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Walden University

College of Health Sciences

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Stephanie Cameron

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Walden University
2015

Abstract

A Study of Nurses' Attitudes Toward Medical Ageism

by

Stephanie D. Cameron

MPH, Walden University, 2009

BS, Alcorn State University, 2006

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Public Health

Walden University

December 2015

Abstract

Medical ageism in the United States affects senior citizens' activities of daily living (ADL) and the quality of their medical care. *Medical ageism* refers to discrimination against, abuse of, stereotyping of, contempt for, and avoidance of older people. Nurses who take care of the elderly are responsible for ensuring that older patients are treated fairly and in a timely manner, so it is important to know whether or not nurses have any bias regarding the elderly. The research questions addressed in this quantitative study explored whether or not there were differences in nurses' perceptions of ageism as moderated by the nurses' own gender, ethnicity, age, or years of experience. This study used a researcher-developed demographic survey and the Age Based Rejection Sensitivity Questionnaire (RSQ-Age). The theoretical framework for this study included the theory of emotional labor. A quantitative, causal-comparative design was used to test the hypotheses. Sixty one nurses were purposively sampled via snowballing sampling. Analysis of variance was used to determine mean differences in ageism between the specified independent variables. Findings from this study revealed that caregivers with less than, or equal to, 5 years of nursing experience had significantly lower ageism scores than nurses with more than 5 years of experience. Gender, ethnicity, or age did not significantly affect ageism scores. This study may contribute to social change by determining how nurses can recognize their own potential fallibilities in the field of gerontology, thereby having the potential to promote positive health outcomes for the elderly.

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Dedication

I dedicate my dissertation work first to God, my family, and my friends. A special feeling of gratitude goes to my loving mother, Lourrie N. Flowers Johnson, whose words of encouragement and push for tenacity ring in my ears. My brothers, Harold, Richmond, Raymond, and Curtis, have never left my side. I also dedicate this dissertation to my many friends and church family who have supported me throughout the process. I appreciate all they have done, especially Harvey McNeal for the many hours of proofreading and encouragement. I dedicate this work and give thanks to my incredible, wonderful children, Riccon and Johnthyn, who keep me safe, happy, and loved, whom I love so much, and who have been there for me throughout the entire doctorate program. May you be a safe harbor for each other.

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Chapter 1: Introduction to the Study

Background of the Study

Within any society, there are subsets of individuals that are differentiated by features such as class, social status, or culture. Differences within a single society have been highlighted in sociological studies, and dynamics within a single society can be reflected in social and political power, health status, and socioeconomic status (Barkan, 2013; Cragun, Cragun, & Konieczny, 2012). Inequalities such as racism, sexism, and ageism have been present in societies where different groups coexist (Brianna & Skylar, 2013; Long, 2013).

Ageism refers to discrimination against, abuse of, stereotyping of, contempt for, and avoidance of older people (Nelson, 2005). Given the excessive promotion by the media of the notion that beauty means youth (Diversiton, 2013), the elderly are sometimes seen as useless or unnecessary. Ageism is one the most pervasive and insidious forms of prejudice in the workplace, as it is difficult to prove (Dittmann, 2003). This negative bias can also be found in the legal arena and health sector (Alliance for Health Reform, 2006; Smedley, Stith, & Nelson, 2003). Prejudicial treatment can cause disempowerment among the elderly. The impact, which may be subtle but pervasive, can manifest in social isolation (a risk factor for mistreatment), lower self-esteem, and a poorer quality of life, such as reduction in financial security or health quality (National Center for Biotechnology Information Bookshelf, 2013). When the effects of ageism are combined with those of *ableism* (bias against the disabled), the health and well-being of the elderly are further jeopardized (Baker, 2012; Day, 2014).

In this quantitative study, I explored whether or not there were differences in nurses' perceptions of ageism based on the nurses' own gender, ethnicity, age, or years of experience. Recognizing any existing differences nurses may have regarding ageism may provide insight into participatory strategies that may reduce health disparities among elderly patients that may result from these attitudes.

Intrinsic in human experience are fear and aversion toward growing old. People fear deterioration, dementia, dependency, and eventually death. Although age as a social construct carries power and authority from one place to another, it also can convey or indicate powerlessness to adjudicate or settle disputes (Open Society Institute, 2006). With aging also comes the increased prospect of age-related diseases and declines in memory, sexuality, and mobile functions.

The merits of providing care to all elderly people versus allocating resources based on chronological age and illness level continue to be a subject for debate among gerontologists (Turcotte, 2003). Resources required for providing care within the current American healthcare system are becoming increasingly limited due to the growing number of aging people; thus, the challenges of serving an aging population have become a social problem for society as a whole. Additionally, due to complacency among providers, the quality of healthcare of the elderly may continue to decline, as elderly people are often expected to receive second-class care (Clarke & Donaldson, 2009). An investigation is needed to identify the factors that lead to ageism, and a strategy must be developed to counter these factors (American Psychological Association, 2013b).

Ageism existed long before it was given its name. Nelson (2005) called old age "fear of our future self" (p. 207). Little is known about the origins of ageism, but the

practice is quite common. Ageism is the third most used method to categorize others, while race and gender make up the top two categories. The tendency to view elderly patients as less than human has been explained as a need to defend oneself against the anxiety that their condition provokes (Carmichael, Dobson, Ingham, Prashar, & Sharifi, 2006; Social Care Institute for Excellence, 2010).

During the late 1900s, victims of ageism experienced difficulties accessing the National Health Service (NHS), a public health system in the United Kingdom that provides free medical treatment for millions of people every year (Schlipköter & Flahault, 2010). Elderly people were refused treatment that younger people easily accessed due to a number of factors, including (a) tight budgets, leading to locally defined systems of "rationing" according to age; (b) embedded routines with discriminatory effects, including ways of defining the benefits of a particular treatment, for example, quality-adjusted life years; and (c) ageist attitudes that may have led care managers to assume that a "more restricted kind of life" was suitable for anyone over 65 (Social Care Institute for Excellence, 2010, p. 6). These are factors that continue to affect many elderly patients.

Problem

Ageism in the United States affects senior citizens' activities of daily living and the quality of their medical care (Barkan, 2012). With the continued growth of the elder population in the United States, the healthcare system must find strategies to maintain quality of care within the confines of the current medical establishment. Several factors are to blame for the discrepancy in care between society's age groups. The elderly are often neglected, becoming either a forgotten community or dismissed as chronic

complainers about their various aches and pains. As a result, elderly people who are not self-sufficient may not receive the medical attention they require (Kobbe, 2012; Kumar & Allcock, 2008). Victims of this type of discrimination face the challenge of not receiving adequate medical attention and long-term care for their illnesses and disabilities (U.S. Department of Health and Human Services, 2002). Additionally, costs associated with hiring support staff for in-home nursing care, assisted living facilities, and nursing homes may cause reduced nursing staff levels, which tend to increase the incidence of poorer patient outcomes (Stone & Weiner, 2001).

Medical ageism as a form of discrimination is omnipresent and persists in the current healthcare system (Carmichael et al., 2006). There are several reasons why this type of discrimination exists in the healthcare system, including the following:

1. Employers who deny health benefits to individuals aged 65 and older are not violating any age discrimination law according to a ruling by the U.S. Equal Opportunity Commission.
2. Underfunding exists in government and corporate pensions.
3. Minimal numbers of elder abuse incidents are reported to authorities.
4. Many elderly victims are financially abused.
5. There are age discrimination claims related to hiring.
6. Millions of elders over the age of 65 are injured, exploited, or mistreated by someone they depend on for protection.
7. Although more than 12% of the population is over 65, less than 2% of primetime television characters are in this age group (Palmore, 1999; Sharma, 2007; U.S. Department of Health and Human Services, 2002).

Purpose

The purpose of this quantitative, nonexperimental study was to determine whether differences among nurses exist in the care provided to elderly patients that are based on the nurses' gender, ethnicity, age, or years of experience. A quantitative research methodology was appropriate for this study, as numerical data were analyzed using an analysis of variance (ANOVA) test. This type of test allowed me to compare means across two or more independent groups to determine whether they differed, provided the dependent variable was scaled at the interval or ratio level. Therefore, a nonexperimental design was appropriate to compare means across two or more independent groups.

Examining ageism and how the current medical establishment perpetuates this problem can provide insight into how this issue may be addressed. The study's sample consisted of approximately 100 nurses in Southern Mississippi. The study's findings may be used to build a framework to improve attitudes of nurses toward the elderly. Furthermore, findings may be used to develop training programs for nurses identifying ways to mitigate ageism.

Research Questions

To guide this quantitative study, five research questions were asked. The independent variables of interest were gender, ethnicity, age, and years of experience; the dependent variable was nurses' attitudes toward ageism. The questions were as follows:

RQ1: Is there a difference in nurses' attitudes toward ageism among the following age groups of nurses (18-34, 35-54, 55+)?

$H_0$1: There is no difference in nurses' attitudes toward ageism between nurses' age groups (18-34, 35-54, 55+).

H_a1: There is a significant difference in nurses’ attitudes toward ageism between nurses’ age groups (18-34, 35-54, 55+).

RQ2: Is there a difference in nurses’ attitudes toward ageism between nurses’ ethnicity groups (European American, African American, Hispanic, and Asian American)?

$H_0$2: There is no difference in nurses’ attitudes toward ageism between nurses’ ethnicity groups (European American, African American, Hispanic, and Asian American).

H_a2: There is a significant difference in nurses’ attitudes toward ageism between nurses’ ethnicity groups (European American, African American, Hispanic, and Asian American).

RQ3: Is there a difference in nurses’ attitudes toward ageism between nurses’ genders (male, female)?

$H_0$3: There is no difference in nurses’ attitudes toward ageism between nurses’ genders (male, female).

H_a3: There is a significant difference in nurses’ attitudes toward ageism between nurses’ genders (male, female).

RQ4: Is there a difference in nurses’ attitudes toward ageism between nurses’ education level (< bachelor’s degree, >= bachelor’s degree)?

$H_0$4: There is no difference in nurses’ attitudes toward ageism between nurses’ education level (< bachelor’s degree, >= bachelor’s degree).

H_a4: There is a significant difference in nurses’ attitudes toward ageism between nurses’ education level (< bachelor’s degree, >= bachelor’s degree).

RQ5: Is there a difference in nurses’ attitudes toward ageism between nurses’ years of experience (<= 5 years, > 5 years)?

$H_0$5: There is no difference in nurses’ attitudes toward ageism between years of experience (<= 5 years, > 5 years).

H_a5: There is a significant difference in nurses’ attitudes toward ageism between years of experience (<= 5 years, > 5 years).

Nature of the Study

A quantitative, nonexperimental research design was used for the study. Nonexperimental research is a design used to describe two or more variables. As random assignment is not feasible when using a nonexperimental design, participants were not randomly assigned to comparison groups. A researcher using a nonexperimental design may match the comparison groups on characteristics that relate to the dependent variable to improve the design. Correlational design, on the other hand, was used to establish the level of variation sharing between the predictor (independent) variable and criterion (dependent) variable (Christensen, Johnson, & Turner, 2011; Rumrill, 2004). This type of design does not indicate whether one variable has any effect on another, but rather it helps to indicate whether a linear relationship between two or more variables exists (Leedy & Ormrod, 2010; Neuman, 2003).

In quantitative research, numerical descriptions of trends or attitudes of a sample are provided and generalization to a larger population is attempted (Creswell, 2009). It

differs from qualitative research because it seeks to accept or reject a particular hypothesis through research (McBride & Schostak, 2012). Quantitative research is more appropriate for answering questions about relationships or differences between specific variables (Creswell, 2009). Quantitative research was best suited for this study because there was an effort to analyze data using descriptive statistics to summarize and compare the attitude toward ageism (dependent) and age group, ethnicity, and gender (independent variables). The study's sample consisted of approximately 43 caregivers from Franklin County, Mississippi. These caregivers were employees of a convalescent home that was assisting 56 residents and had been in operation for over 30 years.

Assumptions

From a positive perspective, it is assumed that an external observer (researcher) can provide honest objectivity. In contrast, from a perspective that is antipositive, the researcher and the facts presented are interdependent. The resulting social science is essentially subjective (Jean Lee, 1992). In theory, a positive perspective motivates study of the whole to uncover causal relationships in order to better understand and predict the social world. An antipositive perspective conveys that the social world can only be understood by focusing primarily upon the researcher performing the action(s). Accordingly, this study was approached from a positive perspective by using methodology and data collection that revealed truth about the processes being studied.

The likelihood of honest responses was assumed, as participation in the study was anonymous and voluntary. The participants were encouraged to voice their concerns without constraints or predetermined ideas. It was also assumed that objective reality would prevail and that the explanation of social occurrences was valid because the

measurement and reporting of the data being used involved a phenomenological research methodology. In addition, it was assumed that the convenience sampling methodology was represented appropriately and provided an opportunity to collect information from the participants that was relevant to the population being studied (Jean Lee, 1992).

Scope and Delimitations

This study was delimited to caregivers in Southern Mississippi who were at least 18 years of age but older than 55 years of age. For inclusion in the study, individuals needed to be nurses who provided health care services to older people. Ageism was measured on a Likert-type scale with an instrument designed specifically for the study. The results of the study were generalizable to caregivers who currently provide their services in Mississippi.

Limitations

The potential for research bias and the size of the sample were among the limitations of this study. Additionally, while it may be appropriate to apply the results to the population of the study site, it may not be an accurate assumption that the findings are applicable to all nurses in other parts of Mississippi or elsewhere. Unknown variables in the study that may have impacted those nurses participating in the study could have affected responses. As the researcher, I may not have been aware of these variables.

Theoretical Framework

The theoretical framework for this study was the theory of emotional labor (Aldridge, 1994). Some previous research has indicated that there is a relationship between nurses’ attitudes and the care they provide for the elderly, whereas other studies have indicated no relationship. This uncertainty and lack of formal theoretical framework

leaves an important gap in the literature. The theory of emotional labor dates back to the 1990s, where researchers believe that nurses working with the elderly are under enormous stress that may be impacted by their emotional status. This phenomenon is characterized as *emotion work* (Gattuso & Bevan, 2000). As such, medical ageism might be the evolving result of this emotional stress.

There are also six other theoretical themes, not formal frameworks, that related to the existence of medical ageism. They are as follows:

1. The presence of statistics strongly indicating that the population is currently aging and that this phenomenon has and will continue to impact the health care system negatively;
2. the identification of health care concerns that are peculiar to the elderly, which suggest that when quality care is the concern, the system characteristically works against older populations;
3. dialogue on ageism relative to the concept and the identification of its possible origins;
4. limitations to the kind and quality of care the elderly have access to, due to inherent complications in the existing system;
5. how the caliber of care is correlated to socioeconomic status (SES); and
6. the proposal of keys for improving health care for the elderly.

Significance

This study was highly significant due to the potential negative effects of ageism on the elderly. Understanding what factors lead to ageism may help alleviate its effects, especially as they relate to nurses and health care. It is important that every individual, no

matter his or her age, receives appropriate medical care. According to the U.S. Census Bureau (2010), by 2030 the population of those aged 65 and over is expected to double. Since 2009, retirement has begun for some of the individuals in this age group (Kinsella & He, 2009). The other age groups must prepare for this change, in part by evaluating the way in which they view elderly people.

As age discrimination proves to be one of the most pervasive and insidious forms of prejudice, recognizing ageism have become a priority for community health leaders (Dittmann, 2003). Prejudice against the elderly in the American healthcare system is identified in clinical studies, surveys, and medical commentaries, where authors state that

1. healthcare professionals are not receiving enough training in geriatrics to properly care for older patients;
2. older patients are less likely than younger people to receive preventive care;
3. older patients are less likely to be screened for diseases and other health problems;
4. proven medical interventions for older patients are often ignored, leading to inappropriate or incomplete treatment; and
5. older people are consistently excluded from clinical trials, even though they are the largest users of approved drugs (Alliance for Aging Research, 2008).

Efforts are needed to counteract ageism and provide the best quality care to the elderly population. To encourage debate and action on this issue, more “training and education for healthcare professionals, greater inclusion of older Americans in clinical trials, utilization of appropriate screening, preventive measures for older Americans, and

empowerment and education of older patients” are needed (Alliance for Aging Research, Press Room, 2008, p 1).

Definitions

The following operational definitions were used in this study:

Ageism. Ageism is defined as (a) all attitudes that hold a prejudice toward the elderly in relation to old age and the aging process; (b) practices that discriminate against the elderly; and (c) beliefs, institutional practices, and policies that undermine the personal dignity of the elderly and are responsible for reducing elderly persons’ opportunities for a satisfactory life (Butler, 1980).

Aging. Aging is the process of getting old (Research Blog Spot, 2007).

Attitude. Bogardus (1931) defined attitude as a tendency to act negatively or positively toward something in the environment. Allport (1967) presented the definition of attitude as "the act of exerting a directive or dynamic influence upon related situations and subjects in order that a mental and neural state of readiness is experienced" (p. 8).

Baby Boomer. A baby boomer is a member of the generation born during the time after World War II, when birth rates peaked in the United States (Longino, 2005). The baby boomer generation is frequently defined as people with birth years from 1946 to 1964.

Elderly person. According to the National Center for Health Statistics (2007), an older person is defined as any individual aged 65 years and older. According to the U.S. Census Bureau (2010), the number of Americans whose age is greater than 65 was estimated to reach over 37.8 million in 2007, and continues to increase each year due to

longer life expectancies. Because the term *elderly* is synonymous with *older*, in this research study, the term *elderly* will be used to characterize an older person.

Family caregiving. Family caregiving is the provision of emotional support, and, in times of illness, care for elderly parents by one or more of their children (Center for Disease Control and Prevention, 2009).

Gerontology. Gerontology is the scientific study aging and its process as individuals increase in age from middle age to the end of life (Andrus Foundation, 2001).

Gerontophobia. Gerontophobia is defined as a senseless or unreasonable hatred, active and typically mutual enmity or ill will or active hostility toward the elderly (Palmore, 2004).

Medical ageism. Medical ageism is the distancing of oneself from the social plight of the elderly through systematic stereotyping and discrimination that can elevate older persons'fears of aging and death (Farxlex Free Dictionary, 2012).

Paradigm. A paradigm is an analytical tool used to bring together or incorporate structure with process (Corbin & Strauss, 1998).

Phenomenon. As described by Goldsmith and Domann (2013), a phenomenon is a frequent pattern of experiences or actions/interactions that stand for what people do or say, alone or together, in answer or reply to the problems and situations they face.

Summary

To address ageism in the healthcare industry, studies need to be conducted to understand this problem and its effects on the elderly and society as a whole. In the study, nurses' attitudes toward ageism were examined to understand how these attitudes might affect the quality of care in geriatrics.

Chapter 2, the literature review, provides historical and up-to-date information on this topic. The work of authors representing different points of view about ageism and the impact it has upon the health industry is presented. In Chapter 3, the methodology related to this study is described. Chapters 4 and 5 will be used to present results and discuss findings respectively.

Chapter 2: Literature Review

Introduction

The existence of ageism is an issue of growing civil and social concern in world societies. In 1950, it was estimated that there were 130 million people over the age of 65 in the world, but with the aging of the baby boomers, it is estimated that the elderly population will increase to 1.4 billion, a tenfold increase in two generations (Tsuno & Homma, 2009). Given these circumstances, ageism is likely to increase in coming years if actions are not taken to mitigate it (Allen, 2006; Dennis & Thomas, 2007; Dickerson & Rousseau, 2009; Rothenberg & Gardner, 2011; Tsuno & Homma, 2009).

This literature review consists of studies on ageism conducted from one era to another. Ageism practices have been found to be prevalent throughout many elements of society, including the workplace. Dennis and Thomas (2007) found that ageism is present in all professions, including healthcare. They noted that personal ageism, institutional ageism, internal ageism, and unintentional ageism all exist in the workplace. Ageism was once considered a problem of Western culture, but Tsuno and Homma (2009) found that in Asian cultures, older people who were once revered and valued as counselors and advisors are now experiencing ageism. In Korea and the Philippines, young people hold views toward the aged that are similar to those held by the young in the United States (Tusuno & Homma, 2009).

The literature review begins with a brief overview of how ageism is evidenced in multiple ways within society. These examples provide a basis for the theoretical framework, which comprises the second part of the literature review. Theories behind the notion of ageism are explored, including social constructivist theory, which indicates that

ageism is a side effect of normative social values privileging youth and functional ability, and successful aging theory, which posits basic norms for successful aging. From the perspective of another relevant theory, terror management theory, ageism is the result of younger people's fear of death that is aroused by the presence of older people. A feminist theoretical approach would focus on ageism against women. Finally, according to psychological theory, ageism has roots in disease-avoidance triggers in human beings (Duncan & Schaller, 2009; Moglen, 2008; Overall, 2006).

