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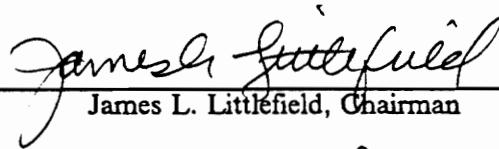
**THE SERVICE INDUSTRY AND THE AGING POPULATION:
MARKETING OPPORTUNITIES IN A DYNAMIC ENVIRONMENT**

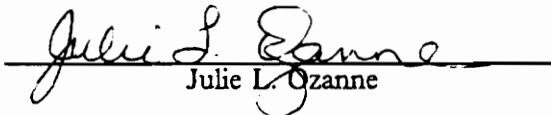
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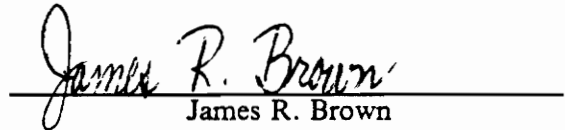
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MARKETING OPPORTUNITIES IN A DYNAMIC ENVIRONMENT**

by

Cathy Creed Hinson

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(ABSTRACT)

The care of the elderly is a growing problem. Existing services are inadequate for the needs of an aging population. In order to suggest new services to deal with the care of the elderly, this report examined four areas: the demographic characteristics of our aging society, the nature of services in general, services provided to the elderly population, and the application of role theory to the caregiver/care recipient dyad. Role theory identified conflicts felt by both the caregiver and care recipient.

These conflicts were explored in three sets of focus group interviews: women 65 years old and older, women familiar with the experience of primary caregiver, and women between the ages of 23 and 42 (the age range representative of the Baby Boom cohort). Information from these interviews was used to understand both current and future perceptions of the elderly and of the role of caregivers in this society and what services they perceive are necessary for the elderly to function independently in this society.

Acknowledgements

It is with pride and relief that I write these concluding statements. Many times during the past year I doubted this moment would come. The personal and emotional turmoil of this year has slowed, but not stopped the successful completion of my thesis.

There are many people to whom I am extremely grateful for their assistance. I have been very fortunate in having a supportive committee. My committee chairman, Dr. Jim Littlefield, along with Dr. Jim Brown and Dr. Julie Ozanne have guided me with great patience from the beginning. Thank all of you for reading the many iterations and giving me the quick turn-around time that was needed to get the project completed on time. Also, thank you for not stopping there. Thank you for your suggestions on how to get this study out to both academia and the public.

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A new friend, Nora Bentley, is especially valued. Without her assistance, the tapes of the interviews would never have been transcribed. The quality and dependability she exhibited in performing this task merit a very special thanks.

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CHAPTER 1

INTRODUCTION

The American society is facing a unique situation--the aging of its population. This "graying" of America will impact on all areas of our society. It is proposed that the existing network of support services available to our elderly population may not be sufficient to meet the needs of this growing subculture. This section examines the changing demographic characteristics of our nation and the impact of these changes on certain services directed toward the elderly.

The Changing Age Structure of the United States

Our society is facing dramatic changes in the age structure of our population. Historically, our culture has exhibited a very strong youth orientation. This phenomenon is exemplified in advertisements that depict youth in a positive manner with products directed toward satisfying their wants and needs. Conversely, the elderly are often depicted in a negative light; that is, frequently advertisements show the elderly as lonely and hampered by an increasing array of physical ailments.

The elderly represent the fastest growing segment of our population (Pifer and Bronte 1986). Society will have to adapt if the needs of this group are to be met. Pifer and Bronte (1986, p. 3) examine the magnitude of our population's aging:

Few Americans realize that their country is in the midst of a demographic revolution that, sooner or later, will affect every individual and every institution in the society. This revolution is the inexorable aging of our population. By the middle of the next century, when this revolution has run its course, the impact will have been at least as powerful as that of any of the great economic and social movements of the past: movements such as the conquest and subsequent closing of the frontier, the successive waves of European immigration, and the development of our great cities; or, from more recent times, the post-World War II baby boom, the civil rights and women's movements, the massive influx of women into the paid labor force, the revolution in sexual mores, and the decay of many of our large urban centers. All these developments have had a profound effect on our nation, but the aging of the population will certainly have equal, if not greater, impact, if some startling but quite possible demographic projections materialize.

In response to this growing and powerful subculture, Pifer and Bronte (1986) suggest that changes will be seen in all areas of society. One change may be to destroy the stereotype that aging consumers are infirm, living in poverty, and spending their already scarce resources on health care (Berkman and Gilson 1986).

Dispelling the Stereotypes of the Elderly

The elderly are a heterogeneous group (Lowy 1970; Maricle and Little 1986). While it is true that some elderly do live at, or below the poverty level, the elderly consumer of the future will be better educated, more active, have higher levels of income, and greater expectations of their later years. This group represents what Hudson (1987) refers to as the "able elderly" (p. 405). Hudson concurs that "poverty, frailty, and dependence are no longer the common denominator of these aged populations" (p. 405). In terms of political influence and personal, economic, and social impact, this group will be a powerful segment in our society.

The Effect of the Aging Society on the Marketing Mix

This demographic revolution will impact on our country's economic orientation and will be felt in the four components of the marketing mix. Changes will be seen in each dimension of the marketing mix. Products and services will be modified to reflect the changing tastes and needs of the aging consumer. The pricing issue will still have to consider that even though the elderly of the future will have earned higher incomes, incomes after retirement may be restricted. The more active consumer will lessen the need to drastically alter distribution outlets. Promotional activities should reflect the "able elderly" in a positive light.

Some areas of the country are preparing for the tremendous increase in the over 65 population. For example, North Carolina is one state that is anticipating a 36.2 percent increase in its over 65 population during the next 14 years (as compared to only a 15 percent increase in the overall population). State officials foresee this aging movement as the impetus that will push the state's economy toward an even greater service orientation (Otterbourg 1987). Sue Drummond, assistant to the Winston-Salem, North Carolina recreation and parks program director, supports the theory of an increased service orientation. Demand for services such as shopping, lawn care, and transportation are expected to increase. Today's elderly are financially capable of seeking these services. With the rise of Social Security and pension plans, the older consumer will have greater clout in the marketplace than previous generations of older adults. This greater financial ability has led Mrs. Drummond to dub the group "Sippies, for Senior Independent Power" (Otterbourg 1987, p. 4).

Florida, Texas, and North Carolina are the top three states that attract retirees. The Greater Winston-Salem Chamber of Commerce in North Carolina has taken active measures to attract the "Gray Generation" (Barron 1987, p. 4). In the Spring of 1987, the "Gray Generation Committee" was formed to promote attributes of the area to retiring individuals. Areas that attract this growing market stand to profit in several ways. It is estimated that the average retired couple

may have \$250,000 to invest in its later years. Additionally, older individuals contribute to the community attractiveness through their varied interests.

The Effect of the Aging Society on Health Care and Services

Demand for health care will also increase. A \$1.5 million grant from the R. J. Reynolds Nabisco Foundation to The Center on Aging at Bowman Gray Hospital Medical Center in Winston-Salem, North Carolina is one example of an increasing interest in this growing segment of our population. The field of geriatrics has been added to the Medical Center to enhance their awareness of the health care needs of the elderly and the family's ability to care for the elderly in their homes. A major goal is to develop programs for each patient and his/her family that will make use of available services within the community (Wofford 1987). Emphasis will be placed on learning how to help the elderly remain independent.

The need to remain independent and functioning in the community is critical to the older individual and his/her family when they consider the alternative of institutionalized care such as nursing homes. Statistics show that 13 weeks in a nursing home would impoverish two-thirds of the elderly population who live alone. As well, 40 percent of all people age 65 or older will spend time (with 16 months representing the average stay) in a nursing home, and the average annual cost of nursing home care is \$22,000 (Klein 1987). Most elderly individuals, or their families, cannot afford such care without impoverishing themselves. While insurance policies are available for long-term care, critics cite them as being affordable only to a minority of older individuals and being too restrictive to be helpful. Affordable long-term care is a major issue facing our nation. Private sector offerings, such as support services directed at assisting older individuals to remain independent, may provide one alternative to this dilemma.

An additional need for support services is evident in the prospective payment system instigated by the Medicare program. In 1983, the Medicare program began a new payment system with health-care providers designed at reducing the cost of health care and eliminating unnecessary tests

and treatments. The Diagnosis Related Group (DRG) system allocates specific dollar amounts for specific illnesses (Davis 1986). If the hospital or care provider can treat and discharge the patient for a cost lower than the DRG allotment, it may keep the difference as profit. However, if the hospital or care provider incurs costs greater than the DRG amount, it must take the loss. One advantage of the DRG program represents cost savings to Medicare recipients through the reduction of excessive tests. However, the main disadvantage is that hospitals may tend to watch their costs and disregard the severity of the patients' condition. Discharge when the costs equal diagnostic allotment may result in older individuals returning to their homes before they are capable of caring for themselves. However, an adequate array of support services could assist them in returning to as close to full functional capacity as possible.

As the elderly segment of our society continues to grow, additional strain will be placed on our existing health care institutions. Services that assist the elderly in remaining functionally independent as long as possible will be needed to reduce the strain placed on these institutions. However, these services may be utilized only by certain segments of the population. Those individuals living in poverty may be economically unable to take advantage of supplemental support services and rely totally on the social program network. Also, individuals from various ethnic backgrounds or traditional beliefs may reject the idea of purchasing support services in favor of total family care.

In the following chapters, several issues relevant to service delivery and the aging population are discussed. Chapter 2 represents a review of existing literature in three areas: demographic characteristics of our aging society, an overview of the service industry, and services provided to the elderly. A brief statement of the purpose of the research concludes Chapter 2. Chapter 3 presents role theory as a theoretical framework from which conflicts in the caregiver/care recipient dyad may be identified. Role theory is examined in the context of the service exchange and two new services are proposed for the aging society. Chapter 4 describes the use of focus group interviews as the means of data collection in this exploratory, descriptive study. Chapter 5 provides the results and analyses of the six focus group interviews conducted. Dominant themes that emerged from these interviews are discussed. Finally, suggestions for service delivery to an aging population are made.

Chapter 6 concludes the research by presenting an overview of the study, conclusions, suggestions for future research and limitations of the study.

CHAPTER 2

LITERATURE REVIEW

This chapter will focus on three areas: the demographic characteristics of our aging society, the nature of services in general, and services provided to the elderly population. A brief statement of the purpose of the research is included.

Demographic Characteristics of Our Aging Society

The Increasing Number of the Elderly

The elderly represent the fastest growing segment of the population. In 1980, there were almost 26 million Americans age 65 or older. Population projections estimate that by the year 2000, there will be 35 million people in this age group or a 34.6 percent increase in two decades (U. S. Bureau of the Census 1983). Statistics such as this give rise to the concept of "population aging."

Definitively, population aging represents a rise in the proportion of individuals 65 years old and over to the total population (Y. P. Chen 1987; Siegel and Taeuber 1986).

Definitively, the elderly represent those individuals aged 65 years to 84 years old. The older aged represent individuals 85 years and older. The number of elderly individuals has doubled since 1950 (numbering approximately 28 million in 1984) and the number of older aged has more than quadrupled since 1950 to 2.6 million (Siegel and Taeuber 1986). Of these two groups, the older aged group (those persons 85 years and over) is proportionately the most rapidly growing segment (Rosenwaik and Dolinsky 1987). Declining mortality, due to the reduction of chronic diseases, is largely responsible for this phenomenon (Rosenwaik and Dolinsky 1987; Siegel and Taeuber 1986). Additional factors contributing to this increase in longevity are greater economic security and ease of procuring medical services provided by government programs such as Social Security, Medicare, and Medicaid (Rosenwaik and Dolinsky 1987).

Baby Boom to Baby Bust

One concern challenging policy and service development for our aging society is how to deal with the “baby boomers.” During the baby boom period of 1945 to 1964, 76 million children were added to the population. The size of this cohort is amazing in that this group represents one third of our population today and equalled the entire population at the beginning of the twentieth century. The baby boom cohort will reach retirement age in the period from 2010 to 2030 causing a dramatic increase in the elderly population (Pifer and Bronte 1986; Siegel and Taeuber 1986). There is great concern that unless a long-range perspective is taken *now* to overcome cultural myopia and the policy implementation lag, policies and services needed to assist this tremendous dependent group through their later years will not be in place. This oversight could have disastrous consequences.

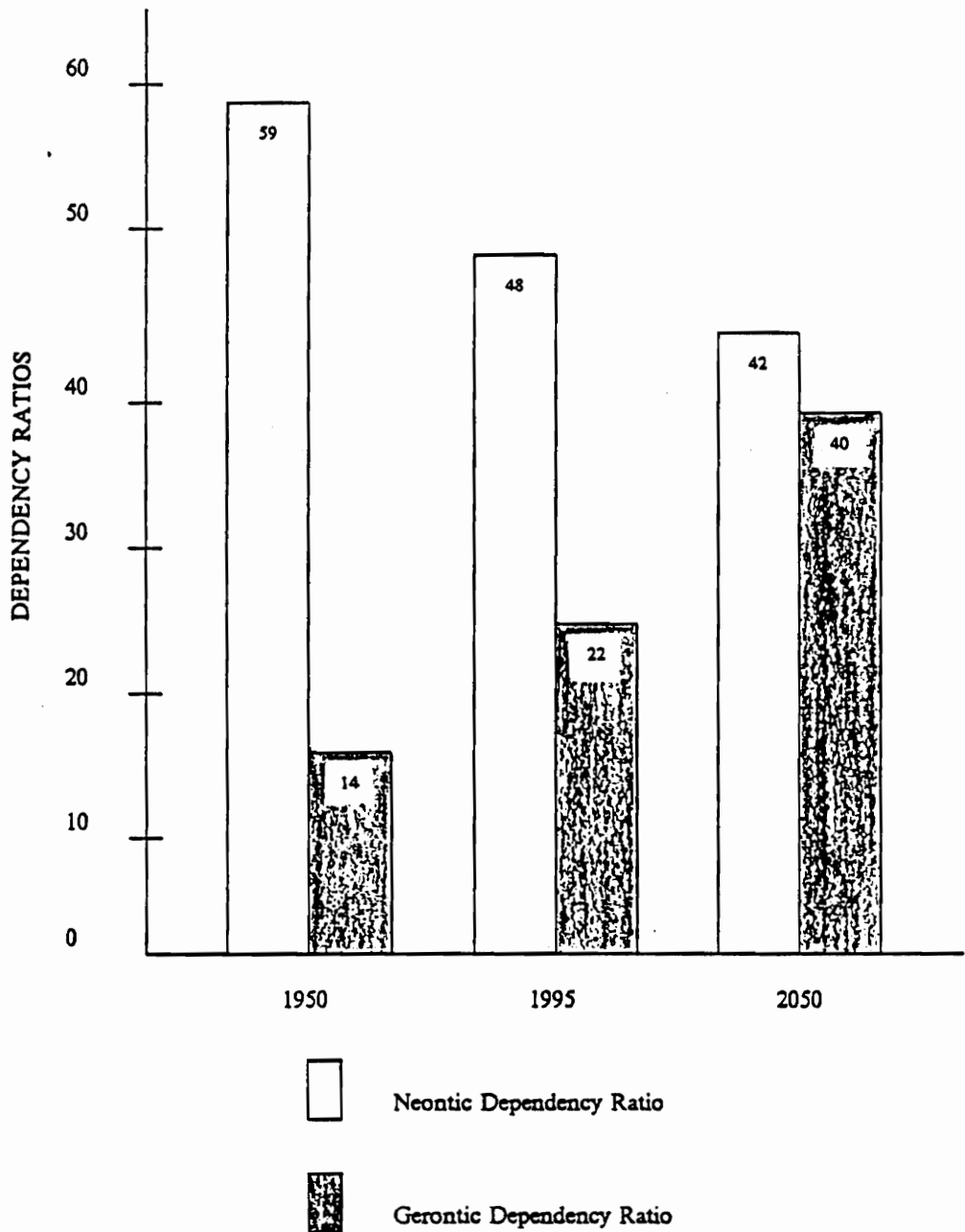
The declining fertility rate since 1964 (i.e., the “baby bust”) is another demographic characteristic that helps define our aging population and is another source of concern (Pifer and Bronte

1986; Rosenwaike and Dolinsky 1987; Siegel and Taeuber 1986). With increasing numbers of elderly and decreasing numbers of young, who will support the old? Siegel and Taeuber (1986) and Y. P. Chen (1987) quantify this concern in dependency ratios. The **gerontic** dependency ratio represents the proportion of the population 65 years and over to those individuals 20 to 64 years of age ("prime working age"). Conversely, the **neontic** dependency ratio represents the proportion of individuals under age 20 to individuals of prime working age. Based on U. S. Census data, Siegel and Taeuber (1986, p. 4) cite the neontic dependency ratios in 1950, 1995, and 2050 as 59, 48, and 42 respectively. While this ratio is decreasing, the gerontic dependency ratio for the same years shows dramatic increases of 14, 22, and 40 (See Figure 1). With a fewer number of young to support a greater number of old, one of the greatest challenges our nation has ever faced is how to provide for the older population (Siegel and Taeuber 1986; Haber 1986).

The Changing Demographics of Women

A broad overview of population demographics aids in understanding the aging of our society, but additional insight can be found by examining trends going on within certain subsets of the population. One of these groups of interest is women. Traditionally, our culture has designated women as the primary kin-keepers or caregivers of our society's dependent groups (Crossman, London, and Barry 1981; Haber 1986; Riley and Riley 1986; Siegel and Taeuber 1986). Crossman, London, and Barry (1981) and Haber (1986) cite that 70 percent of the informal caregiving in our society is currently provided by women.

Monk (1978, p. 766) recalls the pre-World War II era when "three-generational households were common" and proposes that increasing longevity and increasing costs of formal caregiving outside the home (e.g., nursing homes) will initiate a return to this mode of living. With increased longevity caused by declining mortality rates, multi-generational families are not uncommon. Today, approximately 50 percent of all individuals aged 65 and over are members of "four-generation families" (Hagestad 1986, p. 145).



Source: Siegel, Jacob S. and Cynthia M. Taeuber (1986), "Demographic Dimensions of an Aging Population," in *Our Aging Society: Paradox and Promise*, Alan Pifer and Lydia Bronte, eds. New York: W. W. Norton & Company, 70-110.

Figure 1
Gerontic and Neontic Dependency Ratios

Yet, women are not isolated from the dynamic changes that are occurring in this century. One of the most significant changes in our society is in the number of women entering the workforce. In 1940, 27.4 percent of the female population of this country was included in the labor force. By 1984, this number had increased to 53.2 percent (U. S. Bureau of the Census 1985). Statistics such as these emphasize the truth in the statement that this country has become a "time-poor, money-rich society" (Sheth 1983, p. 6).

Another trend that has had deleterious effects on women is the increasing number of divorces. For women, divorce usually represents financial hardship and a lower standard of living (Hagestad 1986). And yet another trend, the "mortality gap", adversely affects older women. Statistics show that women in the United States tend to outlive men by approximately seven to eight years (Hagestad 1986). Women are less likely to remarry (seven times less likely), and therefore a significant number of older women live alone (Siegel and Taeuber 1986). With women having to focus more on meeting their own needs both in the present and the future, how will this impact on the role of primary caregiver that our society has imposed on them?

Public versus Private Resources

Another consideration related to caring for our aging society is the distribution of resources between the public and private sectors. With public resources being diminished, there is agreement that programs and services targeted at the elderly must, in the future, draw from not only the public, but also the private sector (Haber 1986; Hooyman, Gonyea, and Montgomery 1985; Hudson 1987; Pifer and Bronte 1986).

Haber (1986) proposes private sector participation by corporations in providing leave time to employees who must care for an elderly relative, support services in the community such as respite care or mutual help groups, or possibly providing these services at the work place. Hudson (1987) cites three trends that are impacting on how the elderly of the future will be cared for--privatization, decentralization, and informalization. Privatization involves individuals using such support items

as Individual Retirement Accounts or some form of long-term care arrangement such as a retirement community. Decentralization places greater responsibility on state and local officials to identify and meet the needs of their constituents. Informalization requires the able elderly to “arrange, provide, supervise, and monitor services to family and community members” (p. 408). The latter function, informalization, identifies what Hagestad (1986) calls the changing role of the family. Increasingly, family members may serve as mediators or facilitators who identify the needs of elderly individuals and match them to institutions that can meet these needs.

An example of decentralization, or looking to the public sector for support, is seen in P. C. Y. Chen’s (1987) look at Malaysian elderly and how they are cared for by their families. Traditionally, the elderly in Malaysia live with their adult children. Both social and economic support are provided to the elderly parent. Yet Malaysia is experiencing some of the same demographic transitions as America that are making care of the elderly increasingly difficult (i.e., fewer children to care for the aged; increased longevity in the older population). With more and more elderly living alone, the Malaysian government is beginning to develop social support programs aimed at assisting the family in the caregiving role. Children living with elderly parents and providing care for them will be granted income tax relief.

