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PREDICTING COUNSELING PSYCHOLOGISTS' ATTITUDES AND
CLINICAL JUDGMENTS WITH RESPECT TO OLDER ADULTS

by

Jody K. Tomko

A Dissertation
Submitted to the
Faculty of The Graduate College
in partial fulfillment of the
requirements for the
Degree of Doctor of Philosophy
Department of Counselor Education and Counseling Psychology
Dr. Patrick H. Munley, Advisor

Western Michigan University
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CHAPTER I

INTRODUCTION

The population of U.S. elders, those 65 years of age and older was at all time high of 35 million in 1999 and, by 2030, when the last of the Baby Boomers reach retirement, elders will make up more than 20% of the population (American Association for Geriatric Psychiatry, 2002). This growing number of elders will clearly lead to a growing need for mental health services to a population deemed at high risk. In spite of this risk, statistics reveal that elders are being underserved by mental health practitioners. According to the American Psychological Association (2003a), up to 63% of older adults with a mental disorder do not receive the services they need, while only 3% of older adults report seeing a mental health professional.

Underutilization of mental health services by elders is hypothesized to be caused by several factors including older persons' perceptions of mental health treatment and ageism on the part of the clinician (Laganà & Shanks, 2002). Laganà and Shanks report an apparent tendency among the current elder cohort, as well as the population at large, to perceive psychological problems (e.g., depression, anxiety, and cognitive impairment) as part of normal aging. Furthermore, professional bias or therapists' reluctance to work with older clients has been a documented trend since the early 1960s (Kastenbaum, 1964) and clearly continues to negatively affect therapists' work with older clients (Danzinger & Welfel, 2000; James & Haley, 1995; Meeks, 1990; Woolfe & Biggs, 1997; Zivian, Larsen, Knox, Gekoski & Hatchette, 1992).

The perceived effect of therapy with the older client is directly related to one's perception of whether working with the older client is seen as satisfying and appealing (Damron-Rodriguez, Kramer, & Gallagher-Thompson, 1998). Furthermore, if the therapist harbors beliefs that psychotherapy will not be effective for the older client and feels less competent in treating older adults, these beliefs could very well affect the quality of the therapeutic relationship (James & Haley, 1995). And, it is the therapeutic alliance that has been shown to account for a significant amount of the variation in counseling and psychotherapy outcomes for clients (Martin, Garske & Davis, 2000).

In an effort to move beyond professional ageism, there has been a renewed interest in studying the training of geropsychologists (e.g., Gellis, Sherman & Lawrance, 2003; Hinrichsen, Myers & Stewart, 2000) and examining what factors lead to an interest in training and practice with older adults (e.g., Cummings, Adler & DeCoster, 2005; Hinrichsen & McMeniman, 2002). The resurgence of attention to these issues is likely attributable to changing demographics, development of national guidelines for practitioners working with older adults (American Psychological Association, 2004; Molinari et al., 2003), and unfortunately, a clear finding of a shortage of mental health professionals trained to work with older adults (Qualls, Segal, Norman, Niederehe, & Gallagher-Thompson, 2002). The latter point is especially problematic given Baby Boomers' higher utilization of mental health services compared to previous cohorts (Rosowsky, 2005). In addition to the preceding factors, the burgeoning field of multiculturalism and training in multicultural competencies may have also influenced scientists and practitioners to revisit issues of aging.

Counseling psychologists, who traditionally focus on developmental, strengths-based approaches, are one subpopulation of mental health service providers that are poised to address the needs of the aging population. Bruce Fretz, in his 1992 Presidential Address to Division 17 (The Society of Counseling Psychology within the American Psychological Association), named counseling psychologists “particularly well qualified ideologically and practically for meeting the psychological needs of the elderly” (1993, p. 170). Moreover, counseling psychology’s commitment to the importance of culture and value awareness has aimed to increase the number of multiculturally competent counseling psychologists, potentially equipping them to address the diversity of old age.

Purpose of the Study

The purpose of the present study is to examine counseling psychologists’ global attitudes toward older adults and clinical judgments of an older client. The present research addresses two important shortcomings in the current body of literature on attitudes and behavior of mental health professionals treating older adults. First, this is the first extensive survey of a sample of practicing counseling psychologists since Carol Dye’s (1978) investigation more than 30 years ago. Second, it is the first inquiry into the question as to whether multicultural competence relates to attitudes toward older adults and clinical judgments of an older client. In an era in which the first of the Baby Boomers are reaching retirement age and the need for competent mental health professionals trained to work with older clientele has been magnified, it is important to study counseling psychologists’ work with the elder population.

The review of the research literature suggests that the more training and experience a professional has had with older adults, the more favorable their attitudes toward elders will be and the less bias they will demonstrate in their professional clinical judgments. Fear of death is also expected to have an inverse relationship with global attitudes toward older adults (i.e., the greater the participant's fear of death, the poorer the attitudes toward elders) and greater fear of death is expected to increase professional bias in clinical judgments concerning an older client. Additionally, multicultural competence is expected to be related to more positive attitudes toward older adults and less bias in professional judgments involving an older client. The current study will investigate these areas further.

Research Questions

- 1) To what extent does pre-doctoral training in aging predict global attitudes toward older adults and clinical judgment in work with older clients?

Null Hypothesis 1a: After controlling for age and gender, the extent of participants' pre-doctoral training in aging will not contribute significant unique variance to predicting participants' global attitudes toward elders.

Null Hypothesis 1b: After controlling for age and gender, the extent of participants' pre-doctoral training in aging will not contribute significant unique variance to predicting participants' clinical judgment in a case vignette involving an older client.

- 2) To what extent does clinical experience with older adults predict global attitudes toward elders and clinical judgment in work with older adults?

Null Hypothesis 2a: After controlling for age and gender, participants' clinical experience with older adults will not contribute significant unique variance to predicting participants' global attitudes toward older adults.

Null Hypothesis 2b: After controlling for age and gender, participants' clinical experience with older adults will not contribute significant unique variance to predicting participants' professional clinical judgment in a case vignette involving an older client.

3) To what extent does fear of death predict attitudes toward elders and clinical judgment in work with older adults?

Null Hypothesis 3a: After controlling for age and gender, participants' fear of death will not contribute significant unique variance to predicting participants' global attitudes toward older persons.

Null Hypothesis 3b: After controlling for age and gender, participants' fear of death will not contribute significant unique variance to predicting participants' clinical judgment in a case vignette involving an older client.

4) Does multicultural competence predict attitudes toward older adults and clinical judgment of older clients?

Null Hypothesis 4a: After controlling for age and gender, participants' multicultural competence will not contribute significant unique variance to predicting participants' global attitudes toward elders.

Null Hypothesis 4b: After controlling for age and gender, participants' multicultural competence will not contribute significant unique variance to predicting participants' clinical judgment in a case vignette involving an older client.

5) To what extent does pre-doctoral training in aging, clinical experience with older adults, fear of death, and multicultural competence independently contribute to predicting attitudes toward older persons and clinical judgment of older clients?

Null Hypothesis 5a: After controlling for age and gender, participants' pre-doctoral training in aging, clinical experience with older adults, fear of death and multicultural competence as a block of variables will not contribute significant unique variance to predicting participants' global attitudes toward elders.

Null Hypothesis 5b: After controlling for age and gender, participants' training, experience, fear of death and multicultural competence as a block of variables will not contribute significant unique variance to predicting participants' clinical judgment in a case vignette involving an older client.

Finally, this study will also investigate the possible relationship between the demographic variables of age and gender and scores on global attitudes toward older adults and clinical judgments of an older client. To explore these relationships, Pearson r correlations will be calculated between age and attitudes toward older adults and gender and attitudes toward elders. Additionally, Pearson r correlations will be calculated between age and clinical judgments and gender and clinical judgments. The significance of the Pearson r correlations will be determined.

Definition of Terms

1. Older adult/elder – for the purposes of the present study, older adult or elder will be used to describe adults age 65 years and older. Although other age cut-offs such as 50, 55, and 60 have been cited, 65 is the most prevalent within the literature in

psychology and gerontology. In the United States, 65 years of age is accepted as defining an older person given that 65 has been (1935 – 1983) the age at which individuals qualify for full social security benefits or “normal retirement age” as defined by the U.S. government (following the Social Security Amendments of 1983, the age has been systematically increased to 67). Additionally, it is the age selected for use in U.S. Census data to represent the older adult cohort.

According to older adults themselves, unacceptable terms are “old man” or “old woman,” “aged person,” and “geriatric” (Harris, 1975). Another unacceptable and ageist term, according to gerontologists, is “the elderly” (Myers, 1998). Myers notes that “the elderly” is a term fraught with negative connotations and implies that older adults are a homogenous group. Some gerontologists suggest that “elder” is the most positive of terms (Palmore, 2000). Further, Palmore (2005b) reports that older adults view acceptable terms to be “elderly,” “golden age,” “older adult,” “older people,” and “pensioners.”

2. Baby Boomer – an individual born between 1946 and 1964, which in the United States and around the world, is a generation created by a population explosion following World War II. According to the U.S. Census Bureau, the estimated number of Baby Boomers exceeds 78 million and 7,918 Baby Boomers turned 60 each day in 2006 (U.S. Census Bureau, 2006).

3. Ageism – a term coined by Robert Butler in 1969, refers to stereotyping and discriminating against people based on their age. Butler linked ageism with the inevitability of personal mortality. Butler adds that an interesting dimension of ageism that does not apply to other “isms” such as sexism or racism, is the fact that the ageist

faces the real fear of inevitably turning into his/her object of hate (for a discussion regarding what constitutes ageist attitudes see Lutsky, 1980).

4. Professional bias – relatively negative professional judgments, actions or intentions on the basis of a client's age, physical health status or both (James & Haley, 1995). Examples of professional bias include perceiving a client as less appropriate for psychotherapy, recommending differing treatments, and assigning a client a poorer prognosis. Professional bias in mental health treatment is perhaps more widely recognized and researched with respect to clients' race (Solomon, 1992) rather than age.

CHAPTER II

LITERATURE REVIEW

Through the expansive research on attitudes toward older adults, beginning in the 1950s and continuing through today, much has been illuminated regarding the status, development and influences on attitudes toward elders. In this section, attitudes toward older adults among college students, health professionals and mental health professionals are discussed. Then, common negative perceptions concerning psychotherapy with older persons, along with methodological concerns in attitudinal research are reviewed. Next, I discuss factors that impact attitudes toward older adults including demographic variables, training and experience, fear of death and multicultural competence. Finally, I describe the relationship between counseling psychology and multiculturalism and counseling psychology and older adults, drawing a connection between the two fields.

Attitudes toward Older Adults

College Students

As in most psychological research, the first endeavors to measure attitudes toward older adults involved samples of undergraduate college students. While many studies reported the existence of mostly neutral attitudes toward elders among undergraduate students (Funderburk, Damron-Rodriguez, Storms & Solomon, 2006; O'Hanlon & Brookover, 2002), several recent investigations have found relatively negative attitudes (Anguillo, Whitbourne & Powers, 1996; Kimuna, Knox & Zusman, 2005), concluding

that attitudes may be even more negative than in the 60s when Rosencranz and McNevin (1969) first piloted their attitudinal measure (Anguillo et al., 1996).

In the original factor analysis of the Aging Semantic Differential (ASD; Rosencranz & McNevin, 1969), the measure was given to a norm sample of 287 undergraduate students who rated a young, middle-aged and older adult. Findings revealed that attitudes toward older adults were most negative, with evidence that significant relationships with an older adult are related to more positive attitudes. In a similar study conducted in 1996, Hawkins used a semantic differential scale and assessed attitudes towards three groups of older adults among a sample 420 college students. The results supported Rosencranz and McNevin's study – students with prior experience with elders were found to have more favorable attitudes toward older adults.

Interested in a comparison of U.S. students to those in the Republic of China, Tan, Zhang, and Fan (2004) used a modified version of the ASD to examine Chinese college students' attitudes toward older adults. Following Rosencranz and McNevin's example, Tan et al. inquired about students' contact with older adults as a correlate to attitudes, as well as several other demographic variables such as age, only child, work experience with older adults and size of community. The authors found that more than 80% of the students in their sample had lived with an older adult and overall attitudes toward elders were in the positive to neutral range. As expected, contact (both with a related and unrelated older adult) was most significantly correlated with more favorable attitudes toward elders ($p < .01$).

In a recent study of undergraduate attitudes toward older adults and knowledge of aging, Funderburk et al. (2006) addressed a gap in the literature by assessing attitudes

after the passage of time. Funderburk and colleagues used two samples to compare attitudes: 1) every student that had taken a gerontology elective course over a two-year period, and 2) a random sample of students who had not completed a gerontology course. The packets were sent out the beginning of both fall semesters during which the study was being conducted, so the time between completing the course and receiving the study packet ranged from 3 to 18 months. The authors collected a sample of 349 students who had completed a gerontology course and 430 who had not.

The returned surveys included a measure of attitudes toward elders, the Aging Semantic Differential (ASD; Rosencranz & McNevin, 1969), a measure of knowledge of aging (Palmore's Facts on Aging Quiz-1; Palmore, 1988), and a demographic questionnaire that inquired about contact with elders and employment. Several analyses were conducted in order to compare students who had taken a course versus those who had not, to compare across students for those that completed the course at 3, 6 to 9 and 18 months ago, and to determine what variables predicted more positive attitudes toward elders.

Funderburk et al. (2006) found that aging elective students differed from the group that did not take an aging course in that they had more contact with elders as well as more experience working with older adults, were more likely to be a psychology, biology or sociology major, and had more knowledge about aging and more positive attitudes toward elders. Comparison of students taking the survey between 3 and 18 months after the course in gerontology signified that scores were lower (indicating more positive attitudes) at 6 to 9 months than at 3 months and lower at 18 months than at 6 to 9 months, however the differences were not statistically significant. Finally, in the

multiple regression analysis, four variables predicted 8% of the variance in the students' attitudes toward elders. Positive attitudes were related to contact with older adults, taking an aging elective, and better knowledge of aging. The fourth predictor variable included being a biology major, which was associated with negative attitudes.

Healthcare Trainees and Professionals

Several studies have examined health care professionals and pre-professionals interest in working with older patients and attitudes toward older adults. Greene (1984), in her book reporting the results of an exploratory analysis of patient-physician encounters, found that physicians were less responsive when older adults raised concerns than when the doctor initiated. The author discusses this finding as evidence of age bias. A 2000 study of physicians found more evidence of age bias as physicians were less likely to treat a suicidal 78-year-old versus a suicidal 38-year-old (Uncapher & Areán, 2000). Additionally, the physicians in the study were pessimistic about the potential benefit of mental health services for the older target.

Hellbusch, Corbin, Thorson and Stacy (1994) sampled a group of 200 physicians and administered the Kogan Attitudes toward Old People Scale (Kogan, 1961). The authors were interested in investigating whether attitudes of physicians toward older adults were similar to attitudes found in samples of medical students. Hellbusch et al. found that attitudes were generally positive, but the authors urged that there is still room for improvement and cautioned that those who chose to participate in the study could have significantly different attitudes than physicians in general. Interestingly, the authors found that participants' age and number of years in practice were negatively correlated

with attitudes. In other words, older physicians with more years in practice had the most negative attitudes toward older adults.

In one of the few qualitative investigations into attitudes toward working with older adults, Schigelone and Ingersoll-Dayton (2004) interviewed 20 medical students, who, on their first day of medical school, completed a survey indicating their level of interest in geriatric medicine. The authors sampled 20 students to be interviewed at the end of their first year of medical school, 10 who indicated that they had no interest in geriatrics and 10 who indicated they had moderate to very strong interest in geriatrics. Notably, only one student of the original 174 first year medical students surveyed indicated a strong interest in geriatric medicine.

Schigelone and Ingersoll-Dayton (2004) identified the most prominent qualitative differences between the two groups of students (those who reported interest in geriatrics compared with those who reported no interest) as experiences, beliefs and fears. Participants who had more experience with older adults including stronger ties to elder family members were more likely to be interested in geriatrics. Beliefs about geriatric medicine led those who had an interest in working with older adults to be attracted to a perceived slower pace of practice and accepting of a palliative role. In contrast, those who were not interested held beliefs that geriatric medicine lacked excitement, frustration with the palliative role, and that the older patient is often to blame for their illness. Also, Schigelone and Ingersoll-Dayton discovered a surprising result; students who were interested in geriatric medicine expressed much more fears about aging and death. In their explanation of the latter finding, the authors suggest that perhaps students who have an interest in geriatric medicine have more realistic fears, related to a “positive

connection” with older adults. Likewise, students who have no interest in working with older persons have had little experience with aging and death.

Linn and Zeppa (1988) also explored medical students’ attitudes toward older adults in general and specifically toward treating older patients. While medical students had moderately favorable attitudes toward older adults, attitudes toward treating the old were less favorable. Yet, at the same time, the most significant predictor of favorable attitudes toward elderly in general was positive attitudes toward the practice of geriatrics. In their discussion, Linn and Zeppa hypothesize about the origin of the latter result, concluding that perhaps the measure of favorable attitudes toward geriatrics actually measured favorable attitudes toward the practice of medicine (given that attitudes toward pediatrics was also a predictor of attitudes toward older adults). The authors concluded with suggestions about improving attitudes including increasing knowledge of geriatrics with an emphasis on the process of normal aging.

Mental Health Trainees and Professionals

During the 1960s, scholars such as Robert Butler (1969) and Robert Kastenbaum (1964) discussed a phenomenon of ageism among individuals in general and mental health professionals specifically. Kastenbaum called the phenomenon “the reluctant therapist.” Butler then related ageism and the reluctant therapist to the underutilization of services in the elder population (1975). Although ageism was a widespread finding among college student and health care professional samples, it was not until the late 1970s and early 1980s that this notion was empirically tested with mental health professionals. Since that time, researchers have continued to explore attitudes toward

older adults among mental health professionals in an attempt to better understand the complex relationship between mental health providers and their older adult clientele.

