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Clinical Educators' Reactions to Ageing

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ABSTRACT

Ageism and negative attitudes towards ageing have been identified within the literature as a cause for concern. Reactions to ageing are known to be strongly positively correlated with attitudes towards older people in general. Moreover, the link between ageist practice and quality of care is also established, but implications for education and training have not been explored. The aim of this study was to investigate the reactions to ageing of clinical and fieldwork educators of undergraduate students. Clinical and field work educators are largely responsible for all the clinical education received by these students and thus have the potential to be highly influential in the development of their attitudes towards the elderly. Reactions to ageing were measured among clinical educators registered with a University in South East England using The Reaction to Ageing Scale, and scores were classified into typologies. Results were obtained from 62% (n=87) physiotherapy and 87% (n=81) podiatry clinical educators and 71% (n=53) of occupational therapy fieldwork educators, attending training sessions. There was a significantly greater proportion of gerophiles among the physiotherapists than among the other groups. Podiatry gerophiles were significantly older than gerophiles in the other professional groups. The results from this small study suggest that further national work is indicated to examine attitudes in a larger population.

INTRODUCTION

Ageism involves stereotypes and negative attitudes towards a person or group on the grounds of age. These attitudes are often subtle and implicit rather than explicit, and are generally, though not exclusively, directed towards older people. Where such attitudes form the primary motivation behind acts of discrimination against that person or group, then those acts constitute age discrimination.

Picton suggests that ageism, attitude, and stereotyping permeate every aspect of older peoples' lives, and older people constitute much of the workload of Allied Health Professionals.¹ Nevertheless, literature to date demonstrated little examination of how such attitudes manifest in practice settings, and few studies have attempted to unravel the complexity of attitudes towards older people or toward the ageing process in general. Attitudes may be considered to be a combination of positive and negative evaluations by which we interpret the events, situations, and relationships. They are based on our own experience, what others have told us, or what others have patterned for us.

Braithwaite suggests that as attitudes are likely to reflect the coexistence of positive and negative responses, then the broad term "ageism" lacks conceptual clarity.² More recently, Braithwaite et al conclude that "ageism, as consciously held beliefs and attitudes, offer little by the way of prediction or explanation."³

Commonly, people's beliefs about old age are built upon stereotypes that are developed in formative years and which, if unchallenged, become adopted and perpetuated. Studies have shown consistently that younger people, including health professional students, accept common stereotypes about older people and about growing old.⁴

The changing demographics of the general population increase concerns over ageist attitudes among health professionals. Men aged 65 years in 2002 can expect to live to 81 and women 84 years of age.⁵ Over the next 20 years there will be a significant increase in the numbers of elderly people and an increased demand for health care services. The numbers of people over the age of 65 in the UK are predicted to increase from 9.25 million in 1996 to 12 million in 2021. Life expectancy is projected to increase from 74.3 years to 77.9 years for men and from 79.5 years to 82.6 years for women in that period. These estimates rise to 79 years and 84 years respectively by the middle of the century. By this time, the number of people aged over 75 will have doubled, and the number aged over 90 will have more than tripled.

With increasing age, there tends to be greater complexity in both diagnosis and treatment of illness, because older people are more likely to experience multiple, often chronic conditions.⁶ Potentially treatable or manageable health concerns such as balance problems, incontinence, and pain may be attributed to "being old" rather than issues to be dealt with in the most efficacious way. Doctors, for example, may see the problems of older patients as "irreversible, unexciting, or untreatable."⁶ Similarly, among nurses there are reports that older people were invariably considered to be "stupid, decrepit, feeble, unusually eccentric, wise, or sweet natured."⁷ Mandy proposes that some professional groups such as nurses, podiatrists and occupational therapists are more commonly associated with predominantly older people as clients. As a result of this they may be less aware of the changing demographics and increasing numbers of older people. She suggests that other professional groups such as physiotherapists, who are more commonly associated with and treat a wider range patients, may be less aware of the changing demographics and thus the implications for clinical practice.⁸ Such thinking has in turn resulted in her questioning whether health care students and educators are aware of the changing demographics of the population and whether both groups recognise that this may result in a potential change to the role and education of health care professionals. Conversely, others suggest that health professionals' attitudes tend to be more negative than those amongst society in general, perceiving the elderly to be demanding and difficult.⁹