Another example of decentralization shows a country that has failed in meeting the needs of its elderly population. Ucko’s (1986) look at elderly Soviet refugees in the United States illustrates how the USSR’s attempt at decentralization has not been successful. Elderly Soviets who migrated to the United States with their adult children provided a bleak picture of how decentralization worked in the USSR. The Soviet government provides each elderly individual with a monthly pension but in such a limited amount that the Soviet elderly can only survive with the financial assistance of their children. Also, the USSR provides old age homes to their elderly. But these institutions are limited in number and are permeated with abuse of the elderly (i.e., rude treatment, stealing food from the elderly patients).

In summary, we are in the midst of a demographic revolution that demands that we reevaluate our programs directed at how we care for our aging population. Characteristics of this revolution are an increasing number of elderly being cared for by fewer young and radically different circum-

stances for many of our society's primary caregivers--women. One way to help is through the provision of services designed to meet both the needs of older individuals and their caregivers. Before a review of existing services for the elderly is undertaken, we shall examine the fundamentals of the service industry in general.

An Overview of the Service Industry

This section provides a historical orientation to the service industry and projections of its dynamic growth. Four basic characteristics of services are then discussed: intangibility, inseparability, heterogeneity, and perishability.

An Historical Orientation

While our economic past reflects a manufacturing orientation, our future reflects a service orientation. Job opportunities in service industries have grown faster than those in goods-producing industries. It is estimated that 75 percent of all new jobs created between 1982 and 1995 will be in service-producing industries (U. S. Department of Labor 1984). In 1984, services accounted for 50.3 percent of personal consumption expenditures and 47.9 percent of the Gross National Product (U. S. Department of Commerce 1985).

Sheth (1983) found that retailers often do not see emerging trends because of their myopic focus on the daily needs of their businesses. He suggests that to remain healthy, an organization must adapt to changes in its environment. One area of change has been in demographics. While not true for all segments of our population (i.e., those in poverty such as ghetto dwellers), for many segments, changing demographics have led to increased incomes and desires for higher standards of living. To achieve this higher standard of living, marketers will see an increased desire for services that will enhance and simplify an individual's lifestyle. One example of how the marketing of ser-

ices has simplified individuals' lifestyles is in the arena of banking. Automated teller machines (i.e., ATM's) are available to make deposits and/or withdrawals after business hours. Additionally, ATM's may be located not only at banks, but also in such locations as supermarkets or malls. This focus on services appears to be one of the most dynamic marketing challenges of the future.

Characteristics of Services

Attempts to define the concept of a service have resulted in confusion in the past. Yet some common characteristics have been agreed upon. Four major differences, which impact on the marketing functions, exist between products and services: intangibility, inseparability, perishability, and heterogeneity (Beckwith and Fitzgerald 1981; Fern and Brown 1984; Lovelock 1983; Parasuraman, Zeithaml, and Berry 1985; Thomas 1978; Zeithaml 1981; Zeithaml, Parasuraman, and Berry 1985). Intangibility represents the lack of a tangible offering to the consumer. Unlike the purchase of a product (i.e., a car), when the consumer purchases a service, there is no tangible outcome (i.e., when one gets a haircut, the service is the professional performing the task). The labor represents the intangible aspect of the exchange.

Inseparability represents the simultaneous occurrence of production and consumption. Unlike the tangible product, services can be tailor made for the individual. As in the previous example, the automobile may be produced at one time and "consumed" (i.e., purchased) at another time. Yet with the haircut, production and consumption occur at the same time.

Another challenge is in the service's perishability, or the inability to "store" services. When the automobiles are produced, it is quite feasible for them to be stored until required by the consumer. But with the haircut, it is impossible to "store" this service since the process and consumer are inextricably linked.

The final characteristic, heterogeneity, marks the tremendous diversity of the service sector. Each service exchange is conducted in an environment that is conducive to developing widely varying consumption experiences. In the haircut example, it is possible to request and receive a

multitude of various service deliveries (i.e., varying lengths of haircuts, colors, textures, curly versus straight).

These characteristics combine to create a situation that, in the retailing sense, is much more sales person/consumer interactive than a situation involving a product. This higher degree of interaction suggests a need for the marketing concept's consumer orientation in service firms. Yet research has found that service organizations have lagged behind manufacturing organizations in utilizing this concept (Parasuraman, Berry, and Zeithaml 1983).

This goal of achieving a more consumer oriented approach is complicated by the very nature of services. For example, consider the characteristic of intangibility. The intangibility of services, the absence of having a physical object to see or touch, alters the way in which a consumer evaluates the service in terms of information sought, acceptance of new services, and loyalty to existing services (Zeithaml 1981). The most tangible features offered to the consumer are the service firm's facilities and personnel. Perceptions of service quality can be greatly affected by these few tangible attributes (Parasuraman, Zeithaml, and Berry 1985). The interactive aspect of the service experience emphasizes the importance of communication. Each consumer enters the transaction with specific needs. The service firm must be flexible enough and capable of listening, and responding to each individual's varying requests (Beckwith and Fitzgerald 1981). Consumer's cognitive processes in the evaluation of services combine to create problems for the service manager in attempting to identify the consumer's needs. Yet with the projected growth in the service industry, it is a challenge service managers must meet.

These comments and characteristics are applicable to all services whether the service deals with personal care, financial care, or health care. In the next section, existing services for the elderly are discussed.

Services Provided for the Elderly

This section examines the informal and formal support mechanisms available to the elderly and their caregivers. Four typologies of services for the elderly are cited. Also, the use of services and the social/emotional needs of the elderly are addressed.

Informal Support Mechanisms

Informal support, or that support provided by family, friends, and neighbors outside an institutional setting, is often seen as a mechanism that enables the elderly individual to remain in his or her home environment. In fact, the largest source of non-institutional support is provided by family members and friends (Hickey 1980). The ideal "self-determining environment" is one that provides the greatest level of personal choice to both caregivers and care recipients (Haber 1986, p. 39). This self-determining environment encourages support in a home-like situation. This environment may be in the individual's home or that of a family member, friend, or facilities provided by religious or voluntary organizations in the community. These settings are less restrictive than those provided in formal institutions such as nursing homes, thereby preserving the privacy, dignity, and respect of the older individual. Thus, in the concept of the "self-determining environment", maximum family caregiving is encouraged but not to the point of exhausting their resources. Underlying this concept is the implicit importance of retaining one's independence. By fully utilizing the support system within the community in addition to family caregiving resources, the elderly individual may retain the independence desired at this stage of life.

While relatively few individuals (5.7 percent) aged 65 to 74 require assistance for basic home activities such as shopping, chores, and meal preparation, 40 percent of those individuals aged 85 and over require help with these basic duties (Siegle and Taeuber 1986). Of the non-institutionalized disabled population, approximately 75 percent are maintained by care from in-

formal caregivers such as family or friends. As a supplement, 20 percent utilize professional care (Tell, Cohen, Larson, and Batten 1987).

Formal Support Mechanisms

In addition to informal support, formal services are available to assist the elderly in remaining independent. While the young adults favor in-home support, the old are the most receptive to "formal, non-family services" (Hagestad 1986, pp. 148-149). Tell, et al., (1987) found that older individuals are willing to use a variety of supports that would enable them to remain in their homes. One explanation for this may be that younger individuals seek the "ideal" in caregiving for aging relatives--a support system where all needs are met by and within the family unit. They may not give consideration to how this form of caregiving will impact on their work and family lives. Older individuals may be more realistic about the demands of the caregiver/care recipient relationship and therefore be more accepting of formal support mechanisms.

An exploratory study analyzed five levels of long-term care (LTC) arrangements available to older individuals. The five levels of LTC evaluated and their percentages of agreement of usage are: paid in-home care (70%), care from a relative in your home (66%), adult day care (32%), a nursing home (28%), and move to the home of a relative (15%). Additional findings suggested that most older individuals (57%) would find some combination of formal and informal LTC acceptable (McAuley and Blieszner 1985, pp. 189-190).

In a projection of the future of the home health care market, it was noted that the use of home health care services might not cost less than institutional care. However, "quality of life benefits' such as the comfort and security of home and proximity to family members" make a significant difference to the happiness of the individual (Littlefield 1984, p. 54).

These findings support Brody's (1977) and Hickey's (1980) rejection of the perceived institutionalized/non-institutionalized dichotomy. This popular notion suggests that an individual must be involved with one or the other aspects of care with no overlap. Often, once an older in-

dividual is institutionalized, the decision is seen as an irreversible one. But with an adequate network of support services in the community, the individual may, with rehabilitation, be able to return to the home environment. The underlying goal of any type of long-term care program should be to help the individual retain his/her independence. "Regardless of the type of health intervention used, long-term care should help people preserve their autonomy; anything else is merely maintenance, custody, or even neglect" (Hickey 1980, p. 100).

The number of elderly in nursing homes will increase from 1.2 million in 1980 to approximately 1.8 million in 2000 (Davis 1986). To consider institutional care such as nursing homes as a temporary measure until the elderly individual is able to return to the community seems against the interest of this type of institution. However, in light of the changing characteristics of the elderly (i.e., better educated, higher incomes), more efforts may be directed at maintaining non-institutional care. Also, Haber (1986) cites dissatisfaction with nursing home care as a stimulus in taking action that enables the elderly to remain in their homes. If these projections materialize, nursing homes may need to redefine their role from one of just maintenance or warehousing of individuals, to include a mission of assisting the elderly remain autonomous as long as possible.

Four Typologies of Services for the Elderly

Historically, long-term care was associated only with an institutional setting. Yet more recently, "long-term care refers to one or more services provided on a sustained basis to enable individuals whose functional capacities are chronically impaired to be maintained at their maximum levels of health and well-being" (Brody 1977, p. 14). These services may be obtained in an institutional setting or in the community.

While family and friends provide a tremendous source of support for the older individual, several changes in our society dictate a need for formal sources of support. The increased mobility of today's family, dual-career families, and smaller homes may initiate demand for services in the community (Hickey 1980).

Four typologies for services have been developed which identify certain areas of need (See Table 1). Haber (1986) identified two services that were the most valuable to the elderly who are attempting to remain in their home environment: respite alternatives and mutual help groups. Respite care programs are services that provide temporary relief to the elderly and/or their caregivers. These programs are characterized by flexibility, accessibility, and minimal cost if any at all. Respite care provides services such as homemaker or health care services. Mutual help groups consist of community members who come together on the basis of common experiences such as serving as primary caregiver to an older individual. In their meetings, coping strategies and information on local resources are shared. These groups provide a forum in which the common experiences and problems may be discussed. In a study of older women caring for disabled spouses, semimonthly support groups provided an outlet in which the women could honestly express their fears and feelings of guilt with individuals who shared similar circumstances (Crossman, London, and Barry 1981).

Another typology suggests five areas of health and social services available to the elderly in the community: maintenance, supportive medical services, personal care, personal planning, and linkages (S. Brody 1977; Hickey 1980). Maintenance services consist of two components: income maintenance and personal maintenance. Income maintenance provides varying degrees of economic support from a variety of sources (i.e., Supplemental Security Income (SSI), Social Security, Veteran's Benefits, Unemployment Compensation, Worker's Compensation, and Food Stamps). Personal maintenance consists of three components: homemaker services, home-delivered and congregate meals, and chore services. Homemaker services provide a wide array of helping functions that enable the older individual to remain independent in his/her home environment. Attention may be given to cleaning the home, doing the laundry, or running errands. These services may be obtained for a few hours a day or a few hours a week. Historically, this type of service is not strongly supported by public or voluntary funds.

Home-delivered meal programs (i.e., "Meals on Wheels") and congregate meals represent programs directed at the nutritional needs of the elderly. Each program assures the participating individual of at least one hot meal a day. An additional benefit of congregate meals is that older

Table 1

Four Typologies of Services for the Elderly

<u>Source</u>	<u>Typology</u>	<u>Examples</u>
1. Haber (1986)	Respite Care	Homemaker services Health Care Services
	Mutual Help Groups	Shared information Forum for discussion (Problems, etc.)
2. S. Brady (1977) T. Hickey (1980)	Maintenance	Income Maintenance Social Security Workers Compensation, etc. Personal Maintenance Homemaker Services Home-delivered & congregate meals Chore Services
	Supportive Medical Services	Federally funded services in hospitals, health centers Nurses, therapists sent to the home
	Personal Care	Assistance in bathing, dressing, etc.
	Personal Planning	Counseling on financial aid and legal concerns
	Linkages	Information and referral Transportation Outreach

Table 1 (Continued)

Four Typologies of Services for the Elderly

<u>Source</u>	<u>Typology</u>	<u>Examples</u>
3. Monk (1978)	Home Support Services	Friendly visiting Homemaking Telephone reassurance Home delivered meals Chore services Home maintenance services Errand and escort services Home health care
4. Hooyman, Gonyea & Montgomery (1985)	Personal Care	Bathing, dressing, feeding, toileting, care of appearance, medications, nursing care, wheel chair transfer, assistance with walking, and bed transfer
	Household Tasks	Yard Care, laundry, meal preparation, housework, and telephone assistance
	Community Tasks	Transportation, shopping and errands, personal business, and handling money
	Psychosocial Tasks	Telephone check-up and companionship

individuals are able to socialize and meet new friends. Of the personal maintenance components, chore services are the most recent addition to the service package. In 1976, emphasis was placed on providing repairs and renovation to the homes of the elderly.

The second health and social service cited by Brody (1977) and Hickey (1980) is that of supportive medical services. These state-administered federally funded programs provide services in formal settings such as hospitals, public health departments, or local health centers. Nurses may also be sent to the homes of the individual. Services provided include nursing care, physical therapy, occupational therapy, or speech therapy.

Personal care services are differentiated from personal maintenance services by function. While personal maintenance services focus on the elderly person's environment, personal care focuses on the individual. With personal care services, assistance is provided for bathing, dressing, and moving about the home.

Personal planning is a relatively new concept in the service package. Probably stemming from the new "able elderly", counseling services are provided in a wide array of areas such as financial information and legal concerns. These services are yet another step in allowing the older individual to remain independent as long as possible.

Linkages are services that serve to connect the older individual to the community and available support services. The three most common linkages are information and referral, transportation, and outreach services. Information and referral services offer one common source of information about community services and match individual needs with available services. Transportation services may consist of public transportation systems (fares may be reduced for the elderly), separate systems designed for transporting older individuals to either medical appointments or senior centers, or an escort service. Outreach services may consist of telephone alert programs where daily or weekly calls are made to older individuals confined to their homes or friendly visiting programs where scheduled visits are made to the elderly. Both of these outreach services are usually conducted by volunteer organizations.

Just as it was difficult to precisely define the concept and characteristics of services in general, it is also difficult to devise an exhaustive list of all the support services available to the elderly on

the continuum from critical, institutionalized care at one extreme to the most flexible, infrequent in-home service at the other. Monk (1978, p. 770) itemized the most commonly used home support services. These include "friendly visiting, homemaking, telephone reassurance, home delivered meals, chore services, home maintenance services, errand and escort services, home health care, etc...." Companionship and socialization are cited as "an indirect, related service."

In a study looking at the termination of in-home services and caregivers' perceptions of stress, 21 types of assistance were grouped into four categories. These areas were "*personal care tasks* (bathing, dressing, feeding, toileting, care of appearance, medications, nursing care, wheelchair transfer, assistance with walking, and bed transfer), *household tasks* (yard care, laundry, meal preparation, housework, and telephone assistance), *community tasks* (transportation, shopping and errands, personal business, and handling money), and *psychosocial tasks* (telephone check-up and companionship)" (Hooyman, Gonyea, and Montgomery 1985). Of these services, the most frequently used chore services were housework, shopping, transportation, yard work, and meal preparation. Frequency of use of these services was relatively small with the heaviest use of these chore services being 55% using the services one to four days each month.

An alternate form of care might be provided through Continuing Care Retirement Communities (CCRCs) or Life Care at Home (LCAH). LCAH offers the financial security and health services provided by CCRCs in the community rather than in an institutional setting (Tell, et al. 1987). Those individuals interested in LCAH showed a strong interest in remaining in their homes and a willingness to use a variety of support mechanisms to do so.

In summary, it is clear that no exhaustive list of services available to the elderly exists. In the typologies examined, various aspects of daily life were addressed in the existing support services. However, most of these services address the functional aspects of daily life rather than the social or emotional needs of older individuals. The next section addresses these qualitative aspects of daily living.

Services and the Social/Emotional Needs of the Elderly

While home support services offer an inexpensive alternative to institutionalization, some of these services do nothing to enhance the quality of life for their clients. It is proposed that home support services should provide an “environmental restorative function” for older individuals (Monk 1978, p. 769). This concept focuses on eliminating the drabness of the environment of the older individual. Surroundings that provide sensory stimulation aid the older individual in maintaining autonomy. A study that examined three Older Americans Act (OAA) funded, Title III-B home care programs regarding the emotional needs of their clients support Monk’s contention (Kaye 1986). Results showed that clients felt and displayed greater levels of affection for the workers than did the workers toward the clients.

The use of services and types of services available affects not only the emotional state of the recipient, but also that of the caregiver. A study examining the use and the effect of termination of services revealed this relationship (Hooyman, Gonyea, and Montgomery 1985). Clients who used chore services (i.e., meal preparation, laundry, house cleaning, etc.) and clients who had used, but terminated the use of these services were evaluated to determine if the perceived burden of caregiving increased upon the termination of the use of these services. Termination of services was not associated with changing the level of caregiving by the family nor did termination increase their perception of burden or level of stress. However, findings suggest that typical chore services did not help caregivers in the area they perceived most burdensome and stressful--that of providing personal care tasks such as bathing, feeding, and toileting. The study suggests that the performance of these intimate, personal tasks appears to violate the norms between care recipient and caregiver, especially if the relationship is one of relative or spouse and over time, may reduce the “affective quality of their relationship” (Hooyman, Gonyea, and Montgomery 1985, p. 144).

This overview of services available to older individuals shows a strong network of support mechanisms they may utilize to maintain their independence. Yet there are areas where their needs

are not being adequately met. It is proposed that new services may be developed to meet not only the functional needs of the elderly, but also the social and emotional needs.

Purpose of Research

This research will examine consumers' awareness of our aging society and the demand for support services that allow the elderly to remain independent in the community. Role theory (to be discussed later) will be used to identify areas of conflict in the caregiver/care recipient relationship. It is proposed that these areas of conflict represent potential opportunities for service delivery.

CHAPTER 3

THEORETICAL FRAMEWORK

Role theory is examined in this thesis in the context of the caregiver/care recipient relationship. The goal is not to test role theory, but rather to use this conceptual framework to examine the caregiver/care recipient dyad. Role theory suggests potential areas of conflict that may be felt by either the caregiver or care recipient. These areas may then be examined for information that will assist in developing new, desired services aimed at reducing these perceived conflicts.

This chapter provides an overview of role theory and the general concepts of role theory: role expectations and role ambiguity, role congruence and role conflict, and role demands and role overload. Three models of role theory and the caregiver/care recipient dyad are presented. In the context of these models, role theory and the service exchange are examined with implications given for using role theory in developing new services. Finally, two potential services are proposed for the aging society. The viability of these services will be explored in focus group interviews (to be discussed later).

Role Theory--An Overview

The term role comes from the theater and is used to denote the many parts an actor plays (Sarbin and Allen 1968; Shaw and Costanzo 1982; Thomas and Biddle 1966). In role theory, the concern is how the individual performs or manages the many roles he/she plays during a lifetime. In observing individuals performing varied roles, examples of questions that might be asked are: "Is the actor performing in a manner deemed acceptable for a specific role?," or "Would a different role be more suited to a certain individual?" While the dyad is the traditional level of analysis for role theory, the concepts have been successfully applied to areas such as child development, family studies, and organizations.

General Concepts of Role Theory

Role Enactment

The focus of role theory is on role enactment or role performance (Sarbin and Allen 1968; Shaw and Costanzo 1982). Role enactment or role performance is the manner in which an individual carries out or performs the set of actions or behaviors deemed acceptable in a given role or situation. Research has found that the more roles an individual can perform, the more able he/she is to meet the problems encountered in life. For example, an individual who has had the experience of occupying the multiple roles of child and caregiver to an aging parent, in addition to being a spouse and employee at the same time, has very likely developed a perspective and coping skills that will aid him/her in later life (Sarbin and Allen 1968).

Role Expectations and Role Ambiguity

“Role expectations are comprised of the rights and privileges, the duties and obligations, of any occupant of a social position in relation to persons occupying other positions in the social structure” (Sarbin and Allen 1968, p. 497). In other words, role expectations provide boundaries and guidelines in performing varied roles such as husband, parent, or teacher.

Role expectations may vary between the role occupant and other individuals. Yet, knowledge of others’ expectations (even if different from his/her own), enhances the role occupant’s ability to interact with others. If the role occupant does not conform to role expectations, group norms intervene to influence the deviant behavior. Often, conformity may come about, not due to belief in the role, but because of the fear of the actions of others.

In addition to having personal expectations (i.e., expectations for the individual), we also hold positional expectations (i.e., expectations for behaviors of certain positions such as doctors, teachers, parents, etc.). While personal expectations are more concrete, positional expectations tend to be more abstract and therefore more difficult to enact (Biddle 1979). For example, consider the individual who has just graduated from college and will soon begin work in a large organization. He/she, even with little previous work experience, has some knowledge about what will be expected from them on a personal level (i.e., to have a pleasing personality, to be able to learn quickly). Yet, positional expectations may be more vague and therefore, more difficult to enact (i.e., do newcomers to the organization have the authority to delegate work to staff?).