Psychiatrists

In 1980, a prominent study by Ford and Sbordone aimed to assess attitudes of psychiatrists toward older patients. One hundred and seventy-nine psychiatrists rated four hypothetical clients (with four different diagnoses: agoraphobia, alcohol abuse, mania and depression) with regard to their mode of recommended treatment, the “idealness” of the patient, and the patient’s prognosis. The hypothetical patient’s age was the independent variable and there were two forms of the survey so that, for each diagnosis, there was a younger and older patient.

Ford and Sbordone’s (1980) results indicated that younger patients with each of the four psychiatric problems were considered a more “ideal” patient than their older counterparts. With regard to treatment recommendations, there was a significant difference for one diagnosis – depression. It was recommended by almost one-third of the psychiatrists that the 32-year-old receive psychotherapy alone, while only 7.8% of psychiatrists recommended the same treatment for the 72-year-old patient. When the authors analyzed the psychiatrists’ age compared with their rating of “idealness” for each of the patients, they discovered negative correlations (i.e., the older the psychiatrist, the poorer the rating of “idealness”) for the majority of hypothetical situations.

Ford and Sbordone’s study was notable for at least two reasons. One, it was the first study which inquired about how older clients were perceived by psychiatrists. Two, it named ageism as a probable cause for the findings. In 1987, Ray, McKinney and Ford

attempted to extend Ford's earlier findings of psychiatrists' bias toward older clients (Ford & Sbordone, 1980) by surveying 192 clinical psychologists. In accord with Ford and Sbordone's findings, Ray et al. hypothesized that older clients would be perceived by the participants as: a) less desirable to work with, b) having poorer prognoses, c) less appropriate for psychotherapy as a treatment modality, and d) more ideal by younger participants. Clinical vignettes and follow-up questions developed by Ford and Sbordone were utilized as tools to measure psychologists' notions of the extent to which each patient was regarded as "ideal."

Ray et al. (1987) highlighted four major findings with regard to ratings of idealness, recommended treatments, relationship of psychologists' age and their ratings, and relationship between idealness and prognosis ratings. Vignettes of younger clients presenting with neurotic depression and agoraphobia were rated significantly more ideal than vignettes of older clients with the same presentation. Treatment recommendations varied significantly for only one type of patient – the manic male. Specifically, the 69-year-old with symptoms of mania was more likely recommended pharmacological treatment than the 22-year-old with the same symptoms.

Ray and colleagues (1987) did not find a significant relationship between the age of the psychologist and the rating of idealness for younger clients. However, the authors did find a significant positive correlation between psychologists' age and ratings of idealness for older clients presenting with neurotic depression and alcohol abuse. Finally, significant correlations were found for the relationship between ratings of idealness and prognosis across all of the diagnostic categories. Thus, those clients who were rated as more ideal by psychologists were also rated as having better prognoses.

The discussion of results led to comparisons between the findings from Ford and Sbordone's (1980) study and Ray et al.'s findings. Like Ford and Sbordone, Ray et al. (1987) found that psychologists consistently rated older clients as less ideal and having poorer prognoses, but these results were limited to certain client presentations (depression, agoraphobia and mania). Ray and colleagues hypothesized the causality for their findings and attributed the lack of idealness to increased external barriers for older adults with psychiatric diagnoses and the apparent chronicity of an older adult presenting with such symptomology as mania.

Social Workers

Several studies have examined social workers' attitudes toward elders. Gellis et al. (2003) used a modified ASD (Intrieri, von Eye & Kelly, 1995) to measure attitudes toward older adults among graduate students in social work and analyzed the data using multiple regression to predict attitudes toward older adults. On average, social work students held negative attitudes toward older adults (as determined by the total score on a modified version of the ASD). The only variable which predicted more positive attitudes was plans to work with elders after graduation. Correlations between demographic variables and attitudes revealed that males and young students had less favorable attitudes.

In a similar study with more advanced social work students, Cummings et al. (2005) found that students expressed more positive attitudes toward older adults as compared to the Gellis et al. (2003) study, yet elders were the least attractive population with whom to work. In predicting social work students' interest in working with older

clients, self-rated skills, rewarding interaction with older adults, the frequency of contact, belief that gerontology is a good career choice, the number of aging courses, and contact in a professional setting were all significant factors.

Finally, Kane (2004) explored age bias in bachelors and masters level social work students and found evidence for significant age bias in assessment and intervention. Participants in Kane's between-groups analogue study read a vignette describing either a 38-year-old or 72-year-old female. The hypothetical client presented with symptoms of depression pursuant to a recent diagnosis of a "serious type" of cancer. Then, participants answered 16 survey items related to diagnostic, treatment, and prognostic issues.

Following a MANOVA analysis of the data, Kane found eight items to be of significance when comparing the two targets. Although trainees appropriately did not agree that the target should be involuntarily committed or rendered incompetent, they were less likely to recommend psychotherapy for the older target ($p = .03$), less likely to perceive her as having the ability to fully recover ($p < .001$), and if working with the target, were more likely to use an intervention focused on helping the client prepare for death ($p < .001$). Kane concluded that age bias continues to have a considerable effect on clinical judgments for social work students, which leads to significant implications for the education and training of aspiring social work professionals.

Counselors

Most of the published work on attitudes toward older adults does not generally focus on counselors as a subpopulation of mental health professionals. Danzinger and Welfel (2000) designed a study with the intention of addressing this gap in the literature.

Additionally, other purposes of the study were to investigate the relationship of age and gender bias and the effect of healthism on counselor's judgments. In order to understand the impact of professional discipline on attitudes toward older adults, the researchers sampled approximately equal groups of clinical social workers ($n = 31$), psychologists ($n = 30$), and clinical counselors ($n = 32$).

Participants completed an Age Bias Questionnaire which was developed by the authors for their study (Danzinger & Welfel, 2000). The Age Bias Questionnaire consisted of seven questions regarding clinical judgments of one of four target clients described in a vignette (a male client with generalized anxiety disorder, a married female with major depression, a retired male with an adjustment disorder and a widowed female with major depression). The independent variables were the target client's health status, age, and gender; whereby health status (heart disease, kidney disease, diabetes or severe arthritis) and age were manipulated. Social workers, psychologists and counselors rated a target in each of four possible age by health status combinations (i.e., each participant read and rated four clients). After piloting testing the instrument, the authors reported accuracy of diagnosis at 83% for the clients with major depression and 66% for the other three targets. Cronbach's alpha for the survey was reported at 0.78.

Danzinger and Welfel (2000) found several statistically significant results. First, participants judged older clients and female clients as somewhat less competent than younger and male clients. Also, older clients were viewed as having poorer prognoses compared with younger clients. Second, professional discipline had no effect on participants' ratings of competence and prognosis of older clients. Third, participants who had been practicing longer judged older clients to be significantly less competent.

Contrary to their hypotheses and previous findings (e.g., Ford & Elliott, 1999; Gekoski & Knox, 1990; James & Haley, 1995), health status of the client was found to have no effect on ratings of competence or prognosis.

Psychologists

In the first inquiry of U. S. psychologists' involvement with older clients, Carol Dye (1978) surveyed over 1000 clinical and counseling psychologists. She found that psychologists, while interested in offering services to older adults and increasing their knowledge in this topic area, perceive that aged individuals seek out therapy less often, are more set in their ways, do not respond well to therapy and have difficulty learning new behaviors. Additionally, in another set of questions, psychologists rated younger clients as more preferable to work with across every diagnostic category save one.

Dye (1978) concluded that although psychologists are interested in working with the elder population and gaining more knowledge in that area, they also hold some negative perceptions of older adults. And, despite that diagnosis may outweigh age with regard to preference for clients (psychologists had the least preference for working with psychotic clients of any age), younger clients were preferred over older clients consistently. Accordingly, Dye contended, older persons may be considered lower priority for mental health services.

Utilizing a between-subjects design, Joan Settin (1982) surveyed 418 clinical psychologists regarding both attitudes toward and attributions of symptomology for a hypothetical client. Settin also examined therapist variables such as experience and theoretical orientation. Participants received one of eight possible vignettes of a client

with reactive depression, in which the independent variables of age, gender and class were manipulated. Initial demographic data revealed that participants' average age was 45.5 years and older clientele made up only 4% of their average caseload. There were significant findings related to the "usefulness of intervention" and the "interest in providing intervention" for the 72-year-old client who was also perceived as more disoriented. The 72-year-old client was also seen as stronger than the 46-year-old client.

Diagnostically, the psychologists in the sample determined that that 72-year-old client was more likely to have organic brain syndrome and psychosis than the 46-year-old client. Settin (1982) reportedly expected to see an age by class interaction effect, but surprisingly, no such effect was present in the data. Also expected but not found were any interaction effects between therapist characteristics (such as age, therapy orientation, political orientation, gender, clinical experience with older clients, contact with older relatives, or treatment setting) and the client's age.

In discussing her findings, Settin (1982) commented further on the absence of the interaction effect between age and class. She also remarked on each of the therapist variables she included in the study and her rationale for doing so. She hypothesized that older therapists may have heightened fears of aging and therefore hold more negative perceptions of older clients, but it appears that other perhaps personality factors are more important in determining attitudes than chronological age. Settin made the assumption that perhaps theoretical orientation would affect attitudes, given, in particular, psychoanalysis' history of perceptions of inappropriateness of long-term therapy for older adults. She discussed the lack of significant findings as possibly related to the effect of a

progressive movement toward eclecticism. Lastly, Settin proposed that experience did not affect attitudes because of the participants' low frequency of contact with older clientele.

Following Settin's work, Perlick and Atkins (1984) employed a taped psychiatric interview of an actual client to determine any age bias in diagnosis among clinical psychologists. The patient presented with depressed mood, impairment of recent memory, poor attention/concentration, an absence of organic pathology and a remission of symptoms following electroconvulsive therapy. Before listening to the 20-minute taped interview, the patient was described as either a 55-year-old, 75-year-old or no age specified, White, Jewish male. Afterward, participants were asked to complete a diagnostic questionnaire in which the questions were ordered from least to most specificity.

Results of the study revealed that, when participants thought the patient was 75-years-old, he was viewed as "more organically impaired, less severely depressed, and less treatable than when the same patient is perceived as middle-aged, or when age is unknown" (Perlick & Atkins, 1984, p. 817). Perlick and Atkins discussed the above findings as support for earlier studies which described bias in overattributing cognitive impairments of an unknown cause to organic disorder; presuming depression is a normal part of aging, and doubting the benefit of any type of therapy for an older patient.

Perlick and Atkins (1984) discussed two limitations of their study including an inability to generalize the results given the diagnostic presentation and the sex of the patient; however the authors did not discuss additional limitations: a) the small sample size and b) the inconsistency in manipulating the independent variable. First, because only 36 participants were included in the study, this left only 12 participants assigned to

each of the conditions (e.g., old age, middle age, no age specified). Second, in the 'no age' condition, it appears that, not only was age not specific, but also the authors did not specify gender, race or ethnicity as in the other conditions. Instead, distinctly different instructions were presented before the interview, encouraging participants to rely solely on the patient's symptomology regardless of any other factors.

Despite the limitations of the study, Perlick and Atkins (1984) were instrumental in providing evidence that misdiagnosis of elders by psychologists does occur on a too frequent basis. The authors urged that it would behoove psychologists to be thoroughly trained and practice comprehensive evaluations with special attention to factors that affect older adults (e.g., loss of physical health, retirement, bereavement, etc.). Lack of attention to these factors, Perlick and Atkins argue, has the potential to lead professionals to perpetuate ageism.

Meeks, in her 1990 study of clinical psychology trainees and practicing clinical psychologists found that older clients were consistently seen as more likely to have medical problems and have poorer prognoses than younger persons. Meeks also reported that most participants were generally unable to provide an explanation for how they reached their diagnosis. This latter finding provides support for the notion that some biases may be occurring outside the clinician's awareness.

Although Meeks' (1990) approach to understanding diagnostic behavior (using an ANOVA model) was progressive, there was one major limitation of the study: each participant had to read and score 96 vignettes. The author discussed the possibility of boredom influencing the task since some of the diagnostic decisions appeared to be made on a completely random basis. She also reported that several of the participants

complained about the task. This appears to be a significant threat to the reliability of the study.

To examine the existence of ageism, James and Haley (1995) utilized a nationwide sample of 371 practicing clinical psychologists. The authors aimed to test for evidence of ageism and healthism, the latter a term coined by Gekoski and Knox (1990) meaning “devaluative attitudes toward those in poor health” (James & Haley, p. 610). The authors developed a vignette of a woman, Ms. James, who met the *Diagnostic and Statistical Manual of Mental Disorders, 3rd Edition, Revised* (DSM-III-R) for depressive disorder. In this between-subjects design, age (35-year-old or 70-year-old) and health status (health history is unremarkable or health history is remarkable for congenital heart disease) of Ms. James were varied. Thus, each participant rated one of four possible vignettes (young-healthy, young-unhealthy, old-healthy, and old-unhealthy).

Professional bias was measured with an 11-question survey also developed by the authors. Interpersonal bias was assessed with the Personal Acceptability-Unacceptability scale of the Aging Semantic Differential. Results for the measure of professional bias indicated a significant effect for age on appropriateness for psychotherapy and prognosis. The older Ms. James was found to be less appropriate for psychotherapy and perceived as having a poorer prognosis. However, significant main effects were found for health on all items of the survey of professional bias. Targets in poor health were seen as less able to develop an adequate therapeutic relationship, less appropriate for therapy, more likely to have their presenting complaint related to an organic disorder, poorer prognosis and more likely to commit suicide.

With regard to interpersonal bias, as measured by the ASD, a significant main effect was found for health, but not for age (or interaction). The unhealthy target was viewed as more ugly, uncooperative, pessimistic, inflexible, dejected, sad, suspicious, intolerant, unpleasant and dull than the healthy target. To better understand the possible sources of age or health bias, James and Haley (1995) asked participants to report their subjective level of competence in treating Ms. James, their level of comfort in accepting the client, how open the client might be to treatment recommendations and how much the client was to blame for her problems. Again, there were no significant effects of age for this category of investigation, but psychologists who rated the unhealthy targets (both old and young), rated themselves as less competent and less comfortable, while Ms. James was seen as less open to recommendations.

From their results, James and Haley (1995) concluded that healthism is more pervasive than ageism. However, the authors added that this may be more complicated by the fact that older adults frequently present with health concerns and are more likely to have chronic physical illnesses compared to their younger counterparts. Notwithstanding the powerful finding of widespread healthism, ageism continues to be present, even in between-subjects designs.

James and Haley's (1995) investigation was notable for a couple of reasons. Foremost, it was the first study of its kind to use a large national sample of practicing psychologists. And, the authors attempted to control for falsely inducing negative bias by using a between-subjects design and including an adequate description of the target. Ergo, several researchers have followed in James and Haley's footsteps, both by adapting

the vignette of Ms. James and the survey of professional bias, and by replicating the methodology.

Ford and Elliott (1999) were interested in whether bias existed when psychologists rated clients with depression and ill health, hence they adapted James and Haley's (1995) survey of professional bias and used it to rate their own vignette. Ford and Elliott's vignette described a 55-year-old woman referred by her physician. The independent variables were the client's a) physical health status, which was either "unremarkable" or positive for breast cancer with either a poor or good prognosis; and b) mental health status, which was either remarkable or unremarkable for depression as reflected by affect, self-confidence, eye contact, and tone of voice.

Ford and Elliott's (1999) sample included 410 practicing psychologists who completed six measures depicting current mood, expectations about counseling, a portion of the survey of professional bias (James & Haley, 1995), perceived self-efficacy in treating the target client, interpersonal attitudes toward the target client (using the Personal Acceptability-Unacceptability scale of the ASD), and impressions ratings (of the competence, dependence and depression for a target with cancer, AIDS, cardiac or diabetic illness). In contrast to the findings in James and Haley's (1995) study, Ford and Elliot found that targets in good health were perceived as more unfriendly, intolerant, unpleasant and dull than targets in poor health. Further, targets with depression were rated most negatively on 10 of the 14 ASD dimensions. Finally, the results of the survey of professional bias revealed that depressed targets were seen as the least capable of forming a therapeutic relationship and having the poorest prognosis.

The purpose of Helmes and Gee's (2003) investigation was to determine whether age biases are observable among Australian psychologists and counselors, and whether there are any differences in observable age bias between the two groups of professionals. The authors surveyed 707 psychologists and counselors utilizing James and Haley's (1995) vignette and survey of professional bias. James and Haley's instrument was adapted to include a manipulation of the target client's age, using 5 of the 7 questions on the original scale and adding an additional open-ended question that stated "What is your first impression of what Mrs. Watkins' main presenting problem may be?" Participants were mailed the survey and a 42-year-old or 72-year-old client vignette at random.

Diagnosis of the client was the first dependent variable and was coded by Helmes and Gee (2003) as depression, depression-related problem, less related disorder and unrelated disorder and there were slightly more problems identified for the older client ($p = .022$). A multivariate analysis of variance was used to analyze the effects of the age of the client in the vignette and the professional group. Although there was no interaction effect or main effect for professional group, there was a main effect for age. Specifically, participants rated the older client as "less able to develop an adequate therapeutic relationship, to have a poorer prognosis, and to be less appropriate for therapy; and the therapists felt less competent treating her and less willing to accept her as a client" (pp. 663-664).

