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Ohio Long-Term Care Research Project

IMPOSSIBLE SELVES? CHALLENGES AND STRATEGIES FOR ENCOURAGING INDIVIDUAL LONG-TERM CARE PLANNING

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April 2000

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Impossible Selves?
Challenges and Strategies for Encouraging Individual Long-Term Care Planning

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Executive Summary

There is good news about aging these days. While both the numbers of older people and the proportion of the population they represent are increasing, in part due to an increase in life expectancy, the number of years we may expect to live as active, healthy elders is also increasing. This is beginning to change both attitudes and behaviors about aging. Our expectations about our own aging, if we are able and willing to think about it at all, influence the way we live our lives today, as well as the way we plan, or fail to plan, for our futures as old people.

The bad news about aging is that Americans generally fail to plan, particularly for the possibility that they may need long-term care in late life. Hence, long-term care decisions are usually made at a point of crisis, with unnecessary financial and social costs, on both a personal and public level. Financial costs include the depletion of personal assets and/or an increase in the public burden, particularly through Medicaid. Social costs include loss of personal options, family disruption and strain, and costs to communities who must organize themselves to care for people in crisis.

How can we plan for the possibility of late-life dependency? We can plan financially, socially, and environmentally. Some Americans are in a financial position to purchase long-term care insurance, to self-insure, and/or to make the move to a continuing care retirement community. All of us can make social plans, which include discussions and agreements (sometimes legal) with family members or other potential caregivers. And, we can make environmental plans that expand our options pre-crisis, for example a geographic move to be closer to a potential caregiver, or a change or adaptation of housing to extend the possibility of living independently.

Why have we failed to engage in such planning? This report summarizes findings from a study conducted to explore the dynamics of planning or failure to plan for the possibility of long-term care need in late life. Eighteen individuals, aged 64-90, were interviewed; four had made financial plans, two were in a stage of information gathering, and twelve were self-identified non-planners. Four special challenges were identified as important to overcoming inertia about planning, and each of these challenges suggests policy and program strategies to encourage planning.

To overcome inertia about planning, older adults must have: 1) a conception of a future self as dependent; 2) a perception of the effects of dependency; 3) a concern today about future effects; and, 4) reasonable beliefs (self-efficacy beliefs) about our capacities to avoid dependency, to cope with its effects, and to make plans today that will be useful later.

Strategies to encourage planning include addressing the sources of self-efficacy beliefs: previous or related mastery experiences avoiding dependency, coping with it, or planning for it; vicarious experiences, or the experiences of role models for avoiding, coping, and planning; verbal persuasion; and the physical and emotional states of potential planners. Finally, broad policy approaches to encourage individual long-term care planning are identified. Policy makers should work toward policies that expand long-term care options to include those that can be comfortably included in our conceptions about ourselves as dependent older adults; and, financial incentives for long-term care planning should be expanded.

Acknowledgments

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Mary is 81 years old, and recently widowed. She has two living children: one daughter lives three states away, and a son lives an hour away with his wife and ailing mother-in-law. Another daughter succumbed to cancer ten years ago. Mary and her husband Ned enjoyed average health and an active life until her husband, a retired school principal, died suddenly. They had lived modestly throughout their married lives; Mary still lives in the small two-story house in which they raised their children. Though they had saved $80,000 for retirement, they began using the principle from that savings soon after Ned retired on his educator's pension. A staunch believer in education, Ned put $1,000 each year into a trust fund for his grandchildren's education. Mary now receives a reduced widow's pension, a fraction of her husband's pension, and the savings account stands at $20,000. Though both of Ned's older sisters had spent the last years of their lives in nursing homes, Ned and Mary gave little thought to the possibility that they might experience the same need some day. As a matter of fact, Ned was quite convinced that he would instead follow the same fate as his own father and "drop dead" suddenly; for that event, he had made detailed funeral and burial plans, covering Mary's eventual death as well.

Yesterday Mary had a stroke, collapsing at the kitchen sink. She has lost most of her speech and the use of the right side of her body. Doctors expect Mary to live, and after several weeks of therapy to aid her communication and mobility, Mary will still require 24-hour care. Mary's daughter and son have been summoned for a family conference with the hospital discharge planner whose immediate responsibility it is to prepare Mary for the transition from hospital to long-term care. The family sits bewildered at the discharge planner's questions: Is there family who can care for Mary in her home or in their own home? Are there resources for round-the-clock care in Mary's home? How many steps are in Mary's home? Where is the toilet in Mary's home? What services exist in her community? How would Mary accept a move to a nursing home? Does Mary have long-term care insurance? Can she afford $35-40,000 yearly for care in a nursing home? How would Mary tolerate the prospect of impoverishing herself so that she may become eligible for public assistance to pay for her care? What would be the public cost of her care? Has the family had prior discussions about any of these issues?

Ned and Mary had planned for their retirement and for their deaths. They had even planned for their grandchildren's education. They had not *planned for the possibility that one or both of them would need long-term care. As a matter of fact, they had paid little attention to articles, news reports, and a barrage of mailed literature alerting them to the need to plan. Ned loved to hang up on telephone solicitors for long-term care insurance, even while his own sisters sat in nursing homes. Mary saw herself in her sisters-in-law, but planning for such a fate seemed somewhat distasteful, if not futile. Planning for their grandchildren's education? Now, that was something she enjoyed.*

Background

Individual and family long-term care decisions are most commonly made in a crisis; failure to plan for the possibility of long-term care dependency has significant personal and public financial and social costs. The majority of long-term care is provided by family members and is uncompensated. Nearly two-thirds of elderly receiving care in the community rely exclusively on such unpaid sources. When care is paid for, 40% of the $91 billion national cost is assumed by families, the "largest single group of purchasers" (Scanlon, 1998, p.2).

In addition to our reliance on family support, public support for long-term care, especially through Medicaid, makes personal long-term care planning a significant public policy issue. In Ohio, Medicaid represents 19% of the total state budget, and although only 11% of Medicaid recipients are 65 and older, they account for 36% of Medicaid spending. The average cost per age 65+ Medicaid recipient in 1997 was $14,654 per year, and this expense is largely accounted for by nursing home costs (30% of the Medicaid budget)[1]. Home and community-based services represent a minor but substantially increasing proportion of the state Medicaid budget. Currently over half of all long-term care costs in Ohio are covered by Medicaid, 27% by private (out-of-pocket) payment, 5% Medicare, and only 4% by private long-term care insurance (Mehdizadeh and Atchley, 1992). One-fourth of nursing home residents are already Medicaid eligible upon admission, and 14% of residents spend down assets, becoming eligible for Medicaid during their nursing home stay. (Spillman and Kemper, 1995) This 14% of nursing home residents is an especially important target for encouraging long-term care planning. Finally, "Medicaid long-term care expenditures for the elderly are projected to more than double in inflation-adjusted dollars between 1993 and 2018 because of the aging of the population and price increases in excess of general inflation" (Wiener and Stevenson, 1998, p.3).