Role expectations come from ourselves, others, and the positions we occupy. Our culture provides another source of expectations. Cox and Gelfand (1987) found that immigrants who hold strong, traditional values of respect and status for the position of “elder” had the greatest expectations of assistance from their children. However, their children who grew up in the adopted culture might not share the same positional expectations held by their parents in the child/parent relationship.

Clarity of role expectations, or the amount of information needed to perform the part successfully, is a critical element in the role theory framework. There are three types of unclear expectations. First, expectations of the role may be uncertain and vague, second, lack of consensus among others about role expectations, and finally, lack of a match between the role occupant's expectations and expectations of others (Sarbin and Allen 1968). Without clear guidelines, valuable time may be wasted in an attempt to "mind read" the situation. This lack of clarity may lead to decreased effectiveness, frustration, and strain in the role performance. Biddle (1979) refers to this state of discord as ambiguity of a role (i.e., lack of information about the role for successful role performance or behavior). For example, while the role of parent is clearly defined, the role of adult child as caregiver to an aging parent is more vague or ambiguous causing feelings of uncertainty in how to enact his role. Societal expectations and degrees of individual perceived reciprocal responsibility dictate the degree of perceived stress in the caregiver/care recipient relationship. If the expectations of the child in the role of caregiver match with the expectations of society for this role, little frustration is felt. However, if these expectations do not match, role ambiguity may be experienced. Some adult caregivers may experience little stress in this role and have no problems seeking outside support, while others experience a great deal of stress in this role and be fearful of being judged inadequate or an ungrateful son/daughter if they seek outside assistance. The following three sections illustrate how role theory applies to role expectations and role ambiguities in the aging process.

Role Loss in the Later Years

Transition away from the major roles in life through such changes as retirement, widowhood, moving, the raising of one's children can create tremendous stress for the older individual. These roles had provided status. Without these roles, "anomie--a state of normlessness that is presumably uncomfortable--is likely to develop in the absence of structure and behavioral guidelines" (George 1980, p. 2). Yet research has shown that older individuals can adjust successfully to changing roles.

Changes such as grown children leaving home or moving generate little stress. On the other end of the continuum, widowhood or institutionalization create a great deal of stress. Coping skills and personal resources are two individualized variables that assist the older individual in changing roles.

Rosow (1974) cites role loss through retirement and widowhood as involuntary and unwelcome changes forced on older individuals. As one ages and previous activities are relinquished, the role of the older individual becomes more unstructured and more ambiguous. Previously, the role expectations of work had defined and structured his or her life. Role discontinuity, or the lack of smooth transition from one life stage to another occurs. Our society has failed to provide sufficient programs to assist older individuals in the transition from work to retirement and has offered few substitutes for these losses. Another problem is experienced in the lack of role clarity. While active in the work force, the individual is given a specific set of expectations to meet. Yet with aging comes declining responsibilities and expectations.

Riley and Riley (1986) echo the theme of diminishing roles for the elderly as they cite retirement as a "roleless role". Whereas some retired individuals value their new allotment of free time, others miss the status and rewards afforded by active economic participation. For these individuals, "retirement is marked by lowered self-esteem, and a lack of stimulation that can lead to apathy or depression, jeopardizing vigor and effective functioning" (p. 61).

Rosow (1985) has used the term "tenuous" to describe the role of the elderly. Status loss occurs through the losing of main positions in the family unit, withdrawal from the workforce, reduced income, increasingly poor health, and the loss of a spouse. Opportunities to replace these losses in later life are not the norm. It is unlikely that the older individual will remarry or regain full employment.

Havighurst (1954) identified the age range of 50 to 75 as being wrought with changes in social roles. During this period some roles may be intensified (i.e., home gardener, host/hostess in additional free time) whereas other roles may be reduced (i.e., parent, employee). To change or alter roles requires role flexibility. The most common indicator of role flexibility in old age is the ability to cope with a variety of roles in middle age.

Again, the heterogeneity of the elderly must be acknowledged. Kelly (1987) cites the respondent "Nat" as an example. While Nat received tremendous satisfaction from his work as a deputy sheriff, he had never allowed his job to be the central focus of his life-- this position was reserved for his family. In his retirement, visiting family and friends, and traveling have become cherished activities.

The Emotional Aspect of Service Providers' Roles

As cited before, in a study that examined home care programs regarding the non-instrumental (emotional) needs of the clients, results showed that clients felt and displayed greater levels of affection for the workers than did the workers toward the clients (Kaye 1986). There existed a discrepancy in the clients' expectations of the worker regarding the emotional aspect of the service relationship.

In terms of role theory, there was a mismatch between the expectations of the care recipient and the caregiver. The care recipient expected to receive some form of emotional feedback from the service provider. The caregiver, (i.e., the service provider), believed that only the functional aspects of the job were important. Even if the care recipient felt the work was performed satisfactorily, there was still decreased satisfaction because all of their needs/expectations (i.e., both functional and emotional) were not met.

Role Ambiguity in the Caregiver Relationship

In a study of primary care givers, Crossman, London, and Barry (1981) found that in 70% of their sample, the role of primary care giver was occupied by a female family member. Most of this number were wives caring for disabled husbands. As the wives assumed care of not only their disabled spouses, but also full management of the household, role ambiguity was felt as they entered

this non-traditional role. Support groups provided the counterroles of listener and counselor that assisted them in their responsibilities.

Role Congruence and Role Conflict

Self-role congruence refers to the match between a role occupant's values and beliefs and the requirements of the role. A mis-match may lead to a state of incongruence. Role incongruence may produce tension, strain, and lead to poor role performance (Sarbin and Allen 1968).

Thomas and Biddle (1979) define role congruency as a match between the position or role and the expected behaviors of the role. When an individual is confronted by expectations that are counter to what he/she believes to be appropriate behavior, role conflict is experienced. For example, an aging parent suffering from Alzheimer's disease may require supervision and assistance in the basic tasks of feeding, bathing, and dressing themselves. The adult child caregiver may experience strain in performing these intimate activities with a parent. The following three sections are examples of the relationship between role congruence and role conflict.

Role Transition and Adjustment

Empirical applications of role theory in the aging process are seen in the following examples. Phillips (1957) applied role theory to adjustment in the aged. Role changes such as retirement and changes in marital status were found to be related to maladjustment where maladjustment is defined by a mismatch between an individual's needs and the extent to which those needs are met. Additionally, being identified as "old" was significantly related to maladjustment.

Changing Family Roles and Elder Care

Smith (1965) cites the importance of the interaction of the role and its complementary role (i.e., husband/wife, parent/child). The American family is in a state of transition and the extended family is on the decline. Traditional male/female roles are being blurred by economic changes and women moving into the work force, the changing rights of women, and increasing numbers of women pursuing educational opportunities previously limited to men. These changes may alter the way in which older individuals are cared for by adult children. When these children attempt to care for their aging parents, role conflicts and problems may arise. Role reversal--adult children treating older parents as dependent children--may cause conflict for all concerned.

Service Termination and Caregiver Stress

Again, Hooyman, Gonyea, and Montgomery (1985) found that the termination of in-home chore services (i.e., meal preparation, laundry, house cleaning) was not associated with changing the level of caregiving by the family, nor did termination increase their perception of burden or level of stress. However, findings showed that typical chore services did not help care givers in the area they perceived most burdensome and stressful--that of providing personal care tasks such as bathing, feeding, and toileting. The performance of these intimate, personal tasks appears to violate the norms associated with family roles. Feelings of role conflict and role reversal were experienced.

Role Demands and Role Overload

Role demands represent the number of behaviors deemed acceptable for certain roles (Sarbin and Allen 1968). For example, the role of teacher represents certain responsibilities that would not

be expected of someone working in a local factory (i.e., preparing class lectures and acting as advisor to his/her students). Role overload may occur if an individual occupies too many roles each with its own set of prescribed behaviors (Biddle 1979; Sarbin and Allen 1968). Role overload represents the concept that time and energy are finite entities and stress and dissatisfaction occur when these functions are pushed beyond one's ability to cope (Biddle 1979). For example, a female adult may occupy the multiple roles of caregiver to an aging parent, spouse, mother, and career woman. These roles compete for the limited resources of time and energy.

Roles can change over the life course. In an empirical study of nonworking women (traditional homemakers and those who had quit their jobs) and working women (the "conflicted" or those women who were still working but with reduced hours and women still working full time) caring for their aging mothers, the changing roles were viewed as a process that varied according to the needs of elderly family members (Brody, Kleban, Johnsen, Hoffman, and Schoonover 1987). The average age of the daughters was 49.7 years. Each week, an average of 21.4 hours was spent by each daughter caring for her mother.

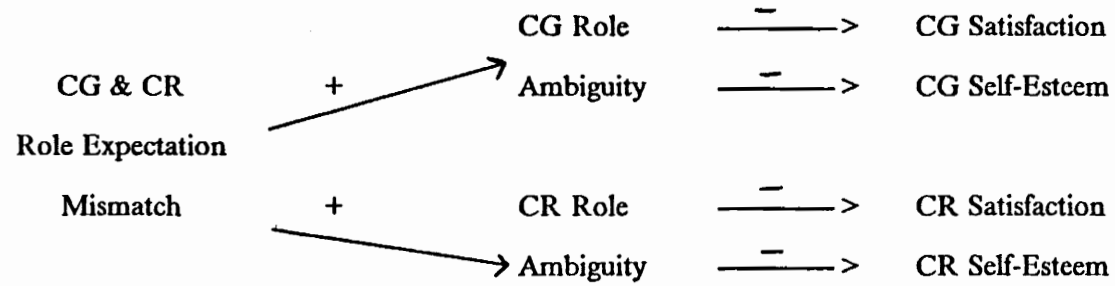
The conflicted women experienced the greatest role overload and felt strain in the multiple demands made by the aging parent, spouse, and career. These women were the most career-oriented and held new views of women's roles in today's society. Conversely, the traditional housewives experienced the least strain in the caregiving situation.

The suggestion was made to provide more alternatives to working women who must also care for aging relatives (i.e., "flextime, job-sharing, or parent-care sabbaticals", p. 208). With increasing numbers of women in the work force and larger numbers of elderly, the United States could examine policies implemented in other industrialized countries that give benefits or concessions to individuals caring for elderly individuals.

Models of Role Theory and the Caregiver/Care Recipient Dyad

In summary, role expectations and role ambiguity, role congruence and role conflict, and role demands and role overload all impact on the enactment or performance of various roles. This impact can also be seen in the caregiver/care recipient relationship (See Figures 2, 3, and 4). The goal is not to measure satisfaction or self esteem, but to evaluate areas of conflict in the caregiver/care recipient dyad.

Consider the situation in which an adult child becomes the primary caregiver to an aging parent. If the child is uncomfortable with assuming this role and does not fully understand all of the behaviors required, he/she may experience role ambiguity. If the child does not accept or is not comfortable with the role requirements (i.e., bathing, feeding the aging parent), a state of role incongruence may occur and lead to role conflict. If this child has a career and a family, he/she may experience role overload as he/she attempts to juggle the increasing demands of the multiple roles of worker, spouse, parent, child, and caregiver with limited time, energy, and possibly limited financial resources. All of these negative reactions lead to decreased satisfaction in the relationship for both parties. The aging parent may experience conflict in his/her new role of the dependent elder. This situation leads to a decrease of self-esteem and a decrease of satisfaction with the relationship. It is proposed that the use of support services could be implemented to reduce role overload and role conflict and thereby increase satisfaction and self-esteem to the caregiver and care recipient. For example, if the caregiver was experiencing role overload, support services such as shopping or "elder sitting" could be utilized to give the caregiver more time. If the caregiver was experiencing role conflict due to having to perform such personal tasks as bathing or toileting to the elderly parent, support services that performed these functions could be used.



Note:

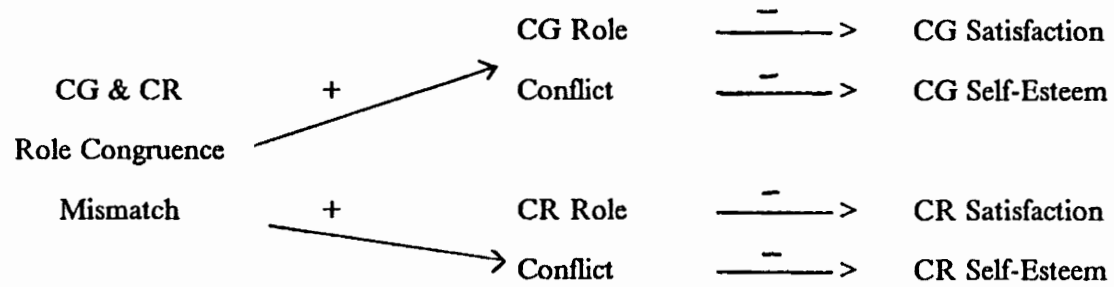
CG = Caregiver, CR = Care Recipient

(Table 2 provides a description of Sets 1, 2, and 3)

Figure 2

Sets 1, 2, 3

Role Expectations and Role Ambiguity



Note:

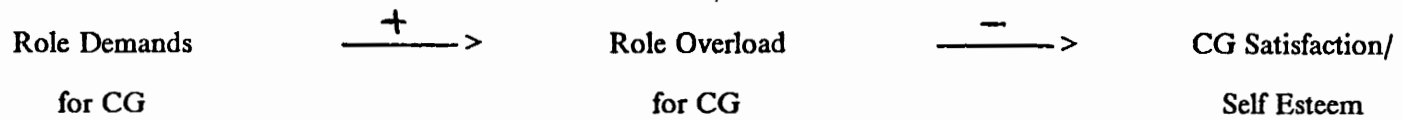
CG = Caregiver, CR = Care Recipient

(Table 2 provides a description of Sets 1, 2, and 3)

Figure 3

Sets 1, 2, 3

Role Congruence and Role Conflict



Note:

CG = Caregiver

(Table 2 provides a description of Sets 1, 2, and 3)

Figure 4

Sets 2, 3

Role Demands and Role Overloads

Role Theory and the Service Exchange

In applying role theory to service development for the aging population, the following citations are helpful. Soloman, Surprenant, Czepiel, and Gutman (1985) examined role theory and the service exchange. The chief advantage cited in using role theory in the service arena is that it forces the use of an interactive perspective. This position is very much in agreement with the consumer satisfaction orientation of the marketing concept. Solomon et al. state that both service provider and service recipient play a role in the service exchange. If problems are to be minimized, each party must be prepared to "read from a common script" (Soloman et al. 1985, p. 102). Therefore, service providers targeting the elderly should not assume the stereotype of the elderly as infirm, but rather treat each service encounter as a unique situation in the true spirit of the service exchange and this dyadic interaction.

The concept of the "common script" provides general themes applicable to the elderly (i.e., knowledge of increased needs for health care), but must also acknowledge the variations within our society. For example, people from different ethnic backgrounds may possess different views on how the caregiver/care recipient relationship is to be performed. In an analysis of the effect of ethnicity on familial assistance provided to Hispanic, Portuguese, and Vietnamese elderly by their Americanized children, Cox and Gelfand (1987) found differences in the expectations of assistance among these three subcultures. Of the three groups, the Vietnamese and Portuguese elderly had the greatest expectations of assistance from their adult children. Further analysis revealed that in a variety of tasks (i.e., advice, cooking, shopping, household help, financial assistance, transportation, and translation), Portuguese elderly received greater assistance on average from their adult children than did the Vietnamese or Hispanic elderly. Knowledge of this cultural impact is critical to the service provider in structuring services that will be acceptable to the ethnic elderly and their caregivers.

Application of role theory to new service provision for the elderly can be seen in the following citation:

Each role that one plays is learned. One's confidence that one is doing the right thing leads to satisfaction with a performance (termed role validation) and success in interacting with others who are, also playing their respective roles (Solomon et al. 1985, p. 102).

Yet, when adult children assume the role of caregiver and parents assume the role of care recipient, the stage is set for conflict and stress. In this reversal of roles, there is little confidence felt. As the elderly family member becomes increasingly dependent upon the child, each member of the dyad struggles to retain his/her perception of their role in the relationship. Often adult children provide care based on feelings of obligation from their own childhood rather than on the pleasure obtained from being with their parent(s). Communication between parent and child (i.e., implicit or explicit; verbal or non-verbal) often reveals this sense of duty and brings pain to the dependent elder (Tamir 1979). New services could be designed to reduce this conflict.

Implications of Role Theory for Care of the Elderly

One implication for role theory is in the development of programs that assist older individuals in the transition from the work environment to retirement. Research has shown that success in adapting to the later years has roots in managing varied roles in earlier years. One method of intervention would be for employers to encourage workers to pursue new leisure interests. Role flexibility is crucial to older individuals satisfaction with their later years. "They must withdraw emotional capital from one role and invest it in another one" (Havighurst 1954, p. 311).

Also, role theory provides the means to identify conflict in the care giver/care recipient relationship. This information would be useful in the development of services that could be used to reduce role stress. Jarret (1985), in examining the role of caregiver, found that often as the needs and demands of the care recipient increased, the degree of affection felt by the care giver for the care recipient decreased. This reduction results in the caregiver experiencing guilt at having their love replaced by feelings of being trapped in their responsibilities. Services available to reduce these negative feelings would serve to increase the quality of life for both caregiver and care recipient.

Proposed New Services for the Aging Society

Research has shown that often older individuals are restricted in their ability to participate in cultural activities in their communities (Kelly 1987). Also, research has shown that existing support services may not aid the caregiver in the most burdensome facets of the caregiving relationship (Hooyman, Gonyea, and Montgomery 1985). The following proposed services (i.e., a Companion Service and a Personal Care Service) are examples of how this research could be used to identify marketing opportunities in an aging society.

A Proposed Companion/Escort Service

While Monk (1978, p. 770) cited companionship and socialization as "an indirect, related service" to the network of home support services, it is proposed that the need for companionship and socialization are not subsets of some more pertinent need, but important enough to merit special consideration. It is proposed that there is potential for a "Companion/Escort Service" in the network of support mechanisms. This service could be in the form of an escort function to social events such as concerts, plays, or festivals, or simply in the form of "listener." In a research project in Spring, 1987, this researcher conducted door-to-door surveys in several Winston-Salem, North Carolina neighborhoods that were predominantly occupied by retired individuals. In these homes, this researcher sensed an overwhelming need to have someone with whom to communicate. This service could serve in the interim.

Chown (1981), in evaluating friendships in old age, stated that usually, social isolation may yield despair, low morale, and a sense of depression. Reisman (1981), in examining adult friendships found that having friends or companions provided an outlet for stress. As studies have indicated, often services meet exterior, functional needs, but not inner, emotional needs. A service of this type could meet their social and emotional needs. Satisfying the needs of the spirit is just as

instrumental to maintaining independence as satisfying the physical needs of housekeeping and meal preparation.

Participation in previously enjoyed activities may be limited not only by financial constraints, but also by physical limitations and fears for personal safety. Kelly (1987) describes an elderly woman who had enjoyed supporting and attending performances by local symphony and theatre groups. At the age of 75, she is constrained not only by financial considerations, but mostly by a loss of vision that has caused her to curtail participation in the cultural resources within her community.

Another consideration faced by elderly individuals who want to participate in community activities is the availability of companions. One fact they face is that family or friends may have passed away or be physically unable to accompany them. It is said that:

A less-than-fascinating companion may be better than none at all. Many people simply do not like to go out to eat, travel, attend concerts, or walk in the park alone. For older women safety may be a concern. Even without a high level of communication, having someone to go or be with may be quite significant (Kelly 1987, p. 58).

A "Companion/Escort Service" that enabled elderly individuals to participate in community events would both increase their quality of life and feelings of independence. If there is a local college or university, a service of this sort could be a source of revenue for fraternities or sororities. Transportation and/or escort service could be provided to doctors appointments or social events. As one caregiver put it "and think of the envious looks your mother will get as she's escorted around town by a 6-foot-2 football player!" (Wood 1988, p. 78). Another example of this service would be in an "Adopt a Grandparent" program where young people are paired with older individuals and perform services such as visiting in the home, running errands, or taking the individual shopping.

A Proposed Personal Care Service

A second new service proposed is one for "Specialized Personal Care" that would assist caregivers in the personal care tasks determined to be most stressful and burdensome (i.e., bathing,

feeding, and toileting). The demands and stress on caregivers and the need for affordable respite care have been acknowledged and are needs that will increase dramatically as our elderly population increases. With fewer young to care for greater numbers of elderly, it is imperative that services be developed to sustain them. A service of this nature would provide respite for both the primary caregiver and the care recipient.

In summary, the aging of our society is posing challenging demands on the network of support services in place today. Clearly this network must be expanded to include services that will meet all needs--functional and personal. To devise and implement this service system is going to be one of the greatest challenges facing our nation. But, "The future is not preordained. Population aging holds within it the promise of a much better society for all of us or, paradoxically, a far worse one. The choice is clearly there, and it is ours to make" (Pifer and Bronte 1986, p. 13).