The review then presents the findings of a number of empirical studies on ageism in specific medical workers, ranging from nurses to nursing home personnel, and proceeds to document even more specific examples of ageism in the provision of care to older people in such areas as breast and other cancers (McGarry, 2009; Melby, 2010; Neville, 2008; Terry, 2008). In cancer cases, doctors also may make ageist assumptions, denying older persons optimal care based on ageist notions of whether or not older people could tolerate aggressive treatment or whether taking such extreme measures is worthwhile for a person who might die soon in any case (Curtis, 2006; Davis, 2010; Dockter & Shane, 2009; Kane & Kane, 2005; Phelan, 2008; Pritchard, 2007; Rosowsky, 2005).

The review, then, presents the results of a number of empirical studies documenting the presence of ageism in society as represented by younger persons, usually demonstrated by their response to images of older persons in clinical trials (Barrett & Cantwell, 2007; Bousfield & Hutchison, 2010; Cottle & Glover, 2007; Kane, 2008; Narayan, 2008; Widrick & Raskin, 2010). A number of these generic studies tested ageism in undergraduate students using instruments developed to detect negative

stereotypes about aging as well as other aspects of ageism. Other studies have indicated that ageism can be combatted with interventions designed to sensitize people to the negative effects of ageism.

The review closes with a number of empirical studies documenting the fact that elderly people are aware of ageism, have experienced ageism, and remain frustrated by ageism (Cherry & Palmore, 2008; Coudin & Alexopoulos, 2010; Giles & Reid, 2005; Greaves & Rogers-Clark, 2011; Harbison, 2008; Koch, 2010). At the same time, social cognitive theory underlies the link between studies of ageism and elder awareness of ageism by indicating that many elders also internalize ageist stereotypes in ways that further compromise their quality of life and care. A new area of research in ageism entails exploring the influence of culture on ageism; thus, the review ends with evidence that ageism is experienced differently, but perhaps not more negatively, by African American older people.

Literature Search Strategy

This literature review was drawn from the following EBSCO databases: Academic Search Premier, MasterFILE Premier, Business Source Premier, ERIC, Communication & Mass Media Complete, Psychology and Behavioral Sciences Collection, PsycINFO, and PsycARTICLES. Additionally, keywords such as *ageism*, *prejudice*, *elderly persons*, *senior citizens*, *healthcare system*, and medical practice were used when searching. The review begins with findings of widespread ageism in society, with studies that can be used to prove that young people hold ageist views of older persons and that personnel from various professions, including healthcare, also frequently hold ageist views of older persons. The review presents the findings of a number of

empirical studies on ageism in medical personnel, ranging from nurses to nursing home personnel, and then proceeds to document specific examples of ageism in the provision of care to older people in such areas as breast and other cancers (McGarry, 2009; Melby, 2010; Neville, 2008; Terry, 2008).

Theoretical Framework

The theoretical framework for this study is the theory of emotional labor (Aldridge, 1994). Some previous research has indicated that there is a relationship between nurses' attitudes and the care they provide for the elderly, whereas other studies have indicated no relationship. This uncertainty and lack of formal theoretical frameworks leaves an important gap in the literature. The Theory of Emotional Labor dates back to the 1990's, at which time researchers believed that nurses working with the elderly were under enormous stress that may have been impacted by their emotional status. This phenomenon was characterized as emotion work (Gattuso, & Bevan, 2000). Medical ageism may be an evolving result of this type of emotional stress.

There are also six other theoretical themes that support the existence of medical ageism (Gattuso, & Bevan, 2000). They are as follows:

1. The presence of statistics strongly indicating that the population is currently aging and that this phenomenon has and will continue to impact the health care system negatively;
2. the identification of health care concerns that are peculiar to the elderly, which suggest that when quality care is the concern, the system characteristically works against older populations;

3. dialogue on ageism relative to the concept and the identification of its possible origins;
4. limitations to the kind and quality of care the elderly have access to, due to inherent complications in the existing system;
5. how the caliber of care is correlated to socioeconomic status (SES); and
6. the proposal of keys for improving health care for the elderly.

Evidence of Ageism in Society

Workplace Discrimination

Ageism in the workplace was the focus of Dennis and Thomas's (2007) study that noted its prevalence there and delineated efforts to combat it. In general, those conducting research into ageism have found four types of ageism:

1. *Personal ageism*, which consists of personal biases against older persons and can manifest in healthcare providers. For example, a provider might assume that an older person is not competent to take care of him or herself.
2. *Institutional ageism*, in which rules are established concerning age, the best examples of which are mandatory retirement laws.
3. *Intentional ageism*, in which case older persons know that they are being treated with bias.
4. *Unintentional ageism*, in which case subjects may not even be aware that they are being treated with bias.

Ageism is prevalent in all these forms in the workplace. For example, 16,585 complaints of ageism were filed with the Equal Employment Opportunity Commission in 2005 (McCann, 2003). However, only 1% of all cases went to trial, and 65% of cases

were thrown out due to lack of reasonable cause (McCann, 2003). The most prevalent form of ageism in the workplace is bias in hiring, which is difficult to prove. Another problem that enables ageism in the workplace is that age discrimination does not violate a civil right.

Surveys of managers have indicated both positive and negative views of older workers, defined as workers over 50. While older workers have been acknowledged for exhibiting solid work habits, positive attitudes, loyalty, punctuality, and respect, some managers have perceived them as inflexible, aversive toward technology, no longer aggressive enough to perform optimally (e.g., in sales), and too costly in terms of health insurance. A survey of managers found that they believed that older workers were more productive than younger workers but that older workers were too expensive to maintain in many cases. It was also found that workers who had passed 40 were no longer offered as many or as prestigious promotion offers and were often excluded from training in new technology because of the assumption that they would resist, resulting, for both cases, in age limiting opportunity.

Dennis and Thomas (2007) found that in workplace culture, age discrimination is often expressed through a rhetoric of exhortation to workers that new blood is needed, MBAs are needed, or young guns are preferred, buttressed by complaints that older workers are tired, slow, and lack pizzazz. Although some progress has been made in reducing ageism in the workplace, there is growing pressure to increase the retirement age of workers (Dennis & Thomas, 2007). Dennis and Thomas (2007) found changing attitudes takes time and may be hard to establish given the deep-seated nature of ageism in the culture.

Allen (2006) found most 65-year-olds in the United Kingdom did not want to retire and did not understand why the law said that they had to. They were also aware that ageism accounted for many of the problems they faced in the workplace. A new law in Britain in 2005 prohibited employers from considering any factor other than ability and experience in hiring persons, particularly not a worker's age, and took efforts as well to "banish ageist banter from the office and the staff canteen" (Allen, 2006, p. 10). Unfortunately, prior to implementation of the law, concerns about never being able to let go of older workers led many companies to take preemptive action by firing middle-aged and elderly workers.

In the United States, although an antidiscrimination law against ageism in the workplace was passed in 1967, recent shifts in working habits, with older persons working longer and being unable to retire due to economic insecurity, are making the law ineffective in protecting older workers from ageism at work (Rothenberg & Gardner, 2011). Rothenberg and Gardner (2011) argued that the Age Discrimination in Employment Act of 1967 has been generally ineffective in protecting workers from ageism-related dismissal or firing as they seek to work longer. A study of hiring practices found that 27% of the time, older persons received less positive feedback than younger persons, while older women received less favorable responses 41% of the time (Rothenberg & Gardner, 2011). Of those who lost jobs in 2005, 75% of younger persons but only 25% of persons over 65 were able to find new work (Rothenberg & Gardner, 2011). Rothenberg and Gardner argued that there is little reason why older persons, especially given the increasing number of information-related jobs, cannot continue to work well into their 70s.

Lack of Connection with Other Generations

Older people typically feel connected if they have intergenerational links through family, but they feel like outsiders if they are only helped by others out of a sense of duty. Belonging has been closely linked to better health and well-being in old age. Depression has been linked to lack of a sense of belonging. A person who ages well "sustains her sense of belonging … and stays involved with life and perceives aging as a process that lasts for life" (Nolan, 2011, p. 326). Involvement with activities has also been found to improve cognitive executive function, whereas those who become isolated experience a decline in cognitive function.

Within immediate and extended families, people may not be invested in pursuing relationships with their elder relatives. Arnold-Cathalifaud, Thumala, Urquiza, and Ojeda (2008) noted, "because social reality emerges from auto-referent processes, the images and representations that people have on different age groups affect the particular way they relate to them because they support the confirmation of these expectations" (p. 109). Thus, views of the elderly end up being self-fulfilling prophecies through which discriminatory behavior is carried out. In this way, Arnold-Cathalifaud et al. argued that "heteroperception" of seniors by youth leads elderly persons to perceive themselves negatively, reducing their self-esteem. This idea, known as the *sociopoietic thesis*, by which imaginary generalizations are translated into real roles in society, may be used to explain why old people end up "living up to the negative images people have of their life stage" (Arnold-Cathalifaud et al., 2008, p. 108).

For this reason, studies of perceptions that young persons hold of older persons are required to provide support for efforts to break this self-fulfilling cycle of

discrimination. A semantic differential test was administered to 683 university students in Chile in order to determine whether views of the elderly contribute to social isolation (Arnold-Cathalifaud et al., 2008). The results confirmed the anthropological approach to cultural construction by showing that young persons viewed old age as a time of deterioration, "social death," isolation, loneliness, and depression, regarding old age as a tragedy that results in resignation and fatalism (Arnold-Cathalifaud et al., 2008). In reviewing the results, Arnold-Cathalifaud et al. (2008) confirmed that a gerontophobic social climate most likely derived from a society where images of success are always linked to vigorous youth. The end result of this negative stereotyping is that older persons "fight to cling to the qualities of an idealized youth, which can generate significant frustration feelings" (Arnold-Cathalifaud et al., 2008, p. 125). It is also argued social expectations and representations with regard to age can negatively affect the health of senior citizens, as they may neglect health treatment because they view declining health as a normal part of old age (Arnold-Cathalifaud et al., 2008). Many senior citizens do not pursue a love life, for example, because the social context plays against them, "making it difficult for them to enjoy these experiences" (Arnold-Cathalifaud et al., 2008, p. 125).

Mueller-Johnson, Toglia, Sweeney, and Ceci (2007) provided 11,267 undergraduate students with witness testimonies on a case, asking participants to measure the witnesses' convincingness, quality of observation, honesty, competence, memory, and other factors, with one testimony coming from a 49-year-old person and another from a 79-year-old person. Most students exhibited ageism by finding the testimony by the older person to be inherently less credible and reliable than the testimony by a younger person. That said, there was no difference in perception of testimony from a 49-year-old and 69-

year-old witness, suggesting that the increased health and activity levels of 69-year-olds resulted in diminished ageism in relation to people in their 60s. At the same time, the main differential based on age was found in women who gave testimony, suggesting a gendered double standard in ageism. It was also found that the more time the students had previously spent with older persons, the more likely it was that they would not exhibit ageist ideas.

Barrett and Cantwell (2007) conducted a similar study in which the drawings of old people by undergraduate students were assessed for the presence of stereotypical attitudes about senior citizens. The results indicated that most drawings combined elements of both negative and positive stereotypes about the old, emphasizing elderly frailty but also kindness. Barrett and Cantwell contended that discrimination based on attitudes can also lead to a more insidious process wherein senior citizens themselves internalize ageism, which can lead them to fail to seek treatment for care, resulting in hearing decline, poorer cardiovascular functioning, worse general health status, and a weakened will to live. Not only can young people's perceptions of older people be discriminatory; older people may translate these perceptions into beliefs about themselves.

Previous studies of college students' views of older persons indicated that most regarded older persons as poor, lonely, and irritable (Barrett & Cantwell, 2007). Other studies showed that older people were viewed as ugly, impotent, senile, and depressed (Barrett & Cantwell, 2007). Various personality profiles have also routinely been ascribed to older people, including "the recluse, the shrew/curmudgeon, the elitist, the vulnerable" as well as the lonely and powerless senior citizen (Barrett & Cantwell, 2007,

p. 329). The sketches in the Barrett and Cantwell (2007) study also revealed stereotyped perceptions, as they were less likely to be filtered through "social desirability screens" (Barrett & Cantwell, 2007, p. 330). Over 25% of the drawings, for example, represented older persons with canes as symbols of their infirmity. Some gender bias in the depictions were also noted, with 82% of women being shown with wrinkles compared to 67% of men, suggesting that the aging is worse for women (Barrett & Cantwell, 2007). They noted that this is an odd perception given that many more women than men reach their 85th birthday. On the basis of the findings, Barrett and Cantwell (2007) also conducted discussion sessions that critiqued the emphasis on successful and active aging in the U.S. as the norm, suggesting this approach too is based on stereotypes.

Allan and Johnson (2009) also tested undergraduate students regarding their attitudes about the elderly, administering the Facts on Aging Quiz, the Anxiety about Aging Scale, and the Fraboni Scale on Ageism to 133 undergraduates, comparing male and female responses. While all students had more or less similar levels of knowledge and anxiety about aging and older people, females were less ageist than males.

Bousfield and Hutchison (2010) found younger people may even be hesitant to come in contact with older persons because the cultural prejudice in favor of youth is so strong. For this reason, they made use of intergroup contact theory as a framework to examine the attitudes and behavioral intentions towards the elderly among a sample of young respondents. The research was based on a definition of ageism as "negative attitudes or behaviors towards an individual solely based on that person's age" (Bousfield & Hutchison, 2010, p. 451). Previous research has found overarching stereotypes of older people as being doddering, but affectionate, combining warmth and incompetence in

ways that results in both positive and negative behavior toward them (Bousfield & Hutchison, 2010).

Widrick and Raskin (2010) used the golden section hypothesis, which posits that most people organize information about their lives in a ratio of 61.8% positive and 38.2% negative, to discover the degree to which the ratio plays out in people's perceptions of the elderly. Additional research has found that when dealing with stigmatizing material, the golden section hypothesis is expressed in reverse, negatively. This reversal is likely related to stigma that occurs whenever one must encounter the unfamiliar. It has also been theorized that the golden section is linked to the fact most languages began by creating positive words and only added negative words later on, meaning that most humans have a positive basis in perceptions, then make negative distinctions based on difference.

The consistency with which the golden section hypothesis has been proven has suggested that the mind contains an algebraic processor for organizing information, usually emphasizing the positive (Widrick & Raskin, 2010). It is only when figure and ground shifts atypically, as when a person is confronted with stigmatized material, that the reverse golden section comes into play. That is, the person highlights what may be a limited amount of negative material against the positive background. Widrick and Raskin (2010) hypothesized that most young people would, in fact, rate older people in terms of a reverse golden section hypothesis, that is, two thirds negative and one third positive. The results showed that while most subjects rated themselves positively 74% of the time, they tended to rate elderly persons in accordance with the reverse golden section hypothesis, indicating that they harbored ageist notions. The finding that the reverse

golden section characterized the perception by young people of older people revealed a deep-seated stigmatization of the older adult in U.S. society. .

Additional studies have explored ageism as it might be applied to subgroups of older people, including men and women. Narayan (2008), for example, surveyed young adults regarding older men and women and found that younger people had relatively positive views about older persons but had much more positive views about older women than older men. Narayan (2008) suggested that increasing diversity in society may be responsible for the general reduction of ageism which runs counter to general perceptions of a double standard about aging.

Family structure in the U.S. leans toward ageism in many ways. Generally negative beliefs and stereotypes about the elderly have persisted over time. For example, younger women and men may view older people as endearingly childlike and therefore good with children. This stereotype simultaneously portrays older people are naturally dependent and submissive, which further leads to assumptions about older people being less mentally sharp or rational. Often these stereotypes lead to perceptions that older people are unreliable, more emotional, overly excitable in minor crises, or innocent about the world, and asexual. It is possible that such negative assumptions are intended to be buffered by idealizations of the elderly as naturally loving, giving, and self-sacrificing.

Negative Assumptions About Elder Sexuality

Kane (2008) examined the issue of sex and perceptions of older people as sexual beings among social work and criminal justice students. An ageist perspective of sexuality includes the perception that elders are old first and sexual second, if not genderless and disinterested in sexual activity. As a result, “when older woman and older

men do engage in sexual behaviors, they may be perceived as committing an age transgression" (Kane, 2008, p. 726). Kane found many undergraduates have negative views of sexuality in older persons. The findings generally found negative views about the sexual attractiveness and behavior of older women and men, and a disinclination to view older people as sexual beings. Specifically, while some older people could be perceived as attractive, none were seen to be beautiful; no students perceived of the possibility of an older woman or man in a skimpy bathing suit as attractive, 70% of criminology students thought that an older woman in a bikini was disgusting, one half of all students found the idea of older persons having sex as disturbing, though they acknowledged that they did have sex (Kane, 2008).

Most students in Kane's (2008) study felt that marriage between older people was for companionship not sex, suggesting they did not think older people translated romantic feelings into sex. In terms of gender, half thought an old man kissing a young woman was acceptable, but only a quarter felt that an older woman kissing a young man was acceptable. However, social work student perceptions were somewhat less negative than criminal justice student perceptions. The results also found significant differences in students' views based on their cultural background. Kane argued educational efforts to improve student knowledge about senior sexuality were merited.

Dickerson and Rosseau (2009) stated a reflection of ageism is seen when older people do not talk about their sexuality problems. As found in studies, sexuality does not decline with age; sexual interest and responsiveness is a normal part of senior life, provided they are in good health; however, there is also research used to show that sex stops as people age. Dickerson and Rosseau (2009) focused on why older African

American women's sexuality was never an issue. For African American senior women, sexuality nearly becomes invisible due to successive super-exploitation for value, abuse, and oppression over the past two centuries.

With regard to particular behaviors of older persons, such as sexuality, it might be surprising students and professionals in human services continue to harbor ageist ideas (Zeiss, 2003). Human services students are usually educated to take the cultural group membership and cultural issues into consideration in the treatment or service of any client and their educational experience is grounded in consideration of diversity. A strengths perspective is also used in most of their education, focusing more on client goals and strengths as opposed to their pathologies.

Disinterest in Working with the Elderly

In healthcare, many doctors and nurses prefer to deal with younger as opposed to older persons, and they harbor ageist notions about disability and decline being natural. The fact geriatricians are less well paid than other specialists contributes to a shortage in the field, and a general perception that working with old people is low status work (American Geriatrics Society, 2014; Association of American Medical Colleges, 2012; Brooks, 2013). It has been documented in many cases, doctors see problems experienced by older patients as symptoms of old age and not a disease, thus missing diagnoses (National Center for Biotechnology Information, 2004).

Ageism is expressed in mental health and health professions simply by the fact it remains extremely difficult to recruit young professionals to specialize in care for the elderly. One study found recruitment is difficult because of the belief gerontology is not chic, old people are not sexy to work with, old age is too painful and sad and it is

relatively pointless to help older people as they are already close to death. Indeed, Rosowsky (2005) felt it necessary to address these ageist beliefs through training in order to recruit more young doctors and professionals into the field of gerontology.

Elder Abuse

Elder abuse is a still worse outcome of ageism, and Phelan (2008) argued ageism provides the basis to covertly allow for a certain degree of social tolerance of elder abuse. Ageism is based, in Phelan's analysis, on the notion while younger persons are productive, retired persons are no longer so and they become dependent on others. These assumptions moreover can become a self-fulfilling prophecy, insofar as older people experience aging as increased dependency and submit to care practices that infantilize them. This devaluing and marginalization of the old sets up covert tolerance for elder abuse (Phelan, 2008).

Other Theoretical Perspectives on Ageism

Ageism and Ableism

A number of different theoretical perspectives have been enlisted to explain the phenomenon of ageism in modern society (Duncan & Schaller, 2009; Moglen, 2008; Overall, 2006). Overall (2006) explored the conceptual and material connections in the concepts of ageism and ableism to better understand the philosophical underpinnings of ageism. She posited age identity is just as socially constructed as any other identity and it is not a natural state but a cultural state. Butler (1990) and other experts on the social construction of gender, argue the application of the building social identity hypothesis "seriously underestimates and misconstrues the role of culture" (Overall, 2006, p. 126).

That is, the so-called biological construction is also a social construction, created and reinforced by social values and relations.

Without denying the physical problems linked to impairments, most impairment can be better viewed as simply differences. The concept of impairment only selects certain states of physical features and attributes to define the person as defective. As for age, Overall (2006) argued similarly old age is not founded upon "the immutable and objective biological foundation of years lived," but on social generation, that is, how the person lived (p. 129).