Long-term care insurance (for both nursing home and home-and-community-based services) is a growing option, but it is not for everyone. Only about 10-20% of the elderly can afford long-term care insurance and only 5% have purchased it (Wiener and Stevenson, 1998). Private insurance now covers less than 1% of long-term care costs, and though an expanding industry, is projected to cover only 3% of long-term care costs by the year 2030 (Aging Today, 1999).

A recent study conducted by the Harvard School of Public Health and Louis Harris & Associates (1995) reports that of individuals self-identified as at risk of needing long-term care in the next year, most were under-prepared for that eventuality. The majority had not visited care settings other than skilled nursing facilities, had not consulted with an attorney to protect assets against long-term care costs, and had not had discussions with family about the possibility of moving to a supportive setting. For Mary's

[1] Ohio's Medicaid expenditures on nursing facilities increased from $651 million in 1985 to $1.78 billion in 1998. Home and community-based care for older low-income adults in Ohio (PASSPORT) has increased from $5 million in 1987 to $189 million in 1999 (Applebaum, Mehdizadeh, and Straker, 2000).

children, point-of-crisis decisions must be made about the level of care and support they are able to provide her. The costs of Mary's care will be considerable, and ultimately she will rely on a host of public and private services for care in her home or the home of one of her children, *or* she may become one of the two-thirds of nursing home residents who turn to Medicaid for a portion or all of the expense of nursing home care (Applebaum, Mehdizadeh, and Straker, 2000). Mary's language impairment and immediate health crisis now limit her capacity to participate in decisions made on her behalf.

What could Mary and Ned have done to plan for this crisis? A recent Scripps Gerontology Center report evaluating nursing home pre-admission review in Ohio called for increased opportunities for pre-crisis planning, concluding that care options need to be explored "while housing and informal care are still in place" (Applebaum, Mehdizadeh, Straker, and Pepe, 1995, p. 63). Mary and Ned could have made some environmental changes that would have expanded Mary's options. They could have moved to a one-story house or apartment, or made "just-in-case" adaptations to their home when they remodeled a few years ago. Or, they could have moved to their daughter's community anticipating her greater capacity to care for a dependent parent. If they had begun early enough, they might have afforded long-term care insurance, perhaps foregoing the educational trusts they had established for their grandchildren. At the very least, Ned and Mary could have had clear discussions with their children, indicating preferences for kinds and locations of care, clarifying expectations about filial obligations, and coming to legal agreements for proxy decisions such as trusts, standby conservatorships and guardianships, living wills, and durable power of attorney for health care.

Why is it that educated and otherwise planful people like Ned and Mary risk such a crisis without a plan in place? The statistical risks of long-term care dependency are not insignificant. The range of estimates for the lifetime risk of nursing home use is 25% to 63% (Cohen, Tell, and Wallack, 1986). While approximately one-third of lifetime risk applies to stays of three months or less (Liu, McBride, and Coughlin, 1994), the most frequently cited study suggests that among all Americans who live beyond age 65, one in three will spend three or more months in a nursing home, one in four will spend a year or more, and one in eleven will spend five or more years (Kemper and Murtaugh, 1991). Liu, et al. (1994), estimate that approximately 27% of persons are at risk for high-cost nursing home care.

The odds of a 65-year-old woman spending more than five years in a nursing home are approximately one in eight.

The risk of long-term care dependency is greater for women. Women are twice as likely as men to receive between two and five years of nursing home care, and more than three times as likely to use five or more years (Kemper and Murtaugh, 1991). The odds of a 65-year-old woman spending more than five years in a nursing home are approximately one in eight.

Advanced age is another clear risk factor: 1% of all 65-74-year-olds reside in nursing homes, while 15% of those 85 and

over do (Resource Services Group, 1997). A couple's risk for long-term care is compounded. It is projected that *seventy percent* of couples turning 65 in 1990 can expect at least one member of the couple to use a nursing home before death (Murtaugh, Kemper, and Spillman, 1990). Although this projection includes short-term stays, the risk of long-term stays is clearly compounded for a couple and speaks to a couple's need to plan accordingly.

Importantly, the studies cited above calculate the statistical risks of nursing home use only, excluding the more common home and community-based care, and leaving us with a deceptive underestimate of the risks of needing any form of long-term care at all. Fewer than half of severely disabled elderly are in nursing homes, and only 22% of all disabled elderly are in nursing homes. The vast majority of care (61%) is provided by informal caregivers (usually family members), in the community, without assistance or compensation (Kassner and Bectel, 1998). Approximately 7% of 65-74- year-olds, 14.5% of 75-84-year-olds, and nearly 31% of 85+-year-olds use formal home health care (Grabbe et al., 1995). Ned and Mary, therefore, may underestimate their risks of dependency in two significant ways: they may consider risk statistics for nursing home care only, and they may fail to combine their individual risks in considering the possibility that at least one of them will require long-term care.

The apparent incongruities between actual risk, perception of risk, and action represent important challenges to understanding and intervening in long-term care planning dynamics.

A number of explanations have been proposed for failure to plan even when statistical risks are known. The process of extrapolating a sense of personal risk from statistical risks for a population can be corrupted by all sorts of social and psychological phenomena. Perhaps most significant is the tendency, at least in American culture, toward unrealistic optimism. Most individuals underestimate their personal risk for negative events and overestimate the odds of positive events (Bandura, 1997; Hoch, 1985; Plous, 1993; Slovic, 1987; Weinstein, 1980). Weinstein's research on unrealistic optimism about future life events supports the hypothesis that the more undesirable the event, the stronger the tendency to underestimate risk for that event. Kulys and Tobin (1980) studied the lack of future concerns among the elderly. They contrast avoidance explanations (avoiding or denying future concerns because they are threatening) with security explanations (experiencing the future as non-threatening because of a present sense of security), and conclude, arguably, that it is "more appropriate and functional for the very old not to be concerned with [remote] future crises" (p. 124). High (1993) explored the low use among the elderly of advance directives (e.g., living wills), and found that most individuals are "delaying or deferring such actions because present circumstances ... do not call for such planning and most are confident that they can rely on others, including the informality of decision making by family members" (p. 509). The apparent incongruities between actual risk, perception of risk, and action represent important challenges to understanding and intervening in long-term care planning dynamics.

What is pre-crisis long-term care planning? Pre-crisis long-term care planning is the commitment of resources or decisions made today toward the possibility of long-term care dependency in the future. These commitments or decisions can be made in any of three planning areas: financial (e.g. long-term care insurance, self-insurance, estate planning), social/environmental (e.g. legal agreements such as living wills and durable power of attorney for health care, clear discussions and agreements with family members, shoring up informal support systems including moves to be nearer family, and moves or adaptations in housing to prolong livability), or comprehensive (a combination of financial and social/ environmental).

An understanding of the dynamics of planning, or failure to plan, can contribute to more effective interventions to encourage and facilitate pre-crisis planning. This report presents findings from a qualitative study using 18 individual interviews to identify and probe the most salient of a group of dynamics identified in an earlier focus group study (McGrew and Straker, 1997): perceptions of vulnerability, timeliness, responsibility, and control, as well as information gathering and resource assessment behaviors.