However, there are other factors that appear to influence ageist attitudes. For example, older students tend to be less ageist than do younger students, and rural students tend to be more ageist than do urban students.¹⁰ Frequency of contact with older people is also an influential factor, and the nature of this contact is crucial: intimate (friends, familial) rather than non-intimate contact appears to be more conducive to positive attitudes.¹¹ While some studies report that greater knowledge about older people is associated with less stereotypical attitudes about them, others have found only weak correlations between knowledge about aging processes and attitudes towards aging.¹²⁻¹⁴

In the light of these findings, it is unsurprising that studies from the 1990s suggest that in the UK, care of the elderly is an unpopular field in most clinical careers including medicine, nursing, and social work.¹⁵ These results were confirmed by Collison in 1992, who reported that ageism was evident within the nursing profession and suggested that this probably reflected attitudes held generally by society towards the elderly.¹⁶ Similarly, Gething et al in 2002 described a study that investigated knowledge, stereotyping, and reactions to self-aging within the nursing profession in the UK and Australia. She concluded that reactions to ageing were strongly positively correlated with attitudes towards older people.¹⁷ Results from both countries indicated strong negative attitudes which devalued older people in terms of both their attributes and capabilities. She further highlighted in this study that the development of strategies to address ageism within the nursing profession were urgently needed.¹⁷ The questionnaire used in these studies was designed to assess how individuals anticipate and react to their own personal aging. It was used to measure negative and positive reactions, which is in contrast to most other instruments which focus on attitudes or level of accurate knowledge possessed about others.

In contrast to those of doctors and nurses, the attitudes and reactions to ageing of allied health care professionals towards older people remain under-researched and are limited to specific clinical areas such as surgery and cardiology, controversy surrounding resuscitation, the exclusion of elderly people from research, and discrimination of quality of care.¹⁸⁻²² While these studies acknowledge the potential for ageism in clinical practice, studies which challenge it are few.²³ Nevertheless despite a dearth of literature, Billings notes that there are clear links between ageist practice and reduced quality of care, and asserts that education and training could address ageism and attitudes to older people.²⁴

It is the workload of allied health professionals that is most likely to be affected by the demographic changes described above. While sharing broadly similar models of clinical education, there is limited relevant research available for this group. This study investigated the personal reactions to ageing among clinical and fieldwork educators from occupational therapy, physiotherapy, and podiatry.

METHODS

Ethical approval for the study was obtained from the University's Ethics Committee in September 2004.

All clinical and fieldwork educators within the disciplines of occupational therapy, physiotherapy, and podiatry were invited to participate in the study when they attended clinical education sessions at a University in South East England during the academic year 2004/5. Only educators currently involved in student clinical and fieldwork education were included. The study was conducted over one academic year, and sampled qualified educators who attended the University for clinical/fieldwork update education training days. (The term "clinical educator" has traditionally been used by the physiotherapy and podiatry professions, while "fieldwork educator" is used by the occupational therapy profession; the terms, however, are synonymous.)

Our own University's database of clinical/fieldwork was consulted to estimate the potential size of the target population under investigation. There were 100 occupational therapy fieldwork educators, 150 physiotherapy clinical educators, and 100 podiatry clinical educators available for sampling. The database detailed all the eligible participants who attended our clinical/fieldwork educator training days and who were responsible for our students' clinical/fieldwork experience. Clinical and fieldwork educators co-ordinating the training sessions within the School of Health Professions were approached by the researcher to obtain access to speak to the educators prior to commencing their training days. The training days were provided for experienced clinical educators to attend as part of their continuing professional development programme. It was also a forum whereby the University could update the educators on changes to the student clinical education programme and also receive feedback from the educators concerning their role and responsibilities. All educators on the database were required to attend once per year.

