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AGEISM:
AN EXPLORATION OF SOCIAL WORKERS' ATTITUDES TOWARD PSYCHOLOGICAL SERVICES FOR ELDERS

by

Anita L. Raymond-Wrage

A Thesis
Submitted to the Graduate Faculty
of
Augsburg College
in Partial Fulfillment of the Requirements
For the Degree
Master of Social Work

Minneapolis, Minnesota
May, 1994

MASTER OF SOCIAL WORK
AUGSBURG COLLEGE
MINNEAPOLIS, MINNESOTA

CERTIFICATE OF APPROVAL

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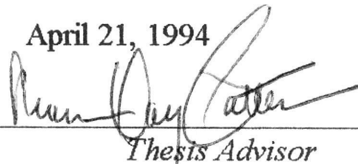

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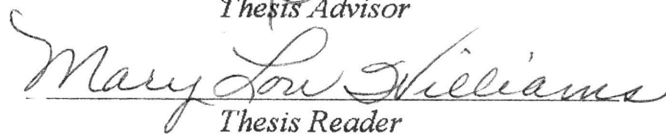

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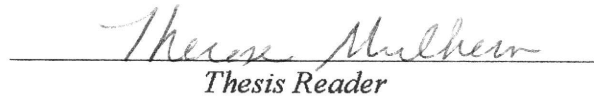

Thesis Reader

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I would not have had the courage to undertake this endeavor without the love and patience of my husband, Ty. He was there for me when I needed him, left when I needed quiet to study, and when the going got tough, he reminded me that "it's grad school, Anita, not a walk in the park".

This study is dedicated to all of these very important people, and to Gladys, who inspired me to study this subject.

ABSTRACT

**AGEISM:
AN EXPLORATION OF SOCIAL WORKERS'
ATTITUDES TOWARD
PSYCHOLOGICAL SERVICES
FOR ELDERS**

A Quantitative Study
by
Anita L. Raymond-Wrage
Spring, 1994

This study sought to explore the value placed on psychological services for elders by social workers. Previous research indicates that psychologists, psychiatrists, physicians and other professionals are biased against the effectiveness of psychological services for older people. Because social workers for elders are often the source of referrals for other types of service provision to meet the needs of older adults, the social worker's ability to recognize depression and to understand the appropriateness of services such as psychotherapy, couples, group, and family therapy is necessary to ensure all the needs of the older adult are met.

By responding to a client vignette, social workers in the Twin Cities showed some discrepancy in their consideration of an older client versus a younger client in the areas of the importance of organic impairment to a client's current situation, and in the types of service preferred to assist the client. Psychotherapy was more often the intervention of choice for a younger client than for an older client. However, many social workers did express support for the provision of psychotherapy for an older client, and most social workers were able to recognize symptoms of depression, without confusing such symptoms with dementia.

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I. INTRODUCTION

Psychological therapy specifically with elders is a topic not often discussed within community service agencies, academia, and the literature, compared to therapy for other age groups. This void may be a result of a number of factors, including a focus on social service delivery and caregiver services rather than a continuum of services which includes therapeutic interventions. Another possible reason is lack of support for the provision of such interventions due to bias against elders.

"Like everyone else...social workers hold certain biases and prejudices toward various individuals and groups, and these individual predispositions may affect the outcome of intervention and the type of treatment provided" (Kosberg & Harris, 1978, p. 70). Based on these biases, social workers and other mental health professionals may neglect or purposefully avoid the provision of mental health and other services to elders (Bernstein, 1990; Garfinkel, 1975; Kastenbaum, 1963; Steuer, 1982).

According to Butler (1975), much of the stereotyping and myths about old age can be partially attributed to both a lack of knowledge about, and personal contact with, older people. However, he feels, a deep and profound prejudice against elders also exists, and, in 1968 he described this prejudice as "ageism". Ageism is pervasive in this culture's language (Covey, 1988; Nuessel, 1982), literature (Donow, 1994), media portrayals, and even in the very systems which purport to assist and advocate for elders. The latter usually occurs inadvertently, through paternalistic and overprotective views of elders (Cohen, 1988; Kalish, 1979) and through the nature of the work with older adults. Because professionals tend to only come in contact with elders who are frail, disabled, and/or need assistance to function, they may overgeneralize that such

conditions are applicable to all elders (Palmore, 1980), not being cognizant of the majority of elders who are going about the business of living anonymously outside the network of formal service provision.

According to Butler, ageism has the following features:

> 1) Prejudicial attitudes toward the aged, toward old age, and toward the ageing process, including attitudes held by the elderly themselves; 2) discriminatory practices against the elderly, particularly in employment, but in other social roles as well; and 3) institutional practices and policies which, often without malice, perpetuate stereotypic beliefs about the elderly, reduce their opportunities for a satisfactory life and undermine their personal dignity (Butler, 1980, p. 8).

To this definition this writer would add the lack of knowledge or accessibility to education about elders and their needs as another part of ageism. It is this writer's concern that as a result of ageism, older clients are perceived as helpless and hopeless and that their spiritual, social, sexual, psychological, educational, and medical needs may not be met. For the purposes of this study, however, this writer is interested in the existence of ageism in social service providers, and the implications of such ageism in service provision and referrals for psychological services.

When one considers the formal service provision of services to elders, needs related to illness and frailty of the older adult often come to mind. For example, it may be safe to say that most people would expect the provision of adult day health centers and senior centers, home delivered meals, homemaker and home health services, medical care including physician and nursing, and residential services. This writer,

however, ponders the lack of psychological services offered to older adults who may be receiving a myriad of other services.

A review of the literature finds support for the provision of mental health services to elders including individual, family and group therapy from cognitive and insight perspectives (Bernstein, 1990; Capuzzi, Gross, & Friel, 1990; Chodorkoff, 1990; Gallagher & Thompson, 1983; Genevay, 1990; Ganote, 1990; Florsheim & Herr, 1990; Kitwood & Bredin, 1992; Oberleder, 1966; Phan & Reifler, 1988; Schlossberg, 1990; Sherman, 1979; Waxman, Carner & Klein, 1984). Yet, in much of the gerontological literature, it appears that older adults with personal problems can best be helped by dealing not with the elders themselves, but with their formal and informal support resources. Case management, peer counseling and some groups are offered, but psychotherapy seems to be viewed as more appropriate for younger populations (Bernstein, 1990).

The neglect of the psychological needs of elders is significant. Gurland and Cross estimate that 15% to 20% of all older people are in need of mental health services (cited in Ray, et al, 1987), yet, according to Santos and VanderBos, of those people 65 years of age or older, less than 3% receive mental health services from psychologists (cited in Ray, et al, 1987).

The cost to society is also significant. Findings have indicated that those older adults who have received psychotherapy exhibited the tendency to use hospital and physician services for medical issues to a lesser degree than older adults who have received no psychotherapy (Hartman and Lazarus, 1992). Put in terms of social costs, availability and accessibility to therapy could bring substantial savings to the budgets of Medicare and Medicaid, two of the primary payors of health service costs for elders.

Further, the types of mental health services received by older adults tend to be different from those received by younger people. Perhaps because of a lack of support for counseling (earlier intervention) for elders with mental health problems, when older people do receive mental health intervention, according to Knight, services usually consist of inpatient hospitalizations and crisis intervention rather than the ongoing outpatient psychotherapy more commonly associated with younger persons (cited in Reekie & Hansen, 1992).

When medical personnel, social workers, and other mental health workers undervalue the aged and carry ageist attitudes, it is natural that elders who come to these providers with challenges will be inadequately served. On the other hand, when the social worker regards the older adult from a perspective based on the strengths and abilities of elders, one is better able to advocate for the receipt of services that will maximize the potential of each individual. Further, for those older persons who are experiencing difficulties in coping with the tasks associated with this particular developmental stage, appropriate services can be recommended and facilitated to help the older person develop insight and new coping skills and learn to rely on coping skills used at other times of difficulty in their lives.

II. LITERATURE REVIEW

It is common in the literature for authors to discuss barriers to the receipt of mental health services by elders as a function of professionals' inability or unwillingness to recognize a need for these services. At the root of this inability and unwillingness are such issues as countertransference and anxiety about one's own death, death of love ones, death in general and the persistence of belief in older people as having untreatable declines in functioning with poor prognoses (Gaitz, 1974; Greene, 1986a; Sprung, 1989). Countertransference, in its current use, refers to the therapist's emotional reactions to the client (Greene, 1986a) and includes such specifics as death anxiety, medication and hospitalization issues, parental issues, dependence issues, and family intervention issues (Sprung, 1989).

In 1971, the Committee on Aging of the Group for the Advancement of Psychiatry cultivated the following explanations for workers' negative reactions toward the treatment of older adults:

1. The aged stimulate the therapist's fears about his or her own aging.
2. They arouse the therapist's conflicts about his or her relationship with parental figures.
3. The therapist believes he or she has nothing useful to offer old people, because he or she believes they cannot change their behavior or that their problems are all due to untreatable organic brain disease.

4. The therapist believes that his or her psychodynamic skills will be wasted working with the aged because they are near death and not really deserving of attention...

5. The patient might die while in treatment, which might challenge the therapist's sense of importance.

6. The therapist's colleagues may be contemptuous of his or her efforts on behalf of aged patients... (Sprung, 1989, p. 598).

While these may be plausible explanations, it is of greater interest to this writer to explore the extent to which such attitudes, biases, and fears play a part in service delivery to elders. A number of research studies have been undertaken in an attempt to actually measure professionals' attitudes and practices with regard to elders. The findings and implications for further research vary with the research methodology undertaken in any given study.

The majority of research studies regarding ageism, attitudes, and barriers to service for the elderly seem to revolve around two themes: 1) attitudes of the general public and professionals, and 2) professionals' responses to elders based on presented situations.

