ELDER ABUSE: EDUCATION FOR PERSONS WITH
EXPERIENCED VIOLENCE

DISSERTATION

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By

Julie A. Reinberg, B.A., M.A.
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The rationale for this study was based on the application of the cycle of domestic violence theory to elder abuse. It examined the effect of history of experienced childhood violence on tolerance, behavioral intentions, and past behaviors of elder abuse toward general and specific elderly targets. The effectiveness of educational interventions for altering tolerance and behavioral intentions of elder abuse was examined.

Two hundred and twenty-five undergraduates were assessed for aging knowledge, general aging attitudes, aging anxiety, elder abuse attitudes, and elder abuse intentions and past behaviors. Participants were assigned to a High or Low Experienced Violence group and participated in an educational group or control group. Posttest and one-month followup measures were obtained.

No differences were found at pretest between High and Low Violence. Level of Violence did not impact intervention efficacy. Elder abuse education altered attitudes, intentions, and behaviors of elder abuse at posttest significantly more than did aging education or
control groups (p < .001), but these effects were no longer significant at followup.

Elder abuse attitudes had higher relationships with elder abuse intentions and reported past behaviors than did global aging attitudes or aging anxiety (p < .05). General elderly targets yielded more tolerance, intentions, and reported past behaviors of elder abuse than did specific elderly targets (p < .001).

Experienced childhood abuse was unrelated to elder abuse expression yielding no support for the role of cycle of violence in elder abuse. Specificity of target mediated elder abuse attitudes, intentions, and behaviors. Primary prevention interventions which aim to reduce tolerance and intentions of elder abuse should include specific information on elder abuse; aging education is ineffective for this goal.
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CHAPTER I

ELDER ABUSE: EDUCATION FOR PERSONS WITH EXPERIENCED VIOLENCE

Domestic violence has been the subject of much theorizing and, to a lesser extent, research. Until recently, one form of domestic violence—elder abuse—has been rarely reported in the professional literature (Anderson & Thobaken, 1984; Matlaw & Mayer, 1986).

According to investigators (e.g., Giordano & Giordano, 1984), there are several reasons for the recent appearance of elder abuse in the literature. First, the study of elder abuse may be a logical extension of the attention normally focused on other forms of family violence, such as child and spouse abuse (Poertner, 1986), in particular. Also, changing demographics in the United States has led to an increase in the percentage of the population who can be classified as "elderly" (Douglass, 1983; Fulmer & Cahill, 1984). In addition, a societal trend toward de-institutionalization suggests that more individuals will be providing home care for their aging parents (Pedrick-Cornell & Gelles, 1982). Thus, violence toward older people may affect more people than before, consequently inviting more interest in its study.
Although many definitions of elder abuse exist, the most comprehensive of these may be "physical, psychological, or sexual acts that jeopardize the individual's medical care, health status, sense of personhood, right to self-determination, personal property or income; as well as the failure to perform acts that make the elder's environment safe and clean" (Phillips, 1983, p. 167).

Comparison of Elder and Child Abuse

Because elder abuse is a relatively new topic of research, there has been less theoretical and empirical work available on the subject than on other forms of family violence (Floyd, 1984). One recently published book on family violence that grew out of a National Conference of Family Abuse (Finkelhor, Gelles, Hotaling, & Straus, 1983) did not even address the issue, choosing instead to focus exclusively on the topics of child and spouse abuse.

Much of the available literature has presented opinions and theories about elder abuse without providing empirical evidence. The theories are based solely on the comparison of two forms of family violence, elder and child abuse. (Pedrick-Cornell & Gelles, 1982; Steinmetz, 1977). This approach may have been more expedient than developing and testing new theories as there are some similarities between these two forms of family violence (Steinmetz, 1978). However, looking only for similarities between the
forms of domestic violence fails to distinguish a geriatric population at risk for mistreatment (Douglass, 1983), because unique aspects of elder abuse, such as ageism, may be disregarded. Rathbone-McCuan (1980) suggested that drawing too many parallels between different forms of family violence may prematurely distort attempts to conceptualize elder abuse. Nevertheless, a few important similarities between child and elder abuse should be mentioned briefly.

One parallel often noted (Hickey & Douglass, 1981; Steinmetz, 1978) reflects the role of certain family members in caregiver functions—parents are caregivers to young children, and adult children are often caregivers to aging parents. Reliance on caregivers is necessary for survival; children and elders are seen as too weak, frail, or incompetent to care for themselves. Dependency makes one a potential victim for abuse (O'Rourke, cited in Giordano & Giordano, 1984). Abused children or impaired older persons remain helpless, as they may not be able to survive without care or may be unable to find needed help.

Although its occurrence in familial relationships with children and elderly relatives is common, the nature of the dependency and its implications are different. The assumption is that with children, in contrast to impaired older people, reliance on caregivers is temporary. Children will outgrow dependency on parents for fulfillment
of emotional, physical, and financial needs; aging and elderly parents tend only to become more dependent as time passes. Realizing that the child's independence is imminent may cause the caregiver to view his or her responsibilities as being short-term and therefore less burdensome. This is clearly not the case when similar services must be provided for the elderly family member, whose dependency is chronic.

Another similarity between child and elder abuse is the stress on the provider of emotional, physical, and financial resources (Beck & Phillips, 1984; Giordano & Giordano, 1984; Steinmetz, 1978). The burden of caring for an aging parent, however, may remain unsupported and unacknowledged by typical sources of social support, such as friends, professionals, and the general public. Perceived burden of caregiving was found to relate to emotional impact on family members who provide for elderly relatives (Poulshock & Deimling, 1984). Without support, this stress may be experienced by the family as a unique and unshared problem.

A final similarity between child and elder abuse is the assumption that the dependent will be protected by loving relationships (Steinmetz, 1978). In view of the fact that the incidence of domestic violence in the United States was estimated to affect from one in ten families
(Beck & Phillips, 1984) to one in two families (Floyd, 1984), this assumption is dangerous.

In summary, while there are some parallels between child and elder abuse issues—dependency on other family members, stress on the caregivers, and assumed protection by the family unit—the dynamics involved in elder and child abuse are clearly not identical. Caregivers and older people alike have special needs and considerations that differ from individuals affected by other forms of family violence. Thus far, particular attention has been given in the literature to defining mistreatment of elderly people. The next section examines the difficulties involved in these attempts, and other problems related to further examination of domestic violence toward older people.

Problems in Investigating Elder Abuse

There have been significant impediments to a thorough investigation of elder abuse. Specific problems include denial of the problem, differential categorization, and definitional problems.

One barrier to investigating the problem of elder abuse is a denial by the professional community that it even exists (Rathbone-McCuan, 1980). Denial prevents detection and, consequently adequate intervention. Personal values and biases about older people contribute to this denial (Booken & Dunkle, 1985). For example, nurses
who were asked to categorize abused versus nonabused elderly people considered the personal characteristics of older people as the main determinants of abuse. "Difficult" elderly people were seen as "getting what they deserve," and therefore, were less likely to be categorized as abused (Phillips, 1983).

In addition to personal biases, a lack of knowledge about the phenomenon of elder abuse may contribute to the inability to realize that a problem exists. The signs of physical violence may be obvious. However, the effects of other types of abuse, such as emotional abuse (e.g., insulting older person), neglect (failure to provide a meal), or violation of rights (entering private room without knocking), may be much more subtle. Consequently, professionals may not recognize this type of domestic violence when it occurs. Factors such as the setting in which violence occurs (e.g., home versus institution) and caregiver/elderly characteristics may affect detection of its occurrence (Phillips, 1983). Stereotypes and myths about older people may lead to general skepticism as to whether or not older people are capable of adequately and reliably reporting abuse (Pollick, 1987).

In response to concerns about professionals' lack of knowledge, several instruments were developed to help identify abusive situations (Fulmer & Cahill, 1984; Galbraith & Zdorkowski, 1984). However, these instruments
have been used primarily for purposes of research, and have not been adequately validated.

Many writers in the field of elder abuse agree that older people as well as professionals have failed to report cases, making detection difficult (Anderson & Thobaken, 1984; Floyd, 1984; Rathbone-McCuan & Voyles, 1982). The literature is unclear as to whether elderly victims of poor treatment actively deny the presence of abusive situations, as may be the case for some other victims of domestic violence (Nadelson & Sauzier, 1986), whether they merely lack information regarding the seriousness of their situations, or both. This distinction would have important implications for further investigation and interventions into the problem. For example, inadequate knowledge suggests that information needs to be provided to older people, as well as to professionals.

Older people may fail to report maltreatment for fear of the consequences to themselves, such as institutionalization or retaliation (Anderson & Thobaken, 1984; Galbraith & Zdorkowski, 1984). They may also fear consequences to the abusers, who are often their own children (Anderson & Thobaken, 1984; Costa, 1984; Galbraith & Zdorkowski, 1984). Consequently, possible solutions to the problem of abuse may seem worse to elderly people than the problem itself (Rathbone-McCuan, 1980).
Another barrier to thorough investigation and detection of elder abuse is differential categorization of types of violence. Categorizing types of abuse has helped to contribute toward the development of detection procedures, but discrepancies exist among classification systems. One controversial categorization issue applies to intentionality of violence (Booken & Dunkle, 1985; Giordano & Giordano, 1984). A purposeful more than an unwitting act of maltreatment is seen as abusive. (Fulmer & Cahill, 1984). However, the effect on older people may be the same. This issue has not been clearly addressed.

Booken and Dunkle (1985) suggested that practitioners use varying definitions of abuse because of differential access to older people. Medical professionals may frequently define violence in physical terms because they have access to elderly people when physical signs of mistreatment are visible. Lau and Kosberg (1979) found that a majority of elderly domestic violence cases are detected by health-related professionals as a result of health problems. Human service professionals, on the other hand, are more likely to see cases of abuse in the earlier stages. Possibly, they are more likely than medical professionals to define abuse in psychological terms.

Another difficulty in categorizing abuse relates to distinctions made between types of violence. One distinction concerns passive abuse and neglect. It is not
clear whether or not they are conceptually identical. Given that acts of passive abuse and neglect rather than physical violence have more frequently been found in connection with cases of elder abuse (Costa, 1984; Douglass, 1983; Hickey & Douglass, 1981), and that their effects may be just as harmful as active behaviors (Hudson, 1986), it would be helpful for researchers to clearly distinguish between the two.

Some researchers make no distinction between active and passive abuse. Unlike others (e.g., Costa, 1984), Lau and Kosberg (1979) found physical violence to be the most common form of elderly maltreatment. However, they included lack of personal care, which is a form of neglect, in their definition of physical violence.

Another problematic distinction is the one made between physical and psychological harm. Psychological abuse includes eliciting fear in the victim, name calling, and verbal assault and threats (Giordano & Giordano, 1984). Often, however, psychological abuse occurs concurrently with other, more dramatic acts of physical violence. Consequently, psychological aspects may be overshadowed by the evidence of physical mistreatment. Yet, it can be as damaging to an elderly person's sense of well-being as actual physical harm.

Self abuse, sometimes called self neglect (Giordano & Giordano, 1984), is another category of abuse that has not
been adequately dimensionalized. Self neglect or abuse includes self-inflicted physical harm and the failure to take care of one's own personal needs. It may reflect prolonging other long-term destructive patterns, such as alcohol use or suicidal behaviors (Lau & Kosberg, 1979). As others (Giordano & Giordano, 1984) have suggested, it may be more closely related to the physical or mental inability of impaired elderly people to provide adequate self care. Different interventions are implied here, which suggests that clarification of this concept would be helpful.

Despite these difficulties in categorizing types of elder abuse, there are groupings that have been used frequently in the literature for pilot studies and preliminary empirical investigations. Block and Sinnott (cited in Giordano & Giordano, 1984) specified four components (physical, psychological, material, and medical abuse) of the Battered Elder Syndrome. Any one or combination of the four components would constitute abuse. The Select Committee on Aging (in Giordano & Giordano, 1984) grouped elder abuse into several categories: physical abuse, negligence, financial exploitation, psychological abuse, violations of rights, and self-neglect.

The reader interested in a thorough review of definitions of elder abuse may refer to Hudson's work (1986). She reviewed and summarized the various
definitions, detection protocols and legislation, and found that the definitions included specific and overlapping behavioral examples, although many lacked a clear, intrinsic conceptualization of elder abuse.

**Theories of Elder Abuse**

Okum (1986) suggested that at least 20 theories of family violence exist; many of which, however, overlap. Though several of these are relevant to elder abuse, they were originally derived from the child abuse literature. As yet, no perspective has been formulated to fit the special dynamics of elder abuse. Thus, in addition to the difficulties involved in investigating elder abuse, there is a lack of specifically relevant theories. Theories applied to elder abuse include family systems, familial stress, intergenerational transmission of violence, and societal attitudes toward elderly individuals.

**Family systems theory.** The primary focus of systems theory on familial as opposed to intraindividual pathology contributes some understanding to the problem of elder abuse. In family violence, all members cooperate in maintaining the status quo by employing certain defense mechanisms. In families where elder abuse occurs, denial is often perpetuated (Beck & Ferguson, 1981). Denial may center around a refusal to acknowledge an elderly person's illness. To deny an older person's mortality allows adult children to also deny their own. Beck and Ferguson (1981)
suggested that a denial system is used to ward off separation anxieties, such as grief over the anticipated loss of the older person. However, one consequence of denial of the older person's illness may be passive abuse.

According to a family systems model, an agreement to deny abuse would have to serve some function for the elderly person. Beck and Ferguson (1981) suggested that older people may deny mistreatment in an effort to preserve their own self image. To acknowledge abusive behavior would be to accept responsibility for faulty parenting, and would result in shame and humiliation. Thus, in an indirect way, older people may be forced to participate in a family denial system in order to maintain their self-esteem.

Overall, systems theory has not been fully explored with regard to elder abuse. Considering the popularity of this approach for treating dysfunctional families, it would be useful to explore it further.

Familial stress theory. In the familial stress theory, stress is considered a causal factor in elder abuse. Because the family is a social unit, it is subject and vulnerable to both intrafamilial and extrafamilial stress (Rathbone-McCuan, 1980). Stress is particularly relevant when one considers that "people under stress and in conflict are potential abusers" (Lau & Kosberg, 1979, p. 13). A recent survey of professionals (Costa, 1984)
reported that the majority of abusers in elder abuse cases were experiencing some form of stress when the abuse occurred.

The literature suggested that caregiver characteristics contribute toward intrafamilial stress. Personality variables of the caregiver/abuser said to cause intrafamilial stress are "defects," such as alcoholism, mental illness and retardation (Chen, Bell, Dolinsky, Doyle, & Dunn, 1981; Lau & Kosberg, 1979). These characteristics often are associated with other familial stress factors, such as job insecurity.

Defective caregivers (Booken & Dunkle, 1985) lack the social judgement necessary to provide adequate care to aging parents, and thereby to prevent abuse (Lau & Kosberg, 1979). Abusers of older family members were found to have domineering personalities, low self-esteem, high levels of anxiety, and low levels of tolerance (Chen et al., 1981), all of which might contribute to familial stress. However, Giordano & Giordano (1984) acknowledged that the causal role of personality characteristics in elder abuse is probably too simplistic.

Characteristics of older people as well as caregivers have been related to familial stress and elder abuse. Some features of elders' personalities have been thought to provoke abuse in the same manner that children were once believed to have caused their own maltreatment. Certain
characteristics may disrupt the ability to develop and maintain satisfying relationships with others (Beck & Phillips, 1984). In a "spoiled identity," one unpalatable aspect of older people overshadows other, more positive characteristics (Beck & Phillips, 1984). Such variables may be social, physical, or cognitive in nature. For example, confusion—a cognitive variable possibly resulting from dementia or relocation—may affect an elderly person's ability to receive or process information. As a function of organicity, an elderly person may be unresponsive to the environment or even "zombie-like." Caregivers who spend time, energy, or attention on elderly people with these or other such characteristics would, according to this theory, become irritated or frustrated; violence is a possible result.

In addition to caregiver and elderly personality variables, the stress theory includes various dimensions of burden that a family might experience as a result of living with an elderly parent. Stress already present in many adult child/aging parent relationships (Costa, 1984; Miller, 1981) may be exacerbated when an aging parent moves in. Routine household procedures may be disrupted, roles and expectations of individual family members may change, and communication patterns may change. Disruptive behavior and impaired social functioning of the elderly person were found to be directly linked with stress (Deimling & Bass,
Caregivers of elderly parents who found the role most stressful believed that their spouse's and/or children's needs became secondary to those of the parents (Pedrick-Cornell & Gelles, 1982).

Dependency is also related to familial stress. Medical advances in recent years have made it possible for people to survive what have historically been fatal illnesses, such as cardiac disease, and many forms of cancer. Though they live longer, these people are often left with physical disabilities and require substantial care. Physical disabilities may place prolonged financial, physical and emotional stress on caretaking families. Giordano & Giordano (1984) emphasized the role of physical impairment in elder abuse, and noted that physically impaired older females are the most frequent type older victim.

**Cycle of violence theory.** The theory that families pass on the tendency for domestic violence over generations is one explanation for domestic abuse. Although labelled as "Family Dynamics" in a recent review article (Giordano & Giordano, 1984), this approach usually refers to learned behavioral patterns acquired within the context of the family itself. Children learn from their families that violence is a normal and acceptable response to stress (Finkelhor et al., 1983; Lau & Kosberg, 1979).
The cycle of violence is also referred to as "intergenerational transmission of violence," learning, or social learning theory. Social learning encompasses the idea that an abusive parent is a role model for a child who as an adult, will also act violently. Thus, the propensity for violence may be passed from parent to child. This concept is often considered to be a partial factor in the occurrence of child abuse as abused children tend to become child abusers themselves (Finkelhor, Hotaling, & Yilo, 1988). Straus, Gelles and Steinmetz (1980) found that respondents who were hit most frequently as teenagers were more likely to use severe aggression with their own children as compared with respondents who were not hit as teens.

The intergenerational transmission of violence has been generally supported in the literature as a partial explanation of marital violence as well as child abuse (Forsstrom-Cohen & Rosenbaum, 1985; Kalmuss, 1984; Marshall & Rose, 1988). In a retrospective study, Rosenbaum and O'Leary (1981) found that wife abusers were significantly more likely to have witnessed parental violence and/or to have experienced child abuse in their families of origin. Ulbrich and Huber (1981) found that parental aggression positively affected men's acceptance of violence toward women.
The exact relationship between childhood and aggression manifested later in life is not clear (Marshall & Rose, 1988). Finer distinctions are being made within the literature to identify specific patterns that contribute to a cycle of violence. One recent distinction has to do with differential effects of observing violence versus receiving violence. Kalmuss (1984), using data from a nationally representative sample, examined the effects of observed and experienced violence in childhood on later severe marital aggression. She found that while both parent-to-parent and parent-to-child violence were significantly related to later marital aggression, severe marital violence was more likely to occur when parental violence had been observed by either marital partner rather than had been experienced as a child.

In Kalmuss's (1984) study, the cycle of marital violence appeared to involve specific modeling through which individuals reproduced the particular type of family aggression they witnessed as children. Specific modeling is in contrast to generalized modeling, whereby aggression communicates the acceptability and increases the likelihood of violence between any family members. However, in Kalmuss's (1984) study, even generalized modeling increased the incidence of severe marital violence more than no aggression at all.
Though somewhat inconsistent with other findings, Kalmuss (1984) found that severe marital violence was not sex specific; that is, marital violence increased the likelihood that both sons and daughters could be victims and perpetrators. Marshall and Rose (1988) examined the effects of early family violence on courtship violence in undergraduate students and reported no sex differences. They differentiated between observed and received violence, and added support to previous findings in which received and observed violence were associated with an increase in expressed and received abuse in adulthood. Forsstrom-Cohen and Rosenbaum (1985) found that college women who observed violence were more aggressive and depressed than college women who observed either nonviolent discord or a satisfactory marriage between parents.

The effects of early exposure to family violence are often manifest in childhood. Forsstrom-Cohen and Rosenbaum (1985) for example, identified aggression and behavioral problems in school-aged children as correlates of witnessing marital violence. Although an example of severe behavioral manifestations, there are reports of children exposed to early family violence (Sargent, 1972) who committed murder. Kazdin (1985) reported that one-third of teenagers who commit assault, rape, and murder grow up in violent homes.
Because the cycle of violence has been found in child abuse and marital violence, it is postulated as a likely explanation for elder abuse (Quinn & Tomita, 1986). Statistics on abused children suggest that this may indeed be the case. Steinmetz (cited in Giordano & Giordano, 1984) reported that half of the children subjected to early violence or abuse in the home go on to abuse their parents in later life, as opposed to one of 400 children who were not exposed to this type of maltreatment.

Perhaps abused children harm their parents in an effort to express their anger over how they were treated as children, and not because violence was learned as a problem-solving strategy. They may have grown up feeling resentful toward their previously violent parents and may view violence as a means of revenge. While researchers are far from pinpointing the exact explanation of why violence is directed to older parents, a number of case studies cited incidents in which violence was transmitted inter-generationally (Chen et al., 1981; Farrar, 1955; Rathbone-McCuan, 1980).

Exposure to aggressive behaviors during childhood may potentiate any later inclination for abuse. Researchers in this field, however, should not assume that identical dynamics underlie elder and child violence. It would be useful to study whether or not a cycle of violence exists
Attitudes toward older people. While there are over 30 definitions of the term "attitude" (Berkowitz, 1986), the component that best distinguishes attitude from other concepts, such as belief, behavioral intention, or behavior, is its evaluative or affective component. Fishbein and Ajzen (1975) suggested that the measurement of attitude should assess a person's judgement that an attitude object is good (evaluative), or makes the person feel good (affective). Sometimes considered an indirect measure of attitudes, beliefs refer to cognitions or the amount of information about an object (Fishbein & Ajzen, 1975) and generally produce weaker affective responses than do attitudes (Berkowitz, 1986). Intentions refer to a person's subjective intents to perform a certain behavior. Behaviors refer to observable acts. These components (attitudes, beliefs, and behavioral intentions) may fall on a continuum in terms of their relative closeness to actual behaviors.

In the literature examined, ageism (negative attitudes toward older people) has been frequently postulated as a cause for maltreatment of older people (Anderson, 1981; Bookin & Dunkle, 1985; Gatz & Pearson, 1988; Giordano & Giordano, 1984; Phillips, 1983). Although a few studies empirically examined the effects of society's negative
attitudes on the treatment of elderly people (Bagshaw & Adams, 1985-86; Kahana & Kiyak, 1984; Reinberg & Hayslip, 1988), many did not apply attitudes to behaviors.

A large body of research from as many as 35 years ago (Tuckman & Lorge, 1953) has suggested the presence of negative attitudes. Included among the more recent studies are the examination of negative attitudes of health care providers (Baker, 1984), preschoolers (Miller, Blalock, & Ginsburg 1984-85; Seefeldt, 1987), children (Murphy, Myers, & Drennan, 1982), adolescents (Steitz & Verner, 1986), college students (Doka, 1985-86; Miko, 1987; Reinberg & Hayslip, 1988; Sanders, Montgomery, Pittman, & Balkwell, 1984), older people (Bassili & Reil, 1981), and other cultures (Seefeldt, 1984).

The results of these studies generally supported the existence of negative attitudes toward the elderly. These findings, however, were not universal (Gatz & Pearson, 1988).

