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Assessing the Prevalence of Gendered Ageism Among Long-Term Care Employees

RESEARCH

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ABSTRACT

Ageism, discrimination based on age, particularly against older adults, intersects with other forms of discrimination, including sexism. In long-term care settings, gendered ageism can manifest in various ways, influencing both the quality and type of care older adults receive based on their gender. Understanding and addressing ageism in these settings is essential to ensuring the dignity, respect, and quality of life for older adults.

The purpose of this mixed methods study was to explore long-term care (LTC) employees' attitudes towards age and gender. A theoretical framework of feminist disability theory and compulsory youthfulness allows for an intersectional critique of ageism, sexism, and ableism and how each contributes to the oppression of long-living adults (age 80 and over) and disabled long-living adults.

Triangulation of data was achieved through surveys, interviews, and artifacts. Sixty employees completed an on-line survey consisting of demographic questions (age, race, gender, years employed in LTC, highest level of education, employment) and the Fraboni Scale of Ageism during the Coronavirus pandemic between August 21, 2020 and September 22, 2020. Data were analyzed using an independent samples t-test, One Way ANOVA, and One Sample Median Test. Twenty-one of these employees also participated in a phone interview during the time period of survey collection. Interview data were analyzed using open coding, axial coding, then thematic analysis. Cultural artifacts available to the primary researcher, and relating to the study, were noted. Considering the primary researcher was not allowed to enter the facility, the types of artifacts collected included social media posts via Twitter, Facebook, and the organization's blog. Blog and social media posts ranged from September 1, 2020 to February 1, 2021. Mixing of qualitative and quantitative data was completed for the final results by merging them via side by side comparison table.

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Quantitative findings indicated there was a statistical difference in FSA scores for younger adults (*M = 49.33, SD = 6.08*), adults (*M = 52.97, SD = 8.66*), and older adults (*M = 46.76, SD = 7.85*). Middle age adults had significantly higher FSA scores than younger adults and older adults. Qualitative data provided the strongest connection that sexist and ageist attitudes exist among employees as it demonstrated that some employees had different expectations of residents based on the residents' gender. A review of social media and policy artifacts concluded there was no resident perspective present in research topics, research trials, blog posts, or community events.

Overall, findings indicated employees' interactions with, and attitudes towards, residents were influenced by themes of compassionate ageism, ableism, and identity, which resulted in meta-theme caregiver validation and reward. Although most employees felt a deep connection with residents, they detached themselves from the aging process, instead seeking affirmation and recognition from residents through gratitude and positive interactions. Results from this study indicated certain power dynamics and suggested that employees actively sought positive care interactions with residents. Most employees preferred to care for residents who appeared to need assistance, were appreciative, and interacted with the employee in a positive way. When this occurred, employees enjoyed relationships with these residents and caring for them on a continuous basis. Essentially, employees preferred to care for someone who conformed to that employee's expectations for care.

INTRODUCTION

When Robert Butler first introduced the concept of ageism in 1969, it was intended to highlight the forms of marginalisation that ageing and long-living adults are exposed to daily (Butler, 1975; Krekula et al., 2018). Butler's definition of ageism, 'the process of systematic stereotyping or discrimination against people because they are old' (p. 48), draws a comparison to what racism and sexism create in relation to skin colour and gender. Ageism allows younger generations to see older people as different from themselves, eventually leading to the inability to identify with older adults as human beings (Butler, 1975). Although ageist attitudes and behaviours are not uncommon (Phibbs & Hooker, 2018), they are unique from other forms of prejudice, such as racism, ableism, or sexism. While not everyone identifies with the same race, ability, or gender, all intend to enter older adulthood (Aronson, 2019). Because all individuals age, the ageing experience should be considered the most universal of human experiences (Ayalon & Tesch-Römer, 2018; Lagacé et al., 2012).

LONG-TERM CARE

In the first quarter of 2018, healthcare became the largest employer in the United States, surpassing manufacturing and retail for the first time in history (Thompson, 2018). The trend is driven mainly by the increasing number of persons over the age of 60 utilising a majority of the nation's healthcare services (Wyman et al., 2018). In the United States, adults aged 65 or older account for 15% of the population yet are responsible for over 35% of total healthcare costs (Wyman et al., 2018.). Disabilities increase with age, an important consideration given the ageing US/United States population. For instance, in 2021, among those 65 to 74 years old, 23.9% reported having a disability. For those 75 years of age and older, this number jumped to 46.1% (Institute on Disability, 2023).

The oldest members of the baby boomer generation reached 73 years of age in 2019, requiring a significant demand in the long-term care (LTC) industry (Mohl, 2019). More than half of the 65 and older population is female, with women ages 85 and older outnumbering men two to one (Pew Research Center, 2016). As these numbers increase, LTC services will need to reflect the uniqueness of this growing population.