A. MEASURING ATTITUDES

For decades researchers have been interested in measuring attitudes toward older people; numerous scales have been developed, each intended to identify the existence of stereotypes and biases present in the general population (Ferraro, 1992; Golde and Kogan, 1959; Kilty, & Feld, 1976; Kogan, 1961; Rosencranz, & McNevin, 1969; Tuckman and Lorge, 1953; Weinberger, & Millham 1975). The findings tended

to show the presence of both positive and negative stereotypes of older adults in the attitudes of respondents. Other researchers, also interested in attitudes toward older people, have focused their attention on professional individuals' and groups' attitudes and beliefs. Tuckman and Lorge (1958) compared the attitudes of a group of workers experienced with elders who had undergone an educational series to results of the surveys distributed to varying age groups in the general public. They found that individuals with some contact with elders were slightly less negative in their attitudes toward the elders than was the general population. Hickey et al. (1976) considered attitudes of professionals before and after in-service training, finding that training seemed to result in more positive attitudes toward older adults. Another study sought to analyze how psychiatrists consider older people and their own aging processes; the negative feelings most often identified were impatience, boredom, and resentment toward elderly clients (Cyrus-Lutz and Gaitz, 1972). Roberta Greene considered the topic from a slightly different perspective, choosing to study the social worker's ageism with regard to death anxiety. Findings indicate a greater preference for working with frail older adults in social workers who work with elders, but also a greater level of death anxiety, as compared to social workers who work primarily with other age groups (Greene, 1984).

Other studies also sought to study professional attitudes toward older adults. Brubaker and Barresi (1979) used Palmore's Facts on Aging Quiz to assess social workers' level of knowledge and correlations to their perceptions regarding service delivery to their elderly clients. Findings indicated that knowledge attainment about old age is associated with personal experiences associated with age; however, the authors were unable to show significant differences between less and more knowledgeable

workers in their attitudes toward service delivery and toward the difficulty of providing services to elders as compared to other age groups.

Additional knowledge quizzes have since been developed for the primary purpose of planning and evaluating education programs which are focused on mental health problems in later life (Pratt, et al., 1992); these could also conceivably be used to assess attitudes toward older adults and mental health issues.

Futrell and Jones (1977) also studied multiple groups of professionals, attempting to ascertain the professionals' general attitudes toward the elderly population, identification of health needs and utilization of services, and the relation among these. Interestingly, the younger the physicians and social workers and the older the nurses, the more likely they held positive attitudes toward older adults.

In contrast, Wolk and Wolk, (1971) found that older workers evidence more positive attitudes toward elders. This study used a mailed questionnaire to study respondents' views of what older people are like; which stereotypes respondents were aware of, but not necessarily accepted; and choice of working with older people.

B. MEASURING PROFESSIONALS' RESPONSES TO ELDERS

The second group of studies goes beyond measuring the attitudes of professionals through standardized tests. In some studies, respondents were asked to consider fictitious situations; in others, actual client records were studied. Both types

of measurements sought to describe actual practices professionals may undertake as a function of their attitudes and beliefs.

A number of studies have made use of client vignettes to study professionals' responses to a given situation; most of these studies present respondents in each of two groups with identical vignettes, with the exception of reversing the given age, so that each respondent answers questions based on a younger person and an older person. In studies of the ratings or attitudes of physicians, psychologists and psychiatrists towards older adults, older adults were generally considered to be less ideal and given poorer prognoses for mental health treatment than were younger clients with the same symptoms, and the older adults were less likely to be treated with, or referred for, psychotherapy than younger clients (Ford and Sbordone, 1980; Kucharski, et al, 1979; Ray, et al., 1987). In each of the studies, the authors were concerned with the low rates of use of mental health services by elders. Each notes that while psychiatric difficulties are present in many older adults, the numbers of them receiving such services were comparatively low, due at least in part, to the attitudes of the psychologists and psychiatrists who would serve them.

Similar results were found in studies using methodologies other than client vignettes. Waxman and Carner (1984) interviewed elderly patients and administered standardized tests to reveal any presence of depression and other mental health issues; subsequent interviews with the patients' physicians showed inferior recognition, treatment, and/or referral of their patients for mental health services. Ginsburg and Goldstein (1974) utilized Minnesota Multi-phasic Personality Inventory scores of actual patients to obtain an objective measure of mental difficulties; patients who were referred for psychological services were compared with those who were not. Not

surprising to the researchers, older adults in this hospital setting were less likely to be referred by their physicians for appropriate psychological services than were younger patients.

Similarly, in reviews of psychiatric consultations in university hospitals, two studies found referrals by physicians hampered by the physicians' misdiagnosis or resistance to the value of such services. Ruskin (1985) found that while "depression was present in 36% of the patients, it was noted by the physician for only eight (12%)...In some cases, the referring physician misdiagnosed depression as either normal aging or dementia. In other cases, the physician did not notice the symptoms of depression at all" (p. 335). In another study of patient medical records, physicians refused to refer for psychiatric consultation because "there's nothing wrong psychiatrically...the patient will be upset by seeing a psychiatrist...psychiatry can't help" (Popkin, Mackenzie, & Callies, 1984, p. 706). In yet another study of age bias in physicians, Hillerbrand and Shaw (1989) considered the medical records of a hospital consultation service, finding that sensitivity to suicidality in older adults on the part of physicians was less than with regard to younger patients.

Using tape recorded psychiatric interviews where the age of the client was adjusted for comparative purposes, respondents were asked to provide diagnostic interviews, judgments of the severity and etiology of symptoms, and report the stated age of the client as a "manipulation check" in a study conducted by Perlick & Atkins (1984). Similar to results in other researchers' studies, this one found that elderly patients were judged to be less severely depressed than the same patient when described as middle-aged, suggesting that symptoms of depression are viewed with less concern in the older patient.

Ray et. al (1985), adopted yet another approach to ageism in psychiatrists, in studying whether particular attributes of psychiatrists would determine age bias in their perceptions of prognosis and treatment. Findings demonstrated a greater tendency toward more negative attitudes about elders in psychiatrists who were female, came from a psychoanalytic theoretical orientation, and who were "Board-certified".

Reekie and Hansen (1992) studied the influence of client age on judgments of social workers through the use of vignettes. This descriptive study sought to test a number of hypotheses: that psychotherapy would be less highly ranked as a treatment option for older clients than for younger clients, and medication would be more often recommended for the former. Poorer prognoses and less ideal candidates for therapy was the presumed outcome for older clients, who would be assigned more severe DSM-III-R diagnoses than would younger clients. Finally, it was thought that there "will be an interaction of age and sex in that the older female client will receive the least recommendations for insight-oriented therapy and the most recommendations for medication, and will be viewed as more organic than male or young female clients" (p. 71).

In comparison to studies of other professionals' attitudes, this study showed no age bias on measures of prognosis, impairment, or treatment recommendations; however, the authors caution this finding based on the sample. The mean age of the respondents was only ten years less than the older client of the vignette, which could impact the aggregate description of perceptions of and attitudes about older people. The authors also cite earlier findings by Coccaro and Miles indicating that knowledge about normal aging and personal contacts which are positive are related to more favorable attitudes of older adults. Reekie and Hansen's findings, then, may be the

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product of a sample of social workers who are more knowledgeable about and thus more positively inclined toward the older client. The authors therefore suggest that further study, perhaps a replication of their study, is warranted with a more heterogeneous sample with regard to age, to investigate the age of the clinicians and their attitudes towards older clients.

A study by Brown (1982) of professionals' perceptions of chemical abuse in older adults supports the above findings. The stance taken by Brown is that chemical use and abuse in older adults has been vastly ignored in research and the literature. Interviews were conducted with administrators of drug treatment, health care, and social service agencies providing services to older people. While many administrators considered the problem serious, causes and treatment approaches varied greatly. Further,

> health care practitioners, who seem in a better position than other types of agencies...to identify and intervene in cases of substance abuse by the elderly (because they see a larger proportion of the elderly, can monitor the drug-taking habits of their clients, and have closer ties to drug treatment facilities), were the least likely to consider the problem serious (Brown, 1982, p. 524-525).

The literature review conducted by this writer then, seems to indicate agreement across studies of the presence of age bias, or ageism, in psychiatrists, psychologists, and physicians, at least partly resulting in the underutilization of mental health services by the elderly. Reekie and Hansen, however, find in their study of social workers' level of ageism based on responses to vignettes, that there is less evidence of such bias in social workers. Their study appears to be the only one which addresses social worker attitudes through the use of vignettes, but has limitations. Most notably, in their sample

of 103, only 10 respondents were under the age of 40. Therefore, with the majority of respondents being closer to the older client age, it is possible that the workers' perceptions about their own aging process may have had bearing on how they answered the questions.

C. SUMMARY

This writer seeks to further the work of previous researchers by exploring the attitudes of a very particular group of professionals -- social workers who work primarily with elders. Any age bias of physicians with regard to the psychological needs of the elders may prevent referrals for service, particularly if the medical system is the only formal service provider in the life of the older adult. Additionally, the age bias of a psychiatrist or psychologist will have implications on the type of service, if any, that is provided to the older adult. However, social workers also play a vital role in assuring that the psychological needs of the older adult are met. While the social worker may or may not be in a position to actually provide psychological services, in all likelihood, the social worker involved with the older adult will, in varying degrees, play as advocate, case manager, and service coordinator. If the social worker is unable, through age bias, to recognize the possible need for psychological service in his or her client, and/or if the social worker does not realize a value in such services, or mistakes symptoms of depression for dementia, he or she will in all likelihood not refer the person for appropriate services. Therefore, this study will specifically survey social workers who work with older adults, a study that has not yet been conducted.

III. RESEARCH QUESTIONS

For many older adults, social workers in long term care facilities, home health and community service agencies are a vital link to services available, and are often in the best position to assess the needs of older adults. Social workers may be very well trained to recognize elders who are having difficulty completing their activities of daily living (such as meal preparation, housekeeping, grooming, etc.), who are socially isolated, and who are in need of financial assistance to pay for formal support services. These same social workers are highly skilled at advocating for their clients and empowering them to ensure needed services are provided. However, their skills are only valuable to the extent that the social workers can in fact recognize needs and understand the possible solutions to meet these needs. If the social worker is the point of entry for older adults to receive formal services, and if the social worker does not understand the value of psychological services, the older adult may be neglected in this area.