Most importantly, the focus group study identified a state of inertia about planning that, unless overcome, would disallow planning activity and behaviors. This state of inertia became the focus of the Interview Study which explored the dynamics of inertia in three planner types: non-planners, pre-planners, and planners.

Methodology

Qualitative interviews are used in research to discover and explore stories, ideas, and information from the perspective of interview participants. Rather than testing a hypothesis, the interviews are designed to allow for highly variable responses among participants. Generalizability and prediction are not objectives in a qualitative study. Instead, the research design is intended to identify both shared and distinct responses (patterns and idiosyncrasies) to the research question(s). The type of data in a qualitative study are "feelings, behavior, thoughts, insights, actions as witnessed and experienced." (Reinharz and Rowles, 1988). The qualitative design is a logical approach to exploring the dynamics and meaning of a phenomenon like planning.

The Interview Study used a combination of purposive and theoretical sampling, seeking a sample of individuals with potential exposure to information about long-term care, in this case through senior centers. This yielded 13 females and 5 males, with an age range of 64-90 (mean =74). Four participants were self-identified planners; each indicated that they had purchased long-term care insurance, one form of long-term care planning. Two participants were pre-planners, engaged in active information gathering, but not yet committed to a plan. The remainder of the sample (twelve participants) were self-identified non-planners; that is, they had not engaged in any pre-planning activities and had no plans in place. These twelve participants were in a state of inertia.

Each participant was interviewed once; the interviews lasted from 75 to 90 minutes. Interviews were audio-recorded and transcribed verbatim. An open-coding system developed by Anselm Strauss (Strauss and Corbin, 1990), a process of "breaking down, examining, comparing, conceptualizing, and categorizing data" (p. 61), was used to analyze text as data.

Findings

OVERCOMING INERTIA: FOUR SPECIAL CHALLENGES

Individual interviews revealed that to overcome inertia and begin pre-planning activity, individuals must have:

1. a conception of a future self as dependent,

2. a perception of the effects (costs) of dependency,

3. a concern today about possible dependency and its effects, and finally,

4. realistic beliefs about personal capacity (self-efficacy) to control the risk of dependency, to cope with its effects, and to plan for its possibility. In most cases, this would require the balancing act of deflating beliefs about the capacity to reduce risk and cope with effects, while inflating beliefs about the capacity to plan.

Two concepts from developmental and cognitive psychology respectively emerged as important to our understanding of this set of challenges: **possible selves** and **self-efficacy beliefs**. Markus and Nurius (1986) introduced the concept of possible selves as a "link between self-concept and motivation" and hence as an important psychological force in human development. Possible selves are those representations of ourselves in the future that are either hoped for or unwanted, even feared. According to Markus and Nurius, these conceptions of future selves mediate personal functioning; our possible selves are reference points guiding today's decisions and behaviors. Theoretically, imagining either a vital and able older self (a hoped-for self) or a frail and impaired older self (unwanted or feared) would encourage exercise and good nutrition. Also theoretically, imagining a frail, impaired older self would encourage planning for that possible self. A disabled self is not an unknown possible self; research indicates this is the most common feared self among adults of all ages (Morgan and Kunkel, 1998).

Self-efficacy beliefs (SEBs), introduced by Albert Bandura (1977), are those ideas we have about our personal capacity to achieve for ourselves a desired outcome or set of outcomes. SEBs not only affect our thinking about our capacities to control our risk of dependency, but they also affect our thinking about how we might cope with its effects. Finally, SEBs affect our thinking about our personal capacities to plan for possible dependency. The sources of SEBs, to be defined and illustrated later, represent key areas for intervention and provide a framework for recommendations from this study. The concepts of possible selves (as well as the related idea of impossible selves) and SEBs are linked in the discussion that follows.

Individuals cannot be expected to overcome inertia about long-term care planning if they are unable or unwilling to imagine themselves in a state of frailty or impairment, requiring assistance or care.

Challenge 1: Conception of a future self as dependent

In order to begin planning for long-term care, individuals must perceive themselves as vulnerable to dependency. Individuals cannot be expected to overcome inertia about long-term care planning if they are unable or unwilling to imagine themselves in a state of frailty or impairment, requiring assistance or care. When we encourage pre-crisis long-term care planning, we ask individuals to imagine a frail or impaired possible self, and to engage in behaviors today on behalf of that future self. This imagining requires some vividness. Possible selves are "not just any set of imagined roles or states of being. Instead they represent specific, individually significant hopes, fears, and fantasies" (Markus and Nurius, 1986, p. 954). These interviews, in probing the perception of vulnerability, revealed a wide range of limits in individual capacities to achieve much vividness or specificity.

The vulnerability question is really several critically different questions about possible selves. Vividness and specificity about possible dependency requires consideration of: odds (How likely is disability?), onset (When might I need care?), nature (What kind of care might I need?), level (How much care might I need?), duration (How long will my need for care last?), and context (What social, environmental, and financial resources will I have?). Although most long-term care needs cannot be forecasted, we cannot expect individuals to consider effects of long-term care dependency, let alone plan for those effects, without some concreteness in their thinking about these possibilities.

Impossible selves

This study revealed two obstacles to a perception of vulnerability: failure of imagination and inflated self-efficacy beliefs. Both contribute to the problem of "impossible selves." The failure or refusal to imagine a frail/impaired possible self with at least some degree of specificity is functionally different from imagining an unwanted or feared self. Again, both hoped-for and unwanted/feared selves guide behaviors and decisions. On the other hand, unimagined, or impossible, frail/impaired selves obstruct a perception of vulnerability. The effect of this is to render related behaviors and decisions irrelevant. The non-planners quoted below will not overcome inertia related to long-term care planning because they do not have a dependent possible self to motivate them. These individuals will not let their thinking "go there."

This is something that I just never wanted to put my thoughts on.

I just kind of flush it out of my mind.

You just sort of hold your breath and, you know, thinking if you don't recognize it, it will go away.

The notion of dependency, if even fleetingly considered, may be so aversive to these individuals that they minimize its possibility.

I can't bear to think about it. I keep puttin' it in the back of my mind. In another place, you know.

I try not to think about that (dementia). ..... I'm trying not to think it, because I think that's the most frightening.

[E]very time I start to think of it a little bit I start imagining myself being more decrepit than I am right now... and I avoided it.

One woman acknowledged that she thought about the possibility of dependency "every once in a while. I don't dwell on it." In the interview, she artfully dodged and skirted the issues, arguing that "I get tired of hearing about assisted living and this and that and what to do in your old age. You know, I take it one day at a time. It's so important to live in the now." Later, she asked to end the interview:

In your projection, you are trying to get an outcome of something that hasn't happened. I don't like to project. I'm not going to answer that. It's good to plan, but I, I, I, that sounds like you're trying to get me to project the outcome of something that isn't even, I don't want to.... I mean it's nothing against you. That's a very good question for some people, but not for me. I think I should end this pretty soon. Um, it's trying to sway me away from my original, my positiveness and my spirituality.... And so, right now, the only thing I can see to do is just keep working and doing what I'm doing and putting one foot in front of the other....

Planners, on the other hand, imagine a dependent possible self, and achieve the first step toward overcoming inertia about planning.

