CORRELATES OF PERCEPTIONS OF ELDERS' SUFFERING FROM DEPRESSION

Michael N. Kane
Debra Lacey
Diane Green

Abstract: *This study investigated social work students' perceptions of elders as depressed and suffering (N= 156). Four predictor variables were identified from a standard regression analysis that account for 32% of the model's adjusted variance: (a) perceptions of elders as vulnerable, (b) perceptions about elders seeking professional help, (c) perceptions of social workers' advocacy for elders, and (d) perceptions of elders as oppressed. Overall, respondents perceived elders as being depressed, vulnerable, members of an oppressed group, abusive of substances, and only moderately resilient in response to mental health services. Implications are discussed for social work education.*

Keywords: *Elders, ageism, mental illness, depression*

INTRODUCTION

There is more diversity among elders than any other group of human beings. Older adults may present as jogging at 90 years of age, disabled at 70 years of age, memory impaired at 65 years of age, sexually active at 80 years of age or cognitively intact at 101 years of age. With such diversity, health, mental health, and social service practitioners should make few assumptions about an older individual based solely on age. Yet ageist perceptions predominate in organizations and among professional providers (Barker, 1999; Laws, 1995).

Ageist attitudes have been found among physicians and medical students (Bowling, 1999; Pettersen, 1995; Wilderom, Press, Perkins, Tebes, Nichols, Calkins, Cyrns, & Schimpfhauser., 1990), nurses and nursing students (Beall, Baumhover, Novak, Edwards, Plant, & Pieroni, 1992; Gomez, Young & Gomez, 1991), social workers and social work students (Carmel, Cwikel, & Galinsky, 1992; Kane, 1999a; 2004a; 2004b; 2004c; Kane, Hamlin, & Hawkins, 2004; Rohan, Berkman, Walker, & Holmes, 1994) and diverse groups of mental health practitioners (Ivey, Wieling & Harris, 2000; James & Hayley, 1995; Kane, 1999b). In general, professionals' and students' attitudes toward older adults are in the negative to neutral portions of the attitude continuum (Kane, 1999a).

While professionals may perceive older adults in many ageist ways, some of the most stigmatizing perceptions portray elders as incompetent, useless, inflexible, despondent,

Michael N. Kane Ph.D., MSW, M.Div., and Diane Green Ph.D., MSW are Associate Professors at the School of Social Work at Florida Atlantic University, Boca Raton, FL. Debra Lacey Ph.D., MSW, M.Ed. is Associate Professor at the School of Social Work, Barry University, Miami Shores, FL.
 Advances in Social Work Vol. 7 No.1 (Spring 2006) 44-56.

frail, irritable, and lonely (Bowling, 1999; Cardinali & Gordon, 2002; Gatz & Pearson, 1988; Grant, 1996; Hummert, Garstka, Shaner, & Strahm, 1994; Kane, 1999a; 1999b; 2000; 2002, 2004b; Palmore, 2001; Ragan & Bowen, 2001). If these attributes were directed toward other groups, professionals might view lonely, despondent, and withdrawn individuals as persons displaying symptoms of depression.

While there is an abundance of literature investigating ageism, there is little research on perceptions of elders as depressed and the predictors of those perceptions. This study investigated social work students' perceptions of elders as depressed. It also investigated perceptions of elders as vulnerable, oppressed, in poverty, and abusive of substances.

PERCEPTIONS OF ELDERS SUFFERING FROM MENTAL HEALTH PROBLEMS AND SUBSTANCE ABUSE

Some literature investigating ageism and mental health has focused on professionals' perceptions of the competence of elders (Becker, Schonfeld, & Stiles, 2002; Dunkelman & Dressel, 1994; Gatz & Pearson, 1988; Kane, 1998; 1999a, 2000; 2001; 2003b; Laws, 1995; Palmore, 2001; Ragan & Bowen, 2001). These perceptions portray elders as having dementia and being memory impaired. While Sadock and Sadock (2003) estimate that five percent of people over 65 years have severe dementia and 15% have mild dementia, most elders are not affected by competence issues. Yet many professionals and much of society believe most elders are suffering from dementia and incompetence. While erroneous, it is an ageist perception (Gatz & Pearson, 1988; Kane, 1999b, 2001; 2002, Sadock & Sadock, 2003). When professionals adopt the belief that all elders are memory impaired and incompetent, many conclude that intervention for elders is pointless as there is no cure for dementia (Kane, 2002; 2003a; 2003b; Kane & Houston-Vega, 2004). The belief that intervention is pointless for memory impaired people is referred to as therapeutic nihilism (Dunkelman & Dressel, 1994). While therapeutic nihilism has been associated with reluctance to provide services to elders with dementia, it may also be associated with reluctant attitudes to provide services to older persons with mental health needs. The principle guiding this reluctance may be related to professionals' perceptions of elders' resilience and elders' capacity for emotional and mental health.