This study focuses less on DSM-III-R disorders such as psychotic, anxiety, mood, and other disorders than on general challenges to everyday functioning that an elder may be experiencing. This focus should not be interpreted to mean that elders do not suffer from such disorders, or that such disorders are unimportant; rather, for this study, the writer is more interested in less complicated conditions, about which the layperson might refer to as depression. These challenges to everyday functioning could involve such issues as complicated grief, difficulties adapting to new roles and life cycle changes, lack of self-confidence and self-esteem, depression and loneliness caused by social isolation, mild to moderate depressive episodes, and so on.

Through this study, this writer seeks to explore the extent to which providers of social services carry ageist beliefs and attitudes about psychological services for elders. To what extent do social workers carry ageist beliefs? How does this ageism pose barriers to referrals for or provision of psychotherapy to elders? Is psychotherapy viewed by social workers as a valuable and necessary component of the range of services available to their elderly clients?

Key concepts requiring further definition are: social workers, ageism, psychotherapy and elders. For the purposes of this study, social workers are identified as those persons who possess a degree in social work, and/or are licensed social workers in the state of Minnesota, and who are currently employed as social workers. Psychotherapy is defined in this study as any situation where a referral was made for therapeutic services, where there is a therapist-client relationship with mutually agreed upon goals, and where the primary goal is to make some sort of change in the older adult's or family's functioning. Therapist in this definition refers to a social worker, psychologist, psychiatrist, or counselor. Elders are defined as those persons sixty years of age or older.

Conceptually, according to Butler (1980) ageism is an attitude or practice that perpetuates stereotypic beliefs about elders, reduces their opportunities for a satisfactory life, and undermines their personal dignity. Operationalizing that term poses considerably more difficulty, and could best be completed by developing indicators of ageism. Because the forms of ageism are many (language, media portrayal, job and other discrimination, and fear and dislike of elders), these indicators will focus on ageism as it relates to the research questions. The following are indicators of ageism for the purposes of this study:

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1. Organic problems are considered to be more relevant in the situation of older adults than for younger adults in the same situation, for whom issues such as life stressors, marital conflict, and family of origin issues will be identified as more relevant.

2. Medication, support services, and neurological/psychological evaluations will be considered more valuable for older clients, while therapy will be more recommended for younger clients.

3. The situations of older clients will be assessed with less optimism than those of younger clients in the areas of overall psychological functioning, capacity for insight, and prognosis.

IV. METHODOLOGY

A. REVIEW OF MEASUREMENT TOOLS

As previously noted, numerous measurement tools have been developed to measure attitudes toward elders. With the availability of so many resources, a careful evaluation must be undertaken to select the measurement tool most suitable to a particular study and the associated research questions. McTavish (1982) cites eighteen different instruments developed to measure attitudes, perceptions, and knowledge of older people, classified by type: "Yes-No Scales", "Likert-Type Agree-Disagree Scales", "Semantic Differential Scales", and "Sentence-Completion and Content Analytic Procedures".

Kogan's (1961) Attitudes Toward Old People scale utilizes 17 positive and 17 negative statements about older people, forming 17 matched positive-negative pairs. These were then interspersed with items from other scales to camouflage the author's interest in items specific to older people. Some examples of the old people items are as follows: "It is foolish to claim that wisdom comes with old age", "Old people should have more power in business and politics", "Most old people get set in their ways and are unable to change" (Kogan, 1961, p. 46). Respondents would indicate their level of agreement to each statement on a Likert-type scale. According to McTavish (1982), some of the response statements pose potential reliability problems due to interpretations of the respondent.

Tuckman and Lorge (1953) developed their own Attitudes Toward Old People scale, using a yes-no format, with 137 statements divided into 13 categories including physical, financial, conservatism, family, attitude toward future, insecurity, mental

deterioration, activities and interests, personality traits, best time of life, sex, cleanliness, and interference. Samples of items include: "They are old fashioned", "They are a burden to their children", "They are hard to get along with" (pp. 255-257).

Utilizing items from both of the above measurement tools, Kilty and Feld (1976) developed a two part questionnaire: the first is composed of 45 belief statements about aging, some of which were taken from Tuckman and Lorge's work and some from Kogan's scales. The second part contains 35 statements designed to address respondents' beliefs about the needs of older people. Examples include: "There is no need for a public transportation system in this area", "Since schools are of benefit to the whole community, all residents--regardless of age--should contribute to the costs of education", "A program providing group meals for elderly individuals would give them a useful social outlet" (p. 590).

A considerably more complicated tool, developed by Weinberger and Millham (1975), requires two phases. Respondents are asked to rate both a "representative" 25 year old and 70 year old person in areas of "general satisfaction; personality characteristics..., level of dependence; and adjustments and adaptability (p. 343). Next, a sample of this group was given an "autobiographical" sketch of an older (fictitious) person, and given the choice to meet the person, to assess any avoidance behavior of the subject. Demographics were also analyzed.

Rosencranz and McNevin's (1969) tool uses a semantic differential construct, wherein respondents are asked to place a mark along a scale of polar adjectives to best describe older adults. For example, a respondent might place a check very close to the term "old-fashioned" and far away form the term "progressive". Other adjective pairs include: "flexible-inflexible" and "liberal-conservative".

Another tool frequently used in studies of attitudes toward old people is Golde and Kogan's (1959) sentence completion tool. Twenty-five matched "experimental-control" sentence stems are provided for the respondent to finish; judges, unaware of the comparative nature of the study, code the data into categories. Sentence stems "are intended to reflect, among other factors, the emotions, physical attributes, interpersonal qualities, and values attributed to 'old people' and 'people in general' "(p. 355). "When I am (old) (older), I would want to be like...: "When (an old person) (a young child) is walking very slowly right in front of my, I feel..." "The thing I like least about (old) people..." (p. 358) are all examples of sentence stems used in the control and experimental forms of the tool.

Deviating from the nature of measuring attitudes, Palmore's (1977) idea was to measure respondents' knowledge of aging. Palmore criticizes scales such as those developed by Kogan, Golde and Kogan, and Tuckman and Lorge in that they are 1) quite lengthy and 2) use statements which are "arbitrarily scored as being 'favorable' or 'unfavorable' " (p. 315), without necessarily being factual, empirical statements. Instead, Palmore has developed a 25 item true-false "quiz" compiled of items which are supported by empirical research. "It is designed to cover the basic physical, mental, and social facets and the most common misconceptions about aging" (p. 315). Items include "Most old people are set in their ways and unable to change." "The majority of old people...are senile..." "Older people tend to become more religious as they age." (pp. 315-316). Palmore later developed the an alternate form with the same format but a different set of true-false questions, also based on physical, psychological, and social aspects of aging. Palmore (1981) advocates for the usefulness of the alternate test in a number of areas including to facilitate discussion of additional misconceptions

of aging and in test-retest situations using one form for the initial test and the other for the retest to avoid the "practice effects" of using one form twice.

Miller and Dodder (1980) were concerned that despite his efforts at developing a valid tool, Palmore failed in that some of the items used ambiguous terminology and in some cases, actually asked a number of questions within one item. Therefore, they revised a number of the questions for clarity. For example, Palmore's "The majority of old people (past age 65) are senile. [sic] (i.e. defective memory, disoriented, or demented)" became, in the Miller-Dodder revision, "The majority (more than half) of older people are senile (defective memory, disoriented, demented, etc.)." Also, Palmore's "Most old people have no interest in, or capacity for, sexual relations" was revised by Miller and Dodder to read, "The majority (more than half) of old people have no capacity for sexual relations." The two researchers concluded, after testing the two forms on similar samples, that "directional statements and certain terms are major factors in how respondents answer questions...Thus it is questionable...if the Palmore scale is measuring knowledge of aging per se or the reaction of respondents to statement wording" (p. 678).

It is the opinion of this writer that each of the above described tools has its limitations and strengths, depending on the nature and purpose of a study for which the tools are being considered. However, to assess the existence of age bias in social workers specific to the issue of psychological services for elders, none of the above is quite appropriate. While Palmore's may be a very useful way to assess the knowledge level of a social worker about the elderly population, it would only scratch the surface of what this writer seeks to explore. The attitudinal information that could be obtained from the Kogan, Tuckman & Lorge, Kilty & Feld, Weinberger & Millham,

Rosencranz & McNevin, and the Golde & Kogan scales would be of interest, but only peripherally so, to this writer. Using a scale designed to measure positive and negative attitudes toward, or stereotypes of, elders does little to explore how those attitudes and stereotypes may affect the practice or behavior of a social worker. Further, "subjects may readily recognize what such scales measure and hence some may respond not in a way that reflects their actual attitudes but rather in a way that creates a favorable impression" (Kogan, 1979, p. 29-30). Therefore, this writer sought to use a tool that would be less vulnerable to obtaining socially desirable answers.

B. USE OF VIGNETTES IN RESEARCH

Alexander and Becker (1978) argue that the use of vignettes, through provision of details and concrete situations, can better study attitudes than can simple scales such as those described previously. By asking respondents to consider specific client information in decision making processes, the researcher can expect increased confidence that the responses are not consciously biased by respondents. When presented with situations approximating real-life scenarios, respondents are less likely to give replies based on what they perceive to be socially desirable answers. Rather, respondents will rely on their judgment and decision making skills. Additionally, to camouflage the fact that the researcher is interested in a concept such as ageism, a client vignette could practically describe a number of factors, of which age is only one feature. It would appear, then, that the use of vignettes describing a client situation and requesting the respondent to answer as if it were a real client, may provide better indications of the existence and effect of any bias against elders by the social worker.

C. SAMPLE POPULATION

As discussed above, this writer seeks to explore social workers' attitudes toward elders with respect to their value of psychological services. While similar to Reekie and Hansen's (1992) study, which sampled a population of members of National Association of Social Workers (NASW) who have a Master of Social Work degree and at least two years of postgraduate experience, this project's population deliberately included younger, less experienced social workers as well.