Compared to James and Haley (1995), Helmes and Gee (2003) found more evidence for age bias. The authors attribute these results to an increased focus on aging for the American Psychological Association, while the Australian Psychological Society has not adopted such a focus. Helmes and Gee suggested that it will be important to

examine these biases in the context of work with actual rather than hypothetical clients, given the mounting evidence that bias may affect therapeutic work.

In summary, studies of mental health providers affirmed the contentions of scholars like Kastenbaum and Butler who claimed that mental health professionals are susceptible to age bias in their practice and may be reluctant to work with older clients. Taken together, these studies uncover a disturbing trend: mental health professionals are exhibiting age bias toward older clients in the form of poorer prognoses, considering them unfavorable clients and less treatable, and misdiagnosis. In the next section, some of the common stereotypes and misperceptions of psychotherapy with older adults are reviewed and discussed.

Negative Perceptions Concerning Psychotherapy with Older Adults

As has been observed in the review of professionals' perceptions of older adults, there are many stereotypes and fallacies regarding psychotherapy with elders.

Kastenbaum (1964) identified three chief factors that he believed to be related to therapists' poor attitudes toward older adults: a) fear of the lowered status associated with treating older adults, b) anxiety around personal fears of aging and death and c) concern that it may be a poor investment to counsel an older adult because they will not benefit from psychotherapy.

To the latter point, Sigmund Freud believed that older persons were not able to be treated with psychoanalysis. In 1924, Freud was quoted as saying that "old people are no longer educable, and on the other hand, the mass of material to be dealt with would prolong the duration of the treatment indefinitely" (as cited in Muslin & Clarke, 1988, pp.

295-296). Unfortunately, evidence for Kastenbaum's interpretation and the commonplace of beliefs such as Freud's continue to exist and impact the field of counseling and psychotherapy yet today.

One widely held belief concerning psychotherapy with older adults is that elders do not benefit from psychotherapy or have poorer prognoses than younger adults. Several studies reviewed found evidence for this bias (e.g., Dye, 1978; Ford & Sbordone, 1980; Helmes & Gee, 2003; James & Haley, 1995; Ray et al., 1987). In an effort to better comprehend under-recruitment of psychologists to the field of geropsychology, Lee, Volans and Gregory (2003) employed the novel approach of asking trainees their thoughts about the reasons for trainees' lack of interest in working with older adults. Participants were procured from clinical psychology training programs in the United Kingdom. Data was collected through semi-structured questionnaires obtained from 371 clinical psychology trainees. Responses to the open-ended questions were coded and themes were identified.

The clinical psychology trainees in Lee and colleagues (2003) study reported that they perceived recruitment for work with older adults as challenging due to a widely held belief that older adults do not benefit from psychotherapy to the degree that younger adults do. Furthermore, trainees identified that this pessimistic attitude was most likely held by both clinicians and clients. Other factors affecting recruitment of psychologists reported by the participants were personal issues (e.g., being faced with one's own mortality, low professional status, ageist attitudes) and training issues (e.g., low priority in education, poor placements and supervision, lack of good role models).

Participants offered the following suggestions for improving recruitment with older adults: a training component, promotion of the field by practicing geropsychologists and strategies for increasing the appeal of providing services to older adults. Lee et al. (2003) concluded that, at least for trainees in the UK, clinical psychology was perceived to have little to offer the population of older adults. In addition, a significant number of participants (45%) believed that psychotherapy may have little consequence on older adults' lives and that work with older adults "was all loss and death" (p. 92). Lastly, the authors acknowledged that while the design of the questionnaire elicited generalizations about older adults, there were a considerable number of negative stereotypes within participants' responses.

Unfortunately, the notion that older adults do not benefit from psychotherapy is not just found with trainees, but also with practicing psychologists, psychiatrists and physicians. For example, Wei, Sambamoorthi, Olsson, Walkup and Crystal (2005) through a comprehensive review of Medicare claims found that use of psychotherapy was much more frequent for younger, more educated individuals. Zivian et al. (1992) found that among psychologists and psychiatrists the consistent preference was to treat younger clients over middle-aged and older adults. Zivian and colleagues hypothesized that the preference for young clients may relate to beliefs about prognosis, difficulty of treatment, or a general age bias. The authors also found that those participants who were older, worked in a mental health facility, had coursework on aging and had a significant higher percentage of older adult clientele were more likely to prefer to work with older adults.

The myth that psychotherapy is not beneficial for elders is just that – a myth. Several studies have provided empirical evidence that suggest psychotherapy is just as

effective with older adults as it is with the younger population (e.g., Myers & Harper, 2004; Knight & McCallum, 1998; Scogin & McElreath, 1994; Thompson, Gallagher, & Breckenridge, 1987) and older adults are typically responsive to a wide variety of treatment approaches (Zarit & Knight, 1996).

In 1987, Thompson and colleagues compared the effectiveness of three treatment conditions (cognitive therapy, behavioral therapy, and brief psychodynamic therapy) and one control (delayed treatment for 6 weeks) for depressed older adults. Using random assignment, the researchers divided the 95 participants into each of the four groups. For the treatment conditions, the participants attended 16-20 sessions with one of 10 doctoral-level specialty-trained psychologists.

All five measures of symptomology showed significant improvements for those in the treatment condition, while those in the delayed-treatment group show no significant improvement (Thompson et al., 1987). Furthermore, when comparing positive response rates between the three treatment conditions there were no significant differences between those treated by behavioral, cognitive or brief psychodynamic and, most importantly, 70% of the sample (after 6 weeks the delayed-treatment condition were randomly assigned to a treatment condition) were either no longer depressed or had improved substantially.

Further evidence from meta-analytic methodology supports the efficacy of psychotherapy for older adults with depression. Scogin and McElreath (1994) examined 17 studies that included a variety of levels/types of therapist training, client's depression severity, duration of therapy, and therapist's treatment orientation. The mean effect size across studies for those participants who received treatment versus no treatment or a

placebo was 0.78 ($p < .05$). As the authors explain, this result means that depressed older adults participating in the study who received some type of psychosocial treatment were on average three-quarters of a standard deviation better than their peers who did not receive treatment.

Myers and Harper (2004) reviewed evidenced-based therapies for older adults, described as part of a larger review by Roth and Fonagy (1996). The authors reviewed studies examining treatments for disorders such as anxiety, depression, sleep disturbances, dementia, and substance abuse, in addition to life transitions such as widowhood, caregiving and grandparenthood. Taken together, Myers and Harper concluded that a) counselors need special training to appropriately address the unique challenges of aging; b) empirical data to support a choice of interventions is limited, however the data available suggest that older adults respond well to treatment and it is the responsibility of the service providers to overcome age bias and choose to work with older adults; c) cognitive and life review therapies are well-established treatments for older adults; and finally d) group counseling is an appropriate intervention for issues associated with aging and late-life development.

Research has also supported the notion that, even for health care professionals, mental illness is viewed to be a normal part of aging (Cohen, Sandel, Thomas, & Barton, 2004; Siegel, 2004). In reality, mental illnesses are no more prevalent in the elderly population than for other age cohorts. National statistics reveal that the overall prevalence for mental disorders among older adults is 15.2%, lower than the rate for any other age group (Narrow, Rae, Robins, & Regier, 2002).

Studies find that the same clinically significant symptomology is judged as less severe in older clients compared to their younger counterparts (Ivey, Wieling, & Harris, 2000; Perlick & Atkins, 1984; Uncapher & Areán, 2000). For example, McConatha and Ebener (1992) studied 95 counselor trainees and did not find support for bias in prognosis or willingness to work with older clients. However, the authors found that trainees perceived the younger client as having a greater number of problems and more severe depression than older clients with an identical presentation. Counseling strategies employed with older clients were most likely to be providing solutions and making suggestions. In addition, participants relied on directive techniques in assisting the older clients. These results could be interpreted to mean that the concerns expressed by the older adult client were expected for their age and not relevant for therapeutic intervention.

Finally, as Kastenbaum (1964) contended, there is evidence that mental health professionals view work with older adults lowers the status of the profession. In Lee et al.'s (2003) study of 371 clinical psychology trainees, 36% ($n = 134$) responded that they believed the difficulty in recruiting students to the geropsychology specialty in the UK related to working with older adults being an unattractive specialty with a poor image and a low status. But, in a survey of trainees in the U.S., 90% said they had some interest in providing services to the elderly upon completion of their program (Hinrichsen, 2000). Yet, there continues to be a projected gap in the psychologists that will be available to provide services to older adults based on the current trainees (Qualls et al., 2002). Perhaps it relates to the fact that clinical and counseling psychology program still offer

little in training to work with older adults, as evidenced by a 1997 survey of programs which found that no programs required a course in aging (Johnson & Rosich).

The implications of these negative perceptions of older adults and geropsychology are detrimental to older adults in need of mental health services. For example, consider the findings of Uncapher and Areán's (2000) investigation – physicians perceive that suicidal elders are less likely than (suicidal) younger adults to be helped by psychological intervention. Thus, it is likely that physicians are not referring their elder patient to psychological services and, given that elders are more likely to present psychological problems to their physicians than to a mental health professional, this likely results in elders not receiving services that they may desperately need (Qualls et al., 2002). It is stated frequently in the literature that elders' mental health problems are often not recognized or not properly treated by health care and mental health professionals alike. This claim appears to be supported by review of literature on professionals' attitudes toward mental health treatment for older adults.

Perspectives on Measuring Attitudes toward Older Adults and Methodological Concerns

The first comprehensive review of the literature on attitudes toward older adults was conducted by McTavish in 1971. In examining studies which investigate attitudes at a societal level, McTavish noted that many researchers support the notion that attitudes toward the elderly are more favorable in primitive societies and become less favorable in relation to the level of modernization, with Western nations holding the least favorable attitudes toward older adults; however there is a sizeable number of critics that argue against the modernization hypothesis. Factors such as family organization and economic

base seem more likely to contribute to societal attitudes rather than degree of modernization.

In his review of individual level studies, McTavish focused on the approach taken to assess attitudes. In the 1950s, Tuckman and Lorge developed one of the first widely used scales measuring attitudes toward old people (1953). Most of the research examined attitudes among undergraduates and found evidence for profoundly negative biases toward elders. McTavish discussed the correlates of attitudes toward older adults and identified age, sex, social class, ethnic group, and contact as the main variables that relate. He concluded that ageism was pervasive in the literature.

In 1988, Gatz and Pearson wrote a seminal critique of the literature on attitudes toward elders. Gatz and Pearson make a complex argument in favor of the existence of age bias, but against the pervasiveness of professional ageism as it was understood at the time. First, the authors contended that the methodology of early studies may have artificially inflated stereotyping based on age. Gatz and Pearson (1988) argue that methods such as rating a generalized target and forced comparisons in a within-subjects design are inappropriate for understanding true differences in perceptions based on age. Second, the complicated relationship between attitudes and behavior allows for ageist attitudes to lead to positive (compensating) behavior, not allowing for a direct link between ageism and discrimination. Third, the authors discussed the media's role in the general attitudes toward older adults and used the example of Alzheimer's disease and misconceptions about its prevalence. Finally, Gatz and Pearson point to the evidence from studies of providers of psychological services that reveal less of an issue of professional age bias in general, but rather a problem with specific clinical judgments.

Just after the publication of Gatz and Pearson's critique, the first meta-analysis of attitudes toward older versus younger adults was published by Kite and Johnson (1988). The purpose of the investigation was twofold: first, to determine whether perceptions of older people are more negative than perceptions toward younger people through the scientific integration of the results of independent studies and second, to determine the factors contributing to mixed findings thus far. The authors examined characteristics of the studies including the type of trait being evaluated, specific versus general target person, the type of design, work-related versus non-work-related settings, study quality, age of the author, year of publication and age of the target. With these study characteristics in mind, Kite and Johnson reviewed all studies published by December 1985 that compared attitudes toward older versus younger adults, yielding a total of 43 independent effect sizes. Of those 43 effect sizes, 30 indicated more negative views of older persons, 10 indicated more negative view of younger adults and 2 reported no difference.

Overall, Kite and Johnson (1988) concluded that attitudes toward older adults are indeed more negative than attitudes toward younger adults; the effect size of this difference being .38 (more than one-third of a standard deviation). Thus, in response to the first research question, Kite and Johnson concluded yes, older adults are viewed more negatively than younger adults. In response to their second research question regarding the factors that have contributed to mixed results, the authors discovered the following study characteristics led to more negative attitudes toward older adults when: a) specific information about the target was not provided; b) within-subjects designs were employed (i.e., when each participant rated both an older and younger target); c) the context was

non-work-related; and d) the study appeared in the *Journal of Gerontology* or an APA journal. With regard to the latter finding, it should be noted that, according to Kite and Johnson, those sources are likely to contain more high quality studies. More positive attitudes toward older adults were exhibited when: a) the author of the study was older, b) the study was recently published, and c) the dependent measure was evaluative and included a large number of items.

Two other important conclusions from Kite and Johnson's (1988) meta-analysis surfaced. First, although the study characteristics accounted for about 42% of the variance among effect sizes and there is a considerable amount of variance left unexplained, the authors note that other meta-analyses on stereotypes have difficulty explaining any more variance. And, second, as in all quantitative research, the findings are only as good as the measures used to assess the construct. For attitudes toward older adults, two predominant measures had been used: Kogan's Old People Scale (Kogan, 1961) and the Aging Semantic Differential (Rosencranz & McNevin, 1969). Both measures had been widely used, but Kite and Johnson noted that both were in need of more testing of their reliability and validity.

Seventeen years later and 189 more effect sizes to examine, an updated meta-analysis of attitudes toward older adults was published (Kite, Stockdale, Whitley, & Johnson, 2005). For this analysis, the authors reviewed all studies comparing attitudes toward older and younger adults published by April of 2000. Recognizing that attitudes toward older adults are multidimensional, Kite and colleagues divided the studies under review into five categories: evaluative (e.g., pleasant, exciting), competence (e.g., smart, independent), attractiveness (e.g., handsome, wrinkled), behaviors (e.g., willingness to

interact with), and age stereotypes (e.g., old-fashioned, talks about past). For each of the five categories, the researchers calculated effect sizes indicating more negative attitudes toward elders (.47, .38, .33, .21, and .24, in the order listed above).

With the increased sophistication in research that comes with 17 years of time, Kite et al. (2005) were able to identify categorical and continuous moderator variables that affected the relationship between independent and dependent variables in the study. The following conditions are moderator variables that lead to less differences between evaluations based on age (i.e., more favorable attitudes toward older adults), when: a) there is more extensive information about the target, b) positive or neutral rather than negative information about the target is presented, c) the respondent is older or younger rather than middle-aged, d) the target is male, e) the study design is between subjects, f) age differences between the older target and the comparison target were smaller, and g) there are more scale points on the measure.

Another potential methodological concern highlighted by Kite et al. (2005) is the prevalence of the use of case vignettes and rating scales to study professionals' perceptions of older adults. Although the results of analogue studies are difficult to generalize to work with actual clients, as Ford and Elliott (1999) point out, psychologists and other mental health professionals frequently receive case information in written form (e.g., reports, referrals, depositions, etc.) and often make preliminary clinical judgments based on that information. Thus, while research methods that employ study of actual clients are ideal, analogue methodology continues to inform mental health practice.

Despite the critiques and mixed results, there is a preponderance of evidence that ageism exists among mental health professionals. In one particular response to the critics,

Shmotkin, Eval, and Lomranz (1992) assert that the findings of their study support the existence of professional ageism simply given that participants had significantly different levels of motivation to work with a client, based solely on the age of that client. Two separate reviews of the literature on ageism and mental health treatment of older adults (Laganà & Shanks, 2002; Robb, Chen & Haley, 2002), conclude that the evidence for the existence of ageism within the profession is undeniable. For example, on a basic level, ageism plays a part in the difficulty recruiting professionals to work with older adults (Robb et al., 2002). In the conclusion to their meta-analysis, Kite and colleagues (2005) plea, “Perhaps it is time to get aside the questions of whether ageism exists and continue to explore when and where the consequences are most severe” (p. 259).

Factors Impacting Attitudes

Although much work has yet to be done to both better understand the factors that contribute to age bias on the part of mental health professionals and to improve attitudes and eradicate ageism, researchers have begun to address the characteristics of the mental health professional that relate to more or less age bias. In this section, the following characteristics of the mental health professional will be explored: demographic factors, training, experience, and fear of death. Albeit some of the research on these factors provides mixed or inconclusive findings, the following six factors are those that have been linked with age bias for professionals.

Demographic Factors

Age

There have been mixed results for the effects of age of the participant on attitudes toward older persons. And, for each finding there have been plausible explanations offered. When studies find that younger participants hold more favorable attitudes (e.g., Ford & Sbordone, 1980; Hellbusch et al., 1994) it is because of younger persons more progressive views of society. Or it is because older participants are both experiencing increased countertransference reactions and, related to number of years in practice with older clients, are burned out and pessimistic. Alternatively, when studies find that older participants are more favorable toward older adults (e.g., Gellis et al., 2003; Ray et al., 1987; Zivian et al., 1992) it is because of a certain level of maturity and experience and an increased levels of empathy. Kite and Wagner (2002) argue that a narrative review of the literature provides no clear direction because there are important methodological differences among studies such as: raters' educational and socioeconomic status as well as ethnicity and sampling strategies for younger and older participant groups (i.e., younger groups are usually college students, older groups are usually convenience samples). However, theory and evidence from the field of social psychology supports the notion that older individuals will have more favorable attitudes toward older individuals.