In a recent meta-analysis, Kite and Johnson (1988) concluded that while attitudes toward the elderly are only mildly negative, they are less favorable than attitudes toward youth. Current trends in the literature suggest that ageism may not be as simple as once thought. Multidimensionality of attitudes toward older people and moderating variables, such as type of targeted older
person, degree of contact, and age of subject may each affect ageism.

One variable possibly moderating negative attitudes toward older people is the age of the target individual. Luszcz and Fitzgerald (1986) examined knowledge and attitudes about aging among people of different generations. Overall, elderly adults were the least favored cohort, while middle-aged adults were the most favored. Members in one's own peer group were judged more favorably than they were judged by members of other peer groups. There was also some support for the hypothesis that elderly subjects have more complex perceptions of the concept of "old people" than do younger people (Brewer & Lui, 1984).

The relationship between degree of prior contact with older people and negative attitudes has had mixed findings. Many researchers (Miller et al., 1984-85; Sanders & Pittman, 1988; Steitz & Verner, 1987) found no significant relationship between subjects' knowledge of aging and the amount and quality of contact they had with an older adult. Others, however, (Peterson, Hall, & Peterson, 1988), found that a significant relationship existed between the amount of contact with older people and knowledge of aging. Riddick (1985) found that the degree of contact with elders was a significant influence in gaining knowledge during an educational intervention; those who had less contact made
significantly greater gains. On the other hand, degree of prior contact with elders did not have a significant influence on attitudinal change about the social value of the elderly or on change in personal anxiety about aging.

One mediating attitudinal variable of special interest for the current study is the nature of the older target, particularly whether the target is generalized or specific. Green's (1981) review of the literature suggested that when subjects describe old people in general, they are forced to rely on generalized, stereotypical information, often negative in character. When, on the other hand, specific elderly people are the target, negative perceptions and attitudes are not found. Luszcz (1985-86) also found support for the stereotyping of older people when broad categorical decisions were required; however, these stereotypes broke down when known people were characterized. Sanders and Pittman (1988) found that high school and college students rated young "generalized" targets more favorably than old "generalized" targets. This was not found for known young versus known elderly. They concluded that, in the absence of additional information, stereotypes of elderly people emerged, and these were often negative.

That researchers' questions regarding generalized older people isolated knowledge of cultural stereotypes, rather than knowledge of individual persons may be one
explanation for this finding (Braithwaite, Gibson, & Holman, 1985-1986). Others (Gatz & Pearson, 1988) proposed that positive ratings of specific elderly people were not inconsistent with generalized negative stereotypes. Braithwaite (1986) suggested that one explanation may be that roles typically portrayed by specific targets, such as a famous politician, for example, are atypical. Psychologically, the target may not be assigned to the stigmatized group. When Braithwaite (1986) used specific elderly targets that were more typical, they were perceived to be less active and less sociable than younger people. Disabled elderly were also judged more harshly than their able counterpart. Braithwaite concluded that negative age stereotyping was evident even toward specific targets. Others (Bassili & Reil, 1981) reported similar results.

Multidimensionality of attitudes toward older people is another explanation for different attitudes regarding specific older people versus older people in general. This explanation was proposed after some researchers found a lack of strong relationships among different measures of attitudes toward the elderly (Hicks, Rogers, & Shemberg, 1976; Kafer, Rakowski, Lachman, & Hickey, 1980). One study, for example, found that five separate attitude measures had only modest relationships with each other (Hicks, Rogers, & Shemberg, 1976). Kafer et al. (1980) found that some individuals had a "patchwork quilt"
(p. 329) of attitudes, such that they had differing attitudes toward personal aging, toward the aged as a group, and toward specific or familiar people. As a result, Kafer et al. (1980) suggested that attitudes toward older people should either be assessed with multiple indices or clearly delineated by separate subscales within the same instrument.

In further support of the multidimensionality of attitudes toward older people, Schmidt and Boland (1986), in a cluster analytic study on a group of university students, found no evidence to support one universal stereotype or attitude. Rather, multiple stereotypes about elderly people, both positive and negative in nature, were present in the sample. The particular stereotype that was salient at the time of assessment determined the attitude toward the older person. Thus, generalized attitudes regarding "older people" may not necessarily represent the attitudes that guide people's behaviors toward specific older adults.

Schmidt and Boland (1986) suggested that perhaps different behaviors are directed toward people representing positive versus negative stereotypes. As stated above, few empirical studies were found that examined the effects of ageism on behaviors toward the aging. Given that elderly maltreatment may be directed toward older adults who are perceived to represent negative stereotypes, there seems to
be value in studying effects of attitudes on the treatment of older people. One approach would be to examine attitudes toward old people in relation to attitudes toward elder abuse, behavioral intentions, and behaviors of elder abuse.

**Attitude-Behavior Relationships**

Two aspects of attitudinal research that are relevant to elder abuse should be considered. They are the relationships among attitudes, intentions, and behaviors and the intervention efforts made to change these components.

**Attitudes, behavioral intentions, and behaviors.** It was originally assumed that attitudes determined behaviors, despite the fact that the research consistently failed to find evidence to support such a cause-and-effect relationship (e.g., Wicker, 1969). While this conclusion slowed research during the late sixties, there has been a fairly recent resurgence of interest in the attitude-behavior link. Some of the renewed interest focuses on the examination of moderating variables. Vested interest, attitude accessibility, and prior experience with the attitude object are some of the variables that have been proposed. Vested interest (Crano, 1984; Sivacek & Crano, 1982) was shown to affect the attitude-behavior relationship such that individuals with a vested interest in the outcome of a specific attitude were more likely to
behave in accordance with their beliefs than those without one. Powell and Fazio (1984) theorized that an attitude would only influence behavior if it were first accessed from memory. They suggested that completing an attitude survey affects this attitude-behavior relationship because it accesses attitudes about the object. Tiller and Fazio (1982) found that the extent of prior experience with the attitude object predicted the consistency between attitudes and later behavior.

Ajzen (1987) in a review of the literature, reported that the lack of support for the attitude-behavior relationship was related to the use of an erroneous criterion measure. He asserted that using single actions as the criterion to measure global attitudes was methodologically incorrect. Because attitudes represent broad domains of behavior, they can only be inferred from a broad set of responses. Ajzen (1987) reported that there was evidence for a positive relationship between attitude measures and multiple-criterion indices of behavior. He further suggested that attitudes about specific behaviors are better predictors of such behaviors than are general attitudes or their intensity (Ajzen, 1987).

Kahana and Kiyak (1984) found similar problems with previous research and suggested that the measurement of attitudes is meaningful only if linked to specific behaviors. They criticized previous methodology for its
lack of attitude-behavior congruence and use of different levels of specificity in operationalizing attitudes and behavior. Their concerns were similar to those of others (Ajzen & Fishbein, 1977). Ajzen and Fishbein (1977) supported the use of assessing different components in the relationship across the same level of generality.

The criticisms applied to the general attitude-behavior relationship may also be applied to the gerontological literature. The lack of the distinction between attitudes, behavioral intentions, and behaviors has been a major problem in investigating attitudes toward older people. It led Schoenfield (1982) to the conclusion that ageism per se may not exist. He suggested that "ageism" is used as an umbrella term to refer to any one of a number of different dimensions of prejudice. Thus, he supported distinguishing between beliefs, attitudes and stereotypical behaviors. Miller and Dodder (1980) agreed with Schoenfield that much of the terminology should not be used interchangeably.

Much of the literature reviewed addressed attitudes rather than intentions or behaviors toward older people. Some studies examined relationships between knowledge, an aspect of the belief component (Kleemack, 1978), and other measures of attitudes toward aging. Stier and Kline (1980) found that higher knowledge was associated with negative ratings of older people. Ortmeyer (1981), on the other
hand, found a moderate positive relationship between knowledge about aging and attitudes toward older people.

The relationship between attitudes toward older people and intentions was examined in a study by Reinberg and Hayslip (1988). Using a college sample, they found a positive correlation between favorable attitudes and intentions of helpful behaviors toward old people. Fossbender (1981) also found a moderate positive relationship upon examining the relationship between attitudes toward older people and intentions of helpful behaviors to older people.

In Reinberg and Hayslip's study, positive attitudes toward old people were also related to the absence of abusive behaviors. The effect of attitudes on less socially desirable behaviors (e.g., abuse) was not examined in Fossbender's (1981) study. Bagshaw and Adams (1985-86) found a positive relationship between negative attitudes toward older people and a custodial (e.g., task-oriented, focus on physical maintenance rather than psychological adjustment) as opposed to therapeutic orientation (e.g., person-oriented, focus on providing meaningful psychological, and social adjustment) focus in nursing staff.

Kahana and Kiyak (1984) investigated interactions between the nursing staff and elderly residents in nursing homes. While they measured only one aspect of behavior,
facilitating independence versus dependence, this was a significant study in that it examined the relationship between attitudes and actual behavior. Staff members who were less likely to stereotype older people demonstrated more positive parenting behaviors and more positive affect toward older people. Intended behaviors were actually less predictive of actual behavior than were stereotypes or evaluations. This finding provided partial support for the attitude-behavior relationship.

A large body of literature on attitudes toward older people has been developed without specific examination of the relationships between attitudes (global and specific) and intentions or actual behaviors. Thus, it appears that researchers are only at the initial phases of applying this information to the gerontological literature. What has been applied does not reflect criticisms of studies on attitude-behavior relationships (e.g., measuring specific as opposed to global attitudes).

Attitude intervention efforts. Promoting attitude change toward older people is important in changing negative stereotypes that people have about elderly people (Anderson, 1980). One method of changing attitudes is through education, which is an appropriate and necessary intervention according to many orientations, particularly the life span developmental approach. Primary prevention through increasing knowledge should occur across all ages
of the life span (Baltes & Danish, 1980). Information is provided prior to the appearance of a problem to minimize the likelihood that it will occur (Danish, Smyer & Nowak, 1980).

Glass and Trent (1980) suggested that the attitudes of young people, in particular, are crucial to the aging problem because the young determine the status and position of elders in our society. Gerontological education in general has been effective in changing global attitudes toward the elderly and the aging process (Anderson, 1980). However, effects of these global attitudes on intentions or behaviors toward the elderly are not clear.

Educational interventions used to promote attitude change usually consist of two general forms: didactic (e.g., lecture) and experiential. Experiential interventions have been defined several ways, e.g., experiencing oneself as being old, direct contact with older people, and group participation/discussion of aging issues (Houlihan, 1985). While the effects of didactic interventions have generally been positive (Berkson & Griggs, 1986; Glass & Trent, 1980; Murphy-Russell, Die, & Walker, 1986; Riddick, 1984) results of experiential interventions have been mixed (Seefeldt, 1987). In several of these studies, global attitudes toward old people became less favorable when assessed after experiential interventions (Auerback & Levenson, 1977; Houlihan, 1985;
Seefeldt, 1987). One explanation for the mixed findings of experiential interventions on attitudes toward older people is that different types of experience were utilized. It may be that experiencing oneself as being old through simulated sensory loss created less favorable attitudes than did actual discussion of discussing aging-related issues.

Houlihan (1985) found that subjects who participated in an experiential presentation on elderly people were more negative toward older people than subjects who participated in a didactic intervention. Either type of education raised the subjects' anxiety about aging. Preschoolers who visited elders in a nursing home setting over the course of a year, had negative attitudes toward old people and the aging process (Seefeldt, 1987). Despite the children's negative attitudes, the nursing home staff believed that positive long term benefits for both the children and older people would be a result. After taking a course with elderly people, college students were more negative toward older people (Auerback & Levenson, 1977). In this case, contact was utilized as a form of intervention. The results of this study may be more readily generalized than those of other studies in this area, perhaps because these results were obtained in a natural setting.

In direct contrast to these findings, other investigators found that experiential interventions
increased positive attitudes toward older people (Berkson & Griggs, 1986; Miko, 1987; Murphy-Russell, et al, 1986). Murphy-Russell et al. (1986) found that the amount of direct contact with older people was the best predictor of positive attitude change. Attitudes became positive immediately after college students shared recreational activities with elderly people (Miko, 1987). However, no long-term effects on attitudinal change were found. It may be that despite some positive gain after such interventions, negative attitudes were reasserted because students avoided such situations or further contact with older people.

Attitudes and knowledge appear to be differentially affected by experiential interventions. In one study, for example, attitudes but not knowledge about older people changed after contact with elderly people (Knox, Gekoski, & Johnson, 1986).

A great deal of literature exists in the area of gerontological intervention, particularly with regard to the assessment and alteration of global attitudes toward older people. Whether or not global attitudes toward the elderly are specifically implicated in elder abuse has not been explicitly addressed.

Elder abuse intervention efforts. Raising awareness and educating the public about social problems have been accepted as methods of primary and secondary prevention.
Domestic violence is one social problem that is beginning to gain public recognition. Particular attention has been given to child abuse and battered women. Educational interventions have often been used with high risk families (Wolfe, Edwards, Manion, & Koverola, 1988). While these intervention efforts have been valuable, the typical focus has been on violence against children. Few interventions were found that targeted elder abuse specifically. The problems discussed earlier, (e.g., the denial of elder abuse, definitional problems, and ageism) may all contribute to the lack of adequate intervention efforts for the problem of elder abuse (Gatz & Pearson, 1988).

Uniform reporting laws and education of professionals and the public are all forms of primary prevention strategies that have been used to prevent child abuse (Gelles & Straus, 1988). These intervention programs may also be effective in minimizing the incidence of elder abuse. It is not clear, however, that programs used for other types of domestic violence should necessarily be applied to elder abuse; different dynamics may be involved. Additionally, general gerontological interventions that target alteration of global attitudes toward aging may not be necessary nor sufficient to minimize the likelihood that young people will mistreat elderly individuals. At this point, it seems critical to examine the specific type of intervention needed to minimize elder abuse.
By the time they become young adults, people have had considerable contact with elderly individuals, particularly their own grandparents (Steitz & Verner, 1987; Knox et al., 1986). Sons and daughters are the most frequently identified abusers of older people (Anderson & Thobaken, 1984; Costa, 1984; Galbraith & Zdorkowski, 1984). While education and remediation are often available for a family once an older person has been harmed, the focus of this study is on reducing the risk of potential violence before it occurs. Young adults or grandchildren who are at risk of becoming abusers later in life may profit particularly from an elder abuse primary prevention strategy.

One of the first steps in an effective intervention program should be the identification of those families at risk (Gelles & Straus, 1988). The literature suggests that one population at risk of becoming elder abusers is people exposed to early family violence (e.g., Steinmetz, cited in Giordano & Giordano, 1984). Which particular interventions are effective in minimizing tolerance and behavioral intentions of abuse should also be examined. To assess intervention effectiveness, the domains of specific attitudes toward elder abuse, behavioral intentions, and behaviors toward older people should be examined.

An examination of the literature revealed few empirical studies that examined educational or other interventions in elder abuse. One study did not address
the above stated domains nor identify a population at risk for abuse. A secondary-school-based health education program was implemented to assess the effectiveness of raising awareness of elder abuse (Peterson, Clifford, & Covar, 1986). Informational lectures, small group discussions, fact sheets and handouts, audiovisual material, and guest speakers were utilized in a five day (one hour per day) program presented to health and psychology students. The control group consisted of health and history students; however, the nature of the control group was not specified (e.g., placebo group discussion versus no contact).

When assessed immediately and one week later, elder abuse education increased knowledge and positive attitudes toward older people and identified certain positive behavioral intentions. However, specific attitudes as well as behavioral intentions of elder abuse were not addressed. Additionally, no attempt was made to identify populations at risk. When researchers (Peterson et al., 1986) repeated the educational program using a college population, they again found significant differences between experimental and unspecified control groups. However, the areas assessed were limited to knowledge about older people and global as opposed to specific attitudes toward older people.
Reinberg and Hayslip (1988), in an attempt to study specific attitudes and behavioral intentions toward older people, assessed the effect of an elder abuse educational program on these variables. They developed the Elder Abuse Attitude and Behavioral Intention Scale (EAABIS) to assess these two domains and compared an elder abuse/aging educational intervention with a family issues oriented intervention. They found both interventions were ineffective in changing attitudes and behavioral intentions of abuse. At pretest, the sample (college juniors and seniors) was already highly educated about aging issues, was intolerant and had few intentions of elder abuse. Thus, Reinberg and Hayslip (1988) proposed that a ceiling effect was present at pretest that undermined the efficacy of the interventions utilized. A primary prevention model would recommend targeting relatively naive participants. Thus, the investigators suggested that a less experienced population might have been more appropriate to receive the intervention.

An additional explanation for the surprising result that neither elder abuse/aging nor family issues intervention changed attitudes or behavioral intentions regarding elder abuse has to do with possible overlap between the two groups. For the elder abuse/aging group, information on elder abuse was embedded within the context of general aging issues. The focus of the family issues
group was on family relationships from an historical perspective, but also touched on issues of older people during its discussion of families. Overlap between the two groups possibly minimized group differences. Observation of the groups indicated that the family discussion participants were highly active, invested, and involved, and brought up many issues related to their personal experiences with families. Participants may have been sensitized to family issues other than from an historical perspective, raising awareness of interactions with older relatives.

Overall, Reinberg and Hayslip (1988) failed to identify effective components for altering attitudes and behavioral intentions of elder abuse. However, due to confounds in the design, it may be that otherwise effective interventions were rendered ineffectual. A dismantling strategy (Kazdin, 1986) in which various components were separated into distinct interventions might have yielded more accurate results. Such an approach would appear to be warranted by the observation that at least some individuals in the Reinberg and Hayslip study did demonstrate a change in attitudes and behavioral intentions regarding elder abuse, and that with surprisingly little intervention.

Reinberg and Hayslip (1988) identified an at-risk population as a likely target for elder abuse education, and examined effects of experienced childhood violence on
attitudes and behavioral intentions of elder abuse. They found that at posttest, as compared to pretest, college students who had low emotional or physical abuse in childhood had fewer behavioral intentions of abuse, while students with high emotional or physical abuse did not. This finding was observed independently of experimental treatments, and was consistent with the authors' hypothesis that experience of abuse affects tolerance of it. Pretest sensitization alone appeared to effectively minimize abusive behavioral intentions for students not at risk for abuse. For students with high experienced violence, exposure alone to the idea of elder abuse did not effectively minimize these intents (Reinberg & Hayslip, 1988).

Statement of the Problem

Global attitudes toward older people have been extensively studied. Ageism, or negative attitudes toward older people, is one theory proposed to partially explain the occurrence of elder abuse. However, for prediction of behavior, recent research supports the utility of assessing specific as opposed to global attitudes regarding behavior and behavioral intentions. Therefore, specific attitudes and behavioral intentions of elder abuse rather than global attitudes toward older people may be more valuable in understanding the antecedents of elder abuse. The first purpose of the present study, therefore, is to examine
specific attitudes, intentions, and behaviors of elder abuse. In this way, more precise predictive information may be obtained regarding probabilities of actual elder abuse behavior.

Education can change attitudes, a change in which, in turn, can lead to a change in behaviors. Educational interventions may be useful to minimize the occurrence of elder abuse; however, distinct interventions may have different impacts on attitudes toward and behavioral intentions of elder abuse. A second purpose of the current study is, therefore, to identify the type(s) of intervention that best minimize(s) attitudes of tolerance and behavioral intentions of abuse.

A population at risk, compared to one not at risk for mistreating elderly people, may have different responses to educational interventions (Reinberg & Hayslip, 1988). According to the cycle of violence theory, people who have been exposed to early family violence are vulnerable to violence in later life, either as abusers or as victims of abuse (Kalmuss, 1984). Consequently, the third purpose of this study is to identify which interventions are most effective for populations at risk for elder abuse.

Finally, past research has found differential attitudes toward older people when the target was general versus specific. General targets were evaluated more
negatively than were specific targets (e.g., Luszcz, 1985-86). The present study also addresses this issue and examines whether or not tolerance, behavioral intentions, and behaviors of elder abuse differ with a general versus specific target.

**Hypotheses**

I) Prior to intervention, History of Experienced Childhood Violence will affect tolerance, behavioral intentions, and past behaviors of elder abuse. This influence of domestic violence is expected to occur such that participants with High Experienced Violence will have greater tolerance and behavioral intentions of elder abuse than will participants with Low Experienced Violence. Also, participants with High Experienced Violence are expected to have more past behaviors of elder abuse relative to participants with Low Experienced Violence.

Ia) It is also expected that, after intervention, a main effect for History of Experienced Childhood Violence will occur such that all High Experienced Violence participants will continue to have more tolerance and greater behavioral intentions of elder abuse than will all Low Violence participants.

II) A Treatment by Time of Measurement interaction is expected such that, while no differences will occur at pretest, at posttest, participants in Elder Abuse and Aging Treatment Groups will have less tolerance and fewer
behavioral intentions of elder abuse than will participants in Family or Pretest-posttest only Treatment Groups.

IIa) At posttest, exposure to Elder Abuse Treatment is expected to result in less tolerance and fewer behavioral intentions of elder abuse than exposure to Aging, Family, or Pretest-Posttest Only Treatments.

IIb) Exposure to Aging Treatment is expected to result in less tolerance and fewer behavioral intentions of elder abuse than exposure to Family or Pretest-Posttest Only Treatments.

III) A History of Experienced Childhood Violence by Treatment Group by Time of Measurement interaction is expected wherein participants with High Experienced Violence and who take part in Elder Abuse or Aging Treatment will have less tolerance and fewer behavioral intentions of elder abuse at posttest than at pretest. Moreover, these High Experienced Violence participants will have less tolerance and fewer behavioral intentions of elder abuse than other High Experienced Violence participants who take part in Family or Pretest-posttest only Treatment Groups.

IV) Attitudes toward elder abuse will correlate with behavioral intentions and with past behaviors of elder abuse more strongly than will global attitudes toward aging.
V) At pretest, level of older target, general versus specific, will affect tolerance and behavioral intentions of elder abuse. A general target will elicit more tolerance and greater behavioral intentions of abuse than will a specific older target.
CHAPTER II

METHOD

Subjects

Participants consisted of freshmen and sophomore undergraduate students enrolled in introductory psychology courses. The students volunteered for the study and were given extra-credit points in their psychology course for their participation.

Two hundred and thirty-two students completed the study after informed consent (Appendix A) was obtained. Of this group, seven students reported that they had had formal education in gerontology. Their data were not included in the statistical analysis in order to ensure that all participants were relatively naive with respect to knowledge of aging.

Demographic data (Appendix B) indicated that the sample (N = 225) included 153 females (68%) and 72 males (32%) who were enrolled in introductory undergraduate psychology courses at a major state university in Texas. Participants had an overall mean age of 19.7 with a mode age of 19. The range was between 17 and 60. Twenty-three students (10.2%) were older than 21. The sample consisted of 121 freshmen (53.3%) and 103 sophomores (45.7%). One
student did not indicate classification. Two hundred and six students (91.5%) were single with both parents still alive; 62.2% (146) had parents who were still married. Familial income was reported as being over $25,000 by 84% of the sample (189), while 50.2% of the sample (113) reported familial income as being over $50,000. In 166 of the cases (73.8%), at least one grandparent was still living. Of the sample, 68% (153) indicated either a "very close" or a "moderately close" relationship with at least one grandparent. Only 11 participants (4.9%) had a grandparent living in the family's home, while 17 (7.6%) had at least one grandparent in an institution. Of the sample, 139 (61.8%) had contact with older people once per month or greater, with 100 participants (44.4%) in contact with older people once per week or greater. Contact with grandparents was made once per month or greater by 82 of the participants (36.4%) with 46 (20.4%) in contact with grandparents once per week or greater. Contact with grandparents was made between once per year and several times per year by 114 (50.7%) of the participants.