Of the mental health concerns for older persons, mood disorders are of significant concern. The incidence of depression is high and effects many elders. Epidemiological estimates suggest that approximately 16% of women and 10% of men aged 65-69 reported depressive symptoms while 22% of women and 15% of men aged 85 and older reported depressive symptoms (Federal Interagency Forum on Aging Related Statistics, 2004). Typically, these symptoms remain undiagnosed and untreated (Bartels & Smyer, 2002; Butler, Lewis & Sunderland, 1998). Lack of professional recognition and intervention for depression may help to explain the fact that the highest rate of suicide is held by elderly males (Bartels & Smyer, 2002; Butler et al., 1998). Complicating and compounding this picture is the prevalence of depression among elders with recently diagnosed and early-stage dementia (Kane, 1999b; Sadock & Sadock, 2003; Yale, 1995).

Understanding professionals' reluctance to diagnose and treat depression among elders is complicated. Health care professionals may fail to recognize the symptoms of depression in older people (Kane, 1999b) or they may attempt to discount the symptoms of depression in elders because of the strong correlation between loss and old age. Other reasons may be more insidious and ageist. For example, physicians limit the number of older adults admitted to their practices (Cykert, Kissling, Layson, & Hanson, 1995; Damiano, Momany, Willard, & Jorgerst, 1997) because of their negative perceptions of working with elders (Cykert et al., 1995; Wilderom et al., 1990). Additionally, reimbursement for work with elders is not a reinforcing incentive because Medicare reimbursement is low (Adams, McIlvain, Lacy, Magsi, Crabtree, Yenny, & Sitorius, 2002). Among mental health practitioners, research indicates that they perceive elders as resistant to treatment and unsuitable for psychotherapy (Ivey, Wieling, & Harris, 2000; Reekie & Hanson, 1992). This research indicates that mental health practitioners believe that elders are not capable of psychosocial improvement and are non-compliant with therapy (Ivey et al., 2000; Reekie & Hanson, 1992). No matter the reasons for practitioners' reluctance to diagnose and treat depression and other mental disorders among elders, epidemiologists predict that by the year 2030 the greatest number of mental health needs will be found among elders (Bartels & Smyer, 2002).

In addition to mental health needs are the closely related needs surrounding the misuse of substances. Elders' misuse and abuse of alcohol and other substances is common and often ignored by professionals (Blow, Oslin & Barry, 2002; Sadock & Sadock, 2003). Prescription and over-the-counter medication misuse is significant (Sadock & Sadock, 2003). Estimates of alcohol abuse by elders range as high as 15% (Blow et al., 2002). Little is known about the usage of illicit street drugs by the current cohort of elders, but estimates remain low (Blow et al., 2002). As the baby-boomers age, however, the expectation is that illicit substance usage will increase. While baby boomers have experimented with various substances, concerns about the effects of these substances on aging bodies are great. Many baby boomers will have used substances in varying frequencies, combinations, and intensities over their lives. While there may be recognizable consequences to the life-long usage of some substances, some boomers will continue to use these substances as they age or experiment with substances previously untried. Since older adults have increased sensitivity to substances, their bodies may face challenges to process these substances (Blow et al., 2002; Sadock & Sadock, 2003). Professionals' knowledge of licit and illicit substance usage on the aging body will remain critically important.

BARRIERS TO AGING: ELDERS SUFFERING VULNERABILITY, POVERTY AND OPPRESSION

A stable component of the American dream has been that after a life time of work, one is entitled to comfortably retire and live off accumulated savings, investments, pensions, and social security (Stanford & Usita, 2002). Contrary to this belief are the economic realities of fixed incomes, limited assets, and inconsistent work histories

over the life course. Increasingly Americans are aware that some elders live in poverty and because of economic necessity must remain in the work force (Stanford & Usita, 2002). It is estimated that 10% of elders live below the poverty threshold with poverty affecting older blacks (24%) and older Latinos (21%) at higher rates than non-Latino whites (8%) (Federal Interagency Forum on Aging Related Statistics, 2004). Older women (12%) are also more likely to be in poverty than older men (8%) (Federal Interagency Forum on Aging Related Statistics, 2004).