The concept of being too old is also relative to a phase of development, for example, being 18 is considered by some to be too old to start becoming a gymnast, age 30 is considered too old to learn a new language, and 50 is too young to retire. People can become old at any age, due to lifestyle decisions, or because they have been pressured by stereotypes to act old (Kenny, 2013; University of Maryland Medical Center, 2011). Old age also varies according to class, with poor people becoming old much sooner, for example, than rich people. With ableism and ageism in the West, "it is taken to be self-evident that lives with so-called impairments, and lives that are elderly, are of lesser value than lives without so-called impairments or lives that are youthful" (Overall, 2006, p. 135). As a result, people with either impairment or old age are treated as either much older or much younger than they really are.

Treated either paternalistically or as in a state of decline, often infantilized, old people are "subjected to explicitly disabling behavior, practices and policies" (Overall, 2006, p. 135) such as mandatory retirement or equating age with some illnesses. These attitudes force older people to try to pass for being younger, in effect bowing to

assimilationist pressures. Doctors and others promote the idea old people are somehow a burden; the old are nonfunctional and nonproductive. This social construction of aging has even lead bioethicists to argue that useless prolongation of life is a hardship on family and the system.

One line of research has worked to better establish benchmarks of the functional ability of older persons in everyday life, not only to assist them in everyday living more effectively, but to establish a model of what is "normal" in aging, and possibly reduce ageist response to normal levels of functioning. Functional ability describes a person's ability to carry out the basic activities of daily living (Riazi, Boon, Dain, & Bridge, 2012; U.S. Department of Health and Human Services, 2008). Potter, Grealy, and O'Connor (2009) argued cognitive and psychological dimensions of this measure, which would include, for example, one's perceived functional ability, needs to be incorporated into such measures to better measure actual functional ability.

Self-Efficacy

The self-referent construct of perceived self-efficacy is especially important in measuring the degree to which an older person maintains control or develops learned helplessness (Bandura, 1997). A greater degree of self-efficacy can not only encourage can-do thinking in older persons, but can also ward off anxiety, helplessness and depression. Current scales of self-concept and self-efficacy also overly focus on narrow skills, failing to cover all of the actions needed for one to live independently. Potter et al (2009) developed a questionnaire that included cognitive and psychological issues across a wider range of tasks and administered it to 300 persons aged 60 to 96 who were recruited through various social organizations in a mid-size British city. The goal was to

prevent older persons from engaging in either an over- or underestimation of their abilities, which might lead to either injury or learned helplessness.

Porter et al (2009) found by using the perceived motor-efficacy scale to measure the capability beliefs of healthy older adults across a variety of everyday jobs and tasks, older adults in their 80s who reported high self-assurance produced minor errors, while those with lower self-confidence were more likely to make more serious. In an additional effort to determine the capability to hold back or restrain from a previously learned action, individuals with levels far above the perceived motor-efficacy did better than the group least able to hold back, but more poorly along with those most able. For that reason, perceived motor-efficacy may be helpful in recognizing older adults at risk of functional limitations and allowing involvements before the beginning or start of illness.

Terror Management Theory

Martens, Goldenberg, and Greenberg (2005) presented a terror management theory perspective on ageism to explore the fear people experience when relating to a group which, “barring premature death, the perpetrators will one day belong” (p. 223). According to terror management theory, older people are frightening to younger people because they represent the future, physical deterioration, death and loss of self-worth (Martens et al., 2005). Terror management theory is based on the idea that humans must control their knowledge of the inevitability of death through symbolic activities; thus, the calm façade of everyday life consists of psychological defenses that symbolically seek solutions to the problem of death, mainly by constructing a worldview.

Through culture, one elevates self above mere animal existence and the certainty of death. A good deal of empirical research has documents that people are threatened by

the idea of death, and fearful of mortality (Martens et al., 2005). They also strive at to banish from consciousness any thought of death. Even when thoughts of death are just outside of awareness, the mind busily creates defensive attitudes and behaviors "that provide symbolic protection" (Martens et al., 2005, p. 225). Studies have shown unconscious death concerns motivate people's creation of meaningful worldview and self-esteem (Jones, 2013; Martens et al., 2005; Tracy, Hart, & Martens, 2011). According to terror management theory, people even have negative reactions to people who hold views different than theirs, because the threat to their worldview exposes them to fears of death.

Martens et al (2005) argued ageism has roots in fear of death as exemplified by the decay of the body of older people; thus, the elderly are reminders mortality is inevitable. Also, witnessing ailments in the elderly also reminds us that we are physical creatures, vulnerable to death, especially when body functions cannot be controlled and become evident in ways formerly kept discreet. This, Martens et al hypothesized the source of young people's disgust with older bodies, and stereotypes of the elderly being infirm; that is, of ageism. The fact the increased dependency of the elderly compromises one's self-esteem also emphasizes one's overall insignificance in the scheme of things, which creates another terrifying thought. The loss of one's symbolic self is likened to dying for many, they see old age as a kind of death already.

These hypotheses were tested in a number of laboratory experiments eliciting young people's response to pictures of older adults or images related to death or filling in the blanks of word fragments after being exposed to images of death (for example coff--, which was more often filled in as coffin after exposure to death image) (Martens et al.,

2005). Another test asked younger people to compare their personalities with those of older people, before and after mortality salience was activated (Martens et al., 2005).

In terms of using terror management theory to reduce ageism, Martens et al (2005) argued it could help people learn how to cope better with fears of death, develop defenses rather than deal with threats, and modify current cultural values to reduce anxiety about death. Classes that teach about death and dying are important to accomplishing this, as it would sensitize younger people to death concerns of the elderly and create a bond between the ages. Martens et al also noted Buddhism and existential philosophy have adapted better to the idea of death than traditional Western symbolic systems. Changing one's sense of the worth in various aspects of life could also adjust one's fear. Older people are concerned with generativity, and contributing to the perpetuation of future generations, providing them a symbolic immortality (Berks, 2010; Boeree, 2006; Martens et al., 2005). Instilling similar goals in younger people might ease their fear of death and thus reduce ageism. By this process, society would restore to elders their role as advisors and counselors, reducing ageism further.

Feminism

Feminism has also contributed insight into ageism by focusing on the degree to which aging women have been demonized in culture for centuries, deriving from images of the witch, the gorgon, and the crone. Moglen (2008) related this imagery to the struggle to separate from the primal mother, which makes it difficult to separate real women from "archaic psychic forms" (p. 324). Through the mechanism of projection of fears, children may withdraw from the concrete shape of mortality in an aging mother, resulting in misogynistic and phobic representations of women's aging bodies. Moglen

proposed a therapeutic model of transaging in which subjects are helped to overcome the categorical identities, as well as power relations and psychological rigidities connected with them, involved in such images of youth and age. This process entails consciousness rising with regard to all aspects of aging that are upsetting us and cause people to project negative emotions and fears onto aging persons.

Disease Avoidance

Duncan and Schaller (2009) argued the theoretical basis for ageism must be looked for in psychological roots, and focused in particular on the likelihood that ageism results from imperfect cue-based disease-avoidance mechanisms in people due to a person's negative response to out of character bodily features of aging, which may trigger aversive semantic concepts (implicit ageism). This notion is based in the dual-process model of stigma and prejudice, whereby immediate reflexive response to perceptual cues displayed by stigmatized individuals results in their stigmatization and results in prejudice (Duncan & Schaller, 2009; Nelson, 2009; Schmader, Johns, & Forbes, 2008). The cues are most likely to lead to negative evaluations, while positive response to the older adult is based on other rules.

In tests that measured reaction-time methods to assess how older adults are implicitly associated with negative semantic information, the results found clear evidence older adults are associated by younger people with negative concepts (American Psychological Association, 2013; Duncan & Schaller, 2009). The negative cues include decreased levels of cognitive flexibility and physical ability, or the limitation of their social exchange relationships, as well as the fact that older persons as noted before remind younger people of their own mortality. Duncan and Schaller (2009) linked this

line of research with studies of how human beings respond to infectious disease as well as to aging. They found these hyper-vigilant, over-inclusive disease-avoidance mechanisms often lead people to avoid contact with entirely healthy individuals who exhibit trigger features, such as being potentially ill or simply being old. The fact aging often features loss of fat tissue, more wrinkles, baldness, change of facial structure, skin discoloration, and other changes to physical appearance, the behavior immune system can read these changes as triggers in an implicitly aversive way and associate aging with compromised immune-competence. This response is likely to be even greater among people normally more hyper-vigilant against disease.

Duncan and Schaller (2009) grimly appreciated the irony that just where older adults might expect more courtesy, they are likely to be more prone to suffer aversion, avoidance, and exclusion according to this conceptualization of the origins of ageism. This can be particularly problematic when healthcare professionals experience this aversion, as staff fear of illness can also lead to more elder neglect.

The Negative Influences of Ageism on Healthcare for the Elderly

Cultural Trends and National Priorities

A substantial body of research has developed, presenting widespread evidence of ageism compromising perception and care of older persons in the healthcare system (Berry, 2009; Blakemore, 2009; Duffin, 2008; Nolan, 2011). Albanese et al (2011) reviewed the equity involved in care for older people in a number of countries to understand the extent of ageism on limiting care for the older adult. Demographic and care data for almost 18,000 elderly persons from Mexico to China and India were analyzed. The results found overall, ageism is not the deciding factor when it came to

equity of care. Out-of-pocket expenses in the context of local or national healthcare insurance were the leading cause of lower quality treatment of the older population. As a result, Albanese et al concluded, although ageism was not a direct risk to older people, older persons are particularly vulnerable to less than equitable care in healthcare systems based on out-of-pocket expenses.

Duffin (2008) argued care for the elderly is usually the first element of healthcare service cut during times of budgetary constraint in the UK. She argued the imbalance of funding in favor of pediatric versus elderly care is another example of institutionalized ageism. In addition, Duffin found that the clinical trial, a basic building block of healthcare, is not conducted as frequently for older people as for younger people. A survey of persons over 60 found most felt their doctor had dismissed symptoms of problems as just old age, and this belief was verified by a doctor who concurred that if a person in his or her 50s takes some falls, tests are made, if a person in his or her 70s falls, tests are not made, it is simply assumed they are "getting old and doddery" (Duffin, 2008, p. 1).

At the same time, Duffin (2008) acknowledged some older people opt out of tests due to the strain of the testing procedure, or whose relatives balk at having their older parents go through, for example, an MRI, which involves being confined in a noisy machine for a considerable amount of time. As a result of these data, then, Duffin posited ageism is "rife" (p. 1) in the UK health system, and that protocols must be developed to prevent subjective biases by doctors, loved ones and even patients who have internalized these views, from preventing older persons from receiving the care they deserve and need.

Berry (2009) also reported on a study of ageism in the mental healthcare system in the UK, finding considerable evidence of lack of quality of care. In an analysis of quality and equity of care in mental health facilities nationally, it was found age discrimination was common, and resulted in a reluctance to accept referrals for patients over 65, and especially patients over 65 with dementia. Berry called for continued reform of the system so that all care was delivered based on need and not patient age. Blakemore (2009) corroborated Berry's assertions about how care for the elderly is limited, noting while 40% of older people who visit general practitioners and 60% who enter nursing homes have mental health problems, they are routinely denied care that would be offered them were they younger. Older people are rarely offered crisis or psychological therapy, or drug and substance abuse services.

In pursuing the matter, Blakemore (2009) found funding issues usually are at the bottom of inequity of care, meaning that care for the elderly is underfunded, forcing doctors to make decisions inconsistent with best practice. That said, Blakemore also found most healthcare centers had made progress in identifying sources of ageism, expanded referrals for persons over 65, begun to provide substance abuse programming, and enlisted more nurses trained in non-discriminatory healthcare practices.

Mental Health and Well-Being

Nolan (2011) focused on the importance of a sense of belonging to the well-being of older persons, and the extent to which this feeling of belonging is compromised by ageist stereotypes of the aged in the healthcare system. Belonging has been found to be a key relational need, equal in importance to one's sense of well-being as self-esteem, shared understanding and trust (Nolan, 2011). For an older person, Nolan defined

belonging as "connected with others and accepted, whether that acceptance comes from herself, her family or society as a whole, and it means she is part of that group, her surroundings and her environment" (p. 319). In short, a person who belongs is an insider, not an outsider; feels secure, participates in a group; is recognized and valued by others; and fits in with one's environment.

Delays in the diagnosis in mental illness have often resulted due to the assumption that some of the symptoms of mental decline are a normal part of aging. Depression is often seen as a normal part of aging as well, and many physicians believe that older persons cannot benefit from psychotherapy (Nolan, 2011). For this reason, medical practitioners often refrain from offering the same protocols of care to older persons. This has shown to be especially true in the treatment of cancer (Nolan, 2011).

While these problems have multiple documented consequences for the wellbeing of the individual and their health outcomes, Nolan (2011) focused the extent lack of engagement in the care of the elderly and delayed diagnoses compromise the sense of belonging an older person may have in the healthcare system. That is, if older persons continue to be treated as outsiders in the medical system, they will not stand up for proper treatment, and may further internalize negative ageist perceptions that will seriously compromise their health through not pursuing healthcare treatment. Neville (2008) corroborated these findings in his study of geriatric patients with delirium, finding delayed diagnoses and ageist attitudes led to poor outcomes for many of his subjects. Healthcare workers commonly considered delirium a side effect of aging and failed to provide effective treatment options that may have otherwise enhanced the patents' quality of life.

Mitford, Reay, McCabe, Paxton and Turkington (2010) identified significant gaps in care administered to schizophrenic patients over age 65. The study was based on the collection of admissions and treatment data for a cohort of such patients admitted to the target hospital in Northumberland, UK. The results indicated one quarter of all patients admitted for first episode psychosis were older than 65, but these patients were admitted later on after first presentation, and then ended up with longer average hospital stays. In terms of treatment, Mitford et al found large gaps in service, with older persons receiving much less up to date care than younger patients. For example, older persons were much less likely to have been assisted by assertive outreach and crisis teams, and had considerably less access to Clozapine and cognitive behavioral therapy. As a result, Mitford et al concluded, due to ageism, older patients presenting with schizophrenia had considerable unmet needs in terms of services, and that policies must be enforced which mandate care service decisions be made based on need, not age.

Negative Perceptions and Behaviors among Medical Personnel

Ageism has been documented among medical personnel, often compromising the quality of care received by elderly persons (McGarry, 2009; Melby, 2010; Neville, 2008; Terry, 2008). Terry (2008) explored the extent to which caregivers for older people, focusing on therapists, unconsciously project ageist constructions on their practice with these clients. He cited examples of malnourishment and unkemptness among older persons going in for routine surgery because nurses might have felt that they are going to die anyway, an attitude Terry identified as "the defense of projective identification" in which fears of death are projected onto older persons (p. 155). In this way, Terry made use of Melanie Klein's notion of projective identification as "an unconscious phantasy in

which unwanted or unmanageable aspects of the self are split off and located in someone else who is then identified with those aspects of the self" (p. 156). A later study has found the person upon whom these ideas are projected, in turn, begins to experience these feelings as their own. Most of the fears projected onto others are fears of dependency, loneliness, and death, terrors akin to those outlined in terror management theory (Goodman, 2012; Levy et al., 2008; PsychWiki, 2010).

In another case, a caretaker expressed contempt for the dependency of patients based on the activation of an abnormal super-ego as critical agency in the unconscious, which has been found to not only intensify experience of loneliness, but also idealize relationships as perfect unions, an internal criticism that results in stigmatizing dependency (Terry, 2008). Fear of dying alone is also another unconscious force expressed in retirement homes where patients with dementia rarely interact with staff, the patients "typically sit silently around the walls of a day-room with a television that no one watches" (Terry, 2008, p. 163). Terry (2008) analyzed the staff as lodging in the older patients their own fears of dying alone. Fear of dying has also been linked with failures in early dependency relationships. Overall, then, Terry provided considerable insight into the fact many therapists may harbor unconscious fears of aging, loneliness, and death that cause them to act in ageist ways.

Furlan, Craven, Ritchie, Coukos, and Fehlings (2009) sought to document ageist attitudes among nurses taking care of older patients with spinal cord injuries in relation to the quality of care provided by nurses at an acute-care unit for spinal injuries in Ontario, Canada. Nurses were surveyed using Kogan's Old People Scale to assess the attitudes of nurses toward the older patients under their care. These results were then compared with

ageist attitudes by nurses working in a rehabilitation center or with individuals with chronic spinal cord injury. The results found all nurses, wherever they worked, harbored some ageist attitudes about older patients, but ageism was worst among nurses in the acute care unit. Nurses working specifically in the field of rehabilitation, and those who had more education in spinal injury, had fewer ageist attitudes.

Furlan et al (2009) also found ageism differs according to type of injury among patients with cervical SCI, because elderly end up with more favorable results, and as survivors of cervical SCI rate their lives more favorably than other SCI patients, were less biased against ageism. Doctors, as well as nurses, felt such an aggressive response was merited. It is also true that context influences ageist attitudes, with rehabilitative and acute care nurses having less ageist attitudes than nurses in the medical system or a general hospital. Older nurses also seemed to have less ageist attitudes toward the elderly. These findings suggested empathy and being in more intensely connected services may reduce ageism. Thus, Furlan et al concluded education is the best way to prevent nurses' ageist attitudes from compromising care to elderly patients with spinal cord injury.

Impacts on Quality and Types of Care

Given ageism has been identified in medical personnel, it only follows ageism would also be in evidence in the kind and quality of care offered to older people (Curtis, 2006; Davis, 2010; Dockter & Shane, 2009; Kane & Kane, 2005; Phelan, 2008; Pritchard, 2007; Rosowsky, 2005). Kane and Kane (2005), in reviewing the research on ageism and its direct impact on quality of care for elderly persons, found ageism in healthcare services can be categorized as impacting access to care generally, with insurance playing a complicating role, and access to specialist treatments specifically,

including diagnosis by specialists and surgery. Kane and Kane (2005) termed the latter kind of access “internal access” that involved the likelihood of a general provider referring one to specialist care (p. 49). Even if access is gained, it has still been found that elderly patients receive different manner of care, doctors often speak to patients through younger relatives, and doctors often spend less time trying to diagnosis problems of elderly patients.

Thus, elderly persons are often subject to disparity in care, most likely due to some hidden ageist assumptions about how much value the care would have. This can include the patient taking fewer medications, having their individual choice revoked, being blocked from provision of medication by systemic barriers, and other reasons such as the fact, older patients may be advised against certain cancer treatments because it is likely they will outlive the diseases in any case (Kane & Kane, 2005). In the same way, elderly people are often not screened because it is not deemed appropriate and are not referred for physical rehabilitation because the doctor thinks they would not be able to withstand its rigors. If a physician fails to refer a patient simply because he or she is old and the physician does not think they would be able to tolerate the therapy, this would be defined as ageism.

In the area of geriatrics, which Kane and Kane (2005) defined as the intersection of gerontology and chronic-disease management, evidence has also been found of ageist bias, as, for example, when a decision is made not to offer an old person care because they would not benefit from it, or the belief a procedure would have limited positive effect due to the limited life expectancy of the patient in any case. The cost effectiveness of health care is calculated on the quality-adjusted life years fact, which Kane and Kane

also felt has some bias in it, in that it discounts the value of “a few good years” left, and generally views life in a nursing home as not worth living (Kane & Kane, 2005, p. 3).

Access to clinical trials. Old people are also systematically excluded from clinical trials. Doctors also complained that the complexity of old persons’ cases take up so much time in accumulating the necessary history day and explaining the problem or treatment to the patient that it is hardly worthwhile, in terms of healthcare system remuneration, to treat them. The fact healthcare reimbursement favors procedures and does not adequately fund geriatric evaluation, contributes to this problem. Kane and Kane (2005) also found a good deal of evidence of age-based rationing of care, with some arguing it is necessary to establish some guideline for when to stop offering prolongation of life care and switch to palliative care, in order not for geriatric care to take away from care for persons of all ages. These proposals have been highly controversial, but as long as the current healthcare system exists, repeated attempts to ration care to the elderly will be made.

Organ transplants. Curtis (2006) specifically examined the extent to which ageism has interfered with older persons receiving kidney transplants. At present, persons over 65 have become the majority of patients experiencing end-stage renal disease, with persons over 70 being the fastest growing group; yet they are a distinct minority in deceased-donor kidney transplantation. This means while the number of patients under 50 on waitlists for transplants has more or less stayed the same, those over 60 on waitlists has tripled. This problem is likely to worsen as the Baby Boomer generation ages.