Materials

Adaptation of the Severity of Violence Against Women Scale. Items from Marshall's Severity of Violence Against Women Scale (Marshall, in press) were used to assess the presence or absence of a history of experienced familial violence during childhood (Appendix C). The Severity of
Violence Against Women Scale was developed to provide a more sensitive instrument than the Conflict Tactics Scale (Straus, 1979) which is widely used to assess family violence. Specific improvements from the Conflict Tactics Scale that the Severity of Violence Against Women Scale addressed were the increased number of items of symbolic and physical aggression, the separation of behaviors varying in severity within an item, and the lack of assumption of ordinal presentation of items.

Initial factor analysis of this scale by L. L. Marshall (personal communication, February, 1989) was conducted using the data from 815 female students and 237 community women. Results from the factor analysis indicated that the acts on the scale represent mild threats of violence, serious threats of violence, a moderate level of physical violence, serious or more life-threatening physical violence and sexual aggression.

For the present study, these items were modified to describe acts done to respondents by the respondents' parents, step-parents, or legal guardians while the respondents were growing up or acts occurring in the present. For the current study, six additional behaviors describing possible acts were added to the original scale. Each of the 52 behaviors comprising the Adaptation of the Severity of Violence Against Women Scale was rated by the respondents on a 4-point scale. A 4-point scale was used
to avoid problems with skewness sometimes found in 5- or 7-point scales that rely on the respondents' subjective opinion of the terms "frequently," "sometimes," and "rarely." The 4-points were labeled "never," "once," "twice to several times," and "more often."

Responses to items taken from the Adaptation of Severity of Violence Against Women Scale were totaled for each participant such that higher scores indicated more reported familial violence. Respondents who fell within the fiftieth percentile or above on this scale were categorized as High Experienced Violence (scored above 74), while the remainder of the sample (scored 74 or below) was categorized as Low Experienced Violence. The theoretical range on this scale was 50 to 208; the obtained range was 54 to 174. The mean score of 74 was skewed toward lower reported violence.

On all items but one (demanded sex whether you wanted to or not), at least one student responded that the behavior had occurred at least once. On five items, one student only responded that the behavior had occurred at least once.

**Facts on Aging Quiz.** Palmore's Facts on Aging Quiz (Palmore, 1977) was the instrument used to assess knowledge of aging. It contains factual statements about aging and was designed to test knowledge and misconceptions about physical, mental, and social aspects of aging. Each item
has been documented by empirical research (Palmore, 1977). The scale consists of 25 True-False items, requires five minutes to complete, and is easily scored (odd numbers are false; even numbers are true).

Originally constructed to overcome the weaknesses of other instruments, Palmore's Facts on Aging Quiz has been widely used for research in the area of knowledge on aging (Palmore, 1980), particularly to measure effects of interventions at pretest and posttest. A second version of the Facts on Aging Quiz, the Facts on Aging Quiz, Part Two (Palmore, 1981), was also developed for test-retest purposes. Because the current study assessed knowledge of aging at only one time, pretest, the original Facts on Aging Quiz (1977) was used due to its more extensive application in the gerontological literature.

On Palmore's Facts on Aging Quiz, test-retest reliability was reported to be high (Laner, cited in Palmore, 1980). Item-to-total correlation (alpha coefficient = .47) was low (Kleemack, 1978). Due to the nonpsychometric nature of Palmore's Facts on Aging Quiz, Palmore (1981) suggested that item-to-total correlations are not crucial to the usefulness of the test. Palmore recommended the inclusion of all 25 items as the minimal number for covering the basic facts of aging despite the low item-to-total correlations of several items.
The Facts on Aging Quiz has been validated on undergraduate and graduate students, and university professors. Those with more formal education in gerontology had higher scores on the Facts on Aging Quiz, indicating construct validity. Also, the items have a high degree of face validity.

One intended use of the scale was to measure misconceptions about older people (Palmore, 1980). It was used in the present study to assess the equality of levels of knowledge between groups prior to intervention. Although at least one other published scale exists that directly assesses knowledge of aging (Dye & Sassenrath, 1979), it has failed to generate substantial application in gerontological research. The Facts on Aging Quiz was chosen for the present study because of its wide use, as well as its established construct validity.

Attitudes toward Old People Scale. Kogan's Attitude toward Old People Scale (Kogan, 1961) has been used extensively in research as an index of global attitudes toward older people (e.g., Bagshaw & Adams, 1985-86; Glass & Trent, 1980; Murphy-Russell et al., 1986). It was used in the current study as a measure of global attitudes about older people as directed toward general older targets. This scale assesses stereotypes and misconceptions about older people. Many of the items were derived from minority stereotype research.
Kogan's scale includes 34 short statements; 17 are positive and 17 are identical but negatively stated. For the present study, random selection of items was used to determine alternate forms. Alternate forms consisting of equal numbers of positive and negative statements were utilized to measure the extent of attitude change after the experimental manipulation. One item was discarded to have equivalent measures (8 positive, 8 negative). Thirty-two filler items (Appendix D), attitudes toward children, were devised and embedded in Kogan's Attitude toward Old People Scale to attempt to prevent demand effects by disguising the nature of the primary interest, attitudes toward older people.

On Kogan's Attitude toward Old People Scale, tests of reliability and homogeneity revealed slightly higher reliability for negative scale items than for positive scale items: Spearman-Brown reliability coefficients for negative items were between $r = .73$ and .83; for the positive scale, coefficients were between $r = .66$ and .77 (Kogan, 1961a and 1961b).

For the present study, the total number of responses indicating either acceptance of a positive item or rejection of a negative item were summed, providing a theoretical range of 0 to 16. Responses to filler items were not included in participants' scores. The alpha coefficient obtained = .48.
Personal Anxiety toward Aging. The Personal Anxiety toward Aging Scale (Kafer et al., 1980) was used as a second measure of global attitudes toward aging. This scale is a 15-item, true-false instrument that includes a broad scope of topic areas reflecting anxiety or uneasiness about one's personal aging. It was developed as one dimension of a broader scale, the Aging Opinion Survey, which assesses multidimensional attitudes toward aging. The Aging Opinion Survey was based on a factor analysis of 203 items. Three factors were obtained: stereotypical aging beliefs, personal anxiety toward aging, and social value of the elderly. These factors accounted for 64.1 percent of the common variance. Internal consistency of the Personal Anxiety toward Aging Scale was .65. In the current study, the reliability was similar with an alpha coefficient = .57.

Moderate correlations were found with a separate attitude dimension, social value of the elderly (Kafer et al., 1980). It was also positively correlated with death anxiety (Vickio & Cavanaugh, 1985), and negatively correlated with parental health (Rakowski, Barber, & Seelbach, 1983). This scale was chosen for its clear and distinct content from Kogan's Attitude toward Old People Scale in order to utilize a second dimension of attitudes toward older people in relation to the Elder Abuse Attitudes and Behavioral Intentions Scale-Revised.
Elder Abuse Attitudes and Behavioral Intentions Scale- Revised. The Elder Abuse Attitudes and Behavioral Intentions Scale-Revised (EAABIS-R) was used to assess attitudes, behavioral intentions, and behaviors toward elder abuse (Appendix E). It was a revision of the Exchanges of Support and Assistance Index developed by the National Council on the Aging (1975, 1976) and revised by the author. In a previous study (Reinberg & Hayslip, 1988), items of the Exchanges of Support and Assistance Index were selected and modified to create the Elder Abuse Attitudes and Behavioral Intentions Scale (EAABIS). The EAABIS has four subscales: (a) Attitudes-Support, attitudes toward providing helpful behaviors to older people (e.g., attitude toward helping an older person get dressed); (b) Intentions-Support, intentions of providing helpful behaviors to older people (e.g., intention of helping an older person dress); (c) Attitudes-Abuse, attitudes toward abusive behaviors toward older people (e.g., attitude toward hitting an older person); and (d) Intentions-Abuse, intentions of abusive behaviors toward older people (e.g., intention of hitting an older person).

The results of a pilot study using the EAABIS indicated that it has adequate reliability and validity to assess attitudes and behavioral intentions of elder abuse with a college population. Alpha coefficients ranged from .70 to .96 in an undergraduate class on aging (n = 47) and
from .75 to .95 in an introductory psychology class (n = 40). Alpha coefficients were higher on the Attitudes-Support and Intentions-Support subscales than the Attitudes-Abuse and the Intentions-Abuse subscales. Test-retest reliability coefficients were computed after an interval of four weeks for a small group of participants from both class on aging and the introductory psychology class. Correlations ranged from $r = .45$ to $r = .69$ on the subscales where Intentions—Abuse was the least stable of the four subscales.

Correlations between the Attitudes scales and Intentions scales suggested convergent validity. Significant correlations were found between Attitudes-Support and Intentions-Support ($r = .42$) and between Attitudes-Abuse and Intentions-Abuse ($r = .48$), which indicated a positive relationship between elder abuse attitudes and behavioral intentions.

Significant correlations were not found between Attitudes—Support and Attitudes—Abuse or between Intentions—Support and Intentions—Abuse. This suggested discriminative validity for the Support and Abuse scales.

In a pilot study using the EAABIS, Attitudes-Abuse and Intentions-Abuse were significantly, although not highly correlated with social desirability for an introductory class in psychology (Attitudes-Abuse: $r = .25$; Intentions-Abuse: $r = .34$). No significant relationship
with social desirability was found for an advanced psychology class on aging. In another study using participants from advanced psychology courses, Reinberg and Hayslip (1988) found that the four scales on the EAABIS were minimally correlated with social desirability and ranged between $r = .12$ and .27.

For the current study, additional directions were written so that all items were assessed for both a general target (older people in general) and a known, specific target (subject's grandparent). All Abuse and Support scales were combined to potentially reduce the effects of fatigue and practice. As indicated, separate directions were needed for general and specific targets. Thus, combining Abuse and Support scales prevented participants from reading 12 sets of directions and responding in 12 separate ways on 12 distinct measures. Moreover, Abuse and Support scales were combined to potentially reduce social desirability responses on abusive items by embedding them within the context of providing varying types of behaviors toward older people.

A total of six subscales comprise the revised EAABIS, the EAABIS-R: General Target Elder Abuse Attitudes; General Target Elder Abuse Intentions; General Target Elder Abuse Behaviors; Specific Target Elder Abuse Attitudes; Specific Target Elder Abuse Intentions, and Specific Target Elder Abuse Behaviors. Each subscale is specific, directed
either toward tolerance, behavioral intentions, or behaviors of elder abuse. Each of these three specific dimensions (tolerance, intentions, behaviors) is directed toward both General and Specific targets. Each subscale consists of the same 50 items; different instructions head each subscale.

Obtained reliabilities of each of the subscales were as follows: (a) General Target Elder Abuse Attitudes, alpha coefficient = .91; (b) General Target Elder Abuse Intentions, alpha coefficient = .92; (c) General Target Elder Abuse Behaviors, alpha coefficient = .93; (d) Specific Target Elder Abuse Attitudes, alpha coefficient = .93; (e) Specific Target Elder Abuse Intentions, alpha coefficient = .92; and (f) Specific Target Elder Abuse Behaviors, alpha coefficient = .91.

Marlowe-Crowne Social Desirability Scale. Marlowe-Crowne Social Desirability Scale (Crowne & Marlowe, 1964) was included in this study as a pretest measure to control for possible differing response sets among people with different backgrounds of experienced violence. The Marlowe-Crowne Social Desirability Scale has been widely used for evaluating the effects of a socially desirable response set.

Questions to evaluate credibility of the study and expectancy effects (Kazdin & Wilcoxin, 1976) were included at pretest. Both the Social Desirability scale and the
credibility/expectancy questionnaire assessed differences between groups prior to the experimental variable.

Procedure

Students in introductory psychology courses signed up to attend one of four evening sessions. On the sign-up sheet, they were informed that the study dealt with family relationships, that they would complete questionnaires, and that they would be involved in any or all of the following activities: listening to a lecture, viewing a film, and participating in a group discussion on family relationships. The students were informed that their participation would require approximately five hours.

The four specified evenings were designated as one of four Treatment Groups: (a) Elder Abuse, (b) Aging, (c) Family, or (d) Pretest-Posttest Only. The subjects were assigned to the particular Treatment based on which evening session they chose to attend, and were blind to the content of the other Treatments.

Informed consent was obtained when the participants arrived. They were then given a fixed pretest package including Marshall's Severity of Violence Scale, Palmore's Facts on Aging Quiz, Kogan's Attitude toward Old People Scale-Form A, Personal Anxiety toward Aging Scale, EAABIS-R, Marlowe-Crowne Social Desirability Scale, and questions to evaluate credibility and expectancy effects. All participants but those in the Pretest-Posttest Only
Treatment Group received identical pretest packages. Students in this group did not receive the credibility/expectancy questionnaire.

Female graduate students were recruited to lead the Treatment Groups. The trainers were compensated financially for their participation. These trainers were similar in age and judged to be similar in physical attractiveness by the experimenter. Subjects rated the group trainers on physical attractiveness, as well as several other variables that were considered to possibly bias subjects' responses (Appendix F). Group trainers were not found to differ from one another on these variables.

Two hundred and twenty-five students were thus assigned to one of four Treatments based on which evening session (Monday through Thursday) they chose to attend, and were blind to the content of the other Treatments. Students attended the Treatment Groups in the following numbers: Elder Abuse Treatment Group had 58 (25.8%) participants, Aging Treatment Group had 60 participants (26.7%), Family Treatment Group had 58 (25.8%) participants, and Pretest-Posttest Only Treatment Group had 49 (21.8%) participants.

After all participants completed the evening session, they were designated as belonging to one of two History of Experienced Childhood Violence groups, as indicated from their percentile ranking on the Severity of Violence Scale.
Those below the 50th percentile belonged to Low Experienced Violence; those at the 50th percentile and above belonged to High Experienced Violence. In order, Elder Abuse, Aging, Family, and Pretest-posttest Treatment Groups had 21 (18.6%), 39 (34.5%), 29 (25.7%), and 24 (21.2%) Low Experienced Violence participants. In order, Elder Abuse, Aging, Family, and Pretest-posttest Treatment Groups had 37 (33.0%), 21 (18.8%), 29 (25.9%), and 25 (22.3%) High Experienced Violence participants.

One hundred and twenty-nine students completed one-month followup questionnaires, thus providing an overall 57.3 percent return rate. From the Elder Abuse, Aging, and Family Treatment Groups, thirty-four students returned for follow-up, thus providing return rates of 58.6, 56.7, and 59.6 percent, respectively. Twenty-seven students assigned to the Pretest-Posttest Only Treatment returned for follow-up, thus providing a return rate of 54.0 percent. In order, Elder Abuse, Aging, Family, and Pretest-Posttest Only Treatment Groups had 12, 21, 16, and 15 Low Experienced Violence follow-up participants and 22, 13, 18, and 12 High Experienced Violence follow-up participants.

Participants in the experimental Treatment Groups (Elder Abuse and Aging) received a two-hour educational intervention. Each intervention was composed of audiovisual material, written material, and group discussion. Four graduate students who had completed
academic work on the subject of aging were recruited to lead the two educational interventions. Two trainers independently led each of the two Treatment Groups (Elder Abuse or Aging). Each of the four experimental group trainers was given approximately four hours of individual training by the experimenter. Group trainers were blind to the content of the other experimental and control groups.

Participants in the Elder Abuse Treatment Group (Appendix G) received a handout on elder abuse and discussed the various definitions of elder abuse. They were presented several cases of elder abuse, and asked to consider whether or not elder abuse was present. Issues that might have influenced the subjects' recognition of elder abuse (e.g., intentionality of the caregiver) were raised and discussed. A film on elder abuse was viewed. All participants were given the opportunity to discuss reactions to the film and any abusive situations of which they personally were aware. The Elder Abuse Hotline number was given to all participants.

Participants in the Aging Treatment Group (Appendix G) received a handout on aging and discussed various definitions of aging. No elder abuse content was included. The life span developmental model of aging was presented. They reviewed Palmore's Facts on Aging Quiz, and discussed various myths and facts about aging. They viewed a film on issues of aging, and were given the opportunity to discuss
reactions to the film and their own relationships to older people.

Two graduate students who had completed academic work in family systems were recruited to lead the Family Treatment Group, which included neither elder abuse nor aging issues. Each of the two Family trainers independently led one Treatment Group. Family Treatment Group trainers were each given approximately four hours of individual training by the experimenter. They were blind to the content of the other experimental and control groups.

As in the Elder Abuse and Aging Treatment Groups, the Family Treatment Group (Appendix G) also consisted of lecture, group discussion, and a film. Sociological and psychological roles of families were discussed. Participants received handouts on different forms of marriages, discussed the advantages/disadvantages of each, and historical changes in the concept of the family. They viewed a film on two separate families and were given an opportunity to discuss their reactions to it.

Following the completion of each treatment group, the participants were given posttest packages that included Kogan's Attitude toward Old People Scale-Form B, the EAABIS-R, the Personal Anxiety toward Aging Scale, and the Severity of Violence Scale. Extra-credit points were given.
Participants in the Pretest-Posttest Only Treatment Group completed the same pretest package as those in the other three treatment groups. They were given a break, and were then asked to complete the posttest package. One additional female graduate student who was blind to the study administered the pretest-posttest packages. Extra-credit points were given.

After the participants completed the evening session, they were designated as belonging to one of the two History of Experienced Childhood Violence groups. Additional evening sessions were given in an identical format until there were sufficient numbers of Low and High Experienced Violence participants represented in each of the Treatment Groups. A minimum of ten subjects under each of the Low and High Experienced Violence conditions and under each of the seven trainers was obtained. Each of the seven trainers ran two groups of participants, either one or two weeks apart.

Approximately one month subsequent to their group participation, all students were called by the experimenter and asked to complete a set of follow-up questions that included Kogan's Attitude toward Old People Scale-Form B, the EAABIS-R, and the Personal Anxiety toward Aging Scale. Additional extra-credit points were given. They were then debriefed (Appendix H) and were offered elder abuse and/or
aging education. Group trainers were also debriefed, paid, and thanked for their participation.
CHAPTER III

RESULTS

Data were analyzed via a 2 x 4 x 6 repeated measures Multivariate Analysis of Variance (MANOVA). The two levels of the first independent variable, History of Experienced Childhood Violence, were High Experienced Violence and Low Experienced Violence. The four levels of the second independent variable, Treatment Groups, were (a) Elder Abuse group, (b) Aging group, (c) Family group, and (d) Pretest-Posttest Only group. The Elder Abuse and Aging Treatment Groups were the experimental groups; the Family and Pretest-Posttest Only Treatment Groups were the control groups. The six levels of the third independent variable, Trainer, were the six group trainers. Trainer effects were nested within Treatment Group; two Trainers were nested within each Treatment Group.

Trainer, nested within the factor Treatment Group, yielded a nonsignificant main effect. The Trainer within Treatment Group by History of Experienced Childhood Violence interaction was nonsignificant as was the Trainer within Treatment Group by Time of Measurement interaction. Moreover, there was no significant Trainer within Treatment Group by History of Experienced Childhood Violence by Time
of Measurement interaction. Additionally, no credibility/expectancy differences were found across Trainers. Therefore, the nested factor, Trainer, was collapsed across Treatment Group. A 2 x 4 repeated measures MANOVA was then utilized to analyze the data. The statistic reported for all multivariate findings is Hotellings $T^2$. Table I-1 (Appendix I) shows means, standard deviations, and theoretical and obtained ranges for all dependent measures.

MANOVA's were computed with and without two covariates, social desirability and credibility/expectancy. As seen in Table I-2 (Appendix I), social desirability was correlated minimally with three dependent variables, while credibility/expectancy was not correlated with any of the dependent variables. Consequently, utilizing social desirability and credibility/expectancy as covariates had minimal effects on the results of the analyses. As seen in Table I-2 (Appendix I), a third variable, knowledge about aging (Palmore's Facts on Aging Quiz), correlated with one dependent variable, Kogan's Attitudes toward Old People Scale. Utilizing an ANOVA, it was found that knowledge about aging did not vary significantly at pretest by Treatment Group or by History of Experienced Childhood Violence. Consequently, it was not used as a covariate.
Hypotheses I and Ia

Hypothesis I predicted that, prior to any treatment, History of Experienced Childhood Violence would differentially influence attitudes toward elder abuse, behavioral intentions of elder abuse, and past behaviors of elder abuse. It was theorized that, at pretest, students with High Experienced Violence would have more tolerance, intentions, and past behaviors of elder abuse than students with Low Experienced Violence. Hypothesis Ia predicted a main effect for History of Experienced Childhood Violence such that scores for High Experienced Violence participants would indicate greater tolerance and behavioral intentions of elder abuse than scores for Low Experienced Violence participants.

Contrary to what was expected at pretest (Hypothesis I), History of Experienced Childhood Violence did not differentially influence attitudes, intentions, or past behaviors of elder abuse. One dependent variable, General Target Elder Abuse Attitudes, \( F (1,223) = 3.76, p < .05 \), was significant at the univariate level. When social desirability and credibility were used as covariates, General Target Elder Abuse Attitudes became nonsignificant at the univariate level. Also contrary to what was expected after treatment, there were no effects (Hypothesis Ia) for History of Experienced Childhood Violence.
Hypotheses II through IIb

Hypothesis II predicted a Treatment Group by Time of Measurement interaction such that, while no differences would be found at pretest, Elder Abuse and Aging Treatment Group participants would have less tolerance and intentions of elder abuse at posttest than Family or Pretest-Posttest Only Treatment Group participants. Hypothesis IIa predicted that Elder Abuse Treatment Group participants would have less tolerance and fewer behavioral intentions of elder abuse than Aging, Family, or Pretest-Posttest Only Treatment Group participants. Hypothesis IIb predicted that Aging Treatment Group participants would have less tolerance and fewer behavioral intentions of abuse than Family or Pretest-Posttest Only Treatment Group participants.

A significant Treatment by Time of Measurement interaction was found at the multivariate level, $F(24, 644) = 2.73, p < .001$, as seen in Table I-3 (Appendix I). The overall multivariate interaction suggested that, while no differences existed among Treatment Groups at pretest, at posttest, at least one Treatment Group scored significantly different than the others for the dependent variables as a set. When social desirability and credibility/expectancy were used as covariates, a similar significant multivariate result was found.
On four subscales of the Elder Abuse Attitudes and Behavioral Intentions Scale-Revised, participants in the Elder Abuse Treatment Group scored significantly higher than participants in the Aging, Family, or Pretest-Posttest Treatment Groups at posttest. As seen in Table I-4 (Appendix I), Elder Abuse Treatment Group posttest means were significantly higher than those of all other Treatment Groups on General Target Elder Abuse Attitudes, General Target Elder Abuse Behaviors, Specific Target Elder Abuse Attitudes, and Specific Target Elder Abuse Intentions. The findings were confirmed with Student Newman Keul's post hoc tests ($p < .05$). These findings provide support for Hypothesis IIa. Hypothesis II and Hypothesis IIb were not supported by the findings.