Role theory provides a framework to explore the needs of an aging population. The following chapter proposes a method (i.e., focus group interviews) in which role theory may be used to identify areas of conflict in the caregiver/care recipient dyad.

CHAPTER 4

METHODOLOGY

In this chapter, first an overview of focus groups is discussed. Next, relevant issues in focus group research are presented. Finally, an overview of the study is provided.

One of the purposes of this research is to determine how aware consumers are of the aging of our society. Have they ever used existing services to aid them in the caregiver/care recipient relationship? If so, what services did they need that were not available? Also, have they made provisions for the care of an aging relative or friend or for their own care in the future? Role theory is used to identify areas of stress or conflict in the caregiver/care recipient dyad. An analysis of role expectations and role ambiguity, role congruence and role conflict, and role demands and role overload will set the stage for proposing new service ideas that may be utilized to restore satisfaction and self-esteem to the caregiver and care recipient relationship. The nature of these questions dictates that an exploratory study be conducted. Churchill (1987) states that exploratory research familiarizes the researcher with the problem. From this familiarity, it is proposed that new services may be developed directed at assisting the elderly to remain independent in their environment and to enhance the quality of the caregiver/care recipient relationship.

An Overview of Focus Group Interviews

The required flexibility of exploratory research requires a flexible method of data collection. For this reason, focus group interviews will be utilized to evaluate consumers' awareness of our aging society and the extent to which they are aware of, or have utilized existing services for the elderly. Definitively, the qualitative research technique of the focus group interview

“... offers a means of obtaining in-depth information on a specific topic through a discussion group atmosphere which allows an insight into the behavior and thinking of the individual group members. Rather than using a structured question-and-answer methodology, the procedure is to encourage a group to discuss feelings, attitudes, and perceptions about the topic being discussed” (Bellenger, Bernhardt, and Goldstucker 1976, p. 7).

Fern (1982; 1986) and Wells (1979) have identified several advantages associated with focus group research. A major advantage of focus group research is the speed with which they can be conducted and their lack of expense relative to other research methods. If little is known about the area of interest, focus groups provide the medium through which hypotheses and theories may be generated. Once generated, the flexibility of focus group interviewing allows in-depth examination of topics as they arise. Inter-group dynamics provide the platform from which individuals' opinions and attitudes are freely expressed. Focus group interaction provides the ability to examine previously quantitative information in greater depth. Often, information generated in focus groups is less distorted due to the proximity between respondents and the client.

As a method of gathering data, focus groups are moderate in their expense, high in their response rate, low to medium in completion time, extremely versatile, provide a moderate amount of information, and a high degree of clarity. In the area of service development, focus groups are an excellent source of information (Cooper and Hisrich 1987).

Issues in Focus Group Interviews

This section describes pertinent issues in focus group research. The homogeneity of groups, the size of focus groups, recruiting focus group participants, the setting in which the focus group is conducted, the focus group moderator, the topic outline, and methods of focus group analysis.

Homogeneous Groups

The focus group interview consists of a relatively homogeneous set of individuals brought together to share their knowledge, feelings, and perceptions about a given subject. Homogeneity within focus groups is desired especially with regard to social class, stage in the family life cycle, and socioeconomic status giving consideration to the fact that individuals possessing greater educational status or monetary resources may restrict group interaction by alienating individuals with lesser resources (Fern 1986; Wells 1979). The interactive atmosphere of the focus group generates a more synergistic approach to information gathering allowing group participants to freely interact and share thoughts and feelings about the subject under investigation.

Focus Group Size

The optimum size of a focus group is a matter of debate with preferences running from six to twelve members. Often the ideal size of the group is a function of the individual moderator's (to be discussed later) style and personal preference. However, group size is related to output. Fern (1982) found that as group size increased beyond four members, productivity increased at a decreasing rate.

Recruiting Focus Group Participants

Unlike quantitative sampling techniques that use probabilistic sampling methods, qualitative research techniques such as focus group interviews often employ “judgmental sampling where the respondents are selected according to the judgment of some person knowledgeable in the area being studied or who is involved in the particular project” (Bellenger, Berndardt, and Goldstucker 1976, p. 42). While it is argued by quantitative researchers that this is not a viable means of sampling, advocates of qualitative research counter that what is lost in randomness is made up in the ‘representativeness’ of sample units who have been selected on the basis of knowledge of the given research area.

When recruiting focus group participants, over-recruiting is encouraged to assure an adequate number of individuals present. For example, the moderator may desire a group size of no less than eight but not more than twelve members. He/she may recruit ten to fifteen individuals. The overscheduling provides a measure of protection against attrition (i.e., emergencies such as illness). Often, if more than the maximum number of individuals desired arrives (i.e., the thirteenth and fourteenth individuals attend), they are thanked for coming and dismissed from the group.

The Focus Group Setting

The focus group interview should be conducted in a setting that is conducive to group interaction (i.e., a large auditorium would be inappropriate for the small number of people present; also, an elaborately appointed corporate boardroom may be intimidating to participants and influence their input). Facilities should be as conveniently located to the participants as possible. The interview usually lasts from one and a half to two hours, so comfortable facilities should be arranged to enhance group output and lessen fatigue. Often, focus group interviews are either audio or video taped. Care should be taken to arrange facilities that are amenable to these requirements.

The Focus Group Moderator

The focus group is conducted by a moderator who serves as guide for the group discussion. Axelrod (1979), Fern (1982, 1986), Payne (1979), and Wells (1979) cite several characteristics of focus group moderators. A moderator with a pleasant personality is an asset when conducting group discussions. Knowledge of group dynamics will enable the moderator to assure an equitable distribution of the discussion among participants. While it is the moderator's responsibility to research and design the topic outline, rarely does the moderator actually participate in the group discussion. Rather, it is the moderator's duty to initiate the discussion and then intervene only when the discussion lulls or proceeds on a tangent. In addition to the above characteristics, as Payne (1979) points out, the moderator takes on a task that on the surface appears easy and casual, but in reality is a large task of research and preparation that is often neglected.

The Topic Outline

Uses of focus group interviews include obtaining information on new concepts when available information is limited and to "generate ideas for new creative concepts" (Bellenger, Bernhardt, and Goldstucker 1976, p. 19). In obtaining this information, unlike quantitative research-- which is conducted in a very structured, question-and-answer format--the focus group interview is conducted in a very unstructured, open manner. Based upon this, the moderator does not use a formal questionnaire to guide the interview. Once the focal topic has been identified and researched, a topic outline listing areas of interest is used by the moderator to guide the discussion. However, the outline is not used as a strict, formal instrument where areas of interest are covered in a rigid order, but rather as a guide for the moderator to insure that, during the interactive discussion, all topics are eventually covered and as an aid to bring the discussion back to the focal topic if participants stray too far from the specific areas of interest.

Analysis of Focus Group Research

Wells (1979) identified three ways in which the information generated in the focus group interview could be analyzed. First, the researcher, relying on his/her memory, records and summarizes the major findings of the interview. This method is most advantageous when time and cost constraints are great. Data is best analyzed in this fashion if the client is present and participating. However, this reliance on memory may not yield total recall of all discussion. Second, listening to the tapes, the researcher identifies and cites meaningful areas of the interview and presents these in the context of his/her knowledge of the past situation and the current status of the phenomena being investigated. Again, this method is advantageous in that general themes are revealed. However, the main disadvantage is that the analyst reports the findings from the limited perspective of his/her own world view. A third method is identified as the "Scissor and Sort" or "Long Couch, Short Hallway" technique (Wells 1979, p. 9). This method involves several systematic steps: (1) transcribing the tapes, (2) editing and coding the material for core content, (3) identify common subject matter, (4) sort the material from each interview into common themes, and (5) prepare the written summary of the information generated by the focus group interviews. The main advantage of this method is that all comments or input are preserved. Reliance on memory is not needed. Once the complete information is transcribed to paper, analysis is conducted for themes and sub-themes. While this method may lack the verve and imagination used in the other methods, it makes up for this in precision and completeness.

An Overview of the Study

Based upon the exploratory nature of this study, focus group interviews were conducted using three different sets of women. These women represented age ranges across the life cycle (i.e., from 23 to older than 65). They represented women who have and have not received assistance in their

daily living. They also represented women who have and who have not experienced the role of caregiver to aging relatives or friends.

Focus Group Interview Participants

The focus groups consisted of three different sets of women (See Table 2). One set consisted of women 65 years and older, a second set consisted of women who are or have been caregivers, and the last set consisted of women between the ages of 23 and 42 (the age range representative of the Baby Boom cohort) who have not been the primary caretakers of elderly parents, a spouse, relatives, or friends. Two focus group interviews were conducted per set to examine differences and similarities in participants' responses.

In Set One, women 65 years and older, the first focus group interview consisted of women 65 and older functioning independently in their homes. These women were receiving no assistance from family, friends, or existing support services in performing their daily activities (i.e., housework, cooking, laundry, errands, etc.). The second group of women 65 and older were still residing in their own homes but with the assistance of family, friends, or available support services in the community (i.e., homemaker services, home health care, transportation, etc.). How does independent living versus relying on assistance affect these women's perceptions of their needs? What can be learned from their experiences that would assist in developing new services?

In the second set, the first focus group interview consisted of women who are currently having the experience of acting as primary caregiver to elderly parents, a spouse, relatives, or friends. The second focus group interview in this set consisted of women who are not currently experiencing the role of primary caregiver to an aging relative or friend but who had occupied this role within the last five years. From their experiences, what can be learned about services needed in the caregiver/care recipient relationship? Also, in retrospect, do the women not currently in this situation perceive service needs differently? If so, how?

Table 2

Focus Group Interview Participants

<u>Set/Group</u>	<u>Participants</u>
Set 1, Focus Group 1	Women 65 years and older functioning independently in their homes who are receiving no assistance from family, friends, or existing support services in performing their daily activities (i.e., housework, cooking, laundry, errands, transportation, etc.).
Set 1, Focus Group 2	Women 65 years and older still residing in their own homes but with the assistance of family, friends, or existing support services in performing their daily activities.
Set 2, Focus Group 1	Women who are currently experiencing the role of primary caregiver to an aging relative or friend.
Set 2, Focus Group 2	Women who are not currently experiencing the role of primary caregiver to an aging relative or friend but who have done so within the last five years.
Set 3, Focus Group 1	Women between the ages of 23 and 42 (i.e., the Baby Boom cohort) in professional positions (i.e., university faculty) who have never occupied the role of primary caregiver to an aging relative or friend.
Set 3, Focus Group 2	Women between the ages of 23 and 42 (i.e., the Baby Boom cohort) in staff positions (i.e., secretarial or administrative support) who have never occupied the role of primary caregiver to an aging relative or friend.

In the third set (i.e., the cohort of Baby Boom women), the first focus group interview consisted of professional women (i.e., university faculty). The second focus group interview consisted of women in staff positions (i.e., secretarial or administrative support). Past research has shown that society allocates the role of primary caregiver to women. The elderly are the fastest growing segment of our society. With 76 million Baby Boomers approaching retirement, the dynamism of this group demands that we give attention to their future needs. In these two focus group interviews, attempts were made to predict the needs of groups that do not yet exist. Does this younger cohort of women feel the responsibility of this role as strongly as the older generations of women? The differentiating factor between these two groups will be in the variables of education level, occupation, and income. Do women of greater educational/income/occupation status have different perceptions of what society sees as their responsibility as primary caregiver to aging parents or a spouse? Also, does their socioeconomic status impact on their willingness to use formal support mechanisms such as services to assist them in this role?

Justification for a sample of women can be seen in the evidence that society has marked this group as primary caregivers to aging individuals. Also, women tend to live longer than men. If widowed, they are much less likely to remarry. Therefore, women are not only the primary caregivers, but are also the most likely care recipients.

Focus Group Size and Moderator

This researcher served as moderator for the six focus group interviews. Personal preference for group size was six to eight participants. To assure dynamic, interactive discussion, a minimum of four participants per group was required for each group interview to be conducted with a maximum of eight to ten participants per group. Eight to ten participants per group were recruited to provide some buffer for attrition.

Focus Group Participants Recruited

Based on the above criteria, judgment sampling was employed to select group participants. The Warmhearth Retirement Village in Blacksburg provided the source of participants for Set 1, Focus Groups 1 and 2. Jack Tharpe, Director of the Warmhearth Retirement Village, permitted access to the residents of the community. David Wynne, President of the Residents' Council, acted as recruiter for Set 1, Focus Group 1 (women 65 and older functioning independently in their homes). Ten women were recruited to participate and all ten attended the interview. However, one undesired consequence occurred in this group. One woman contacted as a potential participant declined due to a previous engagement. On the day of the focus group interview, her previous appointment ended earlier than expected. She proceeded to attend the group--with her husband. The interview was already in progress when they entered the room. The decision was made to allow them to come in and participate rather than turn them away. It was felt that to dismiss them in front of the group would have weakened the rapport established between the participants and the moderator and could possibly have caused a decrease in the communication that was beginning to take place among the participants. It is acknowledged that this violated two premises of the research--acceptable group size (i.e., 12 rather than 10), and mixed gender groups. However, the gentleman did not seem to restrict the interaction but seemed to fit comfortably into the conversation and contributed several meaningful statements.

Hazel Bates, a Retired Senior Volunteer Program (RSVP) member who resides at Warm Hearth, provided assistance in obtaining participants for Set 1, Focus Group 2 (women 65 and older living in their homes with assistance from family, friends, or support services). These women were receiving assistance such as home-delivered meals, help from their families, services such as house cleaning, or assistance with transportation. Eight participants were recruited and four attended the interview.

Participants for Set 2, Focus Groups 1 and 2 (women who were currently experiencing the role of primary caregiver to an aging relative or friend and women who have experienced this role

within the last five years) were obtained by word-of-mouth referrals from local churches and women who are either currently experiencing this role or who have done so in the past. Telephone calls were made to these women to confirm that they met the criteria and request their participation. Ten current caregivers were recruited and four actually attended the the interview. Ten past caregivers were recruited and nine actually attended the interview.

Janet Town, President of the Women's Network on the Virginia Tech campus, provided names of potential participants for Set 3, Focus Groups 1 and 2 (professional women and women in staff positions between the ages of 23 and 42). Telephone calls were made to these women to confirm that they met both criteria (i.e., be within the age range and to have never occupied the role of primary caregiver to an aging relative or friend) and request their participation in the group interview. Eight faculty members were recruited and seven attended the interview. Also, eight staff members were recruited and seven participated.

No monetary form of compensation was offered. Participants were offered a summary write-up of the findings once the research was complete. The majority of the participants (i.e., 32 of 43 participants) requested the summary report.

The Focus Group Setting

Light refreshments were provided at each focus group interview. The management at the Warm Hearth Retirement Village provided the use of their library/conference room for Set 1, Focus Groups 1 and 2. The interview for Set 2, Focus Group 1 was conducted in the library of the Wesley Foundation, which is adjacent to the Virginia Tech campus. The interview for Set 2, Focus Group 2 was conducted at the Donaldson Brown Center on the Virginia Tech campus. Janet Town arranged for Set 3, Focus Groups 1 and 2 to be conducted at a conference room in the Veterinary Medicine School.

These facilities were conveniently located and provided adequate parking space for group participants. Each facility was large enough to seat all of the participants comfortably around a conference room table. The rooms used were suitable for audio taping of the interviews.

The Topic Outlines

The moderator prepared outlines of areas of interest around the focal topic of our aging society and the implications of this phenomenon on other segments of our society (See Tables 3, 4, and 5). Each focus group interview opened with a basic set of questions that addressed the issues of the aging society, the individuals role in this society, the individuals expectations from this society, perceptions of the role of the older individual in this society, perceptions of support provided to older individuals from the government and social services, and the expectations of caregivers to aging individuals. Beyond this common information, specific questions were developed for each group. Using role theory as a framework to identify areas of conflict, the following questions were addressed. Some of these questions were pertinent to all groups (i.e., Have individuals made plans for their own long-term care?), while other questions were directed to specific groups such as caregivers (i.e., What aspects of the caregiving relationship are/were most burdensome?).

- What services available to the elderly and their caregivers have been utilized?
- What services were needed but not supplied?
- In the role of primary caregiver, what aspects of the care giving relationship are/were most burdensome?
- If the primary caregiver is a working woman, how has she combined the roles of worker and caregiver to an elderly family member?
- If she (i.e., the primary caregiver) is married and has a family of her own, has she experienced role overload and/or role conflict juggling the roles of wife/mother/daughter/caregiver?
- If the caregiver/care recipient relationship was one of child/parent or spouse, how comfortable was each party in his/her role--was role conflict experienced in any function of this situation?
- Have individuals made plans for older relatives' long-term care? If so, what?
- Have individuals made plans for their own long-term care? If so, what?

Table 3

Topic Outline

Set 1, Focus Groups 1 and 2

Women 65 years old and older who are functioning independently in their homes and women 65 years old and older residing in their own homes but with the assistance of family, friends, or existing support services in performing their daily activities.

1. Introduction

The aging population and the impact of this phenomenon on other segments of society.

2. We see so much in the media about the aging of our population or the "graying of America" -- what does this phrase mean to you?
3. In the context of this aging society, what do you think your role is in this society? (i.e., How do you view yourselves?)
4. Now, let's talk about expectations --

We all have expectations during our lives -- for example, as parents, we expect our children to apply themselves in school, get good jobs, marry and have families of their own.

What do you expect from

- society? (i.e., does the government "owe" you)
 - your children
 - your families
5. Do you think the role of the older individual is clearly defined in our society; in other words, what does society expect from the older individual?
 6. Let's talk about public policy or how our society has provided support to older individuals.
 - Has the government provided adequate support mechanisms? (i.e., Social Security, Medicare, etc.)
 - Are there enough social services organizations available to meet the needs of an aging population?
 - Which are the most helpful?
 - Are there services that are needed but not available?
 7. Another subject that is related to support for older individuals we see a great deal about in the media is that of "caregivers to older individuals." Where caregivers are individuals (i.e., a child, a spouse, a friend, or other relative) that provides some degree of support to an older individual (where the support may range from transportation to a doctor's appointment or shopping to providing care to very ill individuals or even not providing care themselves but acquiring the care for the older individual from an organization in the community).
 - What do you think the role is of the caregiver in our society (i.e., How do you view the caregiver?)

Table 3 (Continued)

Topic Outline

Set 1, Focus Groups 1 and 2

8. What are your expectations of caregivers to an aging population?
9. Is the role of caregiver clearly defined in our society (i.e., what does society expect from this individual)?
10. Now let's look into our "crystal ball" --

If you should ever need assistance in performing your daily activities (anything from managing your financial affairs -- cooking, or cleaning -- shopping -- attending a concert/play/church -- help with bathing and dressing), what activities do you think you would need help with the most? Why?

11. Which of these activities would you miss the most if you had to give them up? Why?
12. To whom would you turn for help with these activities?
13. If there was a company/business in the community that provided these services -- would you use them?
 - What qualities would you want this business to have?
 - What services could they provide to make your lives easier?
14. For example, if there was such a thing as say companion/escort service that offered someone to accompany you anywhere -- from the market, to the doctor's office, plays and concerts, or even walks at Tech's duck pond -- would this be attractive to you?
 - What would you want/expect this service to provide?
15. Now let's look into our "crystal ball" --

If you should ever need assistance in performing your daily activities (anything from managing your financial affairs -- cooking, or cleaning -- shopping -- attending a concert/play/church -- help with bathing and dressing), what activities do you think you would need help with the most? Why?

- Attractive to you?
 - What would you want/expect?
16. Have you made plans in the future to provide for this increased assistance if you should need it?
 - If so, what?
 - Why select that method?

Table 4

Topic Outline

Set 2, Focus Groups 1 and 2

Women who are currently experiencing the role of primary caregiver to an aging relative or friend and women who are not currently occupying this role but who have done so within the last five years.

1. Introduction

The general topic: the aging population and the impact of this phenomenon on other segments of society.

2. We see so much in the media about the aging of our population or the "graying of America" -- what does this phrase mean to you?
3. In the context of this aging society, what do you think your role is in this society? (i.e., How do you view yourselves?)
4. Now, let's talk about expectations --

We all have expectations during our lives -- for example, as parents, we expect our children to apply themselves in school, get good jobs, marry and have families of their own.

What do you expect from

- society? (i.e., does the government "owe" you)
 - your children
 - your families
5. Do you think the role of the older individual is clearly defined in our society; in other words, what does society expect from the older individual?
 6. Let's talk about public policy or how our society has provided support to older individuals.
 - Has the government provided adequate support mechanisms? (i.e., Social Security, Medicare, etc.)
 - Are there enough social services organizations available to meet the needs of an aging population?
 - Which are the most helpful?
 - Are there services that are needed but not available?
 7. Another subject that is related to support for older individuals we see a great deal about in the media is that of "caregivers to older individuals." Where caregivers are individuals (i.e., a child, a spouse, a friend, or other relative) that provides some degree of support to an older individual (where the support may range from transportation to a doctor's appointment or shopping to providing care to very ill individuals or even not providing care themselves but acquiring the care for the older individual from an organization in the community).
 - Is the role of the caregiver clearly defined in our society (i.e., What does society expect from this individual?)