GENDERED AGEISM

Historically, older women have been depicted in popular culture and media as frail, dependent, and lacking value, whereas older men are often seen as distinguished or wise (Sontag, 1972). Such stereotypes can translate into healthcare and LTC contexts. For example, older women might be treated as if they are inherently more frail or less capable than their male counterparts, irrespective of their actual health or abilities.

Calasanti (2005) emphasizes how societal standards of femininity and masculinity can shape experiences in later life. In LTC settings, this might mean that older women are less likely to receive interventions or treatments typically associated with masculinity (like

specific rehabilitative exercises) or that older men might be overlooked for emotional or psychological support due to stereotypes about stoicism.

Gendered ageism affects not only the direct care older adults receive but also their psychosocial well-being. A study by Chrisler et al. (2016) found that older women often face a double standard of ageing, wherein they experience heightened scrutiny and negative judgements about their appearance and capabilities. Such perceptions can adversely affect their self-esteem, mental health, and life satisfaction.

Negative attitudes towards older adults persist in the healthcare community across professional disciplines and care settings (Inouye, 2021; São Jose & Amado, 2017; Wyman et al., 2018). A systematic review found that ageist attitudes were common among health care professionals, and these negative perceptions of age influenced how older adults felt about themselves (São José & Amado, 2017). Negative attitudes are potential barriers to health equity and health outcomes (Wurm et al., 2017), and ageism may undoubtedly be a contributing factor that leads to neglect or exploitation of older adults (Band-Winterstein, 2015). Front-line LTC employees spend the most amount of time with residents in personal, potentially vulnerable situations. Therefore, a better understanding of the prevalence of ageist attitudes among healthcare workers in LTC can inform practice. Research in LTC, through a feminist lens, can be of value to future research in health care and professional practice as it can highlight the experiences of growing marginalised groups.

THEORETICAL FRAMEWORK

FEMINIST DISABILITY STUDIES

Rosemarie Garland-Thomson first introduced the field of feminist disability studies in 1997. Feminist disability studies confront the ways in which we understand human diversity, the body, and social formations that interpret bodily differences (Garland-Thomson, 2002). Ageist attitudes and behaviours, which are culturally learned and passed down through each generation, generally perceive aged individuals as 'The Other' in youth and mid-life (Kang & Kim, 2022; Sandberg, 2013), similar to the way individuals with a disability are perceived by society (Garland-Thomson, 2002). Older and elderly adults can often be viewed as frail, infirm, and incapacitated, especially those individuals who require nursing home care.

Ageism, like disability, is primarily socially constructed (Butler, 1975), as are female body ideals that embrace youth (Sanberg, 2013). Ageism is the driver of unfair practices in the allocation of opportunities and resources (Palsgaard et al., 2022), which extend to health care and LTC in a youth-oriented culture (Carney & Gray, 2015). Research has also found that having an aged appearance has social and financial consequences. Due to age discrimination, older individuals, especially women, are more likely to, and at times expected to, attempt to slow the ageing process (Brown, 1998), as the ability to remain young in appearance is often associated with one's ability to age successfully (Calastani, 2005).

FEMINIST DISABILITY THEORY

Feminist disability theory (FDT) offers a cultural critique of how socially constructed systems of gender, race, ethnicity, ability, class, and sexuality create and contradict one another (Garland-Thomson, 2011). FDT research aims to challenge stereotypes and give voice to various intersectional experiences through representation, focus on the body, and the politics of medicalisation and appearance of the female and disabled body (Garland-Thomson, 2005).

Although the focus of FDT has been primarily on the experience of being disabled and female, there is also a relationship with the ageing process. Power relations, medicalization of the older body, and appearance expectations are part of the ageing experience, especially for women (Twigg, 2004). As Garland-Thomson (2005) states:

> 'Seldom do we see disability presented as an integral part of one's embodiment, character, life, and way of relating to the world. Instead, we learn to understand disability as something wrong with someone, as an exceptional and escapable calamity rather than as what is perhaps the most universal of human experiences.' (p. 1568)

At its core, FDT interprets disability as a cultural issue rather than a medical or individual issue and examines the power relations within that construct (Garland-Thomson, 2011). Disability is not a flaw but a representation of many individuals, a topic suitable for a wide range of inquiries and research (Garland-Thomson, 2011). As FDT seeks to alter traditional feminism to include and empower women with disabilities, age can also empower individuals, especially women (Morell, 2004) and the feminist movement (Pohl & Boyd, 1993).

Disability is substantial among long-living individuals and often increases with age (Park-Lee et al., 2012). Similar to disability, old age is rarely viewed as a positive way to relate to the world. Yet, because all individuals age, the ageing experience should be considered the most universal of human experiences (Ayalon & Tesch-Römer, 2018; Lagacé et al., 2012).

COMPULSORY YOUTHFULNESS

Compulsory Youthfulness (CY) addresses the oppression supported by the successful ageing paradigm by highlighting how ableism and ageism intersect with successful ageing (Gibbons, 2016).