As seen in Figure 1 (Appendix J), for General Target Elder Abuse Attitudes, Elder Abuse Treatment Group scores increased at posttest (less elder abuse tolerance), while all other Treatment Groups scores decreased. Similarly, as Figure 2 (Appendix J) shows, for Specific Target Elder Abuse Intentions, Elder Abuse Treatment Group scores increased at posttest (fewer elder abuse intentions), while all other Treatment Groups scores decreased.

As seen in Figure 3 (Appendix J), for Specific Target Elder Abuse Attitudes, Elder Abuse Treatment Group scores increased at posttest (less elder abuse tolerance) while other Treatment Groups scores did not change significantly.
Finally, as Figure 4 (Appendix J) shows, for General Target Elder Abuse Behaviors, all Treatment Groups scores decreased at posttest (more reported elder abuse behaviors); however, Elder Abuse Treatment Group scores decreased significantly less than those of the other Treatment Groups.

A Treatment Group by Time of Measurement interaction was also found for Personal Anxiety toward Aging, as seen in Table I-3 (Appendix I). On this measure, as Figure 5 (Appendix J) indicates, the Aging Treatment Group scored significantly lower at posttest (more anxiety toward aging) than all other Treatment Groups. This finding was confirmed with Student Newman Keul's post hoc tests (p < .05). This finding does not support Hypotheses II, IIa, or IIb.

In summary, support was found for Hypothesis IIa. Elder Abuse Treatment Group participants had less tolerance for both general and specific target elder abuse and fewer specific target intentions than did Aging, Family, or Pretest-Posttest Only Treatment Group participants. Additionally, Elder Abuse Treatment Group participants had fewer reported general target abusive behaviors than did other Treatment Groups. No support was found for Hypothesis II or Hypothesis IIb. Aging Treatment Group participation did not result in less elder abuse tolerance
or intentions than Family or Pretest-Posttest Only Treatment Group participation.

**Hypothesis III**

Hypothesis III predicted a History of Experienced Childhood Violence by Treatment Group by Time of Measurement interaction such that, relative to pretest, at posttest, High Experienced Violence participants in Elder Abuse or Aging Treatment Groups would have less tolerance and fewer elder abuse behavioral intentions than High Experienced Violence participants in Family or Pretest-Posttest Only Treatment Groups. All High Experienced Violence participants, however, would have greater tolerance and intentions of elder abuse than all Low Experienced Violence participants.

Contrary to what was expected, there was no multivariate triple interaction. Similarly, when social desirability and credibility/expectancy were used as covariates, there was no significant multivariate finding. Tables I-5 through I-8 (Appendix I) show pretest and posttest means, standard deviations, and ranges for High and Low Experienced Violence in each Treatment Group.

**General Target Elder Abuse Behaviors as the Independent Variable**

In contrast with defining History of Experienced Violence as the independent variable, measured by the Adaptation of the Severity of Violence Against Women Scale,
performed past abusive behaviors toward older people were utilized to alternatively define History of Violence. A median split on General Target Elder Abuse Behaviors was used to differentiate persons by level of this alternative independent variable, Expressed Violence, into Low and High Expressed Violence. Exploratory MANOVA's were performed.

Significant differences for the dependent variables as a set were found between High and Low Expressed Violence at pretest, $F(7,218) = 17.48, p < .001$, as seen in Table I-9 (Appendix I). When both pretest and posttest scores were incorporated into the design, an effect for History of Expressed Violence at the multivariate level was also found, $F(7,211) = 17.36, p < .001$, as seen in Table I-9 (Appendix I).

As seen in Table I-10 (Appendix I), High Expressed Violence means were significantly lower than Low Expressed Violence means on all subscales of the Elder Abuse Attitudes and Behavioral Intentions Scale (General Target Elder Abuse Attitudes through Specific Target Elder Abuse Behaviors). These findings were in the direction predicted in Hypothesis I and Ia and provide support for Hypothesis I and Ia. No other interactions involving History of Expressed Violence were significant.
Specific Target Elder Abuse Behaviors as the Independent Variable

In contrast with defining History of Experienced Violence as the independent variable, measured by the Adaptation of the Severity of Violence Against Women Scale, expressed past abusive behaviors toward grandparents were utilized to alternatively define History of Violence. A median split on Specific Target Elder Abuse Behaviors was used to differentiate persons by level of the alternative independent variable, Expressed Violence, into Low and High Expressed Violence. Exploratory MANOVA's were performed.

Significant differences for the dependent variables as a set were found between High and Low Expressed Violence at pretest, $F(7,218) = 19.22, p < .001$, as seen in Table I-11 (Appendix I). When both pretest and posttest were incorporated in the design, an effect for History of Expressed Violence at the multivariate level was also found, $F(7,211) = 19.32, p < .001$, as seen in Table I-11 (Appendix I).

As seen in Table I-12 (Appendix I), High Expressed Violence means were significantly lower than Low Expressed Violence means on all subscales of the Elder Abuse Attitudes and Behavioral Intentions Scale, with the exception of Specific Target Elder Abuse Intentions at posttest. These findings were in the direction predicted in Hypothesis I and Ia and provide support for Hypothesis I.
and Ia. No other interactions involving History of Expressed Violence were significant.

**Hypothesis IV**

Hypothesis IV predicted that elder abuse attitudes (General and Specific Target Elder Abuse Attitudes) would correlate with both elder abuse intentions (General and Specific Target Elder Abuse Intentions) and past behaviors (General and Specific Target Elder Abuse Behaviors) more strongly than with global aging attitudes (Kogan's Attitudes toward Old People Scale, Personal Anxiety toward Aging). This relationship would occur regardless of the specificity of the elder abuse target.

Pearson product moment correlations were utilized to examine pretest relationships of elder abuse intentions and behaviors with global and specific attitude measures, as shown in Table I-13 (Appendix I). T values were computed to determine significant differences between specific attitudes (elder abuse attitudes) and global aging attitude measures (old people attitudes and aging anxiety), as correlated with elder abuse intentions or behaviors, as seen in Table I-14 (Appendix I). As predicted, significantly higher relationships were found between specific attitudes than between global aging attitudes and elder abuse intentions or past behaviors. This relationship occurred regardless of the specificity of the elder abuse target. These findings support Hypothesis IV.
Attitudes and behavioral intentions of elder abuse were related in the following ways: General Target Elder Abuse Attitudes and Intentions correlated more highly than General Target Elder Abuse Attitudes and Behaviors. Similarly, Specific Target Elder Abuse Attitudes and Intentions correlated more highly than Specific Target Elder Abuse Attitudes and Behaviors.

**Hypothesis V**

Hypothesis V predicted that, at pretest, specificity of elder abuse target would affect tolerance for and behavioral intentions of elder abuse. A general older target (older people) was expected to elicit more tolerance for and greater behavioral intentions of abuse than was a specific older target (grandparent).

T-tests were performed between General and Specific Target Elder Abuse Attitudes and between General and Specific Target Elder Abuse Intentions at pretest. As predicted, General Target Elder Abuse Attitudes were significantly lower than Specific Target Elder Abuse Attitudes, $t = -4.30$, $p < .001$, as shown in Table I-15 (Appendix I). This finding indicates more general than specific target tolerance for elder abuse and provides support for Hypothesis V.

Also as predicted, General Target Elder Abuse Intentions were significantly lower than Specific Target Elder Abuse Intentions, $t = -10.40$, $p < .001$, as shown in
Table I-15 (Appendix I). This finding indicates more general than specific target elder abuse behavioral intentions and provides further support for Hypothesis V.

A T-test was also performed between General and Specific Target Elder Abuse Behaviors. As shown in Table I-15 (Appendix I), General Target Elder Abuse Behaviors were significantly lower than Specific Target Elder Abuse Behaviors, $t = -13.29, p < .001$. This finding indicates more general than specific target elder abuse past behaviors.

Additional Findings

In addition to the above analyses dictated by the hypotheses, the MANOVA yielded a significant main effect for Time of Measurement (pretest and posttest) at the multivariate level, $F (8,210) = 66.81, p < .001$, as shown in Table I-16 (Appendix I).

When social desirability and credibility/expectancy were used as covariates, similar multivariate and univariate results were found. Scores at posttest increased relative to pretest on Kogan's Attitude toward Old People Scale, Specific Target Elder Abuse Attitudes, and Specific Target Elder Abuse Behaviors, as seen in Table I-17 (Appendix I). In order, increased scores on these measures indicate more positive attitudes toward older people, less tolerance for specific target elder abuse, and
fewer reported past behaviors of specific target elder abuse.

Scores at posttest decreased relative to pretest on General Target Elder Abuse Intentions and General Target Elder Abuse Behaviors, as seen in Table I-17 (Appendix I). Decreased scores on these measures indicate greater general target behavioral intentions and reported past behaviors.

In addition to the Time of Measurement finding stated above, pretest analysis indicated that two demographic variables, "parents' marital status," and "paternal grandfather alive or deceased," were significant by History of Experienced Childhood Violence, as seen in Table I-18 (Appendix I). High Experienced Violence participants more frequently had divorced parents and deceased paternal grandfathers than did Low Experienced Violence participants. "Miles away from grandparent" and "relationship with maternal grandfather" approached significance by History of Experienced Childhood Violence. High Experienced Violence participants were further from their nearest grandparent and had more distant relationships with maternal grandfathers than did Low Experienced Violence participants. No demographic variable was significant by Treatment Group.

Followup Analyses

One hundred and twenty-nine students were retested one month after Treatment Group participation. Analyses
indicated attrition rate did not differ significantly by Treatment Group or History of Experienced Violence. Participants' age, sex, and amount of contact with older people were not related to attrition. Having divorced parents, a grandparent living with the family, or more frequent contact with grandparents was related to higher attrition (p < .01).

At followup, a main effect for Time of Measurement (pretest, posttest, and followup) was found, $F (16,488) = 19.15, p < .001$, as seen in Table I-19 (Appendix I). As shown in Table I-20 (Appendix I), on Kogan's Attitude toward Old People Scale, scores at posttest and followup were greater than those at pretest. Increased scores indicate increased positive attitudes toward older people. On Personal Anxiety toward Aging, scores at followup were also greater than at pretest, as shown in Table I-20 (Appendix I).

As shown in Table I-20 (Appendix I), on General Target Elder Abuse Intentions and Behaviors, scores at posttest and followup were significantly lower than those at pretest. Decreased scores on these measures indicate greater reported general target elder abuse intentions and behaviors.

At followup, there were no other significant interactions. A Treatment Group by Time of Measurement interaction that had been significant at posttest was no
longer significant at the multivariate level. As shown in Table I-21 (Appendix I), two dependent variables, General Target Elder Abuse Behaviors and Specific Target Elder Abuse Intentions, were significant at the univariate level. On these two variables, Elder Abuse Treatment Group was significantly higher than the other Treatment groups.
CHAPTER IV

DISCUSSION

Mixed support was found for the first three hypotheses. Hypothesis I, which predicted History of Experienced Childhood Violence differences at pretest, and Hypothesis Ia, which predicted a main effect for History of Experienced Childhood Violence, were not supported by the results. Utilizing alternative variables to assess History of Violence, however, did yield support for these hypotheses. Hypothesis II, which predicted a Treatment Group by Time of Measurement interaction, was partially supported by the finding that exposure to the Elder Abuse Treatment reduced tolerance and behavioral intentions of elder abuse; however, no support was found for the prediction that exposure to the Aging Treatment would also reduce tolerance and behavioral intentions of elder abuse. Hypothesis III predicted a Treatment Group by History of Experienced Childhood Violence by Time of Measurement interaction; no support was found for this hypothesis.

Hypotheses IV and V, which dealt with attitude and target specificity, were supported by the results. Hypothesis IV, which predicted that elder abuse attitudes would correlate more strongly with both elder abuse
intentions and past behaviors than with global attitudes toward aging, was supported. Hypothesis V, which predicted that a general level of an older person target would elicit more tolerance and greater behavioral intentions of elder abuse than would a specific target, was also supported by the results.

Hypotheses I and III: History of Experienced Childhood Violence

Hypothesis I predicted that, prior to any type of experimental treatment, experienced childhood violence would affect tolerance, behavioral intentions, and reported past behaviors of elder abuse. According to this hypothesis, students with greater experienced childhood violence would have more tolerance, intentions, and reported behaviors of elder abuse than would students with less experienced childhood abuse. This prediction was not supported by the results.

Hypothesis III further predicted that elder abuse tolerance and behavioral intentions manifested by students with greater experienced childhood abuse would be difficult to change relative to those held by students with less experienced childhood abuse. These variables, however, would be more likely to change with exposure to Elder Abuse or Aging Treatment than with exposure to either of the two control treatments, Family or Pretest-Posttest Only. As with Hypothesis I, Hypothesis III was not supported by the
results. Theoretical and methodological considerations may help to explain the lack of significant results regarding History of Experienced Childhood Violence.

Theoretical considerations. First, it may be that a cycle of violence, similar to that for child and marital violence, simply does not occur in elder abuse. That is, experienced childhood abuse may not relate to the mistreatment of older people. Other theories of elder abuse, such as familial stress or dysfunctional family systems, may be more predictive of harmful behaviors than the degree of experienced abuse. Prior research (Chen et al., 1981; Costa, 1984) supports the role of familial stress in elder abuse.

Although no significant differences between Experienced Violence groups were found either before or after intervention, trends in the data presented in Tables 5 through 8 seem to suggest differences between High and Low Experienced Violence groups. For example, in three of the four Treatment Groups, the High Experienced Violence means were in the expected direction (e.g., more tolerance of abuse than Low Experienced Violence) for the majority of elder abuse subscales.

One possible explanation is that experienced childhood abuse plays a role in the etiology of elder abuse, but becomes significant only when combined with another factor. Perhaps such factors serve as mediating variables that link
childhood experience with existing elder abuse attitudes and behavioral intentions. As others note, (e.g., O'Rourke, cited in Giordano & Giordano 1981), it is possible that domestic violence toward older people results from an interaction of several factors or dynamics, only one of which may be experienced abuse.

Compared with the cycle of violence theory, a life-span developmental theoretical approach to domestic elder abuse supports a multidimensional or multicausal as opposed to a unidimensional basis for behavior (Baltes & Danish, 1980). Consistent with this theory is the notion that experienced childhood abuse plays an interactive or mediating rather than a directly causal role for reported abusive behavior later in life. In this light, Steinmetz's figures (cited in Giordano & Giordano, 1984) that one in two abused children abuse their parents in later life, as compared to one in four hundred nonabused children, may be misleading in that experienced childhood abuse may have an indirect, as opposed to a directly causal effect on maltreatment of elderly parents. The effects of experienced childhood abuse may be mediated, for example, by aging related physical changes in either the elderly individual or his or her caregiver.

In this light, it is possible that a propensity for violent behavior lies dormant and is not behaviorally realized until a stressful period arises (for example, the
sudden illness of an aging parent), thereby releasing predispositions toward violence. In this case, greater behavioral intentions of elder abuse would exist for High Experienced Violence individuals only if they simultaneously experience situational stress. O'Rourke's finding (cited in Giordano & Giordano, 1984) that two-thirds of caregivers of older parents report exhaustion, anxiety, and decreased health highlights the possible role that stress may play in provoking maladaptive behaviors. Along these lines, it would be interesting to test the cycle of violence theory in conjunction with another major theory, such as familial stress. A life stress index could be given in combination with a survey of violent behaviors in order to assess their interaction on tolerance and behavioral intentions of elder abuse.

A second theoretical issue concerning the nonsignificant History of Experienced Childhood Violence findings involves specific versus generalized modeling (Kalmuss, 1984). In child abuse, both specific modeling (children observe their parents mistreat any child in the family) and generalized modeling (children observe their parents mistreat any member of the family) operate. The influence of both specific and generalized modeling may help explain the striking incidence of abused children who go on to harm their own children. In other forms of domestic violence, however, one type of modeling may be
more influential than the other. In marital violence, for example, specific modeling increases the incidence of severe marital violence more so than does generalized modeling (Kalmuss, 1984). Specific modeling of elder abuse, the observation of one's parents mistreating one's grandparents, may also be a stronger predictor of elder abuse than generalized modeling.

It is probable that different dynamics of generalized versus specific modeling of elder abuse result in differing attitudes, intentions, and behaviors of elder abuse. In specific modeling, observation of elder abuse may relate to denial of harm (Beck & Ferguson, 1981) and a "normalizing" of violence. Children who observe parents neglect or abuse older relatives may view older relatives as suitable scapegoats; children may experience relief that they, themselves, are not objects of abuse. Observation may then lead to future elder abuse through generalization to a legitimization of victimizing older relatives, as opposed to learning to solve problems through violence as some suggest (Finklehor et al., 1983; Lau & Kosberg, 1979).

In this study, students were asked to rate abuse they personally experienced from parents—an example of generalized modeling. No support was found for any causal effects of this form of generalized modeling on later mistreatment of older people. Effects of specific modeling, however, were not investigated. If the dynamics
of specific modeling (e.g., scapegoating) operate as causal factors for elder abuse, this would explain the nonsignificant History of Experienced Violence findings. Compared with children who witness elder abuse, children who experience high abuse personally can perhaps identify with or have empathy for vulnerable, frail, or sick older people. This might render abuse of that relative less likely, and lead to less tolerance and fewer behavioral intentions of elder abuse.

Because the current study only assessed the impact of receiving abuse in childhood on elder abuse, it would be premature to rule out the impact of other forms of domestic violence. This study failed to implicate experienced childhood abuse as a predictor for exhibiting elder abuse behavior. However, other types or combination of types of generalized modeling, such as spouse abuse or sibling abuse, may play some role in fostering elder abuse.

Furthermore, as Marshall (in press) notes, research on domestic violence, including the current study, has often failed to take into account the effect of the recipient's or the abuser's gender on the impact of the violence. Given the finding that physically impaired older females are the most frequent victims of elder abuse (Giordano & Giordano, 1984), there may be interactions between the gender of both the victim and the abuser on the one hand, and the form of domestic violence on the other.
In summary, it seems evident that types of modeling that have not been empirically examined could produce different potentials for abuse. Perhaps history of violence effects are particular to specific modeling, other forms of domestic violence, or interactions of modeling with sex of recipient and abuser. These questions could be examined in further research.

**Methodological considerations.** It is possible that the measurement of the history of violence variable, as originally defined, was invalid, thus contributing to nonsignificant findings in this study. In order to quantify domestic violence, History of Experienced Childhood Violence was defined by a median split on the Adaptation of the Severity of Violence Against Women Scale. For the purposes of this study, the scale asked students to acknowledge specific acts of symbolic and actual physical and sexual aggression received by them from parents (or stepparents or guardians) in the past or present.

As with any self-report measure, particularly those with emotionally laden content (such as the Severity of Violence Against Women Scale), the data derived from this scale may not correspond to actual events. That is, physical, sexual, and symbolic abuse may have been either under or overreported. Unconscious or conscious reasons may have prompted less than accurate reporting of childhood events. Unconsciously, students may have repressed
painful, noxious childhood events, and thus may have been unable to give an accurate history of these events.

As an example of a conscious reason, students may not have been assured, or may not have felt secure, about experimental confidentiality and anonymity. Therefore, they may not have admitted to experienced abusive events. While students were told that results would be anonymous and confidential, it was not possible to completely rule out the influence of biased self-report. If students were concerned about anonymity, however, a socially desirable response bias may have influenced their Severity of Violence reports. No such relationship was found, however.

Additionally, in the same sample, measures of personally performed violence (General and Specific Target Elder Abuse Behaviors) were apparently unaffected or less affected by self-report biases as these measures effectively differentiated High and Low Experienced Violence students. Nevertheless, self-report biases may have been specific to childhood abuse. Therefore, it is feasible that inaccurate reporting of true experienced childhood abuse may have occurred, thus invalidating the results.

The issues raised above concerning validity of self report are common to other, similar measures. One other validity concern is particular to the use of the Severity
of Violence Scale. Prior to the current study, this scale had not been used to measure experienced childhood abuse.

Although further research with this instrument is needed, recent data suggest that the Severity of Violence Against Women Scale was grossly valid for the purposes of the current study. Using this scale, incidence rates of male violence against women were found (Ee, Blond, & Marshall, 1990) that differed from each other and were in line with incidence estimates found in research using alternate measures to tap these variables. These findings indicate that the scale can differentiate at least one form of violence. Additionally, the content of the Severity of Violence Scale is fairly comparable to other measures of familial violence. Furthermore, the range of responses on this scale found in the present study was broad (52 to 174). Finally, only one violent act (out of 52) was not acknowledged as having been received by any participant.

To sum up the lack of positive History of Experienced Childhood Violence findings, the theoretical and methodological considerations discussed above may help account for the nonsignificant results. Although it is possible that a cycle of violence similar to one proposed for child abuse is not present in elder abuse, the topic merits further exploration, particularly in combination with other theoretical models of violence.
**General and Specific Target Elder Abuse Behaviors as Independent Variables**

In contrast to the findings when History of Violence was defined as experienced abuse, when it was alternatively defined as performance of elder abuse, differences between High and Low Expressed Violence groups were found on tolerance and behavioral intentions of elder abuse prior to any intervention. Although not precisely consistent with the prediction of Hypothesis I, these findings support the general hypothesis that these domains are related to some form of past participatory violence.

Moreover, when History of Violence was defined in the same manner (performance of elder abuse), differences between High and Low violence remained after intervention. These results indicate that students who exhibited higher degrees of elder abusive behaviors were more resistant to educational treatment. These findings support the general hypothesis that history of violence mitigates the effectiveness of interventions designed to impact attitudes toward elder abuse.

As previously mentioned with regard to the specific versus generalized model of cycle of violence, these results suggest that, when evaluating the impact of violence on abusive attitudes and intentions, elder abuse behaviors should be addressed. The format of the scale used for the purposes of the current study, however,
precludes any definite conclusions about the role of other forms of domestic violence. It may be that past behavior of performed violence toward any target at all is also predictive of tolerance and behavioral intentions of elder abuse. The students were not asked about history regarding other performed domestic violence, e.g., sibling violence. This should be one avenue of research in further studies on the role of the past violence in elder abuse.

That abusive behavior predicted more approval of violence is consistent with Ulbrich and Huber's (1981) finding that parental aggression was related to acceptance of violence against women. Also, the notion that violence against elderly people may seldom be an isolated incidence is suggested by the finding that future intentions were related to past behavior. This is further supported by the high recidivism rate in other forms of domestic violence (e.g., Demaris & Jackson, 1987). One expects people with a history of violence to intend more future abuse than people who were never violent. It is also reasonable to expect that people who were more rather than less hurtful to older people in the past will be more tolerant of violence. Conceivably, this is defensive in nature. If one condones elder abuse, it makes one's own past violence more acceptable.
Hypothesis II: Treatment Group by Time of Measurement Interaction

Partial support was found for Hypothesis II, which predicted that different educational interventions would have different effects on tolerance and behavioral intentions of abuse. Specifically, Hypothesis II predicted that Elder Abuse Treatment would be more effective than Aging Treatment, both of which would be more effective than two control groups in terms of changing tolerance and behavioral intentions of elder abuse. As predicted, a Treatment Group by Time of Measurement effect was found. The results of this interaction indicated that the Elder Abuse Treatment reduced tendencies toward elder abuse more effectively than did the treatments of the Aging or two control groups. General Target Elder Abuse Intentions, however, were not reduced by the Elder Abuse group.