[I think about becoming dependent] often. All the time. ..... Strokes run in our family..... I'm prone for that..... I don't think I'll have one tomorrow, but it sure is possible.

Individuals may side-step the process of thinking about a dependent possible self by substituting simple expressions of hope. These are not expressions of hoped-for selves that guide behavior and inspire decisions, as found for example in one pre-planner: *I hope I have enough resources so that I can make a choice*. Rather, hope in the cases of some non-planners appears to stanch further thought about possible dependency: a future self so hoped against that it is essentially impossible. Hope is a "cognitive trick" (Bandura, 1997) that gives license to think about other things.

I try not to think about it too much. I'm hoping it won't. That's all.

One non-planner, while expressing hope, also described a sense of very little personal control over such a fate: "Well, I feel like maybe I'm like a bowling pin--- I just have to hope the ball misses me. Not much you can do about it." Others, however, had an inflated sense of their capacity to control their risk of long-term care dependency, a clear impediment to overcoming planning inertia. Inflated self-efficacy beliefs about vulnerability contribute to another perspective on impossible selves.

Individuals may underestimate their risk of dependency because of an illusion that they can control it to a significant level. Self-efficacy beliefs are not always accurate reflections of our capacities.

Self-efficacy beliefs and impossible selves

Individuals may underestimate their risk of dependency because of an illusion that they can control it to a significant level. Self-efficacy beliefs are not always accurate reflections of our capacities. They may under- or over-estimate the control we have in a given situation. Planners with realistic self-efficacy beliefs about dependency may work toward good health in old age while also planning for the risks of late life.

Considering we don't have control, I think for the things I am able to control from day to day.... I think the control lies with me .... [but] I don't think there is such thing as absolute.... [I do] the best I can under today's circumstances.

When beliefs about our capacities to limit dependency risk are significantly inflated, a dependent self may be deemed impossible, as demonstrated by these non-planners:

I don't think [dependency] could happen to me. You see, I'm wearing the superman cape. Oh, this won't happen to me.

I will will myself into invulnerability.

When told the approximate odds of spending five years or more in a nursing home, one woman said, "I guess there's ninety percent that don't. Ninety people out of a hundred? Shoot, I can do that!"

Such overconfidence represents a form of "faulty self-knowledge" (Bandura, 1997, p. 70) and requires some understanding of the sources of self-efficacy beliefs. Where does our sense of personal control over events and fates come from? Bandura identifies four sources: 1) mastery experiences, or personal experiences that can be related to the desired outcome in question; 2) vicarious experiences, or the related experiences of others, especially role models or those with whom there is some identification; 3) verbal persuasion; and 4) physiological or affective states, such as health, energy, and mood. These sources become strategic areas for interventions designed to encourage long-term care planning. All four sources were identifiable in the individual interviews.

Mastery experiences

When appraising personal efficacy in regard to a particular objective, individuals first turn toward their own related experiences, or mastery experiences. Mastery experiences can influence our thinking about risk of long-term care dependency in a number of ways. For example, past or current experiences with accidents or illness serve as indicators of our vulnerability, but at the same time, overcoming them may imbue us with a sense of mastery and control. Faulty appraisals about personal efficacy to avoid dependency derive from the way we process the information about these experiences. Individuals may select and weigh personal experiences, or parts of experiences, when regarding the possibility of future dependency. Planners in the study, when selecting and weighing related experiences, acknowledged their limits in making predictions about future

health and function. One planner clearly perceived the limits of mastery for herself and others:

It could happen to anybody.... I understand that just in a minute, I could walk outta the building and be nursing home material. ..... I just think it's sort of dumb if you don't realize that you, I mean that you can't control everything.

Non-planners, however, borrowed from their personal health mastery experiences to reinforce notions of invulnerability.

I've had just about everything in the book, [but] I've come out of it for some reason or other.... with therapy and determination.

Many non-planners interviewed assigned particular weight to *attitude* in appraising their risk of dependency.

I want to be independent, you know, and I think a lot of it is mental attitude.

It's 99% .... your personality, and everything. Your attitude is everything. You have to be confident.

[I]t's your attitude. And you have to develop that attitude. I think you can develop, you can be anything you wanta be.

Others, as illustrated by the following woman, described specific preventive health behaviors and strategies that produce a paradox: at the same time that these behaviors actually reduce the risk of dependency, as mastery experiences they may inflate one's sense of control and discourage planning.

Um, God dern! I'm trying to take care of myself. I really do take excellent care of myself. I watch going up and down the stairs, and watch where I walk and everything else. And I read a lot, all kinds of articles and so forth on how to take care of yourself. .... I get the flu shot....I get a good physical every year, and the mammogram, and the pap smear .... the regular colonoscopies .... and drink a lot of water, and get my good sleep. And I know what I am supposed to do. I quit smokin' twenty some years ago.... and I quit drinking at the same time.... And I'm doing everything I possibly can, I don't know what else I can do. I think my odds are good of living a while longer and being in decent health.

The two pre-planners in this study had had illness experiences or health care histories that contributed to a more realistic sense of control over their health futures.

Since I got this pacemaker, I never know when I might have a stroke or something like that see. So.... something could happen overnight.

I think that [surgery] is like a wake-up call. You think oh, dear, now what? Will I be all right?

Vicarious experiences

When relevant personal mastery experiences are unavailable or not identified, the experiences of others may substitute in their absence; or these vicarious experiences may combine with mastery experiences to inform an appraisal of self-efficacy. Most often, individuals interviewed cited the experiences of 1) family members, with whom they were likely to share health histories and predispositions, and 2) friends or age peers, with whom they were likely to

identify. As with mastery experiences, the meaning of vicarious experiences in an appraisal of self-efficacy depends on how they are selected and weighted for consideration.

Everybody in my family that has died young, sixties or seventies, ya know, they abused themselves terribly. And the ones that watched it lived to be ninety or a hundred.

Well, I think my overall health isn't too bad, cause when you think about all the people on walker and canes and wheel chairs. I might live quite a while yet.

It only hits me when I hear of somebody having something happen, like breaking a hip or something like that.

Verbal persuasion

Verbal persuasion is evident in many sources: family members, the media, medical and legal professionals. One planner was persuaded to think about her vulnerability by a very persistent daughter who also supplied her with reading materials.

She projected a lot of things, you know, that I didn't think would... could happen. She said, Mother, it happens every day. You have to think seriously about this. And I would sit there at night, you know, and do some reading and so forth. Then I think, that's true. I should.

Perhaps the best evidence of the effect of verbal persuasion on self-efficacy beliefs is the impact the interview itself had on several of the participants. One approach used in the interview was to inform participants about population risks of the need for long-term care after they had estimated their own. The same set of statistics had varying effects, from the threatening effect felt by the woman who asked to end the interview, to the reassuring effect felt by the participant who perceived one in ten odds as strong odds in her favor.

For many of the participants who were well defended against a perception of vulnerability, the interview process eroded that defense sufficiently so that subsequent discussion was built on a new, albeit tenuous, perception of personal risk. This form of verbal "persuasion" actually deflated self-efficacy beliefs about avoiding dependency.