While women and people of color may have experienced oppression throughout their lives, advanced age may heap more financial challenges on these groups as a result of diminished capacities to work and to provide for essential life needs (Stanford & Usita, 2002). Other groups that have experienced oppression and marginalization over the lifespan, such as lesbian, gay and other sexual minorities may experience new forms of discrimination and new economic barriers. These inequities will result from unequal treatment under Social Security, pension plans, and federal law (Cahill & South, 2002).

Oppression impacts the lives of many older adults. For individuals who have faced oppression and discrimination during most of their lives, crisis-competence may have prepared these individuals for the unique stresses of aging (Cahill & South, 2002). These individuals may cope with aging as they have coped with other life challenges. Elders who cope less effectively with the stresses of aging may require other professional intervention.

In spite of the immense diversity among aging adults, old age may impact the physical, psychological and social functioning of a person. For some older adults, their choices and preferences for independent living are affected by physical and psychological needs. These challenges may result in physical, psychological, social or financial dependence. Frailty and vulnerability are critical considerations in the needs of some aging persons. Interestingly, frailty and vulnerability when attributed to elders indiscriminately may be viewed as an ageist reference (Kane 1999a; 2004b; 2004c).

Professionals' perceptions of the resilience of elders in the face of oppression and vulnerability may become critically important as their communicated belief in a client's ability may encourage or discourage clients as well as effect treatment outcome (Sadock & Sadock, 2003). Professionals' belief in clients' competence, strength, and resilience may empower elders to develop and maintain successful coping strategies for aging.

SOCIAL WORKERS AND ELDERS WITH MENTAL HEALTH NEEDS

Social workers provide a vast array of services to elders, especially elders with mental health needs. They offer clinical services at individual, family, and group levels. Some social workers may advocate for elders and elders with mental health needs in larger systems. Other elders with mental health needs will require case management services, socialization, brokering, and advocacy. Some elders will require protection through reporting of abuse, neglect or exploitation. While all professions have preferred models for assessment and intervention, social workers typically do not rely on

bio-medical models of assessment and intervention which highlight deficits (Bartels & Smyer, 2002; Bartels, Haley & Dums, 2002; Bhana & Spencer, 2000). A service plan intended to mediate client deficits flows from an assessment which focuses on client deficits. Although social workers may observe deficits that accompany human aging, they are trained to assess and intervene with clients working from a client's strengths and capabilities. Viewing a client from a strengths perspective allows the practitioner to see past what the client is unable to do in order to implement intervention based on a client's abilities and successes.

Gerontological social workers will have specialized knowledge of interventions and the resources available to elders and elders with mental health needs. Knowledge of resources and supports available to elders will form a continuum ranging from community services to institutional care. Gerontological social workers will have knowledge of those services limited to elders who have the ability to private pay as well as the services that are available to elders on limited incomes. These social workers will be familiar with services that are fully or partially covered by Medicare, Medicaid or private insurance (Barusch, 1995). Gerontological social workers will advocate and perform specialized services in care of elders and elders with specific mental health needs. The need for these specializations will increase as the population ages (Kane, Hamlin & Hawkins, 2004). Social workers will need to take key positions in service delivery environments for older adults as well as in policy formation as they are uniquely qualified for these functions.

This study sought to investigate the perceptions of future social workers about older adults as depressed. Specifically, this study sought to investigate whether perceptions of vulnerability, oppression, substance abuse, and elder resilience influenced perceptions of elders suffering from depression. These perceptions may influence willingness of future social workers to provide services to older adults with mental health needs as well as the type of services they might consider appropriate to aging populations.

METHODOLOGY

Sampling and Data Collection

BSW and MSW student respondents participated in an anonymous, self-administered, in-class survey (N= 156). The sample reflected Florida's immense diversity. Specifically, the demographic variables included gender [female = 127 (81.4%), male = 29 (18.6%)], educational program [BSW = 71 (45.8%), MSW = 84 (54.2%)], ethnocultural identification [European American = 85 (55.2%), African American = 23 (14.9%), Caribbean American = 17 (11.0%), Latino = 27 (17.5%), other = 2 (1.2%)], and age (Mean = 33.85, Min. = 19, Max. = 69). Data gathered specifically for this study was attached to an instrument which investigated social work students' perceptions regarding service of elders and perceptions associated with death.