At each training session, the study was explained by the researcher to the clinical/fieldwork educators, who were invited to participate and provided with a pack containing the assessment questionnaires and participant information sheets. If the educators chose to participate, they were asked to complete the questionnaires and to leave them in a returns box which, at the end of each session, was returned to the researcher. All the questionnaires were completed on site. If the respondents chose not to participate, they were asked to return their packs unmarked in a different returns box. The questionnaires did not collect any identifying information and were anonymous. Participants were assured of confidentiality.

Questionnaire Pack

The questionnaire pack contained a demographic questionnaire and the Reactions to Ageing Questionnaire (RAQ, Appendix 1).²⁵ The demographic questionnaire recorded profession, gender, length of time qualified, and length of time as a clinical educator. The RAQ is a 6-point, 27-item Likert scale. The statements range from "disagree very much" to "agree very much" and give rise to a score ranging from 27-162 with higher scores being regarded as less ageist.²⁵ The RAQ can be scored to classify attitude types: scores from 27-79 are classified as gerophobes and are indicative of negative attitudes towards aging. Scores between 80 and 119 are classified as neutral, and scores of 120+ are indicative of gerophiles, or people with positive attitudes towards ageing.

The RAQ is an open access tool that has been established as a reliable and valid index of personal reactions towards ageing and is internationally recognised and cited extensively within the literature.^{10,25,26} Gething reports Cronbach alpha coefficients of 0.81 indicating a high level of internal consistency.²⁶ Furthermore, comparison with other established measures including Palmore's Facts on Ageing Quiz and the Aging Semantic Differential indicate strong association ($r=0.35$, $p<0.05$ respectively) demonstrating convergent and discriminant validity.²⁵ The RAQ assesses personal reactions to ageing, and it is firmly established that such reactions are strongly positively correlated to attitudes towards older people.^{3,26,27}

Statistical analysis

Differences in demographic measurements between the professional groups were investigated using one-way analysis of variance. Chi-squared tests of association or Fisher's exact tests were used to examine differences in attitudes to aging types between the professional groups and genders. A significance level of 5% was used for all tests. The analysis was carried out using SPSS version 14 (SPSS Inc., Chicago).

RESULTS

The response rate for each of the professional groups is shown in Table 1. The response rate for each group and also of the

whole population exceeds 50% and can therefore be considered to be an accurate reflection of the target population under consideration.

Table 1: Response rate for each Professional Group

Professional Group	Number of Questionnaires distributed	Number of Questionnaires returned	% response rate	Total number of educators on database	% of population
Occupational Therapy	75	53	71	100	53
Physiotherapy	140	87	62	150	58
Podiatry	93	81	87	100	81

The demographic data and distribution of gender for each group are described in Table 2. There was no significant difference in the mean age of each of the professional groups (One-way ANOVA: $F=0.021$, $df=2,216$, $p=0.980$).

Table 2: Demographic data of each professional group.

Professional Group	Occupational Therapy	Physiotherapy	Podiatry	p value
Total Number	53	87	81	
Male	8	14	19	
Female	45	71	62	
Age (SE) (95% CI)	37.0 (1.3) (34.4, 39.5)	36.6 (1.0) (34.6, 38.7)	36.8 (1.2) (34.4, 39.1)	0.98
Qualified Length (SE) (95% CI)	10.2 (1.3) (7.6, 12.7)	12.7 (1.1) (10.6, 14.9)	13.0 (1.1) (10.8, 15.2)	0.22
Length as Cli Educator (SE) (95% CI)	5.8 (1.0) (3.7, 7.9)	5.4 (0.5) (4.3, 6.5)	7.0 (0.9) (5.2, 8.7)	0.30

The descriptive statistics for the RAQ for each professional group were calculated. The mean and range of the scores were considered. The podiatry group produced the lowest minimum score, and the biggest range of scores. See Table 3.