Table 4 (Continued)

Topic Outline

Set 2, Focus Groups 1 and 2

8. What are your expectations of caregivers to an aging population?
9. Is the role of caregiver clearly defined in our society (i.e., what does society expect from this individual)?
10. Are/were you working outside the home or operating a business in your home at the same time as providing care?
11. Do/did you have a family of your own at the time?
12. Is/was the role of "caregiver" clearly defined in your mind as to what was expected of you?
13. What aspects of the caregiving relationship are/were the most difficult (personal aspects (toileting/feeding/bathing) transportation)?
 - for you?
 - for the care recipient?
14. If there was a company/business in the community that provided these services -- would you use them?
 - What qualities would you want this business to have?
 - What services could they provide to make your lives easier?
15. Did you seek/use any assistance from friends?
16. Did you seek/use any assistance from families?
17. Did you seek/use any assistance from community (church support groups)?
18. Did you seek/use any assistance from services (homemaker)?
19. If yes, what was most helpful? Why?
20. What, if anything, did you dislike about the service/help?
21. What services do/did you need that are/were not available?
 - What would you want/expect from these services?
22. For example, if there was an escort service that offered someone to accompany the individual you are/were caring for anywhere -- from the market, to the doctor's office, plays and concerts, or even walks at Tech's duck pond -- would this be attractive to you?
 - What would you want/expect this service to provide?
23. For example, if there was a personal care service (bathing, dressing)?
 - Attractive to you?
 - What would you want/expect?

Table 4 (Continued)

Topic Outline

Set 2, Focus Groups 1 and 2

24. (For present caregivers) have you made plans in the future to provide for this increased assistance for the individual you are caring for if necessary?
- If so, what?
 - Why select that method?
25. Have you made plans for yourself?
- If so, what?
 - Why?

Table 5

Topic Outline

Set 3, Focus Groups 1 and 2

Women between the ages of 23 and 42 (i.e., the Baby Boom cohort) in professional positions and in staff/administrative support positions.

1. Introduction

The aging population and the impact of this phenomenon on other segments of society.

2. We see so much in the media about the aging of our population or the "graying of America" -- what does this phrase mean to you?
3. In the context of this aging society, what do you think your role is in this society? (i.e., How do you view yourselves?)
4. Now, let's talk about expectations --

We all have expectations during our lives -- for example, as parents, we expect our children to apply themselves in school, get good jobs, marry and have families of their own.

What do you expect from

- society? (i.e., does the government "owe" you)
 - your children
 - your families
5. Do you think the role of the older individual is clearly defined in our society; in other words, what does society expect from the older individual?
 6. Let's talk about public policy or how our society has provided support to older individuals.
 - Has the government provided adequate support mechanisms? (i.e., Social Security, Medicare, etc.)
 - Are there enough social services organizations available to meet the needs of an aging population? (i.e., home health - to maintenance to errands)
 - Which are the most helpful?
 - Are there services that are needed but not available?
 7. Another subject that is related to support for older individuals we see a great deal about in the media is that of "caregivers to older individuals." Where caregivers are individuals (i.e., a child, a spouse, a friend, or other relative) that provides some degree of support to an older individual (where the support may range from transportation to a doctor's appointment or shopping to providing care to very ill individuals or even not providing care themselves but acquiring the care for the older individual from an organization in the community).
 - What do you think the role is of the caregiver in our society (i.e., How do you view the caregiver?)

Table 5 (Continued)

Topic Outline

Set 1, Focus Groups 1 and 2

8. What are your expectations of caregivers to an aging population?
9. Is the role of caregiver clearly defined in our society (i.e., what does society expect from this individual)?
 - Who is this individual?
10. Now let's look into our "crystal ball" --
You work, possibly have families of your own -- what if an aging parent/relative/friend needs care and they look to you -- How will you care for them?
11. Whose responsibility is this?
12. How would you juggle the demands on your time?
13. What part of the caregiving relationship do you think would be most difficult?
14. If there was a company/business in the community that provided these services -- would you use them?
 - What qualities would you want this business to have?
 - What services could they provide to make your lives easier?
15. Would you use services in the community?
 - What?
 - Why?
16. Have you made plans for your own care in the future?
 - What?
 - Why?
17. Have you made plans for the care of a parent in the future?
 - What?
 - Why?

- In the area of proposed new services, if a service that offered companionship to the elderly (i.e., accompaniment to concerts, plays, dinner out, or simply conversation) existed, would it be utilized?
- In the area of proposed new services, if a service existed that offered relief to the caregiver in the form of personal care to the care recipient (i.e., assistance with bathing, feeding, toileting), would it be utilized?

Analysis of the Focus Group Research

The “Scissor and Sort” or “Long Couch, Short Hallway” method described by Wells was used as the method of analysis. This method provided the the most accurate and complete summation of each interview. Reliance on memory was not necessary. Audio tape recordings of each interview were transcribed. Participants were assured that their confidentiality would be guaranteed. Therefore, where proper names were used in the conversations, “---” was placed in the transcripts. Segments of the first two tapes that were transcribed were evaluated against the transcriptions to determine accuracy.

The next chapter describes how these transcriptions were used to identify dominant themes that emerged from each focus group interview. From these themes, new services are proposed to assist the aging population.

CHAPTER 5

RESULTS AND ANALYSIS

This chapter examines the major themes generated in each focus group interview and offers suggestions for new services. From the transcriptions, information collected from these six groups was analyzed for dominant themes. From the questions in the topic outlines that were common to all six groups, a priori categories or themes were generated. Additional categories were derived from the discussion of different groups (See Table 6). In each transcript, every quote was evaluated and either assigned a category number, noted as irrelevant, or as input from the moderator. The number of the category to which the quote was assigned was noted on the transcript. After systematically going through each transcript and assigning category numbers, the "Scissor and Sort" step of the Wells method was used. Categories were pooled (i.e., all "1's", ..., all "15's", etc.) and a summary report was prepared for each group. From these themes, attitudes toward the aging population and the role of caregiver were identified and used to propose areas of service delivery to enhance the quality of life for both the caregiver and the care recipient and assist the older individual at remaining independent in his/her home.

Table 7 shows a listing of these dominant themes by group ranging from the highest to the lowest number of responses per category (i.e., number 1 represents the dominant theme, etc.). Two

Table 6
Number of Responses per Category

A priori categories:	S1 FG 1	S1 FG 2	S2 FG 1	S2 FG 2	S3 FG 1	S3 FG 2
Perceptions of the aging population or the "graying of America"	2	2	2	4	3	4
How participants view themselves in this aging society	10	6	1	1	12	5
Participants expectations of:						
a. of society (i.e., government)	7	7	7	5	15	2
b. of their children	11	8	2	6	6	9
c. of their families	1	3	4	2	9	4
d. of younger generations	16	2	7	3	8	2
e. of friends	9	3			2	3
Societies expectations of older individuals	6	9	3	6	3	4
Perceptions of support provided to older individuals by:						
a. government (i.e., Social Security, Medicare)	20	19	7	9	11	11
b. social services (i.e., home health, maintenance)	2		5	3	10	4
Most helpful services	8	5	2	2	5	
Services needed but not available	18	19	10	19	15	17
Caregiver issues:						
a. societies expectations of caregivers	8	1	1	1	8	2
b. participant's expectations of caregivers	17	7	3	4	15	3
c. most difficult aspect of caregiving relationship		1	5	6	1	3

Table 6 (Continued)
Number of Responses per Category

	S1 FG 1	S1 FG 2	S2 FG 1	S2 FG 2	S3 FG 1	S3 FG 2
Willingness to use services in community:						
a. services provided by social service organizations (i.e., home-health care, meals-on-wheels)	1	2			3	
b. services from private/for fee organizations					11	
Willingness to use/attractiveness of proposed services:						
a. Companion/Escort Service	7	2	2	7	2	4
b. Personal Care Service	3	4	3	2	7	1
Attributes desired of services	3	8	7	12	9	2
Planning for long-term care in the future:						
a. for yourselves	2	4	6	6	2	6
b. for other individuals (i.e., parents)			5	5	9	5
Activities of daily living that would be missed most if given up due to health	1	3				
Categories Generated by Groups:						
Euthanasia/Death with dignity			4	13		
Assistance with caregiving sought from:						
a. friends		3	1			
b. family		1	2	1		
c. church	2		1	1		1

Table 6 (Continued)
Number of Responses per Category

	S1 FG 1	S1 FG 2	S2 FG 1	S2 FG 2	S3 FG 1	S3 FG 2
Anxieties/problems experienced in the caregiving relationship						
a. strain on time			6	5	4	1
b. strain on financial resources	1		7	3	1	
c. strain on caregiver's health			6	11		1
d. strain on/loss of intimacy with spouse			7	11		1
e. loss of freedom/independence/privacy				3	7	3
f. combined duties of child care and elder care				1	1	
g. need/desire of older individual to live with child				2	1	1
h. guilt/resentment			5	11	2	8
i. role reversal			2	3	5	1
j. strain on children in the home			4	3	2	
k. feeling obligated to care for parents				3	1	9
Changing structure of the American family (i.e., divorce, separation, communal living)	1		3	10	27	13
Acknowledging the aging of a parent and anticipating how to deal with the situation				1	5	4
Economic aspects/concerns of the aging process:						
a. retirement issues	17				11	6
b. medical costs (i.e., health care, prescriptions)	7	7	11	6	1	
c. costs associated with use of in-time services	6	1	4	7		3
Elderly as resources				1	9	5
Elder abuse					1	2

Table 7

Dominant Themes by Group

Set 1, Focus Group 1

Women 65 years old and older functioning independently in their homes.

1. Perceptions of support provided to older individuals by the government (i.e., Social Security, Medicare)
2. Services needed by not available
3. *Retirement issues
4. *Participants' expectations of caregivers
5. Participants' expectations of younger generations
6. Participants' expectations of society
7. Participants' view of themselves in the aging society
8. Participants' expectations of friends

*Tied in number of responses

Set 1, Focus Group 2

Women 65 years old and older residing in their own homes who are receiving assistance in performing their daily activities.

1. *Perceptions of support provided to older individuals by the government (i.e., Social Security, Medicare)
2. *Services needed but not available
3. Societies' expectations of older individuals
4. + Participants' expectations of their children
5. + Attributes desired of services
6. --Participants' expectations of society
7. --Participants' expectations of caregivers
8. --Medicare costs (i.e., health care prescriptions)

*, +, -- Tied in number of responses

Table 7 (Continued)
Dominant Themes by Group

Set 2, Focus Group 1

Women who are currently occupying the role of primary caregiver to an aging relative or friend.

1. Medical costs (i.e., health care, prescriptions)
 2. Services needed but not available
 3. *Participants' expectations of society
 4. *Participants' expectations of younger generations
 5. *Perceptions of support provided to older individuals by the government (i.e., Social Security, Medicare)
 6. *Attributes desired of services
 7. *Strain on financial resources in the caregiving relationship
 8. *Strain on/loss of intimacy with spouse
- *Tied in number of responses

Set 2, Focus 2

Women who are not currently occupying the role of primary caregiver to an aging relative or friend but who have done so within the last five years.

1. Services needed but not available
 2. Euthanasia/Death with dignity
 3. Attributes desired of services
 4. *Strain on the caregiver's health
 5. *Strain on/loss of intimacy with spouse
 6. *Guilt/resentment in the caregiving relationship
 7. Changing structure of the American family
 8. Perceptions of support provided to older individuals by the government (i.e., Social Security, Medicare)
- *Tied in number of responses

Table 7 (Continued)

Dominant Themes by Group

Set 3, Focus Group 1

Women between the ages of 23 and 42 (i.e., the Baby Boom cohort) in professional positions who have never been primary caregivers to aging relatives or friends.

1. The changing structure of the American family
2. *The participants' expectations of society
3. *The participants' expectations of caregivers
4. *Services needed but not available
5. The participants' view of themselves in the aging society.
6. **Perceptions of support provided to older individuals by the government (i.e., Social Security, Medicare)
7. **Retirement issues
8. **Willingness to use services from private/for fee organizations

*, ** Tied in number of responses

Set 3, Focus Group 2

Women between the ages of 23 and 42 (i.e., the Baby Boom cohort) in staff/administrative support positions who have never been primary caregivers to aging relatives or friends.

1. Services needed but not available
2. Changing structure of the American family
3. Perceptions of support provided to older individuals by the government (i.e., Social Security, Medicare)
4. Feeling obligated to care for parents
5. Expectations of their children
6. Guilt/resentment in the caregiving relationship
7. *Retirement issues
8. *Planning for long-term care in the future for themselves

*Tied in number of responses

themes--Perceptions of Support Provided to Older Individuals by the Government (i.e., Social Security and Medicare) and Services Needed But Not Available--were common to all six focus group interviews. Initially, the theme Perceptions of Support Provided to Older Individuals is discussed along with related sub-themes. Next, themes common to some, but not all, groups are discussed. Finally, using information from these previous topics as support, the other theme common to all groups, Services Needed But Not Available, is discussed with related sub-themes (i.e., Attributes Desired of Services) and proposals for new service delivery are made.

Perceptions of Support Provided to Older Individuals

The topic Perceptions of Support Provided to Older Individuals by the Government (i.e., Social Security, Medicare) was a dominant theme common to all six focus groups. The first group, women 65 years old and older functioning independently in their homes, was very concerned about this support. A tremendous amount of this group's conversation focused on government-provided programs such as Social Security and Medicare. It was evident that this group depends tremendously on these support mechanisms to meet their needs. As one woman put it, "Well, I've given quite a bit of thought to the fact that Social Security, we all worry about that, may run out." They avidly listen to any news story that pertains to these topics and cited current legislative activities as ways to improve these support programs. One opinion held by these individuals was that many people view Social Security benefits as charity. They adamantly disagree with this, citing the many years that they paid into the system.

Also there seemed to be an opinion that younger generations "think that we're eating up the funds. It's not the senior citizens who are eating up the funds at all." In their view, Social Security was intended to benefit dependents and retired individuals. They perceived that the drain on the program was coming from

"... these organizations, that mind your children, feed your children, free food in school, none of that was supposed to be taken into consideration under Social Security. A lot of things have been added to be covered by Social Security that the law was never in-

tended for. Never. It was for dependents and retired employees. But it wasn't supposed to include all these freebies that are getting thrown in and that's why Social Security is, well I don't think it is now, but on the verge of people saying that we're going to go bankrupt and the next generation or the one after that would not have the funds left to cover their retirement. That's a lot of nonsense."

Another area of concern was in regard to how the government invested Social Security dollars. Several people thought the government was investing these funds "for us at an enormous rate of interest." Yet one woman who had worked for a large bank was very sure that these large banks were allowed to hold Social Security funds without paying interest on it. Others were not so sure. Several participants feared that Social Security funds would be used to "try to lower the deficit." One woman remembered that in the early 1940's, "part of our Social Security was used to finance World War II."

Regardless of their point of view and information or misinformation, Social Security benefits are extremely important to this group. They strongly believe that they have paid their way over the years and these benefits are rightfully theirs.

Like the women 65 years old and older functioning independently, the women 65 years old and older functioning in their homes with assistance were also very concerned about Social Security, Medicare, and Medicaid. Living on fixed incomes and experiencing declining health, these programs are extremely important to these women. As one participant stated, "And I think the elderly people that are trying on the small salary that they have, should get more support from the government." Most of these women were covered by the Medicare program. It was their perception that individuals who had nothing and were covered by Medicaid were significantly better off (i.e., greater subsidization of rent, medical bills). It seemed to be an injustice to them that while they had worked very hard and might have some small nest egg put aside, they were being penalized for their meager life savings.

The women who are currently acting as caregivers to aging relatives of friends are also concerned about the limitations of these federally-funded programs, but from a different perspective. This group acknowledged that programs such as Social Security, Medicare, and Medicaid provide some small level of support for older individuals. But, according to these women, these services

do not adequately meet the needs of the elderly. They cited other countries that provide socialized medicine as possible models for health care in the United States.

These women believed that most people do not realize the burden that the cost of caregiving poses for the average family. They cited laws that require the elderly individual to impoverish him/herself before aid can be received. As one woman stated,

“The thing that frightens me again, it seems I’m on the money rampage, but, the way we’re set up, the burden, financial care is falling more and more and more on the children. Because the institutions, alright my father’s in ---, right now, he is on Medicaid. But he had to be penniless to the point of nothing but \$1500 that went into a burial fund, nothing, everything had to go, everything had to be depleted. You can’t even bury him for \$1500, I’m going to have the burden of burial. My children are going to face this burden financially if I get to where I can’t function.”

Similarly, women who had provided care in the past viewed this support from a personal perspective. This group cited the programs provided to older individuals by the government such as Medicare and Medicaid as being “twenty years behind times” and “it’s getting worse.” With enough money, it is possible to provide adequate care for older individuals. However, if an individual had money, he/she was not qualified for assistance from some of these programs such as Medicaid. Also, with the high price of care such as nursing homes, the older individual would be impoverished very quickly. Another limitation of programs such as Medicaid was in their restrictions, “The disappointing thing about the system for me was that for Medicaid to cover having a person come into the house, he had to be worse than he was.”

In a related area, another cause of concern was the lack of funding available for in-home care. As two women stated,

“Now, it would have saved the government a whole lot more money if they would have let us have what we needed in our home, rather than put him in the hospital. The only alternative was to put him in the hospital. Now then, they would have covered it. What we really did, we could have gotten by with such, so much less ...”

“There is money for the hospital bed, but there isn’t money for the compassionate person to come.”

The Baby Boom women in both professional and staff/support positions based their opinions on these programs on information gathered mainly from the media rather than personal experience with these programs. In terms of economic and medical support, the Baby Boom women who were university faculty did not think that our society is prepared to handle the aging of the popu-

lation. In terms of Social Security, these women had little hope of receiving these benefits in the future. They cited the fact that many people have the misperception that Social Security was intended to provide an adequate income in the retirement years. They shared an interest that personal planning was critical for one's future.

Their greatest concern for their later years dealt with adequate medical care. As one participant put it,

“ ... my main expectation and wishful thinking from society is with regard to catastrophic and long-term medical care and I feel like, everything else I could take care of. Everything that's sort of predictable that's sort of routine, but the thought of getting completely financially wiped out with one major illness or one long bout of something.”

This fear of losing a lifetime's savings was a reoccurring topic. The “impoverished elderly” or “elderization and poverty” seemed to be a major concern. Several stories of elderly individuals losing their homes or leaving a spouse in poverty due to long-term illness were cited as examples of the critical need for long-term catastrophic health care.

A related medical topic was what medical services were paid for in the home environment as opposed to in an institution. A redefinition of medical payment was requested that would allow an individual to remain in his/her home environment and receive medical services that under today's system, would require an individual to enter a nursing home.

Similarly, one of the main concerns of Baby Boom women in support positions was that of the level of support provided to older individuals. Their opinions in this area stemmed from watching older family members utilize support programs provided by the government or service organizations. They also appeared to be well-read in this area, citing current legislative activities in long-term care as examples. In terms of health care and government programs such as Medicare to assist with these costs, they felt our country was performing poorly. Many cited as a major injustice to the elderly the high cost of health care in the later years and the need to impoverish oneself before aid could be received. They cited stories they had heard about families becoming destitute--losing their homes, their cars--in the face of a long-term illness. One woman saw this as a disincentive for saving for old age because the current system will not allow the older individual or family to keep the savings acquired during the life of the ill individual. Another inequity in health pro-

grams cited was in the method of payment for needed services. One woman cited the story of an older woman who had to go into the hospital for therapy that could have been provided in the home--but in the home, the service would not have been paid for. In summary,

“And I just think that until the Baby Boomers get old and it’s economically viable to take care of us because there’s too many of us not to, that, you know, that they’re going to ignore it. Or until we’re such that, all of are old enough to vote and out-vote all these people and to vote in the things that we need. I think that’s the thing that’s going to change things.”

Economic Aspects of Aging

Two topics related to the economic aspect of aging were retirement issues and medical costs. These two topics were of concern only to certain groups of women.

Retirement Issues

Retirement issues emerged as a dominant theme in three of the six focus group interviews: women 65 years old and older functioning independently, Baby Boom women in professional positions, and Baby Boom women in staff/support positions.

To the women 65 years old and older functioning independently, again, Social Security benefits came into play:

“Let me ask you this. I think it’s a Mexican standoff, the workforce is now paying one heck of a percentage of their wages for Social Security, 7.51 percent, which seems like a lot of money. And that’s true, but on the other hand, how in the world can two people that were forced to retire at age 62, how are they going to cut it nowadays? The upcoming generation, the workforce now says well, we’re going to be paying Social Security ‘til ‘H’ freezes over and there’s not going to be enough and they say how can we afford to raise Social Security now, but with the cost of living as is, two people that were forced to retire before 65 it’s practically impossible, well not impossible, but it’s hard. Unless you have some sort of annuity or part-time job or some such thing.”

Many participants in this group expressed a strong desire to continue working at either part-time or full-time jobs. They still saw themselves as being capable and productive in the workforce.