Social identity theory (SIT; Tajfel & Turner, 1979) states that we strive to maintain positive images of our in-group, i.e., those individuals that we perceive as similar to ourselves along some important dimension of identity such as age. A recent study provided additional empirical support for the theory by testing the attitudes of three

age groups of people (Celejewski & Dion, 1998). As SIT would predict, the older group of participants rated the older targets more favorably than did young and middle age participants. In fact, Celejewski and Dion's study not only supports SIT, but gives meaning to findings of a lack of negative attitudes among young and middle age participants toward an older adult. When participants were asked to imagine themselves as an older adult, thus shifting the target older adult to a member of the participant's in-group, the participant had more favorable attitudes toward the older adult. SIT predicts positive attitudes based on perceptions of the in-group, which is not equivalent to predicting negative attitudes based on perceptions of the target as not a member of the in-group (Kite & Wagner, 2002).

In a 2004 study of attitudes about aging and older adults among young, middle age and older adults, Laditka, Fischer, Laditka and Segal found that older participants (age 60 +; $n = 167$) rated older targets more positively on Polizzi's Refined Version of the Aging Semantic Differential (Polizzi, 2003) than young and middle age participants. Furthermore, a study examining the factor structure of the Fraboni Scale of Ageism (Rupp, Vodanovich, & Credé, 2005) found that, among college students, younger individuals and men scored significantly higher, indicating a higher degree of ageism, than older individuals (age 40 +; 9% of the total sample) and women ($p < .001$). Finally, Kite et al. 's (2005) meta-analysis of 232 effect sizes concluded that for two out of three categories of studies (rating the competence level and indicating behavioral intentions of an older versus younger adult), younger participants had more negative responses toward the older target than older participants.

Gender

Just as with age, the review of the literature reveals some mixed results regarding the effect of the participant's gender on attitudes toward older adults, including an early comprehensive review of the literature by McTavish (1971) and meta-analysis by Kite et al. (2005). After reviewing more than 20 years of findings, McTavish concluded that of the important factors that correlate with attitudes toward older adults, sex appears to show up consistently. In these earlier studies, women were found to have more positive attitudes toward older adults than men. Kite and colleagues meta-analysis results indicated the following mixed findings: a) gender was not relevant when measuring evaluations (attitudes), b) when participants were rating a target's competence, the overall effect across studies was that men had more favorable ratings, and c) when measuring behavior and/or behavioral intentions of the participant toward the target, the overall effect was that women behaved more favorably. Despite the mixed findings, several more recent studies continue to find women to have more favorable attitudes toward older adults (e.g. Funderburk et al., 2006; Gellis et al., 2003; Rupp et al., 2005).

In their 1981 investigation of attitudes toward older adults among undergraduate and graduate students, Thorson and Perkins aimed to better understand McTavish's (1971) finding by exploring personality factors that may correlate with gender. Thorson and Perkins hypothesized that individuals higher in dominance and aggression would have more negative attitudes toward older adults. Further, based on previous research, they also hypothesized that women, older participants, those with higher levels of education, and persons who had living grandparents would have more positive attitudes toward older adults. Using Kogan's measure of attitudes toward old people (1961) and a

measure of personality traits, Thorson and Perkins (1981) studied 212 graduate and undergraduate students in the southern U.S. The authors found that age and sex were more important contributors than personality factors such as nurturance or aggression.

Among the more recent studies that found a gender correlation, Gellis et al.'s (2003) investigation of graduate students in social work measured knowledge about aging issues and attitudes toward older adults using a revision of the Aging Semantic Differential (Intrieri et al., 1995). Participants had overall negative attitudes toward older adults (i.e., mean of the ASD was above neutral), however women's attitudes were significantly more favorable. Then, in a large scale study of undergraduates ($N = 779$) who did and did not take an elective course in aging, Funderburk et al. (2006) found that women in the sample had slightly more positive attitudes toward older adults ($p = .05$), although gender was not a significant predictor in the authors' regression analysis predicting attitudes toward older adults on Rosencranz and McNevin's (1969) Aging Semantic Differential.

In summary, above all other demographic factors (e.g., race/ethnicity, socioeconomic status, etc), although findings have been mixed, there is evidence of some effects of age and gender on attitudes toward older adults. Taken together, the findings of the above studies indicate that older individuals and women typically have more favorable attitudes toward older adults. In the next sections, variables having relatively consistent effect on attitudes toward older adults are examined.

Training and Experience

Several studies have explored the impact of training in issues associated with aging. In general, the more training an individual has in aging, the more favorable that individual's attitudes are toward older adults. For undergraduate college students, attitudes have been found to improve after instruction and/or experience with older adults (Anguillo, et al., 1996; Funderburk et al., 2006; O'Hanlon & Brookover, 2002). And, some professional experience with older adults led to continued interest in future work with older persons (Paton, Sar, Barber & Holland, 2001). However, the persistence of improved attitudes over time is still in question (Stuart-Hamilton & Mahoney, 2003).

There is a substantial body of literature which addresses the issue of improving health care professionals' attitudes toward elders. Intrieri, Kelly, Brown, and Castilla (1993) conducted a 6-week experimental program to evaluate the effects of training on medical students' attitudes and skills with elders. Third-year medical students participating in a required psychiatry rotation were assessed on attitudes toward older adults (using the Aging Semantic Differential; Rosencranz & McNevin, 1969), knowledge of aging, and interview skills (assessed by a 15-minute clinical interview with an older adult that was videotaped and coded by two independent raters). Participants also completed measures of social desirability, social distress, and evaluation anxiety to determine if there were any differences between the experimental and control groups given that assignment to groups was only partially random.

The control group took all measures but did not complete the gerontological training. The experimental group took all measures in addition to completing four 90-minute group sessions (over the course of 6 weeks - one week prior for pre-testing and

one week after for post-testing) with teaching units on normal aging, sensory-loss activities, information on the sociodemographics of aging, and training on interview skills with older adults. Results of the experiment revealed significant differences between the treatment and control groups. On two of the three subscales of the Aging Semantic Differential (the instrument used to measure attitudes toward elders), the experimental group demonstrated more positive attitudes (Intrieri et al., 1993). With regard to interview behaviors, the treatment group spent more time talking with the older patient and used more clarifying statements than the control group.

Intrieri and colleagues (1993) were surprised to find that there were no significant changes on scores of knowledge of aging between the experimental and control groups. Yet, total scores on the ASD for the experimental group dropped 10 points from slightly below neutral at baseline (126.24) to 118.08, at post-test (a total score of 32 is equivalent to the most positive attitudes, while 224 indicates the most negative, with a neutral mean of 128). Stuart-Hamilton and Mahoney (2003) also found evidence of a divergence between attitudes and knowledge subsequent to training on aging issues, but in their study, negative attitudes persisted alongside increased knowledge.

Training and experience for health professionals proved to significantly improve both attitudes toward older adults and interest in geriatric practice. In their 1998 study of health professionals trainees (students, interns, residents and fellows) in the areas of medicine, psychology, pharmacy, occupational therapy, social work, nursing and speech pathology, Damron-Rodriguez et al. assessed participants' interest, knowledge, and attitudes toward older adults before and after clinical rotations in geriatrics. The authors found that the geriatric clinical rotation had a positive effect on increasing trainees'

interest in geriatrics, improving general knowledge of older adults, decreasing attitude bias in knowledge of elders, increasing positive attitudes toward older adults' capability and adaptation, and increasing positive attitudes toward working with older patients. Interestingly, it was the pre-doctoral psychology interns whose knowledge, positive aging bias, and positive attitudes toward working with older adults improved more than any other subgroup of participants.

To understand more about the effect of geriatric training on psychologists, Hillman, Stricker, and Zwieg (1997) studied 186 clinical psychologists regarding their clinical judgments of older adults. Rather than finding significant age bias in the participants' judgments of the clinical vignettes, the authors unexpectedly found "specific, appropriate, age-related diagnostic and treatment biases, particularly when they have reported having specialized gerontological training or course work" (p. 181). The 56% of the sample that had additional gerontological training or coursework were significantly more likely to: a) rule out age-related diagnoses of dementia, b) to rule out organicity and c) to make the critical treatment recommendation of a medical exam.

Stuart-Hamilton and Mahoney (2003) measured knowledge of aging (with the Facts on Aging Quiz; Palmore, 1988) and attitudes toward older adults (Fraboni Scale of Ageism; Fraboni, Saltstone, & Hughes, 1990) of social care and council workers in the United Kingdom before and after an aging awareness intervention. The intervention involved a 2.5 hour workshop in which participants alternated between listening to short lectures on facts about aging and taking part in discussion groups on the topic of the experience of being an older adult interacting with council employees. Pre-test measures (n = 200) were administered at the start of the workshop and post-test measures (n = 139)

were mailed out one month after the workshop and completed by the workshop participants at their leisure.

As expected, the results revealed a significant negative correlation between knowledge and attitudes before the intervention (Stuart-Hamilton & Mahoney, 2003). In other words, increased knowledge about aging was associated with lower levels of ageism. Nevertheless, at Time 2, one month after the workshop, the correlation was not significant and the only one of the three subscales of the Fraboni Scale of Ageism was significantly changed. Thus, simply attempting to increase knowledge of aging may not improve attitudes toward older adults.

Gregory Hinrichsen, a prolific scholar in geropsychology has conducted a series of investigations into training psychologists for work with the older population (e.g., Hinrichsen, 2000; Hinrichsen et al., 2000; Hinrichsen & McMeniman, 2002). In one such article, Hinrichsen & McMeniman (2002) explore the impact of geropsychology training on knowledge, attitudes and career interest in aging. Comparing two groups of psychology externs and interns with and without a geropsychology placement, the authors found that trainees who completed the placement (consisting of 9 months of assessment and treatment with older adults, coursework on aging and supervision with geropsychologists) had more knowledge of mental health issues in older persons. Moreover, those who completed the geropsychology placement had fewer negative attitudes toward older adults and a higher level of interest in geropsychology.

In 1992, Shmotkin et al. chose to investigate the “reluctant therapist” (Kastenbaum, 1964) trend with Israeli participants. All in the field of clinical psychology, the 190 participants ranged in experience from graduate students, to interns, to practicing

professionals. Each of the participants completed demographic information in addition to a packet of assessment tools measuring their clinical flexibility, motivation to work with older clients, acceptance of stereotypes of elders, attitudes toward older adults (using a semantic differential scale chosen for its use of pancultural adjectives), perceived proximity to death, death fear and concern, and relationship with parents.

Shmotkin et al. (1992) found that approximately 72% of the participants sampled stated that they would “want very much” to work with young adults, while only 4.8% would “want very much” to work with older adults. The authors used stepwise regression to understand which variables predicted the participants’ level of motivation to work with older adults. Educational level, past experience with older adults, attitudes toward psychotherapy for elders, attitudes toward personal aging, location on the life line, and relation with father were all significant predictors in the model, with the two best predictors (accounting for 38% of the variance) being attitudes toward psychotherapy with older persons and past experience in professional work with elders.

Research findings, however, have been mixed and at times more experience has been found to be related to less favorable attitudes toward elders. For instance, Revenson, in her 1989 investigation of compassionate stereotyping of the elderly among physicians using an analogue design, found that those physicians who were considered high-contact (based on the percentage of patients on their current caseload over 65) rated the older target as more ineffective and dependent (subscales on the ASD), lower in psychological adjustment and in greater need of all types of support. Danzinger and Welfel (2000) found that for psychologists, social workers and counselors, the more the number of years

in practice, the less competent the target was rated, regardless of age, gender or health status.

Fear of Death

There are several theories that aim to explain the fear and anxiety associated with death such as self-realization theories, searching-for-meaning theories, personal construct theories, theories of denial and positive illusions, multiple selves and the self-concept discrepancy theory, and Erikson's psychosocial theory (see Tomer, 1994 for a review). Among the theories of denial and positive illusions is the Terror Management Theory (Rosenblatt, Greenberg, Solomon, Pyszczynski, & Lyon, 1989), based on the writings of Ernest Becker (1962-1975; e.g., Becker, 1973). The terror management perspective has been supported by empirical evidence (Cicirelli, 2002) and can be used to explain ageism. In their 2005 article, Martens, Goldenberg, and Greenberg discussed a theoretical analysis applying terror management theory to ageism.

Martens et al. (2005) proposed that elders represent three distinct psychological threats that lead to negative reactions. First, older persons are a "potent reminder" (p. 225) of inevitable death. We as humans come to realize that even if we survive all of the potential threats to our life (e.g., terrorist attack, car accident, cancer, etc.) we will all still grow old and die. The second threat Martens et al. labeled *animality*. Older adults remind us that our physical bodies will deteriorate in the form of life-threatening illness and loss of control over body functions. Thirdly, elders threaten insignificance. Martens et al. explained that given death anxiety's close link with self-esteem, older adults are threatening because those characteristics that provide us with self-esteem (e.g.,

competence, mental abilities, physical beauty and strength, etc.) are stereotypically absent for elders.

Support for the terror management theory of ageism, in the context of experimental research, is mounting. In an article reporting the results of three studies linking thoughts and fears about death to attitudes toward older persons among undergraduates, Martens, Greenberg, Schimel, and Landau's (2004) findings offered support for the terror management theory of ageism (also cited in Martens et al., 2005). Study 1 demonstrated that older people are associated with death, evidenced by participants used more death-related word associations after viewing pictures of older people than did participants who viewed pictures of young people. Study 2 confirmed that increasing mortality salience by presenting participants with open-ended questions about death, caused participants to rate older individuals less favorable (and to see themselves as more different from older persons than younger persons). Finally, in Study 3 the results of the experiments in Study 2 were compared with participants' ratings completed several weeks prior to the experiment of their personality characteristics and the personality characteristics of older adults. It was participants who rated their personalities to be more like an older person's who experienced less favorable attitudes toward elders. Based on the combined outcomes of the studies, Marten's et al. (2004) concluded that concerns about death can lead to more pronounced ageist reactions.

In a clinical inquiry that led to support of the terror management theory of ageism, almost half of the clinical psychology trainees in Lee and colleagues 2003 study, when asked about personal issues that may affect the under-recruitment of psychologists to work with older adults, suspected that fears of aging and death contributed. One

participant said, “perhaps there is a general dislike of staring one’s own mortality in the face every day” (p. 88). Further testing of the theory applied to mental health professionals has produced mixed outcomes. For instance, Arnold (2002) in her dissertation research on factors that predict a trainees’ (doctoral level clinical and counseling psychology students) decision to work with older adults, found that lower scores on the death anxiety measure contributed along with positive attitudes toward elders to an interest in working with older adults after graduation.

DePaola and colleagues have published two studies finding evidence for the link between attitudes toward older adults and fears or anxiety about death. In examining this phenomenon, DePaola, Neimeyer, Lupfer, and Fiedler (1992) compared nursing home personnel with matched controls who did not work in a nursing home. In a multiple regression analysis aimed at understanding the factors which contribute to negative attitudes toward older adults, one component of fear of death (a subscale of the Multidimensional Fear of Death Scale; Neimeyer & Moore, 1994) as well as providing direct care to older adults were the significant variables found to predict negative attitudes toward older adults. DePaola also found that among older adults (mean age 69.4 years) negative views of elders were significantly associated with death anxiety (DePaola, Griffin, Young, & Neimeyer, 2003). In a multiple regression model predicting perceptions of older persons as a group, the authors discovered that anxiety about aging, participant’s age, and fear of the unknown were significant predictors of negative attitudes toward older adults (DePaola et al., 2003).

Utilizing Collett-Lester’s Fear of Death Scale (Collett & Lester, 1969), Shmotkin and colleagues (1992) found no correlation between motivation to work with older adults

and scores on the measure, thus the variable was left out of the multiple regression equation predicting motivation. For Shmotkin et al.'s participants, other factors including attitudes toward aging in general, attitudes toward psychotherapy with older adults, and past professional experience with older persons were significant predictors of motivation to work with older adults. In another study of nursing student's attitudes toward older adults, the Collett-Lester's Fear of Death Scale found no relationship between attitudes and fears of death (Gomez, Young & Gomez, 1991).

Although the previous studies utilizing the Collett-Lester Fear of Death Scale failed to find a correlation between fear of death and attitudes toward older adults, the scale is often used to test the success of death education programs. Evidence for the validity of the most updated version of the measure (Lester & Abdel-Khalek, 2003) was presented in Mooney's (2005) study of nursing students. Following a program aimed at decreasing death anxiety, scores on the Collett-Lester measure were significantly decreased. Further, Mooney and O'Gorman (2001) examined the construct validity of the revised Collett-Lester Fear of Death Scale and concluded, after a series of studies, that the measure had good psychometric properties.

Lastly, there is some evidence that perhaps the relationship between fears of death and interest in gerontological careers runs contrary to the predictions of terror management theory. Salter and Salter (1976) found evidence for the "anxiety-reduction" hypothesis that people who fear death engage in behaviors aimed at facing their fears. For example, participants in Salter and Salter's study with higher levels of death anxiety were more likely to support a national campaign for awareness of aging, more likely to have a desire to visit and help the elderly, and more likely to actually do so. Schigelone and

Ingersoll-Dayton (2004) were surprised to discover that medical students participating in their qualitative study regarding the factors that influence an interest or disinterest in geriatric medicine expressed much more fears about aging and death when they had an interest in geriatric medicine. Taken together, however, the review of the literature offers some support for the terror management theory of ageism, which contends that ageism is related to increased fears of death.

Multicultural Competence

Theoretically, multicultural competence should be associated with more favorable attitudes toward older adults and more appropriate clinical judgments of older clients. A multiculturally competent mental health professional is in the process of developing self-awareness, an understanding of clients' worldviews free of judgments, and actively pursuing skills to incorporate culturally-appropriate interventions (Sue, Arredondo, & McDavis, 1992). Encouraging development of the domains of awareness, knowledge and skills was designed to influence better work with clients of different cultures.