Table 3: Descriptive statistics for the RAQ Scores for each professional group

Descriptive Statistics				
Professional Group	Median Score	Minimum	Maximum	Range
Occupational Therapy	102	68	155	87
Physiotherapy	105	67	175	108
Podiatry	101	44	162	118

The data were classified into different attitude typologies per professional group and are presented in Table 4. The data set was analysed to explore the distribution of all three typological categories (gerophobes, neutrals, and gerophiles). However, as the study was particularly concerned with the categories of gerophiles and gerophobes, subsequent analyses are confined to the distribution of these two groups.

A comparison of the proportions of gerophile and gerophobe categories in each professional group indicated that there is a greater proportion of gerophiles in the physiotherapy educators ($\chi^2 = 6.19$; $df = 2$, $p < 0.045$) than in the other professional groups.

Table 4: Classification of Attitude types within the sample

Professional Group	Attitude Typology	
	Gerophobes (27-79)	Gerophiles (120+)
Occupational Therapy	5 (9%)	7 (13%)
Physiotherapy	5 (6%)	21 (24%)
Podiatry	14 (17.5%)	13 (16%)
Total	24 (11%)	41 (18%)

The distribution of attitude typology by gender was derived. The largest group was found to be male gerophiles.

Table 5: To Show the Distribution of Attitude Typology by Gender

Gender	Attitude Typology	
	Gerophobes (27-79)	Gerophiles (120+)
Male	5 (12%)	11 (27%)
Female	18 (10%)	30 (17%)
Total	23*	41

*2 missing cases

There was no significant difference between genders in the distribution of typology ($\chi^2 = 2.593$, $df=2$, $p=0.273$) as shown in Table 5. The attitude typology data were explored according to gender and professional group. These distributions are shown in Table 6.

Table 6: Attitude Typology by Gender and Professional Group

Professional Group	Gender	Attitude Typology	
		Gerophobes (27-79)	Gerophiles (120+)
Occupational Therapy	Male	0	2
	Female	5	5
Total		5	7
Physiotherapy	Male	1	6
	Female	4	15
*2 missing cases			
Total		5	21
Podiatry	Male	4	3
	Female	9	10
Total		13	13

No significant differences were found between the distribution of typology by gender or professional group (Fisher's exact test: occupational therapy: $p=0.470$; physiotherapy: $p=0.999$; podiatry: $p=0.999$).

The distribution of typologies per professional group were considered in relation to age. The mean ages for gerophobes and gerophiles were 38.9 and 39.4 years. Table 7 shows the mean ages according to professional group, gender and typology. The mean age of male gerophiles in podiatry was the highest. However the subgroups are too small to suggest any statistically significant differences

Table 7: Mean Ages of Gerophobes and Gerophiles by gender and Professional Group.

Typology per Professional Group				
	Male Podiatry Gerophobes	Female Podiatry Gerophobes	Male Podiatry Gerophiles	Female Podiatry Gerophiles
Mean Age	36.8	38.8	55.0	36.9
	Male Physiotherapy Gerophobes	Female Physiotherapy Gerophobes	Male Physiotherapy Gerophiles	Female Physiotherapy Gerophiles
Mean Age	47.0	37.5	36.2	35.8
	Male Occupational Therapy Gerophobes	Female Occupational Therapy Gerophobes	Male Occupational Therapy Gerophiles	Female Occupational Therapy Gerophiles
Mean Age	*	42.2	49.5	44.4

DISCUSSION

The aim of this study was to explore clinicians' and fieldwork educators' personal reactions to ageing as an indicator of attitudes towards ageing. The disciplines involved in the study included occupational therapists, physiotherapists and podiatrists.