To address this problem, Curtis (2006) explored applying utilitarian philosophy to the problem. Utilitarianism argues the correct action to take in any situation in life is the

one that produces the greatest good for the most people. Many experts such as Braun, Meier-Kriesche and colleagues argued this approach should be used to manage allocation of deceased-donor organs, arguing that this approach serves those most likely to benefit the most from transplantation. In practice, however, this approach has been found to discriminate against minorities and the elderly, based on the reasoning that due to other health problems and age, the transplant was less likely to lead to long-term gains. Some experts even argued the increased age of the person receiving the donation would reduce the "maximization of good" of the transplantation process (Curtis, 2006). By contrast, Kant's notion of moral imperatives argued against utilitarianism by arguing the rightness of the action was to be taken in spite of consequences. His notion of the categorical imperative argued "all right actions should be able to be made universal" (Curtis, 2006, p. 1264); that is, keeping a promise of quality care to persons older than 65 would be such an imperative and a promise that cannot be broken.

With waitlist times sometimes adding up to 10 years, it seems increasingly less likely, according to utilitarian arguments, that an older person will receive a transplant, leaving them to opt for dialysis or find a living donor. Curtis (2006) worried the utilitarian-grounded system will result in a decision-making process based on simple mathematics, a process "too appealing to the bureaucratic mind," where "mathematicians would replace ethicists," with an undertone of ageism, that will make it impossible for older patients to receive transplants (p. 1265).

Cancer treatment. Davis (2010) also found women over 65 are not receiving appropriate care to prevent or detect breast cancer. Older women are less likely than women under 50 to receive chemotherapy and radiotherapy, and 40 times less likely to

undergo surgery to treat cancer. Statistically, 15% of older women receive chemotherapy, compared to 77% of younger women. Some 94% of doctors conceded that older women are prevented from receiving biological and other forms of therapy, including primary surgery, while 60% said older patients sometimes also did not even receive standard diagnostic treatment. Some 43% of breast cancer oncologists in the UK, where the study was done, conceded that age discrimination in terms of care dispensation was a recognized problem. For Davis, this problem was even more problematic insofar as breast cancer becomes more prevalent and dangerous with age. Davis recommended that minimum care requirements be established as guidelines and held to for all breast cancer patients regardless of age.

Dockter and Shane (2009) conducted a study on ageism in the access of older patients to chemotherapy, seeking to determine if doctors are not referring older patients for chemotherapy out of concern for the patient, or because of ageism. Age discrimination has been found to the prevalent in referrals of services to treat breast cancer previously, as noted above. While 50% of cases of breast cancer involve women over 65, only 8% of those patients receive chemotherapy. Even though they are the core group of patients diagnosed with breast cancer, moreover, few women over 65 are given the option of surgery. Women in their 50s are four times more likely than women in their 70s to be offered chemotherapy or surgery. A clinical study of the use of chemotherapy drugs, epirubicin and gemcitabine, tested the efficacy of the drugs on women in their 50s and 70s, however, and found the older women reacted just as positively to the drugs as younger women.

Dockter and Shane (2009) found chemotherapy works well for women in their 70s. Reasons for this imbalance in care, in spite of proof of success, is that elderly people are denied care as care would have greater value and lasting effect on younger persons; thus, care for the aged should be eliminated. On the other side of the argument, few savings accrue from not offering care to the elderly. Dockter and Shane (2009) encountered a wide range of rationales for denying care to elder patients, but most of the reasons given by doctors for not offering older people the same level of care as younger persons receive are fundamentally spurious; the researchers concluded their perspectives were a result of ageism.

Pritchard (2007) also examined the administration of tamoxifen to 517 women over 65 who were being treated for breast cancer. The results found surgery, plus tamoxifen resulted in better recovery for all subjects, and the use of tamoxifen alone was not related to improved outcomes. Pritchard noted women over 70 only received tamoxifen treatment, not surgery, based on the concept they were less fit for surgery, or because of co-morbidity of other problems. In the U.S. especially, this paradigm for care for the elderly breast cancer patient as opposed to those under 65 has been used in 42% of cases, regardless of whether or not a co-morbidity was present. It also remains true while breast cancer diagnosis increases as a woman passes 70, most tests do not include women over 70, a fact Pritchard called “in itself a form of ageism” (p. 1011). The approach to treatment needs to change, as statistics now show that the average life expectancy of a woman over 70 is 16 years in the U.S. and 13 years in Canada. Current practice, then, no longer corresponds to the reality of aging in older women. Indeed, given 70% of older women who receive surgery as well as tamoxifen survive while only 47% of women who

receive tamoxifen alone survive, current practice represents inappropriate treatment based on ageism (Pritchard, 2007).

In examining other reasons why women over 70 do not receive adequate treatment, it was found many older women have trouble finding the correct information about care, and resist the protracted treatment connected with intake including daily radiation therapy (Pritchard, 2007). The development of more conservative surgical procedures; however, makes many of the former fears of fitness in facing surgery obsolete, with sentinel node surgery much less intrusive than complete axillary dissection, and mastectomy generally as a surgical form has a very low mortality rate. For all of these reasons, Pritchard (2007) urged leaders of hospital to overcome ageism in current practice and policy and offer older women the care they need, which, for breast cancer, will include a combination of surgery and tamoxifen.

Abuse by Healthcare Workers

Nurses can perpetuate ageism through abusive actions, practices, and attitudes, mainly through infantilization, negative stereotyping, and making decisions on the patients' behalf. As a result, through paternalism and neglect, abuse can develop. If older people accept the situation of powerlessness and resign themselves to it as part of being old, they can even contribute to setting themselves up for abuse (Phelan, 2008). In medical care, in particular, supported by a Cartesian dualism that sees the body as a mechanism that will inevitably break down, the older body comes to be seen as declining and eventually broken down. This dualism then creates a power dynamic between younger practitioner and older patients, which again reinforces abuse. Phelan (2008) concluded these practices are so endemic that only the application of a universal human

rights paradigm to protect the fundamental rights of older people in medical care will break the complicit union of ageist discourse and practice in enabling and disguising elder abuse.

Similarly, Kane and Kane (2005) argued all arguments rationalizing the denial of care to the elderly are ageist insofar as “they seem predicated on a web of assumptions about the worth of the state of being old and ill” (p. 4). In terms of long term care, Kane and Kane found while younger persons demand services because they want to remain active and fully participating in life, older persons appear to cope with decline and are willing to settle for nursing homes or other less-involved care. Old persons appear to have internalized ageism by viewing decline as an inevitable consequence of aging “that must be borne with equanimity” (Kane & Kane, 2005, p. 6).

Healthcare Experiences of Elderly African Americans

The population of older people in the world is disproportionately distributed into different ethnic groups. In the coming years, the elderly population will be unevenly distributed across the world, with the elderly declining in Europe, remaining at roughly 10% in the U.S., but rising to almost 60% in Asia based on a 95% uncertainty range (Tsuno & Homma, 2009). Another problem that emerged is while in traditional cultures the older adult was valued as counselor and advisor and respected for their experience, the emphasis on youth has increased. Reinforced by modernization and urbanization, this feature of American culture is spreading throughout the world (Tsuno & Homma, 2009). While elderly persons used to reside with their children, it is now more common for them to live separately. Nonetheless, Tsuno and Homma (2009) still found the heritage of

Confucian values, with its emphasis on familial and social values, continues to support some degree of respect for the elderly in Asian countries.

At the same time, recent studies have shown complex and inconsistent responses of Asians to older persons, but overall suggesting that ageism is appearing more frequently in these cultures (Tsuno & Homma, 2009). Indeed, one study found in Korea and the Philippines, young people held more or less similar views toward the aged as young people in the U.S. Thus, ageism, formerly believed to be restricted to commercialist cultures with an overbearing emphasis on youthful competitiveness is no longer just an American issue, but has become a worldview problem as well. Either way, studies on ageism and aging have begun to explore cultural variation in the practice.

The expectations older people have about aging may impact their response to ageist stereotypes, or be fed by those stereotypes. Sarkisian, Shunkwiler, Aguilar, and Moore's (2006) belief old age is not simply a physical episode, but also a behavioral and conceptual construct provided a perspective from which to examine passive coping mechanisms, lower rates of use of health services, less help seeking behavior, and greater mortality among elders with low self-perception. By contrast, older persons with more positive self-perceptions about aging are less likely to experience disability or die. Thus, Sarkisian et al.'s (2006) research was contextualized by the "substantial interest within the multidisciplinary gerontological community in gaining an understanding of whether or how beliefs about aging influence health" (p. 1277). To determine if African Americans and Latino seniors had different expectations about old age, Sarkisian et al. (2006) administered an Expectations Regarding Aging survey to 611 seniors at community-based senior centers in Los Angeles. Gender, physical component, mental

component, ability to perform actions, number of comorbidities and the geriatric depression scale were among the factors studied. After adjusting for a number of variables, it was found that Latinos have lower expectations for old age than African Americans; however, when adjusting for education, it was found that ethnicity does not appear to dramatically influence the nature of age expectations.

Sarkisian et al. (2006) expressed concern that insofar as low age expectation is linked to a sedentary lifestyle, that lifestyle is linked to diabetes, and diabetes rates are high among Latinos, low age expectations among Latinos enables diabetes onset. It is also true that by and large in Latino culture, exercise and physical activity is "considered inappropriate in older age" (Sarkisian et al., 2006, p. 1283). The relatively moderate age expectations of older African Americans would also suggest that age expectations do not contribute to exacerbating problems experienced by African Americans in old age.

One of the most difficult aspects of aging that ageists struggle with comprehending is the continuation of a sexual life into old age. Dickerson and Rousseau (2009) focused on why the sexuality of older African American women in particular is never raised as an issue. They argued that the issue can be addressed by widening the definition of sexuality to include all behavior and desire about sexual matters, including fantasy, as well as pro-creational, recreational, and relational sexuality. Dickerson and Rousseau posited that sexuality among older persons is often dealt with through omission; that is, it is never talked about it— a reflection therefore, of ageism.

Ageist beliefs generally hold that older people are too senile or old-fashioned in their morality to engage in sex, and if you are getting old, you are finished sexually. Dickerson and Rousseau (2009) also noted this perception may be related to the fact that,

while sex by those contributing to the workforce is deemed to be part of their productive contribution to society, sex by persons who have retired and no longer work, and therefore would engage in sex for its own sake, are looked down upon. Studies have shown sexuality does not decline with age, and that sexual interest and responsiveness is a normal part of senior life, "if one's general health is good" (Dickerson & Rousseau, 2009, p. 309).

Indeed, the fact that seniors have been able to let go of excessive obligations and have slowed down would mean that they have more time to focus on sex. Nonetheless, most research into the issue finds that sex stops as people age (Dickerson & Rousseau, 2009). For African American senior women, their sexuality nearly becomes invisible. In particular, Black women's sexuality has been linked with exotic pleasures, dangers to domesticity, primitive threats against civilization, and also reaction; these stigmatizing narratives are said to permeate the lives of African American women (Dickerson & Rousseau, 2009).

However, Baby Boomer women in general, have much more individualistic notions about their right to sexual pleasure, and have been found to compare their views with those of their mothers, to be more willing to take action to obtain sexual pleasure at an older age, engaging in more liberal sexual activities, and having no difficulties with sex outside of marriage. That said, studies comparing White and Black Baby Boomer women find that Black women had attitudes about sexuality in older age more similar to their mothers. Among older people generally, 20% reported having a physical condition that preventing them from fuller participation in sexuality; however, 85% of senior

women reported the same impairment of sex by health, with 68% reporting hypertension and 53% reporting arthritis as the cause (Dickerson & Rousseau, 2009).

Still, it was found few health professionals raise the issue of sexual functioning, and fewer senior patients raise the issue with doctors. Only 45% of older men and 14% of older women had sought care for decline of sexual functioning (Dickerson & Rousseau, 2009). In one study of older Black women, it was found intimacy, which can include kissing and touching, as well as empathy and companionship, is more important than sexual intercourse. However, when an older woman becomes a widow (more likely due to the imbalance in life expectancy between the sexes), the death of the spouse usually signifies the end of both intimacy and sex.

As a result of these problems, Dickerson and Rousseau (2009) argued "sexual health should be an integral part of the comprehensive healthcare plan of senior women and physicians must explore the sexual concerns of senior women and how they relate to the overall well-being" (p. 324). Melby (2010) also addressed the fact too many healthcare workers believe old people should not be sexually active, addressing the issue as it related to nursing home policies. In a survey of 81 nursing homes, one third of the staff was disgusted by the fact residents sometimes made sexual expressions to each other. At the same time, four or five nursing homes reported sexual talk and acts among the residents, and two thirds reported the development of romantic relationships between residents (Melby, 2010).

General statistics report one in four persons over 75 are sexually active, defined as any sexual contact, regardless of whether or not intercourse or orgasm occurs. Moreover, 73% of survey participants aged 57 to 64 were active, and 73% of those up to age 74,

findings that are roughly similar to adults aged 18 to 59 (Melby, 2010). Melby (2010) also found older persons are more patient with sex, perhaps less concerned with performance issues, engage in sexual activity out of reminiscence of previous sex experiences, and, in general, engage in sex in ways that nursing homes must develop more enlightened policies about in order to acknowledge this reality. At present, too many nursing homes continue to harbor ageist ideas about sexuality in older adults.

Age self-stereotypes represent beliefs old persons harbor about aging, usually characterized by having internalized ageist stereotypes from society. It has been found that having negative age self-stereotypes makes an old person's cardiovascular response to stress less effective, while positive age self-stereotypes tend to protect oneself from the negative cardiovascular effects of stress (Levy et al., 2008). The negative impact of negative age self-stereotypes on cardiovascular response to stress has only been proven for European American participants (Levy et al., 208). Therefore, Levy et al. (2008) examined the extent to which negative age self-stereotypes in a sample of older African Americans contributed to cardiovascular stress problems. Levy et al. found those exposed to negative age stereotypes "showed a significantly exacerbated autonomic response to mental challenges, in systolic blood pressure, diastolic blood pressure and skin conductance" (p. 86). Levy et al. argued African Americans are likely exposed to many negative age stereotypes as well, such as television programs where older characters "provide comic relief by displaying incompetence" (p. 87). These can then be accumulated over a lifetime and, when one reaches old age, one begins to turn them against oneself.

It has also been found negative race stereotypes generate stress in African Americans, especially in situations that might confirm the negative race stereotype. Cumulative stress theory would argue that through a combination of these exposures, and chronic psychosocial adversity, stress builds up in a person and causes the autonomic nervous system to become maladaptive for coping with chronic stress and overreact to all stressors later in life (Levy et al., 2008). Thirty four older African Americans with a mean age of 73.1 were surveyed with the Charlson Comorbidity Index, the Activities of Daily Living Scale and the Instrumental Activities of Daily Living Scale, while vital conditions were measured using the Critikon Dinamap Vital Signs Monitor after completing a verbal challenge. Age stereotype priming tests were then administered. The results confirmed African American elders experienced higher cardiovascular response to stress when exposed to negative as opposed to positive age stereotypes (Levy et al., 2008). The positive primes may have reduced stress because they triggered an internalized sense of membership in a group, of having a social identity, based on the notion that during stress those with in group resources are likely to cope more effectively.

The fact African American elders in particular often have more positive views of old age than European Americans means, to Levy et al. (2008), that exposure to positive stereotypes can minimize cardiovascular response. However, in general, Levy et al. found response to stereotypes of any kind was exaggerated by the kind of age self-stereotype held by the participant, and older persons who have internalized negative age self-stereotypes are more susceptible to stress, which has been found to compromise health. In this particular study, the research found a positive and negative aspect of older African

American response to age, apparently cancelling out any differential effect of ageism on their overall level of health.

How the Elderly Internalize Ageist Stereotypes

In the field of gerontology, it is believed many of the difficulties faced by senior citizens with disabilities are the result of social exclusion, as opposed to problems connected with their physical and mental health (Barrett & Cantwell, 2007; Bousfield & Hutchison, 2010; Cottle & Glover, 2007; Kane, 2008; Narayan, 2008; Widrick & Raskin, 2010). Negative social stereotypes about what an old person is able to do often is at odds with what senior citizens can in fact do. That older people are living longer due to gains in healthcare makes this gap between perception and reality more of a problem for old people than ever before.

A number of studies have found gaps between social perceptions of old people and what elderly persons themselves thought that they were able to do (Xie, Watkins, Golbeck, & Huang, 2012). Most studies viewed old age as a time of life when “the positive characteristics of life are lost” (Arnold-Cathalifaud et al., 2008, p. 105). It is a time when abilities are lost, sexual interest declines and difficulties are experienced adjusting to new technology. Youth and middle age are viewed as times when one can achieve success; old age is believed to be a time of deterioration. Most young people also perceive they will have to take care of older people in their lifetimes. One study found young people viewed older people as sad, inflexible, and unappealing while others have confirmed negative stereotypes about older persons are now universal.

By accepting the stereotype of inevitable frailty, many older people allow themselves to settle for a lesser quality of care than younger persons would receive. The

fact healthcare providers often fail to present older patients with other care options only contributes to this resignation. Intrusive intervention in making decisions on behalf of older patients is still another example of ageism in the medical system (Day, 2014; Qualls & Smyer, 2008). If decision makers suggest sending an old person to a nursing home without offering any other options or offering options that they might offer a younger person, then that too is ageist.

Research, has indicated older patients in fact want aggressive response to their problems, and are not that different from younger patients in demanding care that allow for fuller participation in life (Kane & Kane, 2005). Recent rules that all nursing home patients are to be given a default do not resuscitate order also struck Kane and Kane (2005) as ageist. Ending policies that call for certain types of treatments based on age alone, then, would be a good first step in ending what Kane and Kane (2005) saw as endemic and subtle ageism in most of the care for elderly persons in the U.S. medical system.

It has been identified from earlier research that older persons are not treated with dignity and respect in the healthcare system based on stereotypes. While ageism has received much less attention from research than racism, the aging of the populations of most industrialized countries has increased interest in the topic. Allport's (1967) intergroup contact theory proposed that by interacting with members of outgroups, people's attitudes toward those groups can be improved. The thesis is based on the premise that the contact is among relative equals, with common goals, cooperation and institutional support. Later research suggested contact itself may be enough to change attitudes (Allport, 1967; Quantity Assurance Project, 2007). This has been found in

students who worked with elderly patients, children working with elderly relatives, and other contacts that do not meet the above requirements.

Another model of intergroup contact has examined the role that intergroup anxiety played in mediating the effects of contact (Allport, 1967; Turner, Hewstone, Voci, & Vonfakou, 2008). This anxiety can arise when one has fears that contact can result in embarrassment or misunderstanding. This can then lead to either avoidance of contact or contact which sours one further on the group and in fact increases stereotypical perceptions. With regard to the relationship between the young and the old, anxiety is believed to play a major role in contact problems, as it has been found the young often view the older as emblems of their fears of loss, loneliness, loss of beauty and death.

Research into the perceptions of ageism among the elderly is fairly conclusive, finding that almost 80% of all adults over the age of 60 report having experienced ageism and 60% have observed ageism against same-aged peers (Cherry & Palmore, 2008; Coudin & Alexopoulos, 2010; Giles & Reid, 2005; Greaves & Rogers-Clark, 2011; Harbison, 2008; Koch, 2010). Only 36% of persons over 60; however, report being abused because of ageism, though Giles and Reid (2005) suggested this finding may be due to the personal-group discrimination discrepancy. This discrepancy occurs when members of groups who are possible targets of discrimination distinguish a higher level of discrimination aimed at their group as a whole rather that at themselves as individuals.

In reviewing the research on ageism, Giles and Reid (2005) also found an assumption only young people engage in ageism, when many older persons report being subjected to ageist attitudes by people their own age. This could be termed intra-generational ageism, and can consist of such simple things as pointing out hair loss or

other problems, for the purpose of highlighting one's own comparable vigor. Thus, many older adults "articulate ageist sentiments…to differentiate positively from those they believe to be really older people" (Giles & Reid, 2005, p. 391).

Coudin and Alexopoulos (2010) surveyed 57 older adults to determine how stereotypes of their dependency on others contributed to self-reported loneliness, risk-taking, subjective health, and help-seeking behavior in France. In France, in particular, old people are stereotyped as being "irritable, boring, grumpy, weak, mournful, debilitated and most importantly cognitively impaired" (Coudin & Alexopoulos, 2010, p. 516). Coudin and Alexopoulos conceptualized negative aging stereotypes as contributing as an iatrogenic effect in a social environment on the self-evaluations and behaviors of older adults. This leads to the older persons to engage in self-stereotyping. The results found that negative stereotype activation in the social environment of elderly individuals did in fact result in lower levels of risk taking, lower levels of extraversion, and lower levels of subjective health and more help-seeking behavior and loneliness.