The aforementioned domains are highly relevant to the mental health professional working with elders. To work effectively with older adults, mental health professionals would likely benefit from development of: a) an awareness of the pervasiveness of ageism in American culture, the ways in which ageism affects the field of mental health and self-awareness of one's own issues with aging and personal contribution to the perpetuation of ageism; b) knowledge of normal aging, developmental issues faced by older adults, and theories applicable to aging; and c) skills to implement interventions appropriate for older adults and conduct age-specific assessments.

Given that the multiculturally competent mental health professional has generally a better understanding and acceptance of clients from other cultures and specifically developed areas of awareness, knowledge and skills in treating a diverse population of clients, the multiculturally competent mental health professional should be better equipped to work with older adults. This professional is probably more likely to have developed the domains listed above relevant to counseling and psychotherapy with elders. Currently, there is a body of research devoted to issues faced by racial/ethnic minority elders (e.g., Baden & Wong, 2008; Barker, 1994; Brotman, 2003; Fried & Mehrotra, 1998; Hinrichsen, 2006; Holmes & Holmes, 1995; Keith, Fry, Glascock, Ikels, Dickerson Putman, Harpending, & Draper, 1994; Markides & Mindel, 1987; Sokolovsky, 1990; Stanford & Torres Gil, 1992; Xakellis et al., 2004; Yali & Revenson, 2004; Yang & Levkoff, 2005). Yet, the application of multicultural competencies to work with elders has not been explored.

On a systemic level, the multicultural movement and the movement to address the needs of our aging population encompass the same ideals. Both movements grew out of a larger recognition that the population of ethnic/racial minorities as well as those over the age of 65 is growing exponentially and there is evidence that health professionals are not effectively treating these groups. Additionally, both causes focus attention on education and training of upcoming professionals.

Often cited as a paramount event in the history of the multicultural competency movement, the Vail Conference, held in 1973, aimed to address professional training in psychology. It was there where Joseph White and his colleagues from the Association of Black Psychologists urged the profession to consider practice without competence in

cross-cultural issues unethical (Korman, 1974). In considering White's call to the profession, in 1982 Derald Wing Sue wrote a position paper that was the impetus for the development of the multicultural competencies.

Credited with establishing the field of geropsychology, the "Older Boulder" conference, as it is affectionately known, was the first national conference on training psychologists to work with older clientele, held in Boulder, Colorado in 1981. Then, in 2000, the APA Interdivisional Task Force, in association with the U.S. Department of Veteran Affairs Technical Advisory Group in Geropsychology (TAGG), developed guidelines for competency in psychologists' care of older adults. The seven competency areas discussed include normal aging, assessment, treatment, prevention and crisis intervention, consultation, interfacing with other disciplines, and special ethical issues (Molinari et al., 2003). The task force also developed recommendations about the knowledge and skills required of psychologists working with older adults, which were adopted by APA in 2004 as the *Guidelines for Psychological Practice with Older Adults*.

Just as Derald Wing Sue used the changing demographics of the United States to support his argument that the field of mental health must adopt multicultural competencies, it is clear at this point in U.S. history that mental health professionals training to work with older adults will be in high demand. From 1950 to 2005, the average annual growth rate of the U.S. population was 1.2%, while the average annual growth rate of the population of elders –age 65 and older- was 2.0%, with those ages 75 and older growing at the fastest rate of 2.8% per year (National Center for Health Statistics, 2006). Furthermore, as the Baby Boomers age to reach older adulthood (by 2029, all of the Baby Boomers will be 65 or older), the population of older adults will

jump to 10% of the total population. By 2050, those 75 years and older will make up 12% of the population.

Counseling Psychology, Multiculturalism and Older Adults

The field of counseling psychology is one group of professionals that have made a significant effort not only to advance the multicultural movement, but also to educate and train its students to be multiculturally competent professionals. Counseling psychologists are actively involved in the dialogue about training and research in multicultural issues.

Ten years after Sue (1982) made a call to the profession to train mental health professionals to work with culturally diverse, Thomas Parham, then president of the Association for Counseling and Multicultural Development, appointed Sue along with Patricia Arredondo and Roderick McDavis to a special committee. The committee urged the profession to adopt standards of multicultural competence (Ridley & Kleiner, 2003). Division 17 eventually endorsed the multicultural competencies during the presidency of Gerald Stone, 1997-1998 (Heppner, Casas, Carter, & Stone, 2000), which were later passed by the APA senate in 2003 (American Psychological Association, 2003b).

The competencies adopted by Division 17 were based on Sue et al.'s (1992) multicultural counseling competencies. Sue's et al.'s model, as well as a model operationalizing the competencies as they relate to identity (Arredondo, Toporek, Brown, Jones, Locke, Sanchez & Stadler, 1996), is among the most prominent models of multicultural counseling competencies in the field. Sue et al. highlight three key areas of multicultural counseling competence: counselor self-awareness, counselors' understanding of clients' worldviews free of judgments, and counselor's active pursuit of

multicultural counseling competence. These dimensions are summarized as beliefs and attitudes, knowledge, and skills. The authors outline a 3 (characteristics) x 3 (dimensions) matrix for understanding how each competency can be understood in terms of its own beliefs and attitudes, knowledge, and skills. The competencies include: counselor awareness of own assumptions, values, and biases; understanding the worldview of the culturally different client; and developing appropriate intervention strategies and techniques.

In Arredondo et al.'s (1996) operationalization and revision of the multicultural competencies, she and her colleagues made an important distinction between multiculturalism and diversity. Ethnicity, race, and culture are the focus of multiculturalism, as defined by the authors. And, diversity is other individual differences such as age, gender, sexual orientation, religion, physical ability or disability, or any other dimension important to an individual's identity. In their article, Arredondo and colleagues go on to illustrate these different and overlapping identities with a model, the Personal Dimensions of Identity (PDI). The PDI model divides identities and contexts in "A," "B," and "C" dimensions (e.g., age, gender and race are "A" dimensions, educational background and relationship status are "B" dimensions, and historical movements/eras is the "C" dimension). Hence, the authors of the PDI model recognize and honor the complexity of multiple identities across multiple contexts and encourage counselors to do the same.

In 1985, Charles Ridley, counseling psychologist and future fellow of Division 17, proposed five imperatives that made a steadfast rationale for integration of the multicultural competencies. First, the *professional participation* imperative states that

psychology as a profession should reflect the cultural diversity of society. Ridley argued that, thus far, psychology had not done so evidenced by the negligible number of ethnic minorities (7.2%) that had been granted doctoral degrees in clinical and counseling psychology. Ridley urged, “professional psychology cannot retain its integrity by representing only the interests of the dominant culture” (1985, p. 612). The *ethical* imperative asserts that psychologists without special training in treating ethnic and racial minorities are practicing outside their scope of competence which is unethical. The *cultural-context* imperative argues that all psychotherapy takes place within the context of culture. Just as the norms and values of a culture dictate what is a mental illness, they also dictate appropriate interventions, thus it is essential that psychologists be both knowledgeable and sensitive to the client’s culture.

In order for the cultural-context imperative to be met, the *scholarly* imperative must be addressed. Ridley (1985) asserted that it is psychology’s responsibility to “correct the inadequate and incorrect presentation of ethnic minorities in the psychological literature” (p. 614). Some of the examples that Ridley lists of the negative presentation of ethnic minorities include: the perpetuation of false stereotypes, an overemphasis on psychopathology, evaluation of ethnic minorities using middle-class White norms, and the failure of research to contribute to the betterment of the groups being studied. Lastly, the *legal* imperative is directly connected to the ethical imperative and names the delivery of services outside the scope of one’s competence a violation of the rights (i.e., the right to equal access and opportunity for mental health services) of ethnic minority clients.

One strategy for determining the success of such calls to the profession as Ridley's, is to examine the state of the literature for the profession. In an informal investigation modeled after Werth, Kopera-Frye, Blevins, and Bossick (2003) investigation of the prevalence of aging issues addressed in the flagship counseling psychology journals (see below for a description of the study), I performed a literature search of the *Journal of Counseling Psychology (JCP)* and *The Counseling Psychologist (TCP)* (from their inception: 1969 for *TCP* and 1954 for *JCP*) for research focused on multicultural issues. Using just the search term "multicultural," 449 articles matched in *TCP* and 239 in *JCP*. The sheer volume of articles addressing this issue in counseling psychology journals lends evidence to the significance of this topic to the profession.

Another strategy for monitoring change within the profession is to look to the ways in which the profession is training its upcoming practitioners and scholars. Hills and Strozier (1992) conducted a survey of counseling psychology programs which aimed to understand the extent to which multicultural issues are addressed. Of the 61 APA-approved counseling psychology training programs in the United States (as of September 1988), 49 participated in the survey. The authors examined five areas regarding multiculturalism including coursework, number of faculty involved in multicultural issues, faculty attitudes about the importance of multicultural issues, demographic information on the faculty, students and community, and perceived pressure to develop coursework and research in multiculturalism.

Hills and Strozier (1992) reported that 87% of counseling psychology programs offered at least one course that focused on multicultural issues and 59% of programs required that course for graduation. Eleven percent of faculty members were non-White,

mostly concentrated in the ranks of associate, adjunct and assistant professors (only 4% of full professors were minorities). Within the varying ranks of full, associate, adjunct and assistant professors, faculty were involved in multicultural teaching, supervising, research and workshops at or above the expected levels (expected percentage of participation in each activity was calculated based on the percentages of the total number of faculty represented by each rank). However, full professors were much less involved with 25-27% of that group participating in each of the four activities.

As expected, the program's level of commitment to multicultural issues was directly related to its faculty and students. The number of courses with a primary emphasis on multicultural issues, the availability of said courses, and the number of courses with a component of multiculturalism were all significantly correlated with professors' involvement in teaching, supervising, research, and workshop attendance, along with the number of ethnically diverse faculty members (Hills & Strozier, 1992). With regard to the student population, the number of ethnically diverse (non-White) students in the program was significantly correlated with: multicultural courses offered; the number of ethnically diverse faculty; the level of involvement in multicultural pursuits by full professors; the total number of faculty involved in multicultural issues; the length of time that the program had deemed multicultural issues important; presence of faculty members who had developed an expertise in multiculturalism; and the size and ethnic make-up of the local community.

Further evidence of the integration of multiculturalism into counseling psychology training comes from two studies of counseling psychology students who rated their programs (Constantine, Ladany, Inman & Ponterotto, 1996) and themselves

(Pope-Davis, Reynolds, Dings, & Nielson, 1995) with regard to multicultural competencies. Constantine et al. reported that counseling psychology students perceived their programs to be meeting multicultural competencies overall, especially with regard to curriculum issues and research considerations. Programs were less than adequate in meeting specific multicultural competencies in the areas of minority representation (bilingual faculty), counseling practice and supervision (active multicultural affairs committee), competency evaluation (using a valid assessment instrument to measure students' multicultural competencies), and physical environment (some type of multicultural resource center located in the department). In comparing counseling with clinical psychology students, Pope-Davis et al. (1995) found that counseling psychology students rated themselves significantly more multiculturally competent and completed an average of 1.6 multicultural counseling courses compared to 0.9 for clinical psychology students.

Finally, Quintana and Bernal (1995) conducted an investigation comparing counseling psychology with clinical psychology programs across existing standards and recommendations for multicultural training. The authors found that counseling psychology programs better met multicultural training standards on 25 of 28 dimensions. However, Quintana and Bernal noted that the difference between the programs was small and although counseling psychology programs were generally successful at increasing multicultural awareness, they continued to struggle with teaching multicultural skills. In concluding, Quintana and Bernal stated that counseling psychology has the potential to make important contributions to the mental health of ethnic and racial minorities, adding that: "This psychology specialty has historically demonstrated responsiveness to

sociodemographic shifts in U.S. society (e.g., during the 1940s and 1950s) and leadership in addressing the mental health needs of a population that has traditionally been neglected (i.e., women)” (p.119).

The tenets of counseling psychology that predisposed the field to be a leader in the development and training of multicultural competencies could also be considered the same forces that will hopefully direct counseling psychology to be a leader in the geropsychology movement. Unfortunately, counseling psychology’s track record in gerontological issues has not been as positive as that for multiculturalism.

One of the first calls to counseling psychology to address the needs of aging adults came from two researchers, who happen to be octogenarians themselves. In 1972, Sidney and Alice Pressey published an article in the *Journal of Counseling Psychology* based on their personal experiences living in a residential home for older persons. Based on their observations, Pressey and Pressey made a call to the field that there is an immense need for counselors to work with older adults and their families, older clients could benefit from seeing an older counselor who would be able to empathize with their situation and counseling elders provides unique prospects.

Carol Dye’s 1978 study of psychologists (reviewed previously) was the first and continues to be the only known investigation into counseling psychologists work with older adults. Dye found that psychologists, both clinical and counseling, were interested in working with older adults, but believed them to be less appropriate for psychotherapy, more set in their ways, and more likely to encounter difficulty learning new behaviors. Dye speculated that these attitudes could lead to misdiagnosis as well as generally devaluing older adults as candidates for therapy.

Twenty years after Pressey and Pressey's article, Bruce Fretz echoed their plea in his presidential address to Division 17 (Society of Counseling Psychology) of the American Psychological Association (Fretz, 1993). Fretz offered a critical view of counseling psychology's commitment to diversity and highlighted the ways in which counseling psychology can incorporate training on the diversity and challenges of old age. He went on to suggest that geropsychology need not be a specific subspecialty, but could be incorporating into existing curricula, which, for counseling psychology, already focused on diversity and empowering the oppressed.

On the premise of Dr. Fretz's call to action inspiring the profession to incorporate gerontological research in the scope of counseling psychology, Werth et al. (2003) examined the state of the literature. Werth and colleagues conducted a review of 10 years of articles published in the *Journal of Counseling Psychology* and *The Counseling Psychologist* to determine the quantity of research involving older adults. For empirical studies, the authors identified how often older adults were part of the sample and, for nonempirical articles, how often older adults were a focus of the discussion. Of the 984 articles examined, a grand total of 16 publications (8 empirical and 8 nonempirical) were devoted to older adults. Of those 8 nonempirical articles, 5 were contained in one issue of *TCP* demarcated to aging issues. Werth et al. argued that despite the calls for more research in the area, the answer had been feeble.

Following up on Werth et al.'s content analysis of *TCP* and *JCP*, I queried PsychINFO for any article relating to "elderly," "older adults," "older persons," "65" or "65+," "senior citizens," "elders," "third age," "gerontology," "geriatrics," and "geropsychology" within *TCP* or *JCP* from 2001-2008. Only two articles matched my

search results, one in *JCP*, and one in *TCP* – Werth and colleagues study. Furthermore, searching the journals from their inception (1969 for *TCP* and 1954 for *JCP*) through 1990 when Werth and colleagues initiated their analysis, the same search yielded 10 articles in *TCP* and 12 articles in *JCP*. Hence, it appears that the trend has continued in which counseling psychology research has not demonstrated a focus on issues faced by older adults.

Fortunately, the area of training of counseling psychologists for work with older adults appears to be expanding at a higher rate. In a status report on the state of training for delivery of services to older adults within APA-approved programs and internships in clinical and counseling psychology, Cohen and Cooley (1983) mailed surveys to all of the clinical and counseling psychology doctoral and internship programs listed in the 1979 APA Committee on Accreditation roster. Of those contacted, 87% of clinical psychology programs (104 of 120), 92% of the counseling psychology programs (23 of 25) and 82% of internship programs (138 of 169) participated.

For counseling psychology programs in particular, two formal and six informal programs on aging were in existence. The finding that 34% of counseling programs included in the study had established either a formal or informal program of study in aging was positive, according to Cohen and Cooley (1983). Cohen and Cooley were optimistic that counseling psychology may become a resource for training psychologists to work with the older adult population, stating:

Although counseling psychology programs have traditionally focused on college students, they seemed to have widened their scope. Many of their activities and points of view seem to be syntonetic for work with the aging. Their orientation is

for enhancing growth, and they have sophistication in skill assessment and career counseling. Some of the more recent developments in health counseling undertaken as a part of the curriculum of counseling psychology seem to equip these psychologists to deal most effectively with just the type of problem that confronts retirees as they shift life roles” (1983, p.727).

Results of a 1997 study of clinical and counseling psychology training programs revealed continued progress in the advancement of training clinical and counseling psychologists for work with older persons (Johnson & Rosich). Although the findings were not separated for clinical and counseling programs, the researchers found 63% of the programs offered a course in aging and 42% had at least one faculty member with a specialization in gerontology. However, there were some disappointing discoveries as well. None of the programs required students to take a course on aging. Moreover, 35% of programs still did not have a specific course on aging and 54% did not have a faculty member interested in aging issues.

Despite the still struggling effort to train counseling psychologists in issues pertinent to work with older adults, training in multicultural issues has become a practically universal component of counseling psychology programs. Thus, given counseling psychologists’ multicultural training, it is important to determine if efforts in training students to be multiculturally competent mental health professionals does in fact impact their work with older adults.

Summary

The plethora of research in the area has indicated that the study of ageism and age bias among professionals is an important endeavor. Research has moved away from simply attempting to prove that age bias exists to better understanding the factors that influence ageist attitudes and behavior. Training, experience, and fear of death have all been cited as important issues impacting attitudes toward and work with older clients. Further, I have proposed that levels of multicultural competence could affect work with older adults. Counseling psychologists appear to be an important subgroup of professionals to study given their philosophy of treatment, emphasis on multicultural training, and the lack of attention to their practice with older adults.

CHAPTER III

METHODOLOGY

Introduction

The chapter is divided into the following sections sample, procedure, instrumentation, data analysis and summary. In the first section, there is a description of the research participants as well as the sampling strategy and rationale. The procedure section includes the method for data collection. In the instrumentation section, the various measures that were utilized to conduct this study are described with regard to their use and psychometric properties. The final section of this chapter outlines the data analysis procedures that are implemented in Chapter IV.