The prediction that the Aging Treatment would be more effective than the two control group treatments in reducing tolerance and behavioral intentions of elder abuse was not supported. Thus, these data did not support general aging education as a means of changing tolerance or behavioral intentions of elder abuse. Instead, only an intervention that included specific information on elder abuse reduced these tendencies.

**Elder Abuse Treatment Group findings.** Participation in an intervention containing elder abuse education
effectively reduced tolerance and behavioral intentions of elder abuse. This is in contrast to previous findings by Reinberg and Hayslip (1988), which found no effect for an elder abuse/aging educational intervention.

Several differences between the current and prior study may have contributed to the Elder Abuse Treatment efficacy. First, the current sample was younger, with a mean age of 19.7, compared to the previous mean age of 24. As a group, younger students have had fewer years to be exposed to older people. Additionally, the scores of the current sample were lower than those of the previous sample on Palmore's Facts on Aging Quiz (10.8 compared with 15 out of 25 questions correct), indicating less knowledge about aging. Furthermore, the scores of the current sample were lower than those of the previous sample on Kogan's Attitudes toward Older People Scale (10.8 compared with 12 out of 16 positive responses), indicating fewer positive attitudes toward older people prior to experimental treatment.

As Reinberg and Hayslip (1988) suggested, relative naivete with respect to knowledge of aging is expected to mediate intervention efficacy; students who are naive, in contrast with those who are knowledgeable, are expected to make greater gains. Therefore, it is possible that the present Elder Abuse Treatment was more effective than was
Reinberg and Hayslip's (1988) treatment because the current sample had more to gain from such education.

Perhaps more importantly, the current study used a dismantling strategy (Kazdin & Wilcoxon, 1976) to separate possible confounding effects of elder abuse and aging education. In light of the current findings that the Aging Treatment was not better than control treatments in terms of changing attitudes or behavioral intentions of abuse, one can assume that, in a younger, less educated college population, elder abuse information is both necessary and sufficient for changing these aspects of domestic elder abuse.

Baltes and Danish (1980) recommended primary prevention for problems related to aging. That is, they recommended increasing knowledge about an aging-related problem before people are older, stressing that education about aging should be provided at all points in the lifespan. The hypothesized effectiveness of primary prevention is based on the theory that education about a potential problem before it occurs minimizes the likelihood that the problem will in fact occur (Danish, Smyer & Novak, 1980). Education was used successfully as an intervention strategy with families at risk for other forms of domestic violence (Wolfe, Edwards, Manion, & Koverola, 1988).

In the current study, the model of primary prevention was applied to the problem of elder abuse. This model
suggests that providing education about elder abuse reduces the risk that such abuse will occur. On the basis of the present findings, people exposed to the Elder Abuse Treatment, in contrast with the other treatments, would be expected to have less incidence of expressed violence toward older people throughout the participants' lifetimes. To establish this, longitudinal studies are needed.

In order to demonstrate that the application of a primary prevention model can be effective, it must first be established that participants actually learn the target material. That tolerance and behavioral intentions of abuse were reduced only in the Elder Abuse Treatment Group, and were unchanged in the other Treatment Groups, suggests that learning occurred only through elder abuse education. Thus, according to this model, only participants who gained this specific knowledge would be less inclined to engage in elder abuse behaviors. Although it appears that gerontological education effectively changes global attitudes toward older people and aging (e.g., Anderson, 1980), it is evidently not an effective strategy as a primary prevention of elder abuse.

There was no Treatment Group by Time of Measurement interaction for General Target Elder Abuse Intentions. This indicates that this dependent variable was not effectively impacted by elder abuse education. This may be partially explained by the findings supporting
Hypothesis V: there were more behavioral intentions of abuse for general than for specific targets. Thus, it appears that the nature of the target was a mediating variable for behavioral intentions of elder abuse, influencing the effectiveness of the Elder Abuse Treatment.

Previous findings (Luszcz, 1985-86) supported the conclusion that general target intentions are based on stereotypical information about older people. However, one might then expect level of target to serve as a mediating variable for elder abuse attitudes, such that little change through intervention would occur. The finding of the present study that elder abuse education reduced General Target Elder Abuse Attitudes suggests that tolerance of violence is easier to acknowledge, even toward general targets, because there is no behavioral commitment. Thus, it may be easier to change one's tolerance level than one's intentions, because tolerance of actual abusive behavior requires fewer responsibilities.

One interesting and unexpected finding is that General Elder Abuse Behaviors changed significantly with elder abuse education. This is puzzling for two reasons. First, the questionnaire was written to elicit past behaviors that were not expected to change. One likely explanation for the apparent but confusing increase in reported abusive behaviors can be offered by the possibility that, as a function of testing, all participants became more aware of
violence they had performed. Upon posttest, they gave more accurate reports of past abusive behaviors. Alternatively, as they became more aware of what constitutes harmful behaviors toward older people, they became more liberal in judging their own past behaviors as abusive.

All groups reported more past behaviors of abuse at posttest. The Elder Abuse group, however, reported fewer past abusive behaviors at posttest than did the other groups. Thus, the other confusing piece of this interaction is that one would expect increased information about elder abuse to promote more sensitivity and knowledge about behaviors constituting abuse compared with treatment that did not include elder abuse education. Perhaps what occurred was a combination of increased awareness of past abuse and a reaction to its disturbing implications. Within the Elder Abuse Treatment, value judgements were made about elder abuse and neglect: the students were told that these were detrimental to the wellbeing of older people, and therefore wrong. While this may not have unconditionally affected their candidness, it understandably may have tempered their willingness to admit to previous neglect or abuse. Thus, elder abuse information may have provoked defensiveness about reporting past behaviors.

**Aging Treatment Group findings.** While it was not expected that the Aging Treatment would have been as
effective as the Elder Abuse Treatment for altering tolerance and behavioral intentions of elder abuse, it was predicted that it would be more effective than either of the two control treatments. The results did not support the prediction. Thus, only an intervention containing specific information about elder abuse caused change to occur. As was pointed out previously, there is an emphasis in the gerontological intervention literature on changing global attitudes toward aging with the underlying assumption that this change affects behaviors toward older people. The current results call into question this underlying assumption and suggest that gerontological interventions geared toward elder abuse are needed for the minimization of elder abuse behaviors.

At posttest, Aging Treatment Group participants were significantly more anxious toward personal aging than were participants in all other Treatment Groups. Therefore, it is possible that increased aging anxiety interfered with the efficacy of aging education for reducing elder abuse tolerance and intentions.

Other studies (e.g., Houlihan, 1985) also found that anxiety increased after aging education. In Houlihan's study, increased anxiety did not interfere with intervention effectiveness; however, the target of change in her study was global attitudes toward older people. Attitudes toward elder abuse were not assessed as they were
in the present study. Perhaps aging anxiety only interferes with intervention effectiveness when the attitude target is domestic elder abuse.

As noted previously, the type of intervention used in gerontological education--experiential (e.g., contact with older people, group participation) versus didactic (e.g., lecture)--may also impact on intervention efficacy. In the current study, the causal factor in the Aging Treatment's ineffectiveness may have been specific to these components. It was impossible, however, to partial out the effects of the format of intervention in this study because they were confounded; the Aging intervention used aspects of each type.

In reevaluating the content of the Aging intervention for possible causes of increased aging anxiety, the author found that negative information about older people was elicited in experimental participants during a discussion about stereotypes. This negative material may have decreased potential benefits from the intervention. Although other interventions utilized discussion on stereotypes with good results (e.g., Murphy-Russell et al., 1986; Riddick, 1985), the dimension of change was typically global attitudes toward, or knowledge about, aging. Knowledge change requires minimal commitment, one might therefore expect these interventions to be efficacious. Discussing aging stereotypes, even in the context of
education, may specifically affect elder abuse attitudes and intentions, rather than global attitudes, through increased anxiety. Alternatively, aspects of the present Aging intervention other than discussion (e.g., ineffective film; content failed to hold participants attention) may have been responsible for the lack of significant Aging Treatment Group findings.

**Time of Measurement (Pretest and Posttest)**

A significant Time of Measurement effect was found at the multivariate level. This significant effect was particular to several dependent variables: Kogan's Attitudes toward Old People Scale, General and Specific Target Elder Abuse Behaviors, Specific Target Elder Abuse Attitudes, and General Target Elder Abuse Intentions.

First, on Kogan's Attitudes toward Old People Scale, scores increased at posttest. This finding indicates an increase in positive attitudes toward older people over time, and is in contrast to Reinberg and Hayslip's (1988) results in which positive attitudes toward older people decreased over time. In that study, a regression toward the mean was the most likely explanation due to more extreme positive initial attitudes (12 out of a possible 16 positive attitudes statements). The fact that the current sample, when compared with the prior sample, was younger, more naive with respect to aging, and less positive toward older people at pretest, suggests that the current sample
may have been more susceptible and vulnerable to the influences of testing. Perhaps students did not have the opportunity to examine or express their feelings about older people prior to participation in the current study. These factors, combined with the finding that students became more positive over time regardless of Treatment Group, suggest that a testing effect occurred. A contrast between a pretest-posttest only group with a posttest only group would help to support or disprove this explanation.

Next, Specific and General Target Elder Abuse Behaviors had dissimilar Time of Measurement effects. Specific Target Elder Abuse Behaviors increased at posttest, indicating fewer reported past abusive behaviors toward grandparents. General Target Elder Abuse Behaviors, on the other hand, decreased at posttest, indicating greater reported past abusive behaviors toward general older people.

As was discussed previously, what probably occurred was a testing effect. As a function of being asked to respond to performed acts of violence, participants may have become more aware of their own potential for abuse. Upon posttest, awareness of one's own abuse may have altered responses.

While the different results for grandparents and older people appear contradictory, they were consistent with past research on general versus specific older targets.
Different response patterns are demonstrated when the target is specific and known versus when the target is general older people (e.g., Luszcz, 1985-86; Sanders & Pittman, 1988).

In the present study, students may have reported more abusive behaviors toward general targets because the higher degree of anonymity in "older people in general," as compared to "grandparent," provided more safety. A diffusion of responsibility may have occurred, such that students felt less responsibility for actions regarding older people in general, while feeling more responsibility or guilt for behaviors directed toward grandparents. Consequently, fewer abusive behaviors were reported for grandparents at posttest.

Next, the Time of Measurement effect on Specific Target Elder Abuse Attitudes indicated less tolerance of abuse toward grandparents at posttest than at pretest. Again, as a function of testing, participants probably became aware of violence affecting their grandparents and, as a result, attitudes of abuse became less tolerant. That tolerance for general targets was not reduced provides further support for the differential responding to general versus specific targets.

Finally, the results regarding General Target Elder Abuse Intentions at posttest indicated greater intentions of abuse toward older people than at pretest. It should be
recalled that, within the Elder Abuse Treatment Group, only General Target Elder Abuse Intentions were not significantly affected. That there were fewer intentions toward specific targets supports the previous suggestion that level of target is a mediating variable with regard to behavioral intentions of abuse. These findings also support Schmidt and Boland's (1988) suggestion that different behaviors may be directed to people who represent different stereotypes.

**Followup Findings**

One month after taking part in Treatment Groups, participants were retested to evaluate stability of treatment efficacy. The multivariate Treatment by Time of Measurement interaction, which had been significant at posttest, was no longer significant. The effectiveness of the Elder Abuse Treatment weakened with time. Possible explanations include inadequate strength of the intervention, the self-selection bias, a possible artifactual nature of the initial Treatment by Group interaction, history effects, and societal influences.

**Treatment by Time of Measurement Interaction for followup.** One explanation for nonsignificant findings at followup is that, while elder abuse education was sufficient for initially altering attitudes and intentions of elder abuse, it was simply not strong enough to have lasting effects. Lack of enduring effects may be due to
the content, length, or format of the Elder Abuse Treatment Group (see Appendix G). Perhaps using older people or elder abusers themselves as part of the intervention would have produced more robust effects.

One intervention, which provided elder abuse education to a high school sample, did have enduring effects (Peterson et al., 1986). Similar results were found with a college sample. The followup period, however, was one week, compared with the one month followup period in the current study. Additionally, the followup survey in the Peterson et al. (1986) study used different dimensions to evaluate effectiveness of the intervention, including enjoyment of presentation, knowledge and attitude change, and identification of helping behavioral intentions. Neither elder abuse tolerance nor behavioral intentions of abuse were measured. To determine effectiveness of different intervention formats, it would be helpful to measure tolerance and behavioral intentions of elder abuse.

A second explanation for nonsignificant Followup Treatment Group by Time of Measurement effects is a self-selection bias. It is possible that students who were influenced by elder abuse education and maintained altered attitudes and intentions of elder abuse did not return for followup, while students who did not maintain altered elder abuse attitudes and intentions did return. Although this seems unlikely, attrition rates were higher for students
who had more frequent contact with grandparents, a
grandparent living at home, and consequently more
opportunity for elder abuse. Thus, perhaps these students
benefitted proportionately more from the initial
intervention, and felt they did not require followup
evaluation and debriefing.

Another possible explanation for nonsignificant
Treatment Group by Time of Measurement interaction at
followup is that the interaction found at posttest may have
been an artifact, an interaction between pretest
sensitization and the Elder Abuse education. Experimental
demand characteristics may have contributed to the posttest
change in these participants because the treatment was
overtly related to the variables being measured. The Elder
Abuse group was the only Treatment Group that discussed
issues specifically related to domestic elder abuse.
Discussing elder abuse probably did increase awareness of
the desired responses, as was intended. Students who were
uninformed with respect to elder abuse issues were educated
about appropriate versus inappropriate behavior.

While desirable scale responses were, of course, not
provided, the general trend of desirable responses was
probably implied by the nature of the elder abuse
intervention. It was expected that providing information
about the consequences of elder abuse would not only
educate students, but would also alter their attitudes and
intentions. Perhaps, however, immediate change was related to retesting because participants were confronted with feelings related to their own grandparents. Valid attitude change may not have occurred.

Even if attitude change was genuine, history may have mediated such change. Thus, a fourth explanation for the lack of significant Treatment Group findings at followup is history effects (Campbell & Stanley, 1963). Experiences may have occurred between the posttest and followup such that tolerance and intentions of elder abuse, previously altered by the intervention, may have changed once again. Negatively portrayed older people depicted on television, conflict with parents or grandparents, or other events may have undermined previous positive gains from the Elder Abuse Treatment. Although one expects that history effects would impact other Treatment Groups similarly, Elder Abuse Treatment Group participants may have been particularly susceptible to history effects as a function of increased exposure to the topic of elder abuse.

A final explanation for the lack of significant followup findings, somewhat related to history effects, has to do with societal influences. Other studies on gerontological interventions (e.g., Miko, 1987) also found no long term effects after initial positive change on general attitudes toward older people. This raises the question of how attitudes about elder abuse develop and are
maintained. Generally, attitudes are learned through society and its influences, such as the family or peers. Elder abuse attitudes also probably form from these sources, and perhaps specifically derive from attitudes toward older people and attitudes toward violence.

Perhaps attitudes related to elder abuse did not have long term effects in the present study because they were not supported or reinforced by the culture or the family. Although immediate positive changes were found, they may have been context-specific to the setting that supported change, i.e., the Elder Abuse Treatment Group. Once participants completed the study, they returned to the environment that fostered the continuation of their initial attitudes toward elder abuse.

Many studies have demonstrated the presence of negative attitudes toward older people in divergent populations, from health care workers (Baker, 1984) to older people themselves (Bassili & Reil, 1981). Moreover, the American culture tends to promote and glorify violence and also supports domestic violence as a legitimate form of discipline and control (Straus et al. 1980). It is, therefore, perhaps not surprising that any change in attitudes toward elder abuse was not stable after one month. It would be advantageous, therefore, for recipients of elder abuse education to have periodic "booster sessions" to increase the long-term effectiveness of this
type of intervention. Additionally, as Booken and Dunkle (1985) pointed out, attitudes that lead to the maltreatment of older people may need to be modified at the community as well as the individual level for interventions to have more lasting effects.

It is not possible to conclude definitively which one of the above explanations led to nonsignificant followup effects in the current study. In light of the profusion of studies demonstrating the presence of ageism, it is plausible to say that society, as a whole, does not support such attitude changes. Given that few interventions have focused on altering elder abuse attitudes and behavioral intentions, it is probably premature to rule out the possibility that other interventions may have enduring effects. Research utilizing different formats of interventions would be useful to determine the durability of elder abuse attitude and behavioral intention change.

**Time of measurement (pretest, posttest, and followup).** A Time of Measurement main effect did remain significant at the multivariate level at followup. At the univariate level, a Time of Measurement effect was significant at followup for several dependent variables: Kogan's Attitude toward Old People Scale, Personal Anxiety toward Aging, and General Target Elder Abuse Intentions and Behaviors. Across time, attitudes toward older people become more positive and participants became less anxious toward aging,
and there were greater general target abusive intentions and reported behaviors.

For the most part, followup findings indicated stability with respect to comparisons at posttest. The Time of Measurement (pretest and posttest) effect for Kogan's Attitudes toward Old People Scale remained significant at followup. That this sample became more positive at posttest, and then remained more positive at followup, reinforces the previously discussed interpretation that a testing effect occurred. It supports the conclusion that, as a function of students' youth, naivete with respect to aging, and relatively less positive attitudes compared with a prior sample at pretest (Reinberg & Hayslip, 1988), participants were susceptible to influences of testing. That testing itself apparently served to increase positive attitudes toward older people suggests that minimal intervention is necessary to increase positive global attitudes. This is in contrast to the specific elder abuse education required to reduce elder abuse tolerance and intentions.

On the Personal Anxiety toward Aging measure, students were less anxious about aging at followup, as compared with pretest. When the original 225 participants were tested, only Aging Treatment Group participants were more anxious at posttest than at pretest; other Treatment Groups had less anxiety. Perhaps those Aging participants who became
anxious after intervention were the ones who did not attend the followup session. Alternatively, anxiety may have been context-specific (e.g., related to negative stereotype discussion) and therefore temporary. Positive attitudes toward older people that remained positive over a month may additionally have helped to reduce aging anxiety.

Finally, on General Target Elder Abuse Intentions and Behaviors, posttest and followup scores, as compared with pretest scores, indicated greater behavioral intentions and reported past behaviors of abuse toward old people in general. Once again, Specific and General Target scales were affected differently, as no Time of Measurement effects were obtained for specific targets. This reinforces the conclusion that differential response patterns occur for general and specific older people; this is discussed further below.

Although the increased intentions of abuse for older people at followup raises concern, this finding did not differ by Treatment Group, and no increased intentions occurred regarding for violence toward grandparents. Therefore, it seems possible that, as a function of testing, students became desensitized to elder abuse directed toward old people in general. They were repeatedly exposed to various types of violent behaviors on the Elder Abuse Attitudes and Behavioral Intentions Scale. This may have served to normalize the abuse and
consequently, to increase intentions toward general older people. That the known target was grandparents may have mediated any normalization, such that students were not desensitized to specific target abuse. Perhaps insufficient information about this form of domestic violence in the context of exposure to elder abuse behaviors does normalize elder abuse.

After the followup session, students were given information about elder abuse (Appendix H), the chance to ask any questions they had about the study, and the opportunity to gain further education about elder abuse. It is hoped that these measures adequately reduced any increased behavioral intentions of abuse toward older people.

Hypothesis IV: Attitude Specificity

Hypotheses I through III focused on History of Experienced Childhood Violence and the effectiveness of the Treatment Groups. The focus of the remaining two hypotheses, Hypotheses IV and V, addressed somewhat different problems. These two hypotheses dealt with specificity of measures in the attitude-behavior relationship and specificity of target of attitudinal measures.

With regard to Hypothesis IV, specificity of attitudes in the attitude-behavior relationship was examined. Specific attitude measures (elder abuse attitudes) were
expected to relate more closely to intentions and behaviors than were global attitudes (toward aging and anxiety). This was supported by the findings.

In this study, elder abuse attitudes were associated more strongly with elder abuse intentions and behaviors than were global aging attitudes. Global attitudes toward old people and personal anxiety about aging were not significantly related to elder abuse behaviors and intentions. The findings of this study suggest that the measurement of global attitudes is not as useful for studying elder abuse as the measurement of specific attitudes because global attitudes may not link with specific behaviors.

The results indicate that, if one wants to assess elder abuse intentions and behaviors, it is irrelevant to target global aging attitudes as the index of change because they are poorly related to intentions and behaviors of elder abuse. One should exercise caution when interpreting the effects of global attitudes on behaviors toward older people. At least with regard to elder abuse, it seems that specific attitudes are better indicators of abusive behavioral intentions and behaviors than are global attitudes.

Global measures, especially global attitudes toward older people, are frequently used in gerontological studies on attitudes as the target of change after intervention
(e.g., Murphy-Russell et al., 1986; Riddick, 1985). The current findings, however, support the criticisms of some researchers (Ajzen, 1987; Ajzen & Fishbein, 1977; Kahuna & Kiyak, 1984) who suggest that the attitude-behavior relationship is meaningful only when the dimensions are assessed across the same level of specificity. In this study, the measurement specificity problem is handled by relating attitudes toward a particular issue regarding aging with intentions and acts related to this issue.

The relationship between elder abuse attitudes and behavioral intentions was stronger than the relationship between such attitudes and past behaviors. Thus, mediating variables probably interacted with attitudes to predict actual behaviors. Opportunity to perform the behaviors is one possible mediating variable. Although one may hold attitudes that condone domestic violence, if one does not encounter a situation in which such acts might be performed (such as very little contact with grandparent), then a weaker relationship between attitudes and behaviors exists.

**Hypothesis V: Target Specificity**

The final hypothesis, Hypothesis V was also supported by the results of the study. Level of target of older person, general versus target, affected tolerance and behavioral intentions of elder abuse. A general target elicited more tolerance and behavioral intentions of abuse than did a specific older target.
As previously suggested, level of target seems to be a mediating variable with regard to elder abuse. Elder abuse was tolerated more when general "older people" rather than specific older people (i.e., grandparents), were the target. Perhaps in this case, as some researchers have suggested (Green, 1981; Luszcz, 1985-86), more tolerance and behavioral intentions of elder abuse existed with generalized older people than with grandparents, because students were forced to rely more on negative, stereotypical information.

When asked to respond in relation to their own grandparents, the stereotypes may have broken down because their grandparents did not match the generalized stereotype of older persons. Schmidt and Boland’s (1986) finding that multiple stereotypes exist for older people supports this conclusion. Thus, if students view older people in general as frail and helpless, they might see their own grandparents as strong and capable.

The extent to which the subject knows the target may also be a confounding variable. Braithwaite (1986) found that, when unknown but specific targets were used, participants still had negative stereotypes about the targets. However, grandparents may not be psychologically assigned to the stigmatized group to the same degree as other specific targets. Issues such as family loyalty and closeness to grandparents may minimize reported tolerance
and intentions. It would be interesting to use unknown but specific targets (e.g., nursing home residents) to further explore this possibility.

Conclusions

Overall, the results of the study imply that, in elder abuse, a distinct cycle of violence comparable to that proposed for other forms of domestic violence is not evident. This indicates not only that elder abuse may be qualitatively different from other forms of domestic violence, but also reinforces the importance of developing and researching theories specific to the cause and maintenance of elder abuse. Despite some similarities to child abuse, it is not sufficient to merely expand on child abuse theories. Further research in the field of elder abuse should explore the interaction of family violence theories, as well as propose new approaches to the study of elder abuse.