Coudin and Alexopoulos (2010) considered the major finding of the study to be that negative stereotypes increased older person's help-seeking behavior, indicative of having adopted a more dependent self-perception. Thus, Coudin and Alexopoulos concluded that "the mere activation of a negative stereotype leads older individuals to feel lonely, to depreciate their health status, to avoid taking any risks and to systematically seek for help in their social environment" (p. 522).

The Relating to Older People Evaluation (ROPE) survey was developed to measure ageist behaviors by people as a result of their perceptions of peoples of different age (Cherry & Palmore, 2008). The survey can be administered to young people, but also

to older adults, to gain a sense of the degree to which they are aware of ageism. The scale was developed based on the gerontological and social cognitive perspective that “ageism may also influence older person’s implicit beliefs about their own competencies as well as self-stereotypes” (Cherry & Palmore, 2008, p. 850). As a construct, ageism entails detection not only of overtly negative attitudes towards age but also the extent to which acts of courtesy or kindness to the old may also be in fact discriminatory.

Previous scales for measuring ageism, including the Attitudes toward Old Persons Scale, the Aging Semantic Differential scale, and the Fraboni Ageism scale, were developed with a focus on perceptions as opposed to actions. Palmore’s Facts on Aging Quiz has documented ageism since the 1970s, and the Ageism Survey was developed specifically to detect ageist attitudes defined as prejudice and discrimination. However, the attitudes *of* older persons have been understudied. Thus, the Relating to Old People Evaluation, measuring personal both positive and negative discrimination as a self-report measure, brings their responses to attitudes into the discussion. Some 314 individuals, both college students and community-dwelling older adults living in the community of Louisiana State University were surveyed with the scale. The results found 90% of persons engaged in seemingly positive but ageist behavior, including holding doors open and complementing old people how they look despite their age. Explicitly negative acts such as saying negative things about old age, complaining about older drivers, telling old people that they are too old to engage in particular behaviors, were reported about 65% of the time (Cherry & Palmore, 2008).

Older people were also found to have as many ageist attitudes as younger people, and often accepted without awareness ageist underpinnings of responses to their age.

That is, many older people did not perceive holding open doors or being complimented for how good they look as ageist, even though in Cherry and Palmore's (2008) view, these actions were ageist. Older women in particular are apparently unaware of the ageist nature of positive ageist behavior directed at them. Cherry and Palmore (2008) concluded that many of these perceptions may be based in ignorance regarding what older persons are able and not able to accomplish, and that continuing education workshops may help in reducing these perceptions.

McGuire, Klein, and Chen (2008) made use of the Palmore Ageism survey to survey 247 community-dwelling older adults in East Tennessee to determine their perception of the existence of ageism by examining ageist behaviors including avoiding contact with older people, denial of age, being patronized and the presence of negative attitudes about the elderly. The results found 84% of participants reported experiencing at least one form of ageism, including jokes, birthday cards that poked fun at older people, disrespect, and other problems. The scale also addresses larger issues such as getting a loan, housing, promotion and crime victimization issues, and everyday issues including "a doctor or nurse assumed my ailments were caused by my age" and "I was denied medical treatment because of my age" (McGuire et al., 2008, p. 11). The results also found a demographic difference in response between suburban and rural older persons. In most cases, urban and suburban senior citizens reported experiencing much more daily ageism involved in human interactions, and almost three times more denial of medical treatment because of age. In addition, McGuire et al. (2008) found urban and suburban culture, perhaps because it is focused on young professional life, is more ageist than rural culture.

One method devised to counteract ageism in response to older persons is to elicit their stories of aging through interviews. Koch (2010) interviewed 16 healthy centenarians in the UK to determine if the themes they talked about were consistent with ageist assumptions about the natures of their lives. Koch found, while ageist discourse emphasizes dependency and frailness, the centenarians talked about living independently, their continued growth and development, the ongoing nature of their close relationships, and their philosophy of life, entailing such phrases as accepting what life brings, doing what you can to make life better and moving on. The centenarians reported going to the movies, playing cards in bridge clubs weekly, going to art exhibitions, attending church, and often only required outside assistance for shopping and other simple services. Those who lived with chronic conditions had learned to manage and had made most of their physical problems manageable, including hearing loss. Many mentioned family support and the fact that their having turned 100 was an occasion of celebration and made them into something of a minor celebrity.

Indeed, some evidence suggested having reached that milestone reversed many of the ageist assumptions and attitudes that had bothered them when younger (i.e., 75). In analyzing what centenarians had in common, Koch (2010) found all demonstrated good skills in handling stress and loss, and support from relatives reduced stress even more. That is, most viewed the stresses in their lives somewhat matter-of-factly. The centenarians considered losses to be part of life and “did not view their lives as being particularly stressful” (Koch, 2010, p. 6). In other words, they left stress and losses behind, while another centenarian also mentioned “I don’t think of death. I think of living and what I am going to do and what I am going to enjoy” (Koch, 2010, p. 36).

Overall, the centenarians presented positive views of aging, counteracting the negative stereotypes imposed by ageist society. Koch also found simply by asking centenarians to tell their story, the personalized attention made them feel more valued. Koch viewed these centenarians as prototypes of successful aging.

In a similar vein, Quine, Morrell, and Kendig (2007) surveyed over 8,000 older Australians about their hopes and fears regarding the future. Ageist stereotypes characterize old age as a "time of worry, fear, loss and decline" and view older people, as a result, as weak, defenseless, and filled with fears (Quine et al., 2007, p. 321). At the same time, Quine et al. argued that old people often perceive that being made to feel old is often demoralizing, and perhaps has a more negative impact on them than their actual situations in life. Hopes and fears, however, were conceptualized in this study as "a dynamic part of an evolving self through the life span" (Quine et al., 2007, p. 321).

This part of being an old person has also not been studied enough; most likely due to the ageist assumption older persons have no future. This oversight has been reinforced by the lack of attention given to the positive aspects of aging. The results found by and large, older people expressed more hopes than fears, and most of their hopes were other-centered, focused on family, their communities and the world at large. Specifically, hopes expressed were to stay healthy, be free of disability and living independently, while the main fear expressed was loss of independence (Quine et al., 2007). More hope for future family harmony and happiness was expressed; however, and most expressed the hope that their partner would live long as well.

Fears were generally also expressed in familial terms, with fear of becoming a burden on the family being the most commonly expressed fear. In all matters, Quine et al.

(2007) found a great deal of diversity in response. The results of Quine et al. dispel the ageist stereotype of old persons becoming self-interested and fearful as they age, revealing rather a more outwardly focused altruistic attitude.

Greaves and Rogers-Clark (2011) presented a study of an older woman's experience with social isolation and interacting with the healthcare system. Social isolation is believed to derive from a number of causes, but results in an older person becoming less involved in social life. According to disengagement theory, social isolation is seen as a natural occurrence of aging, but this was debunked by activity theory, which suggested that people who maintained social networks were less likely to become socially isolated. Continuity suggested persons develop coping mechanisms that respond to change over time, linked to their personalities, with some people having more ability to maintain social contact than others. Finally, gerotranscendance theory also offered a reason for selective withdrawal from society, positing that older people become more selective in their choices of social activities, less interest in materialism and increased interest in positive solitude as opposed to superficial social interaction.

Greaves and Rogers-Clark (2011) examined the validity of theoretical explanations for social isolation by exploring the experiences of six women over the age of 78 seeking healthcare but having relatively limited contact with other people. Respondents mentioned the attitudes of others toward, them complaining of having become invisible, of being angry at not being able to receive optimal care, being treated like a thing, experiencing protracted waiting times for surgery, inadequate attention by doctors, the importance of maintaining some independence by living in their homes, and concerns over physical safety with regard to crime. Greaves and Rogers-Clark found

consistent evidence from seniors themselves that they are subjected to ageism on a daily basis, including by the healthcare system, and that they are fully aware of it.

Another problem in many of the social services or healthcare settings offered to older women is that practitioners base their actions on perceptions of the norm of younger patients, and fail to take into account the various reasons why older people may feel differently about their health or current life situation. For example, Harbison (2008) examined the gaps in care for older women in abusive relationships by social services and healthcare workers in Canada. A recent study found that old women in rural communities stuck in abusive relationships were nonetheless valued by their community for being stoic, and even admired, if with pity, for staying committed to their marriage. Younger women responded to this study by arguing these women were perpetuating the cycle of violence, but Harbison wondered if younger women entirely understand the dynamics that form the perceptions of older women about the nature of abuse. She suggested by condemning old women and the reasons they give for staying in abusive relationships younger feminists were engaging in ageism.

Indeed, Harbison (2008) found most feminist studies of old women concentrated on women in their 60s, with little attention paid to women in their 70s and 80s. The fact that women older than 70 handle abuse differently than younger women is often overlooked or dismissed. In fact, older women experiencing abuse often remain committed to staying in their home and with their family are more concerned about privacy and confidentiality, and more worried over the shame and stigma associated with abuse should the information become public. The majority of older women want to stay in the abusive relationship.

To better understand how older women in rural Canada perceived abuse and services provided them, Harbison (2008) interviewed 45 helpers, mostly seniors themselves, of a rural social services department who came in contact with older abuse clients. A prevalent reluctance to speak about the problem in public was noted among the respondents. Older abused women rarely decide to leave the relationship, mainly because they are not sure where they would go. Older women had the notion “having made your bed you should lie on it” and remained deeply attached to their spouses, even if they are abusive (Harbison, 2008, p. 221). Harbison also commented “perhaps most difficult to accept for women who are feminists is the fact that older women’s positive identities may be associated with the ability to endure abuse and to cope, or as a caregiver for their abusive partner” (p. 230). Harbison argued, therefore, to provide better services for this particular subgroup of older women, service providers need to overcome ageist-based models of leaving and rejection of the partner as the model for dealing with abuse and develop a model that is more in tune with the realities and perceptions of older women.

Promoting Healthy Attitudes Toward Aging

Empirical studies explored evidence of ageism in healthcare worker response to geriatric or older patients over the entire course of the lifetime in medical care. For example, Adelman et al. (2007) examined the extent to which first year medical students, first introduced to geriatric patients as part of their training, responded to the introduction to the older body. The study was undertaken out of concern over the fact an insufficient number of medical students chose to pursue geriatric medicine, leading to shortage in the specialty (Adelman et al., 2007). Most medical schools also do not require geriatric

training. It has also been found that many medical students continue to hold negative views about older patients, and older persons generally.

Efforts by the Weill Cornell Medical College to “geriatize” its first-year curriculum by introducing medical students to senior subjects were assessed. The program sought to overcome documented student hesitation about caring for the aged by introducing them to positive imagery of the pursuit in film and live drama, followed by discussion groups, case study role-play scenarios with older patients, exemplifying common ageist pitfalls in treatment of the elderly, and contrasting these session with gero-friendly examples of how to address older patients’ needs, primarily by using a biopsychosocial model (Adelman et al., 2007). The results found not only did students respond favorably to the intervention, but that the intervention helped them reassess unexamined ageist attitudes about care for the elderly. Although few students involved in the intervention expressed an interest in subsequently pursuing geriatrics as a specialty, Adelman et al. (2007) concluded that such interventions are reflective of efforts that must be made to overcome ageism as a way to recruit more medical students into the field.

McGarry (2009) argued while education is an excellent way to reduce ageism in medical personnel, developing caring values in practice and nursing is perhaps a more important way to do so. Caring attitudes involved getting to know the older patient, seeing them as a person and not just an old person, and developing a relationship from which some satisfaction is gained. Thus, a person-centered care protocol for care would improve care of the elderly and reduce ageism. McGarry also found most students who graduated from coursework that emphasized these behaviors found that in actual practice in hospitals and clinics, the pace of the work was so fast that it left little time for personal

interaction with older patients, or for individualized care mandated by the caring model. McGarry worried that the failure of the clinical practice to reaffirm the caring principles learned by the students will compromise their commitment to nursing. The conclusion, then, is that education alone is not enough to reduce ageism; a clinical practice environment with a focus on positive learning and developing caring relationships with patients is also required.

Ageism has been found in many populations of nursing students in nursing schools, prompting Ferrario, Freeman, Nellett, and Scheel (2008) to develop a framework based on a model of successful aging to counteract the findings of ageism. Ferrario et al. argued for the necessity of revamping nursing school curriculum to prevent ageism on the basis of findings that nurses with negative attitudes about the aged often forget to offer older patients appropriate care, or, conversely, favor using physical or chemical restraints for the elderly patient as opposed to less restrictive behavioral management strategies. The paradigm presented was based on humanistic role models studies, which have found a humanistic approach can engender more positive views in younger persons toward older adults. It is also important the nursing school faculty include at least one specialist in the care of older person, and that the overall paradigm of instruction in medicine, always emphasizing prevention of all decline or disease, should be altered.

The humanistic model of teaching posits the teacher and leaner create a relationship by which positive values of transmitted from one to the other. The use of curriculum to change nursing students' attitudes about the elderly was justified by earlier findings that such interventions can improve their attitudes about care for the elderly, that uninformed faculty can transmit negative attitudes to the students, and negative student

attitudes can in fact negatively influence quality of care for the elderly (Ferrario et al., 2008). Ferrario et al. (2008) also introduced the model to prompt more nursing students to specialize in working with older adults, at present the least preferred career choice among medical students of all kinds. The strategy of placing students in care situations with older persons and emphasizing the positive aspects of aging in the curriculum was found to encourage students to pursue geriatric studies.

Thus, Ferrario et al.'s (2008) framework of successful aging has debunked many of the stereotypes that continue to cling to older persons. This three-factor model of successful aging included (a) probability of disease or disability, (b) continuation of high cognitive and physical functional capacity, and (c) active engagement with life. Wisdom, resilience, mental vigor and positive spirituality have also been added by others to this model (Ferrario et al., 2008). However, this model has also been criticized for being based on a traditional medical model and not allowing for the fact that the majority of older persons are not entirely free of illness or disability, and often are not that socially engaged.

In one study of the model, it was found while 50% of older people considered themselves relatively healthy, and in any case successfully aging, only 18% met the criteria of the above model (Ferrario et al., 2008). Another study found 42.7% of older adults with diseases still considered themselves to be aging successfully (Ferrario et al., 2008). Still another study found 92% of older adults reported they were successfully aging even though only 5% met the criteria set down above. That is, they reported a high quality of life in spite of having physical disabilities or common illnesses (Ferrario et al., 2008). This kind of finding has led some researchers to revise a model of successful

aging to acknowledge that simply maintenance of adaptation, coping, and compensating to achieve meaningful goals and preserve one's autonomous self can also be considered as part of a successful model of aging. Adaptation involves resilience, while learning new ways to function in spite of loss, that is, developing in oneself reserve capacity or plasticity, as well as staying active in making decisions about one's life, are also considered part of aging (Ferrario et al., 2008).

Thus, synthesizing biomedical and psychosocial theories, a new model of successful aging as a dynamic process through the life course entailing the ability "to grow and learn by using past experiences to cope with present circumstances while maintaining a realistic sense of self" has developed (Ferrario et al., 2008, p. 51). This model includes six factors: physical and mental health, acknowledging the ability to live with vitality in spite of some chronic conditions, as well as engaging with others, satisfaction with one's life, adaptation and coping, or being able to compensate for losses by adjusting one's life and coping to maintain control over one's life, maintaining autonomy, self-regulation and independence, and maintaining active engagement with life and social relationships, and having developed a positive spirituality which promoted all of the above.

To assess this model, a curriculum based on the model was administered to 117 nursing students in their last term at an Illinois-based nursing program, measuring their ageism before and after administration with the Palmore Facts on Aging Quiz. The curriculum emphasized the normal, positive aspects of changes involved in aging, training students as possible specialists in gerontology, and requiring coursework and clinical experiences with older patients. Ferrario et al. (2008) found student attitudes

about the elderly were improved by the curriculum changes, though few students grasped the potential for spiritual growth in old age. Thus, Ferrario et al. concluded “students’ attitudes toward older adults could be improved by the role modeling or pro-aging attitudes by faculty trained as specialists in gerontological nursing” (p. 63). The study, therefore, confirmed making use of an evidence-based organizing framework for the education of medical personnel can foster a positive paradigm shift that will prevent the development of ageism in future students. That is, by using a more holistic and humanistic, as opposed to purely medical sense of aging, more positive attitudes about aging can be developed.

Bousfield and Hutchison (2010) specifically examined the relationship between 55 students’ contact with older people and their attitudes toward the elderly using a scale developed by the researchers. The results indicated the more favorable interactions with the elderly had been, the less likely young people were to harbor negative perceptions about interacting with older persons. The quality of the contact with the older person was particularly important for improving student views of the elderly. If, however, the students measured as being neurotic (anxious, fearful, phobic, and irrational) had greater intergroup anxiety focused on issues of aging and death, meaning contact was less positive.

Hutchison, Fox, Laas, Matharu, and Urzi (2010) used the same theoretical basis to replicate this research by examining the relationship between young people’s previous contact with older persons and their continued willingness to remain in contact with elderly persons. They surveyed 61 students between 21 and 38 with regard to contact frequency, intergenerational anxiety, outcome expectancies, and willingness to engage in

future contact. These results also found frequent and positive interaction with older persons improved young persons' expectancy of positive outcomes from contact with older persons. Previous experience also reduced intergroup anxiety related to aging and generally a greater willingness to come in contact with older persons. The research then reinforced the validity of the intergroup contact theory basis of research into ageism by finding that contact between younger and older persons on a more regular basis reduced ageism in younger persons.

Cottle and Glover (2007) demonstrated efforts can be taken to improve young person's attitudes about aging and older persons, and by that means reduce ageism in society. Their study was grounded in previous research which found that younger adults harbor ageist views of older people; it has, however, also been found that perceptions of old age often vary as a function of the student's age, the extent to which they have come in contact with the elderly and their knowledge about aging (Cottle & Glover, 2007). A lifespan course delivered to 253 undergraduate students focused on creating a model of positive change during the aging process, most of whom were female and 79% of who were European American, completed the Aging Semantic Differential Scale as well as measuring knowledge of aging based on the Palmore Facts of Aging Quiz I and II to determine the effectiveness of the curriculum. Pre and posttests about aging and perceptions of older people were administered to determine if the course had a positive impact on improving attitudes. The results showed while it was possible through education to improve student knowledge and attitudes about aging, less success was found in reducing ageism. Cottle and Glover noted that ageism is deeply embedded in

social and cultural beliefs, and ageist beliefs have been found in children as young as four.

Summary

Overall, the literature review discussed widespread, societal, targeted, and specific ageist beliefs in healthcare personnel from all levels of the field. This includes doctors, whose ageist actions affect their decisions relative to the type of care given to older people. Efforts and interventions that might counteract ageism prevalence in the current healthcare system and in society at large are necessary.

Theoretical frameworks for ageism were discussed including emotion labor, social constructivist theory, successful aging model, terror management theory, feminism, and psychological theory (Duncan & Schaller, 2009; Moglen, 2008; Overall, 2006).

Overall, the review indicated ageism is prevalent in healthcare, and ageist attitudes and stereotypes have a significant negative impact on the quality of care experienced by the elderly. This has both direct and indirect impacts on their physical and mental health. Research indicates ageism is a fixture within society and healthcare is no exception. The literature also highlights the negative implications of such attitudes on the physical and mental wellbeing of older adults and the need to address negative assumptions and inequitable healthcare. Chapter 3 provides a detailed discussion of the methods that will be used in the proposed study.

Chapter 3: Methodology

Introduction

The purpose of this research study was to explore differences among nurses in ageism as they relate to nurses' age, ethnicity, and gender. Several factors are hypothesized to be responsible for the differences in care between the young and old. With aches and pains often viewed as an inevitable part of aging, and youth promoted as beauty, elderly patients are being forgotten. In many instances, elderly people who are not self-sufficient receive assistance from limited hired support staff through in-home nursing care, assisted living facilities, or nursing homes. It is at these facilities that many become neglected and discriminated for being older and not being self-sufficient.

The research method that was used in the study is described in this section. The overview includes five primary areas: (a) research design, (b) description of population and sample, (c) instrument development, (d) data collection, and (e) data analysis.

Research Design and Rationale

The five hypotheses were analyzed using a quantitative, nonexperimental research design. A nonexperimental research design is used to describe two or more variables. As random assignment is not feasible when using a nonexperimental design, participants are not randomly assigned to comparison groups. Comparison groups were matched on characteristics that related to the dependent variable to improve the design. Correlational design, on the other hand, was used to establish the level of variation sharing between the predictor (independent) variable and criterion (dependent) variable (Christensen, Johnson, & Turner, 2011; Rumrill, 2004). This quantitative design does not imply that one variable has any effect on another, but rather it helps to indicate when a linear

relationship between two or more variables exists (Leedy & Ormrod, 2010; Neuman, 2003).

