their age.

C. **Exposure to Demographic (11 statements)**
   1. **Familial**
      I have witnessed a parent or guardian care for a dependent elderly relative.
      I have helped take care of a dependent elderly relative.
      I have visited elderly relative(s) in nursing homes.
      I have had a loved one with Alzheimer’s.
   2. **Educational**
      I took courses in high school or in post high school facilities in geriatrics.
      Courses in geriatrics were offered in my high school or my post high school facilities and I chose not to take them.
   3. **Institutional**
      I have not really been exposed to health and sociological issues concerning the elderly.
      I have never volunteered or worked with the elderly population.
      I would like to volunteer or work with the elderly population.
      I have volunteered and worked with the elderly population.
      I have volunteered and worked with the elderly population because of previous experience [visiting a relative in a nursing home, for example].

D. **Work Preferences (3 statements)**
   I feel some reluctance about working with the elderly.
   I am open to working with the elderly.
I’d rather not work with the elderly.

*Note on Construction: The statements in Part A reflect widely held stereotypes, not based in fact. The statements in Part B, although worded similarly, are based in fact. The statements in Parts C and D assess the range in which people have been exposed to and prefer to work with the elderly demographic.

![Scoring Sheet](image)

Above is the Q-sort template in which participants placed the number of the statements under the column associated with the participants’ chosen rank for the statements.
Appendix C

Statement of Purpose

Dear Participant,

I am a student at Providence College, inviting you to participate in a study about how PC students perceive and understand ageist stereotypes and how these perceptions incline (or disincline) them to work with the elderly. Data gathered in this study will be reported confidentially in a research paper for use in a health policy and management course at Providence College.

At the present time, undergraduate students are being recruited for this research. Participating will involve reviewing and categorizing statements into the following groups: “strongly disagree,” “mixed feelings,” and “strongly agree.” The administration is estimated to take 30 minutes.

There are no anticipated significant risks associated with involvement in this research. The nature of these questions may potentially cause minor emotional discomfort or stress. Participants are free to decline to participate in this study at any time.

Benefits of participating in this study include contributing to the generation of knowledge that may aid in work with others in the future. There is no other anticipated compensation.

Confidentially of participants will be protected by reporting information in a way that cannot be traced back to the individual participant.

Participation in this study is voluntary. Your decision to participate or to decline to participate in any capacity will have no influence on your relationship with the researcher or the Department of Health Policy and Management in any way.

If the researcher cannot be reached, or if you would like to talk to someone other than the researcher about (1) concerns regarding this study, (2) research participant rights, (3) research-related injuries, or (4) other human subjects issues, please contact the Chair of the Providence College Institutional Review Board (IRB). Contact information for the IRB Chair can be obtained from the Office of Academic Affairs (Provost), Harkins 208, (401)-865-2195 or irb@providence.edu.

Thank you for your participation.

Researcher’s contact information:

Genevieve Ilg, gilg@friars.providence.edu
Acknowledgements

Dr. Todd Olszewski, assistant professor of health policy and management, independent study advisor

The Health Policy and Management Department

Dr. Michael Hayes, associate professor of social work

Dr. Steven Sears, dean and associate vice president of student affairs

Elena Yee, director of the Balfour Office of Multicultural Activities

The Institutional Review Board of Providence College

Providence College’s Undergraduate Research Grant

Andrew Gellert, my fiancé
References