> 'Framed through an intersectional perspective, compulsory youthfulness is produced through ableism and ageism, which are systems of beliefs, values, and practices that create and reinforce youthfulness and able-bodied/able-mindedness as ideals, thereby casting old age and disability as devalued states of being.' (Gibbons, 2016: p. 2).

CY brings awareness to successful ageing discourses that falsely present both being old and disabled as choices rather than the result of biological changes and cultural, political, economic, and social structures (Gibbons, 2016).

Cultural stereotypes often paint old age as a time of loss, dependence, frailty, and disability (Gibbons, 2016). Most individuals expect to become functionally limited in older adulthood. Thus, impairment and old age are typically linked, as are able-bodiedness and youthfulness (Gibbons, 2016). In an attempt to counter these stereotypes, activists, social scientists, and policymakers have engaged in efforts to reframe old age as a time of leisure, functionality, and health. Successful ageing has often been used to associate the ageing process with health, functionality, and the absence of disease and disability (Rowe & Kahn, 2015). While the successful ageing movement aims to eradicate negative stereotypes about old age, the unintended consequence has been a promotion to remain youthful and able-bodied throughout the life course. Many individuals attempt to counter old age stereotypes through successful ageing techniques, assuming they can stay disability- or ageing-free by choosing to participate in youthful practices. As a result, older adults who are unable or unwilling to remain young-looking and able-bodied/able-minded are seen as abnormal and responsible for their own perceived vulnerability (Gibbons, 2016).

FDT AND CY IN LONG-TERM CARE

Pairing CY with FDT allows for an intersectional critique of ageism, sexism, and ableism and how each contributes to the oppression of long-living adults and disabled long-living adults. Although ageism should not be redefined as ableism, it is essential to consider the connection between ageing and disability, as 'disability and aging are processes that interweave throughout the life course' (Verbrugge & Yang, 2002: p. 253). In parallel, FDT and CY can address this connection, specific to the gerontological and feminist discourse surrounding long-living adults, resulting in the inclusion of disability and age in feminist work.

FDT and CY seek to create a social justice shift by reimagining disability (Garland-Thomson, 2005) and how society perceives the ageing process (Gibbons, 2016). A similar shift in perspective can also be applied to practitioner and researcher efforts to combat ageist stereotypes among older women and men in health care (Pohl & Boyd, 1993). FDT and CY can aid in assessing and explaining employees' attitudes towards ageing and gender among residents in LTC. Potential sexist and ageist attitudes and behaviours in LTC could be the result of culturally constructed roles and definitions of acceptable ageing for women and men. For example, older adults in institutional care could be assumed to be at fault for their increased need for assistance (Chrisler et al., 2016; Gibbons, 2016). Negative ageing attitudes not only make it easier for the perceiver to disregard the welfare and humanity of older adults but also impact older adults' physical and mental health and well-being (Bellingtier & Neupert, 2016; Chrisler et al., 2016; Palsgaard et al., 2022).

Research has only begun to assess LTC employees' attitudes about gender and ageing and how these attitudes are enacted in social and professional interactions with residents (Ayalon, 2020; Haunch et al., 2021). A feminist disability analysis of LTC employee attitudes towards ageing can potentially improve public and private policies in health care and LTC and respond to the needs of all individuals.

PURPOSE AND METHODS

The purpose of this study was to assess attitudes towards ageing among LTC employees, determine if ageist attitudes exist, and explore if resident gender impacts these attitudes. A mixed-methods case study design was utilised (Creswell & Creswell, 2018). Although the study was qualitatively focused on exploring employees' attitudes and beliefs towards ageing, both qualitative and quantitative measures were employed, and data from both sources were collected concurrently (Morse, 2003). Mixed-methods case study research is utilised when there is a need for research that captures and provides insight into the complexity of pressing social, economic, and health issues. Both mixed-methods research and case study research offer unique methodological advantages to address the complexity of research problems and issues (Clark, Foote & Walton, 2018), such as attitudes and beliefs towards ageing during the COVID-19 pandemic. Data were analysed separately and then integrated for interpretation.

LOCATION

The chosen LTC site serving as the case for this study is a medical school affiliate and leader in influential geriatric research to advance the quality of life for older adults. Located in a densely populated high-income state capitol in the northeastern region of the United States, the two main campuses attract professionals interested in working with residents in LTC, rehabilitation, and assisted living. The Centers for Medicare & Medicaid Services (CMS) developed a quality rating system to help consumers compare nursing homes. This organisation was purposefully selected for its CMS quality rating system scores, similar to those of other New England facilities.

PARTICIPANTS

All participating employees were required to work at the organisation during the study, interact daily with residents in the facility, and agree to complete a survey. Informed consent was collected from interested employees in the survey portion of the study. The primary researcher adhered to all government and facility social distancing protocols during the data collection process during the COVID-19 pandemic. The study was approved by Clemson University's institutional review board (IRB2020-163) prior to contacting participants.