Historically, many health care disciplines have viewed working with the elderly as an unrewarding and frustrating area of practice or a low profile speciality.^{28,29} Furthermore, literature has suggested that negative attitudes exist within healthcare professionals that in turn will have a detrimental effect to the provision of healthcare and may be perpetuated into health care undergraduate education.⁹ Mandy also suggested that some professional groups may be less aware of the changing demographic profile of patients requiring allied health care and the implications for their practice.⁸ Each of the three disciplines who participated in this study have different professional roles and provide different types of healthcare. Although each of the professional groups has a role with all age groups of their clients/patients, anecdotally, podiatry has been reported to be more commonly associated with the care of older people.^{30,31} If this is the case, it could be suggested that they may be more adequately prepared to accommodate the increasing numbers of elderly people and the demands they may put upon health care service.

The sample ranged from 50-81% of the available population on the University data base and is considered to accurately represent the population providing clinical education to our students. The response rate from podiatry clinicians was particularly good at 81%. A model of education that involves placement of pre-registration podiatry students with qualified clinical educators in NHS is new to the podiatry profession. Previously, clinical education has been provided in specialist clinics run by University departments responsible for the students' education. The new model of clinical education requires clinical educators to have completed training prior to being allowed to supervise student clinical education. The need for such accreditation may help explain the high attendance and response rates for the podiatry clinicians.

The sample sizes for occupational therapists and physiotherapists were smaller than expected, which may have been because many of the educators on the data base were already accredited and only had to attend one day per year to maintain their accreditation.

The descriptive statistics suggest that the respondents from each professional group were comparable in terms of age, length of time qualified, and the length of time as a clinical educator. Interestingly, the demographic values for the podiatry educators were similar to the other groups even though they were new to this type of education course. However, the educators who participated in the study would have included clinicians who had acted in a visiting clinician capacity and who had contributed to the clinical education within the University podiatry departments. The sample would also have included clinicians who mentored newly qualified podiatrists in the clinical environment who perceived themselves to be clinical educators. The clinical educators training sessions therefore served to formalise and accredit the work being done by the podiatry clinical educators. Unfortunately the questionnaire did not ask clinicians to identify their area of work expertise, which would have given information about how many of the clinicians identified themselves as working with elderly clients. This was a limitation of the study.

The raw results for each professional group were classified by attitude typology and compared statistically. When the gerophobe and gerophile typologies were considered, the physiotherapists had a significantly higher proportion of gerophiles than did the other professional groups.

This is not an unexpected finding in light of the strategy that was proposed by the Chartered Society of Physiotherapists (CSP) in 1996 and adopted in 1999 which acknowledged the changing demographics of patients and recognised the growth in elder care.³² At this time, a modification to the older peoples' care framework was implemented in which it was proposed that each university physiotherapy programme should have a lead senior lecturer in elder rehabilitation.³³ Furthermore, the physiotherapy profession has embraced the notion of positive discrimination towards older people by the development of a special interest group in older people. AGILE is a Clinical Interest Group of the CSP including therapists, health carers or assistants, students, or associate members of an allied profession working with older people.³⁴ They acknowledged that ageism might affect the quality of physiotherapy given to older people and have promoted quality for all. All these developments may have contributed to raising knowledge and awareness and understanding of older peoples' needs and care, a strategy which is clearly supported by the literature.³⁵

The occupational therapy results are of interest and comparable to other similarly constructed research studies. Gattuso reported a comparison of means with archived data on a sample of occupational therapy students (N = 136) at Charles Sturt University in Perth Australia using the RAQ provided a profile of descriptive data, including a mean of 102.3, sd 17.4, and range of 52-148.¹⁰ This profile was similar to the profile of the occupational therapy fieldwork educators reported in this study. The Gattuso study also reported a similar distribution of typologies including 7 gerophiles and 9 gerophobes. In this study there were 7 gerophiles, of which 2 were male, and 5 gerophobes.