In quantitative research, numerical descriptions of trends or attitudes of a sample are provided, and generalization to a larger population is attempted (Creswell, 2009). Quantitative research differs from qualitative research because the former's purpose is to seek to accept or reject a particular hypothesis (McBride & Schostak, 2012). Quantitative research is more appropriate for answering questions about relationships or differences between specific variables (Creswell, 2009). Quantitative research was best suited for this study because I sought to analyze data using descriptive statistics to summarize and compare the data among dependent and independent variables. A *t* test and analysis of variance (ANOVA) were used to evaluate the research questions. The *t* test and ANOVA technique provides a means for a researcher to compare means across two or more independent groups to determine whether they differ significantly, provided that the dependent variable is scaled at the interval or ratio level.

Research Questions

Five research questions were used to guide this study. The dependent variable was attitudes toward ageism; the independent variables were demographic characteristics and years of experience. The research questions were as follows:

RQ1: Is there a difference in nurses' attitudes toward ageism between nurses' age groups (18-34, 35-54, 55+)?

$H_0$1: There is no difference in nurses' attitudes toward ageism between nurses' age groups (18-34, 35-54, 55+).

H_a1: There is a difference in nurses' attitudes toward ageism between nurses' age groups (18-34, 35-54, 55+).

RQ2: Is there a difference in nurses' attitudes toward ageism between ethnicity groups (European American, African American, Hispanic, and Asian American)?

H_02: There is no difference in nurses' attitudes toward ageism between ethnicity groups (European American, African American, Hispanic, and Asian American).

H_a2: There is a difference in nurses' attitudes toward ageism between ethnicity groups (European American, African American, Hispanic, and Asian American).

RQ3: Is there a difference in nurses' attitudes toward ageism between genders (male, female)?

H_03: There is no difference in nurses' attitudes toward ageism between genders (male, female).

H_a3: There is a difference in nurses' attitudes toward ageism between genders (male, female).

RQ4: Is there a difference in nurses' attitudes toward ageism between nurses' education levels (< bachelor's degree, >= bachelor's degree)?

H_04: There is no difference in nurses' attitudes toward ageism between nurses' education levels (< bachelor's degree, >= bachelor's degree).

H_a4: There is a difference in nurses' attitudes toward ageism between nurses' education levels (< bachelor's degree, >= bachelor's degree).

RQ5: Is there a difference in nurses' attitudes toward ageism between nurses' years of experience (<= 5 years, > 5 years)?

$H_0$5: There is no difference in nurses' attitudes toward ageism between years of experience (<= 5 years, > 5 years).

H_a5: There is a difference in nurses' attitudes toward ageism between years of experience (<= 5 years, > 5 years).

A structured view of the five hypotheses and related methodological components including dependent variable, independent variables, and statistical technique used to test each hypothesis to find a statistical relationship, if one exists, is provided in Table 1. Although these methodological components are presented here in brief, they will be discussed in depth later in this section.

Table 1

Hypotheses With Related Methodological Components

Hypotheses	Independent variable	Dependent variable	Statistical technique
H1	Age group	Nurses' attitudes toward ageism	*t* test
H2	Ethnicity groups	Ageism	ANOVA
H3	Gender	Ageism	*t* test
H4	Education	Ageism	*t* test
H5	Years of experience	Ageism	*t* test

Operational Model

Through the use of surveys, the differences between attitudes toward ageism and demographic characteristics and years of experience were examined. Four independent variables and a single dependent variable were specified in the model. The four independent variables were age group (18-34, 35-54, 55+), ethnicity group (European American, African American), gender (female, male), education (< bachelor's, >=

bachelor's), and experience (<=5 years, > 5 years). The single dependent variable was nurses' attitudes toward ageism (see Figure 1).

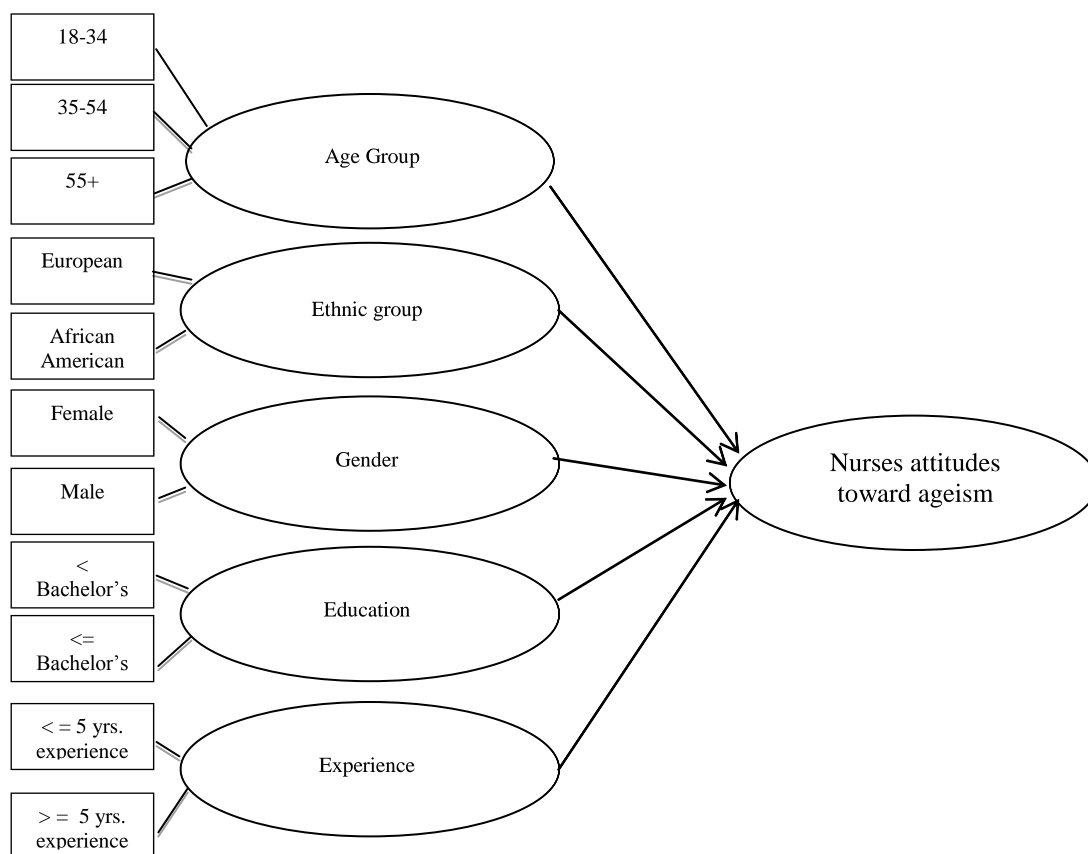

Figure 1. Operational model.

Population, Sample, and Sampling Methodology

Population

The population for the study consisted of caregivers in Southern Mississippi. These caregivers were health professionals, representatives of nongovernment organizations, and members of other groups that provide services for elderly people. According to the National Family Caregivers Association (2012), there were approximately 65 million caregivers in the United States in 2009, and approximately

280,802 were in the state of Mississippi in 2004 (Caregivers Action Network, 2013). To be included in the population, caregivers needed to be at least 18 years of age.

Sample

The study's sample consisted of approximately 100 caregivers living in Southern Mississippi. In order to conduct this survey, several sites were used. The survey was collected from (a) caregivers employed in convalescent homes, (b) family caregivers, (c) home health aides, (d) caregivers in adult day care centers, and (e) caregivers in skilled nursing. The population of caregivers included individuals of both genders and all ethnicities who were older than 18 years of age. To limit the scope of the research and reduce impact from confounding variables, caregivers who were under the age of 18 were not recruited to take the surveys.

Sampling Methodology

A nonrandom sampling technique employing purposeful sampling was used to obtain participants from the population. *Nonrandom* refers to the fact that nurses were not selected at random, given the nature of the design and scope of project. Berinsky (2008) posits that there are seven types of purposeful sampling techniques. These types include typical, unique, maximum variation, convenience, snowball, chain, and network. For this study, snowball sampling was used to select participants from the population. This type of sampling allows for the selection of individuals who are readily available to be researched and willing to solicit participation from others. Merriam (1998) asserted that this type of sampling technique is used due to restrictions of "time, money, location, and availability of sites or respondents" (p. 63).

Snowball sampling was used in exploratory research to collect data from participants that reflected characteristics of the population under study. Snowball sampling requires a core of willing participants to tell and encourage acquaintances to participate in a particular study. This sampling method enables the researcher to collect data from participants who may not have otherwise been reached by other sampling methods. By its nature, snowball sampling affects (Keppel & Zedeck, 2001).

Despite deficiencies associated with generalizability, snowball sampling provides the means to rapidly collect a sample, which may reduce the affects that time has on data collection (Neuman, 2003).

Power Analysis

A priori sample determination was assessed by conducting a formal power analysis. Three factors are taken into consideration when conducting such an analysis including the intended power of the study, the effect size of the phenomena under study, and level of significance to be used in rejecting the null hypotheses (alpha). Study power is the probability of rejecting a false null hypothesis. As matter of convention, adequate power to reject a false null hypothesis is .80 (Kuehl, 2000). Effect size is an estimate measurement of the strength of the relationship between variables in the study (Cohen, 1988). The effect size was characterized by Cohen (1988) as Cohen's f^2 small, medium, and large, with each level representing a specified effect size. Thus, a small effect = .10, medium = .25 and large = .40.

Alpha is defined as how confident one is when rejecting the null hypothesis. Social science research convention suggests that alpha should be set at .05. Thus, with

power set at .80, effect size set at .25, and alpha set at .05, the sample size required was 128 participants (Faul, Lang, & Buchner, 2007).

Although the power analysis calls for 128 participants, only approximately 100 participants were likely be available to the researcher. When sample size is reduced, study power is reduced. In support of the lower participant number, the condition under which the mean of a sufficiently large number of independent random variables, each with finite mean and variance, will begin to approximate the mean of a population is when the sample size reaches about 30 participants, as stated in the Central Limit Theorem (Rice, 1995). This implies that a sample size of around 100 participants was sufficient.

Procedures

Recruitment and Participation

Approval from the Walden University IRB and from the authors of the Age Based Rejection Sensitivity Questionnaire was obtained prior to collecting data. Upon approval, data was collected from participants in Southern Mississippi.

The first group of individuals to be emailed consists of professional caregiver acquaintances. Those individuals implicitly agreed to participate in the study and stated they were willing to forward the survey link to their professional caregiver friends who meet general selection criteria.

Participants were recruited using a snowball sampling method. Approximately 100 caregivers were asked to recruit friends and acquaintances. The original set of 100 caregivers were asked to email an electronic link to individuals that meet inclusion

criteria. Caregiver inclusion criteria was both genders, all ethnicities, and between the ages of 18 and 55 years.

Data Collection

A recruitment letter (Appendix E) was emailed to the first set of five willing professional acquaintances. The letter included a link to a web-based survey hosted by SurveyMonkey. Access to an electronic Web-based survey was made available to all eligible participants, and included the Age Based Rejection Sensitivity Questionnaire (RSQ-Age), demographic survey, and informed consent. Prior to administering the survey, potential participants were informed about the purpose of the study, the data collection procedures, their rights to opt out from the research study at any time without consequences, and possible risks and benefits of the study. To participate in the study, all participants first read, and implicitly agreed with the informed consent. They then were allowed to complete the surveys online. All data was recorded using Microsoft Excel. Statistical Package for the Social Sciences (SPSS) software program was used to analyze the data.

Instrumentation

Two surveys were used to measure the variables of interest in this study. The demographic tool is a three-item tool designed to collect data on age, ethnicity, and gender. The Age Based Rejection Sensitivity Questionnaire is an eight-item survey that took less than 10 minutes to complete.

Age Based Rejection Sensitivity Questionnaire

The Age Based Rejection Sensitivity Questionnaire (RSQ-Age) created by Kang and Chasteen (2009) is an eight-item survey developed to measure ageism. Permission to

use the survey was obtained from the authors prior to the data collection process. Response options were scaled using a Likert-type scaling strategy that include 1=*strongly disagree*, 2=*disagree*, 3=*slightly disagree*, 4=*slightly agree*, 5=*agree*, 6=*strongly agree*. Given that options are anchored by numerical values the level of scaling is considered interval rather than ordinal. Specifically, an equal numerical relationship is assumed between response options. The psychometric properties of the Age Based Rejection Sensitivity Questionnaire were found to be reliable where internal consistency of items yielded $\alpha = .91$. A copy of this instrument is in Appendix B.

Demographic Survey

The demographic survey developed by the researcher (Appendix A) is four-item instrument designed to collect data on inclusionary criteria/independent variables. All four questions are scaled at the nominal level. Respondents were asked to define their gender, ethnicity, age group, and years of experience. The demographic survey is expected to take less than one minute to complete.

Operationalization of Variables

Five variables are identified in this study, one dependent variable and four independent variables. The dependent variable is nurses' attitudes toward ageism and it is scaled at the interval level. The independent variables are age group, ethnicity, gender, and years of experience. All four variables are scaled at the nominal level.

Nurses' Attitudes About Ageism

Nurses' attitudes about ageism is operationalized as a caregivers' attitude of mind that gives rise to age discrimination, a set of actions that may advantage (positive discrimination) or disadvantage (negative discrimination) an older person (Hope, 2008;

Wells, Foreman, Gething, & Petralia, 2004). Age discrimination may be direct when an older person is treated differently solely based on their age or indirect when an older person is disproportionately disadvantaged by a policy or set of actions equally and universally applied. Data for the variable is collected via the use of Age Based Rejection Sensitivity Questionnaire (RSQ-Age). The questionnaire has eight questions. This variable is scaled at the interval level where a six-point Likert-type scale that ranges from low to high, with 1= *strongly disagree*, 2 = *disagree*, 3 = *slightly disagree*, 4 = slightly *agree,* and 5 = *agree*, and 6 = *strongly agree* will be used. As evidenced by the scale, no escape option is available.

Age Groups

Age groups are defined as three segments of a population that is approximately the same age or is within a specified range of ages (Werner, 2011). The three groups are people that are between 18 and 34 years, 35 and 54 years, and 55 years or older. Data for the variable is collected via the use of a single question on the demographic survey where participants will classify their age. This variable is scaled at the nominal level.

Ethnicity Groups

Ethnicity groups are operationalized as groups of people that identify with other people through a common heritage, consisting of a common culture (Karen, Humes, Jones, & Ramirez, 2011). The four main groups in the United States are: (a) European American, (b) African American, (c) Hispanic, and (d) Asian American. Data for the variable is collected via the use of a single question on the demographic survey. This variable is scaled at the nominal level.

Gender

Gender is defined as the characteristics that a society or culture delineates as masculine or feminine (World Health Organization, 2012). Like the previous independent variables, data for gender is collected via the use of a single question on the demographic survey. This variable is also scaled at the nominal level.

Education Level

This variable is defined as level of formal education at an accredited school or university obtained through the course of one's life. The variable is scaled at the nominal level meaning only two levels (less than bachelor's and greater than or equal to Bachelors) will be recognized.

Years of Experience

This variable is defined as a nurse who has less than, or equal to 5 years' experience versus a nurse who has more than 5 years of experience. The variable is scaled at the nominal level meaning only two levels (less than 5 years' experience and 5 years' experience or more) will be recognized.

Data Analysis Plan

For Research Questions 1, 3, 4, and 5 a student *t* test was used. The *t* test is used to compare means across two independent groups to determine if they differ significantly. For Research Question 2, an ANOVA test was used. ANOVA is often used to compare means of two or more groups. The student *t* test and ANOVA produce the same results, meaning reported confidence levels would be the same if one used a *t* test or ANOVA test. Mathematically, this is proven by the following equation: $t^2 = F$; where t is the reported value for the student *t* test and F is the reported value for the ANOVA test. In

1908, William Sealy Gosset developed the t test and published under the pseudonym Student, which is why it is called the Student t test (Lindman, 1974).

ANOVA was developed by the statistician and geneticist R. A. Fisher in the 1920s and 1930s (Lindman, 1974) and is sometimes referred to as Fisher's ANOVA. ANOVA uses the equation:

$$F = \text{Between Mean Squares} \div \text{Within Mean Squares}$$

The ANOVA equation is simply the sum of squared differences between groups divided by the sum of squared differences within groups. The basic calculation assesses the variation in scores found between groups and divides that by the variation in scores found within groups. The resulting ratio (designated by F) is a measure of the strength of independence. F is always positive and always greater than 0.

Eta squared is also a measure of the strength of independence and is calculated using the following equation:

$$\textit{Eta squared} = \text{Sum of squares between groups} \div \text{Total sum of squares}$$

Eta squared is also referred to as an effect size and is characterized by the following scale developed by Cohen (1988): .01 = Small, .06 = Medium and .14 = Large. Thus, the two measures of validity, F and *Eta squared*, will be used to determine if ethnicity groups differ significantly.

The analysis procedure was conducted using the Statistical Package for the Social Sciences (SPSS) software program, Student Version 20.0. A non-parametric (*Mann–Whitney U*) test was used to test H1 and H3 if the distributions were found to be non-normally distributed. Similarly, a Kruskal–Wallis one-way analysis of variance was used to test H2 if the distributions of the groups were not normally distributed. Further,

ethnicity groups were collapsed to Majority and minority if groups are not appropriately represented.

Results are presented in three discrete sections in Chapter 4. These sections include the Demographic, Detail of Analyses, and Summary of Results sections. The Demographic section includes a profile of participants responding to the survey. The Detail of Analysis section includes a complete breakdown of the analysis conducted by hypothesis including evaluation of appropriate assumptions and final inferential results. The Summary of Results section includes a recap of the study, study design, results by hypothesis and what the reader will find in Chapter 5.

Limitations and Delimitations

Limitations

Although quantitative data are well-organized, they may miss contextual detail. The development of standard questions by the researcher can lead to structural bias and false representation, where data may reflect the researcher's view instead of the subjects'. Results may also provide less detail on behavior, attitudes, and motivation.

While it may be appropriate to apply the results to the population, it may not be an accurate assumption of all caregivers in other parts of the United States. Unknown variables in the study that may impact the outcome of the results of those individuals participating could affect responses. These variables may not be known to the researcher at the time of the study.

Delimitations

This study was delimited to caregivers (nurses) in Franklin County, Mississippi who are at least 18 years of age. They must be nurses who provide health care services

for older people. With an instrument designed specifically for the proposed study, ageism was measured on a Likert-type scale. The scope of the research study addressed the identified hypotheses and did not exceed the theoretical foundation this research study was based.

Threats to Validity

External Validity

A threat to the external validity is research into ageism provides limitless directions. The most demanding issue is collecting data in support of the existence of ageism, establishing prevalence and the need for adjustment at the beginning.

Internal Validity

In the process of conducting these ethical studies and trying to keep the health of subjects who differ very much in their quantities, is always an affair. Threats to the internal validity is frequent, high dropout rates results from illness, disability, or death and preserving the validity to find cross-sectional studies in light of cohort inconsistencies is alarming. Although the difficulties of conducting this research is a problem all by itself, it is also factor in the ability to quickly build bodies of research. In order to create an acceptable development toward an explanation, which will become an increasingly disturbing problem if left unaddressed, geriatrics must devote more time to countless quality studies.

Ethical Procedures

The risk level to participants was minimal. Ethical considerations include the participant's right to anonymity. No personal identifying information was used during the

data collection. Prior to data analysis, each participant's survey answers were coded numerically to prevent identification of the participant.

An additional ethical consideration was voluntary participation. Participants were informed about the study and its purpose. The researcher explained both the benefits of the study and any potential risks. The researcher also clearly indicated participation is voluntary and participants are not required to participate if they feel uncomfortable in any way.

Summary

This quantitative study was designed to explore the differences in nurses' attitudes about ageism, based on their gender, ethnicity, age, and years of experience as a nurse. The research methodology that was used to accomplish this purpose is described in this section. Additionally, the proposed sample, data collection procedures, and data interpretation/analysis are described in this chapter. Finally, ethical considerations are addressed to ensure confidentiality and protection of participants.

Chapter 4: Results

Introduction

This type of test allowed me to compare means across two or more independent groups to determine if they differed, provided that the dependent variable was scaled at the interval or ratio level. The purpose of this quantitative, non-experimental study was to explore the difference between nurses' ageism attitudes relative to their gender, ethnicity, age, or years of experience. A quantitative research methodology was appropriate for this study, and numerical data was analyzed using an Analysis of Variance (ANOVA) test. A non-experimental design was therefore appropriate to compare means across two or more independent groups. This chapter was used to discuss the process and information related to the study.