The organisation's email system sent an e-mail invitation to participate to 1,012 employees (460 nurses, 513 CNAs, 21 life enhancement professionals, ten expressive arts therapists, and eight social workers). Sixty employees agreed to participate in the study during the height of COVID-19, resulting in an approximate six percent return rate. Fifty-six employees completed the survey in full within the study time frame. Demographic information of survey participants includes (a) Gender: Female (56), Male (0); (b) Race: White (32), Black or African American (16), Hispanic or Latino (3), Asian (1) and More than One Race (4); (c) Age: Ages 18–35 (9), Ages 35–55 (30) Age 56 and over (17); and (d) Current Position: Nursing Assitant (17), Nurse (25), Clinical Coordinator (5), Expressive Arts Therapist (3), Social Worker (2), Recreation Coordinator (3) and Dietitian (1).

A total of 21 employees completed a 30- to 45-minute phone interview with the primary researcher after completing the survey. Employees were all female, full-time, part-time, or per diem, between the ages of 18 and 65, and identified as: nurses (10), clinical coordinators (4), nursing assistants (3), social workers (2), recreational therapists (1) and dietitians (1).

Participants who completed the survey were asked if they would also be interested in completing an interview. The primary researcher contacted those who indicated 'yes' on the survey. Surveys and interviews took place during the same period. Interviews were scheduled after participants completed the study.

DATA COLLECTION

Quantitative Data Collection

The primary researcher created the survey, which was administered through Qualtrics, a web-based survey platform. Employees first completed demographic questions and the Fraboni Scale of Ageism (FSA) (Fraboni et al., 1990). The FSA is divided into three primary factors: antilocution, avoidance and discrimination (Fraboni et al., 1990). Antilocution refers to remarks made against a person, group, or community that are not addressed directly to the target; avoidance is the behaviour of avoiding the targeted 'out groups' and discrimination is the prejudicial treatment of the targeted 'out groups,' which leads to significant disadvantages for the targets of this behaviour (Allport, 1979).

The FSA is a self-reporting measurement scale of 29 questions with a four-point Likert format for scoring. Response choices are presented as 'strongly disagree,' 'disagree,' 'agree' and 'strongly agree'. Responses are scored from one through four for negative statements and four through one for positive statements. Higher scores indicate higher levels of ageism. Responses to the FSA were assigned values (1, 2, 3, or 4) and quantified according to FSA scoring. After thorough testing, the FSA was found to have adequate construct validity and high internal reliability ($\alpha = .86$) compared to other measures (Fraboni et al., 1990).

Qualitative Data Collection

Though interview questions for a case study follow a formal protocol, the interview itself was conducted much like a conversation and took place with great care, considering the topic's sensitivity (Yin, 2018). Interviews followed a semi-structured design and asked employees about their relationships with residents and their views on aging. Interview questions were developed by the primary researcher and vetted for biased, leading, or dead-end questions through collaboration with secondary researchers. Interview questions included a grand tour question: 'Please describe what it is like to work with the residents at this facility. Feel free to provide stories and examples, using as much detail as possible.' Follow-up prompts included: 'What did you mean when you said _____', 'Can you describe that more in detail?', 'Can you tell the story of what led up to that incident?' 'Please tell me more about that.', 'How did you feel when the client did that?' 'Why do you think you felt that way?' and 'What did you do when the client did that?' Other prompts included 'Tell me about your career', 'Let's talk about aging/gender', 'Tell me what it's like working in long-term care during the pandemic.', and 'Tell me what your residents are able to do.' The primary researcher conducted all in-depth phone interviews, which were collected via audio recorder.

DATA ANALYSIS

Since all data collection took place through one organisation, the qualitative and quantitative data were analysed at the same stage in the research process (Creswell & Creswell, 2018). Findings were compared during cross-analysis. The mixing of data was completed for the final results. Results from qualitative and quantitative findings were merged through side-by-side comparison. All identifying information was kept confidential and in a locked drawer in the primary researcher's office.

Quantitative Data Analysis

Quantitative data from the survey and demographic variables were entered into the Statistical Package for Social Sciences (SPSS) and coded in preparation for

analysis. The analysis included an independent samples t-test, One-Way ANOVA, and one sample median test. The data were tested for distribution normality through a Shapiro-Wilk test. Levene's test of homogeneity was used to ensure the variance was equal across groups.

Qualitative Data Analysis

All interview information was audio recorded through a recording device, transcribed verbatim by an outside agency, reviewed by the primary researcher, and analysed with the assistance of Nvivo qualitative data analysis software. After the interviews, open coding, axial coding, and thematic analysis occurred (Saldaña, 2016). The initial open coding process considered frequent words and concepts carefully and led to pattern coding, resulting in several codes such as *successful ageing, control, loss, mortality, safety, and connection*. These codes were then reviewed and organised during the axial coding process to create more structure. The primary researcher focused on how participants felt about themselves and the residents they cared for within the concept of aging. (Saldaña, 2016). Codes were then collapsed into themes to explore concepts of personal ageing and the perceived ageing of individuals in LTC (Saldaña, 2016). A secondary researcher reviewed transcripts, confirmed patterns and codes, and assisted in coding and cross-thematic development.