Instrumentation

Based on a literature review, multiple items were developed to consider respondents' perceptions about the emotional states of elders and their resilience. Face validity was determined by the researchers, social work educators and practitioners. A five point Likert-type scale (1= strongly agree, 2 = agree, 3 = Not sure - Neither agree nor Disagree, 4 = Disagree, 5 = strongly disagree) was adopted to respond to each of the items. Each of the variables is described below.

Perceptions of elders as suffering from depression: This variable, chosen as the dependent variable for this analysis, consisted of four items (elders suffer from depression, depression is untreated in elders, etc.). Scores ranged from a minimum of 4 to a maximum of 20, with lower scores indicating greater perceptions that elders are depressed. The mean score of 9.0 (SD =2.7) suggests that respondents perceived elders to be depressed. A reliability coefficient was calculated at .7

Perceptions of elders as vulnerable: Using five items (To grow old is to become vulnerable, being old means being vulnerable, older people are vulnerable, etc.), this independent variable was used to measure perceptions of elders as vulnerable members of society by virtue of their age. Scores ranged from a minimum of 5 to a maximum of 24 out of a possible 25. Lower scores suggest perceptions of greater vulnerability among elders. The mean score was 12.2 (SD = 3.5). Reliability was calculated at .7.

Perceptions of elders negative actions to treat themselves: This independent variable consisted of four items that asked respondents about their perceptions of elders using street drugs, abusing alcohol and other substances, and of using substances to self-medicate feelings of sadness. Scores ranged from a minimum of 9 to a maximum of 20, with a mean value of 15.5 (SD = 2.2). This suggests that respondents perceived elders to be somewhat abusive of substances.

Perceptions of the resilience of elders with mental illness or substance abuse: This variable was comprised of two items (elders with mental illness don't improve, substance abuse in old age is permanent). Reliability analysis was calculated at .7. Scores ranged from a minimum of 2 to a maximum of 10 with lower scores suggesting more negative perceptions of elders' resilience. In this study, a mean of 6.4 (SD = 1.6) was calculated.

Perceptions about elders seeking professional help: This variable consisted of two items (elders seek psychotherapeutic services, elders are treatment compliant). With a minimum score of 3 and a maximum score of 10, the mean was calculated at 7.0 (SD = 1.4). Lower scores suggest positive perceptions of elders seeking psychotherapeutic services.

Perceptions of social workers' advocacy for elders: This variable consisted of 5 items which investigated perceptions of social workers' advocacy for elders (Social workers perform valuable services to the elder community, solve problems, report elder abuse, etc.). With a reliability score calculated at .8, scores ranged from a minimum of 5 to a maximum of 25. The mean score of 8.3 suggests that respondents perceived social workers as effective advocates for elder clients.

Perceptions of elders in poverty: This variable consisted of 2 items (poor people need help, are minorities) with scores ranging from 2 to a maximum of 10 and a mean score of 4.8 (SD = 1.8). Lower scores suggest that respondents perceive the poor as needing assistance.

Perceptions of elders as oppressed: Two items referencing elders as oppressed people were used to measure perceptions of elders as an oppressed group. With scores ranging from a minimum of 2 to a maximum of 10, the mean score was 4.2 (SD = 1.6). A reliability coefficient was calculated at .7. Lower scores indicate agreement with the idea that elders are an oppressed population.

RESULTS

Table 1 contains univariate statistics for all continuous variables. Bivariate correlations between the dependent variable and all independent variables were computed. Statistically significant associations were found between the dependent variable and the following independent variables: perceptions of elders as vulnerable (r= .384, p = .000), perceptions of elders' negative actions to treat themselves (r = -.182, p = .024), perceptions about elders seeking professional help (r = -.218, p = .007), perceptions of social workers' advocacy for elders (r = .362, p = .000), perceptions of elders in poverty (r =.261, p = .002), and perceptions of elders as oppressed (r = .479, p = .000). Table 2 contains detailed correlation information.