It was decided by this writer that to survey only those social workers whose primary client group is elders would provide more valuable information. This writer's assumption is that those who do not work with elders could be expected to be less knowledgeable about this client group, and may not be working with this group *because of* their fears and discomfort and hopelessness with regard to elders. (The notion of correlations between choice of work with elders and level of ageism is supported by Greene's [1984] study). While the attitudes and practices of social workers and society in general toward elders may impact the existence and effects of ageism, for the purposes of this study, the writer wanted to explore the presence of ageism at its most relevant point in the field of social work -- in those very workers whose caseloads consist of elders.

Limits were placed on who was considered a social worker. In order to be considered for the study, the respondent must be employed as a social worker, *and* possess a degree in social work, *and/or* be a licensed social worker in the state of Minnesota. While there are many individuals in Minnesota who identify themselves as social workers and who do not meet the above criteria, this project sought to study those persons who, through licensure and/or values taught in social work curricula, are

held to higher standards of professionalism and conduct by the field and the community at large. Because of this writer's focus on the practices and attitudes of social workers toward their clients, those who are not in direct service were excluded from the study.

The sample was obtained from a population consisting of two local organizations composed of persons interested in work with elders, the Minneapolis Area Senior Workers Association and the St. Paul Senior Workers' Association. The fees of the organizations are very modest, and monthly meetings are held at different locations each month. Therefore, it was believed by this writer that these organizations represented a more accurate cross-section of social workers who work with elders than would an organization such as NASW, which has significantly higher membership dues, does not hold regular general membership meetings, and is comprised of social workers who work in diverse practice settings and with more diverse populations than just with elders. While there are other organizations which are also comprised of professionals who work with seniors, the two Senior Workers associations were chosen for their easy accessibility to this writer.

D. QUESTIONNAIRE DEVELOPMENT

Close attention needed to be given to the questionnaire format; too much emphasis on DSM-III-R diagnoses and a very clinical focus would be beyond the abilities of many persons with Bachelor of Social Work degrees only, or to those with no social work degree who obtained licensure status based on experience. For this reason, Reekie and Hansen's (1992) survey tool was, with their permission, adapted to

better suit the skills of social workers at varying levels of experience and education (see Appendix A).

Two identical questionnaires were developed, with the exceptions of client age differing among the two questionnaires. The questionnaire was pretested with a small group of people, all licensed, employed social workers: one of whom held an MSW, one held a BSW, and one was grandparented into licensure based on her experience and related degree. Minor changes were made to the questionnaire as a result.

After basic demographic information was requested, respondents were asked to consider a vignette which described a female, middle class client with symptoms of depression drawn from the DSM-III-R criteria for a major depressive episode (Diagnostic and Statistical Manual of Mental Disorders, 1987). Ethnic and racial features were deliberately not identified to limit focus to age, not cultural differences.

Respondents were then asked to rank, on a Likert-type scale, the relevance of life stressors, marital relationship, biochemical disorder, family of origin issues, intrapsychic difficulties, organic impairment, and interpersonal problems. With examples given for some of the above categories, it was felt that respondents practicing in social work would be able to rank each feature as to its relevance to the presented client. In identifying potential ageism, this writer questioned whether, when comparing responses to the older client with responses to the younger client, results would show a tendency to rank items such as organic impairment and biochemical disorder as more relevant to the older client than to the younger client.

Next, treatment interventions were rank ordered: support services, medication, marital therapy, psychotherapy, neurological/psychological evaluation, case management, hospitalization, and no treatment. Medication was expected to be ranked

higher more often for the older client, while psychotherapy would be more highly ranked more often for the younger client.

Respondents were also asked to rate on Likert-type format the following features: overall psychological functioning, motivation for treatment, capacity for insight, prognosis with and without intervention. It was thought that motivation for treatment, capacity for insight, and prognosis with intervention would be assigned lower values for the older client.

Finally, respondents were asked to state what diagnosis might be assigned to the client based on the given information. While most social workers are not licensed to diagnose, they are familiar with diagnoses assigned to their clients and may have opinions as to the accuracy of the diagnoses. This question was not meant to imply that the social worker should diagnose the client, but rather to assess the respondent's perception of the condition of the individual; persons who view it a normal process of aging to have dementia may be unable to recognize depression and mistake it for dementia in the described client.

Respondents were also given the opportunity to provide additional considerations, to allow freedom for expression of important issues not provided in the areas of dynamics, treatment interventions, and prognosis.

E. DATA COLLECTION

This study was conducted in the Spring of 1994 in Minneapolis, Minnesota. A 50% random sample was drawn from the population consisting of the Senior Workers Associations of Minneapolis and St. Paul; questionnaires were sent to 182 individuals. Of the sample group, a random 50% received a creme-colored form describing the

situation of a 71 year old woman while the other 50% received a white form describing the exact same situation, except the client was 36 years old. In order to disguise the actual purpose of the study, and thus to protect from systematic error related to socially desirable answers, none of the respondents were informed that they were chosen because of their membership in an organization related to work with elders. Rather, respondents were told (see Appendix B) the writer was interested in the perspectives of social workers who work with adults. While permission was sought from the Minneapolis and St. Paul Senior Workers Associations' executive boards to utilize their membership lists, neither organization was told that the writer would limit obtaining samples to these groups. Additionally, neither group was told the focus was on ageism.

Respondents who were not currently employed as social workers were asked not to complete the questionnaire, as were individuals who had neither a social work degree nor possessed social work licensure.

V. FINDINGS

The majority of the respondents believed the client to be depressed, although there was some question among the respondents to the older client that dementia may also be present. Neurological/psychological evaluation was valued more for the older than the younger client, for whom psychotherapy was the preferred intervention.

A. DEMOGRAPHICS

Of the 182 mailed questionnaires, 101 (55%) were returned; of those, 54 did not meet criteria for completing the questionnaire, such as not being employed as a social worker and lacking a degree in social work or not possessing a license in social work. Additionally, those not in direct service with elders were excluded. Two were discarded as incomplete. Of the returned, completed surveys data were obtained from 45 surveys. Twenty-two respondents addressed the situation of the younger client, with the remaining 23 completing the survey for the older client.

The mean age of the respondents was 39 years, the median age is 39, with a range of 24 years to 61 years old. The most frequently listed primary work setting was a private, non-profit community service agency. Forty respondents were female and 5 were male. All respondents listed their race/ethnicity as Caucasian.

B. RELEVANCE OF ISSUES

After asking the respondents to read the presented vignette, the questionnaire requested that respondents estimate the relevance of the following issues for the client, Mrs. Brown: life stressors (e.g., grief, caring for parent, etc.); marital relationship;

biochemical disorder (e.g., depression, bi-polar disorder, etc.); family of origin issues; intrapsychic difficulties (e.g., personality disorder, poor coping skills, etc.); organic impairment (e.g., multi-infarct dementia, Alzheimer's Disease, etc.); and interpersonal problems (e.g., communications skills, friendships, etc.). Respondents were asked to circle the level of relevance on a Likert-type format.

For both the younger and the older client, life stressors were considered by the majority of respondents who answered this section to be relevant or very relevant, as were the marital relationship and biochemical disorder. Family of origin issues were also considered relevant or very relevant for the majority of respondents for both clients, however, two respondents considered these issues as irrelevant and very irrelevant for the older client, while two considered such as neither relevant nor irrelevant (neutral) for the younger client.

With regard to intrapsychic difficulties, 34.8% (n=8) of the respondents for the older client considered this to be relevant or very relevant, when the categories are combined, as did 50% (n=11) of the respondents in for the younger client (see Table 1).

Approximately thirty percent (n=7) of the respondents for the older client found organic impairment to be relevant or very relevant, when categories were combined, and 39.1% (n=9) were neutral on this issue, compared to the respondents for the younger client, in which only 18.1% (n=4) of the respondents found organic impairment to be relevant or very relevant and another 18% (n=4) of the respondents for the younger client were neutral on the relevance of organic impairment (see Table 2).

The relevance of interpersonal problems for both the younger and older client varied across the continuum, with the majority of respondents considering this issue to be in the neutral to very relevant range.

Most of the issues were rated with comparable levels of relevance for the younger and older clients. Notable differences, however, were the areas of intrapsychic difficulties and organic impairment. Half of the respondents for the younger Mrs. Brown considered intrapsychic difficulties to be of some degree of relevance, compared to only 34% (n=8) of the responses from those addressing the older client. Responses to the issue of organic impairment should also be noted; in the case of the younger client, 63% (n=14) of the respondents asserted the irrelevance of organic impairment to the situation, while only 22% (n=5) of the respondents for the older client were able to do the same (Also refer to Appendix C, Graph 1).

Table 1
Relevance of Intrapsychic Difficulties

	Respondents for Older Client		Respondents for Younger Client	
	#	%	#	%
Very Irrelevant	2	8.6	1	4.5
Irrelevant	3	13.0	3	13.6
Neutral	9	39.0	7	31.8
Relevant	4	17.4	7	31.8
Very Relevant	4	17.4	4	18.1
No Answer	1	4.5	--	--
Total	23	99.9*	22	99.8*

*Does not total 100% due to rounding

Table 2

Relevance of Organic Impairment

	Respondents for Older Client		Respondents for Younger Client	
	#	%	#	%
Very Irrelevant	2	8.6	7	31.8
Irrelevant	3	13.0	7	31.8
Neutral	9	39.1	4	18.2
Relevant	3	13.0	3	13.6
Very Relevant	4	17.3	1	4.5
No Answer	2	8.6	--	--
Total	23	99.6*	22	99.9*

*Does not total 100% due to rounding

C. RECOMMENDATIONS FOR INTERVENTION

After responding to the relevance of the issues as stated above, respondents were asked to rank order their recommendations for intervention. Respondents were asked to rank each intervention, from the first choice to the last choice. The interventions considered were: support services (e.g., peer counseling, befriender, support groups, etc.); medication and/or evaluation for medication needs; marital therapy; psychotherapy; neurological/psychological evaluation; case management; hospitalization; no treatment. One respondent for the older client declined to answer this section of the questionnaire; all respondents for the younger client completed this portion.