Final Mixing of Data

Once the quantitative and qualitative data had been collected, all the data were reviewed for the final results. The mixing of qualitative and quantitative data was completed for the final results by merging them via a side-by-side comparison table, giving equal priority to both methods (Creswell & Creswell, 2018).

Methods of Verification

Statistical measures such as validity and reliability cannot easily be used to judge the rigour of qualitative work (Anfara et al., 2002). Instead, Lincoln and Guba (1985) established substitute criteria they referred to as trustworthiness. Because the emphasis of the study lies in qualitative data, Lincoln and Guba's substitutive criteria were used. The transition from statistical terms to terms of trustworthiness, as expressed by Lincoln and Guba (p. 42), is illustrated in Table 1.

STATISTICAL TERM	TRUSTWORTHINESS TERM	MEANS OF ACHIEVEMENT
Internal Validity	Credibility	Data Convergence
External Validity	Transferability	Purposeful Sampling
Objectivity	Confirmability	Reflexivity, Secondary Researcher
Reliability	Dependability	Participant Audit

Table 1 Achieving Trustworthiness.

RESULTS

QUALITATIVE FINDINGS

Qualitative analysis of interviews yielded three major themes: compassionate ageism, identity and ableism. All three themes contributed to a meta-theme of caregiving validation and reward. The thematic structure is depicted in Figure 1.

Compassionate Ageism

The theme of compassionate ageism was constructed by collapsing codes of *vulnerability*, *protection*, and *fear*. Compassionate ageism is the belief that all older adults are vulnerable and require special policies to help and protect them (Friedan, 1963). A majority of employees interviewed expressed affection for the residents in their care. Often, residents were referred to as 'family,' and work was called 'home away from home'. Employees expressed comfort in their role as carers and often identified as protectors. Employees also made statements describing residents as vulnerable. Many employees reported that they identified residents as susceptible to harm and wanted to protect them.

Vulnerability and fear seemed to be exacerbated by the pandemic, even though not all residents diagnosed with COVID-19 died from the virus. When asked about caring for residents during COVID-19, an employee stated:

> I see them as even more vulnerable than I did before. They were almost like a captive audience. There was nothing they could do. They couldn't run, they couldn't hide, and they were so dependent on us to keep them safe, and that's still staying with me.

Yet, the susceptibility of the residents was viewed positively by most employees. One participant drew a similarity between the terms 'vulnerability' and 'childlike' in residents with dementia, stating that they preferred to work with residents who appeared innocent and in need of assistance. When asked why the dementia population was their favourite to work with, the employee stated: 'I think because they're just so vulnerable and almost

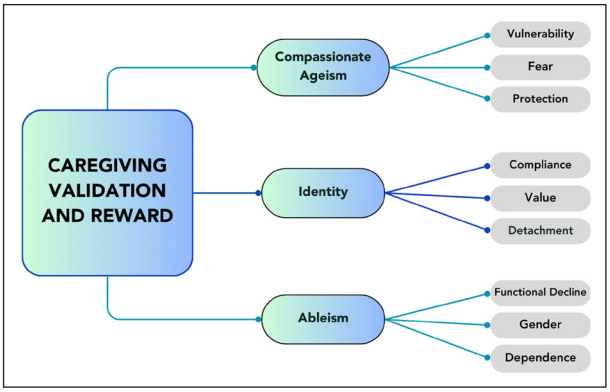

Figure 1 Thematic structure of caregiving validation and reward.

childlike. That just like I feel a sense of protection towards them. I want to be their protector.' Residents were viewed as not only vulnerable but also helpless. COVID-19 appeared to increase the perception of victimization among residents. Employees feared for the residents, increasing the perception of resident vulnerability.

Identity

The theme of identity was constructed by collapsing codes *value*, *compliance*, and *separation*. Identity refers to employees' ideal image of who they are and who they want to be (Meister et al., 2014). Employees want to portray their identity to the world, which usually comes about as they journey through life, and experiences are used as benchmarks for evaluating themselves (Meister et al.). Specifically, the theme of identity refers to how employees connect with residents, themselves, and the ageing process. Employees valued their roles as carers, preferred to work with residents who complied with the employee's care efforts, and often viewed their ageing journey as separate from the ageing journey of the residents they cared for.

Employees reported that they valued their interactions with the residents, how these interactions translated to job skills and how the interactions made them feel about themselves. Interactions with residents resulted in employees receiving something of value from the residents. For one employee, this was friendship: 'Once they become attached to you and feel comfortable with you talking about things. It's almost like you gain a friend.' Employees reported finding value in these friendly interactions with residents and spoke to how these interactions made them feel in return. One employee stated:

> Every day, I sing to Irene, 'You Are My Sunshine' and it makes me feel better. On my worst days, I have to see Irene and sing. She used to pull my hand and say, 'I love you like I love the sunshine.' To me, there's no better feeling.