The more I talk to you (interviewer), the more I think I'd better start getting serious! It's just, it's kind of an eye opener.

Physiological and affective states

Physiological and affective states can influence all self-efficacy beliefs. Even with positive mastery and vicarious experiences, and even with the encouragement of others, if we do not feel physically or emotionally strong, we are unlikely to feel efficacious, particularly when it comes to controlling our personal risk of dependency.

Right now the direction I'm heading is dismal.

My chances of becoming disabled are greater than my wife's because I'm bigger, bulkier, and getting more and more unsteady as time goes on.

On the other hand, good health, adequate energy, and a good mood may inflate our sense of control over such states in the future.

Well, I'm just thinking that if I'm fine today, then everything'll go fine tomorrow.

[Y]ou keep thinking: Oh, I'll be able to do everything I need to..... I guess just feeling pretty well makes you think, oh, this can go on forever.

Challenge 2: Perception of the effects of dependency

Imagining a dependent possible self with some vividness is likely to produce some sense of the effects or costs of dependency. One observed effect of dependency is the threat to autonomy it represents.

I want to go (to an apartment near son in another state) when I'm on my two feet and I can go where I want to go, not where somebody is going to put me.

I want to be independent and I want to do what I want to do and not what my kids are telling me to do or what they think I should do.

Some participants were able to imagine the need for certain kinds of care.

In my situation (chronic gastrointestinal problems)... I'd have an awful lot of things that would have to be done for me.

Other effects include impact on informal caregivers, both family and friends.

I have been thinking, people will do -- your friends -- when it is a temporary thing but if this were a permanent thing, you can't ask people to do forever. [Friends] have limits.

I understand that the caretaker gets short shrift, and can get pretty upset and stretched out, so I don't want be dependent on anybody.

I just personally feel that there's no house big enough..... I feel that [my children] have their lives to live and they shouldn't have to be burdened with me.

I don't want anybody doing anything for me. And when my son says, Mom we will take care of you, I don't want that. I don't want that..... I'd have to go into a nursing home.

A few of the participants mentioned the impact of long-term care on personal finances.

The bills (from husband's long illness) were, oh, I couldn't believe it, and that got me thinking, Goodness Gracious! And I have had friends who have, their spouse has Alzheimer's and things. And it is terrible that they have to get down, they have to almost get to poverty.... And that's so sad.

I've got four grandchildren and they're all going to be in college, and I'd hate to see them lose that possibility.

The following two quotes are from planners who purchased long-term care insurance after observing second-hand the financial costs of nursing home care:

[I was] running to the nursing home every day and seeing the money going down, down, down. She went through a hundred thousand dollars. In three years she ended up going on welfare.

I observed [when] my mother and mother-in-law both went into nursing homes... with long lives. And their estate was wiped away quickly. I figured I could wind up that way. And I wanted to be able to have the estate for my children and grandchildren.

Clearly, the above two planners were motivated to plan in part by a perception of their own vulnerability to dependency and a corresponding perception of its effects. How is it that the others, perhaps even with similar perceptions, remain in a state of inertia?

Self-efficacy beliefs and the effects of dependency: ideas about coping

The effects of dependency, whether they be on family, friends, finances, or self, call into consideration the capacity of individuals to mitigate against those effects. Clearly, one approach is to plan for them; most of the participants in this study, however, related images of themselves as copers, either muddling through or conquering problems and circumstances as they arise. While the interview structure forced participants to imagine dependent possible selves, the following non-planners quickly substituted a coping self in their responses. This suggests inflated self-efficacy beliefs about coping with dependency derived from a combination of mastery and vicarious experiences, as well as some sense of physiological and affective strength.

I take things as they come.... And I've always done that. I've just had too many things in my life that I just endured when it has to be done, but I don't dwell on it and I don't think about it ..... You do what you have to do.

I think I'm still living in those days where little ol' ladies just, just did the best they could, and stayed in their houses, and you know, didn't do very much takin' care of the house, I'm sure. They managed.

I don't have any qualms about not making up my mind, because, as I said, I really feel that I could take, we could take care of me or us. I've heard all these horror stories from people who've gone in to nursing homes, that I think, Huh! I could take care of myself better than that!

If I'm forced into it ... I would make the best of it. That's just the way I am.

I kind of take things as they come, that's my attitude. I'm a survivor.

The following related their ideas about coping "self-efficacy by proxy" (Bandura, p. 17), relying on others to see them through whatever comes.

I keep thinking, Well, you know, my husband's a good little nurse. And we would get along ..... I really can't think of anything right out that would make me do anything different.

I know that my children would not let me, you know, that they would take care of me in some fashion. ... They would all get together and decide what's best for Mom.

Another coping proxy identified by at least one participant is government. Unlike other participants who expressed dismay at going "on welfare," this participant was consoled by the prospect of Medicaid as her financial safety net.

There's a little lady, the aunt of the lady across the street from us, suddenly turned 99 or so. And she evidently didn't have any insurance. And she has finally spent all her money, and sold her little house, from that money. And so finally she ran out completely. And she's in one of the Catholic nursing homes, I think. And she's on Medicaid now. And they, the care doesn't really seem to have changed that much. So it's consoling that

there, that there is some sort of care for people who don't have anything.

Challenge 3: Concern today about possible dependency and its effects

In a stand-up routine, comedian Jerry Seinfeld (1998) lends a straightforward analysis of the disconnect we often feel between our now and future selves.

"At night, I'm Night Guy. Night Guy's gotta swing. I don't worry about tomorrow. That's Morning Guy's problem."

Participants in this study who could imagine dependent future selves clearly regarded those selves as unwanted or feared; however, for some, these unwanted/feared selves were so devalued that the individuals were not motivated to plan for them.

Even when we can imagine a dependent future self and its effects with some specificity, and even when we recognize our limits of coping with those effects, the disconnect between our now and future self allows for reduced concern for that future self. The remoteness of that possible self, what one participant described as "twilight time," allows us to diminish, even devalue, it. This principle is found in microeconomic theory: an object decreases in value with increasing remoteness in time (Warnyerd, 1990). Participants in this study who could imagine dependent future selves clearly regarded those selves as unwanted or feared; however, for some, these unwanted/feared selves were so devalued that the individuals were not motivated to plan for them. In these cases then, unwanted possible selves guide today's behaviors and decisions, not by motivating us toward behaviors on behalf of the future self, but by focusing our attention on today's preferred self.

In some cases, simple ageist notions of a future self reduced concern for that self. The younger self was more worthy than the older self.

And [people in nursing homes] are over, what, 85 or something like that....So, after that, you know, I don't much wanta worry about that anyhow.

I keep saying, this (house) only has to last ten years. Cause after that, I won't give a hoot.

In other cases, the well/independent self was revealed to be more worthy of resources than an imagined frail or dependent self.

[As a frail person,] you're not having that much fun for all the money you're spending.

I just think you worry about saving too much money, and worrying about what would happen to you, so that you can't enjoy... I think you can really just lose the joy of the moment worrying about, shall I spend money for this, or should I stick it away because it might keep me in a nursing home another month?