A standard regression analysis that incorporated all the independent variables significantly correlated with the dependent variable (perceptions of elders as suffering from depression) was performed. These variables included perceptions of elders as vulnerable, perceptions of elders' negative actions to treat themselves, perceptions about elders seeking professional help, perceptions of social workers' advocacy for elders , perceptions of elders in poverty, and perceptions of elders as oppressed. This model produced an initial solution with three significant predictor variables (R = .589, Adjusted R^2 = .315, F = 10.995, p = .000).

In further exploration and to build an economic model, variables which did not approach significance were excluded from further analysis. The final model adopted for this study used four predictor variables which accounted for 32.0% of the adjusted variance. These predictor variables included: (a) perceptions of elders as vulnerable, (b) perceptions about elders seeking professional help, (c) perceptions of social workers' advocacy for elders, and (d) perceptions of elders as oppressed. The final model summary is found in Table 3.

Discussion

Respondents perceived elders as suffering from depression, members of an oppressed group, vulnerable, moderately abusive of substances, and only somewhat resilient with the usage of mental health services. Respondents strongly perceived social workers as effective advocates for elders. These perceptions are generally in line with the ageism literature that suggests that elders are perceived in the neutral to negative end of the attitude continuum.

Table 1. Univariate statistics for the dependent and predictor variables

Perceptions of:	Mean	S.D.	Min	Max
elders as vulnerable	12.25	3.58	5	24
elders as suffering from depression	9.06	2.72	4	20
Elders negative actions to treat themselves	15.56	2.24	9	20
Resilience of elders with mental illness/substance abuse	6.50	1.66	2	10
Elders seeking professional help	7.09	1.41	3	10
Social workers' advocacy for elders	8.39	2.82	5	25
Elders in poverty	4.80	1.81	2	10
elders as oppressed	4.29	1.66	2	10

Table 2. Bi-variate correlations of the independent to the dependent variable (perceptions of elders as suffering from depression

Perceptions of:	Correlation	p-value
elders as vulnerable		
elders as suffering from depression	.384	.000*
Elders negative actions to treat themselves	-.182	.024*
Resilience of elders with mental illness/substance abuse	-.076	.351
Elders seeking professional help	-.218	.007*
Social workers' advocacy for elders	.362	.000*
Elders in poverty	.261	.002*
elders as oppressed	.479	.000*
Gender	.088	.281
Educational Program	-.109	.182

Table 3. Regression Summary Table: Final Model with the dependent variable (perceptions of elders as suffering from depression

Predictor Variables	B	Beta	T	Sig.
Perceptions of elders as vulnerable	.190	.250	3.544	.001*
Perceptions about elders seeking professional help	-.310	.131	-2.368	.019*
Perception of social workers' advocacy for elders	.124	.129	1.687	.094
Perception of elders as oppressed	.543	.334	4.343	.000*

Of note, however, is the finding that elders were perceived by respondents as depressed. While not all elders suffer from depression or its associated symptoms, this finding suggests that future social workers are cognizant of the prevalence of depression among elders and potentially may be more likely to recognize the symptoms of depression in older adults. The finding that respondents perceived elders as only moderately benefiting from mental health services was disappointing and supports other literature which investigated ageism among mental health providers (cf: Ivey et al., 2000; Reekie & Hanson, 1992). This remains an important area for continuing education in social work. Future and current social workers may benefit from understanding that elders are resilient and capable making and maintaining meaningful

psychotherapeutic gains.

Bivariate correlations revealed associations between the dependent variable of perceptions of elders as suffering from depression and (a) perceptions of elders as vulnerable, (b) perceptions of elders' negative actions to treat themselves, (c) perceptions of elders seeking professional help, (d) perceptions of social workers' advocacy for elders, (e) perceptions of elders in poverty, and (f) perceptions of elders as oppressed. It is interesting to note that the variable "perceptions of resilience of elders with mental illness or substance abuse" was not correlated with the dependent variable of perceptions of elders as suffering from depression. This may suggest that while respondents perceived elders as suffering from depression, they did not tie this perception to the perception of elder recovery from either mental illness or substance abuse concerns. These again would be important considerations for continuing education programs as they consider how best to change perceptions and to increase practitioners' abilities to assess elders and to develop service goals appropriately.