Data Analysis Procedure

Inferential statistics were used to draw conclusions from the sample tested. The Statistical Package for the Social Sciences (SPSS) was used to code and tabulate scores collected from the survey and provide summarized values where applicable. These values included the mean, central tendency, variance, and standard deviation. Demographic statistics were provided including count and percent statistics. Reliability analysis was conducted on the dependent variable. Analyses of variance (ANOVA) were used to evaluate four research questions. The research questions were,

RQ1: Is there a difference in nurses' attitudes toward ageism between nurses' age groups (18-34, 35-54, 55+)?

RQ2: Is there a difference in nurses' attitudes toward ageism between nurses' ethnicity groups (European American, African American, Hispanic, and Asian American)?

RQ3: Is there a difference in nurses' attitudes toward ageism between nurses' genders (male, female)?

RQ4: Is there a difference in nurses' attitudes toward ageism between levels of nursing experience (≤5, >5)?

Table 2

Summary of Variables and Statistical Tests Used to Evaluate Research Questions 1-4

Research question	Dependent variable	Independent variable	Test
1	Nurses' attitudes toward ageism	Age	ANOVA
2	Nurses' attitudes toward ageism	Ethnicity	ANOVA
3	Nurses' attitudes toward ageism	Gender	ANOVA
4	Nurses' attitudes toward ageism	Nursing experience	ANOVA

Prior to analyzing the four research questions, data cleaning and data screening were undertaken to ensure the variables of interest met appropriate statistical assumptions. Thus, the following analyses were assessed using an analytic strategy in that the variables will be first evaluated for univariate outliers, normality, and homogeneity of variance. Subsequently, four ANOVAs were run to determine if any significant differences existed between variables of interest.

Demographics

Data were collected from a sample of 62 caregivers from Franklin County, Mississippi. Thirteen participants were male (21.0%) and 49 were female (79.0%). Additionally, 32% of participants were 18-34 years old (n = 20), 52% were 35-54 years old (n = 32), and 16% were 55 years or older (n = 10). Nine participants were European

American (14.5%), while the remaining 53 participants were African American (85.5%). Furthermore, 39% had less than five years of nursing experience (*n* = 24), 60% had five or more years of experience (*n* = 37), and one participant (case #10) did not provide a response. Displayed in Table 3 are frequency and percent statistics of participants' gender, age, ethnicity, and years of nursing experience.

Table 3

Frequency and Percent Statistics of Participants' Gender, Age, Ethnicity, and Years of Nursing Experience

Demographic	Frequency	Percent
Gender		
Male	13	21.0
Female	49	79.0
Age		
18-34 years	20	32.3
35-54 years	32	51.6
55 years and older	10	16.1
Ethnicity		
European American	9	14.5
African American	53	85.5
Years of experience		
Less than or equal to 5 years	24	38.7
More than 5 years	37	59.7
Missing	1	1.6

Reliability Analysis

Reliability analysis was run to determine if the dependent variable, nurses' attitudes about ageism, was sufficiently reliable. Nurses' attitude about ageism was measured by eight items on the *Age Based Rejection Sensitivity Questionnaire* (RSQ-Age). Reliability analysis allows one to study the properties of measurement scales and the items that compose the scales (Tabachnick & Fidell, 2007). Cronbach's alpha

reliability analysis procedure calculates a reliability coefficient that ranges between 0 and 1. The reliability coefficient is based on the average inter-item correlation. Scale reliability is assumed if the coefficient is ≥.60. Results from the test found that the variable construct was sufficiently reliable, *Cronbach's alpha* (n = 62) = .690. Thus, the assumption was not violated and the eight items on the RSQ-Age were used to measure the dependent variable for Research Questions 1-4.

Analyses of Research Questions 1-4

Research Questions 1-4 were evaluated using analyses of variance (ANOVA) to determine if any significant differences in nurses' attitudes about ageism existed between age groups, ethnicities, gender, and years of nursing experience. The dependent variable was nurses' attitudes about ageism, as measured by eight items on the RSQ-Age. Response parameters were measured on a 6-point Likert-type scale where 1= *strongly disagree*, 2 = *disagree*, 3 = *slightly disagree*, 4 = *slightly agree,* 5 = *agree*, and 6 = *strongly agree*. Composite scores were calculated for each participant by averaging case scores across the eight items of the RSQ-Age; composite scores were used as the dependent variable for Research Questions 1-4. The independent variables for Research Questions 1-4 were age groups (18-35, 36-55, and 55+), ethnicities (European American and African American), gender (male and female), and years of nursing experience (≤5 years, >5 years), respectively.

Data Cleaning

Before the research question was evaluated, the data were screened for missing data and univariate outliers. Missing data were investigated using frequency counts and two cases existed. Specifically, one participant (case #6) did not respond to the question

measuring nursing experience and was removed from the analysis of Research Question 4. The second missing case (case #10) did not respond to one item on the RSQ-Age and had the missing score replaced by the survey item's series mean as to retain as many participants as possible. Therefore, case #10 was included in the analyses of Research Questions 1-4.

The data were screened for univariate outliers by transforming raw scores (leadership quality) to z scores and comparing z scores to a critical value of +/- 3.29, $p < .001$ (Tabachnick & Fidell, 2007). The z scores that exceed this critical value are more than three standard deviations away from the mean and thus represent outliers. The distributions were evaluated and one case with a univariate outlier was found and removed from the analyses. Thus, 62 responses from participants were received, 61 were evaluated for Research Questions 1-3 ($n = 61$), and 60 were evaluated for research question 4 ($n = 60$). Descriptive statistics for nurses' attitudes about ageism scores are displayed in Table 4 by age groups, ethnicities, gender, and years of nursing experience.

Table 4

Descriptive Statistics of Nurses' Attitudes Toward Ageism by Age Groups, Ethnicity, Gender, and Nursing Experience

Nurses' attitudes towards ageism	*n*	Min	Max	Mean	Std. deviation	Skewness	Kurtosis
Age							
18-34 years	20	3.000	5.375	4.369	0.576	-0.719	0.460
35-54 years	31	2.375	6.000	4.464	0.764	-0.570	0.828
55 years and older	10	2.125	5.000	3.850	0.957	-0.675	-0.204
Ethnicity							
European American	9	3.000	4.625	4.181	0.512	-1.660	3.470
African American	52	2.125	6.000	4.358	0.799	-0.770	0.779
Gender							
Male	12	2.125	5.250	3.990	1.033	-0.739	-0.649
Female	49	2.500	6.000	4.416	0.668	-0.329	0.617
Nursing experience							
Less than or equal to 5 years	23	2.125	6.000	4.054	0.896	-0.237	0.439
More than 5 years	37	2.500	5.625	4.476	0.616	-0.960	1.788

Test of Normality

Before Research Question 1 was analyzed, basic parametric assumptions were assessed. That is, for the dependent variable (attitudes about ageism), assumptions of normality and homogeneity of variance were tested. To test if the distributions were significantly skewed, the skew coefficients were divided by the skew standard error, resulting in a z-skew coefficient. This technique was recommended by Tabachnick and Fidell (2007). Specifically, *z*-skew coefficients exceeding the critical range between -3.29 and +3.29 ($p < .001$) may indicate non-normality. Thus, based on the evaluation of the z-skew coefficients, no distributions exceeded the critical range. Kurtosis was also evaluated using the same method and no distributions were found to be significantly kurtotic. Therefore, the distributions were assumed to be normally distributed. Displayed

in Table 5 are skew and kurtosis statistics of nurses' attitudes about ageism scores by age groups, ethnicities, gender, and years of nursing experience.

Table 5

Skew and Kurtosis Statistics of Nurses' Attitudes Towards Ageism by Age Groups, Ethnicity, Gender, and Nursing Experience

Nurses' attitudes towards ageism	*n*	Skewness	Skew std. error	z-skew	Kurtosis	Kurtosis std. error	z-kurtosis
Age							
18-34 years	20	-0.719	0.512	-1.404	0.460	0.992	0.464
35-54 years	31	-0.570	0.421	-1.354	0.828	0.821	1.009
55 years and older	10	-0.675	0.687	-0.983	-0.204	1.334	-0.153
Ethnicity							
European American	9	-1.660	0.717	-2.315	3.470	1.400	2.479
African American	52	-0.770	0.330	-2.333	0.779	0.650	1.198
Gender							
Male	12	-0.739	0.637	-1.160	-0.649	1.232	-0.527
Female	49	-0.329	0.340	-0.968	0.617	0.668	0.924
Nursing experience							
Less than or equal to 5 years	23	-0.237	0.481	-0.493	0.439	0.935	0.470
More than 5 years	37	-0.960	0.388	-2.474	1.788	0.759	2.356

Homogeneity of Variance

Levene's Test of Equality of Error Variance was run to determine if the error variance of the dependent variable (attitudes about ageism) were equal across levels of the independent variables (age groups, ethnicities, gender, and years of nursing experience). Results from the test indicated that the distributions for males and females did not meet the assumption of homogeneity of variance, $F(1, 59) = 5.371$, *sig.* = .024. Since the dependent variable was not equally distributed across genders, a non-parametric Kruskal-Wallis test was conducted to affirm the results from the ANOVA analysis. The remaining independent variables did not violate the assumption of homogeneity of

variance and were assumed to be equally distributed. Displayed in Table 6 are details of the Levene's tests.

Table 6

Levene's Test of Equality of Error Variances for Research Questions 1-4

Research Question	Independent Variable	*F*	df1	df2	Sig.
1	Age	1.142	2	58	.326
2	Ethnicity	2.126	1	59	.150
3	Gender	5.371	1	59	.024*
4	Nursing experience	2.985	1	58	.089

*Distribution violated the assumption of homogeneity of error variance, *sig.* < .050.

Results of Hypothesis 1

$H1_{Null}$: There is no difference in nurses' attitudes toward ageism between nurses' age groups (18-34, 35-54, 55+)

$H1_{Alternative}$: There is a significant difference in nurses' attitudes toward ageism between nurses' age groups (18-34, 35-54, 55+).

Using SPSS 22.0, analysis of variance (ANOVA) was conducted to determine if any significant differences in nurses' attitudes about ageism existed between age groups. Results from the ANOVA test revealed that a significant difference did not exist between age groups (18-34, 35-54, 55+), $F(2, 58) = 2.614$, $p = .082$, *partial eta squared* = .083. Thus, the null hypothesis for Research Question 1 was retained. Although caregivers that were 55 years or older had the lowest mean ageism score ($M = 3.850$, $SD = 0.957$), it was not significantly different than participants between 18 and 34 years old ($M = 4.369$, $SD = 0.576$) or caregivers between 35 and 54 years old ($M = 4.464$, $SD = 0.764$)—see Table 6 in Appendix B for a means plot of nurses' attitudes towards ageism by age groups. Displayed in Table 7 is a model summary of the ANOVA analysis of Hypothesis 1.

Table 7

Test of Between Subjects Effects Derived From ANOVA of Hypothesis 1

Source	Type III Sum of Squares	df	Mean Square	F	Sig.	Partial Eta Squared	Observed Power
Corrected Model	2.888	2	1.444	2.614	.082	0.083	0.501
Intercept	882.511	1	882.511	1597.261	< .001	0.965	1.000
Age	2.888	2	1.444	2.614	.082	0.083	0.501
Error	32.046	58	0.553				
Total	1179.656	61					
Corrected Total	34.934	60					

Dependent Variable: Nurses' attitudes towards ageism, $n = 61$

Results of Hypothesis 2

$H_0 2$: There is no difference in nurses' attitudes toward ageism between nurses' ethnicity groups (European American and African American).

$H_a 2$: There is a significant difference in nurses' attitudes toward ageism between nurses' ethnicity groups (European American and African American).

Analysis of variance (ANOVA) was conducted to determine if any significant differences in nurses' attitudes about ageism existed between ethnicities. Results from the ANOVA test revealed that a significant difference did not exist between ethnicities (European American and African American), $F(1, 59) = 0.412$, $p = .524$, *partial eta squared* = .007. Thus, the null hypothesis for Research Question 2 was retained. That is, European Americans did not have significantly lower attitudes' towards ageism scores ($M = 4.181$, $SD = 0.512$) than African Americans ($M = 4.358$, $SD = 0.799$)—see Table 7 in Appendix B for a means plot of nurses' attitudes towards ageism scores by ethnicities. Displayed in Table 8 is a model summary of the ANOVA analysis of Hypothesis 2.

Table 8

Test of Between Subjects Effects Derived From ANOVA of Hypothesis 2

Source	Type III Sum of Squares	Df	Mean Square	F	Sig.	Partial Eta Squared	Observed Power
Corrected Model	0.242	1	0.242	0.412	.524	.007	.097
Intercept	559.374	1	559.374	951.320	< .001	.942	1.000
Ethnicity	0.242	1	0.242	0.412	.524	.007	.097
Error	34.692	59	0.588				
Total	1179.656	61					
Corrected Total	34.934	60					

Note. Dependent variable: nurses' attitudes towards ageism, $n = 61$.

Results of Hypothesis 3

$H_0 3$: There is no difference in nurses' attitudes toward ageism between nurses' genders (male, female).

$H_a 3$: There is a significant difference in nurses' attitudes toward ageism between nurses' genders (male, female).

Analysis of variance (ANOVA) was conducted to determine if any significant differences in nurses' attitudes about ageism existed between males and females. Results from the ANOVA test revealed that a significant difference did not exist between gender, $F(1, 59) = 3.114$, *sig.* = .083, *partial eta squared* = .050. Similar results were found from the non-parametric Kruskal-Wallis test, $\chi^2(1, n = 61) = 1.093$, *sig.* = .296. Thus, the null hypothesis for Research Question 3 was retained. That is, male caregivers did not have significantly lower attitudes' towards ageism scores ($M = 3.990$, $SD = 1.033$) than females ($M = 4.416$, $SD = 0.668$)—see Table 8 in Appendix B for a means plot of nurses' attitudes towards ageism scores by gender. Displayed in Table 9 is a model summary of the ANOVA analysis of Hypothesis 3.

Table 9

Test of Between Subjects Effects Derived From ANOVA of Hypothesis 3

Source	Type III Sum of Squares	Df	Mean Square	F	Sig.	Partial Eta Squared	Observed Power
Corrected Model	1.751	1	1.751	3.114	.083	.050	.411
Intercept	681.027	1	681.027	1210.890	< .001	.954	1.000
Gender	1.751	1	1.751	3.114	.083	.050	.411
Error	33.183	59	0.562				
Total	1179.656	61					
Corrected Total	34.934	60					

Note. Dependent variable: nurses' attitudes towards ageism, $n = 61$.

Results of Hypothesis 4

$H_0$4: There is no difference in nurses' attitudes toward ageism between levels of nursing experience (≤5, >5).

H_a4: There is a significant difference in nurses' attitudes toward ageism between levels of nursing experience (≤5, >5).

Analysis of variance (ANOVA) was conducted to determine if any significant differences in nurses' attitudes about ageism existed between levels of nursing experience. Results from the ANOVA test revealed that a significant difference did exist between levels of nursing experience (≤5, >5), $F(1, 58) = 4.680$, *sig.* = .035, *partial eta squared* = .075. Thus, the null hypothesis for Research Question 4 was rejected in favor of the alternative hypothesis. That is, caregivers with less than, or equal to five years of nursing experience had significantly lower attitudes' towards ageism scores ($M = 4.054$, $SD = 0.896$) than those with more than five years of experience ($M = 4.476$, $SD = 0.616$)—see Table 9 in Appendix B for a means plot of nurses' attitudes towards ageism scores by levels of nursing experience. Displayed in Table 10 is a model summary of the ANOVA analysis of Hypothesis 4.

Table 10

Test of Between Subjects Effects Derived from ANOVA of Hypothesis 4

Source	Type III Sum of Squares	df	Mean Square	F	Sig.	Partial Eta Squared	Observed Power
Corrected Model	2.526	1	2.526	4.680	.035	.075	.567
Intercept	1032.161	1	1032.161	1912.509	< .001	.971	1.000
Nursing experience	2.526	1	2.526	4.680	.035	.075	.567
Error	31.302	58	0.540				
Total	1150.766	60					
Corrected Total	33.828	59					

Note. Dependent variable: nurses' attitudes towards ageism, $n = 60$.

Summary

An analyses of variance (ANOVA) was used to answer the research questions. The purpose of the design was to determine if any significant dissimilarity in nurses' attitudes about ageism existed between age groups, ethnicities, gender, and years of experience.

A non-random sample was extracted from 62 caregivers who resided in Southern Mississippi and who had less than, or equal to, five years' experience or more than five years' experience. The sample was obtained from nurses that were employed at: (a) convalescent homes, (b) family caregivers, (c) home health aides, (d) adult day care centers, and (e) skilled nursing. A table of frequency and percent statistics of participants' sex, age, ethnicity, and years of experience was used for the initial sampling point. Every person's attitude was measured by 8-items on the Age Based Rejection Sensitivity Questionnaire (RSQ-Age).

The summary of the results for Research Questions 1-4 showed a profile of the participants responding to the survey. The detailed analysis included a complete

breakdown of the analysis conducted by hypothesis including evaluation of appropriate assumptions and final inferential results.

Table 11

Summary of Results for Research Questions 1-4

Research Question	Dependent Variable	Independent Variable	Test	Sig.
1	Nurses' attitudes toward ageism	Age	ANOVA	.082
2	Nurses' attitudes toward ageism	Ethnicity	ANOVA	.524
3	Nurses' attitudes toward ageism	Gender	ANOVA	.083
4	Nurses' attitudes toward ageism	Nursing experience	ANOVA	.035

Findings will be presented in three discrete sections in Chapter 5. These sections include the Interpretation of the Findings, Limitation of the Study, and Summary of Findings sections. Chapter 5 will provide the recap of the study, the study design, results by hypothesis, along with recommendations for future research, and implementations.

Chapter 5: Summary, Conclusions, and Recommendations

Introduction

Ageism is the discrimination against, abuse, stereotyping, contempt for, and avoidance of older people (Nelson, 2005). Age discrimination like racism, sexism, and are present within any society. While the population of elderly in the United States continues to climb, the health care system may fail to maintain quality of care well into old age. Numerous factors lead to differences in the quality of care received by the young and that of the elderly.

The reviewed literature showed that ageism practices are prevalent in many parts of society, including the workplace. Ageism practices are found to be very prevalent in many parts of society, including the workplace. Furthermore, the research has indicated it exists in all professions, including healthcare, in the forms of personal ageism, institutional ageism, internal ageism, and unintentional ageism (Dennis & Thomas, 2007). Studies also indicate that ageism can be remediated with interventions designed to sensitize people to its negative effects.

Summary of Findings

In this study, 62 caregivers from Franklin County, Mississippi who provide services for elderly people were surveyed. Data was entered into the Statistical Package for the Social Sciences (SPSS 22) and were then tested using analyses of variance (ANOVA) to evaluate the four research hypotheses. Results of the research hypotheses are summarized below. The research hypotheses were

$H_0 1$: There is no difference in nurses' attitudes toward ageism between nurses' age groups (18-34, 35-54, 55+)

H_a1: There is a significant difference in nurses' attitudes toward ageism between nurses' age groups (18-34, 35-54, 55+).

H_02: There is no difference in nurses' attitudes toward ageism between nurses' ethnicity groups (European American and African American).

H_a2: There is a significant difference in nurses' attitudes toward ageism between nurses' ethnicity groups (European American and African American).

H_03: There is no difference in nurses' attitudes toward ageism between nurses' genders (male, female).

H_a3: There is a significant difference in nurses' attitudes toward ageism between nurses' genders (male, female).

H_04: There is no difference in nurses' attitudes toward ageism between levels of nursing experience (≤5, >5).

H_a4: There is a significant difference in nurses' attitudes toward ageism between levels of nursing experience (≤5, >5).

Table 12

Summary of Variables and Statistical Tests Used to Evaluate Research Hypotheses 1-4

Research question	Dependent variable	Independent variable	Test	Sig.
1	Nurses' attitudes toward ageism	Age	ANOVA	.082
2	Nurses' attitudes toward ageism	Ethnicity	ANOVA	.524
3	Nurses' attitudes toward ageism	Sex	ANOVA	.083
4	Nurses' attitudes toward ageism	Nursing experience	ANOVA	.035

Results of Hypotheses 1-4

Analyses of variance (ANOVA) was conducted to determine if any significant differences in nurses' attitudes about ageism existed between age groups, ethnicities,

genders, and years of nursing experience. Results from the ANOVA tests revealed a significant difference did exist between levels of nursing experience (*p* = .035). Thus, the null hypothesis for research question 4 was rejected in favor of the alternative hypothesis. That is, caregivers with less than five years of nursing experience had significantly lower attitudes' towards ageism scores (*M* = 4.054) than those with five or more years of experience (*M* = 4.476). Results from hypotheses 1-3 found no significant differences existed between age groups (*sig.* = .082), ethnicities (*sig.* = .524), or gender (*sig.* = .083).