Sample

Participants for this study (approved by the Human Subjects Institutional Review Board; see Appendix A) were a national sample of doctoral-level counseling psychologists who were members of the American Psychological Association and who were identified as practitioners according to the criteria specified below. Survey packets were mailed to 1368 potential participants, 382 were returned for a response rate of 27.9%. Of the 382 returned survey packets, 18 were unusable due to insufficient data. The remaining 364 participants ranged in age from 32 to 80, with a mean age of 51.87 ($SD = 8.23$). Women represented 63.5% of the sample ($n = 231$), 36.5% were men ($n = 133$) and no participants identified as transgendered.

With regard to race/ethnicity, the sample was 93.1% Caucasian/White ($n = 339$). The next largest group of participants identified as Black or African American, 2.5% ($n = 9$). The remainder of participants were 2.2% Bi-Racial/Multi-Racial ($n = 8$), 1.1% Hispanic/Latino(a) ($n = 4$), 0.5% American Indian or Alaskan Native ($n = 2$), 0.3% Asian or Pacific Islander ($n = 1$), and 0.3% ($n = 1$) did not indicate race. Overall, 6.6% of the sample was ethnic/racial minorities. All participants earned a doctoral degree, with 90.9% ($n = 331$) having a Ph.D., 6.9% or 25 participants an Ed.D., and 2.2% or 8 participants a Psy.D. The average number of years in practice was 14.92 ($SD = 4.62$) and ranged from 4 to 30 years.

Participants were asked to indicate their primary theoretical orientation. Categories for theoretical orientation were chosen to match the categories listed on the Association of Psychology Postdoctoral and Internship Centers (APPIC) Application for Psychology Internship (2007/2008 version). Of those who indicated a primary orientation, 32.1% ($n = 117$) endorsed Cognitive-Behavioral, 20.6% ($n = 75$) Eclectic, 10.4% Integrative ($n = 38$), and 8.2% Psychodynamic/Psychoanalytic ($n = 30$). The remaining options for theoretical orientation were endorsed by 20.1% of the sample and included Interpersonal ($n = 21$), Humanistic/Existential ($n = 20$), Other ($n = 18$), Systems ($n = 9$), Behavioral ($n = 5$), and Biological ($n = 1$). The remaining 8.2% of the sample ($n = 30$) endorsed multiple theoretical orientations without indicating which was primary, although Cognitive-Behavioral continued to be the theory most often endorsed (63.3% of those who checked multiple theoretical orientations included Cognitive-Behavioral).

The categories for work setting were chosen to match James' (1995) demographic questionnaire. Of the counseling psychologists who participated in the study, 36.5% were

working primarily in an Individual Private Practice setting ($n = 133$). The second most common work setting was Group Private Practice, which 19.2% of the sample ($n = 70$) endorsed. Seventeen percent ($n = 62$) endorsed an “Other” setting and specified such settings as non-profit agencies, universities (e.g., academic faculty), pastoral counseling agency, correctional system, etc. Those working in a University/College Counseling Center made up 10.4% ($n = 38$) of the sample and 5.8% ($n = 21$) were working in an Outpatient Mental Health Center. Medical Hospitals and Psychiatric Hospitals were the remaining two categories and represented 6.9% ($n = 25$) of the sample. Finally, 4.1% ($n = 15$) did not indicate a primary work setting.

Participants reported the approximate number of clients they were currently seeing from each of four age groups: under 20 years old, between 20 and 39, between 40 and 64, and over the age of 65. For each participant, number of clients was converted to percentage of total caseload. The following represent the average percentages of clients from each of the four age groups: under 20 = 19.3%, 20 to 39 = 34.1%, and 40 to 64 = 36.5%. Participants saw the fewest number of clients in the age group of 65 years and older: 10.1%. Further, 34.6 % ($n = 126$) of the participants did not currently see any clients over the age of 65. Fourteen participants reported that they were not currently seeing clients. Of those, eleven participants indicated that at the time they received the survey they were either retired or not currently in the work force and three marked “0” for all client ages. Nine participants left the question blank.

Finally, participants were asked to rate the extensiveness of their pre-doctoral training and post-doctoral clinical experience on a scale from 1 “none” to 7 “very extensive” with regard to: a) older adults, and b) ethnic/racial minorities (see

Instrumentation section for a description of the Training and Experience Questionnaire). For both variables, pre-doctoral training ranged from a minimum score of 3 to a maximum score of 21 and post-doctoral clinical experience ranged from 4 to 28, with higher scores indicating more extensive training/experience. Participants ranked their pre-doctoral training in aging as 9.13 ($SD = 4.60$) and post-doctoral clinical experience with older adults as 13.69 ($SD = 6.02$) on average. The mean score for pre-doctoral multicultural training was 13.00 ($SD = 4.07$) and post-doctoral clinical experience with ethnic/racial minorities was scored on average at 16.80 ($SD = 4.92$).

Procedure

Potential participants were identified through the American Psychological Association's (APA) Research Office. Criteria for the mailing list generated by APA were: a) member of APA; b) major field: counseling psychology; c) doctoral level degree; d) identified as practitioners/*special assessment payers* (i.e., licensed, practicing psychologists; a special assessment fee is required by APA if a member is practicing); and e) graduated from their doctoral program between 1 and 24 years ago. This range was chosen in order to identify counseling psychologists who have some experience since graduation (i.e., minimum 1 year) and who may have had the opportunity for some formal multicultural training within their doctoral program.

Hills and Strozier (1992) conducted the first survey of multicultural training in counseling psychology programs (see Bernal & Padilla, 1982 for a survey of clinical psychology programs). Data was gathered 20 years ago (September, 1988) and demonstrated that of the 49 APA-approved counseling psychology training programs in

the United States that participated in the study (80% of the total number of programs), 87% of counseling psychology programs offered at least one course that focused on multicultural issues and 59% of programs required that course for graduation. Thus, a majority of counseling psychologists who received their doctorate within the prior two decades were expected to have had the opportunity to have taken at least one multicultural counseling course. Since the APA Research Office organized data by categories of 15-19 years and 20-24 years post-doctorate, 20-24 years was used as the cutoff to include those who had received their doctorate primarily within the last two decades.

The mailing list of potential participants was ordered from the APA research office. The mailing list included *all* potential participants who met the above criteria (i.e., the entire population). The population included 1935 counseling psychologists. The list was divided by race/ethnicity so that all potential participants who identified as American Indian/Alaskan Native, Asian/Pacific Islander, Black/African American, Hispanic/Latino(a) or Bi-racial/Multi-racial (i.e., racial/ethnic minority groups in the United States) were in the first group ($n = 132$), all potential participants who identified as Caucasian/White in the second group ($n = 1590$), and all potential participants who did not specify race/ethnicity in the third group ($n = 213$).

The purpose of the sampling procedure in the present study was to obtain a large sample of counseling psychologists, with adequate representation of racial/ethnic minority counseling psychologists. Delgado-Romero, Galván, Maschino and Roland (2005) in their 10-year review of race and ethnicity in counseling psychology research, highlight a long list of scholars that have called attention to the lack of racial and ethnic

minorities being represented within the samples of psychological research in general and counseling psychology research in particular. Delgado-Romero and colleagues investigation revealed that African Americans, Hispanics, and Native Americans are “underrepresented in counseling and counseling psychology research relative to their numbers in the U.S. population” (2005, p. 441). The authors go on to urge counseling psychologists to make the next review of literature reflect change in inclusion and reporting of race and ethnicity of participants.

To try to ensure adequate representation of ethnic and racial minority counseling psychologists in the present study, multiple sampling methods were employed. First, I drew from stratified sampling techniques. In stratified sampling, the population is divided into mutually exclusive subgroups, called strata, and then samples are taken from each stratum (Rea & Parker, 2005). In the case of the present study, the strata were racial/ethnic groups. Usually samples taken from each stratum are chosen by random selection and customarily each stratum includes no less than 100 participants in order not to exceed a 10 % margin of error (Rea & Parker). Because some population strata within the expected sample were not expected to reach 100 (see population estimates below, based on Munley, Pate & Duncan, 2008), stratified sampling could not be applied for racial/ethnic minorities. Therefore, the entire population of ethnic and racial minority counseling psychologists was sampled. Further, because the population of Caucasian/White counseling psychologists was so large, random selection was used to sample this stratum.

A recent study by Munley et al. (2008) of the demographic, educational, employment and professional characteristics of counseling psychologists who are

members of APA indicated the following racial/ethnic breakdown among counseling psychologists in APA for whom race/ethnicity was specified: .4% American Indian, 2% Asian, 2.5% Hispanic, 2.9% Black, 91.8% White, and .3% Other or Multiracial. Given the demographics of the population, and the relatively low percentages of racial/ethnic minority counseling psychologists, a reasonable strategy for sampling was adopted that involved sending surveys to all racial/ethnic minority counseling psychologists and to a random sample of White counseling psychologists.

Recruitment involved three steps: 1) surveys were mailed out to all 132 racial/ethnic minority counseling psychologists identified by APA who met the criteria for this study; 2) surveys were also mailed out in waves to random samples of 250 Caucasian/White and unspecified race members, until the desired sample size was met (five waves in total); and 3) a reminder postcard (see Appendix B) was sent 3 weeks after the initial mailing in order to obtain as many participants from each stratum as possible. Enclosed in the study packet was an anonymous consent; a demographic information form; a brief case vignette and survey of professional bias (James & Haley, 1995); Polizzi's Refined Version of the Aging Semantic Differential (Polizzi, 2003); the Aging Semantic Differential (Rosencranz & McNevin, 1969); the Collett-Lester Fear of Death Scale Version 3.0 (Lester & Abdel-Khalek, 2003); the Multicultural Counseling Knowledge and Awareness Scale (Ponterotto, Gretchen, Utsey, Rieger & Austin, 2002); and a short training and experience questionnaire. Within each study packet, the demographic information form was presented first and the training and experience questionnaire last. Otherwise, the order of all other measures was counterbalanced. The study packet took approximately 15-20 minutes to complete.

The Anonymous Survey Consent (see Appendix C) contained information about the study for potential participants. Potential participants were informed that all information collected was completely anonymous and in no way linked to personal identifying information, and participants were instructed not to put their name anywhere on the forms. Participants were also informed that they may choose to not answer any question and simply leave it blank. If the participant chose not to participate in the survey, they were given the options to return the blank survey, discard the survey materials, or send back the pre-paid incentive postcard (see Appendix D) indicating that they would like to be removed from the mailing list.

Participants were asked to return completed study packets in the enclosed pre-paid envelope. As an incentive for participation, potential participants were offered the opportunity to win one of two \$100 Discover® gift cards via a drawing held at the completion of data analysis. If participants wished to be included in the drawing, they were instructed to complete and return incentive postcard separately from their study packet to ensure anonymity.

Instrumentation

Demographic Information

Participants completed a short demographic information form (see Appendix E) in which they were asked to report age, gender and race in addition to type of degree, number of years in practice, theoretical orientation, current work setting, and estimations of the number of clients seen from different age groups. The demographic information form was modeled after the one utilized by James (1995).

Clinical Judgments

Clinical judgments were measured by a case vignette and a survey of professional bias (James & Haley, 1995). The vignette describes a 70-year-old woman who meets the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 1987, 2000) criteria for depression. The case vignette has been employed in other research on clinical judgments of an older client (Helmes & Gee, 2003). The vignette reads:

Ms. James is a 70-year-old white female who arrives at your office on time for her first appointment. Her insurance offers full coverage for psychotherapy. Scanning the patient information sheet she completed while waiting for her appointment, you note that Ms. James's medical history is unremarkable. You learn from her that she is recently widowed and that her presenting complaint is depression secondary to her husband's death approximately 8 months ago. Ms. James is casually attired and presents with a somewhat flattened affect. She appears to respond to your questions openly, with little hesitation. She becomes tearful as she recounts her husband's death to you, a prolonged battle with cancer. She indicates that she has lost all interest in activities which formerly gave her pleasure, that she frequently awakens at 2:00 a.m. and is unable to return to sleep, and that she has recently lost 15 pounds. Ms. James also states that she has begun to wonder if life is worth living anymore.

According to James (1995) (the unpublished dissertation of the first author of James and Haley, 1995), the external validity of the vignette was addressed by examining each of the factors contributing to the specificity of the case. First, the target is female

for three distinct reasons a) more women than men are in therapy, b) depression is more prevalent in women than men, and c) older women outnumber older men (James, 1995, pp. 28). Second, depression is commonly diagnosed and successfully treated by clinical psychologists (and there are no significant differences between men and women with regard to responsiveness to treatment). Finally, the target endorsed five symptoms of depression, fitting the criteria outlined in the *Diagnostic and Statistical Manual of Mental Disorders* (III-R and IV-TR; American Psychiatric Association 1987, 2000): depressed mood, anhedonia, weight loss, sleep difficulties, and recurrent thoughts of death.

The survey of professional bias follows the case vignette. Survey questions were designed to assess participants' professional clinical judgments. Higher scores on the survey indicate a greater degree of professional bias (item #7 regarding suicide and item #11 regarding blame are reversed scored). Similar vignettes and surveys of clinical judgments have been developed for use in numerous other studies regarding professionals and pre-professionals' attitudes toward elders (e.g., Danzinger & Welfel, 2000; Hillman et al., 1997; Kane, 2004; McConatha & Ebener, 1992; Meeks, 1990; Revenson, 1989; Uncapher & Areán, 2000).

For the present study, James and Haley's (1995) survey of professional bias was used. Two of the items were revised for the current study: a) item number one was revised to refer to DSM-IV-TR instead of DSM-III-R, and b) item number four was revised to request ratings of the appropriateness of each treatment recommendation instead of a rank ordering of the recommendations. The following is the survey of professional bias as it was presented to participants in the present study. James and Haley's original wording for items one and four are presented in parentheses.

1. "What do you think is the most likely primary *DSM-IV-TR (Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision)* diagnosis for Ms. James's presenting complaint?"

(Original #1: What do you think is the most likely primary *DSM-III-R (Diagnostic and Statistical Manual of Mental Disorders, 3rd Edition, Revised)* diagnosis for Ms. James's presenting complaint?)
2. "How do you view Ms. James's ability to develop an adequate therapeutic relationship with you?"

Rated on a 7-point scale from 1 "very good" to 7 "very poor."
3. "How appropriate a candidate for psychotherapy do you see Ms. James as being?"

Rated on a 7-point scale from 1 "very appropriate" to 7 "very inappropriate."
4. "Please rate the appropriateness of each of the following treatment recommendations for Ms. James: a. Short-term psychotherapy; b. Long-term psychotherapy; c. Pharmacological intervention; and d. Hospitalization."

Each treatment option was rated on a 7-point scale from 1 "very appropriate" to 7 "very inappropriate."

(Original #4: Please rank order your treatment recommendations for Ms. James: short-term psychotherapy, long-term psychotherapy, pharmacological intervention, hospitalization).
5. "How likely do you feel the probability of Ms. James's presenting complaint being related to an organic mental disorder is?"

Rated on a 7-point scale from 1 "very unlikely" to 7 "very likely."

6. “With regard to her presenting complaint, how would you rate Ms. James’s prognosis?”

Rated on a 7-point scale from 1 “very good” to 7 “very poor.”

7. “How likely do you rate the probability of Ms. James attempting suicide in the near future?”

Rated on a 7-point scale from 1 “very likely” to 7 “very unlikely.”

8. “How would you rate your subjective level of competence in treating Ms. James’s presenting complaint?”

Rated on a 7-point scale from 1 “very competent” to 7 “no competence.”

9. “How comfortable would you feel in treating Ms. James’s presenting complaint?”

Rated on a 7-point scale from 1 “very comfortable” to 7 “very uncomfortable.”

10. “How open to your treatment recommendations do you see Ms. James as being?”

Rated on a 7-point scale from 1 “completely open” to 7 “completely closed.”

11. “How much do you think Ms. James is to blame for her problems?”

Rated on a 7-point scale from 1 “completely to blame” to 7 “completely blameless.”

Three of the eleven questions from the survey of professional bias (ability to form a therapeutic relationship [#2], appropriateness for therapy [#3], and prognosis [#6]) have been used in prior research. Both Ford and Elliott (1999) and Helmes and Gee (2003) employed an adapted version of the survey of professional bias, utilizing these same three questions. All three studies that have employed the survey of professional bias (Ford & Elliott, 1999; Helmes & Gee, 2003; James & Haley, 1995) were interested in

understanding the between group differences (participants who rated a younger client versus participants who rated an older client) for each survey question. However, for the present study, a total score for these three items was originally planned to be used to provide a continuous variable measure of professional bias in order to assess and examine the relationship between professional bias and other therapist variables.

Conceptually, the three questions appeared related and were directed at therapists' assessment of appropriateness for therapy and thus impact the outcome of psychotherapy (James & Haley, 1995). Further, using the three questions together to measure the concept as compared with one question (as the previous studies did in their ANOVA analyses), was expected to improve the reliability and validity of the measure. Prior to completing the regression analyses, the reliability of the three items from the survey of professional bias presented in Helmes and Gee (2003) and Ford and Elliott (1999) was examined. Cronbach's alpha for the three-item scale ($n = 364$) was .57.