But comments such as "Nobody would give us a job," "Lord knows I've tried," and "Tell me about it. I've climbed the wall over here looking for a job. I have resumes up the gazoo, but it didn't do any good" communicate their frustration at having employment opportunities denied to them.

Another factor was the way the government penalizes wages earned in retirement. As one woman put it, "Every two dollars you earn over \$4000 a year, penalizes you one." Some saw this as a disincentive to work beyond retirement. In summary, these people felt strongly that they should be allowed to continue to work if they chose "and earn as much as you can."

The professional Baby Boom women generated a strong interest in retirement issues also. Of particular interest was the issue of a mandatory retirement age. Many of the women did not want to quit work "because we are a certain age." It was pointed out that current legislation allows older individuals "to work older and older." Two consequences of this were pointed out--one, that with people working into their later years, there were fewer opportunities for younger generations and the counterpoint, that with older individuals continuing to work, they were not acting as "takers" or draining the system. Yet in terms of continuing to work, one participant said, "I don't want to work 'till I'm 75--so old, I want to have some fun." Yet the economic aspects of retiring were seen as a significant factor. Again, the concern of increasing medical costs was mentioned.

The issue of part-time work after retirement was addressed. The example of seeing elderly individuals as baggers in supermarkets generated a great deal of discussion. The questions of why they were doing it was an area of concern. If the individual was doing this because he/she wanted to, that seemed acceptable. However, if the person was performing this job as a matter of financial necessity, many of the participants felt concerned. This job was perceived as demeaning. However, one participant pointed out that this job also offered lower responsibility and that aspect might be very attractive to a retired individual. It seemed that if the retired individual wanted to work after retirement, it should be at a job that prescribed some sort of status.

The Baby Boom women in staff or support positions were also interested in the issue of retirement. They cited examples of witnessing their parents retire due to mandatory age requirements long before their productive capabilities were spent. In their opinion, this was a very unjust situ-

ation for several reasons. They felt that our society holds a false assumption that because an individual is old, he/she is helpless and does not want to work. One participant felt that the continued part-time employment her mother was performing beyond the mandatory retirement age was "one thing that keeps her as independent and not sitting around thinking what I can do for her, or you know, how sick she is today, because she's busy." Another reason cited for continuing employment was the economic aspect of retirement. One participant witnessed her father being restricted by law to being unable to make as much money as he wanted between the ages of 62 to 70 without penalty to his Social Security benefits. Another woman felt that the financial aspect of aging was "where the nightmare lies presently." Some cited a future of fewer young people caring for greater numbers of old people. One participant best summed up their view by saying "We've got to be earning our way, and I think we're the generation of the mindset that we want to be earning our way."

Medical Costs

A second economic aspect of the aging process--medical costs--was a concern to two groups: women 65 years old and older functioning with assistance and women who are currently in the caregiver role.

The women 65 years old and older receiving assistance with their daily activities were experiencing all of the physiological infirmities associated with the aging process. Increasing health problems made them very aware of health care costs in the later years. Even on Medicare, the costs of an illness can be devastating. As a couple of participant's explained,

"... but now last month my medicine was \$300 and some. And I think, and I don't have insurance that covers my medicine."

"A year ago, I had a gall bladder surgery and I carried Medicare and Blue Cross Plus Extended. And my surgeon's bill, Medicare and Blue Cross did not take care of it. I had \$550 to pay out of my pocket. So things like that, it makes it tough."

These women wished for better support programs to assist them in their health care needs and in the event they should ever require nursing home care.

To women currently in the caregiver role, we are living longer, but we are also paying a tremendous price for this longevity. One woman stated,

"I'm looking at it with a little fear down the road because in not too many years I'm going to be where the elderly population is now and it's going to be the bulk of our population. The health care costs, trying to live economically, just sustain yourself, economically, is the fear that I have because it's progressing, the health care costs are just, oh they are monumental. They just keep going up and up and up. With all our modern technology and medicine, we're keeping people alive longer, but we're also having to maintain their care with hospital costs, and medical costs and medicine and so forth, and it's taken everything just about for a lot of people now, just to live with their medicine and their health care. So it frightens me, will I even have a place to live when I get there, just to keep myself alive."

One area of the financial nightmare is in the need for prescription drugs for the elderly. These women knew older individuals who practically "plop their whole Social Security check down for their maintenance (drugs)." Another area of financial strain concerns hospital visits. They cited an average out-of-pocket expense of \$536 per admission to the hospital that Medicare does not cover. They said it was not unusual to have to admit an ailing parent to the hospital "an average of once a week."

If the older individual was in a nursing home and had to be admitted to the hospital, a figure of \$56 a day out-of-pocket expense was required to hold the bed in the nursing home. To let the bed go might mean a wait of six months until another bed became available. These women cited these as no-win situations.

Several of these women stated the desire to keep their infirm relatives in their homes. But the need for day and night shift help in the caregiving relationship was cited as costing "approximately \$3000 a month." But the financial aspect is only one facet of this relationship.

"If the government would give me enough money to have my dad at home with me that I could afford to have someone give me the relief I need to care for him, maintain my family, then my emotional state would be a heck of a lot better."

Another aspect of the financial burden on the caregiving relationship was in the stress it put on family relationships. One woman described misunderstandings and feelings of inequity in the monetary burden among brothers and sisters. As she put it,

"If there's brothers and sisters, no matter how close you think you are to your brothers and sisters, if you take on the care of the parent, anything you do, get it in writing, because people change their ideas and when it gets, again, financially, when you get involved in that. Your family can be almost unrecognizable. And there you've got the burden of the parent plus the burden of why don't you do things this way, or you

should have done this or you should have done the other. You should get in writing everything.”

Participants’ Planning for Long-Term Care

In terms of planning for either their own or their parents long-term care, only one group (i.e., Baby Boom women in staff/support positions) was concerned with this issue as a dominant theme. Primarily, their activities dealt with planning for their aging relatives rather than for themselves.

Several of these women were seeing signs that their parents’ health was not what it once was. This was prompting many of them to question what they would do in the future to care for their parents. One woman and her mother talked about this situation with her mother assuring her that she did not expect the daughter to take care of her. Another woman and her father were building a small house near her home. Underlying this project was the understanding that if anything happened to her father, her mother would have a place near her daughter. In another family, one woman’s brother uses the family get-together at Christmas to attempt to plan for their aging mother’s long-term care. The brother waits until Christmas when the family is together and then makes comments such as “We need to be thinking about your mother.” This woman resented this and felt uncomfortable in taking part in any plan as long as her mother was capable of making her own decisions. Several of the women’s parents had done the planning (i.e., getting their finances in order, burial plans) and had informed their daughters of their decisions.

In regards to planning for their own security in their later years, the group was divided in that some had taken active measures in planning and others had not. One woman said “I’m still trying to make plans in the current time.” Others acknowledged the need to plan and had taken steps to “participate in IRAs and tax shelters and certainly look at retirement plans and things like that.”

Participants' View of Themselves in the Aging Society

Three groups presented very different views of how the participants see themselves in the aging society. The women 65 years old and older functioning independently and the women 65 years old and older living with assistance presented a rather dim view of how society feels about older individuals and how they fight this perception by struggling to maintain their independence. The third group for whom this is a dominant theme (i.e., Baby Boom women in professional positions), offer a futuristic view of how these women see themselves in the aging society.

Initially, it should be stated that the majority of the women 65 years old and older living independently felt society had a negative view of the elderly. For example,

"I don't know. It seems to be a trend that senior citizens nowadays are beginning to be treated like second cousins, so to speak."

"Poor relatives."

"The general populous seems to forget that we carried the load for a long time and I don't know if it's the Baby Boomers that are coming up now that feel like they--let me rephrase that. They think we are, if you want to use the common expression, a drag on society."

In spite of these views, this group felt proud of the work they had performed. They truly felt they had done their part and now desired the respect that their contribution to society merited.

Just as strongly as they had requested dignity and respect earlier, now they asserted that " ... the key word there for all of us is independence." They were thankful to be independent, requiring no help from anyone. Again, their words best sum up their feelings.

"Well I think we all want to be independent."

"Well they say grow old gracefully and I fight it every step of the way."

"I have to fight it every day, just about."

"Like I said so many times, it's not the years, it's the infirmities."

Also, the women 65 years old and older living with assistance presented a rather dim view of aging today. According to this group, society has very few expectations of older individuals. As one participant stated, "Sometimes you feel like they think we're all a bunch of senile people."

They sensed that in stores, clerks became frustrated or aggravated with them due to their slower movements or difficulty in hearing what was said to them. For older individuals who are sick, the perception was that society has "kind of marked them off and forgotten them."

The professional Baby Boom women offer a different view of themselves in the aging society. One participant described this group in an overall profile of the population as "an egg moving up through the age groups." Several comments reflected the idea that there is strength in numbers:

"Says to me I'll always have a peer group--I'm in the Baby Boom group, so whatever age I am will be the one around which all economic development takes place. It has given me a sense of security in my life."

"That we are the image-makers. Whatever sales promo--anything is going to be geared to the dominant age group, the one that is the largest."

The television program, TheGolden Girls , was cited as an example of how the media is adapting to the aging of the population.

Yet one woman offered an antithetical view of being a member of the Baby Boom cohort. Instead of feeling the strength of numbers, she perceived a competition for scarce resources. In her words

" ... I always thought the opposite. I didn't get a lot of security out of this Baby Boom population that were all my mates, but rather that the group that came before didn't have anybody to compete with and got all the goodies. And got all the high salaries and more opportunities and I think we are also seeing, in a relative sense, lesser opportunities to do savings and so forth across the board, although we're a pretty unique group in many regards."

One woman described what had come to her as a pleasant surprise. Once she had dreaded the thought of aging. Yet today she said

" ... I really feel better, I never thought I would feel this way. I was always prepared to have anxieties about 30, 40, something like that and they are not materializing, at least to the extent that I expected them."

She continued to explain why she thought this was occurring.

"And I have a sneaking suspicion that something else is happening here too and that is that women are maturing into age better than they used to. Just consider the reentry rates of women into college. That's just one small example. The later child bearing age. Women are handling maturity and age and the graying of American better than they ever used to before and that's going to enrich the whole meaning of what it means to be older."

In spite of this tremendous sense of power in the cohort's aging process, there seemed to be an acknowledged denial of their own individual aging. Several of the participants stated that they

could not really picture themselves as “being decrepit and needing care.” One woman strongly believed that “we have control over how healthy we are.” Yet most of the participants acknowledged that perhaps they were deluding themselves. One participant best summed up this group’s view of themselves:

“And also that we’re all independent professional women in here and if you were to have our mothers at the same age setting around this table, you know, they’re used to being taken care of so to speak and we’re used to forging out on our own. So we have that invincibility idea.”

Participants’ Expectations of Others

Several groups of participants had definite expectations of society, their children, younger generations, their friends, and caregivers. The following sections will discuss these topics.

Participants’ Expectations of Society

Four groups, women 65 years old and older, both living independently and receiving assistance, women currently occupying the role of caregiver, and Baby Boom women in professional positions had strong feelings about their expectations from society.

When women 65 years old and older living independently were asked what they expected from society, this group answered, almost in unison, “dignity and respect.” It cannot be overstated how strongly and emphatically these words were spoken. In their words, regarding this respect,

“I said I think it’s been earned.”

“Respect. But it’s not given a lot.”

When asked why respect is not given to older individuals, one participant replied

“I don’t know, I think it kinda comes back maybe to the resentment of we’re taking care of older people. But nobody’s taking care of us, we’re taking care of ourselves, we’ve paid into Social Security.”

Women 65 years old and older receiving assistance felt that society (i.e., the government) had an obligation to support older individuals. In their words,

"I plan to stay and pay as long as I'm able 'til my money runs out and then in case I would have to go to a nursing home, and then when my money's gone, the government would just have to pick it up or kick me out, one."

"I feel like --- does, I think in time, if the time would come that after my money runs out and I was in a nursing home, that the government should do something, pay it."

But until that dependent time came, this group felt strongly that they could, and should contribute to society. As one woman put it, "It's not so much what I expect from society as what I can give society." They cited acts such as playing the piano for the church and helping each other as positive contributions to society.

To the next group of women, current caregivers, serving as caregiver to an aging relative or friend and having to deal with the support programs (or lack of them) provided to the care recipients has had a definite impact on this groups' expectations of society. Their words best describe their feelings.

"Well, I really don't think we should expect society to take care of us. I really don't."

"I mean, I certainly don't expect society to take care of me. Or to be responsible for me. You know it's really my duty to see that I'm squared away."

"And we're going to be that way too because we're seeing all these things happen, we haven't learned to trust that society is going to take care of us."

Professional women in the Baby Boom cohort felt that society was not doing enough to prepare for the aging population. Again, they applied the safety in numbers principles to this area of society. Until the Baby Boom cohort reached their later years, they felt that politically, little would be done to change the system. In terms of Social Security, most of the participants did not expect to receive any benefits from this program. Even though information is being distributed that encourages people to financially plan for their futures, the consensus was that most people are not taking active steps in their future planning. The primary societal expectation of this group dealt with health care issues. It was felt that this is one area in which we have not met the needs of the older population.

Subjectively, this group had two expectations of society. One participant expressed a strong desire that as she aged, she would like society to value her more. The status of advanced age should

be something of honor and value. Another issue addressed the technology that allows us to prolong life for what seems an indefinite span of time. With the high cost associated with this medical technology, the question was raised as to who was/should be responsible for this cost--society or the individual? The solution was posed that responsibility should be taken at the individual level in the form of such acts as developing living wills.

Participants' Expectations of Their Children

Two groups of participants, women 65 years old and older receiving assistance and Baby Boom women in staff/support positions, had expectations of their children. With both ends of the life cycle represented by these two groups, their comments are strikingly similar.

Women 65 years old and older receiving assistance expected their children "to be good citizens and teach their children to be and to work, and go to church and be good citizens of the community they live in." Looking to the future when they might need care, this group felt strongly that they did not want to be a burden on their children. As one woman stated,

"When they have a husband and children themselves I think they should be able to live their life. Now I don't mean they shouldn't care for you. But I mean as far as taking you in their home, if you become disabled, it puts a hardship on them"

Similarly, Baby Boom women in staff positions expect nothing at all from their children in terms of caring for them in their older years. These women expressed a tremendous sense of having enjoyed their children but wanted them to grow up to be good, responsible citizens (i.e., " ... non-sexist, non-racist, humanistic, good people with strong social justice ...") who felt no obligation to care for anyone but themselves. One participant felt that children today are reared in families that are not as tradition-oriented in caring for older individuals.

Participants' Expectations of Younger Generations

With regard to expectations of younger generations, two groups of participants had strong opinions regarding this topic.

Women 65 years old and older living independently generated mixed emotions on the younger generations. Some thought they were an irresponsible lot while others believed they would rally to support the older generations. One segment thought that younger generations "don't appreciate what they do have. See it's been handed to them on a silver platter. They've been raised up like that." It was felt that younger people could be "a little more economical." They felt that these upcoming generations should develop a greater sense of responsibility toward the older generations. The younger generations were accused of being apathetic towards the political aspects of aging. Unless "the upcoming generation will snap out of it and see what's going on and get involved" predictions of socialized medicine "and every other daggone thing ... I don't believe we want that" were feared.

But another contingent voiced a very different opinion of the younger generations. "We've got some brilliant minds coming up. They are here now and they are coming and I think eventually they're going to get this idea that we cannot go on this way and there's going to be a revolution." In this passive revolution, it was predicted that when younger people see "how their parents have been treated," "they'll make a stand, I'm sure of it." One of the conditions that is predicted to spur this movement is health costs. As one participant put it:

"The high cost of medical bills, it's stripping the older generation of any dignity that they might have. You can read, I read in the paper where people are putting up and having to mortgage their homes in order to pay their medical bills and everything, and any child with any get up and go is going to say, hey, that's never going to happen to me. And I think they'll get angry."

With women who are currently giving care to older relatives or friends, the caregiving experience has strongly impacted this group's expectations of others. They have some strong words for the upcoming generations.

"If these, if we turn our whole thinking around and these little kids are started education in a different way, then a different arrangement will be made."

" ... So these, these young folks who are coming up are going to have to learn that they have got to take care of themselves"

"Learn it at an early age."

"And I don't think that's pie in the sky. I think that can happen. I think it will happen. Because of the fact that there are more and more older people, and it's not working out and you can put the finger in the dike for a little while, right now, but you've got to start back here."

"I, I think there's need, there's always need, but maybe that's what needs to be started is education, I mean with the little kids, that society is not going to take care of you, you know you damn well better get out there and make all your arrangements yourself."

Participants' Expectations of Friends

To one group, women 65 years old and older living independently, their friends play a very important role in their lives. This group was extremely supportive of their friends in this retirement community. Like their view of the caregiver relationship, the assistance they provide to their friends " ... has to be done in love." They watch out for one another by doing such things as noticing if the morning paper is taken in or carrying food to a sick neighbor. They are extremely proud of their sense of community and level of caring. But while it is one thing to give this friendship freely, it is quite another to be told to do so. In talking about support provided to and received from friends, the following statement was made about the management of their retirement community.

" ... I heard the rumor the other day that the powers that be in this place said that we should look after each other. I think that's a bunch of huey! We do. There is not a one among us, if there's a neighbor that's sick or needs help, we're right there and we've done it ever since we've lived here. I've been here five and one-half years, longer than, just about as long as anybody. But when they come and say that it's our duty, bull!"

Again, a strong sense of independence and caring for each other was seen as an act of love, not an obligation.

Participants' Expectations of Caregivers

Three groups of women had expectations of individuals who occupy the role of caregiver. Women 65 years old and older living independently had clear expectations of what a caregiver should do. Generally, they saw an adult child in this role. They saw two broad areas of support--physical and emotional support. In terms of emotional support, to this group, "the physical aspect is the most immediate, the love just sort of goes along with it." These women believed that if the caregiver did not feel love in the caregiver role, he/she would "walk away from it." Psychological support was cited as a major need of the terminally ill. Another emotional support provided by caregivers could be "... even just sitting and talking. That helps a lot." Telephone contact was also a valued support mechanism. One woman had instructions to call a certain relative every night when she got out of the shower. This support was met with enthusiasm from the group. As one participant put it, "That's not a bad idea. I've seen the time when I wished I had somebody there."

The physical aspect of support involved the caregiver performing a wide array of tasks--shoveling snow from walkways, general housework such as vacuuming, washing the dishes, scrubbing the bathtub, or grocery shopping. In more personal assistance, some of the participants experienced difficulty in bathing (i.e., limited movement posed difficulty in washing their backs). Another participant expressed that "getting in and out of the tub gives me the problems."

If the caregiver was an adult child with children of their own, there was agreement that the caregiver role "worked a big hardship on them." Getting someone to watch their children in order to perform the caregiver role was seen as a major difficulty. If the children were brought along, they might be an irritant due to their making noise and running in the house.

Regardless of who the caregiver is, women 65 years old and older receiving assistance had very clear expectations of the individual occupying this role. For example, they expected the caregiver to be trained in how to handle older individuals (i.e., in the event of a fall) and how to properly administer medication. In addition to this practical training, the group felt strongly about the

subjective qualities of the caregiver. They felt the person in this role should be kind and “Caring and loving, that’s the most important thing of all.”

Finally, Baby Boom women in professional positions felt that society delegated the care of the elderly to the family in general and women (i.e., daughters and daughters-in-law) in particular. As one participant put it “Biology is destiny.” These women basically agreed with the societal expectation, but did not necessarily like it:

“ ... I think the role is very well defined, and I think who does it is very well defined. And I think the reluctance to say that is because we don’t like that. And that we would like to see if defined otherwise.”

Women are viewed as the more “ ... nurturing sex in general” While some of the women knew men who would take care of their parents, this was viewed as the exception rather than the rule. This group believed that, in the future, men might be more likely to move into the caregiver role.

Some of these women cited the societal changes they described earlier as inhibitors to their accepting the caregiver role (i.e., women entering the work force). As one woman said, “ ... there is no way I cannot work.” Another woman stated “So I am going to have to be gone, be it child or an elderly parent. I am going to have to be gone during the day.”

Changing Structure of the American Family

For three groups of women (i.e., women who have been caregivers in the past and both groups of the Baby Boom cohort), the changing structure of the American family was a great cause of concern.

Past caregivers described a society in which dramatic changes are occurring in the family unit. In the past, they cited families as being close both emotionally and physically. As one woman stated,

“And it used to be that people stayed with their families. Families stayed together and they had some kind of relationship going. Maybe it was a baby-sitting relationship or

a helpful relationship or a handyman relationship, or a dropping by and having coffee relationship ... ”

Yet the family of today is very different in their opinion. The family of today has become decentralized. With so many people working, time to spend with family members has declined. Also, older individuals have a greater desire to remain independent in their later years rejecting the concept of moving in with their children.

This group thought that as a society, we are confused about traditional roles.

“I think roles in general in society today are not defined. I mean, there’s just a total breakdown in the family. Parents don’t know what the parenting role is, husbands and wives don’t know what that role is. Children don’t know what’s a typical family because there’s single parents, blended families, 50 percent in divorced homes. I think society in general is very confused.”