Often, caregiving is framed as a natural act of love or compassion rather than skilled work (Scales & Lepore, 2020). Direct care workers often report being intrinsically motivated to pursue their work by their desire to help others (Scales & Lepore). Not only were employees intrinsically motivated to work in LTC, but they also pursued this work for altruistic purposes.

Although a high value was placed on resident interactions, not all interactions were valued the same. Residents were expected to respond to care efforts with patience and gratitude. Favourite residents were those who could comply with the employee's care exchange expectations, such as engaging positively with the employee. Resident compliance ensured that employees experienced gratification during the care exchange and fulfilled the employee's desire to be needed within that employee's expectations. One employee stated: 'The ones that really need me. The ones that can't really help themselves, but that I can do for them. I like them the best.' Not only did employees have a desire to be needed, but they also expected the care interaction to be positive and rewarding. Many employees stated that their least favourite residents were those who were unappreciative of the service they were providing. One employee took negative responses to care interactions personally. As she reported: 'If you're that intimate with somebody, and they are just so nasty to you, it hurts.' Although employees desired positive interactions with complying residents, there was also the expectation that residents truly needed their assistance.

Even though employees placed value on positive interactions with residents and stated they enjoyed caring for and spending time with older adults, they were quick to detach themselves from the residents when the topic of their ageing was introduced. When asked if they would one day enter a nursing home, only two of the 21 employees interviewed stated they would willingly live in a nursing home. Most said that their quality of life was dependent on being able to stay home with their families for as long as possible. One employee stated:

> This is weird because it's the opposite thing, but I want one of my kids to take care of me. I don't want to be in a nursing home at all. I just want to be home with my family. This isn't happiness, this isn't quality.

For others, entering a nursing home was typically associated with a loss of freedom and functioning. Many employees stated they wanted to remain social and active, something they did not connect with living in a nursing home. One employee shared: 'I need to have people around, I need to go to the beach, I need to smell the flowers, I need to sit back, and even if I'm creeping on my knees like a baby, I want to stay home.'

Most employees expressed a need to remain happy, healthy, and surrounded by loved ones as they age. Although employees desired positive social connections with the residents, and many referred to residents as 'family', most could not see themselves happily living in the same environment they enjoy working in. One employee reported:

> We had to stay over a couple of times during snowstorms, and I remember we slept in some of the empty patient's rooms. I remember waking up and just looking at those walls and thinking how horrible it would be to live here.

Even though employees enjoyed working with older adults and often sought positive care interactions, they

did not look forward to their own ageing or becoming nursing home residents themselves. Employees identified as 'non-ageing'. That is, they separated themselves from the ageing process the residents were experiencing.

Ableism

The theme of ableism was constructed by collapsing codes of *functional decline*, *dependence* and *gender*. Ableism refers to attitudes in society that devalue and limit the potential of persons with disabilities (Maybee, 2020). Considering that older adults can be discriminated against based on their lack of abilities, not only their age, Van der Horst and Vickerstaff (2021) suggest that ableism, or differential treatment based on impairments, is indeed part of ageism. In this context, differential treatment of older adults could be based on impairments that older people are more likely to have, such as cognitive or physical limitations, rather than age (Van der Horst & Vickerstaff). One employee expressed a distinct preference for the more physically interactive residents:

> I don't mind if they have memory issues but I like to work with ones that are still mobile. That can walk with a walker or ones that are in a wheelchair but enjoy going off the unit and where we can take them outside to sit.

Often, employees expressed that a resident's quality of life was directly related to independence and physical and mental functioning. Those who aged and experienced impairments, resulting in dependence on others, would have little to no purpose in life. Relying on others for care was viewed as a burden. One employee assumed that residents who required more assistance felt like they were a burden to others:

> That independence also helps with your self-esteem and your confidence and your mental health because you don't want to feel like such a burden to everyone else for them to take care of you. I think once they start slowly losing their independence, they lose a sense of self.

Employees also expressed dissatisfaction with the possibility of their own functional decline as they age. Although employees stated they enjoyed helping the residents, dependence in older age was viewed as a weakness for both themselves and the residents. Employees equated confidence, mental health and self-esteem with one's functioning ability. In this context, ageing itself appears to be an impairment.

The gender of the residents also appeared to impact how employees responded to their needs. In general, women were perceived or expected to be more independent than men. For some, this was attributed to projecting the role of carer on female residents. One employee stated:

> I always think women as a whole are stronger and I think that the men, a lot of time are used to being taken care of by the women, so, I think that the women tend to be a little more independent.