An initial contribution of this study lies in appreciating the value of elder abuse education as provided by primary preventative aspects of intervention. Specific education about the mistreatment of older people reduces tolerance and abusive behavioral intentions toward specific targets. This suggests that elder abuse rather than general information provided at the community level may promote even wider effects.
General gerontological intervention is not sufficient to promote changes in specific elder abuse attitude and behavioral intention change. For education to ultimately affect behaviors, the presumed goal of promoting attitude change, specific education should focus on the targeted attitude in aging research. General attitudes about aging are not related to specific attitudes about elder abuse or behavioral intentions of elder abuse; general aging information is not sufficient to promote change on these dimensions. Therefore, researchers in gerontology who wish to affect change in behaviors toward older people should first establish empirically that the targeted behavior change is related to general attitudes of aging. If not, they should gear intervention efforts to the specific target in order to positively effect the desired change.
INFORMED CONSENT FORM

TITLE OF STUDY: Domestic relations and family background
INVESTIGATORS: Bert Hayslip, Ph.D.; Julie Reinberg, M.A.

PURPOSE OF THE STUDY: The purpose of this study is to explore certain kinds of lifetime experiences and how these experiences affect attitudes toward older people. Also, the purpose of the study is to explore the effect of education on attitudes toward older people.

PROCEDURES: The participants will attend a session requiring approximately five hours. During this session, they will complete paper and pencil questionnaires and may participate in any of the following: listening to educational material, viewing a film, and group discussion. Participants will then fill out additional paper and pencil questionnaires. Approximately one month after the initial session, participants will complete additional questionnaires.

PLEASE---ONLY STUDENTS INTERESTED AND WILLING TO ATTEND BOTH SESSIONS OF THIS STUDY SHOULD PARTICIPATE.

SAFEGUARDS: The participant's answers will be kept completely confidential. Only first names and code numbers will be used. I am not interested in comparing responses of individuals, only in examining differences between groups.

Participation in this study is entirely voluntary, and you may end your participation at any time you desire. To the best of our knowledge, participation in this study will not cause physical or psychological harm.

BENEFITS: Participation in a study such as the present one provides a new experience for the individual. Such an experience may offer possibilities for continuing growth and development. In addition, the opportunity to learn about family relationships is present. This may add to the individual's emotional and social growth.

This study provides an opportunity to increase our understanding of familial relationships and older people. Potentially, this may be beneficial to both society in general and older people in particular as we learn more about this connection. More positive treatment toward older people is one possible outcome.

ADDITIONAL QUESTIONS: If you have further questions about your participation, feel free to contact Julie Reinberg at (214) 315-1017 or Bert Hayslip at (817) 565-2675.
INFORMED CONSENT FORM

TITLE OF STUDY: Domestic relations and family background
INVESTIGATORS: Bert Hayslip, Ph.D.; Julie Reinberg, M.A.

This is to certify that I ______________________ am
(your name)

participating as a volunteer in a scientific study as an
authorized part of the educational and research program of
the University of North Texas.

The investigation and my part in the investigation have
been defined and fully explained to me by Julie Reinberg,
and I understand her explanation. The procedures of this
investigation and their risks and discomforts have been
described in a separate statement, and are discussed in
detail.

I have been given an opportunity to ask whatever
questions I may have had, and all such questions and
inquiries have been answered to my satisfaction.

I understand that I may refuse to answer any question
in the questionnaires.

I understand that any data or answers to questions will
remain confidential and only group data will be reported.

I FURTHER UNDERSTAND THAT I AM FREE TO WITHDRAW MY
CONSENT AND TERMINATE MY PARTICIPATION AT ANY TIME.

__________________________  ________________________
(signature)  (date)
APPENDIX B

DEMOGRAPHIC QUESTIONNAIRE
CODE #

Please put your FIRST NAME ONLY and phone number where you can be reached in the space provided. If you would prefer to go by a code number, enter the number located on the upper right hand corner on this page in the space provided for your name.

In further contact with the investigator, only first names or code numbers will be used.

(name or code number)

(daytime phone number)

(evening phone number)

For each item, please enter in the space the number corresponding to each of the following items.

1. Age
   - 1. Male
   - 2. Female

2. Male = 1 Female = 2

3. Freshman = 1 Sophomore = 2

4. Single = 1
   Married, Separated, Divorced = 2

5. Both parents are alive = 1
   At least one parent deceased = 2

6. If parents both alive:
   Parents married = 1
   Parents divorced = 2

7. Combined family income last year:
   Under $5,000 = 1
   $5,000 - 15,000 = 2
   $15,000 - 25,000 = 3
   $25,000 - 35,000 = 4
   $35,000 - 50,000 = 5
   $50,000 - 75,000 = 6

8. Paternal grandfather alive = 1
   Paternal grandfather died = 2

9. Paternal grandmother alive = 1
   Paternal grandmother died = 2
10. Maternal grandfather alive = 1
   Maternal grandfather died = 2

11. Maternal grandmother alive = 1
    Maternal grandmother died = 2

12. If any grandparents are alive, how many miles away does the closest grandparent live to you or your family?
    Less than 10 miles = 1
    11-100 miles = 2
    101-500 miles = 3
    more than 500 miles = 4

13. If any grandparents are alive, are any living with you or your family?
    No grandparents living with you or your family = 1
    One or more grandparents living with family = 2

14. Any grandparents living in an institution?
    No grandparents living in an institution = 1
    One or more grandparents living with family = 2

For items 15 - 18, refer to below:
never knew = 1
very distant = 2
moderately distant = 3
neutral = 4
moderately close = 5
very close = 6

15. My relationship with my paternal grandfather is
16. My relationship with my paternal grandmother is
17 My relationship with my maternal grandfather is
18 My relationship with my maternal grandmother is

19. The amount of contact I have had with older people over the last year was:
    No contact = 0
    Contact once a year = 1
    Contact several times a year = 2
    Contact once a month = 3
    Contact once a week = 4
    Contact every day = 5

20. I have taken a course on Aging:
    Yes = 1      No = 2

21. I have worked with older people at a nursing home, retirement community, or other setting:
    Yes = 1      No = 2
APPENDIX C

ADAPTATION OF MARSHALL'S SEVERITY OF VIOLENCE SCALE
Adaptation of Marshall's Severity of Violence Scale

Family members interact with each other in many different ways. Even in the best of relationships, anger, frustration, disappointment, and tension are expressed. These feelings are often expressed in both verbal and nonverbal ways; however, our understanding of these expressions are quite limited. Much is still being learned about family interactions.

Please indicate degree of frequency you experienced each of the following items from a parent, step-parent, or legal guardian while you were growing up or are experiencing now from a parent, step-parent, or legal guardian. Indicate your answer by entering the number corresponding to your answer in the blank to the left of the item. For example, if one of your parents once threatened you with a weapon, you should enter a "2" in the blank to the left of the first question.

Please answer each question as honestly as possible. Remember, all answers are anonymous and kept confidential.

<table>
<thead>
<tr>
<th>Never</th>
<th>Once</th>
<th>Twice to several times</th>
<th>More often</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

1. Shocked a finger at you
2. Swore at you
3. Parent (step-parent, guardian) sulked
4. Insulted you
5. Parent (step-parent, guardian stomped out of the room
6. Cried in order to get you to do something
7. Said something to spite you
8. Threatened to hurt you
9. Scratched you
10. Pulled your hair
11. Pushed or shoved you
12. Twisted your arm
13. shook a fist at you
14. Acted like a bully toward you
15. Threatened to destroy property
16. Threw an object at you
17. shook or roughly handled you
18. Grabbed you suddenly or forcefully
19. Intimidated or tried to scare you into doing something
20. Held you down, pinning you in place
21. Slapped you around your face or head
22. Drove dangerously to spite or frighten you
23. Acted like they wanted to kill you
24. Threatened to harm or damage things you cared about
25. Threatened someone you cared about
26. Threatened you with a gun or knife
27. Threw, smashed, or broke an object
28. Hit or kicked a wall, door or furniture
29. Slapped you with the palm of the hand
30. Destroyed something belonging to you
31. Slapped you with the back of the hand
32. Bit you
33. Choked you
34. Punched you
35. Beat you up
36. Hit you with an object
37. Beat you up
38. Stomped on you
39. Spanked you
40. Kicked you
41. Threatened you with a club-like object
42. Threatened to kill self
43. Had sex with you while they were angry
44. Demanded sex whether you wanted to or not
45. Burned you with something
46. Made you have intercourse against your will
47. Used a knife on you
48. Physically forced you to have sex
49. Used a club-like object on you
50. Used an object on you in a sexual way
51. Made you have oral or anal sex against your will
APPENDIX D

FILLER ITEMS: KOGAN'S ATTITUDE TOWARD OLD PEOPLE SCALE
Filler items for Kogan Old People Scale

For each of the following items, enter 1 for TRUE 2 for FALSE

Make sure you place your answer in the blank space beside the item.

____  It would probably be better if most children lived in neighborhoods where there were also many older people.

____  Most children are really not different from anybody else; they're as easy to understand as adults.

____  Most children are basically selfish, and are unable or unwilling to share.

____  Most children would prefer to drop out of school as soon as possible, and be supported by parents.

____  Most children tend to let their bedrooms become shabby and unattractive.

____  One of the more delightful aspects of children is their innocence.

____  Most children make one feel ill at ease.

____  Most children bore others by their insistence on talking about themselves.

____  Children often have important contributions to make, even to adult conversations.

____  When you think about it, children have the same faults as anybody else.

____  You can count on finding a nice residential neighborhood when there are many of children living in it.

____  There are a few exceptions, but in general most children are pretty much alike.

____  Most children should be more concerned with their personal appearance; they are too untidy.

____  Most children are cooperative and agreeable.

____  One seldom hears children complaining about the behavior of adults.
Most children make excessive demands for love and reassurance.

It would probably be better if children did not live around older people, because their play is often loud and disruptive.

There is something different about most children; it's hard to figure out what makes them tick.

Most children are capable of new adjustments when the situation demands it.

Most children would prefer to remain in school just as long as they possibly can rather than dropping out early.

Most children can generally be counted on to be fairly tidy with their belongings.

Children can drive a person crazy with their constant questioning about the world.

Most children are very relaxing to be with.

One of the most interesting and entertaining qualities of most children is their active imaginations.

Most children spend too much time prying into what they have no business knowing.

If children expect to be liked, their first step is to try to get rid of their irritating faults.

In order to maintain a nice residential neighborhood, it would be best if too many children did not live in it.

It is evident that most children are very different from one another.

Most children seem to be quite clean and neat in their personal appearance.

Most children are rude, cranky, and unpleasant.

Most children are constantly complaining about the behavior of adults.

Most children need no more love and reassurance than anyone else.
APPENDIX E

ELDER ABUSE ATTITUDES AND BEHAVIORAL INTENTIONS SCALE
On the following pages, you will be asked to respond to the same set of questions several times. Each time you respond, the directions at the top will be slightly different. It is important that you read each set of directions carefully. Please answer all the items.
Appendix E—Continued

ELDER ABUSE ATTITUDES AND BEHAVIORAL INTENTIONS SCALE
General Target Elder Abuse Attitudes

SECTION 1

Read the following directions carefully and answer each item honestly. Remember, all answers are confidential.

People behave in many different ways toward older people. Please indicate for each of the following items, whether you think there are ever times or situations when it may be appropriate to behave in that way toward an older person. On the first item for example, if you think that children should sometimes help an older person dress, enter "3" for "Sometimes" in the blank to the left of the item. Assume that other sources of help may or may not be available.

Please answer all of the following items.

<table>
<thead>
<tr>
<th>Never</th>
<th>Hardly ever=</th>
<th>Sometimes=</th>
<th>Quite often=</th>
<th>All the time = 5</th>
</tr>
</thead>
</table>

1. Help dress
2. Fix car
3. Prepare meals for him/her
4. Bathe him/her
5. Feed him/her
6. Help use the toilet
7. Change bedpan
8. Help get out of bed
9. Shop for personal care items
10. Help get out of a chair
11. Give oral medication
12. Take to doctor
13. Help walk
14. Give medical injections
15. Shop for groceries
16. Take to a friend's house
17. Take to church
18. Balance monthly budget
19. Take to the bank
20. Do light housework (dishes, dust)
21. Do heavy yardwork
22. Give gifts
23. Fix small household items
24. Make major financial decisions
25. Take to social gathering
26. Slap with a hand to prevent from doing something
27. Withhold food  
28. Read personal mail  
29. Use social security check without his/her knowledge  
30. Tie to bed to punish  
31. Call him/her insulting names  
32. Threaten to lock in room  
33. Hit with fist or object to punish  
34. Tie to bed to prevent him/her from doing something  
35. Use savings without permission  
36. Prevent from receiving visitors  
37. Lock in room to punish  
38. Threten to tie to bed  
39. Hit with fist or object to prevent him/her  
40. Withhold medications  
41. Not bathe or dress when necessary  
42. Sell his/her personal property without permission  
43. Enter his/her room without knocking  
44. Lock him/her in room to prevent doing something  
45. Make him/her wear diapers if incontinent  
46. Not visit when asked  
47. Close bank account without his/her knowledge  
48. Not call when asked  
49. Threaten to hit  
50. Talk about that person in his/her presence
ELDER ABUSE ATTITUDES AND BEHAVIORAL INTENTIONS SCALE
General Target Elder Abuse Intentions

SECTION 2

Please indicate for each of the following items whether you might respond toward an older person in the following ways. Even if you do not know any older people, think about each item in a hypothetical way, and whether you might respond in that way. Assume that other sources of help may or may not be available.

Enter the number corresponding to your answer in the blank to the left of each item.

<table>
<thead>
<tr>
<th>Never</th>
<th>Hardly ever</th>
<th>Sometimes</th>
<th>Quite often</th>
<th>All the time</th>
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<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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</table>

1. Help dress
2. Fix car
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5. Feed him/her
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26. Slap with a hand to prevent from doing something
27. Withhold food
28. Read personal mail
29. Use social security check without his/her knowledge
30. Tie to bed to punish
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<td>31.</td>
<td>Call him/her insulting names</td>
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<td>Threaten to lock in room</td>
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<td>Threaten to hit</td>
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<td>Talk about that person in his/her presence</td>
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ELDER ABUSE ATTITUDES AND BEHAVIORAL INTENTIONS SCALE
General Target Elder Abuse Behaviors

SECTION 3

Next, indicate whether you have ever responded to an older person in each of the following ways.

<table>
<thead>
<tr>
<th>Never</th>
<th>Hardly ever</th>
<th>Sometimes</th>
<th>Quite often</th>
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</table>

1. Helped dress
2. Fixed car
3. Prepared meals for him/her
4. Bathed him/her
5. Fed him/her
6. Helped use the toilet
7. Changed bedpan
8. Helped get out of bed
9. Shopped for personal care items
10. Helped get out of a chair
11. Given oral medication
12. Taken to doctor
13. Helped walk
14. Given medical injections
15. Shopped for groceries
16. Taken to a friend's house
17. Taken to church
18. Balanced monthly budget
19. Taken to bank
20. Done light housework (dishes, dust)
21. Done heavy yardwork
22. Given gifts
23. Fixed small household items
24. Make major financial decisions
25. Taken to social gathering
26. Slapped with a hand to prevent from doing something
27. Withheld food
28. Read personal mail
29. Used social security check without his/her knowledge
30. Tied to bed to punish
31. Called him/her insulting names
32. Threatened to lock in room
33. Hit with fist or object to punish
34. Tied to bed to prevent him/her from doing something
35. Used savings without permission
36. Prevented from receiving visitors
37. Locked in room to punish
38. Hit with fist or object to prevent him/her from doing something
39. Threatened to tie to bed
40. Withheld medications
41. Not bathed or dressed when necessary
42. Sold his/her personal property without permission
43. Entered his/her room without knocking
44. Locked him/her in room to prevent doing something
45. Made him/her wear diapers if incontinent
46. Not visited when asked
47. Closed bank account without his/her knowledge
48. Not called when asked
49. Threatened to hit
50. Talked about that person in his/her presence
ELDER ABUSE ATTITUDES AND BEHAVIORAL INTENTIONS SCALE
Specific Target Elder Abuse Attitudes

SECTION 4

People behave in lots of different ways toward grandparents. Please indicate for each of the following items, whether you think there are ever times or situations when it may be appropriate to behave in that way toward your grandparent. On the first item for example, if you think you should sometimes help your grandparents dress, enter "3" for "Sometimes" in the blank to the left of the item. Assume that other sources of help may or may not be available.

<table>
<thead>
<tr>
<th>Never (1)</th>
<th>Hardly ever (2)</th>
<th>Sometimes (3)</th>
<th>Quite often (4)</th>
<th>All the time (5)</th>
</tr>
</thead>
</table>
Use scale below to indicate to what extent your responses to the above 25 questions apply to your:

<table>
<thead>
<tr>
<th>Never</th>
<th>Hardly ever=</th>
<th>Sometimes=</th>
<th>Quite often=</th>
<th>All the time = 5</th>
</tr>
</thead>
</table>

26. Maternal grandmother
27. Maternal grandfather
28. Paternal grandmother
29. Paternal grandfather

For the following questions, refer to directions at beginning of SECTION 4:

30. Slap with a hand to prevent from doing something
31. Withhold food
32. Read personal mail
33. Use social security check without his/her knowledge
34. Tie to bed to punish
35. Call him/her insulting names
36. Threaten to lock in room
37. Hit with fist or object to punish
38. Tie to bed to prevent him/her from doing something
39. Use savings without permission
40. Prevent from receiving visitors
41. Lock in room to punish
42. Threaten to tie to bed
43. Hit with fist or object to prevent him/her from doing something
44. Withhold medications
45. Not bathe or dress when necessary
46. Sell his/her personal property without permission
47. Enter his/her room without knocking
48. Lock him/her in room to prevent doing something
49. Make him/her wear diapers if incontinent
50. Not visit when asked
51. Close bank account without his/her knowledge
52. Not call when asked
53. Threaten to hit
54. Talk about that person in his/her pre
Elder Abuse Attitudes and Behavioral Intentions Scale
Specific Target Elder Abuse Intentions

SECTION 5

Please indicate for each of the following items whether you might respond toward your grandparent in the following ways. Even if you do not know your grandparents, think about each person in a hypothetical way, and whether you might respond to that person in that way if he/she were living. Assume that other sources of help may or may not be available.

Enter the number corresponding to your answer in the blank to the left of each item.

<table>
<thead>
<tr>
<th>Never</th>
<th>Hardly ever</th>
<th>Sometimes</th>
<th>Quite often</th>
<th>All the time</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

1. Help dress
2. Fix car
3. Prepare meals for him/her
4. Bathe him/her
5. Feed him/her
6. Help use the toilet
7. Change bedpan
8. Help get out of bed
9. Shop for personal care items
10. Help get out of a chair
11. Give oral medication
12. Take to doctor
13. Help walk
14. Give medical injections
15. Shop for groceries
16. Take to a friend’s house
17. Take to church
18. Balance monthly budget
19. Take to bank
20. Do light housework (dishes, dust)
21. Do heavy yardwork
22. Give gifts
23. Fix small household items
24. Make major financial decisions
25. Take to social gathering
Appendix E—Continued

Use scale below to indicate to what extent your responses to the above 25 questions apply to your:

26. Maternal grandmother
27. Maternal grandfather
28. Paternal grandmother
29. Paternal grandfather

Never  |  Hardly ever= |  Sometimes= |  Quite often= |  All the time = 5
       |           |            |              |                |

For the following questions, refer to directions at beginning of SECTION 5.

30. Slap with a hand to prevent from doing something
31. Withhold food
32. Read personal mail
33. Use social security check without his/her knowledge
34. Tie to bed to punish
35. Call him/her insulting names
36. Threaten to lock in room
37. Hit with fist or object to punish
38. Tie to bed to prevent him/her from doing something
39. Use savings without permission
40. Prevent from receiving visitors
41. Lock in room to punish
42. Threaten to tie to bed
43. Hit with fist or object to prevent him/her from doing something
44. Withhold medications
45. Not bathe or dress when necessary
46. Sell his/her personal property without permission
47. Enter his/her room without knocking
48. Lock him/her in room to prevent doing something
49. Make him/her wear diapers if incontinent
50. Not visit when asked
51. Close bank account without his/her knowledge
52. Not call when asked
53. Threaten to hit
54. Talk about that person in his/her presence
ELDER ABUSE ATTITUDES AND BEHAVIORAL INTENTIONS SCALE
Specific Target Elder Abuse Behaviors

SECTION 6

Next, indicate whether you have ever responded to your grandparent in each of the following ways. Again, if your grandparents have died, consider whether you ever responded to them in each of the following ways while they were alive.

<table>
<thead>
<tr>
<th>Never</th>
<th>Hardly ever</th>
<th>Sometimes</th>
<th>Quite often</th>
<th>All the time</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

1. Helped dress
2. Fixed car
3. Prepared meals for him/her
4. Bathed him/her
5. Fed him/her
6. Helped use the toilet
7. Changed bedpan
8. Helped get out of bed
9. Shopped for personal care items
10. Helped get out of a chair
11. Given oral medication
12. Taken to doctor
13. Helped walk
14. Given medical injections
15. Shopped for groceries
16. Taken to a friend's house
17. Taken to church
18. Balanced monthly budget
19. Taken to bank
20. Done light housework (dishes, dust)
21. Done heavy yardwork
22. Given gifts
23. Fixed small household items
24. Make major financial decisions
25. Taken to social gathering
Appendix E--Continued

For the following questions, refer to directions at beginning of SECTION 6.

___ 30. Slapped with a hand to prevent from doing something
___ 31. Withheld food
___ 32. Read personal mail
___ 33. Used social security check without his/her knowledge
___ 34. Tied to bed to punish
___ 35. Called him/her insulting names
___ 36. Threatened to lock in room
___ 37. Hit with fist or object to punish
___ 38. Tied to bed to prevent him/her from doing something
___ 39. Used savings without permission
___ 40. Prevented from receiving visitors
___ 41. Locked in room to punish
___ 42. Threatened to lock to bed
___ 43. Hit with fist or object to prevent him/her from doing something
___ 44. Withheld medications
___ 45. Not bathed or dressed when necessary
___ 46. Sold his/her personal property without permission
___ 47. Entered his/her room without knocking
___ 48. Locked him/her in room to prevent doing something
___ 49. Made him/her wear diapers if incontinent
___ 50. Not visited when asked
___ 51. Closed bank account without his/her knowledge
___ 52. Not called when asked
___ 53. Threatened to hit
___ 54. Talked about that person in his/her presence

Use scale to indicate to what extent your responses to the above 25 questions apply to your:

___ 26. Maternal grandmother
___ 27. Maternal grandfather
___ 28. Paternal grandmother
___ 29. Paternal grandfather
APPENDIX F

TRAINER RATINGS
Trainer ratings

Using the following scale, how would you rate the group leader on each of the following dimensions:

<table>
<thead>
<tr>
<th>Never</th>
<th>Hardly ever=</th>
<th>Sometimes=</th>
<th>Quite often=</th>
<th>All the time = 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
</tbody>
</table>

1. Knowledgable about the subject material
2. Presented the material in an interesting manner
3. Responsive and open to questions and differences of opinions
4. Enjoyed presenting the material
5. Physical attractiveness
APPENDIX G

EDUCATIONAL INTERVENTIONS
ELDER ABUSE TREATMENT GROUP

I. (5 Minutes) Introduction: Elder Abuse

A. Everyone is familiar with child/spouse abuse. Another form of domestic violence that has been ignored until very recently is elder abuse.