In the model building, three variables were significantly predictive. These included: (a) perceptions of elders as vulnerable, (b) perceptions about elders seeking professional help, (c) perceptions of elders as oppressed. A fourth variable approached significance (perceptions of social workers' advocacy for elders, $p = .094$). In an effort to avoid a type II error, the variable was retained in the final model. Perceptions of elders as suffering from depression logically appears to be tied to perceptions of elders as vulnerable and perceptions of elders as oppressed. Social workers are trained to assess the impact of environmental factors on an individual's functioning and health. It is clear that respondents have made appropriate connections regarding the impact of oppression and vulnerability. It is interesting to see that the variable of perceptions of elders as suffering from depression was tied to the variable of perceptions about elders seeking professional help. While respondents perceived elders as suffering from depression, they perceived elders as only moderately resilient with the usage of mental health services. This is further explained in the negative bivariate correlation between this variable and the dependent variable. In other words, the perception about elders suffering from depression increases as the perception of elder's use of psychotherapeutic services decreases. In further consideration, the dependent variable was not significantly correlated in the bivariate analysis with perceptions of elders' resilience with mental illness or substance abuse. Items in this variable investigated perceptions about elder's capacity to recover from mental illness or substance abuse problems. The lack of correlation to the dependent variable may suggest that respondents believe that elders who suffer from depression may improve if they seek mental health services appropriately; without reference to the resilience possessed by elders who have mental health or substance problems.

Of equal interest are two variables that did not significantly predict perceptions of elders as suffering from depression: perceptions of elders in poverty and perceptions of elders' negative actions to treat themselves. While it may be logical to consider that perceptions of elders in poverty might be predictive of perceptions of elders as suffering from depression, it was not. This suggests that perhaps respondents disconnected this social stressor as a significant contributor to depression. It is difficult to consider

that the impact of poverty on the mental health of elders was overlooked by respondents when oppression and vulnerability contributed significantly to the model's variance. This finding is confusing and requires further investigation.

It is equally interesting to note that perceptions of elders' negative actions to treat themselves (self medicating behaviors, etc.) did not significantly contribute to the model building. Social work education generally includes material on substance abuse and mental illness. Most students are exposed to concepts such as dual diagnosis as well as the bio-psycho-social aspects of substance abuse in HBSE content and the practice sequence. While respondents perceived elders as somewhat abusive of substances, they did not make a connection between substance usage and depression. This may be problematic, as elder may use substances to self-medicate symptoms of depression following major losses as in late-onset substance abuse (Blow et al., 2002; Sadock & Sadock, 2003). This is distinct from situations in which elders have been abusing substances for their entire life. Intervention is predicated on this distinction. Current and future practitioners clearly need the knowledge and skills to adequately assess this area in their practice. Again, this area is an important consideration in developing continuing education agendas that stress the well-being of older adults.

These findings have implications for social work continuing education. Social work educators have always been attentive to stigmatizing social perceptions. Social work curricula seek to impart knowledge and skill from a value-based perspective. Practitioners are encouraged from micro, mezzo and macro levels to challenge discrimination and oppression. Additionally, practitioners are encouraged to develop advocacy skills for vulnerable and oppressed populations. While students in this study identified elders as depressed and as members of an oppressed group, they believed that elders are abusive of substances and only moderately resilient with mental health intervention. These perceptions suggest that these students have received the message that depression in older populations is largely untreated and that multiple factors may be connected to depression. While their perceptions of elders as abusive of substances clearly merits further investigation, it stands to reason that respondents and practitioners need to see a connection between substance usage and depression. What is particularly troublesome, however, is the perception that elders are only moderately resilient when provided mental heath services. Consistent with other literature, this suggests a variant type of therapeutic nihilism (Dunkelman & Dressel, 1994), an insidiously harmful type of ageism that discredits intervention and service. Classroom and continuing educators will need to incorporate elders in their cases studies that use empowerment and strengths perspectives. Highlighting elders as capable and resilient will encourage a more balanced representation of aging.

SUGGESTIONS FOR FUTURE RESEARCH/LIMITATIONS

This study used anonymous responses from a convenience sample of social work students. Florida has been viewed as a retirement haven for elders. Thus, respondents' perceptions may be predicated on common perceptions regarding the region as well as perceptions about the bio-psycho-social realities of aging. Thus, for greater generalizability, probability samples should be drawn from various geographic areas that may

better represent the perceptions of social work students.

References

Adams, W. L., McIlvain, H. E., Lacy, N. L., Magsi, H., Crabtree, B. F., Yenny, S. K., & Sitorius, M. A. (2002). Primary care for elderly people: Why do doctors find it so hard? *The Gerontologist, 42,* 835-842.