Given the relatively low Cronbach's alpha for the three items originally identified for use as the measure of professional bias in the current study, there was justification for considering inclusion of additional items from the survey of professional bias to increase the internal consistency of the measure for the present study. Three additional items from James and Haley (1995) also related to the assessment of the appropriateness for therapy and professional bias and included the therapist's subjective level of competence (#8) and comfort in treating Ms. James (#9), and Ms. James openness to the treatment recommendations (#10). The correlation matrix for items on the survey of professional bias was examined and indicated empirical support for adding these three additional items to the original three items (see Table 1). Cronbach's alpha for this revised six-item

Table 1
Correlation Matrix for Items from the Survey of Professional Bias

	Relation- ship	Candi-date	Prognosis	Compe- tence	Comfort	Openness	Organic	Suicide	Blame
Relationship (2)	1								
Candidate (3)	.38***	1							
Prognosis (6)	.39***	.20***	1						
Competence (8)	.28***	.23***	.36***	1					
Comfort (9)	.32***	.21***	.37***	.79***	1				
Openness (10)	.41***	.18**	.35***	.24***	.28***	1			
Organic (5)	.14*	.09	.22***	.24***	.16**	.11*	1		
Suicide (7)	-.15**	-.05	-.24***	-.13*	-.17**	-.20***	-.20***	1	
Blame (11)	-.14**	-.13*	-.22***	-.08	-.06	-.19***	-.22***	.13*	1

Note. Numbers enclosed in parentheses correspond with the numbered questions on the survey of professional bias. See "Clinical Judgments" section of the Methodology for the survey questions. Suicide (7) and Blame (11) are reverse scored. Pearson r for the matrix is based on $N = 359$.

* $p < .05$. ** $p < .01$. *** $p < .001$.

measure of professional bias was .73. Thus, the revised six-item survey of professional bias was used in the regression analyses.

Attitudes toward Older Adults

To measure attitudes toward older persons, Polizzi's Refined Version of the Aging Semantic Differential (Polizzi's ASD; Polizzi, 2003) was used. Polizzi's ASD consists of 24 pairs of bipolar adjectives. Participants were asked to mark along a 7-point continuum at the point that best represents a spontaneous judgment about the person being rated. For the present study, participants rated "a person 70-85 years of age." Lower scores on Polizzi's ASD indicate more favorable attitudes toward older persons, with scores ranging from 24 (most favorable) to 168 (least favorable). A score of 96 indicates neutral attitudes toward older adults. Polizzi's ASD was designed for use of the total score (see discussion of the factor analysis below). Furthermore, there is evidence of the appropriate use of the total score on the original ASD as a dependent variable in a multiple regression (Funderburk et al., 2006). Thus for the present study, total score on Polizzi's ASD was used as the criterion variable. Cronbach's alpha for Polizzi's ASD in the present study was .95.

Originally, the development of the semantic differential technique to measure meaning was proposed by Osgood and Suci in 1955. A factor analysis of the original semantic differential scale (50 adjectives) revealed a three-factor structure described as evaluation, potency and activity. Osgood and Suci noted that all items on the evaluation factor loaded at .75 or better and this factor was "purely" evaluative, thus measuring attitudes (1955). Since then, numerous instruments have been developed and hundreds of

articles and books published based on the semantic differential technique. The technique is widely applicable as a measurement tool and was developed both empirically and theoretically and rigorously tested for reliability and validity (see Osgood, Suci, & Tannenbaum, 1978b for a review). Utilizing the semantic differential to test attitudes in particular, the test-retest reliability was .91 (Osgood, Suci, & Tannenbaum, 1978a) and the concurrent validity was .90 (with Thurstone scales; Thurstone, 1947) and .78 (with a Guttman scale; Guttman, 1954) (1978a). Thurstone and Guttman scales were popular ways to measure attitudes and are comparable to the Likert scale (Likert, 1932). Others have provided evidence for the reliability and validity of the semantic differential as a technique to measure attitudes (e.g., Bagozzi, 1981; Emmerson & Neely, 1988; Kelly & Levy, 1961; McNeil, 1970; Sherry & Piotrowski, 1986; Tzeng & Osgood, 1976).

In 1969, based on the semantic differential technique and Osgood, Suci and Tannenbaum's work, Rosencranz and McNevin developed the Aging Semantic Differential. The ASD consists of 32 pairs of bipolar adjectives, in which participants were asked to mark along a 7-point continuum at the point that best represents a spontaneous judgment about the social object indicated. Scores on Rosencranz and McNevin's ASD range from 32 (most favorable) to 224 (least favorable); a score of 128 is the mid-point and considered neutral attitudes toward older adults.

Using a sample of 287 undergraduate students who each rated a male 20-30 years of age, a male 40-55 years of age, and a male 70-85 years of age, Rosencranz and McNevin (1969) conducted a factor analysis of the ASD. Three dimensions emerged from the factor analysis: Instrumental-Ineffective, Autonomous-Dependent and Personal Acceptability-Unacceptability. The Instrumental-Ineffective subscale showed the highest

factor loadings and reflected the capability and competence dimension (because low scores equal more favorable attitudes, a lower score on this subscale indicates a rating of highly effective). A social object that is scored low on the Autonomous-Dependent subscale is viewed as giving as much or more of oneself to others as one gets from others. Finally, the Personal Acceptability-Unacceptability dimension measures ability to be interpersonally attractive.

The ASD is one of the most widely used and accepted tools for measuring students' and professionals' attitudes toward older adults (Intrieri et al., 1995; Kite & Johnson, 1988; Lutsky, 1980; Palmore, 2005a; Robinson, Gunderson, Rosher & Tomkowiak, 2003; Rupp et al., 2005). However, there have been significant criticisms of the instrument. First, the three-factor structure of the instrument that Rosencranz and McNevin (1969) found has not been replicated in other investigations. Intrieri and colleagues (1995) reviewed the attempts to repeat the factor structure of the ASD and the results of those studies. With the exception of Gekoski, Knox, and Kelly (1991) who found a different three-factor structure, all other investigations have supported a four-factor structure of the instrument (Holtzman, Beck & Kerber, 1979; Intrieri et al., 1995; Underwood, Eklund, & Whisler, 1985). In fact, some have agreed that the fourth factor measures a sense of personal satisfaction and label it "integrity" (Holtzman et al., 1979; Intrieri et al., 1995). Second, Rosencranz and McNevin (1969) did not test reliability or validity of the instrument at the time of development and subsequent research has reported problematic reliability and validity for the instrument (Intrieri et al., 1995; Polizzi & Steitz, 1998). Third, as Polizzi and Steitz's (1998) noted, in developing the

measure Rosencranz and McNevin listed all positive adjectives on the left and negative on the right, which increases the opportunity for response pattern bias.

A fourth criticism of the ASD has been Rosencranz and McNevin's use of a man as the social object for the study, excluding reference to women. In addition to being sexist, this omission also resulted in a validity problem, given that attitudes toward older men and older women have been found to be different (Polizzi & Milliken, 2002). Fifth, researchers using the original ASD have been inconsistent in the use of the social object. Since Rosencranz and McNevin's (1969) use of "a man 70-85 years of age," there have been various substitutes for the social object including use of a more generalized term such as "most old people" (Couper, Sheehan, & Thomas, 1991; Wilson & Glamser, 1982) and also more specified objects such as a fictional vignette target (James & Haley, 1995). Polizzi and Milliken (2002) identify two problems with various substitutes: a) using more or less generalized objects affects the participants' ratings, and b) the use of ageist and stereotypical language is inappropriate and results in less accurate measures of attitudes. Thus, results cannot be compared across studies because the measure has not been used consistently. Polizzi and Milliken found that a social object described as "old" or "elderly" was rated more negatively than a man or woman age 70-85 years of age.

To address these criticisms, Polizzi (2003) developed a refined version of the Aging Semantic Differential. To begin, Polizzi constructed a measure of 81 adjective pairs to assess attitudes toward an older adult by two samples of undergraduate students. Out of the 81 adjective pairs, 30 of the 32 original items on Rosencranz and McNevin's ASD (1969) were included. Two of the adjective pairs (busy-idle and expectant-resigned) were excluded due to the opinion by a five-member panel of doctoral-level experts in the

fields of adult development and aging, psycholinguistics, and cultural diversity that they were outdated and rarely used. Four of the 30 pairs from the original ASD were updated to modernize the language (progressive-old-fashioned to progressive-conservative, handsome-ugly to attractive-unattractive, neat-untidy to neat-messy, and aggressive-defensive to aggressive-passive). Twenty-two adjective pairs were taken from Osgood and Suci's (1955) original list (which included a total of 50 adjectives, the other 28 were already included from Rosencranz and McNevin's version). Five adjective pairs were taken from two studies of the use of the semantic differential technique to examine attitudes toward older adults (Ansello, 1978; Fillmer, 1984) because the adjectives were most frequently used. Finally, 24 new adjective pairs were developed with the assistance of five adults belonging to various age groups, who generated a list of negative adjectives used to describe people 20-30 and people 70-85 years of age, and a panel of experts who created corresponding positive adjectives (Polizzi, 2003).

Following the creation of the measure, an assessment of redundancies in semantics and frequencies of use was conducted. Four independent raters evaluated the adjectives for positive, negative, and neutral valence for young or old people, and the positive and negative items were randomly reversed in position (Polizzi, 2003). Principal component analysis was used to reduce the items and examine the factors. As a result of the analysis, 15 adjective pairs were eliminated based on either a) signs on the factor loadings of the adjectives indicated that they were rated differently depending on the sex of social object or the participant; or b) the items loaded at less than .40.

Factor analysis of the instrument revealed that a four-factor structure best fit the data for the social objects of both a man and a woman (Polizzi, 2003). Factor 1 loaded the

most items and accounted for the most variance, 39% and 37% for man and woman, respectively. The authors assessed that this factor appeared to be measuring the participants' evaluation of the person being rated, thus this factor was labeled "Attitudes." Hence, Polizzi concluded that the refined ASD should only use the 24-item Attitudes factor to obtain a measure of "pure" attitudes.

Polizzi (2003) included in his investigation a measure of test-retest reliability and reported more than adequate test-retest reliabilities of .84 for man and .82 for woman (for the Attitude factor only). Cronbach's alphas for entire list of 66 adjectives were .97 for the man and .97 for the woman. For the Attitude factor only, Polizzi reported Cronbach's alphas of .96 for man and .96 for woman. Additional reliability data for Polizzi's refined version of the ASD were reported by Laditka et al. (2004). In comparing two groups of participants, college students and adults 60 years and older who belonged to an elderhostel organization, the authors found significant differences based on the age of the target and participant and the gender of the target. Laditka et al. reported internal consistency for all four factors as ranging from .93 to .94

To address the remaining criticisms of the original instrument, during the development of the measure, Polizzi (2003) randomly reversed the 81 items used in the principal component analysis to control for response pattern bias. Because response bias was not noted for the 24 item Attitudes factor, for the final version of the measure, all positive items were presented on the left. Polizzi used both a man and a woman as the person being rated, thus assessing for differences based on gender. And, finally, the adjective language was updated and modernized, the social object used was specific as

Rosencranz and McNevin intended, and stereotypic/ageist language (e.g., “old,” “elderly,” etc.) was removed (including from the instructions for the instrument).

In reviewing the literature, four studies were found that utilized Polizzi’s refined version of the ASD. In the first, as reported above, Laditka et al. (2004) examined age and gender differences among raters of Polizzi’s ASD. Mean scores for participants of both genders and all ages rating a target of both genders, age 70-85 was 85.29. In the second, Karlin, Emick, Emick Mehls, and Murry (2005) investigated age discrimination among psychology and nursing students. Karlin et al. found a general lack of age discrimination on Polizzi’s ASD (i.e., more than 90% of participants scored at or below neutral or 96) and no significant difference between the two groups of students on attitudes toward older adults (psychology students mean= 89.4, nursing students mean = 87.7). In the third study by Maurer et al. (2006), the effects of a geriatric rotation on the attitudes of medical interns were explored. The authors’ results revealed that although attitudes were generally positive pre-rotation, the interns’ attitudes following the geriatric rotation significantly improved. Finally in the fourth and most recent study found utilizing Polizzi’s ASD, Mueller-Johnson, Toggia, Sweeney, and Cecia (2007) reported two experiments testing the hypothesis that ageism affects the credibility of witnesses in court proceedings. In the first experiment, Mueller-Johnson et al. provided support for the hypothesis that older witnesses were perceived as less credible. In the second experiment, the authors found that ageist attitudes as measured by Polizzi’s ASD were predictive of judgments made about the credibility of a witness.

Since there has been very limited research comparing the original version of the ASD (Rosencranz & McNevin, 1969) with Polizzi’s (2003) refined version, it was

decided to include both versions of the measure for participants in the present study for possible comparison purposes. The original version was presented after Polizzi's refined version with duplicative adjective pairs removed from the original version. Internal consistency for the original version of the ASD in the present study was .94.

Fear of Death

The Collett-Lester Fear of Death Scale Version 3.0 (Lester & Abdel-Khalek, 2003) was employed to assess participants' fear of death. There are four subscales measuring fear of one's own death, one's own dying, death of others, and dying of others. Scores range from 28 to 140. Twenty-eight statements are rated on a 5-point Likert scale from "very" (5) to "not" (1) in describing how anxious or disturbed participants feel when thinking about each item. For example, some items from the fear of your own death subscale include: "the total isolation of death," "missing out on so much after you die," and "how it will feel to be dead." From the dying of others subscale, some items are: "having the person want to talk about death with you," seeing the physical degeneration of the person's body," and "being reminded that you are going to go through the experience also one day." The total score of all four subscales was used in analysis. Lester and Abdel-Khalek (2003) stated that use of the total score is customary. Lester (2004) and Mooney and O'Gorman (2001) reported significant intercorrelations between subscales, further supporting the use of the total score of the four subscales.

As indicated by the scale name, Lester and Abdel-Khalek (2003) have published the third revision of the original Collett-Lester Fear of Death Scale. The original scale was developed by Collett and Lester in 1969 and was the first scale of its kind to

distinguish between fears of death as they relate to self versus others and as they relate to death versus dying (Lester, 1990). The original scale was never published, thus when David Lester decided to publish the scale for mainstream use, he addressed the two main problems with the original version. First, there were an unequal number of items on each subscale, so Lester included eight items for each subscale. Second, use of the measure in other research revealed a likely problem in scoring as different authors found vastly different subscale means (Lester, 1990), thus Lester revised the scoring to eliminate any reverse scoring and used a scale from 1-5 versus the original -3 to +3.

The current version of the Collett-Lester Fear of Death Scale (3.0; Lester & Abdel-Khalek, 2003) was developed to address one problem with the revised scale. The last item on the death of others subscale was deemed to be scored inappropriately and actually should be reverse scored. In order for ease of use and consistency, this item was dropped from the measure, and, in effect, led the authors to drop one item from each of the other subscales (item with the lowest item-total correlation). Lester and Abdel-Khalek argued that an equal number of items are important for interpretation and use of the total score, which is the purpose of the original design of the measure.

Several studies have supported the validity of the original Collett-Lester Fear of Death Scale (Collett & Lester, 1969), reporting evidence of concurrent validity with other fear of death and death anxiety scales, such as Templar's (1970) Death Anxiety Scale (Lester, 1990; Vargo, 1980) and the Arabic Scale of Death Anxiety (Abdel-Khalek, 2004). Additionally, concurrent validity was reported in terms of other death related variables such as anxiety about talking about dying, nurses' responses to dying patients,

subjective estimates of life expectancy and having negative images of death (Lester, 1990).

Internal consistency of each of the subscales on the Collett-Lester Fear of Death Scale Version 3.0 were reported (Cronbach's alphas) as .91 for death of self, .92 for dying of self, .88 for death of others, .92 for dying of others (Lester & Abdel-Khalek, 2003) for a sample of 191 undergraduates. The test-retest reliability for 27 college students enrolled in a psychology course was .85 for death of self, .79 for dying of self, .86 for death of others and .83 for dying of others. Spearman-Brown correlations were .91, .90, .72 and .88, respectively (Lester, 1990). Finally, in response to criticism regarding the structure of the subscales, Lester performed a factor analysis of the measure with a sample of 144 college students. He found that five orthogonal factors were extracted, four of which corresponded with the four subscales of the measure, while only one item from the fear of death of others scale loaded on the fifth factor. Based on these results, Lester concluded that the measure had adequate subscale structure (2004). Cronbach's alphas in the present study were: .93 for the total measure, .81 for the fear of your own death subscale, .88 for fear of your own dying, .80 for fear of others' death, and .84 for fear of others' dying.

Multicultural Competence

The Multicultural Counseling Knowledge and Awareness Scale (MCKAS; Ponterotto et al., 2002) is a 32-item instrument used to measure awareness and knowledge with regard to multicultural issues in counseling. Respondents are asked to rate the truth of each item as it applies to them using a 7-point Likert scale ranging from

“not at all true,” to “totally true,” so that the range of possible scores is 32 to 224. An example of an item from the MCKAS is: “I am aware of institutional barriers which may inhibit minorities from using mental health services.” There are two subscales of the MCKAS: awareness and knowledge. Higher total scores on the MCKAS indicate a higher level of self-assessed multicultural competence (several items are reverse-scored). The total score on the MCKAS was used in the analysis.

The MCKAS was developed through both empirical and rational approaches and based on the theoretical framework of Sue et al. (1992). Sue et al. highlighted three key areas of multicultural counseling competence: counselor self-awareness, counselors’ understanding of clients’ worldviews free of judgments, and counselor’s active pursuit of multicultural competence. These dimensions are summarized as beliefs and attitudes, knowledge, and skills. The original version of the scale (Multicultural Counseling Awareness Scale - MCAS) was developed in 1996 by Ponterotto et al. and included subscales assessing knowledge/skills, awareness, and social desirability (three items). The MCAS was widely cited as an appropriate research tool for assessing counselors’ level of multicultural competence and stacked up well when compared to other measures of multicultural counseling competence (Kocarek, Talbot, Batka, & Anderson, 2001; Ponterotto, Rieger, Bartlett & Sparks, 1994). For instance, Kocarek et al. reported that, out of the three measures studied, the MCAS was most appropriate for general usage.