B. Does not just occur in nursing homes and institutions. Frequently the abusers are caregivers particularly sons and daughters.

II. (5 Minutes) Elder abuse handout

III. (15 Minutes) Discussions:

A. Definitions of elder abuse--group discussion

Leader: What is Elder Abuse? Discuss agreement/disagreement with these distinctions on handout.

1. Do they agree that psychological abuse constitutes "abuse."

2. Do they agree that neglect--either physical or psychological constitutes "abuse."

3. physical vs. psychological

4. abuse vs. neglect

B. (20) Case Histories: Is this abuse?

1. Mrs. Smith was admitted to the hospital twice last summer. She had fractured ribs, black eyes, a mark resembling a footprint on her back, and a loop-shaped bruise on her thigh "like something had been wrapped around it." She told hospital staff that her
sisters had beaten her to get her money and her house. The hospital offered to locate emergency shelter and legal advice for her, and the doctors told her she could stay until new living arrangements were made. But, Mrs. Smith wanted to return to her own house to live. The hospital arranged home visits by nurses, neighbors, and members of a social service agency.

The nurses made several trips after Mrs. Smith returned home, but were told (presumably by the sisters) that their services were no longer needed. About 10 days after the nurses last visit, Mrs. Smith died. The coroner determined she had died of unnatural causes—brain hemorrhage and severe bruises to the head, arms, leg, abdomen, chest and groin.

a. Discussion: is this physical abuse?
b. Does the fact that she returned home of her own free will negate the abuse?

2. Mr. Jones is a 72 year old man with quadriplegia. He lived with his wife who had total responsibility for his care. The physical care was difficult, but the wife fed him adequately, turned him frequently, and helped from his bed for one meal a day. His surroundings were clean and pleasant. He had every conceivable device at this bedside to facilitate his care. His wife refused to let him have visitors. "Lots of people in and out of here would mess up the
place," she told the nurse. He had not seen anyone besides his wife for over a year. He was not permitted to watch TV or listen to the radio. Mrs. Jones read him printed matter of her choice and obtained recordings from which he could learn languages. She chose his entertainment so he would not be "exposed to trash." Sometimes, after they argued about these restrictions, she withheld a meal as "punishment."

3. Is this psychological abuse?

4. Violation of rights?

5. Mr. Miller, 79, lived alone in a house provided rent free by a cousin. He was quite frail—in fact, he could barely shop for groceries. The house itself was badly deteriorated. Several window panes were missing; doors were missing or had no locks. Mr. Jones could not afford a phone. Almost regularly he was robbed on social security day by young men who came to the door and demanded his check. Because the doors gave him no protection and since he had been beaten severely in the past, he simply gave the thieves what they wanted. The police knew the situation but said they could do nothing because Mr. Jones could not identify his assailants. Although the cousin was aware of the situation, he had not been in touch with his relative for many years.
6. Abuse present in this case?
7. Who is the abuser—thieves or cousin?
8. Is it abuse or neglect?

IV. (30 Minutes) Film: Elder Abuse

V. (10 Minutes) Reactions to film

VI. (5 Minutes) Give Elder abuse Hotline: 1-800-252-4500

VI. Fill out questionnaires
ELDER ABUSE FACT SHEET

* 500,000 to 2.5 million elderly individuals are victims of abuse each year

* 1 out of every 6 elderly individuals will be victims of abuse

* Elder abuse cuts across all cultural and socio-economic boundaries

* The general characteristics of a victim of elder abuse is: female, white, over 75, physically impaired, and living with family

Physical abuse

Violence that results in bodily harm or mental distress. It includes assault, unjustified denial of another's rights, sexual abuse, restrictions on freedom of movement, and murder.

Negligence

The breach of duty or carelessness that results in injury or the violation of rights.

Psychological abuse

The provoking of the fear of violence or isolation, including name calling and other forms of verbal assault. Includes threats of placement in a nursing home. It may be spontaneous or a systematic effort to dehumanize.

Violation of rights

The breaching of rights that are guaranteed to all citizens by the Constitution, federal statues, federal courts and the states.

Financial Exploitation

The theft or conversion of money or objects of value belonging to an elderly person by a relative or caretaker. It can be accomplished by force or through misrepresentation.
AGING TREATMENT GROUP

I. (5 Minutes) Introduction

A. Ask group what they think the definition of aging is? Different definitions: chronological, physical, psychological.

B. Give the Life Span view of aging: people age across the lifespan, no one stage is more important than others.

II. (5 Minutes) Aging handout

III. (15) Discussion: Myths/Facts about aging.

What are the perceptions people have about the elderly? Have them take a few minutes and think about an older person. Who did they think about? Specific person they know or an older people in general? What were they doing? What were some adjectives they would use to describe the older person?

What are other terms people might use to describe older people? Some examples: sick, frail, fragile, easy crime victims, live in institutions, poor, inactive, can't learn new skills, don't have sex, confused, don't work, lonely, rigid. These are all common myths and misperceptions people have about older persons.

IV. (30 Minutes) Review of Palmore's Facts on Aging Quiz. Trainer read the question and ask group whether they believe it is true or false, and why. Then, Trainer
Appendix G--Continued

give the correct answer and explanation. It is not necessary to cover all the facts.

V. (30 Minutes) Film: The Sixth Sense

VI. (5 Minutes) Reactions to film

IX. Fill out questionnaires
AGING FACT SHEET

* By the year 2000, one out of every five people will be 65 years or older.

* The fastest growing age group in the United States are people over the age of 85.

* About eighty percent of the aged are healthy enough to carry out their normal activities.

* Approximately five percent of people over 65 live in long-stay institutions (i.e., nursing homes, mental hospitals, homes for the aged, etc.).

MYTHS AND FACTS ON AGING

Myth: Older people have great difficulty adjusting to change.
Fact: Older people can and do adjust to many drastic changes such as losing spouses, moving to new residences, illness, change in lifestyle, and change in economic status.

Myth: Most older people think of themselves as being physically ill.
Fact: Studies indicate that they usually consider themselves to be more healthy than others their same age. It is other people who attribute physical limits and disabilities to older people.

Myth: Older people do not like physical contact with other people.
Fact: As senses of vision and hearing fail, touch can become a more important form of communication as people age.
I. Introduction: We are going to talk about family from a societal and historical perspective. (15 Minutes) Group discussion.

A. Meaning of family.

What is a family? What is the societal/psychological role "family"? (Get them to generate ideas, and encourage them to explain what the terms mean to them. Trainer can add information as needed).

1. Procreation: all societies have certain rules which regulate the process of who is qualified to bear children, when reproduction begins, how many children should be born, how the children should be cared for, etc. (Can get them to generate what they think are the rules in our society, and if and how they are changing).

2. Socialization: includes all learning of values, attitudes, knowledge, skills and techniques of the society—teaching of culture. The culture has norms for what is and is not to be learned in the family. (What are some of the values, attitudes that are learned in the family in our culture? What is not learned in our culture, e.g., sexual activity (Incest taboo).

3. Sex role learning: what males/females do in
the society (Are these roles changing? How? Do they think this is for the better or worse?)

4. Caretaking: People's survival depends on certain physical needs—food, shelter and clothing. Without these they will not remain healthy and health is necessary for survival. Also, family provides psychological needs, also necessary for health for children (Do they think the two are equally important? Why or why not?)

B. (5 Minutes) Handout: Forms of marriages.
C. (10 Minutes) Discussion: What might be inherent advantages/disadvantages in each? How might these different forms of marriages affect the roles of family in society that were just discussed? (Can cover how the different forms affect jealousies, social or legal factors such as inheritance, property rights, and lineage, emotional needs of spouses and children, and child-rearing practices)

III. (10 Minutes) Discussion: How do they think "family" has changed over the years—what effect has divorce, remarriage, single parenting, had on the traditional notion of family? (Traditional—nuclear, single mother, father, children. A new term used to describe American families is serial monogamy.)

V. (30 Minutes) Film: Family Matters
VI. (10 Minutes) Reactions: Discuss film; what are
similarities and differences between the two families. Any similarities with their own? How do they think each of the two families fit the concepts discussed earlier (e.g., procreation, socialization)

V. (5 Minutes) Questions/Comments

VI. Fill out questionnaires
Forms of Marriages

Promiscuity:
Promiscuity refers to no marriage and unrestricted sexual relations. In a promiscuous society, every male would be eligible to mate with every female, with blood ties no barrier. This form of marriage does not exist at the human level.

Group Marriage
Group marriage refers to the marriage of several women to several men. Although instances have been reported, it is an atypical pattern. It has no advantages over other forms of marriages (e.g., jealousy is intensified).

Polygamy
Polygamy is a general term that refers to all marriage forms that involve the taking of plural spouses. It is intimately related to economic functioning and status considerations.

Polygyny
Polygyny is the marriage of one man to several women, and is the more common form of polygamy. It is found in many societies, and is most typically limited to the marriage of the first wife's sisters. It implies the necessity of relatively high living standards, and tends to permit economically or politically powerful males to acquire plural wives at the expense of less powerful males.

Polyandry
Polyandry is the marriage of one woman to several men, and is exceedingly rare. It is sometimes associated with hard living conditions where female infanticide is used as a means of population control. It may serve the purposes of providing a wife for an excess number of males and of raising the family subsistence level by utilizing several breadwinners.

Monogamy
Monogamy is the marriage of one man to one woman, and is the only form of marriage that is accepted by all societies, even where other forms of marriage are permitted.
Dear Participant:

Thank you for taking part in this study. As some of you may know, elder abuse is a growing phenomenon in our country. As many as 2 million elderly people may be subject to physical and emotional mistreatment. However, much of the public is unaware that the problem of elder abuse exists.

The major purpose of this study was to raise people’s awareness of the presence of elder abuse. I am interested in developing an educational program that will inform people about elder abuse and decrease any potential behaviors of maltreatment toward older people.

You participated in one of several types of educational programs I developed. Some of you did not participate in any of the educational programs, and served as part of a control group. Only one of the programs offered information specifically about elder abuse. Other programs focused on more general issues in aging and on the family’s role in society. If you are interested in learning more about any of these topics, three films which I used are available at the Media Library, and may be viewed at your convenience. The titles of these films and call numbers are listed below.

Another purpose of this study was to examine the relationship between a variety of background variables (such as relationships with grandparents, knowledge about older people, and amount of experienced abuse), and attitudes toward elder abuse. I hope to find out which types of educational programs are effective for people with different backgrounds.

During the first summer session, I will offer to anyone who took part in this study the opportunity to participate in any of the educational programs. If you are interested, please check the Research Bulletin Board (2nd floor, Terrill Hall) at the start of the first summer session, and sign up for any or all of the programs you are interested in.

On the following page are some facts about elder abuse. For your own knowledge, you should be aware of these basic facts.

Again, thank you for taking part in this study.

Sincerely

Julie Reinberg
Appendix H--Continued

Audiovisual material available at the Media library:

Elder abuse: M.V. 746 Elder abuse and neglect in the family

Aging: M.V. 575 The Sixth sense

Family relationships: M.V. 476 Family Matters
ELDER ABUSE FACT SHEET

* 500,000 to 2.5 million elderly individuals are victims of abuse each year.

* 1 out of every 6 elderly individuals will be victims of abuse.

* Elder abuse cuts across all cultural and socioeconomic boundaries.

* The general characteristics of a victim of elder abuse is: female, white, over 75, physically impaired, and living with family.

* Familial caregivers (sons, daughters, spouses of the older person) are often the abusers.

* Different kinds of behaviors may be considered abusive including:

1) physical violence: hitting, locking in room

2) verbal or emotional abuse: threatening to hit, name calling

3) physical or emotional neglect: failure to provide proper nutrition, failure to provide proper medical care, ignoring or isolating older person

4) violation of constitutional rights: reading personal mail

5) financial exploitation: stealing social security checks, persuading older person to invest in worthless venture

* There are many suggested causes of elder abuse such as stress in the family, alcoholism or mental illness in the caregiver, violence as a learned and engrained pattern of relating to family members.

* Elder abuse is against the law. If you are aware of any situations that you have concerns or questions about, there is a toll free hotline number that you may use. The number is: 1-800-252-4500
### Table I-1

**Means, Standard Deviations, and Ranges for Dependent Measures at Pretest, Posttest, and Followup**

<table>
<thead>
<tr>
<th>Dependent Measure</th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>Theoretical Range</th>
<th>Obtained Range</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Min</td>
<td>Max</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Range</td>
<td>Min</td>
</tr>
<tr>
<td>Soc Des</td>
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<tr>
<td>Knowledge</td>
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<td>16</td>
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<td>AttitudeZ</td>
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<td>0</td>
<td>16</td>
</tr>
<tr>
<td>AnxtX</td>
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<td>2.59</td>
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<td>15</td>
</tr>
<tr>
<td>AnxtY</td>
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<td>0</td>
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<td>AnxtZ</td>
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<td>Gen AttX</td>
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<tr>
<td>Gen AttY</td>
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<td>Gen AttZ</td>
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<td>Gen IntY</td>
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<td>Gen IntZ</td>
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<td>Spec IntZ</td>
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(cont)
### Appendix I—Continued

#### Table I-1 (cont)

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<th>Dependent Measure</th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>Theoretical Range</th>
<th>Obtained Range</th>
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<tr>
<td></td>
<td></td>
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<td>Spec BehY</td>
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<td>Spec BehZ</td>
<td>186.50</td>
<td>20.54</td>
<td>50</td>
<td>250</td>
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</tbody>
</table>

**Note.**  
Attitude = Kogan's Attitude toward Old People.  
Anxt = Personal Anxiety toward Aging.  
Gen Att = General Target Elder Abuse Attitudes.  
Gen Int = General Target Elder Abuse Intentions.  
Gen Beh = General Target Elder Abuse Behaviors.  
Spec Att = Specific Target Elder Abuse Attitudes.  
Spec Int = Specific Target Elder Abuse Intentions.  
Spec Beh = Specific Target Elder Abuse Behaviors.  
Table I-2

Pretest Correlations Between Covariates and Dependent Measures

<table>
<thead>
<tr>
<th>Dependent Measure</th>
<th>Knowledge of Aging</th>
<th>Social desirability</th>
<th>Credibility/expectancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attitude</td>
<td>-.30 **</td>
<td>.14</td>
<td>.03</td>
</tr>
<tr>
<td>Anxt</td>
<td>.08</td>
<td>-.26 **</td>
<td>.06</td>
</tr>
<tr>
<td>Gen Att</td>
<td>.03</td>
<td>.14</td>
<td>-.08</td>
</tr>
<tr>
<td>Gen Int</td>
<td>-.03</td>
<td>.17 *</td>
<td>.00</td>
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<tr>
<td>Gen Beh</td>
<td>.03</td>
<td>.17</td>
<td>.01</td>
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<td>.06</td>
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</tr>
<tr>
<td>Spec Int</td>
<td>.03</td>
<td>.18 *</td>
<td>.03</td>
</tr>
<tr>
<td>Spec Beh</td>
<td>.04</td>
<td>.11</td>
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<tr>
<td>Hist of Viol</td>
<td>.03</td>
<td>-.13</td>
<td>-.13</td>
</tr>
<tr>
<td>Knowledge</td>
<td>-.05</td>
<td>-.05</td>
<td>-.01</td>
</tr>
<tr>
<td>Soc Des</td>
<td>-.05</td>
<td>.09</td>
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</tr>
<tr>
<td>Cred/Expt</td>
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<td>.09</td>
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* p < .01. ** p < .001.
Table I-3

**Findings for Dependent Measures for the Treatment Group by Time of Measurement Interaction**

<table>
<thead>
<tr>
<th>DEPENDENT MEASURE</th>
<th>F Value</th>
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<tr>
<td>Attitudes Toward Older People</td>
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</tr>
<tr>
<td>Personal Anxiety Toward Aging</td>
<td>2.94&lt;sup&gt;a&lt;/sup&gt;</td>
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<tr>
<td>General Target Elder Abuse Attitudes</td>
<td>4.38&lt;sup&gt;a&lt;/sup&gt;</td>
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<tr>
<td>General Target Elder Abuse Intentions</td>
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<tr>
<td>General Target Elder Abuse Behaviors</td>
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<tr>
<td>Specific Target Elder Abuse Attitudes</td>
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<td>Specific Target Elder Abuse Intentions</td>
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</tr>
<tr>
<td>Specific Target Elder Abuse Behaviors</td>
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</tbody>
</table>

<sup>a</sup>F = (3,217), p < .05.
Table I-4

Pretest and Posttest Treatment Group Means

<table>
<thead>
<tr>
<th>Treatment Group</th>
<th>Elder Abuse (n = 58)</th>
<th>Aging (n = 60)</th>
<th>Family (n = 58)</th>
<th>Pretest-Posttest (n = 49)</th>
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(cont)
Table I-4 (cont)

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Note.

Attitude = Kogan's Attitude toward Old People    X = Pretest
Anxt    = Personal Anxiety toward Aging            Y = Posttest
Gen Att  = General Target Elder Abuse Attitudes
Gen Int  = General Target Elder Abuse Intentions
Gen Beh  = General Target Elder Abuse Behaviors
Spec Att = Specific Target Elder Abuse Attitudes
Spec Int = Specific Target Elder Abuse Intentions
Spec Beh = Specific Target Elder Abuse Behaviors

aAging Treatment posttest mean less than other Treatment Group posttest means.
bElder Abuse Treatment Group posttest mean greater than other Treatment Group posttest means.
### Table I-5

**Elder Abuse Treatment Group Means, Standard Deviations, and Ranges for Low and High Experienced Violence at Pretest and Posttest**

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**Note.**

- Attitude = Kogan's Attitude toward Old People.
- Anxt = Personal Anxiety toward Aging.
- Gen/Spec = General Target/Specific Target.
- Att/Int/Beh = Attitudes/Intentions/Behaviors.
- X = Pretest. Y = Posttest.
Table I-6

Aging Treatment Group Means, Standard Deviations, and Ranges for Low and High Experienced Childhood Violence at Pretest and Posttest

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### Table I-7

**Family Treatment Group Means, Standard Deviations, and Ranges for High and Low Childhood Experienced Violence at Pretest and Posttest**

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**Note.**
- Attitude = Kogan's Attitude toward Old People.
- Anxt = Personal Anxiety toward Aging.
- Gen/Spec = General Target/Specific Target.
- Att/Int/Beh = Attitudes/Intentions/Behaviors.
- X = Pretest. Y = Posttest.
Appendix I—Continued

Table I-8

Pretest-Posttest Only Treatment Group Means, Standard Deviations, and Ranges for High and Low Experienced Childhood Violence at Pretest and Posttest

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### Table I-9

**Findings for Dependent Measures at Pretest and Posttest with General Target Elder Abuse Behaviors as Independent Variable**

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**Note:**

E.A. = Elder Abuse.

\[ a_\text{F} = (1,224), p < .01. \quad b_\text{F} = (1,217), p < .01. \]
### Table I-10

Means, Standard Deviations and Ranges for Dependent Measures at Pretest and Posttest Utilizing General Target Elder Abuse Behaviors to Define Level of Expressed Violence

<table>
<thead>
<tr>
<th>Dependent Measure</th>
<th>Low</th>
<th>High</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>Std.Dev.</td>
<td>Mean</td>
</tr>
<tr>
<td>AttitudeX</td>
<td>10.69</td>
<td>2.04</td>
<td>10.40</td>
</tr>
<tr>
<td>AttitudeY</td>
<td>12.57</td>
<td>2.15</td>
<td>12.36</td>
</tr>
<tr>
<td>AnxtX</td>
<td>6.54</td>
<td>2.56</td>
<td>6.43</td>
</tr>
<tr>
<td>AnxtY</td>
<td>6.60</td>
<td>2.59</td>
<td>6.60</td>
</tr>
<tr>
<td>Gen AttX</td>
<td><strong>209.41</strong></td>
<td><strong>17.24</strong></td>
<td>203.60</td>
</tr>
<tr>
<td>Gen AttY</td>
<td><strong>209.60</strong></td>
<td><strong>18.67</strong></td>
<td>199.52</td>
</tr>
<tr>
<td>Gen IntX</td>
<td><strong>219.57</strong></td>
<td><strong>17.47</strong></td>
<td>208.79</td>
</tr>
<tr>
<td>Gen IntY</td>
<td><strong>213.00</strong></td>
<td><strong>18.71</strong></td>
<td>210.31</td>
</tr>
<tr>
<td>Spec AttX</td>
<td><strong>218.18</strong></td>
<td><strong>23.55</strong></td>
<td>207.21</td>
</tr>
<tr>
<td>Spec AttY</td>
<td><strong>223.47</strong></td>
<td><strong>23.76</strong></td>
<td>203.14</td>
</tr>
<tr>
<td>Spec IntX</td>
<td><strong>230.44</strong></td>
<td><strong>21.78</strong></td>
<td>221.07</td>
</tr>
<tr>
<td>Spec IntY</td>
<td><strong>227.02</strong></td>
<td><strong>22.50</strong></td>
<td>220.69</td>
</tr>
<tr>
<td>Spec BehX</td>
<td><strong>197.45</strong></td>
<td><strong>20.15</strong></td>
<td>174.10</td>
</tr>
<tr>
<td>Spec BehY</td>
<td><strong>199.95</strong></td>
<td><strong>21.46</strong></td>
<td>176.09</td>
</tr>
</tbody>
</table>

**Note.**  
Attitude = Kogan's Attitude toward Old People.  
Anxt = Personal Anxiety toward Aging.  
Gen/Spec = General Target/Specific Target.  
Att/Int/Beh = Attitudes/Intentions/Behaviors.  
X = Pretest. Y = Posttest.

*aHigh and Low Expressed Violence Groups are significantly different.
Table I-11

Findings for Dependent Measures at Pretest and Posttest with Specific Target Elder Abuse Behaviors as Independent Variable

<table>
<thead>
<tr>
<th>Time of Measurement</th>
<th>Pretest $F$ Value</th>
<th>Posttest $F$ Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>GENERAL TARGET E.A. ATTITUDES</td>
<td>4.03</td>
<td>6.19$^b$</td>
</tr>
<tr>
<td>GENERAL TARGET E.A. INTENTIONS</td>
<td>5.55</td>
<td>6.27$^b$</td>
</tr>
<tr>
<td>GENERAL TARGET E.A. BEHAVIORS</td>
<td>125.06</td>
<td>124.90$^b$</td>
</tr>
<tr>
<td>SPECIFIC TARGET E.A. ATTITUDES</td>
<td>10.67</td>
<td>13.86$^b$</td>
</tr>
<tr>
<td>SPECIFIC TARGET E.A. INTENTIONS</td>
<td>4.76</td>
<td>3.42</td>
</tr>
</tbody>
</table>

Note.

E.A. = Elder Abuse.