Barker, R. L. (1999). *The social work dictionary* (4th Ed.). Washington, DC: National Association of Social Workers.

Bartels, S. J., & Smyer, M. S. (2002). Mental disorders of aging: An emerging public health crisis. *Generations: Journal of the American Society of Aging, xxvi*(1), 14-20.

Bartels, S. J., Haley, W. E., & Dums, A. R. (2002). Implementing evidence-based practices in geriatric mental health. *Generations: Journal of the American Society of Aging, xxvi*(1), 90-98.

Barush, A. S. (1995). Programming for family care of elderly dependents: Mandates, incentives, and service rationing. *Social Work, 40,* 315-322.

Beall, C., Baumhover, L. A., Novak, D. A., Edwards, B. M., Plant, M. A., & Pieroni, R. E. (1992). Educating about Alzheimer's disease: Curricular implications for health professionals. *Gerontology & Geriatric Education, 12*(3), 93-107.

Becker, M., Schonfeld, L., & Stiles, P.G. (2002). Assisted living: The new frontier for mental health care? *Generations: Journal of the American Society of Aging, xxvi*(1), 72-77.

Bhana, N. & Spencer, C. M. (2000). Respirdone: A review of its use in the management of the behavioural and psychological symptoms of dementia. *Drugs and Aging, 16,* 451-471.

Blow, F. C., Oslin, D.W., & Barry, K. L. (2002). Misuse and abuse of alcohol, illicit drugs, and psychoactive medication among older people. *Generations, xxvi* (1), 50-58.

Bowling, A. (1999). Ageism in cardiology. *British Medical Journal, 319,* 1353-1355.

Butler, R. N., Lewis, M. I., & Sunderland, T. (1998). *Aging and mental health: Positive psychosocial and biomedical approaches* (5th Ed.). Boston: Allyn & Bacon.

Cahill, S., & South, K. (2002). Policy issues affecting lesbian, gay, bisexual and transgender people in retirement. *Generations, xxvi* (11), 49-54.

Cardinali, R., & Gordon, Z. (2002). Ageism: No longer the equal opportunity stepchild. *Equal Opportunities International, 21*(2), 58-69.

Carmel, S., Cwikel, J., & Galinsky, D. (1992). Changes in knowledge, attitudes, and work preferences following courses in gerontology among medical, nursing, and social work students. *Educational Gerontology, 18,* 329-342.

Cykert, S., Kissling, G., Layson, R., & Hansen, C. (1995). Health insurance does not guarantee access to primary care: A national study of physicians' acceptance of publicly insured patients. *Journal of General Internal Medicine, 10,* 345-348.

Damiano, P., Momany, E., Willard, K., & Jogerst, G. (1997). Factors affecting primary care physician participation in Medicare. *Medical Care, 35,* 1008-1019.

Dunkelman, D. M., & Dressel, R. C. (1994). The nursing home environment and dementia care. In M. K. Aronson (Ed.), *Reshaping dementia care - Practice and policy in long-term care,* (pp. 60-68). Thousand Oaks, CA: Sage Publications.

Federal Interagency Forum on Aging Related Statistics. (2004). Older Americans 2004: Key indicators of well-being. Washington, DC: US Government Printing Office.

Gatz, M., & Pearson, C. G. (1988). Ageism revised and the provision of

psychological services. *American Psychologist, 43*(3), 184-188.

Gomez, G. E., Young, E. A., & Gomez, E. A. (1991). Attitude toward the elderly, fear of death, and work preference of baccalaureate nursing students. *Gerontology & Geriatrics Education, 11*(4), 45-56.

Grant, L.D. (1996). Effects of ageism on individual and health care providers' responses to healthy aging. *Health & Social Work, 21*, 9-17.

Hummert, M.L., Garstka, T. A., Shaner, J. L., & Strahm, S. (1994). Stereotypes of the elderly by young, middle-aged, and elderly adults. *Journal of Gerontology Psychological Sciences, 49* 240-249.

Ivey, D.C., Wieling, E., & Harris, S.M. (2000). Save the young - The elderly have lived their lives: Ageism in marriage and family therapy. *Family Process, 39, 163-175.*

James, J.W., & Hayley, W. E. (1995). Age and health bias in practicing clinical psychologists. *Psychology and Aging, 10,* 610-616.