1. First Choice

In reviewing the answers of those respondents who completed this section, the first choice of recommendations for intervention for the older client was neurological/psychological evaluation, with 56.5% (n=13) favoring this treatment. Five of the respondents for the older client (21.7%, n=5) rated psychotherapy as the number one intervention. For the younger client, respondents most often (31.8%, n=7) recommended psychotherapy as the first choice, followed by neurological/psychological evaluation (27%, n=6).

2. Second Choice

The majority (56.5%, n=13) of the respondents for the older client chose medication and/or medication evaluation as the second most favored intervention of choice, while only 36% (n=8) of the respondents to the younger client valued this as the second intervention of choice. Twenty-seven percent (n= 6) of the respondents to the younger client ranked psychotherapy and another 27% (n=6) preferred neurological/psychological evaluation as the second choice.

3. Third Choice

For the older client, support services were the most popular third choice (34.7%, n=8), followed by medication evaluation and case management (27% each, n= 5) for the respondents' third choice. For the younger client, respondents most often indicated medication and/or medication evaluation (27%, n=6) and marital therapy (22.7%, n=5) as the third ranked item.

4. Fourth Choice

In the fourth ranked position, the respondents to the older client most often chose marital therapy (43.4%, n=10) followed by psychotherapy (21.7%, n=5).

Respondents for the younger client also most often placed marital therapy (31.8%, n=7) in the fourth rank, followed by support services (22.7%, n= 5).

5. Remaining Choices

While respondents for the older client split their fifth choice among marital therapy (34.7%, n=8), support services (21.7%, n=4), and case management (22.7%, n=5), a full 50% (n=11) of the respondents for the younger client ranked support services in the fifth position.

The majority of respondents (39.1%, n=9) for the older client ranked case management as the intervention of sixth choice; respondents for the younger client also preferred case management (45%, n=10) as the sixth choice.

For the vast majority of all respondents, hospitalization and no treatment were ranked as seventh and eighth, respectively, for both clients.

6. Summary

In summary, neurological/psychological evaluation was the most valued intervention for the older client, falling into the first or second ranked position for nearly three-quarters (69.5%, n=16) of the respondents, while for respondents for the younger client, this recommendation comprised only 54.5% (n=11) of the first or second ranked items (see Table 3).

Medication and/or medication evaluation was ranked as the second intervention of choice for a number of respondents in both groups; however, differences between the two groups could be noted. Of those who considered the older client, 56.5% (n=13) viewed this as the second best intervention, while this intervention was the second favored treatment with only 36.3% (n=8) of the respondents for the younger person (see Table 4).

Psychotherapy was the intervention of first or second choice for 34.7% (n=8) of the respondents to the older client, while it comprised 59% (n=13) of the younger client respondents' first and second choices (see Table 5). (See also, Appendix C, Graph 2)

For respondents of both the younger and older client, hospitalization and no treatment were interventions that were not considered valuable to this particular situation.

Table 3

Ranking of Neurological/Psychological Evaluation

	Respondents for Older Client		Respondents for Younger Client	
	#	%	#	%
First Choice	13	56.5	6	27.0
Second Choice	3	13.0	6	27.0
Combined	16	69.5	12	54.0

Table 4

Ranking of Medication/Medication Evaluation

	Respondents for Older Client		Respondents for Younger Client	
	#	%	#	%
First Choice	--	--	1	4.5
Second Choice	13	56.5	8	36.0
Combined	13	56.5	9	40.9

Table 5				
Ranking of Psychotherapy				
	Respondents for Older Client		Respondents for Younger Client	
	#	%	#	%
First Choice	5	21.7	7	31.8
Second Choice	3	13.0	6	27.2
Combined	8	34.7	13	59.0

D. ASSESSMENT OF OVERALL SITUATION

After ranking the given treatment recommendations, respondents were asked to assess, in statements presented in a Likert format, Mrs. Brown's overall functioning, motivation for treatment, capacity for insight, and prognosis with and without intervention. With regard to capacity for insight, the responses from the two groups were very comparable, with similar ratings above and below average, with the majority of both groups viewing Mrs. Brown's capacity for insight as average.

Most of the respondents for both the younger and the older client viewed the client's overall psychological functioning as less than average, although only 4.3% (n=1) of the respondents for the older client rated her functioning as average or above, while 31.8% (n=7) of the respondents in for the younger client believed her functioning to be average or above (see Table 6).

Nearly three-quarters (n=17) of those who responded to the older client and 81.8% (n=18) of those responding to the younger client rated Mrs. Brown as having at least average motivation for treatment, although nearly twice as many in the younger client group than in the older client group rated her as higher than average in motivation (see Table 7).

Additionally, most respondents in both groups believed Mrs. Brown to have above average prognosis with intervention. Without intervention, 91.3% (n=21) of the respondents for the older client rated her as below average or poor in her prognosis without intervention, while 81.8% (n=18) of the respondents to the younger client believed her to have below average or poor prognosis without intervention. (see Tables 8 and 9).

Table 6

Overall Psychological Functioning

	Respondents for Older Client		Respondents for Younger Client	
	#	%	#	%
Poor	3	13.0	2	9.0
Below Average	17	73.9	13	59.0
Average	1	4.3	6	27.0
Above Average	--	--	1	4.5
Excellent	--	--	--	--
No Answer	2	8.6	--	--
Total	23	99.8*	22	99.5*

*Does not total 100% due to rounding

Table 7

Motivation for Treatment

	Respondents for Older Client		Respondents for Younger Client	
	#	%	#	%
Poor	--	--	2	9.1
Below Average	4	17.3	2	9.1
Average	12	52.2	8	36.4
Above Average	5	21.7	9	40.9
Excellent	--	--	1	4.5
No Answer	2	8.6	--	--
Total	23	99.8*	22	100

*Does not total 100% due to rounding

Table 8

Prognosis With Intervention

	Respondents for Older Client		Respondents for Younger Client	
	#	%	#	%
Poor	--	--	--	--
Below Average	--	--	2	9.1
Average	1	4.3	1	4.5
Above Average	11	47.8	12	54.5
Excellent	9	39.1	7	31.8
No Answer	2	8.6	--	--
Total	23	99.8*	22	99.9*

*Does not total 100% due to rounding

Table 9

Prognosis Without Intervention

	Respondents for Older Client		Respondents for Younger Client	
	#	%	#	%
Poor	11	47.8	10	45.5
Below Average	10	43.4	8	36.4
Average	--	--	4	18.2
Above Average	--	--	--	--
Excellent	--	--	--	--
No Answer	2	8.6	--	--
Total	23	99.8*	22	100.1*

*Does not total 100% due to rounding

E. DIAGNOSIS

Respondents were then asked to indicate what diagnosis they believed would be assigned to Mrs. Brown. Two individuals for the younger Mrs. Brown indicated an inability to diagnose because of social worker status, none of the respondents to the older client expressed this concern. A total of five people elected not to answer this question.

The majority of respondents who answered this question listed depression, or some variant of depression, as the diagnosis most likely to be assigned to Mrs. Brown, in both age groups. In addition to depression, such answers as situational depression; major depression; depression and/or anxiety; depression (possibly dementia); either depression or early stage dementia, were all given by respondents for the older client.

Respondents to the younger Mrs. Brown also most frequently listed depression as well as situational depression; depression, dependent personality; depression due to low self-esteem brought to surface by life stressors; dysthymia, adjustment disorder.

F. FINAL COMMENTS

Before returning their questionnaires, respondents were provided the opportunity to add anything else they thought to be pertinent to the situation. A number of respondents chose to add comments in the space provided for such, which will be summarized as follows.

Respondents for the younger client reiterated self-esteem as a possible issue, as well as advocating for a CAT scan to rule out neurological components, then a psychological evaluation, as well as considering the current medication regime as a possible source of problem. Respondents felt therapy for the mother and daughter are important, encouragement to continue with therapy, and support services to follow through with therapy are all recommended. Respondents want to start with a good physical exam; exploration of resources for the care of the aging mother and caregiver support for the daughter, exploration of the support system to seek additional involvement of others, provision of information about support services, exploration of more family history information, and spiritual interventions were all recommended.

For those respondents to the elder Mrs. Brown's situation, a number of areas were also identified as important. Memory evaluation, if memory continues to be a problem after treatment, interventions in other areas, a "mini-mental status exam" and evaluation for organic disorder such as dementia were recommended by respondents. Mrs. Brown's mother was the recipient of attention by the older client group in

suggesting that the mother should receive an assessment by an Alternative Care Grant [a state program designed to prevent premature nursing home placement through assessments, service provision, and grants to pay for services] screener. It was also believed that Mrs. Brown needs to process her life-long conflict with her mother, dealing with the fear and guilt associated with the poor relationship. The respondents felt that Mrs. Brown's past coping skills should be explored, as well as whether she may have been in need of mental health services in the past. Additionally, they were of the opinion that Mrs. Brown should be given minor and temporary medication to "monitor suicide potential", and she should be assisted to see her strengths and those of her husband, such as "her love for her husband". Finally, the respondents indicated that she should be aided to recognize and process her losses and begin to see new hopes and dreams. Stress management and teaching alternatives to the "bondage" of being a caretaker were also suggested.

VI. DISCUSSION

This study sought to explore whether ageism exists among social workers who primarily work with older adults, and specifically explored social workers' attitudes toward older adults and mental health services. An analysis of the data provided does appear to reveal ageism in the respondents.

A. THE RELEVANCE OF ORGANIC IMPAIRMENT AND OTHER DYNAMICS

The indicators of ageism suggested by this writer were that when asked to respond to the provided client situation, respondents for the older client would consider organic problems as having more relevance for the older client than for the younger one; and life stressors, marital conflict, and family of origin issues would hold the most relevance for individuals responding to the younger client. Further, medication, support services, and neurological/psychological evaluations would be considered as interventions of first choice for older clients, while therapy (marital, psychotherapy) would be considered more strongly for younger clients. The general situations of the two clients would reveal less hope for the older client in the areas of overall psychological functioning, capacity for insight, motivation for treatment and prognosis.