Conclusions and Implications

Medical ageism is omnipresent and may continue to persist in the current healthcare system. There are several reasons why this type of discrimination exists in the healthcare system. In light of these reasons, the research question raised was: How are nurses' attitudes about ageism affected by nurses' age, ethnicity, and/or gender. Thus, the focus of this quantitative study was to identify differences in attitudes of nurses about ageism and their demographic characteristics. Research suggests that demographic characteristics may impact nurses' attitudes about ageism. Our findings, indeed, partially support this research in that nurses' experience was found to be a relevant factor.

Specifically, although age of nurse did not significantly affect nurse's attitudes toward ageism at the $p < .05$ level, the probability of error was within a 10% margin at .082. This finding suggests that a larger sample size would likely produce a significant affect. Caregivers that were 55 years or older were found to have the lowest mean ageism score (*M* = 3.850), while caregivers between 18 and 34 years old had the second highest average ageism score (*M* = 4.369), and caregivers between 35 and 54 years old produced the highest mean ageism score (*M* = 4.464). These facts imply that older nurses may be

more compassionate and caring toward the elderly and are able to identify better with the group. In contrast, these findings may also imply that middle aged nurses may need more training or additional mentoring to improve attitudes toward elderly patients.

Findings from the study also revealed that gender was not significant at $p < .05$, but was significant at $p < .10$. This implies that a slightly larger sample size may yield a significant difference in ageism attitudes between males and female nurses. As suggested by findings, male nurses were more tolerant of older patients compared to female nurses. This finding was surprising given the maternal characteristics associated with the female gender.

Findings also revealed that less experienced nurses were observed to have lower ageism scores compared to more experienced nurses. As such, institutions may want to increase their proportion of less experienced nurses to help improve care to the elderly. However, many younger generation nurses prefer working for hospitals (med-surg), clinical medicine, or pediatrics. In contrast, older, more experienced nurses often consider nursing home work when they can no longer keep up with the physical demands of hospital/peds work. That said, there is the possibility that higher ageism among older/more experienced nurses may be a manifestation of higher job stress or burnout.

Limitations

Several limitations were encountered that are inherent to this type of study including self-reporting bias and application of results to population (the sample tested may not accurately reflect the overall population). Another limitation was the difficulty of obtaining participants that met the inclusion criteria. For example, there are proportionally fewer male nurses compared to female nurses. The difference in sheer

numbers makes it considerable more difficult to find a sufficient number of male nurses willing to participate in the study. This fact may have had an impact on results.

Recommendations for Further Research

Many gerontologist assert that medical schools are starting points for many ageist views; and for this reason should be the focus to fight against ageism. It is apparent that if there are no changes in the education of health care providers, ageism will persist and older patients will sometimes receive poor-quality treatment. There must be a joint effort between the healthcare system and medical schools, if older patients are going to get better care, as they affect each other. If gerontology is going to get any better there must be some help from related fields. Another recommendation for future research would be to survey the same group of nurses with job stress or burnout inventories to see if that could be related to the higher rates of ageism. Thus, one might ask the question: What is the relationship between job stress and ageism in nurses?

Recommendations for Practice

Studies done on ageism indicate a significant problem in the healthcare field. Most of the problems come from not being able to uncover information that support the fact that ageism is real and that change needs to be top priority. Information from medical school students suggest that commitment to the field yields ageist attitudes. Many other factors also cause problems for the aged in the healthcare system, a lot which do not get attention. To put it simply, there needs to more attention paid to ageism in the field of gerontology.

Summary

Ageism is a serious problem in the healthcare industry and practice has yet to consider it as a serious issue. Most of the problems related to lack of information available to industry and research. Although the field of gerontology has been established for thirty years, the field of has yet to focus on ageism in the health care system. Findings from this study support the proposition that nurses experience affects attitudes toward ageism. Based on this, the field of geriatrics should provide more support to researchers to discover the depth and breadth of the problem. Further, researchers should put more time into quality studies, in order to move closer to a solution. If left alone, ageism will continually be a troublesome problem.

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Appendix A: Demographic Survey

1. What is your sex?
    a. Male
    b. Female
2. What is your ethnicity
    a. European American
    b. African American
    c. Hispanic
    d. Asian American
    e. Other
3. What is your age group?
    a. 18-34 years
    b. 35-54 years
    c. 55 + years
4. How many years of experience do you have as a nurse?
    a. Less than 5 years' experience
    b. 5 years' experience or more

Appendix B: Age Based Rejection Sensitivity Questionnaire (RSQ-Age)

1. Older persons are usually outdated in their work skills.

Strongly Disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree
1	2	3	4	5	6

2. Older people are usually productive workers.

Strongly Disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree
1	2	3	4	5	6

3. Older workers bring skills and expertise to jobs which younger members do not provide.

Strongly Disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree
1	2	3	4	5	6

4. Older workers are being recruited on their ability and experience alone.

Strongly Disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree
1	2	3	4	5	6

5. Older workers are usually sacked without warning so that employers can keep their workforce youthful.

Strongly Disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree
1	2	3	4	5	6

6. Older workers are usually not competent to participate in the development of his or her medical care like younger patients.

Strongly Disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree
1	2	3	4	5	6

7. Older workers bring solid performance, basic skills, and getting along with coworkers which younger people do not provide.

Strongly Disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree
1	2	3	4	5	6

8. Older workers are usually an employer's last choice.

Strongly Disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree
1	2	3	4	5	6

Appendix C: Informed Consent Form

The study is being completed by Stephanie Cameron who is a doctoral student in Public Health at Walden University working on a dissertation. This study is a requirement to fulfill the researcher's degree and will not be used for decision-making by an organization.

You are invited to volunteer in this research. The purpose of the research is to examine ageism in the healthcare sector. Your participation in this study is completely voluntary. If you participate, you will be asked to complete a 10-minute questionnaire. The following three questions represent a sample of the questions you will be asked on the survey:

1. Older persons are usually outdated in their work skills.
2. Older people are usually productive workers.
3. Older workers bring skills and expertise to jobs which younger members do not provide.

You may withdraw at any time during the study. Your participation is completely voluntary. If you choose to withdraw, your data will be removed from the study. Your decision about whether to participate or discontinue participating will not jeopardize your future relations with Walden University. You can do so without fear of penalty or negative consequences of any kind.

The information you provide will be treated confidentially, and all data will be kept securely. The documentation will be stored in a bank safe deposit box registered only to Stephanie Cameron. Results of the research will be reported as summary data only, and no individually identifiable information will be presented. All information obtained will be held with the strictest confidentiality. All recorded information will be stored securely for five years. At the end of five years, all recorded data and other information will be deleted and all written data will be shredded.

There are no risks associated with the study and there is no direct or immediate personal benefit to you from your participation in this research, except for the contribution to the study.

For the professional audience, the potential benefit of this research will contribute additional knowledge to the literature on ageism in the healthcare sector. There are no benefits for any participants for participating in the study. Participants will not receive any monetary compensation for participating in study.

Participants have the right to review the results of the research if they wish to do so. A copy of the results may be obtained by sending Stephanie Cameron an email. Stephanie Cameron's address is: stephanie_cmrn@yahoo.com or by phone 601-384-1708. Should participants have any questions about the research they may contact Stephanie Cameron at stephanie_cmrn@yahoo.com or by phone 601-384-1708 or you may contact my dissertation Chairman, Dr. John Nemecek at john.nemecek@waldenu.edu. If participants have specific concerns or questions about their rights as participants, they may contact the Walden University IRB at irb@waldenu.edu.

By taking this survey you agree to the terms of the consent form.

Appendix D: Research Tool Permission Letter

Subject:	Re: Permission Letter Instrument/Stephanie Cameron
From:	Alison Chasteen (chasteen@psych.utoronto.ca)
To:	stephanie_cmrn@yahoo.com;
Date:	Thursday, November 14, 2013 8:47 AM

Dear Stephanie:
I give you permission to use our Age-Based Rejection Sensitivity Questionnaire with no restrictions. It is a published scale that is available in the public domain and you are permitted to have full access to it for your research purposes.

Alison Chasteen

Alison Chasteen
Associate Professor
Department of Psychology
University of Toronto
100 St. George Street
Toronto, ON Canada M5S 3G3

Voice 416.978.3398
Fax 416.978.4811
Web www.psych.utoronto.ca/~chasteen

Appendix E: Recruitment Form

The study is being completed by Stephanie Cameron who is a doctoral student in Public Health at Walden University working on a dissertation. This study is a requirement to fulfill the researcher's degree and will not be used for decision-making by an organization.

You are invited to volunteer in this research. The purpose of the research is to examine ageism in the healthcare sector. Your participation in this study is completely voluntary. If you participate, you will be asked to complete a 10-minute questionnaire.

You may withdraw at any time during the study. Your participation is completely voluntary. If you choose to withdraw, your data will be removed from the study. You have the right to review the results of the research if you wish to do so. A copy of the results may be obtained by contacting Stephanie Cameron at email address stephanie_cmrn@yahoo.com or by phone 601-384-1708. Should you have any concerns or questions, you may contact the Walden University IRB at irb@waldenu.edu.

Please forward the following link to other caregivers that you feel would be willing to participate in this study. Your contribution is greatly appreciated.

Warmly,

Stephanie Cameron

Appendix F: Means—Nurses' Attitudes Toward Ageism

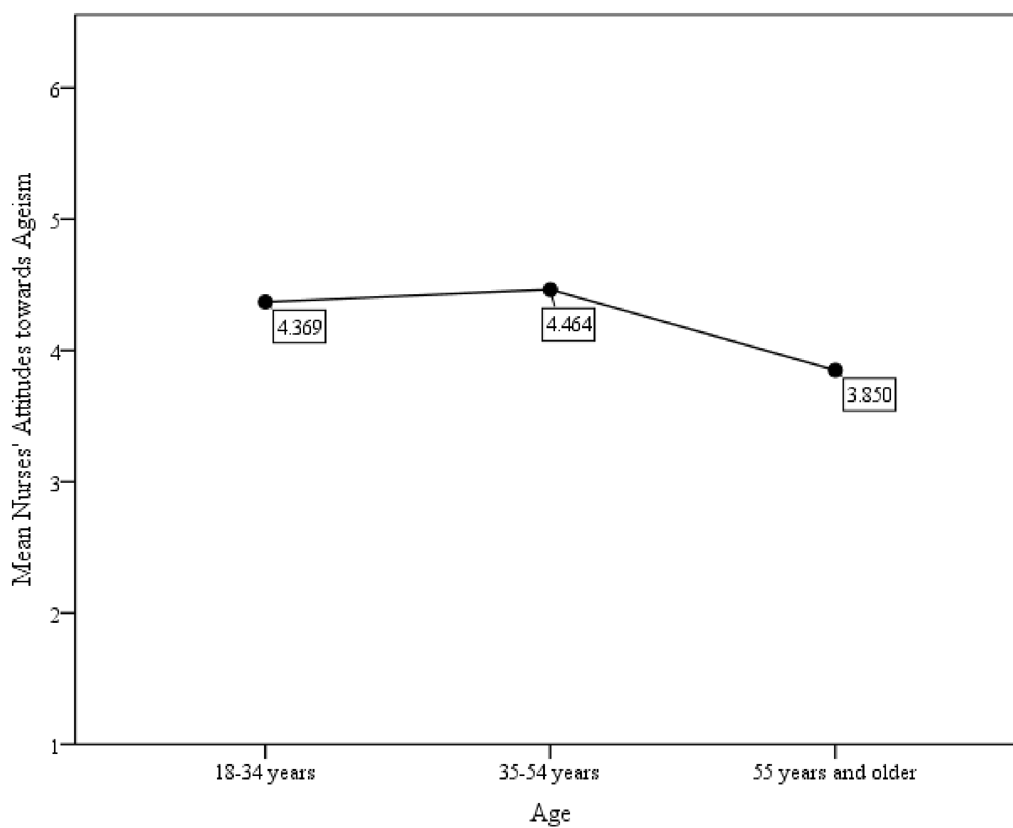

Figure F1. Means plot of nurses' attitudes about ageism by age group.

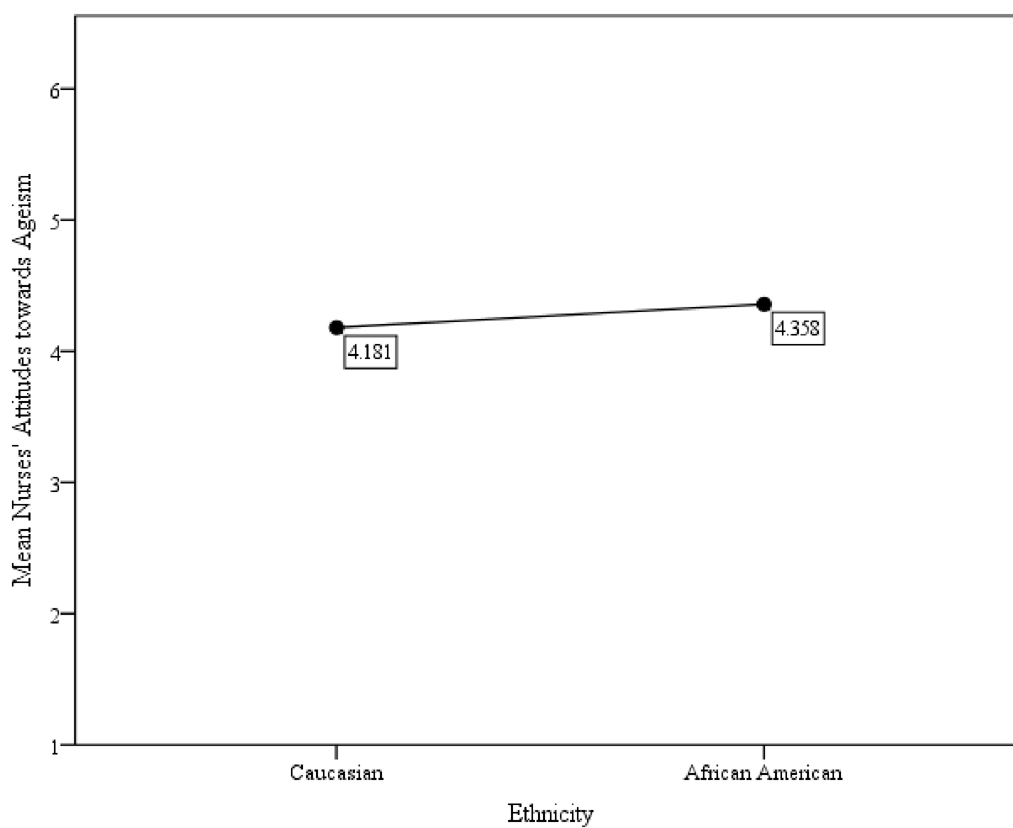

Figure F2. Means plot of nurses' attitudes about ageism by ethnicity.

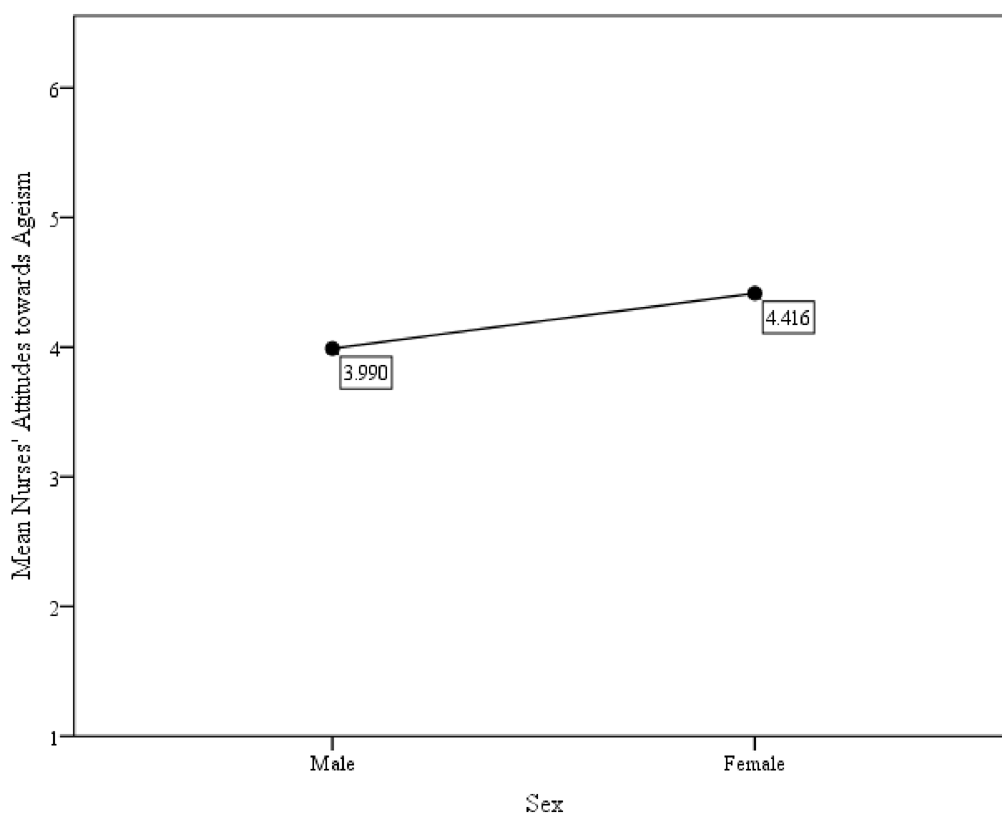

Figure F3. Means plot of nurses’ attitudes about ageism by sex.

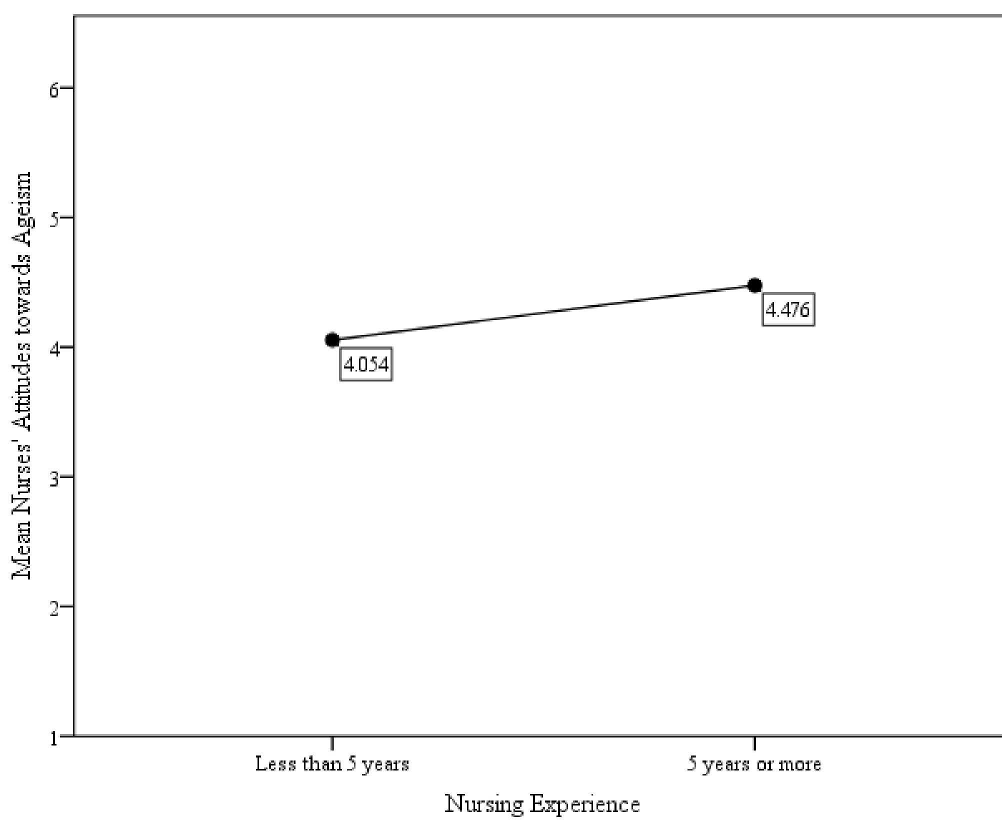

Figure F4. Scatterplot of nurses' attitudes about ageism by nursing experience.