Considering that all of the employees interviewed were female, it is possible that employees projected their feelings and expectations of caregiving onto the female residents, resulting in an expectation of ability. One employee attributed this perceived independence to a need to remain young. She stated: 'I think women want to fight for their youth a little bit more, whereas men are more accepting of it.' In general, female residents were perceived to be more resilient than men. It is possible that employees assumed ageing expectations based on resident gender.

Caregiving Validation and Reward

Data suggested that when interacting with residents, employees:

a. valued their identity as an older adult carer,
b. viewed residents as vulnerable and sought to protect them, especially during the COVID-19 pandemic,
c. feared for their own future limitations,
d. detached themselves from the ageing process,
e. equated dependence with a decreased quality of life,
f. desired gratitude from the residents for services provided, and
g. sought approval through positive care interactions.

When employees felt needed, received gratitude from residents, and experienced the desired positive interactions between carer and care receiver, they received validation. This validation created an environment of reward based on power dynamics between employees and residents. Employees actively sought recognition from residents who received care from them.

In power-dynamic scenarios, residents needed to fulfil the expectations of the employees. Most employees felt a connection with residents that fit the profile of a typical nursing home resident. Preferable residents were compliant, long-living, and grateful for the care provided by the employees. These residents rewarded employees with positive interactions, creating a resident/carer co-dependence. Residents need assistance, and employees depend on recognition and gratitude from this assistance to feel successful in their role as carers.

Overall, employees sought validation for the care provided to residents and received rewards when care interactions met their expectations. Residents were able to provide this desired reward by being a certain age (typically older), having an appropriate diagnosis for their age, and positively responding to employees.

QUANTITATIVE FINDINGS

Parametric statistical tests were used to compare FSA scores between groups. A Shapiro-Wilk test did not show a significant departure from normality for antilocution scores, W(56) = .963, p = .088. A Shapiro-Wilk test did show a significant departure from normality for avoidance scores, W(56) = .952, p = .027, and discrimination scores, W(56) = .954, p = .033. Table 2 details the variances for each factor.

Demographic variables included highest level of education, years employed in LTC, gender, employment, nursing department versus non-nursing department, current position, age, and race. An independent samples t-test was conducted to determine if there was a relationship between pre- and post-secondary school and overall FSA scores, gender and overall FSA scores, and department and overall FSA scores. There was no statistically significant difference in FSA scores based on based on pre- and post-secondary school $t(53, 1.298) = .181$, p = .20, gender $t(54, 2.328) = .315$, p = .754 or nursing versus non-nursing department $t(54,13.065) = -1.51$, p = .137.

A one-way ANOVA, with post hoc option Least Significant Difference (LSD), was conducted to determine if there was a relationship between years employed in LTC and overall FSA scores and race and overall FSA scores. There was no statistically significant difference in FSA scores based on years employed in LTC, $F(2, 54) = .511$, p = .603, or race, $F(5, 55) = .394$, p = .851.

Due to the small sample size, ages were combined to create three larger groupings for more comparable testing. A one-way ANOVA, with post hoc option LSD, was conducted to determine if there was a relationship between younger adults (age 18–35), middle-aged adults (age 36–55), older adults (age 56 and over), and overall FSA scores. A statistically significant difference in FSA scores based on this larger grouping, F(2, 55) = 3.310, p = .044. Overall, there was a statistical difference in FSA scores for younger adults ($M = 49.33$, $SD = 6.08$), adults ($M = 52.97$, $SD = 8.66$), and older adults ($M = 46.76$, $SD = 7.85$). Middle-aged adults had significantly higher FSA scores than younger adults and older adults, as presented in Table 3.

DISCUSSION

Middle-aged adults, aged 36–55, had statistically significantly higher FSA scores than younger adults (age 18–35) and older adults (age 56 and over). This result could indicate that middle-aged adults, at a stage closest to the older adult age bracket, are reminded of their mortality by working with older adults. Research has shown a positive association between ageism and end-of-life anxieties (Bergman et al., 2018). In addition, a recent study found a correlation between high death anxiety and increased levels of ageism among nurses working with older adults (Rababa et al., 2021).

Middle-aged adults in this study could have also begun experiencing ageism themselves. Chasteen et al. (2020) discovered that middle-aged and older adults reported ageism in the workplace while seeking goods and services. It is plausible that middle-aged adults are rejecting the ageing process and attempting to differentiate themselves from older adults. Middle-aged adults could also be making efforts to age successfully, believing they have control over the ageing process.

Qualitative data provided the most robust connection that sexist and ageist attitudes exist among employees, as it demonstrated that some employees had different expectations of residents based on the residents' gender. Still, most employees expected positive interactions when providing care for residents. When interviewed, employees expressed a desire to care for and protect the residents. Fear for resident safety is not surprising, considering that since the beginning of the pandemic, COVID-19 has been portrayed as an infectious disease that primarily affects older adults (Ayalon, 2020). Although marked by good intentions, the desire to protect older adults can potentially frame them as victims of the ageing process. This victimisation can lead to a corruption of care, which, based on statements expressed in the interviews, is not the employees' intention. In addition, implicit age and gender bias appeared to enforce participants' own caregiving identities. The more the employee felt needed, the more the employee felt a sense of validation and reward in the caregiving exchange.