$^a F = (1,224), p < .05$.  $^b F = (1,217), p < .05$. 
Table I-12

Means, Standard Deviations and Ranges for Dependent Measures at Pretest and Posttest Utilizing Specific Target Elder Abuse Behaviors to Define Level of Expressed Violence

<table>
<thead>
<tr>
<th>Dependent Measure</th>
<th>Low</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>Std.Dev.</td>
<td>Mean</td>
<td>Std.Dev.</td>
<td>Min Max</td>
</tr>
<tr>
<td>AttitudeX</td>
<td>10.81</td>
<td>1.94</td>
<td>10.30</td>
<td>2.42</td>
<td>3 15</td>
</tr>
<tr>
<td>AttitudeY</td>
<td>12.65</td>
<td>2.01</td>
<td>12.32</td>
<td>2.20</td>
<td>5 16</td>
</tr>
<tr>
<td>AnxtX</td>
<td>6.49</td>
<td>2.47</td>
<td>6.47</td>
<td>2.69</td>
<td>0 14</td>
</tr>
<tr>
<td>AnxtY</td>
<td>6.65</td>
<td>2.57</td>
<td>6.60</td>
<td>2.64</td>
<td>1 14</td>
</tr>
<tr>
<td>Gen AttX</td>
<td>a208.75</td>
<td>17.33</td>
<td>204.43</td>
<td>14.95</td>
<td>154 250</td>
</tr>
<tr>
<td>Gen AttY</td>
<td>a208.21</td>
<td>18.16</td>
<td>201.16</td>
<td>22.30</td>
<td>151 250</td>
</tr>
<tr>
<td>Gen IntX</td>
<td>a216.33</td>
<td>17.14</td>
<td>210.87</td>
<td>17.63</td>
<td>167 250</td>
</tr>
<tr>
<td>Gen IntY</td>
<td>a211.24</td>
<td>18.90</td>
<td>205.07</td>
<td>17.17</td>
<td>165 250</td>
</tr>
<tr>
<td>Gen BehX</td>
<td>a185.91</td>
<td>17.26</td>
<td>165.13</td>
<td>9.85</td>
<td>150 245</td>
</tr>
<tr>
<td>Gen BehY</td>
<td>a178.10</td>
<td>18.67</td>
<td>156.07</td>
<td>11.63</td>
<td>138 237</td>
</tr>
<tr>
<td>Spec AttX</td>
<td>a219.72</td>
<td>22.58</td>
<td>208.44</td>
<td>24.62</td>
<td>144 270</td>
</tr>
<tr>
<td>Spec AttY</td>
<td>a222.83</td>
<td>22.53</td>
<td>211.29</td>
<td>24.45</td>
<td>154 250</td>
</tr>
<tr>
<td>Spec IntX</td>
<td>a228.94</td>
<td>22.05</td>
<td>222.82</td>
<td>20.11</td>
<td>181 250</td>
</tr>
<tr>
<td>Spec IntY</td>
<td>226.21</td>
<td>21.78</td>
<td>221.51</td>
<td>20.68</td>
<td>174 250</td>
</tr>
</tbody>
</table>


aHigh and Low Expressed Violence Groups are significantly different.
Table I-13

Pretest Correlations of Dependent Measures with Global Aging and Specific Elder Abuse Attitude Measures

<table>
<thead>
<tr>
<th>Dependent Measure</th>
<th>Global Attitude</th>
<th>Anxt</th>
<th>Specific Spec Att</th>
<th>Gen Att</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxt</td>
<td>-.30 *</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spec Att</td>
<td>.01</td>
<td>.00</td>
<td>.00</td>
<td></td>
</tr>
<tr>
<td>Gen Att</td>
<td>-.04</td>
<td>.03</td>
<td>.33 *</td>
<td></td>
</tr>
<tr>
<td>Spec Int</td>
<td>.06</td>
<td>-.04</td>
<td>.58 *</td>
<td>.35 *</td>
</tr>
<tr>
<td>Spec Beh</td>
<td>.04</td>
<td>.00</td>
<td>.37 *</td>
<td>.29 *</td>
</tr>
<tr>
<td>Gen Int</td>
<td>.07</td>
<td>.01</td>
<td>.37 *</td>
<td>.54 *</td>
</tr>
<tr>
<td>Gen Beh</td>
<td>.02</td>
<td>-.01</td>
<td>.32 *</td>
<td>.35 *</td>
</tr>
</tbody>
</table>

Note. Attitude = Attitude toward Old People.
Anxt = Personal Anxiety toward Aging.
Gen Att = General Target Elder Abuse Attitudes.
Gen Int = General Target Elder Abuse Intentions.
Gen Beh = General Target Elder Abuse Behaviors.
Spec Att = Specific Target Elder Abuse Attitudes.
Spec Int = Specific Target Elder Abuse Intentions.
Spec Beh = Specific Target Elder Abuse Behaviors.
X = Pretest. Y = Posttest.

* p < .001.
Table I-14

T Values Expressing the Differences in Correlations among Specific and Global Attitude Measures, Intentions, and Past Behaviors

<table>
<thead>
<tr>
<th>Criterion Measure</th>
<th>Specific Measure</th>
<th>Global Measure</th>
<th>T Value *</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gen Int</td>
<td>Spec Att (.37)</td>
<td>Attitude (.07)</td>
<td>3.43</td>
</tr>
<tr>
<td>Spec Int</td>
<td>Spec Att (.58)</td>
<td>Attitude (.06)</td>
<td>6.77</td>
</tr>
<tr>
<td>Gen Beh</td>
<td>Spec Att (.32)</td>
<td>Attitude (.02)</td>
<td>3.35</td>
</tr>
<tr>
<td>Spec Beh</td>
<td>Spec Att (.37)</td>
<td>Attitude (.04)</td>
<td>3.76</td>
</tr>
<tr>
<td>Gen Int</td>
<td>Spec Att (.37)</td>
<td>Anxiety (.01)</td>
<td>4.08</td>
</tr>
<tr>
<td>Spec Int</td>
<td>Spec Att (.58)</td>
<td>Anxiety (-.04)</td>
<td>8.03</td>
</tr>
<tr>
<td>Gen Beh</td>
<td>Spec Att (.32)</td>
<td>Anxiety (-.01)</td>
<td>3.67</td>
</tr>
<tr>
<td>Spec Beh</td>
<td>Spec Att (.37)</td>
<td>Anxiety (.00)</td>
<td>4.20</td>
</tr>
<tr>
<td>Gen Int</td>
<td>Gen Att (.54)</td>
<td>Attitude (.07)</td>
<td>5.80</td>
</tr>
<tr>
<td>Spec Int</td>
<td>Gen Att (.35)</td>
<td>Attitude (.06)</td>
<td>3.21</td>
</tr>
<tr>
<td>Gen Beh</td>
<td>Gen Att (.35)</td>
<td>Attitude (.02)</td>
<td>3.64</td>
</tr>
<tr>
<td>Spec Beh</td>
<td>Gen Att (.29)</td>
<td>Attitude (.04)</td>
<td>2.70</td>
</tr>
<tr>
<td>Gen Int</td>
<td>Gen Att (.54)</td>
<td>Anxiety (.01)</td>
<td>6.74</td>
</tr>
<tr>
<td>Spec Int</td>
<td>Gen Att (.35)</td>
<td>Anxiety (-.04)</td>
<td>4.46</td>
</tr>
<tr>
<td>Gen Beh</td>
<td>Gen Att (.35)</td>
<td>Anxiety (-.01)</td>
<td>4.11</td>
</tr>
<tr>
<td>Spec Beh</td>
<td>Gen Att (.29)</td>
<td>Anxiety (.00)</td>
<td>3.24</td>
</tr>
</tbody>
</table>

Note. Attitude = Attitude toward Old People. 
Anxt = Personal Anxiety toward Aging. 
Gen/Spec = General Target/Specific Target. 
Att/Int/Beh = Attitudes/Intentions/Behaviors. 
X = Pretest. Y = Posttest.

aCorrelation coefficient between Specific attitude and criterion measure. bCorrelation coefficient between Global attitude and criterion measure.

* All T values have \( p < .05 \)
### Table I-15

**T Values Between General and Specific Target Attitudes, Intentions, and Past Behaviors of Elder Abuse**

<table>
<thead>
<tr>
<th>Dependent Measure</th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>Standard Error</th>
<th>T Value*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gen Att</td>
<td>206.56</td>
<td>16.29</td>
<td>1.08</td>
<td>-4.30</td>
</tr>
<tr>
<td>Spec Att</td>
<td>212.82</td>
<td>24.18</td>
<td>1.60</td>
<td></td>
</tr>
<tr>
<td>Gen Int</td>
<td>213.16</td>
<td>17.59</td>
<td>1.17</td>
<td>-10.40</td>
</tr>
<tr>
<td>Spec Int</td>
<td>225.90</td>
<td>21.46</td>
<td>1.41</td>
<td></td>
</tr>
<tr>
<td>Gen Beh</td>
<td>175.06</td>
<td>17.43</td>
<td>1.16</td>
<td>-13.29</td>
</tr>
<tr>
<td>Spec Beh</td>
<td>185.53</td>
<td>20.09</td>
<td>1.33</td>
<td></td>
</tr>
</tbody>
</table>


*All T values have p < .001.*
Table 16
Findings for Dependent Measures for Time of Measurement at Pretest and Posttest

<table>
<thead>
<tr>
<th>DEPENDENT MEASURE</th>
<th>F Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attitudes Toward Older People</td>
<td>171.62a</td>
</tr>
<tr>
<td>Personal Anxiety Toward Aging</td>
<td>2.97</td>
</tr>
<tr>
<td>General Target Elder Abuse Attitudes</td>
<td>3.30</td>
</tr>
<tr>
<td>General Target Elder Abuse Intentions</td>
<td>30.76a</td>
</tr>
<tr>
<td>General Target Elder Abuse Behaviors</td>
<td>212.96a</td>
</tr>
<tr>
<td>Specific Target Elder Abuse Attitudes</td>
<td>7.36a</td>
</tr>
<tr>
<td>Specific Target Elder Abuse Intentions</td>
<td>3.20</td>
</tr>
<tr>
<td>Specific Target Elder Abuse Behaviors</td>
<td>6.75a</td>
</tr>
</tbody>
</table>

aF = (1,217), p < .05.
Table I-17

Combined Treatment Group Means and Standard Deviations at Pretest and Posttest

<table>
<thead>
<tr>
<th>Dependent Measure</th>
<th>Pretest</th>
<th>Posttest</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>Std. Dev.</td>
</tr>
<tr>
<td>Attitude</td>
<td>a10.54</td>
<td>2.21</td>
</tr>
<tr>
<td>Anxt</td>
<td>6.45</td>
<td>2.59</td>
</tr>
<tr>
<td>Gen Att</td>
<td>206.56</td>
<td>16.29</td>
</tr>
<tr>
<td>Gen Int</td>
<td>a213.16</td>
<td>17.59</td>
</tr>
<tr>
<td>Gen Beh</td>
<td>a175.06</td>
<td>17.43</td>
</tr>
<tr>
<td>Spec Att</td>
<td>a212.82</td>
<td>24.18</td>
</tr>
<tr>
<td>Spec Int</td>
<td>225.90</td>
<td>21.24</td>
</tr>
<tr>
<td>Spec Beh</td>
<td>a185.53</td>
<td>20.09</td>
</tr>
</tbody>
</table>

Note. Attitude = Attitude toward Old People.  
Anxt = Personal Anxiety toward Aging.  
Gen Att = General Target Elder Abuse Attitudes.  
Gen Int = General Target Elder Abuse Intentions.  
Gen Beh = General Target Elder Abuse Behaviors.  
Spec Att = Specific Target Elder Abuse Attitudes.  
Spec Int = Specific Target Elder Abuse Intentions.  
Spec Beh = Specific Target Elder Abuse Behaviors.  
aPosttest mean different from Pretest mean.
## Significance of Differences Between Low and High Experienced Violence on Demographic Measures

<table>
<thead>
<tr>
<th>Level of Experienced Violence</th>
<th>Low Mean</th>
<th>Std. Dev.</th>
<th>High Mean</th>
<th>Std. Dev.</th>
<th>Statistic Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>19.68</td>
<td>2.30</td>
<td>19.70</td>
<td>2.43</td>
<td>0.01</td>
</tr>
<tr>
<td>Miles from grandparents</td>
<td>2.46</td>
<td>1.41</td>
<td>2.15</td>
<td>1.34</td>
<td>3.59&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>Sex</td>
<td>1.71</td>
<td></td>
<td>1.66</td>
<td></td>
<td>0.59</td>
</tr>
<tr>
<td>Classification</td>
<td>1.45</td>
<td></td>
<td>1.42</td>
<td></td>
<td>1.16</td>
</tr>
<tr>
<td>Marital status</td>
<td>1.02</td>
<td></td>
<td>1.06</td>
<td></td>
<td>0.11</td>
</tr>
<tr>
<td>Parents alive</td>
<td>1.03</td>
<td></td>
<td>1.08</td>
<td></td>
<td>0.07</td>
</tr>
<tr>
<td>Family's income</td>
<td>4.88</td>
<td></td>
<td>5.02</td>
<td></td>
<td>0.80</td>
</tr>
<tr>
<td>Parents marital status</td>
<td>1.72</td>
<td></td>
<td>2.03</td>
<td></td>
<td>8.87&lt;sup&gt;b&lt;/sup&gt;</td>
</tr>
<tr>
<td>Paternal grandfather living</td>
<td>1.50</td>
<td></td>
<td>1.69</td>
<td></td>
<td>8.52&lt;sup&gt;b&lt;/sup&gt;</td>
</tr>
<tr>
<td>Paternal grandmother living</td>
<td>1.37</td>
<td></td>
<td>1.37</td>
<td></td>
<td>2.17</td>
</tr>
<tr>
<td>Maternal grandfather living</td>
<td>1.58</td>
<td></td>
<td>1.59</td>
<td></td>
<td>0.00</td>
</tr>
<tr>
<td>Maternal grandmother living (cont)</td>
<td>1.24</td>
<td></td>
<td>1.32</td>
<td></td>
<td>1.22</td>
</tr>
</tbody>
</table>
### Table I-18 (cont)

<table>
<thead>
<tr>
<th>Relationship</th>
<th>Low Mean</th>
<th>Std. Dev.</th>
<th>High Mean</th>
<th>Std. Dev.</th>
<th>Statistic Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grandparent living with family</td>
<td>0.29</td>
<td>0.09</td>
<td></td>
<td></td>
<td>1.57</td>
</tr>
<tr>
<td>Grandparent living in institution</td>
<td>0.27</td>
<td>0.20</td>
<td></td>
<td></td>
<td>0.00</td>
</tr>
<tr>
<td>Relationship with paternal grandfather</td>
<td>3.38</td>
<td>3.00</td>
<td></td>
<td></td>
<td>6.23</td>
</tr>
<tr>
<td>Relationship with paternal grandmother</td>
<td>3.97</td>
<td>4.04</td>
<td></td>
<td></td>
<td>2.86</td>
</tr>
<tr>
<td>Relationship with maternal grandfather</td>
<td>3.94</td>
<td>3.25</td>
<td></td>
<td></td>
<td>9.50&lt;sup&gt;c&lt;/sup&gt;</td>
</tr>
<tr>
<td>Relationship with maternal grandmother</td>
<td>4.76</td>
<td>4.39</td>
<td></td>
<td></td>
<td>6.22</td>
</tr>
<tr>
<td>Extent of contact with older people</td>
<td>3.14</td>
<td>3.01</td>
<td></td>
<td></td>
<td>2.36</td>
</tr>
<tr>
<td>Extent of contact with grandparents</td>
<td>2.00</td>
<td>2.19</td>
<td></td>
<td></td>
<td>3.96</td>
</tr>
</tbody>
</table>

**Note.**

<sup>a</sup>χ<sup>2</sup> = (1,224), p < .10.  
<sup>b</sup>χ<sup>2</sup> = 1, p < .01.  
<sup>c</sup>χ<sup>2</sup> = 5, p < .10.
Table 19

Findings for Dependent Measures for Time of Measurement at Pretest, Posttest, and Followup

<table>
<thead>
<tr>
<th>DEPENDENT MEASURE</th>
<th>F Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attitudes toward Older People</td>
<td>58.34a</td>
</tr>
<tr>
<td>Personal Anxiety Toward Aging</td>
<td>4.00a</td>
</tr>
<tr>
<td>General Target Elder Abuse Attitudes</td>
<td>0.51</td>
</tr>
<tr>
<td>General Target Elder Abuse Intentions</td>
<td>7.10a</td>
</tr>
<tr>
<td>General Target Elder Abuse Behaviors</td>
<td>52.25a</td>
</tr>
<tr>
<td>Specific Target Elder Abuse Attitudes</td>
<td>1.71</td>
</tr>
<tr>
<td>Specific Target Elder Abuse Intentions</td>
<td>3.49</td>
</tr>
<tr>
<td>Specific Target Elder Abuse Behaviors</td>
<td>1.48</td>
</tr>
</tbody>
</table>

\[ F = 2.250, p < .05. \]
Table I-20

Combined Treatment Group Means at Pretest, Posttest, and Followup

<table>
<thead>
<tr>
<th>Dependent Measure</th>
<th>Pretest</th>
<th>Posttest</th>
<th>Followup</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>Std. Dev.</td>
<td>Mean</td>
</tr>
<tr>
<td>Attitude</td>
<td>10.42</td>
<td>2.18</td>
<td>12.26</td>
</tr>
<tr>
<td>Anxt</td>
<td>6.42</td>
<td>2.55</td>
<td>6.54</td>
</tr>
<tr>
<td>Gen Att</td>
<td>205.99</td>
<td>16.06</td>
<td>206.33</td>
</tr>
<tr>
<td>Gen Int</td>
<td>213.95</td>
<td>17.62</td>
<td>209.85</td>
</tr>
<tr>
<td>Gen Beh</td>
<td>175.06</td>
<td>17.46</td>
<td>166.99</td>
</tr>
<tr>
<td>Spec Att</td>
<td>214.53</td>
<td>23.10</td>
<td>217.90</td>
</tr>
<tr>
<td>Spec Int</td>
<td>226.71</td>
<td>20.80</td>
<td>223.98</td>
</tr>
<tr>
<td>Spec Beh</td>
<td>185.29</td>
<td>20.54</td>
<td>187.50</td>
</tr>
</tbody>
</table>

Note.  
Attitude = Attitude toward Old People.  
Anxt = Personal Anxiety toward Aging.  
Gen Att = General Target Elder Abuse Attitudes.  
Gen Int = General Target Elder Abuse Intentions.  
Gen Beh = General Target Elder Abuse Behaviors.  
Spec Att = Specific Target Elder Abuse Attitudes.  
Spec Int = Specific Target Elder Abuse Intentions.  
Spec Beh = Specific Target Elder Abuse Behaviors.

\(^{a}\)Pretest different from Posttest and Followup.  
\(^{b}\)Pretest different from Followup.
Table I-21

Pretest, Posttest, and Followup Treatment Group Means and Standard Deviations

<table>
<thead>
<tr>
<th>Dependent Measure</th>
<th>Elder Abuse (n = 34)</th>
<th>Aging (n = 34)</th>
<th>Family (n = 34)</th>
<th>Pretest-Posttest (n = 27)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>SD</td>
<td>Mean</td>
<td>SD</td>
</tr>
<tr>
<td>AttitudeX</td>
<td>10.68</td>
<td>2.07</td>
<td>10.41</td>
<td>2.11</td>
</tr>
<tr>
<td>AttitudeY</td>
<td>12.09</td>
<td>1.94</td>
<td>13.15</td>
<td>2.17</td>
</tr>
<tr>
<td>AttitudeZ</td>
<td>12.24</td>
<td>2.23</td>
<td>12.81</td>
<td>2.37</td>
</tr>
<tr>
<td>AnxtX</td>
<td>6.59</td>
<td>2.35</td>
<td>6.56</td>
<td>2.53</td>
</tr>
<tr>
<td>AnxtY</td>
<td>6.79</td>
<td>2.59</td>
<td>6.19</td>
<td>2.53</td>
</tr>
<tr>
<td>AnxtZ</td>
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<td>6.59</td>
<td>2.78</td>
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<tr>
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<td>17.67</td>
<td>205.20</td>
<td>13.29</td>
</tr>
<tr>
<td>Gen AttY</td>
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<td>17.66</td>
<td>204.75</td>
<td>14.47</td>
</tr>
<tr>
<td>Gen AttZ</td>
<td>213.53</td>
<td>20.98</td>
<td>207.54</td>
<td>16.65</td>
</tr>
<tr>
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<td>20.05</td>
<td>212.79</td>
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</tr>
<tr>
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<td>17.73</td>
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<td>21.76</td>
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<td>16.43</td>
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</table>

(cont)
Table 21 (cont)

<table>
<thead>
<tr>
<th>Dependent Measure</th>
<th>Elder Abuse (n = 34)</th>
<th>Aging (n = 34)</th>
<th>Family (n = 34)</th>
<th>Pretest-Posttest (n = 27)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>SD</td>
<td>Mean</td>
<td>SD</td>
</tr>
<tr>
<td>Gen BehX</td>
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<td>21.36</td>
<td>174.04</td>
<td>16.03</td>
</tr>
<tr>
<td>Gen BehY</td>
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<td>16.85</td>
</tr>
<tr>
<td>Gen BehZ</td>
<td>172.68</td>
<td>21.66</td>
<td>164.07</td>
<td>16.50</td>
</tr>
<tr>
<td>Spec AttX</td>
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<td>24.72</td>
<td>217.57</td>
<td>23.72</td>
</tr>
<tr>
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<td>221.41</td>
<td>23.82</td>
</tr>
<tr>
<td>Spec AttZ</td>
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<td>27.36</td>
<td>218.73</td>
<td>23.32</td>
</tr>
<tr>
<td>Spec IntX</td>
<td>226.97</td>
<td>23.84</td>
<td>231.54</td>
<td>19.74</td>
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<tr>
<td>Spec IntY</td>
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<td>22.14</td>
<td>225.68</td>
<td>20.37</td>
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<td>Spec IntZ</td>
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<td>24.27</td>
<td>223.39</td>
<td>22.10</td>
</tr>
<tr>
<td>Spec BehX</td>
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<td>25.71</td>
<td>187.41</td>
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<td>27.10</td>
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<td>Spec BehZ</td>
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<td>24.36</td>
<td>189.31</td>
<td>19.72</td>
</tr>
</tbody>
</table>

(cont)
Table 21 (cont)

**Note.**  
Attitude = Attitude toward Old People.  
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Gen Int = General Target Elder Abuse Intentions.  
Gen Beh = General Target Elder Abuse Behaviors.  
Spec Att = Specific Target Elder Abuse Attitudes.  
Spec Int = Specific Target Elder Abuse Intentions.  
Spec Beh = Specific Target Elder Abuse Behaviors.

\(^a\)Elder Abuse Treatment Group mean higher than other Treatment Groups.
APPENDIX J

FIGURES
Figure J-1. Treatment Group by Time of Measurement Interaction: General Target Elder Abuse Attitudes.
Figure J-2. Treatment Group by Time of Measurement Interaction: Specific Target Elder Abuse Intentions.
Figure J-3. Treatment Group by Time of Measurement Interaction: Specific Target Elder Abuse Attitudes.
Figure J-4. Treatment Group by Time of Measurement Interaction: General Target Elder Abuse Behaviors.
Figure J-5. *Treatment Group by Time of Measurement Interaction: Personal Anxiety Toward Aging.*
REFERENCES