One male participant described with great vividness a future self he so degraded that he had pre-arranged what he described as his long-term care "plan": in the event of his dependency, his attorney would effect both a divorce from his wife (who holds all of the couple's assets) and his move to a nursing home as a Medicaid resident:

That I could become dependent ... I would not wish that upon my wife ... [taking care of] a worthless, lifeless chunk of man. Not able to get out of bed or take care of myself, particularly in the bathroom.

Some were able to distinguish between worthy and less worthy future selves, as the following woman suggests:

As long as I could take care of myself, or even if I lost my mind if I was cute and funny and humorous and so forth: "Oh, Mother! Look at Mother! Isn't she cute! She's got that purple dress on today with the red shoes and the orange socks." You know.... if they thought that was cute, that would be all right. But, if I got nasty....

Suicide

References to a suicide "out" in five of the eighteen interviews appeared to be the ultimate expressions of a devalued dependent self.

If I would have a sickness where I had my mental capacity truthfully I would have no desire. I have no desire to go on. I'm not one for longevity. I'm one for quality.

I figure, why should I [live in a state of dependency]? What good am I? I'm not any good to myself or anyone else, you know.

Suicide "plans" function to inflate a sense of control over the effects of dependency, and at the very least, like hope, they give license to side-step issues of long-term care planning. In the interviews, the possibility of suicide was invoked as an alternative to coping with or planning for dependency. For three of the five, declarations about suicide plans were revealed to be superficial, one even referring to her own talk as "silly." Even so, these superficial notions of "ending it" effectively deflected further thinking about dependency and planning.

I can't afford [a retirement] place but who cares? When my money's gone, I'll kill myself. I have told my children it will be the pillow over my face.... or a large bottle of tranquilizers or somethin'.

As long as I have my health, I'm not a burden to anybody, hey, I'd like to just go on and on and on, but the day I become a burden, uh, Dr. Kevorkian, here I am. (Upon probing:) It was just a statement, you know, you think, I don't wanna, I don't wanna.

After [our money dried up] I would be so disgusted, I'd prefer to start saving pills. (When confronted re: this, said: *I don't know what I would do. It's just that I don't want to think about it.)* (And later: *It's one of those silly things you say that when it gets to be too much for ya, that's what you'll do. I haven't decided what I'll do. I think I'll just, you know, fold up. ..... Just pulling within myself and deciding that, that's it. I've had enough.)*

The two participants most serious about suicide as a "plan" were men. The following quote demonstrates little in the way of a concrete plan, but reveals a strong belief in his capacity to end a state of dependency, should it develop.

Once they would put me in ... if I ever had to go to a home and I knew what was going on, I'm sorry, but I think I would probably starve myself to death... [Starving oneself] would be about all you were able to do when you were in that position..... I'm just too determined. That's just my personality.... I would just do it and that would be it. .... What good am I? I'm

not good to myself or anyone else, you know?..... As long as I have control, I know what I would do. [Others] probably would try (to interfere with his refusal to eat), but, I mean, you know, if you make up your mind to do something, you're going to do it.

Another male had clearly defined methods, and he related his intent in earnest:

Actually, what I've thought of was suicide. .... When I get close to that, I start collecting pills. ...I don't intend to [be dependent]. Not me .... Of course, I may change my mind when the time comes.... I have many ways of terminating my dependency. I'm diabetic. I take insulin. I could take a big shot of it. ... When I go to bed. You know, go out while I'm sleeping. I could do that. And I wouldn't be afraid to do so. ... I'll tell my wife it's gonna happen... But I won't tell her when I'm gonna do it.... And I'll tell her why I'm gonna do it. And I'll try and help her prepare for that time. ....When I feel, sense it's coming, I'd try to do what I can to do something about it..... to not be a burden.

Both of the men above have achieved a sense of vividness in imaging a future self and its effects. They have also devalued that self and have resorted to plans to terminate that self. Clearly, for these men, these unwanted/feared selves have motivated the decision to seriously consider suicide. The suicide plan has become the substitute plan for long-term care dependency. Although it may be argued that this plan is not surefire --- that it represents inflated beliefs about their personal likelihood of completing a suicide --- for all intents and purposes it makes long-term care planning moot.

The suicide "out," whether superficial or fully intended, appears to reflect an earnest desire not to live a dependent life. It also in part reflects a sense of despair about personal capacity to defend against dependency and its effects. Preparing for the possibility of a future need for long-term care requires a belief in our capacity to develop and commit to an effective long-term care plan.

Planning, after all, requires the belief that one has the capacity to plan and that planning makes a difference. There are evident impediments to achieving self-efficacy beliefs about planning for long-term care: future uncertainty, remoteness, and a failure to identify a connection between self-efficacy about long-term care planning with mastery experiences in other areas of planning.

Challenge 4: Self-efficacy beliefs about planning

Non-planners may be able to imagine a dependent possible self, understand the effects of that dependency as well as their limits of coping with those effects, and they may express deep concern, yet remain in a state of inertia about planning. Planning, after all, requires the belief that one has the capacity to plan and that planning makes a difference. There are evident impediments to achieving self-efficacy beliefs about planning for long-term care: future uncertainty, remoteness, and a failure to identify a connection between self-efficacy about long-

term care planning with mastery experiences in other areas of planning. The unpredictability of the future, particularly with regard to the course of aging, but also with regard to the changing face of long-term care itself, can contribute to a degree of a futility in our thinking about planning. Futility is the product of the magnitude of the task compounded by a low sense of personal control.

I just figured that what'll happen is gonna happen. That's all. I can try not to make it so it'll be too bad. But there's nothing I can do about it.

W]hen you're older, I think it's come what may. There's not much you can do about it. And all the planning in the world except saying, "well, I wanna go here, I wanna go there," ..... you have no control over it!

Some non-planners expressed a perception that it is difficult to choose among moving or changing alternatives:

Well, I get Modern Maturity and all that AARP news, and you know, articles in the paper.... and a couple of documentary things on television. ... And I keep reading these things about the HMOs and all that system. And that's another thing we've decided to wait and see what really is gonna happen about that. .... It's really hard to decide.

Mastery experiences related to planning, or the perceived lack of them, were most salient in these interviews. Interestingly, two widows in the study had financial long-term care plans, somewhat in spite of themselves: because they perceived themselves as having no financial mastery experiences, they forfeited planning to professional planners in a way that they once had to their husbands. For these women, proxy control produced outcomes not considered by their husbands while alive: the purchase of long-term care insurance for one, and what appears to be Medicaid estate planning for the other. For most participants, however, perceived lack of mastery contributed to inertia:

Right now it's frightening. .....[I]f I had the bucks that I used to have, I would spend more time on it. I'd try to plan my life..... Right now, it's as if you were talking about some of the theories of Einstein. This is so strange to me right now, this area, so you know, it's totally ambiguous.

I throw (long term care insurance literature) in the wastebasket... because, see. I don't understand 'em to start with.

It is evident from these interviews that inertia about planning cannot be overcome without realistic considerations about personal risks and capacities. The failure of non-planners to imagine and care about a possible dependent self, combined with faulty self-efficacy beliefs about coping and planning, leaves them, their families, and their society to confront the financial and social costs of long-term care decisions made in a crisis.