If consideration of organic impairment as more relevant for the older than for the younger client constitutes a form of ageism or age bias, this criterion seems to have been met. The majority of those who responded to the younger client were willing to rate organic impairment as irrelevant or very irrelevant; even those who were neutral on the matter were fewer in number than their counterparts in the group responding to the

older client. Regarding the older client, just over 30% of the respondents believed the issue to be at least relevant, and another nearly forty percent were neutral on the matter.

Thus, when given two identical client situations with the only difference being age, respondents often believed organic impairment was present, merely on the basis of a client's advanced age. A possible conclusion is that with the vignette describing symptoms of depression which included impaired concentration and self-reported memory loss, some respondents began to consider the possibility of dementia. Because of age, the issue of memory loss and impaired concentration appeared to be a sign of dementia while the same memory loss and impaired concentration did not trigger the concern for organic impairment for the younger client. This conclusion is of concern to this writer as a form of ageism -- confusing old age with onset of a disease which causes dementia.

While dementia is thought to be present in approximately 5% to 15% of older adults (Greene, 1986b; Hulicka, 1992, Warshaw, 1982), with the percentages increasing as the individual lives to age 80 or 90 or older, dementia is not a normal process of aging, but rather the result of a disease process (Greene, 1986b). To generalize the presence of dementia to all older people is to seriously risk neglecting the mental health and medical needs of many, many people. If it is thought that self-reported memory difficulties and impaired concentration are signs of dementia, it may also be concluded by the social worker that to evaluate and/or treat for other causes would be a useless endeavor. Ultimately, in this case vignette, Mrs. Brown may not be referred for services to treat the depression.

This writer also posited that along with a higher relevance attributed to organic impairment for the older client, life stressors, marital conflict, and family of origin issues would be considered of higher relevance for the younger client than the older one. These factors were not shown to have substantially different levels of relevance for the older and for the younger client.

This finding is encouraging as social workers seem to recognize the part various dynamics play in the overall situation of any individual. These social workers view the client as part of a larger system and would presumably, in practice, address the various areas of strength and challenge in the client's life. While the importance of organic impairment may be overestimated by social workers, the workers would recognize and would presumably intervene with other contributors to a client's problematic situation by considering the marital and familial relationships and stressful life events.

B. THE ASCRIBED VALUE OF SPECIFIC INTERVENTIONS

1. Neurological and/or Psychological Evaluation

The second indicator of ageism described by this writer, that some interventions would be more highly ranked for the older than the younger client, did appear. The majority (56.5%) of respondents to the older client indicated the intervention of first choice to be neurological/psychological evaluation; this intervention was the first choice of some respondents for the younger client as well, but in lower numbers (27%). While these evaluations may indeed be a wise place to start in assisting the client, it is interesting to note that respondents for the younger client were closely split between psychotherapy and neurological/psychological evaluation. One possible reason for this may be related to the tendency to view organic impairment as a relevant issue for the

older client; neurological evaluations are often recommended by physicians and supported by social workers to evaluate for the presence of dementia.

As an indicator of ageism, this finding should be viewed with caution, however. As discussed in previous sections, dementia is not a normal process of aging, yet, depending on the age of the older person, there is a greater likelihood for older people to exhibit dementia than for younger people. Even if the percentages of dementia in older adults is fairly small, it does occur, and therefore, to seek a neurological/psychological exam may be perfectly appropriate. This writer remains skeptical, however, as in the case of Mrs. Brown, symptoms of dementia are not obvious, while the symptoms of depression are. This writer wonders why the majority of respondents for the older Mrs. Brown would first want to rule out dementia, which does not even present as an apparent issue. Perhaps viewing this response as ageist is a reasonable conclusion.

2. Psychotherapy

One-fifth of the respondents (22%) did value psychotherapy as the first choice for the older client. This finding is somewhat encouraging and indicates that elders are not viewed as poor candidates for psychotherapy by this group as a whole.

3. Medication and/or Medication Evaluation

Medication is another intervention that did show differences in the ranking by respondents to the older and younger client. Medication and/or medication evaluation were frequently ranked as the second most valuable intervention for both the younger and the older client, however, for the older client it was considerably more valued (56.5% versus the 36% of the respondents to the younger client who ranked this as the second choice intervention). Again, this may be a very appropriate approach to treating

Mrs. Brown's symptoms of depression, and is supported in the field (Osgood, 1989; Osgood, 1985; Fairview Riverside Medical Center, 1993; Mental Health Association of Minnesota, 1988; Mental Health Association of Minnesota) as a valuable component to treating depression in younger and older persons with depression. Medication and psychotherapy are often used in conjunction with one another in the treatment of depression; however, in this study, medication seems to be even more highly valued for the older adult than for the younger adult, based on the percentages listed above. Therefore, it may be fair to conclude that social workers view medication as an appropriate treatment of the described symptoms in elders; yet, when a younger adult with the same symptoms is observed, medication is not as frequently noted as the treatment of choice. From this study, it appears that social workers believe that once a neurological/psychological evaluation has supported the diagnosis of depression, for the older person medication would be warranted. This is of concern if elders suffering from depression do not have the opportunity to benefit from other therapeutic interventions besides, or in addition to, medication. They may not be presented with the opportunity to process grief, loss issues, gain insight and coping skills if medication alone is considered the intervention of choice.

4. Overall Functioning and Prognosis

The third indicator of ageism posed by this writer was that the older client would be viewed as having lower psychological functioning, less capacity for insight, and poorer prognosis than the younger client. This area was for the most part unfounded in the study results.

In regard to overall psychological functioning, both clients were viewed by the majority of the respondents to be in the lower end of the range. However, some

31.8% of the respondents felt the younger client was functioning at an average or better level, while none of the respondents felt the older client was functioning any better than below average. In a situation where the presenting stressors and symptoms are identical for both the older and younger client, some meaning should be attached to the finding that not one person viewed the overall psychological functioning as average or better for the older client, while more than one-quarter of those in the younger client group did.

The responses to capacity for insight showed only minor differences between the two clients and therefore did not indicate age bias in this category: 80.9% of the respondents for the older client and 81.8% of the respondents for the younger client rated Mrs. Brown as having at least an average capacity for insight.

With regard to prognosis for improvement, both sets of respondents regard the prognosis of the clients with intervention as average or better. Of note, while none of the respondents for the older client rated Mrs. Brown as having a less than average prognosis, 9% of the respondents for the younger client indicated such. Without intervention, the younger and older client were felt to have similarly poor prognoses, although 18% of the respondents for the younger Mrs. Brown rated her prognosis without intervention as average, while none of the other group of respondents did so. A possible interpretation of this finding is that respondents believe the younger client to have greater strengths, and thus a better chance of dealing with her issues on her own and without the assistance of others. These differences are fairly small, however, and would not necessarily indicate ageism with regard to the outlook for the older Mrs. Brown.

With regard to the diagnosis, most respondents for both clients agreed that Mrs. Brown appeared to be suffering from depression. The only differences that surfaced in this matter were that a small number of respondents were concerned that the elder client may be suffering from early dementia, and may be suicidal. None of the respondents for the younger client mentioned either of these possibilities.

C. SUMMARY

The study appears to reveal some existence of ageist attitudes in social workers who work primarily with elders. Returning to Butler's (1980) definition of ageism as an attitude or practice that perpetuates stereotypic beliefs about elders, reduces their opportunities for a satisfactory life, and undermines their personal dignity, this study is important for its focus on the attitudes and potential practice of social workers. To the degree that social workers regard their elder clients differently in the above described areas than they would younger clients with the same challenges, the psychological needs of elders may be unmet, which could have a negative impact on life satisfaction. The older client who presents with some memory and concentration impairment may be regarded as suffering from early dementia and not receive treatment for depression, which may cause the problems to escalate to a point where the client is unable to function at all, and a loss of dignity for the severely depressed person requiring others to provide all personal cares. As discussed previously, the literature indicates that elders more often enter the mental health system in crisis, often requiring hospitalization. If recognized as a mental health need earlier, hospitalization might be avoided and the quality of life of the individual enhanced. In the presented vignette, it

appears that the younger client would receive psychotherapy as an intervention of choice, while the elder client may only receive medications to treat the symptoms.

VII. LIMITATIONS

A. SAMPLE SIZE AND POPULATION

The findings of this study must be interpreted with some caution. The sample size was relatively small, and the rate of response was smaller still. There were just under 25 participants in each group under study; therefore, even where substantial differences were noted in the percentages, the actual numbers of respondents making up those percentages were very small. Generalizability to the population of social workers who work with elders is questionable based on these findings alone. Further, other organizations, such as the Minnesota Association for Continuity of Care (MACC), the Minnesota Gerontological Society (MGS), the Minnesota Association of Homes for the Aged (MAHA), or NASW, may be the organization of choice for a number of social workers who work with elders.

Additionally, the sampling procedure drew from a group of social workers which is presumably concerned about keeping abreast of aging issues, hence their membership in the senior organizations. There may be significant numbers of social workers who choose not to join organizations at all; it would thus be very difficult, short of conducting a sweeping survey of all organizations who provide social services to elders, to have access to these individuals for further study. Perhaps if those social workers who have no professional group membership were surveyed, the results would show more or less occurrence of ageism with regard to elders and psychological services. The findings of this study, therefore, are generalizable only with caution as they are the result of the sampling of a small group of social workers who are only a portion of all social workers who work with elders in the Twin Cities area.

B. SOCIAL DESIRABILITY

Despite the significant attention of the writer to avoiding respondents becoming aware of the nature of the study, in fact, in some situations this may have been unavoidable. This writer is also a social worker who is employed in a fairly visible position, and has recently completed an internship, in the field of aging. To the degree that this writer's name was recognized by respondents, they may have assumed that the research would focus on aging issues and may have thus replied in a manner that would be presumed to be desirable.