In this confusion, the accusation was made that society on the whole is becoming more self-centered. In terms of providing care to older individuals, one woman stated that many people shunned the responsibility of caring for older individuals “because it’s interfering with my pleasures in life.”

The dominant theme generated by Baby Boom women in professional positions was the changes that have occurred in the American family. Several factors contributing to these changes were discussed. One of the main factors that has affected the American family was the increased mobility of today’s family unit. The group was divided on whether the family of today is as mobile as it has been in the past. One participant cited the statistic of a family relocating an average of seven times in the past but thought that number might be too high for today’s family. The loss of the extended family unit was a major consequence of a family’s moves to find better employment. The elderly population was also considered to be increasingly mobile. One woman cited both her parents and her husband’s parents as examples of this phenomenon. After retirement, both sets of parents pulled up stakes and moved away from their homes, families, and friends.

This mobility has an impact on how the elderly are cared for in one aspect. One woman remembered growing up in a neighborhood where everyone knew everyone else. It was the rule, rather than the exception, that neighborhood children would perform errands such as getting the groceries for elderly neighbors. Yet today, she believed, people in neighborhoods rarely know each other.

One woman stated that she was the only child in her family who had moved away from her hometown. Because her parents had their other children and grandchildren nearby, she felt that the pressures on her to conform and remain near the family home were lessened. Another participant described the problems associated with being away from parents. During holidays, she and her husband had always made efforts to take their children to one or the other set of grandparents. This woman was tired of experiencing these times in this fashion. As she reported, "My feeling is because I have children, that it's time to move on. That I want my children to have some place to go home to for Christmas. That I wanted to make the cookies. ... And I want to be the homestead now."

The changing size of the family unit was cited as a major alteration to the American family. Several of the participants had parents who came from large families of eight or twelve children. But they cite the Baby Boomers as either choosing to have no children or very small families of one or two children. They viewed the family of three or four children as unusual.

Another factor seen as having a detrimental effect on the American family is the increase in the divorce rate. One woman used the experiences of a friend who teaches elementary school as an example of this trend. This friend is constantly having to deal with the extended families of her students created by divorce--a mother, a father, and stepparents. The question was raised as to what effect this would have on the "care for the grandparents if there are these, so many divisions?" Would the children feel a strong sense of responsibility to these older individuals--if so, which ones, the real grandparents or the step grandparents?

Looking at older individuals on a more positive note, this group cited an interesting trend. In the past, as one participant stated " ... you know, the loneliness of old age, where all of your friends are dying and you're the only one left and you're the burden and all of this. I think we're going to see less of that just due to numbers." Family members might be more dispersed, but the concept of "the Golden Girl type thing" of cohorts living together was seen as a positive way of life in the later years.

Similarly, Baby Boom women in staff/support positions saw "the breakdown of the American family, you know the traditional mother, father family," "the disintegration of the traditional

family,” and “our society has changed from being a generational-knit family where the grandparents are now becoming a separate part of society rather than being part of the family.” Several societal trends were cited as the cause of these changes: the increase in the divorce rate, women going outside the home for employment, and relocation and being transferred to find employment. The negative impact of these societal changes on women was noted. The observation was made that women today have more responsibilities and, therefore, may not have the time or opportunities to plan or save for retirement. One participant remembered her grandmother coming to live with her family to provide child care but acknowledged that today, the more likely option would be to utilize child care services in the community. Another participant cited smaller families as a significant societal change. As an only child of only children, she had watched her friend’s (also from small families) families die and leave these, in a sense, only children. These circumstances made the value of friends even more important in the face of not having an extended family. The suggestion for communal living was made so that, in their old age, these friends would live together and take care of each other. With so many single parent households today, one participant brought up an interesting issue, that of “biological parents versus psychological parents.” In a custody battle involving her daughter, her father had sided against her. As a result, she feels no affection or sense of obligation to her father. This participant and her daughter live with her mother who is divorced from her father. Her grandmother may move in with them in the near future. Again, the sub-theme of communal living where three (possibly four) generations of women would live together and support each other was addressed. As the participant put it, “The male halves have just kind of ... been discarded.”

Anxieties/Problems Experienced in Caregiving

Both past and current caregivers provided input on their experiences with the caregiving relationship. Also, Baby Boom women in staff/support positions had strong feelings about the per-

ceived stresses associated with the caregiving role. The following sections address these areas of conflict.

Strain on Caregiver's Health

Women who were not currently occupying the role of caregiver clearly described the stress associated with the caregiver role. Both physical and emotional stress took their toll on these women and it was them who became in need of care. One woman stated,

"I think first of all, we have to agree that we are all special people to care for these people in our homes, because there's a lot of people that can't do it. Two issues that I feel concerned about is, number one, we can become physically ill ourselves. ... "

Even though they knew they had to "keep yourself healthy," several of these women experienced physical problems directly related to the caregiving role. Many of them cited the stress of juggling multiple roles as a number one culprit. Even using services to relieve the burden could create problems.

"They (i.e., the service provider) will call you up and say, 'We don't have anybody this morning. Can you bathe your parent?' and you might be having company that afternoon. So you say, 'Sure, I'm a Supermom, I can do anything.' And then you collapse ... "

Physical stress was also a problem,

"And for a whole year, she insisted that I put her on the potty, do things for her, 'til my back just went"

Exhaustion was a common complaint. One woman told about a local support group for caregivers.

Another participant replied,

"Do you know the ironic part of it all is, I was so exhausted by nighttime I couldn't go."

Strain on/Loss of Intimacy With Spouse

Both current and past caregivers described the negative impact the caregiving experience had on their marriages. Current caregivers were very articulate in describing the stress the caregiving situation put on their marriages. Like their financial resources, their time and energy were limited. Their words best describe the conflict they experienced in the caregiving role.

"It can be nerve racking, as she says. When they ask you over the same thing, half a dozen times, and they don't hear well and you have to repeat yourself and they don't understand when you tell them something, it gets to you after a while. And too, you know, being the woman, I found with dad in the home, I tried to keep my husband and my children happy, tried to keep my dad happy and it seemed like I was being torn."

"You're in the middle."

"You are constantly in the middle between the person you're caring for and your family. And sometimes you feel like there's just not enough of you to go around. And there isn't. Because you can never do enough, ever."

"And I think it depends on your husband or your wife, or whatever, how much strain and stress it puts on you. It's your father. Is it fair to your husband to have to share you with your dad"

Similarly, past caregivers experienced the same problems. One woman described her situation.

"He'd come home, I'd be with her all day long, I'd be exhausted, and he'd say, oh, let mother stay up for another hour, I haven't seen her, you know, and you're just --- it's time for mother to go to bed. You know, or he would give her popcorn in bed. Or he'd say well let her have some peanuts and she's not supposed to have them because of her throat. This, this caused real disagreements. And marriages don't need that. And if you had a good marriage like we did, it certainly, we didn't know how to cope with it, because we had never dealt with arguing and stress among each other and it was not pleasant. At all. To take this person that you loved, your husband, and say, listen, you can't do this, you know that. At the end of my four years, I was, I was finally saying, you put her diaper on. I just, I needed a night without it. And you know, he would say, well I can't, she wouldn't want me to see her private parts, and so forth. And I would say, that's it, do it. You know you just get so. And on marriages, it's extremely hard."

The husband's resentment of time spent in the caregiving relationship, rather than the money spent, seemed to be the biggest stressor on these marriages. Also, the loss of privacy and upsetting the home life made bad conditions worse. Nursing home care seemed the only alternative to one woman,

“And our families are at the situation now the reason mother is going in the nursing home is the marriages can’t take it anymore.”

Guilt/Resentment in the Caregiving Relationship

In addition to the physical problems and strain on their marriages, past caregivers experienced a tremendous sense of guilt in the caregiving relationship. When they had to relinquish caregiving responsibilities, they often felt selfish. One woman described the situation when she went to visit her mother and found her “all dressed up”:

“But in, at this time, she wanted to go someplace and she didn’t know where or anything. It was just like, could we go out shopping or something and I didn’t have the time, and it was ... and I felt so selfish that I didn’t take the time. Because it was such a trial to go anywhere with her and right that minute I couldn’t and right that minute I should have. Because then I wouldn’t be living with this guilt. If just that one time I’d gone. ... But it never happened again and it hadn’t happened before, just that one time, that one time I could have said oh, what the hell.”

Guilt was also experienced when they wished others (i.e., brothers and sisters) would help lighten the burden. Several of these women had brothers and sisters but “none of them wants to take care of her.” Also, having to institutionalize their parent(s) knowing they did not want to be put in a nursing home created a tremendous amount of guilt.

Feeling Obligated to Care for Parents--Anticipated Guilt

When women in the Baby Boom cohort occupying staff/support positions were asked to imagine themselves in the role of primary caregiver to an aging relative or friend, two dominant themes emerged: that of feeling obligated to care for their parents and the guilt or resentment they felt they would experience in this relationship. This group had very strong feelings about being *obligated* to care for their parents. Several of this groups’ parents had either implicitly or explicitly let it be known that they expected to be cared for if their health failed. In terms of reciprocity, one

woman felt bad that she appeared ungrateful in not wanting to care for her mother. After all her mother had done for her, to reject this responsibility seemed selfish. Another participant remembered asking her mother why she had had children. The response was that she "would have somebody to take care of her in old age." To this response, the woman shared these feelings:

"Which makes me feel like somehow I'm supposed to be responsible for doing that, and that I didn't ask to be born, and to be made responsible for somebody else. The purpose of my being is to take care of her when she gets old! I mean that's the wrong reason to have children. That's one of the reasons I don't have any. I never could find the right reason. So I kind of resent that. I also resent the fact that she's made it very clear that she would never want to be put in a nursing home."

Several women remembered their mothers caring for grandmothers in the home and being very resentful of the situation. One woman wondered why this situation had not made her mother, who expected to be cared for, more understanding. Another participant who had witnessed similar situations had a possible answer: "Because it's like fraternity hazing, you know, I went through it, you can go through it."

With these feelings of obligation, there was a tremendous sense of guilt and resentment communicated. Resentment at being **expected** to assume this role when they seem to have "spread myself so thin in so many areas." Yet one woman voiced a different philosophy--one that may grow in the future--

"I would not want to take care of my parents. I don't want to take care of my kids anymore. It's a new way of living. My mother always worked and I never was in this thing, you know, where it was your obligation."

Another woman echoed the changing caregiver attitude by saying

"I think we've put a lot of these guilt trips on ourselves. Because like I said, I've spread myself so thin that I don't have the time to spend with her (i.e., the participant's mother) that I used to and I'm finding I'm less guilty about that than I used to be. She's adjusting. I think it's what we let them get used to a lot of times."

Euthanasia/Death With Dignity

One group, past caregivers, felt strongly against prolonging life after the quality had gone. One woman shared the story of her husband's mother and his aunt, both stroke victims, who were in extremely poor health.

"And we have, these two girls are sisters, and we have them both begging, pull the plug, let me go, let me die with dignity. Do this and yet they expect my husband to live with that guilt."

Other women cited similar stories of older relatives begging "let me go. I don't want to live."

Two of these women's daughters had been greatly affected by witnessing the quality of life experienced by their older relatives. In school, these girls had written papers on euthanasia. As one woman stated, "... she was saying in her paper, this is not fair to make my grandmother, whom I love, live this way just because our country has these laws. That all we're doing is maintaining her. That's all."

Several of these women believed "that there should be death with dignity and that we should be able to say when there is enough let me go." One woman stated, "But you know, if I had a choice I'll take a hammer to myself in the head." Another woman described an organization, the Hemlock Society, that offers information on the right to die with dignity. The idea that, while you are in control, you could make the judgment not to prolong your life beyond a certain point was met with approval.

Services Needed But Not Available and

Attributes Desired of Services

The topic, Services Needed But Not Available, was a dominant theme common to all six focus groups. Through their various experiences discussed in previous sections, each group had definite service suggestions for the aging population. Based on their suggestions, Table 8 shows a listing of proposed services by focus group. This section looks at their suggestions and the attri-

Table 8

Proposed New Services

Set 1, Focus Group 1

Women 65 years old and older functioning independently in their homes.

- Maintenance Tasks (i.e., shopping, vacuuming, snow removal)
- Transportation (i.e., to doctors, shopping -- and include assistance in entering/exiting the vehicle plus assistance in handling packages)
- A Personal Care Service (i.e., assistance with bathing)
- A Companion/Escort Service (i.e., their Buddy System)

Set 1, Focus Group 2

Women 65 years old and older residing in their own homes who are receiving assistance in performing their daily activities.

- Transportation (i.e., to doctors, shopping -- and include assistance in entering/exiting the vehicle plus assistance in handling packages)
- A Personal Care Service (i.e., assistance with bathing, medication)
- A Companion/Escort Services (i.e., their "look-in" system)

Set 2, Focus Group 1

Women who are currently occupying the role of primary caregiver to an aging relative or friend.

- A Sitter Service (i.e., caregiver respite)
- Financial Planning Services
- Comprehensive Long-Term Care Insurance

Table 8 (Continued)

Proposed New Services

Set 2, Focus Group 2

Women who are not currently occupying the role of primary caregiver to an aging relative or friend but who have done so within the last five years.

- Day/Elder Care
- A Personal Care Service
- A Companion/Escort Service
- An Information Hotline/Referral Service (i.e., a link to available services/support in the community)
- An Educational Service -- How to Prepare for Your Own Long-Term Care

Set 3, Focus Group 1

Women between the ages of 23 and 42 (i.e., the Baby Boom cohort) in professional positions who have never been primary caregiver to an aging relative or friend.

- Financial Planning Services
- Comprehensive Long-Term Care Insurance
- Day/Elder Care
- Personalized Services (i.e., home repair, cooking, shopping)
- A Personal Care Service (i.e., assistance with bathing, toileting)
- A Companion/Escort Service (i.e., including their "Mealmate" option)

Set 3, Focus Group 2

Women between the ages of 23 and 42 (i.e., the Baby Boom cohort) in staff/administrative support positions who have never been primary caregiver to an aging relative or friend.

- Day/Elder Care (to assist able parents remain productive)
- A Companion/Escort Service (to assist able parents) (i.e., respite for both caregiver and care recipient or themselves in later years)
- A Personal Care Service (to assist them in one of the perceived most difficult functions of the caregiving relationship)
- A Counseling Service -- How to care for the elderly
- An Educational Service -- How to prepare for your own long-term care

butes certain groups deemed desirable. Finally, one group emerged as unique in their willingness to use services from private/for fee organizations.

Women 65 Years Old and Older Functioning Independently

Women 65 years old and older functioning independently expressed several areas of need where services could be used for assistance. Two women wondered what they would do if their husbands developed Alzheimer's. Both suggested the need for a sitter to come in and relieve them for brief periods. One woman said this person would "not have to do anything, other than just be with him and see that his needs are taken care of for an afternoon a week or whatever would be available."

A related health care topic dealt with problems that might arise from their own illnesses such as stroke. One woman had worked as a volunteer with stroke victims in helping them regain their ability to talk or walk. Having had and recovered from three strokes herself, she felt, and others agreed, that having a service available that would come in on "just temporary basis" and help these individuals regain their independence would be a valuable support mechanism.

Another area of service delivery dealt with the mechanics of daily living. Assistance with grocery shopping, shoveling snow from walkways, or vacuuming were seen as needed services. Also, transportation was seen as a real issue. Even though the retirement community had a van that these individuals could use, they felt it was not geared to their needs. As one woman put it "And that van is difficult for anyone with any disability, the slightest disability."

The aspect of a Personal Care service could be used to deal with experiencing difficulty in daily functions such as bathing. As one participant said, "I wish I had somebody to wash my back." This service could also provide the safety of getting into and out of the tub that proves difficult to older individuals. Another suggestion they had that related to the proposed Companion/Escort service was for a "Buddy System." In this service, people would "go in regularly and do nothing more than sit and talk."

In summary, in terms of role theory, this group had clear expectations of those individuals occupying the role of caregiver. To them this job was clearly defined. To these women, this was a job performed out of love, not obligation. If the caregiver experienced any difficulty (i.e., conflict or ambiguity) with these expectations, it was felt they would simply “walk away from it.” In summary, these individuals are a proud group struggling to maintain their independence. In proposing new services to them, cost would be a significant variable to be evaluated. Based upon their comments, the following service suggestions are made (See Table 8).

- Maintenance Tasks (i.e., shopping, vacuuming, snow removal)
- Transportation (i.e., to doctors, shopping and include assistance in entering/exiting the vehicle plus assistance in handling packages)
- A Personal Care Service (i.e., assistance with toileting, bathing)
- A Companion/Escort Service (i.e., their “Buddy System”)

Women 65 Years Old and Older Receiving Assistance

One of the main areas of need women 65 years old and older receiving assistance saw transportation. They cited that many of the residents of their retirement community had “no people” and “very few friends” to assist them in running errands and basic transportation needs such as trips to doctor’s appointments. Often, health was cited as a reason for giving up driving themselves. According to one participant, “I had a car and I had to stop driving a year ago because my potassium drops so low.”

Even though the retirement community provided a van, they did not see this as sufficient to meet their needs. For anyone with a disability, getting on and off of the van was very difficult. Also, the van did not run on Sundays and, therefore, no transportation was available to attend local church services. Also, during the summer months, local taxi services ran limited hours.

Related to the proposed Personal Care service was the suggestion for a service in which residents could rely on “someone to inspect, you know, go in apartments, every day to see if they are

alright.” This service and the proposed Companion/Escort service were met with enthusiasm, on the condition that they could afford them.

In addition to having specific service suggestions, this group had definite ideas about the qualities the service provider should have. With regard to the service provider of the Companion service, they wanted “ ... someone that was pleasant and had love for people and humorous,” and “You could trust them,” and “Honest and you could trust to ride with them and all that.”

In all services, they had a strong desire for a sense of security--both physical and mental. In the Personal Care service, again, they wanted the service provider to have been trained in how to handle and lift older individuals. If someone was coming into their home, they wanted peace of mind in having someone honest that “wouldn’t come in and pick up things.” This trust could be achieved by having service providers bonded. This would be one attribute that should be highly stressed in the promotion of the service.

In summary, this group had well-defined expectations of individuals in the caregiver relationship. They strongly wanted to maintain their independence and not be a burden on their children. If the day should come when they were forced to rely on their children for care, it is likely they would experience a great deal of stress and conflict.

Cost would be a significant variable to be evaluated in service delivery to this group. Based on the previous observations, the following services are proposed that would assist this group in maintaining their autonomy (See Table 8):

- Transportation (i.e., to doctors, shopping--and include assistance in entering/exiting the vehicle plus assistance in handling packages)
- A Personal Care Service (i.e., assistance with bathing, medication)
- A Companion/Escort Service (i.e., include their “look-in” feature)

Current Caregivers

Women who currently occupied the role of caregiver acknowledged the existence of support mechanisms in the community (i.e., home health care, etc.) that Medicare would pay for but said

that there simply was not enough help there to meet the demand. They cited these programs as being very restrictive in terms of length of use. For example, if a patient stabilizes beyond a certain point, the service is cut back--whether the patient or his/her caregiver would like it continued or not.

They cited a need for respite for the caregiver. Someone who would come and sit with the elderly individual to allow them to go shopping or run errands was seen as a valuable service. In terms of both proposed services--the Personal Care service and the Companion/Escort service--these women thought these services would be viable options for some older individuals but not for others. They saw this as a very individualized matter citing some older individuals who loved meeting/being with new people and others who were only comfortable in allowing their families to care for them.

This group had several attributes they deemed as desirable in service delivery to older individuals. Patience was a major characteristic required in the caregiving relationship. Also, the service provider should like dealing with older individuals. Honesty was demanded in the person was to come into the home (i.e., not "pick up things"). And above all, the person should be " ... qualified, super qualified, you know with credentials and training."

In summary, this group of women was experiencing ambiguity and conflict in the caregiving relationship. Torn between jobs, families, and their aging relatives, they were experiencing an overload situation. To assist them in their caregiving duties and based upon their expectations of society and younger generations, the following service suggestions are made (See Table 8):

- A Sitter Service
- Financial Planning Service
- Comprehensive Long-Term Care Insurance

Past Caregivers

According to women who had been caregivers in the past, one of the needs they had which was not met in the caregiving situation was for information. In most cases, there was little or no time to prepare for the needs of this role. Their comments best describe the situation:

“Because when my parents came here, all of a sudden, boom, I had them here. And there was no listing, I didn’t know that there were certain agencies around. I didn’t even know about them. I wish I had. I’d hear about, somebody would say, well have you tried so and so, and I’d say no, I didn’t know that was available. There needs to be a comprehensive listing of agencies and what services they can provide.”

“The doctors even if they, if they’ve been busy themselves, and they’re more concerned with children or whatever, they all need to have this in their office.”

“Information just wasn’t there fast enough.”

In addition to information on the caregiving relationship, this group requested information that would educate them in their own aging process.

“I think the government or somebody should get a handbook out on how to prepare for your own aging. Some of the things that you should, some of the steps you should go through to prepare, although some people couldn’t face it.”

Another service suggestion this group had was for adult day care. The idea of a day care for older individuals was extremely attractive to this group. Having a place they could leave their relative or parent for a couple of hours would provide a welcome respite from this around-the-clock responsibility.