How do perceptions about future dependency and its costs, as well as related self-efficacy beliefs, manifest themselves in pre-crisis long-term care planning? A look at one study participant who purchased long-term care insurance illustrates this process.

PROFILE OF A PLANNER

Mrs. G. is a 72-year old widow. Her husband died one year ago at age 74 following a three-year, at-home convalescence from a

stroke. She lives in her four-bedroom two-story home with her 39-year old self-supporting son who never left home. She has three other sons and two daughters; one daughter and another son live nearby, and the other children live out of state. Mrs. G., a free-lance artist, is healthy and active, although she still has "problems" from a total hip replacement two years ago; specifically, she is only comfortable sleeping in a chair and does not use a bed. Mrs. G. was her husband's primary caregiver and was secondary caregiver to her sister who died of cancer, and to her father who lived in a nursing home for one year before his death.

Mrs. G. purchased long-term care insurance for herself one year before her husband's death. He did not qualify because of pre-existing conditions, and she wanted to make the purchase for herself before she turned 70, when the premiums would increase significantly.

Conception of future self as dependent and related self-efficacy beliefs

Mrs. G. has a vivid conception of a possible dependent self. Although currently quite active, her experience with hip surgery as well as her identification with her family history appear to have contributed to a sense of vulnerability.

In five years, when I'm 77, uh, 78 years old... about that time I probably will be the point where I'm not as active. I may not be able to use the stairs.

Mrs. G. was also able to imagine herself incontinent and with cognitive impairment.

You might as well face up to it now while you can think about it clearly. [To do otherwise] isn't being in touch with reality.

Mrs. G. is aware of the limits of her power to avoid dependency.

I've reconciled myself to the fact that some one of these days it's going to happen. That's all there is to it. It's inevitable..... given my family's history..... I would be foolish not to recognize the fact that it's possible.

Perception of the effects (costs) of dependency

Mrs. G. also has imagined and considered the costs of dependency. Her frame of reference for this perception includes the financial and family costs of caring for her husband and of caring for her parents and sister.

[H]aving been through it with a parent helps me know that. And I'll probably have to move out of my home..... I made thirty trips back and forth [out of state] to care for my sister. I would stay so many days there to take care of her, come back and take care of [my husband], make sure everything was right and go back again..... She would not go into a nursing home.

Self-efficacy beliefs about coping with the effects of dependency

Mrs. G. appears to have realistic beliefs about her capacity to care for herself in the face of frailty or disability. Again she borrows from her own experience (hip surgery), but acknowledges the change in circumstances (husband's death) that limits her coping resources.

And so, knowing what it (hip problems and surgery) was like the first time, knowing that my husband would not be able to help me ... as he did the first time.....

She also insists that the son who lives with her "should have a life of his own to live" and does not count on him to help her remain at home.

I would not be able to use the stairs, and if I should become incontinent or have memory loss... It can be too difficult for other members of the family.

Concern today about possible dependency and its effects

Mrs. G. expresses serious concern about her imagined dependent future self and its impact on her family. She purchased long-term care insurance in part as an expression of her resolve to use nursing home care, or formal home care services, in the event of her disability. Rather than regarding her purchase as insurance against financial losses, she regarded it as protecting herself and her family against difficult decisions at a point of crisis.

I decided it would be better for me and for them (husband and son) for me to have nursing home care..... I didn't want to be dependent on other members of my family..... I think that it is my responsibility. I don't think I should depend on my children. I've always thought that ... one of the most difficult things in the world is for a child to say to a parent, You have to go to a nursing home..... and I wanted to take that away from my children..... I said, I will go to a nursing home willingly. I don't want you to make this difficult decision. My sister would not go into a nursing home. I thought that all in all this was a difficult decision for other members of the family to make, and I thought that by taking this out of their hands I wouldn't, wouldn't cause them any problems.

Self-efficacy beliefs related to planning

How is it that Mrs. G., who believes she has limited capacity to avoid dependency and its effects, on the other hand believes enough in her capacity to plan for possible dependency to investigate and purchase long-term care insurance? Mrs. G. has sufficient mastery experiences in the area of planning and finances so that she does not need to turn to vicarious experiences for self-efficacy beliefs related to planning. Importantly, her planning mastery experiences are relatively recent; they were encouraged and facilitated through the verbal persuasion of her husband toward the end of his life.

I've always been an organizer, but not financially until [my husband] decided I should. .... He handed me the checkbook and said, "I'm retired from taking care of all the bills.....This is something you are going to learn from the ground up, on your own, and with your own system." I believe he was preparing me for a time when he wouldn't be able to take care of things.

Mrs. G.'s insurance agent was also verbally persuasive, although aggressive persuasion was not needed.

I would take [the insurance agent's advice] because I thought she gave good advice.... I trust the insurance advisor.

Mrs. G. also regards herself as a "problem-solver" and successfully fought for Social Security benefits after her husband's stroke; her mastery experiences include writing to her congressman and consulting with benefit offices.

Another source of self-efficacy beliefs for Mrs. G. is her physical and affective state. She

feels relatively good, has the energy to plan, and has "adjusted" to her decisions.
I know what a difficult decision it is to leave your home and go to a nursing home and I realize that, but I've adjusted to that.

Mrs. G.'s affective strength is reinforced by the support of her family through open discussions. She talks with her family about her long-term care plans....

as we have gotten together as a group. Sometimes it's just standing around, sometimes it's when we are all sitting.....Whenever the children come around for the holidays we have card games that last until 3 or 4 in the morning.... I have been pretty explicit with them.... I think they understand that..... this is a family decision.

Financial vs. social/environmental plans

Her explicit discussions with her children are part of Mrs. G.'s social plan: expectations about the care responsibilities of children have been clearly expressed. She has also had discussions with them about what is important to her in selecting a nursing home should she need it.

I want my children to check on the ratio of registered nurses to patients. I would like to be in a facility where that was relatively low. My granddaughter is an ICU cardiac nurse, and I ask for her expertise and input on this also.

Mrs. G. has not made an environmental plan explicitly for herself, except that she has expressed her willingness to go into a nursing home if needed. Adaptations to her home (e.g. wheelchair ramp from garage to house) had been made when her husband had his stroke. Earlier adaptations (e.g. converting a downstairs living area into a bedroom) had been made in anticipation that her mother might come to live with them. Her home, as it stands, is relatively disability-friendly. Furthermore, though there appears to be an even exchange of support between Mrs. G. and the son who lives with her (she cooks and cleans, he performs heavy chores), Mrs. G. may be able to live in her home with her son's support longer than she might have otherwise.

Mrs. G. is a woman who is careful about her spending but who appears to have sufficient assets to purchase long-term care insurance without significant financial sacrifice. This distinguishes her from the majority of older individuals confronted with this option. Even so, many individuals with comparable resources (some in this study) do not plan because they have not achieved the requisite conditions: they have not imagined a dependent future self, considered the effects of that dependency, recognized their limits regarding both avoiding dependency and coping with those effects, had concern about future dependency and its effects, and had sufficient self-efficacy beliefs about their capacity to plan for long-term care. As illustrated in her profile, Mrs. G. has met those requirements and is close to having a comprehensive, pre-crisis, long-term care plan in place.