VARIABLE	N	FSA MEAN	STD. DEVIATION
Younger Adults (18–35)	9	49.33	6.08
Middle-Aged Adults (36–55)	30	52.97	8.66
Older Adults (56 and over)	17	46.76	7.85
Total	56	50.50	8.41

Table 3 FSA Overall Score by Young Adults, Adults, and Older Adults.

	N	RANGE	MIN	MAX	MEAN	STD. DEVI.	SKEWNESS	KURTOSIS
Antilocution	56	15	11	26	19.00	3.97	–.119	–.925
Avoidance	56	12	11	23	15.50	3.01	.489	–.369
Discrimination	56	10	11	21	16.04	2.77	–.065	–1.01

Table 2 Range of FSA Factors.

AGEING DETACHMENT

Many employees praised their positive relationships with residents but reported they would not live in a nursing home if given the opportunity. There was little acknowledgment that, at some point, employees could reside in a nursing home or experience other signs of aging. Even though most employees reported pride in working with older adults in LTC, many employees shared plans to control the ageing process to maximise their own quality of life. Comments that conveyed future attempts to control the ageing process were reminiscent of Rowe and Kahn's successful ageing model, which could suggest that employees feel residents reside in LTC due to a personal lack of effort to remain in the community. By detaching themselves from the ageing process, employees effectively othered the residents.

POWER DYNAMICS

Results from this study suggested that employees sought positive care interactions with residents. Most employees preferred to care for residents who appeared to need assistance, were appreciative, and positively interacted with the employee. When this occurred, employees enjoyed relationships with these residents and enjoyed caring for them on a continuous basis. Essentially, employees preferred to care for someone who conformed to that employee's expectations for care.

The nursing home is a controlled social environment. Residents are exposed to people and situations chosen by leadership. Considering that healthcare professionals are involved in intimate exchanges of care that include personal hygiene and body management, it is plausible that care relationship experiences can potentially shape one's perceptions of the other, impacting how care is given and received. As such, carer/care receiver dynamics can be fragile and vulnerable to negativity if the carer carries age bias (Drewniak et al., 2017; Palsgaard et al., 2022). For example, implicit age bias or gender bias could lead to various forms of elder abuse and impact the self-concept of the resident.

IMPLICATIONS FOR PRACTICE

There are many ways geriatricians and health care professionals can work towards serving long-living adults with less implicit bias regarding age, gender, disability, culture and other identities and backgrounds. Critiquing and changing how healthcare professionals are educated is an excellent place to begin. Progress in geriatric training within curricula across various health professions must catch up with the need for increased ageing services (Bardach & Rowles, 2012). For example, physicians receive at least three times more medical training focused on paediatrics than geriatrics, with many physicians receiving no formal training in geriatrics (Inouye, 2021). Another example includes the need for more gerontological content within the U.S. nursing curricula. Recognising the unique situations of each individual and coordinating care to enhance strengths, not ageing stereotypes, will increase the quality of life for residents in LTC.

LIMITATIONS

The limitations of this study included a small sample size, female-only participants, and limited employee availability and data collection due to the current pandemic. Although the survey was available online, employees could have been too overwhelmed to participate simply by living and working through the pandemic (Shreffler et al., 2020). Front-line healthcare workers are typically female (Day & Christnaucht, 2019) and did experience an increase in work-related stress due to COVID-19 (Shreffler et al., 2020). First, the primary researcher could only recruit virtually via email, which could have impacted the return rate. Depending on work schedules and responsibilities, some employees may have had varying access to email. Second, the organisation was located in New England. Thus, it cannot be assumed that the results apply to other areas of the United States. Third, the primary researcher originally intended to conduct observations of resident-carer interactions. Observations would have allowed the primary researcher a data point that was not self-reported. This study's strengths include using mixed methods and qualitative data collection to explore LTC employees' attitudes towards ageing and the residents they care for.

CONCLUSION

Ageism, sexism, and ableism are pervasive forces that underlie and shape the lives of long-living people and the views they hold of themselves (Duffy, 2017). Research suggests that women, long-living individuals, and people with disabilities do not fit societal expectations (Browne, 1998; Garland-Thomson, 2011), potentially leading to prejudice and discrimination (Buttigieg et al., 2018; Calasanti, 2004; Gibbons, 2016). Creating a priority for identifying and addressing implicit ageism in LTC can shift our health paradigm and redesign a long-term healthcare system that can improve health outcomes for all identities, ensuring equitable access to health needs and removing outdated facility policies. Future research should continue to explore employee attitudes towards ageing, resident attitudes towards their own ageing and relationships between residents and employees providing intimate care.

COMPETING INTERESTS

The authors have no competing interests to declare.

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