Also, both the proposed services--the Companion/Escort service and the Personal Care service--were viewed as useful support mechanisms. In particular, the Companion service was seen as an attractive option for older individuals who enjoyed meeting and being with people. If they wanted to get dressed up and go out when their caregiver was busy, this service could meet this need. The Personal Care service was seen as “good because then the time you were with your parent would be quality time, and not wiping feet time.” Both services were seen as a way to “enhance the life of the caregiver and it would enhance the life of the family.”

This group had several attributes they demanded from service providers. The main characteristic was honesty. If the service provider would come into the home, it was felt they should be

bonded. Several of these women cited having items missing from their homes after seeking outside assistance in their caregiving. As one woman put it,

“Even though you sign this big form, when we signed that form, it was saying things like, not to leave your purses around, not to, you know, by the end of reading that form you don’t want to have them in the house. Because it leads you to believe you can’t trust them.”

The service provider should be compassionate in dealing with elderly clients. They should not smoke or drink. Also, being able to rely on one provider was seen as a plus.

“The other difficulty is having someone consistent. Frequently there is such a turnover in these agencies.”

“So you might get used to someone for two weeks, they just get to know the person, the ill person develops a relationship and then they are gone. And emotionally, that is extremely hard for everybody.”

In summary, while these women were not currently experiencing the role of caregiver, they painted a vivid picture of the stress, conflict, ambiguity, and overload present in this situation.

Based on their input, the following service suggestions are made (See Table 8):

- Day/Elder Care
- A Personal Care Service
- A Companion/Escort Service
- An Information Hotline/Referral Service (i.e., a link to available services/support in the community)
- An Educational Service--How to Prepare for Your Own Long-Term Care

Baby Boom Women in Professional Positions

Baby Boom women in professional positions (i.e., university faculty) suggested a wide array of services that would be useful in the aging society. In terms of the aging population becoming healthier due to increased interest in diet and exercise, one participant cited a need for “gerontology fitness” programs.

The concept of elder day care was extremely attractive to this group. This was considered an ideal respite program that would “let me have a breather and that might be just what you’d need

to continue on I think.” One woman questioned if whether the elderly individual would feel degraded at the thought of going to a day care “kind of like day care for children.” However, the group agreed that this concept was not demeaning and the solution to this problem was “it’s how you sell it.” For example, the suggestion was made to call it “Day at the Club.” One woman cited an aunt who used a similar facility. Her aunt referred to this as her “drop-in” where the senior citizens did things like play cards or have lunch.

Another service suggestion was related to the proposed Personal Care service. The idea of having someone come in and bathe older individuals was attractive. One woman’s mother cared for her uncle. When he reached his nineties, he became unable to perform this function. He was unwilling to allow any family member perform this task. A student nurse came regularly to perform this task much to the relief of the uncle and the family.

Other suggested services involved the “individualized kinds of things that would be, that years ago the kid down the block” would do. For example, services such as having someone to perform repairs in the home and shop for groceries were seen as attractive. Another attractive service was to have someone to come in and cook meals and assist in dispensing medication in a timely manner. One participant cited older relatives who would not prepare meals or eat properly and had difficulty in remembering to take their medications on time.

One of the most interesting concepts this group generated was that of having a “mealmate.” Many of the women in this group were single. They cited the loneliness of mealtimes as being very difficult for them. The following conversation developed.

“And I’ve actually thought about getting a roommate, which I haven’t thought about in years.”

“Well why not just a mealmate?”

“Why not adopt an older person and have them come in and eat with you?”

This idea was seen as extremely attractive. The idea of dealing with a difficult issue at the “community” level was seen as a very positive action.

In summary, while these women were not acting as primary caregivers to aging relatives or friends, they had clear ideas on how they would handle this role. To assist them in this role, the use of an extensive service network would be desirable. Expectations of the caregiver/care recipient

dyad did not emerge as a major issue to these women. In terms of self-role congruence, or the match between the requirements of the caregiver role and their beliefs or values, this group could feel conflicted if they had to perform the tasks of bathing or toileting. In terms of role demands and role overload, these women were adamant that even if they should be thrust into the caregiver role, they would have to continue to work outside the home. Based upon these observations, the following service suggestions are made (See Table 8).

- Financial Planning Services
- Comprehensive Long-Term Care Insurance
- Day/Elder Care
- Personalized Services (i.e., home repair, cooking, shopping)
- A Personal Care Service (i.e., assistance with bathing, toileting)
- A Companion/Escort Service (i.e., including the “Mealmate” option)

Baby Boom Women in Staff/Support Positions

The dominant theme addressed by Baby Boom women in staff/support positions was that of service availability to an aging population. Perhaps their strong views on the caregiving relationship generated their suggestions and opinions in this area. One woman suggested that the church was a source of “... women there who are caretaker types ...” that could be utilized for brief periods of respite. The moving away from a “generational-knit family” was seen as increasing the need for more services for older people. The service network available today was seen as fractured and developed with no thought to the future: “... we just keep doing so many little bits and pieces that you know, has it really been organizationally really thought out and one organization be really in charge of home health, and maybe group homes, and the communal homes.” One woman agreed that we need a “larger social service concept.” Again the sub-theme of a communal environment was seen as an attractive, safe option for the later years.

Affordability of services was a concern. The solution to this issue was to incorporate volunteer or support group concepts into the service system. The suggestion was made that a support

group of people with aging parents could take turns assisting each other to relieve the burden of this situation. A barter or trade-off system was suggested as one way to meet the economic needs for support services--for example, trade four hours of elder sitting for four hours of gardening.

Another option that was extremely attractive to this group was a combining of the day cares. Related to their view of the elderly as resources, they saw a great opportunity in allowing the able elderly to remain productive and share their wisdom with younger generations. They saw this as a means of enhancing the lives of both the elderly individuals and the children while performing a valuable service to working mothers.

This group suggested services that would "counsel elderly people on finding employment." One of the most interesting concepts they had was to develop a service to "counsel them, of their old age and dealing with themselves, their bodies, their minds, what is happening to them." This idea of teaching us about our aging was related to the changing of the American family. It was noted that our parents and grandparents were shown the aging process because then, the family was intact. In addition, this group requested "education on how to work with the elderly too." In summary, as one woman stated, "And someone to be able to address us with options and what is available in terms of services and you know, just different means of coping."

In all service suggestions, trust and security were desired attributes. A related topic of abuse to the elderly was brought up. It was felt that this phenomena was occurring in both health care institutions (i.e., nursing homes) and in private homes. They felt this would be a key issue in elder care in the future.

This group found both proposed services--a Companion/Escort service and a Personal Care service--attractive. In particular, the concept of a Companion service was well received. Two citations relate to the desirability of this service. After visiting an elderly aunt in a nursing home in another state, one woman was determined to get her aunt out of the home every chance she could. Another aunt told her " ... sometimes your body just starts getting tired. And the mind is still working." The niece was struck by the need of these individuals to experience stimuli and to "get her out to expose to different kinds of things." This service could meet this purpose between her visits. Another comment related to the Companion service addressed the issue of security:

“I was thinking it would be especially good if you’ve got women in particular afraid to get out and especially as they get older, to get the women out in groups together, and it would be companionship in safety.”

In summary, while these women were not acting as primary caregivers to aging relatives or friends, they anticipated a great deal of stress in this relationship. It was clear that for many of them, their expectations and the expectations of their parents in terms of long-term care were at odds. In terms of self-role congruence, or the match between the requirements of the caregiver role and their beliefs or values, again this group feels conflicted. They have developed a tremendous sense of independence and a feeling that they should not be expected to be obligated to care for anyone other than themselves. All of these women worked and most of them had children. They made it clear that the demands on their time were great. To add the caregiving relationship would be just one more burden when they felt they had already “spread themselves thin.”

Based upon these observations, services should be developed to help them in two areas: 1) Services that would, in the event of their assuming the caregiver role, assist them in performing the duties required of them and 2) Looking to their own aging, services that would serve an educational role (See Table 8). In particular, the following service suggestions are made:

- Day/Elder Care (An option to assist able parents remain productive)
- A Companion/Escort Service (To assist able parents (i.e., respite for both caregiver and care recipient) or themselves in their later years)
- A Personal Care Service (To assist them in one of the perceived most difficult functions of the caregiving relationship)
- A Counseling Service--How to Care for the Elderly
- An Educational Service--How to Prepare for Your Own Long-Term Care

Willingness to Use Services From Private/For Fee Organizations

Unique to one group was their attitudes toward the use of services from private/for fee organizations. One of the dominant themes generated by Baby Boom women in professional positions was their willingness to use these services. In this area, they were very articulate about why

they would prefer these services. Again, the changing structure of the American family (i.e., increased use of child care, increase in people eating out) was cited as a reason that service usage on the whole has increased. Their words best describe this exchange:

“We’ve certainly gravitated toward that (i.e., ‘willingness to accept paid-for services’). We’re a good example of the reasons why we’ve gravitated that way. We all work, we’re not sitting home like women used to do.”

“We are used to having a certain amount of economic, independent economic power that maybe our mothers didn’t.”

In terms of assuming the caregiver role, the use of private sector services is just as attractive. Again, their words best describe their feelings.

“And now, I mean, my kids eat out all the time, I eat out all the time, I’ve paid to have my children taken care of, I’ve paid for other services so it’s just natural that I will pay for my parents’ services or my own when I get to that age and be more accepting of that.”

“I also, I think feel almost that I would prefer a service that I would pay for, a private concern to a volunteer one, because with volunteers sometimes they get busy and don’t show up. With a business, you have the notion, perhaps mistakenly, that they are going to be more responsible and really going to provide the service.”

“... I find myself much more willing now to call for help, when it’s an organized, out-there service, especially if I get to pay for it, than I would ask a friend. I would have a really hard time asking a friend to relieve me and watch my elderly parent for an afternoon so I could go zonk out in the movie or something. I would rather have a commercial service.”

“And I guess my feeling that it should be commercial comes from being a mobile person and not having those long-time roots in a community and not having the freedom that I can really call on friends to help out.”

In summary, this group has an extremely strong view of their economic position in the community and is willing to use private sector services to meet their own needs or the needs of their families. It is proposed that in the future of the aging society, this group should be examined more closely to ascertain their needs.

CHAPTER 6

SUMMARY AND CONCLUSIONS

Initially, this chapter provides an overview of the study. Next, conclusions are drawn from the focus group findings. Suggestions for future research are made. Finally, limitations of the study are identified.

Overview of the Study

This study looked at the aging of the population or the “graying of America” from the perspective of three different groups of women: 1) women 65 years old and older living independently in their homes and women 65 years old and older receiving assistance in performing their daily activities, 2) women who are currently occupying the role of primary caregiver to an aging relative or friend and women who have occupied this role within the last five years, and 3) women between the ages of 23 and 42 (i.e., the age range representative of the Baby Boom cohort) in both professional and staff/support positions. Justification for an all female sample was found in research that

showed that not only are women the primary caregivers in our society (Crossman, London, and Barry 1981; Haber 1986), but also that women tend to outlive men by approximately seven to eight years (Hagestad 1986), therefore possibly becoming the primary care recipients as well.

Role theory provided the theoretical framework from which the caregiver/care recipient dyad could be evaluated. The objective of this study was not to test role theory or evaluate satisfaction or self-esteem in this dyadic relationship, but rather to use this framework to identify areas of potential conflict in which services could be used to reduce the conflict.

Focus group interviews were used as the method of data collection. Analysis of these group interviews consisted of transcribing audio tapes of each interview and evaluating each group's transcription for dominant themes. From these themes, possible new services were identified.

Conclusions

Women 65 years old and older living independently in their homes showed a strong interest in government programs such as Social Security and Medicare. They are financially dependent on these programs and exhibited a strong desire to continue working beyond retirement to supplement these funds. Cost would be a significant factor in services directed at this group. Services that enable them to maintain their independence (i.e., assistance with heavy household tasks--vacuuming, snow removal) are advised.

Similarly, women 65 years old and older receiving assistance in performing their daily activities were concerned with support they received from Social Security and Medicare. Again, living on fixed incomes, cost would be a significant factor to be considered in service delivery to these women. Because of frailer health, services are advised that assist these women in their daily activities (i.e., shopping, bathing) and increase their sense of security (i.e., a "look-in" system).

Women acting as current caregivers to older individuals were extremely concerned with the financial strain presented in the caregiving relationship (i.e., health care, prescriptions). If the care recipient is living in the caregiver's home, there is a need for respite care for the caregiver. An ex-

ample of potential service opportunities is seen in the potential for respite care (i.e., a Sitter Service) and comprehensive long-term care insurance.

Similarly, women who have occupied the role of primary caregiver in the past expressed a need for respite from the around-the-clock responsibilities of this role. In addition to respite, they had a real need for comprehensive information of services and support available in the community.

The professional women in the Baby Boom cohort offer a significant opportunity for service development in the future. Secure in their professional status and economic strength, they have become accustomed to using private/for fee services for themselves and their families. As they advance in the aging society, services aimed at helping them plan for their own or a relatives' long-term care would be attractive. They acknowledged that even if they should ever acquire the role of primary caregiver to an aging relative or friend, they would still have to work outside the home. Therefore, support services (i.e., the proposed Personal Care service) would be helpful to them in this role.

Like the university faculty women, the Baby Boom women in staff/support positions offer a tremendous opportunity for service delivery in the future. Like the past caregivers, they expressed an interest in information. Information was requested regarding how to deal with their own aging and how to care for the elderly. Also, in the event they should ever become the primary caregiver to an aging relative or friend, support services such as the proposed Personal Care Service or the Companion/Escort Service could be used to assist them.

In summary, the proposed services can be grouped into four categories: Functional Services, Personal Services, Planning Services, and Informational Services (See Table 9). Functional Services consist of Maintenance tasks (i.e., shopping, vacuuming), Transportation, and Personalized Services (i.e., home repair, cooking). Personal services consist of a Sitter Service, Day/Elder Care, a Personal Care Service (i.e., bathing, dressing), and a Companion/Escort Service. Planning Services consist of Financial Planning Services and Comprehensive Long-Term Care Insurance. Finally, Informational Services consist of An Information/Hotline Referral Service, An Educational Service--How to Prepare for Your Own Long-Term Care and A Counseling Service--How to Care for the Elderly.

Table 9

Proposed Typology for Service Delivery

<u>Type of Service</u>	<u>Examples</u>
Functional	Maintenance tasks (i.e., shopping, vacuuming) Transportation Personalized services (i.e., home repair, cooking)
Personal	A Sitter Service Day/Elder Care A Personal Care Service (i.e., bathing, dressing) A Companion/Escort Service
Planning	Financial Planning Services Comprehensive Long-Term Care Insurance
Informational	An Information/Hotline Referral Service An Educational Service--How to Prepare for Your Own Long-Term Care A Counseling Service--How to Care for the Elderly

Table 10 illustrates the proposed service typology and the suggested services by group. Suggested services for women 65 years old and older functioning independently in their homes (i.e., Set 1, Focus Group 1) are two of the Functional Services (i.e., Maintenance tasks and Transportation) and two of the Personal Services (i.e., A Personal Care Service and A Companion/Escort Service). Similarly, suggested services for women 65 years old and older receiving assistance (i.e., Set 1, Focus Group 2) are one of the Functional Services (i.e., Transportation) and two of the Personal Services (i.e., A Personal Care Service and A Companion/Escort Service).

For women currently in the caregiving role (i.e., Set 2, Focus Group 1), one of the Personal Services (i.e., A Sitter Service and both of the Planning Services are suggested. For past caregivers, (i.e., Set 2, Focus Group 2), three of the Personal Services (i.e., Day/Elder Care, A Personal Care Service, and A Companion/Escort Service) and two of the Informational Services (i.e., An Information/Hotline Referral Service and An Educational Service--How to Prepare for Your Own Long-Term Care) are suggested.

Suggested services for Baby Boom women in professional positions (i.e., Set 3, Focus Group 1) are one of the Functional Services (i.e., Personalized Services), three of the Personal Services (i.e., Day/Elder Care, A Personal Care Service, and A Companion/Escort Service) and both of the Planning Services. For Baby Boom women in staff/administrative positions (i.e., Set 3, Focus Group 2), suggested services are three of the Personal Services (i.e., Day/Elder Care, A Personal Care Service, and A Companion/Escort Service) and two of the Informational Services (i.e., An Educational Service--How to Prepare for Your Own Long-Term Care and A Counseling Service--How to Care for the Elderly).

Suggestions for Future Research

Based on the participants' reactions to the group interviews and feedback received after the interviews, it is proposed that a more detailed study be conducted to identify specific areas of service needs for the aging population. It was not unusual for group participants to linger after they had

Table 10

Proposed Service Typology by Group

Service Categories:	S1 FG 1	S1 FG 2	S2 FG 1	S2 FG 2	S3 FG 1	S3 FG 2
Functional						
Maintenance tasks (i.e., shopping, vacuuming)	X					
Transportation	X	X				
Personalized services (i.e., home repair, cooking)					X	
Personal						
A Sitter Service			X			
Day/Elder Care				X	X	X
A Personal Care Service (i.e., bathing, dressing)	X	X		X	X	X
A Companion/Escort Service	X	X		X	X	X
Planning						
Financial Planning Services			X		X	
Comprehensive Long-Term Care Insurance			X		X	
Informational						
An Information/Hotline Referral Service				X		
An Educational Service--How to Prepare for Your Own Long-Term Care				X		X
A Counseling Service--How to Care for the Elderly						X

been dismissed, still talking among themselves about their thoughts or experiences in the caregiver relationship. Many of the women expressed an interest in learning the results of the study and offered additional time and information if necessary. One group even offered monetary support to fund the project if that would help obtain services that would relieve the stress experienced in the caregiving relationship.

After one of the group interviews, a participant called the next day to say she thought the meeting was a “real significant conversation” and that at home the previous evening, she and her husband had spent the rest of the evening discussing their own long-term care.

Focus group research is often used to generate hypotheses. If future studies are conducted based on these findings, several suggestions are made on particular areas to evaluate. For example, socioeconomic variables such as income and level of education may have an impact on service needs and usage. In this study, while information on participants’ income and education was not gathered, it was felt that these variables did influence the participants’ input.

For example, both groups of women 65 years old and older were living on fixed incomes. While certain services might be attractive to them (i.e., A Personal Care Service or A Companion/Escort Service), limited financial resources might restrict their ability to use them. Most of the caregivers, both current and past, indicated that they had cared for their aging relatives in their homes. The majority of them had not worked outside the home during this period and described purchasing or renting professional equipment (i.e., hospital beds, mechanical lifts) to assist them in their caregiving tasks. Also, many of them cited having hired private sitters or nurses to come in to their homes on a regular basis to assist them.

Both groups of Baby Boom women indicated that if put in the role of primary caregiver, they would turn to the service network for assistance. Unlike the majority of the caregivers, they would not be able to quit work and remain home to care for their aging relative. Also, the Baby Boom women in professional positions indicated not only a willingness, but a preference for private/for fee services.

Therefore, based upon these observations, in future studies the following questions should be addressed:

- Does income affect the preference and use of services?
- Does the level of education affect the preference and use of services?

Limitations of the Study

The sample was not randomly selected from the population and, therefore, the results should not be generalized beyond the individuals who participated. Also, due to the descriptive, qualitative nature of the study, any attempts to quantify the results would be misleading.

A pre-test focus group was not conducted. If this study was conducted again, this step would be included. The primary benefit of this step would be in learning how to handle “tangent” or side-track conversations. While much benefit was obtained from these conversations that strayed away from the issue being discussed, much time was wasted also.

The use of an all-women sample may be questionable. Even with research showing that women are the primary caregivers, changing societal trends may alter this statistic. With an increase in women working outside the home, an increasing divorce rate, and people choosing to either delay marriage or remain single, in the future men may have to accept the role of primary caregiver once assumed by women.

The sample was selected from a small, Southeastern college town. The results may have been different if the sample had been selected from other areas (i.e., an urban area, the North, etc.).

The input from women who are not currently occupying the role of primary caregiver but who have done so within the last five years may be viewed as out-dated information. It could be argued that time has dulled their perspective on the situation and may not offer an accurate representation of their needs. However, this did not seem to be the case. If anything, it appeared that the distance of time had allowed them to deal with the stresses and guilt associated with the caregiving relationship. This hindsight allowed them the ability of distinctly verbalizing the tremendous difficulties they experienced in this role.

Both groups of women 65 years old and older may have brought an unintentional bias into the interviews based on their residence in the Warmhearth Retirement Community. Even though one group of women was living independently in their homes within this community and the other group was functioning with assistance in their daily activities (i.e., primarily transportation), it can be argued that they have given considerable thought to their own aging process by buying into the concept of living within a retirement community that offers optional advanced care if the need should arise in the future.

Finally, the results of this study may be subject to middle-class bias. Individuals in this study are, in varying degrees, economically capable of providing existing and proposed services to either themselves or aging relatives. Individuals with restricted economic resources would typically have services provided to them by the social service system. Another example of exclusion from the results would be various ethnic segments of the population who reject the idea of purchased services in favor of the family providing total care.

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