Implications and Recommendations

As we approach the next century, we live in a climate of optimism about aging long and well that is unprecedented in American society. As one newsmagazine reporter recently observed, Americans appear to be moving from a fear of aging to a fear of not aging like John Glenn (Shapiro, 1998). Vicarious role models like John Glenn are becoming the public norm, while Ronald Reagan's experience with Alzheimer's Disease is largely hidden from public view. This optimism may be well-founded. In 1980, James Fries introduced the prospect of a compression of morbidity, or a decrease in the rates of disability among the aged, even while life expectancy increases. Fries's projections have been born out: there has been a decline of 1-2% in disability rates each year since 1982, with some acceleration in decline in the last five years analyzed. (National Long Term Care Survey, 1994) Manton, et al. (1993) attribute this decline to improved education, health care, nutrition, and lifestyle of older adults. This is good news for all Americans, and should contribute to beliefs in our efficacy to affect our own health and well-being. On the other hand, such good news can become the source of thoughtless optimism about disability--- and failure to plan. Individual risks remain and may plateau, and the public burden of long-term care is growing as society ages. By 2010, the number of severely disabled people in Ohio is projected to increase by nearly 6% (Mehdizadeh et al., 1996), and Baby Boomers will swell the old age ranks in unprecedented numbers between the years 2010 and 2030.

The importance of optimism to well-being is significant and should be of some concern in our pursuit of strategies to encourage planning.

The importance of optimism to well-being is significant and should be of some concern in our pursuit of strategies to encourage planning. Optimism is essential to psychological well-being (Bandura, 1997) and is important to motivation. Optimism that is derived from mastery and vicarious experiences has the capacity to encourage health-promoting and retirement-planning behaviors. It is our challenge to preserve a sense of optimism about aging well without contributing to unrealistic optimism about the risk of dependency. This is no small task. The delicate challenge is to deflate beliefs about controlling the risk of dependency and the capacity to cope, while inflating beliefs about the capacity to plan for an unpredictable future---- without eroding the positive function of optimism.

Bandura describes the risk of a "spiraling weakening" (p. 211) of self-efficacy beliefs with advancing age, resulting in a "progressive loss of motivation, interest, and skill." It is clear that the sources of self-efficacy beliefs--- mastery and vicarious experiences, verbal persuasion, and physiological and affective states--- provide an important framework for intervention, and they are neatly linked in the process. Encouraging and facilitating individual and family long-term care planning can be

accomplished through addressing the sources of self-efficacy beliefs that keep individuals in a state of inertia. Impossible selves can be made possible by making the language and stories of long-term care dependency commonplace in the language and stories of successful aging. This is both the challenge and the strategy for encouraging and facilitating individual and family long-term care planning.

STRATEGIES

A number of strategies inspired by dynamics identified in the Interview Study may be adapted and applied by all invested parties --- service providers, consultants, legal advisors, financial planners, insurance brokers, family members, and policy makers. These are largely communication strategies that may be incorporated into existing programs, practices, and relationships. All are designed to both coax individuals out of inertia, and to support them on their paths toward planning.

Mastery experiences

Build on other mastery experiences.

Identifying links between related mastery experiences and the task at hand will enhance planning efficacy. Promotional materials and interactions should elicit self-identified mastery experiences, either through cues ("Now that you have successfully raised your children….") or through open-ended prompts ("What has been your greatest accomplishment? Make this your next.") This can also be accomplished in CareChoice Ohio consultation and in other advising and informing relationships and programs.

Link long-term care planning to health promotion.

Many participants in the Interview Study pointed to mastering their health as a planning strategy, an approach that should be reinforced. Health promotion in late life includes the development of adaptive behaviors and activity. Long-term care planning can be promoted as one more adaptive strategy, e.g. housing changes that reduce fall risks, and long-term care insurance that allows for a range of lifestyle options.

Straightforward information about risks embedded in examples of successful life planning for a healthy retirement should make possible dependency easier to swallow, much like a teaspoon of medicine in a glassful of orange juice.

Link long-term care planning to retirement planning.

Retirement planning without long-term care planning is not uncommon. Pension counseling programs and other retirement planning vehicles can be powerful influences in promoting and facilitating long-term care planning. Straightforward information about risks embedded in examples of successful life planning for a healthy retirement should make possible dependency easier to swallow, much like a teaspoon of medicine in a glassful of orange juice. Mastery in retirement planning can be transferred to mastery in long-term care planning.

Vicarious experiences

Identify and provide role models for planning.

When possible and appropriate, help individuals identify personal role models for successful planning. Include age peers, paid or volunteer, in education and consultation efforts (Care Choice Ohio). Use case studies of successful long-term care planning in promotional and educational materials. Finally, why not make John Glenn, Ohio's own symbol of optimal aging, a spokesman for long-term care planning as he shares his own plans?

Verbal persuasion

Surf the wave of optimism.

All parties would be well advised to surf the wave of optimism about aging in a way that wraps long-term care planning into the package of health-promoting and retirement planning behaviors. The tone of all approaches should be consistent with this growing tone of optimism even as risks are communicated.

Communicate a sense of worthiness of future selves.

The tone of all approaches should also affirm the worthiness of future selves, no matter their states. This sense should be the lens through which all persuasive strategies are monitored and evaluated.

Clearly communicate social and environmental planning possibilities in addition to financial strategies.

Individuals with limited financial resources need to identify social, legal, and environmental means of expanding their long-term care options. Persuasion that focuses on financial planning only may discourage a significant audience of potential planners in these other areas.

Avoid scare tactics.

Scare tactics will surely backfire. They heighten anxiety and avoidance.

Physiological and affective states

Attention and sensitivity to physiological and affective states should increase the effectiveness of all strategies to encouraging planning. The story of Mary and Ned, while still communicating the risk of dependency, should be told with a "how-to" ending that functions as a vicarious example of planning efficacy, linking other areas of mastery to long-term care planning, and without creating or exacerbating (and preferably ameliorating) feelings of fatigue, anxiety or despair.

Education and consultation activities should not overtax the energy and attention capacities of participants. Promotional literature should be positive, straightforward, culturally appropriate, and basic. Educational literature should be available in levels, allowing individuals to seek and obtain details according to their capacity to understand and use them.

Conclusion: A Policy Note

It is our challenge to recognize and address the dynamics that contribute to the failure to plan for possible dependent selves. At the same time, it is essential that energy and resources continue to be expended toward the expansion of long-term care options--- to increase the scenarios of possible selves that will inspire planning for the most attractive options. Public resources spent on the least attractive options contribute to a sense of impossible selves that is difficult to overcome with even the most powerful of persuasive strategies. Ned and Mary are more likely to plan for a future that they can bear to imagine and that they believe to be worthy of decisions today. Finally, financial incentives for planning will contribute to a sense of mastery, can certainly be persuasive, and will contribute to improved physiological and affective well-being. As individuals, families, and the public continue to share the responsibility for long-term care, they must also cooperate in planning for the future.

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