An older cross sectional study by Todd et al also investigated occupational therapy attitudes towards older people and reported "uncharacteristically positive" attitudes towards the elderly.³⁶ These results may be explained as a result of the occupational therapy profession recognising the importance and need for increased knowledge about ageing and working with older patients with complex and multiple medical histories and the relationship of increased knowledge with the development of positive attitudes.^{37, 38} More recent work reported by Giles et al would concur with this notion and reported that occupational therapists exhibited more positive bias towards the elderly than physiotherapists, although the study did use a different assessment tool.³⁹

The limited literature investigating podiatrists' attitudes towards ageing in the UK is largely dated and empirical.⁴⁰ The results from this study will contribute empirical data to this limited literature. The range of raw scores from the podiatrists was larger than for the other two professional groups, as was the proportion of identified gerophobes. However, these differences were not statistically significant. The podiatrists who classified themselves as gerophiles were significantly older than the gerophiles in the other professional groups. This result is consistent with other studies which have suggested that positive attitudes towards ageing are significantly associated with older aged males.^{41,10}

Other studies involving podiatry and the elderly, have been undertaken in the USA and Australia. As the Australian model of podiatry education is based on the UK model, studies emanating from Australia can be considered to be comparable.⁴² Early work by Chumbler and Robins and Chumbler et al suggest that attitudes are related to rewards and that if students entered the profession for extrinsic rewards such as income and prestige they were more likely to display negative attitudes towards the elderly.^{43,44} Conversely if the reasons were altruistic and intrinsic then the students had more positive attitudes towards ageing.

More recent work in Australia by Menz, in a series of articles, reported that podiatry students had a reasonable knowledge of aging and attitudes improved after completion of a course on geriatrics, however, career aspirations did not change and geriatrics were considered to be a low profile speciality.²⁹ A second article by Menz et al suggested that only 4% proposed to specialise in geriatrics, with 25% preferring general practice or 21% sports medicine.⁴⁵ The median age reported from the three institutions involved in their study was 21 years, which is significantly younger than the mean age reported in this study. Menz et al also suggested that there was no difference in attitudes between male and female students and that the attitudes towards ageing were neither overly positive or negative.²⁹ However, the rewards for being a podiatrist were reported to be slightly more intrinsic than extrinsic. The differences in these results may be explained by the use of different measurement tools, and because the Australian sample was significantly younger. Other factors are known to influence attitudes towards ageing, including age, frequency and nature of contact and greater knowledge about the elderly.^{10,11,14}

The results did not support the suggestion by Mandy that some professional groups are more prepared to deal with the changing demographics of health care.⁹ However, it is important that students have a full understanding of the nature and the needs of all the client groups with whom they will be treating. Moreover, undergraduate curricula should reflect the changing nature of health care, increasing numbers of elderly and very elderly patients and their needs. The potential for ageism in health care needs also to be explored in the undergraduate and post graduate curricula to avoid the potential for its development.

Clinical educators are clearly in a unique position to ensure that intergenerational unity exists within the student experience, and furthermore to eliminate the barriers that support and sustain ageist behaviours.⁴⁰ The results from the educators surveyed in this study appeared to concur with this philosophy and overall the results were encouraging and would echo this suggestion.

The exploration of attitudes to ageing is new to the professions involved in this study and will contribute to the literature. It is acknowledged that the sample included in the study is relatively small in relation to the numbers of qualified clinical and fieldwork educators within the UK. However, it does represent the attitudes of those clinical and fieldwork educators who are involved with a University within the south east of England and is an accurate reflection of that population. The results would suggest that further national and international research is indicated to explore these issues more fully. It is also acknowledged that more details concerning the clinicians' frequency and contact with elderly patients would have contributed to results and interpretation of the study. Future studies may wish to consider collecting such data.

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Appendix 1**Please ring the following:**

Gender: Male / Female

Age

Year of Qualification.....

For how many years have you been a clinical educator.....