C. THE QUESTIONNAIRE

The data collection instrument should also be considered in its ability to provide a reliable and valid measurement of attitudes of social workers. It is possible that some of the questions were unanswered because the respondent did not understand what was being asked, what the response categories meant, and so on. Or, respondents may not have known what was meant, but arbitrarily answered anyway. An issue other researchers have struggled with is the degree to which one's attitudes, as revealed in a questionnaire or in a scale, indicate the actual practice of that individual. A possibly better way to measure the attitudes of social workers toward elders and therapy would be to conduct a qualitative study, allowing the respondent more freedom in analyzing the client situation and making recommendations for intervention with freedom to qualify answers and elaborate on their opinions about the situation, interventions, and prognosis.

In providing opportunities to rank recommendations for intervention, the decision by this writer to list neurological evaluation in the same line with psychological

evaluation was poor. While in many situations, both evaluations are requested at the same time, it would have provided better data for analysis if these two types of evaluation were listed separately. This may have allowed respondents to identify preferences for one type of evaluation over the other for each of the clients. In the current study, the majority of respondents for both the older and the younger client indicated neurological/psychological evaluation to be one of the most preferred interventions. However, without the separation of the two, it is impossible to compare whether there were any differences in the rates of recommendation for the two different evaluations between the older and younger client. Further, it is impossible to identify whether, when referring for neurological/psychological evaluation, the respondents were more interested in one evaluation over the other.

Additionally, it possibly would have been more useful to first ask respondents to rank evaluative recommendations, then provide "results" of the evaluation, and finally to ask respondents to rank the remaining specific interventions, separating interventions from evaluations.

To this writer's mind, an ideal quantitative study would have provided each respondent with at least one older and one younger client, again disguising age as the salient issue, in similar situations, so that comparisons could be made against individual respondent's judgments, rather than comparing with other respondents' questionnaires. In this way, the measurement of individual ageism would have had increased validity. Wingard, Heath, and Himelstein (1982) further evaluated the nature of context in determining the presence of negative attitudes toward elders. Their results show that subjects who were asked to make comparisons of older people to younger people exhibited more negative attitudes than did subjects who made judgments of older

people in isolation. Perhaps, then, in the current study, respondents revealed less bias than they might otherwise have in comparison to a younger client.

Finally, while the use of vignettes may offer a more valid study of attitudes and potential practices as a result of such attitudes, there is not, to this writer's knowledge, a significantly reliable and valid instrument to determine if such attitudes actually correspond to practices in real life situations. While very complex and not very feasible, one way to accomplish this might be to measure attitudes with one of the data collection instruments described in this work, then to unobtrusively follow the subjects from case situation to case situation and observe these interactions. More realistically, a study of social workers' referral patterns or study of case notes may provide insight to the actual practices of social workers.

D. MEASURING ATTITUDES

Challenges to studies of attitude toward elders, such as this project, do appear in the literature. For example, Knight (1985-1986) compared two measures of attitudes commonly used in the research field with reference to ageist attitudes, in order to test reliability and validity. Testing a semantic differential scale and Kogan's old people scale, Knight tentatively concluded that the measures may be reliable but not valid measures and that other variables such as working with elders, and personal experiences with elders, are ignored, when in fact, there may be correlations. A second tentative conclusion was that the scales are adequate measures of attitudes, but that attitudes are irrelevant to actual work with elders. Knight believes, as a result of the study, that attitudes are not barriers to the provision of therapy to elders, but that in fact work site is a major barrier to therapists' work with elders. The conclusion of his study

is that intervention to barriers to therapy should shift attention from individual therapists' attitudes to a systems level of change of "physical environment, agency policy, staff-client interaction, an the social climate" (p. 267).

Fay Lomax Cook (1992) also criticizes previous attempts to measure ageist attitudes. She argues that because of the tremendous diversity that exists among the population of older adults, it may be inappropriate to ask respondents to reply to questions which do not allow for differentiation among older people. Further, "what may be a stereotype for one group within the old may not be a stereotype for another" (p. 293).

Neither of these critiques, however, appear to consider the use of vignettes in studying attitudes toward elders; the use of the vignettes eliminates the need to broadly generalize and does appear to allow for respondents to address a specific client, which more closely approximates a real life situation.

VIII. CONCLUSION

A. FINDINGS

This study did find differences in the treatment of an older and a younger client by social workers. This is one of two studies known to this writer which sought to measure the presence of ageism in social workers' attitudes toward psychological services for elders through the use of client vignettes. It was hoped that the use of vignettes could more closely approximate the real-life situations and practices of social workers than would the use of more conventional attitude measurement scales.

The most notable finding was in the area of differentiating between dementia and depression. Many social workers who work with elders are likely to be in a position to see mostly frail, ill elders, many of whom may have some level of dementia. Those elders who do not meet this description or who receive informal support from their families and others, may not be seen by, or known to, social workers such as those sampled for this study, as they would not necessarily be in need of assistance from the formal service providers. Therefore, social workers may be somewhat predisposed to see evidence of dementia in elders, and could mistake symptoms of depression for the presence of dementia. For this reason, therapy, whether individual, couple, family, or group, may not be recommended by the social worker for the elder in a situation where in fact, it may have been a much needed intervention.

B. THE OLDER PERSON IN THE MENTAL HEALTH SYSTEM

When depression is recognized, the elder may be referred to a physician or psychiatrist for medication evaluation. While it would not necessarily be appropriate

for a social worker to recommend medication or therapy if it is not her level of expertise and licensure, she is still able to advocate for the provision of the most appropriate service for her client. Additionally, as shown in the review of the literature, the treating physician or psychiatrist may not value psychotherapy for elders and may restrict treatment of depression to medications. The social worker may need to advocate on behalf of the client for the receipt of services which include a more comprehensive approach to the treatment of depression. Therefore, it is important that social workers recognize depression and differentiate it from dementia and to understand the value of therapy, in conjunction with or instead of medication, to treat depression in the older adult.

C. RECOMMENDATIONS

Education can be a valuable tool in changing perceptions about elders (Hickey, et al., 1976; Intrieri, et al., 1993; Patterson, 1981). Also, aging issues in college curriculum can be an important, and possibly the only, way to stimulate interest in elders and the issues facing them (Hulicka, 1992). Perhaps in teaching basic information about aging and the normal processes of aging, the pleasant and unpleasant nature of growing old, individuals will better be able to address their own and their peers' ageism and even choose to work with elders in a professional career, such as in law, medicine, behavioral science, or social work. Within undergraduate and graduate social work programs which this writer has attended, issues of aging are for the most part ignored. Were elders considered relevant members of families and value placed on family therapy which includes elders, perhaps more students would welcome the prospect of social work and family therapy with aged populations.

This study has demonstrated a continued need for the evaluation of attitudes of professionals who work with older adults. It has been suggested that the development of curriculum and continuing education opportunities which emphasize the appropriateness of therapy with elders and their families could play a vital role in the type of service provided to elders. The provision of psychotherapeutic services has been advocated as a crucial piece of the social service continuum, and one that, if not seen as a valuable component by social workers, would fail to be used to assist those older adults suffering from depression due to unresolved family of origin issues, marital and interpersonal conflict and life cycle stressors.

Physicians, psychiatrists, and psychologists may, through their own ageism and countertransference, pose barriers to the provision of mental health services. Elders themselves may not see therapy as an appropriate and effective treatment alternative (Waxman, Carner, & Klein, 1984). Despite, and perhaps because of, these potential barriers, social workers play a key role in attending to the mental health needs of older adults. The social worker may be the initial, or only, formal service provider for elders and therefore, his or her ability to assess the mental health needs as well as social, medical, spiritual, financial, and functional needs of the older client is imperative to ensure that the client's whole being is treated in the social worker-client relationship. It cannot be argued that the medical health needs are out of the realm of the social worker's expertise; just as the social worker is expected to recognize potential medical issues and refer the client to a nurse or physician who is trained to address the medical concerns, so must the social worker be prepared to refer to the appropriate resource for mental health service provision. To fail to do so simply because the client is old is ageist and a gross misservice to the older adult and his or her informal support network.

APPENDIX A

QUESTIONNAIRE

A. BACKGROUND INFORMATION

1. Are you currently employed as a social worker? ___yes ___no

If you answered no, STOP. You have completed the questionnaire. Please mail the questionnaire in the enclosed postage-paid envelope. If you answered yes, please continue.

2. Do you have a degree(s) in social work? ____ yes ____no

   a. Please specify any degree(s) held, including social work and other degree(s):

3. Are you a licensed social worker in Minnesota? ____yes ____no

   a. If yes, please specify licensure:

   ___ LSW ___ LGSW
   ___ LISW ___ LICSW

If you answered no to questions #2 <u>and</u> #3, STOP. You have completed the questionnaire. Please mail the questionnaire in the enclosed postage-paid envelope. If you answered yes to <u>either or both</u> of questions #2 and #3, please continue.

4. Please indicate the practice area of your primary job (at least 50% of your current work time):

   ___ a. direct service with children & youth (birth through 18 years)
   ___ b. direct service with families (all ages of adults and children)
   ___ c. direct service with adults (aged 19 to 64)
   ___ d. direct service with elderly (ages 65 and over)
   ___ e. if not in direct service, please identify primary work responsibility and target group ____________________________

5. How long have you worked with this population as a social worker?

   ___ a. less than one year
   ___ b. one or more years, but less than 5 years
   ___ c. 5 or more years, but less than 10 years
   ___ d. 10 or more years, but less than 20 years
   ___ c. 20 or more years (please specify number of years) ______________

6. In your current employment, indicate the setting of your primary job:
   ___ a. public community service agency (e.g., county or state employment)
   ___ b. private non-profit community service agency
   ___ c. hospital
   ___ d. nursing home
   ___ e. home health agency
   ___ f. private practice (self-employed, solo, partnership, or group practice)
   ___ g. other (please specify) ____________________

7. What is your current job title? ____________________

8. Please list memberships in any professional organizations to which you belong:

   ____________________ ____________________
   ____________________ ____________________
   ____________________ ____________________

9. Your age at last birthday: ________

10. Sex: ___Female ___Male

11. Race/Ethnicity:
   ___ a. African American
   ___ b. Native American
   ___ c. Asian American
   ___ d. Hispanic
   ___ e. Caucasian
   ___ f. Other (please specify) ____________________

B. Please read the following scenario and assume you are a social worker in a community services agency which provides social services to families. Please answer the questions that follow the scenario with reference to this client.