Kane, M. N. (1998). Consent and competency in elders with Alzheimer's disease. *American Journal of Alzheimer' Disease, 13*(4), 179-188.

Kane, M. N. (1999a). Factors affecting social work students' willingness to work with elders with Alzheimer's Disease. *Journal of Social Work Education, 35*(1), 71-85.

Kane, M. N. (1999b). Mental health issues and Alzheimer's disease. *American Journal of Alzheimer's Disease, 14*(2), 111-119.

Kane, M. N. (2000). Ethnoculturally-sensitive practice and Alzheimer's disease. *American Journal of Alzheimer' Disease, 15*(4), 80-86.

Kane, M. N. (2001). Legal guardianship and other alternatives in the care of elders with Alzheimer's disease. *American Journal of Alzheimer' Disease and Other Dementias, 16*(2), 89-96.

Kane, M.N. (2002). Awareness of ageism, motivation, and countertransference in the care of elders with Alzheimer's disease. *American Journal of Alzheimer' Disease and Other Dementias, 17*(2), 101-109.

Kane, M. N. (2003a). Investigating the factor structure of an instrument to measure attitudes and preparedness to work with elders with Alzheimer's disease. *Gerontology & Geriatrics Education, 24*(1), 15-29.

Kane, M. N. (2003b). Teaching direct practice techniques for work with elder with Alzheimer's disease: A simulated group experience. *Educational Gerontology: An International Journal, 29*(9), 777-794.

Kane, M. N. (2004a). Predictors for future work with elders. *Journal of Gerontological Social Work, 42 (3/4), 19-38.*

Kane, M. N. (2004b). Ageism and Intervention: What social work students believe about teaching people differently because of age. *Educational Gerontology: An International Journal, 30*(9), 767-784.

Kane, M. N. (2004c). Perceptions of adequacy for direct practice with elders with Alzheimer's disease. *Arete, 28*(1), 65-76.

Kane, M. N., & Houston-Vega, M. K. (2004). Maximizing content on elders with dementia while teaching multicultural diversity. *Journal of Social Work Education, 40*(2), 285-303.

Kane, M. N., Hamlin, E. R., & Hawkins, W. E. (2004). How adequate do social workers feel to work with elders with Alzheimer's disease? *Social Work in Mental Health, 2*(4), 63-84.

Laws, G. (1995). Understanding ageism: Lessons from feminism and postmodernism. *The Gerontologist, 35*(1), 112-118.

Palmore, E.H. (2001). The ageism survey: First findings/response. *The Gerontologist, 41*, 572-575.

Pettersen, K. I. (1995). Age-related discrimination in the use of fibrinolytic therapy in acute myocardial infarction in Norway. *Age and Aging, 24*, 198-203.

Ragan, A. M., & Bowen, A. J. (2001). Improving attitudes regarding the elderly population: The effects of information and reinforcement for change. *The Gerontologist, 41*, 511-515.

Reekie, L., & Hansen, F. J. (1992). The influence of client age on clinical judgements of male and female social workers. *Journal of Gerontological Social Work, 19*, 67-82.

Rohan, E. A., Berkman, B., Walker, S., & Holmes, W. (1994). The geriatric oncology patient: Ageism in social work practice. *Journal of Gerontological Social Work, 23*(½), 201-221.

Sadock, B. J., & Sadock, V. A. (2003). *Kaplan & Sadock's Synopsis of psychiatry* (9th ed.). Philadelphia: Lippincott Williams & Wilkins.

Stanford, E. P., & Usita, P. M. (2002). Retirement: Who is at risk? *Generations, xxvi* (11), 45-48.

Wilderom, C. P. M., Press, E. G., Perkins, D. V., Tebes, J. A., Nichols, L., Calkins, E., Cyrns, A. G., & Schimpfhauser, F. (1990). Correlates of entering medical students' attitudes toward geriatrics. *Educational Gerontology, 16*(5), 429-446.

Yale, R. (1995). *Developing support groups for individuals with early-stage Alzheimer's disease.* Baltimore: Health Professions Press.

Author's Note

Address correspondence to Michael N. Kane Ph.D., Associate Professor, School of Social Work, Florida Atlantic University, 777 Glades Road - P.O. Box 3091 Boca Raton, FL. 33431-0991. E-mail: MNKane@aol.com