REACTIONS TO AGEING QUESTIONNAIRE (Gething 1994)

Here is a list of statements describing how people may feel about themselves as they grow older. Tell us how much you agree/disagree with each statement with reference to how you imagine you will feel over the age of sixty five

Tick the answer closest to your feelings.**1 Old age will be an enjoyable time of life**

- disagree very much
- disagree somewhat
- disagree a little
- agree a little
- agree somewhat
- agree very much

2 I worry that I might become senile and lose my mind

- disagree very much
- disagree somewhat
- disagree a little
- agree a little
- agree somewhat
- agree very much

3 I hope that I might look back on my life with a sense of pride

- disagree very much
- disagree somewhat
- disagree a little
- agree a little
- agree somewhat
- agree very much

4 I will be more lonely than I am now

- disagree very much
- disagree somewhat
- disagree a little
- agree a little
- agree somewhat
- agree very much

5 Old age brings satisfactions which are not available to the young

- disagree very much
- disagree somewhat
- disagree a little
- agree a little
- agree somewhat
- agree very much

6 Becoming frail is rarely an issue which concerns me

- disagree very much
- disagree somewhat
- disagree a little
- agree a little
- agree somewhat
- agree very much

7 I worry about dying and leaving behind those I love

- disagree very much
- disagree somewhat
- disagree a little
- agree a little
- agree somewhat
- agree very much

8 It worries me that I won't enjoy life as much as I do now

- disagree very much
- disagree somewhat
- disagree a little
- agree a little
- agree somewhat
- agree very much

9 I find the thought of growing old depressing

- disagree very much
- disagree somewhat
- disagree a little
- agree a little
- agree somewhat
- agree very much

10 Life can get better once you pass middle age

- disagree very much
- disagree somewhat
- disagree a little
- agree a little
- agree somewhat
- agree very much

11 I will regret the loss of strength and attractiveness

- disagree very much
- disagree somewhat
- disagree a little
- agree a little
- agree somewhat
- agree very much

12 I don't feel there is much to be scared about becoming an older person

- disagree very much
- disagree somewhat
- disagree a little
- agree a little
- agree somewhat
- agree very much

13 I worry about loss of independence

- disagree very much
- disagree somewhat
- disagree a little
- agree a little
- agree somewhat
- agree very much

14 I expect to be a loving, caring person

- disagree very much
- disagree somewhat
- disagree a little
- agree a little
- agree somewhat
- agree very much

15 I will be able to accept the death of friends and loved ones as a natural part of life

- disagree very much
- disagree somewhat
- disagree a little
- agree a little
- agree somewhat
- agree very much

16 I look forward to growing old with someone I love

- disagree very much
- disagree somewhat
- disagree a little
- agree a little
- agree somewhat
- agree very much

17 I worry about becoming frail

- disagree very much
- disagree somewhat
- disagree a little
- agree a little
- agree somewhat
- agree very much

18 I will become more irritable and grouchy than I am now

- disagree very much
- disagree somewhat
- disagree a little
- agree a little
- agree somewhat
- agree very much

19 Others may find me difficult to get along with

- disagree very much
- disagree somewhat
- disagree a little
- agree a little
- agree somewhat
- agree very much

20 I will be more set in my ways and reluctant to change

- disagree very much
- disagree somewhat
- disagree a little
- agree a little
- agree somewhat
- agree very much

21 I won't like growing old

- disagree very much
- disagree somewhat
- disagree a little
- agree a little
- agree somewhat
- agree very much

22 I do not worry about the thought of becoming senile and losing my mind

- disagree very much
- disagree somewhat
- disagree a little
- agree a little
- agree somewhat
- agree very much

23 I will worry about the loss of loved ones around me

- disagree very much
- disagree somewhat
- disagree a little
- agree a little
- agree somewhat
- agree very much

24 In my old age I will be as enthusiastic about life as I am now

- disagree very much
- disagree somewhat
- disagree a little
- agree a little
- agree somewhat
- agree very much

25 There is a lot to look forward to in regard to being old

- disagree very much
- disagree somewhat
- disagree a little
- agree a little
- agree somewhat
- agree very much

26 I won't feel as safe on my own as I do now

- disagree very much
- disagree somewhat
- disagree a little
- agree a little
- agree somewhat
- agree very much

27 I am concerned about who will care for me if I become frail

- disagree very much
- disagree somewhat
- disagree a little
- agree a little
- agree somewhat
- agree very much