Joyce Brown, a 36 (71) year old middle class woman, has been referred to you by her physician who found no physiological causes for her symptoms. Mrs. Brown has no history of psychiatric treatment or drug/alcohol abuse. Her physician reports that she is in good general health.

Mrs. Brown sought medical advice at her husband's insistence after a 15 pound weight loss in the last few months. Lately she has not been able to read, something she always enjoyed in the past. She reported that it has also become difficult for her to concentrate even for a few minutes on the daily paper. She complains of having a poor memory. She also described herself as having less energy and struggling with consistent feelings of lethargy and tiredness. She sometimes sleeps twelve or fourteen hours at a time, and still feels tired and out of sorts.

When questioned about her marital relationship, Mrs. Brown appeared tearful, and stated that she and her husband argue constantly, mainly about "small things." "He gets really frustrated with me. And I can see why; nothing that I do seems to turn out right. Sometimes I think that he'd be better off without me." Mrs. Brown reported that she used to enjoy organizing gatherings with friends, but that now she does not feel like going out or seeing people. "I just don't feel like doing much of anything lately." Throughout the interview, Mrs. Brown answered questions in a subdued voice and seemed close to tears. Although she did not often make eye contact, she was generally cooperative and polite.

An exploration of recent stressors revealed that Mrs. Brown's mother was recently diagnosed as having a rare form of cancer. Mrs. Brown's relationship with her mother has apparently been difficult. She describes her late father as "the peacemaker in the family, a wonderful and loving person." After Mrs. Brown's father died, she and her mother did not speak to each other for several years. "My mother is a cold person who only thinks of herself." Now that her mother is so ill, Mrs. Brown and her husband are afraid that they may have to assume some of the financial and physical burden for her care, and this has been an additional source of marital stress.

12. Based on the information given above, please estimate the relevance of the following issues for this client by circling the appropriate number:

	Very Irrelevant		Neutral		Very Relevant
Life Stressors (e.g., grief, caring for parent, etc.)	1	2	3	4	5
Marital Relationship	1	2	3	4	5
Biochemical Disorder (e.g., depression, bi-polar disorder, etc.)	1	2	3	4	5
Family of Origin Issues	1	2	3	4	5
Intrapsychic Difficulties (e.g., personality disorder, poor coping skills, etc.)	1	2	3	4	5
Organic Impairment (e.g., multi-infarct dementia, Alzheimer's Disease, etc.)	1	2	3	4	5
Interpersonal Problems (e.g., communication skills, friendships, etc.)	1	2	3	4	5

13. Please rank order your recommendations for intervention for Mrs. Brown, based on the information given above, and assuming availability, quality, and accessibility of services. Rank all choices below, placing a "1" by your first choice, a "2" by your second choice, and so on, with "8" being your last choice.

_____ a. Support Services (e.g. peer counseling, befriender, support groups, etc.)
_____ b. Medication and/or evaluation for medication needs
_____ c. Marital Therapy
_____ d. Psychotherapy (e.g., individual, group therapy)
_____ e. Neurological/Psychological Evaluation
_____ f. Case Management
_____ g. Hospitalization
_____ h. No Treatment

14. Please assess Mrs. Brown with regard to the following :

	Poor		Average		Excellent
Overall Psychological Functioning	1	2	3	4	5
Motivation for Treatment	1	2	3	4	5
Capacity for Insight	1	2	3	4	5
Prognosis with Intervention	1	2	3	4	5
Prognosis without Intervention	1	2	3	4	5

15. Based on your understanding of the situation, what diagnosis would you expect to be appropriate for Mrs. Brown? ______________________________

16. Please add anything else you would consider relevant in this situation (e.g. interventions not described above, etc.)

Thank You. Please mail your questionnaire in the self-addressed, stamped envelope provided by <u>March 25,</u> 1994 to: Anita Raymond-Wrage, (Researcher's Address)

APPENDIX B

March 10, 1994

Dear Social Worker:
As an MSW student at Augsburg College in Minneapolis, I am conducting a research project on the perspectives and experiences of, and services provided by, social workers who work primarily with adults. The enclosed questionnaire has been sent to a sample of social workers practicing in the Twin Cities area.

The information you provide is anonymous. Please feel free to skip any question which you do not feel comfortable answering, and continue with the questionnaire. All questionnaires will be destroyed on completion of this study; until that time, I will be the only one with access to the returned questionnaires.

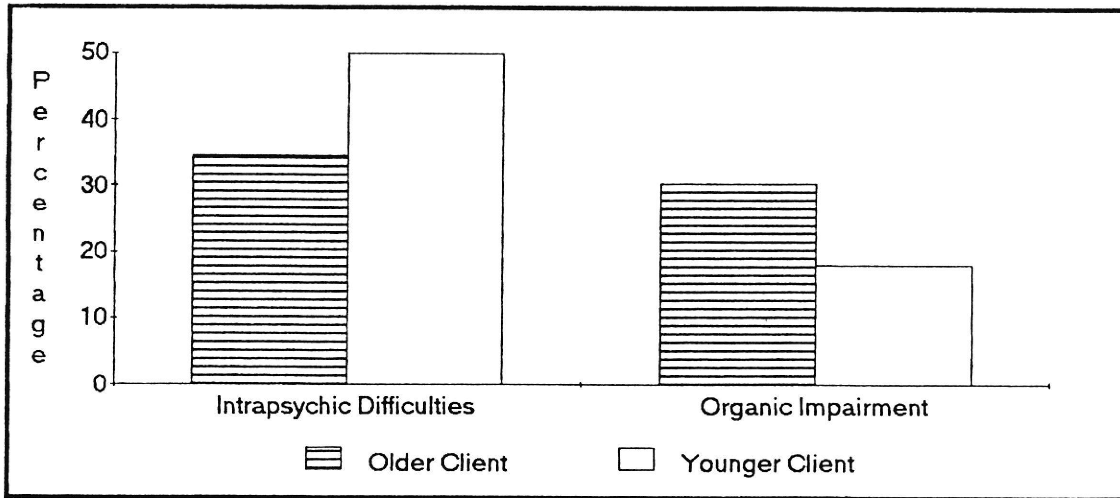
If you agree to participate in the research project, please take approximately 15 to 20 minutes to complete the questionnaire and return it in the enclosed self-addressed, stamped envelope by **March 26, 1994**. Please return the form even if you do not complete the questionnaire.

Thank you for your consideration of this project. Your assistance in completing the attached questionnaire will be most helpful to my research in services provided by social workers. Inquiries to the completed study can be made at the address below. If you should have any questions, please do not hesitate to contact me at (researcher's phone number)
Sincerely,

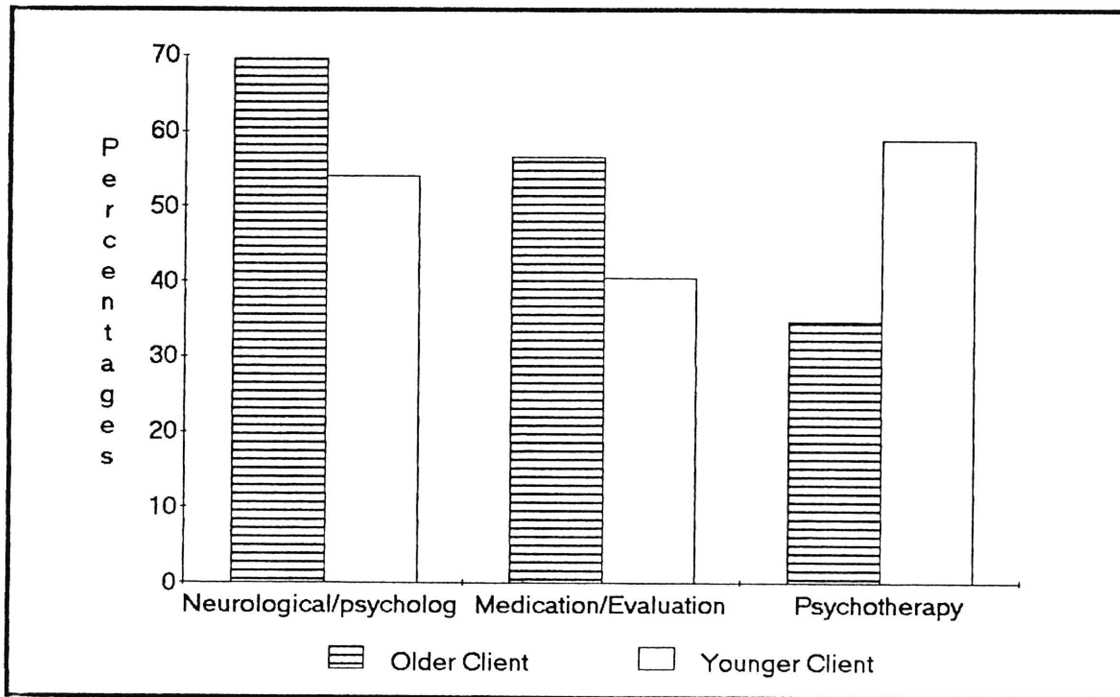
Anita Raymond-Wrage
(Researcher's Address)

APPENDIX C

Graph 1
Comparison of Ratings
of Relevant and Very Relevant
Between
Older and Younger
Client



Graph 2
Comparison of
Frequency of
Top Rankings of
Intervention Recommendations



*NOTE: First and second ranked categories were combined for illustrative purposes.

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