After some specific critiques of the original scale, Ponterotto et al. (2002) conducted two studies, the first with a sample of 525 students and professionals in counseling and counseling psychology designed to revise the original MCAS measure. The second study, using a sample of 199 counselors-in-training, aimed to examine the

reliability and validity of the new scale. Confirmatory factor analysis revealed a good fit for the two-factor model of the scale. Tests of convergent, criterion and discriminant validity comparing the MCKAS with the Multicultural Counseling Inventory (MCI; Sodowsky, Taffe, Gutkin & Wise, 1994) and the Multigroup Ethnic Identity Measure (MEIM; Phinney, 1992) supported the validity of the scale. The authors found a medium effect size for the correlation between the MCKAS Knowledge subscale with three subscales of the MCI ($r = .49$ Knowledge, $r = .43$ Skill, and $r = .44$ Awareness) and a large effect size for the MCKAS Awareness scale with the MCI Counseling Relationship subscale ($r = .74$). Alpha reliability coefficients for the sample of counselors-in-training were .85 for the Knowledge subscale and .85 for the Awareness subscale. Cronbach's alpha for the MCKAS in the present study was .89 for the Knowledge subscale, .79 for the Awareness subscale and .89 for the entire measure.

Training and Experience Questionnaire

Fourteen questions relating to the participants' perceived level of pre and post-doctoral training and experience in multiculturalism and aging issues were included on the Training and Experience Questionnaire (developed by the author; see Appendix F). Participants were asked to rate the extent of their pre-doctoral training (i.e., coursework, practica and internship), and post-doctoral clinical experience, including workshops, conferences, and post-doctoral fellowships as well as direct client contact with racially/ethnically diverse clients and older adults. For ease of reference, from this point on, pre-doctoral training will be referred to as "training" and post-doctoral clinical experience will be referred to as "clinical experience."

Multiple regression analyses included only the seven questions related to pre-doctoral training in aging and clinical experience with older adults. Data collected via the seven questions on pre-doctoral training in multiculturalism and post-doctoral clinical experience with racially/ethnically diverse clients were planned to be used to describe the characteristics of the sample. Cronbach's alpha for the three-item extensiveness of pre-doctoral training in aging was .87. For the four-item extensiveness of post-doctoral clinical experience in working with older adults, Cronbach's alpha was .90.

Data Analysis

SPSS[®] statistical software was utilized to perform all statistical analyses. Descriptive statistics, correlation analyses and multiple regression analyses were used to analyze the data and to examine the research questions. Assumptions of linearity, homoscedasticity, and multicollinearity were examined to determine that the data are appropriate for multiple regression. Predictor variables included pre-doctoral training in aging, post-doctoral experience with older adults, fear of death, and multicultural competence; the two separate criterion variables were global attitudes toward older adults as measured by Polizzi's Aging Semantic Differential and clinical judgments of the target as assessed by six items from James and Haley's (1995) survey of professional bias.

Descriptive statistics were calculated for each of the variables. Pearson r correlations between the variables were calculated to examine the single order correlational relationships among the variables in the study. Hierarchical multiple regression was performed. The analysis was conducted in the following manner separately for each of the criterion variables. First, the demographic variables of age and

gender were entered into the regression model. Second, each of the predictor variables of training, experience, fear of death, and multicultural competence were entered into the regression model individually and tested for significance in accounting for unique variance in the criterion variables after controlling for age and gender. Finally, the predictor variables of training, experience, fear of death, and multicultural competence were entered as a block of variables and their contributions as a block of variables in predicting the criterion variables were examined and tested for significance.

To examine the first research question concerning “To what extent does pre-doctoral training in aging predict global attitudes toward elders and clinical judgment in work with older clients?” and to test null hypothesis 1a, hierarchical multiple regression analysis was performed. In this analysis, the criterion variable was Polizzi’s ASD. To control for age and gender in this analysis, the predictor variables of age and gender were entered together as a block for the first model of this analysis. The variable of participants’ extensiveness of pre-doctoral training in aging and working with older adults was then entered in the second model for this analysis. The F test for significant difference in variance accounted for in attitudes toward older adults, as measured by Polizzi’s ASD, were calculated and used to test null hypothesis 1a. To test null hypothesis 1b, a second hierarchical multiple regression analysis was performed with participants’ clinical judgment concerning the case vignette serving as the criterion variable. To control for age and gender in this analysis, the predictor variables of age and gender were entered together as a block for the first model of this analysis. The variable of participants’ training experience in aging issues and working with older adults was then entered in the second model for this analysis. The F test for significant difference in

variance accounted for in participants clinical judgments concerning the case vignette was calculated and used to test null hypothesis 1b.

To examine the second research question concerning “To what extent does clinical experience with elders predict global attitudes toward older adults and clinical judgment in work with older adults?” and to test null hypothesis 2a, hierarchical multiple regression analysis was performed. In this analysis, the criterion variable was Polizzi’s ASD. To control for age and gender in this analysis, the predictor variables of age and gender were entered together as a block for the first model of this analysis. The variable of participants’ clinical experience was then entered in the second model for this analysis. The F test for significant difference in variance accounted for in attitudes toward older persons, as measured by Polizzi’s ASD, was then calculated and used to test null hypothesis 2a. To test null hypothesis 2b, a second hierarchical multiple regression analysis was performed with participants’ clinical judgment concerning the case vignette serving as the criterion variable. To control for age and gender in this analysis, the predictor variables of age and gender were entered together as a block for the first model of this analysis. The variable of participants’ clinical experience was then entered in the second model for this analysis. The F test for significant difference in variance accounted for in participants clinical judgments concerning the case vignette was then calculated and used to test null hypothesis 2b.

To examine the third research question concerning “To what extent does fear of death predict attitudes toward elders and clinical judgment in work with older adults?” and to test null hypothesis 3a, hierarchical multiple regression analysis was performed. In this analysis, the criterion variable was Polizzi’s ASD. To control for age and gender

in this analysis, the predictor variables of age and gender were entered together as a block for the first model of this analysis. The variable of participants' fear of death was then entered in the second model for this analysis. The F test for significant difference in variance accounted for in attitudes toward older persons, as measured by Polizzi's ASD, was then calculated and used to test null hypothesis 3a. To test null hypothesis 3b, a second hierarchical multiple regression analysis was performed with participants' clinical judgment concerning the case vignette as the criterion variable. To control for age and gender in this analysis, the predictor variables of age and gender were entered together as a block for the first model of this analysis. The variable of participants' fear of death was then entered in the second model for this analysis. The F test for significant difference in variance accounted for in participants clinical judgments concerning the case vignette was then calculated and used to test null hypothesis 3b.

To examine the fourth research question concerning "Does multicultural competence predict attitudes toward elders and clinical judgment of older clients?" and to test null hypothesis 3a, hierarchical multiple regression analysis was performed. In this analysis, the criterion variable was Polizzi's ASD. To control for age and gender in this analysis, the predictor variables of age and gender were entered together as a block for the first model of this analysis. The variable of participants' multicultural competence was then entered in the second model for this analysis. The F test for significant difference in variance accounted for in attitudes toward older adults, as measured by Polizzi's ASD, was then calculated and used to test null hypothesis 4a. To test null hypothesis 4b, a second hierarchical multiple regression analysis was performed with participants' clinical judgment concerning the case vignette as the criterion variable. To

control for age and gender in this analysis, the predictor variables of age and gender were entered together as a block for the first model of this analysis. The variable of participants' multicultural competence was then entered in the second model for this analysis. The F test for significant difference in variance accounted for in participants' clinical judgments concerning the case vignette was then calculated and used to test null hypothesis 4b.

To examine the fifth research question, "To what extent does pre-doctoral training in aging and working with older adults, experience, fear of death, and multicultural competence independently contribute to predicting attitudes toward elders and clinical judgment of older clients?" and to test null hypotheses 5a and 5b, the variables of pre-doctoral training in aging and working with older adults, clinical experience, fear of death, and multicultural competence were entered together as a block of variables in the second model of the analysis to predict attitudes toward older persons and clinical judgments concerning the case vignette. The F test for significant difference in variance accounted for in participants' attitudes toward elders and in their clinical judgments concerning the case vignette was then calculated and used to test null hypotheses 5a and 5b.

CHAPTER IV

RESULTS

Introduction

Chapter IV presents the research findings of this study. First, descriptive statistics and correlations among the variables are reported. These are followed by the results of the main statistical analyses for each of the research questions.

Descriptive Statistics and Correlations among the Variables

The means, standard deviations, and Pearson r correlations were calculated. Scores on Polizzi's Aging Semantic Differential (Polizzi, 2003) ranged from 24 to 122 with a mean of 81.72 ($SD = 17.86$, $N = 350$). For the six items selected as the criterion measure of professional bias in clinical judgment from James and Haley's (1995) survey of professional bias, scores ranged from 6 to 24, with a mean of 12.07 ($SD = 3.65$, $N = 364$). Participants' pre-doctoral training in aging was measured by items on the Training and Experience Questionnaire (TEQ) and ranged from 3 to 21 with a mean of 9.13 ($SD = 4.60$). Post-doctoral clinical experience with older adults, also measured by items from the TEQ ranged from 4 to 28 with a mean of 13.69 ($SD = 6.02$). For Collett and Lester's Fear of Death Scale Version 3.0 (Lester & Abdel-Khalek, 2003), the participants' scores ranged from 31 to 140 with a mean of 73.43 ($SD = 19.21$). Finally, on Ponterotto et al.'s (2002) Multicultural Knowledge and Awareness Scale (MCKAS) participants' scores ranged from 121 to 220. The average total score on the MCKAS was 176.42 ($SD = 19.30$). For the original Aging Semantic Differential (Rosencranz & McNevin, 1969)

scores ranged between 52 and 174 with a mean of 122.30 ($SD = 19.20$). Pearson r correlations among each of the variables of the study were calculated and are presented in Table 2.

Prior to testing the hypotheses of the study utilizing multiple regression, the data were examined to determine whether the data met the assumptions of multiple regression. Multiple regression makes three common assumptions: linearity of relationships, homoscedasticity, and absence of multicollinearity among the independent variables. First, the standardized residual partial plots were examined to detect evidence for violations to linearity and homoscedasticity. Scatter plots did not provide evidence that violated these assumptions. Second, the collinearity diagnostics were examined for multicollinearity of the independent variables. According to Tabachnick and Fidell (2001), condition indices greater than 30 with at least two variance proportions greater than .50 indicate multicollinearity. No data met these circumstances, thus the independent variables were not highly correlated and multicollinearity was ruled out. Taken together, the data fit the assumptions of multiple regression, thus it was appropriate to continue with data analyses.

Hypothesis Testing

Research Question 1: To what extent does pre-doctoral training in aging predict global attitudes toward older adults and clinical judgment in work with older clients?

Table 2
Correlation Matrix for Criterion and Predictor Variables

	Attitudes	Clinical Judgments	Age	Gender	Training in Aging	Clinical Experience	Fear of Death	MCC
Attitudes	1							
Clinical Judgments	.10	1						
Age	-.05	-.18**	1					
Gender	-.13*	.07	-.02	1				
Training in Aging	-.07	-.03	-.10	-.01	1			
Clinical Experience	-.05	-.11*	.12*	.02	.56***	1		
Fear of Death	.07	.07	-.08	-.15**	-.13*	-.08	1	
MCC	-.03	-.19***	-.14*	-.25***	-.05	-.03	.02	1

Note. Pearson r for the matrix is based on $N = 364$ with the exception of correlations for Attitudes (as measured by Polizzi's ASD), which are based on $N = 350$.

For the Gender variable, women were coded "1" and men were coded "2." Clinical Experience = Post-doctoral clinical experience with older adults. MCC = Multicultural counseling competence (as measured by the MCKAS).

* $p < .05$. ** $p < .01$. *** $p < .001$.

Null Hypothesis 1a

After controlling for age and gender, the extent of participants' pre-doctoral training in aging will not contribute significant unique variance to predicting participants' global attitudes toward elders.

To consider this first research question and to test null hypothesis 1a, hierarchical multiple regression was performed with the criterion variable as Polizzi's Aging Semantic Differential. In this and all of the following regression analyses with Polizzi's ASD as the criterion variable, the predictor variables of age and gender were entered together as a block for the first model in order to control for age and gender. Age and gender accounted for 1.9% of the variance in attitudes toward older adults (Multiple $R = .138$; $R^2 = .019$; Adjusted $R^2 = .013$; R^2 Change = .019; $F_{\text{Change}}(2, 347) = 3.36$; $p = .036$). Gender was identified as a significant predictor in this model ($t = -2.38$, $p = .018$), age of the participant was not ($t = -1.07$, $p = .283$).

The variable of participants' extensiveness of pre-doctoral training in aging was then entered in the second model for the analysis (Multiple $R = .155$; $R^2 = .019$; Adjusted $R^2 = .016$; R^2 Change = .005; $F_{\text{Change}}(1, 346) = 1.83$; $p = .177$). Results of this regression analysis are presented in Table 3. Pre-doctoral training in aging did not account for significant additional variance in attitudes towards older adults after controlling for age and gender and pre-doctoral training in aging was not a significant predictor of attitudes toward older adults ($t = -1.35$, $p = .177$). Null hypothesis 1a failed to be rejected.

Table 3
Pre-Doctoral Training in Aging and Attitudes toward Older Adults

Model	<i>B</i>	Std. Error	Beta	<i>t</i>
1 (Constant)	94.56	6.69		14.14
Age	-.12	.12	-.06	-1.07
Gender	-4.70	1.97	-.13	-2.38*
2 (Constant)	97.87	7.11		13.76
Age	-.14	.12	-.06	-1.19
Gender	-4.74	1.97	-.13	-2.41*
Training in Aging	-.28	.21	-.07	-1.35

Note. Model 1: Multiple $R = .138$; $R^2 = .019$; Adjusted $R^2 = .013$; R^2 Change = .019; $F_{\text{Change}}(2, 347) = 3.36$; $p = .036$. Model 2: Multiple $R = .155$; $R^2 = .019$; Adjusted $R^2 = .016$; R^2 Change = .005; $F_{\text{Change}}(1, 346) = 1.83$; $p = .177$. For the Gender variable, women were coded "1" and men were coded "2."

* $p < .05$. ** $p < .01$.

Null Hypothesis 1b

After controlling for age and gender, the extent of participants' pre-doctoral training in aging will not contribute significant unique variance to predicting participants' clinical judgment in a case vignette involving an older client.

To test null hypothesis 1b, a second hierarchical multiple regression analysis was performed with participants' clinical judgment concerning the case vignette serving as the criterion variable. In this and all of the following regression analyses with clinical

judgment as the criterion variable, the predictor variables of age and gender were entered together as a block for the first model in order to control for age and gender. Age and gender accounted for 3.6% of the variance in participants' clinical judgment (Multiple $R = .189$; $R^2 = .036$; Adjusted $R^2 = .030$; R^2 Change = .036; $F_{\text{Change}}(2, 361) = 6.67$; $p = .001$). Age ($t = -3.38$, $p = .001$) was identified as a significant predictor in this model, while gender ($t = 1.31$, $p = .192$) was not.

The variable of participants' pre-doctoral training in aging was entered in the second model for the analysis (Multiple $R = .194$; $R^2 = .038$; Adjusted $R^2 = .030$; R^2 Change = .002; $F_{\text{Change}}(1, 360) = .75$; $p = .387$). Results of this regression analysis are presented in Table 4. Pre-doctoral training in aging did not account for significant additional variance in clinical judgment concerning the case vignette after controlling for age and gender, and pre-doctoral training in aging was not a significant predictor ($t = -.87$, $p = .387$). Therefore, null hypothesis 1b failed to be rejected.

Research Question 2: To what extent does clinical experience with older adults predict global attitudes toward elders and clinical judgment in work with older adults?

Null Hypothesis 2a

After controlling for age and gender, participants' clinical experience with older adults will not contribute significant unique variance to predicting participants' global attitudes toward older adults.

Table 4
Pre-Doctoral Training in Aging and Clinical Judgment

Model	<i>B</i>	Std. Error	Beta	<i>t</i>
1 (Constant)	15.40	1.33		11.58
Age	-.08	.02	-.18	-3.38**
Gender	.51	.39	.07	1.31
2 (Constant)	15.83	1.42		11.14
Age	-.08	.02	-.18	-3.45**
Gender	.51	.39	.07	1.29
Training in Aging	-.04	.04	-.05	-.87

Note. Model 1: Multiple $R = .189$; $R^2 = .036$; Adjusted $R^2 = .030$; R^2 Change = .036; $F_{\text{Change}}(2, 361) = 6.67$; $p = .001$. Model 2: Multiple $R = .194$; $R^2 = .038$; Adjusted $R^2 = .030$; R^2 Change = .002; $F_{\text{Change}}(1, 360) = .75$; $p = .387$. For the Gender variable, women were coded "1" and men were coded "2."

* $p < .05$. ** $p < .01$.

In this analysis, the criterion variable was Polizzi's ASD. The variable of participants' clinical experience with older clients was entered in the second model of the analysis. Clinical experience with older clients did not account for significant additional variance in attitudes towards older adults after controlling for age and gender (Multiple $R = .143$; $R^2 = .020$; Adjusted $R^2 = .012$; R^2 Change = .001; $F_{\text{Change}}(1, 346) = .50$; $p = .482$). Results of this regression analysis are presented in Table 5. Clinical experience with older clients was not a significant predictor of attitudes toward older adults

Table 5

Clinical Experience with Older Adults and Attitudes toward Older Adults

Model	<i>B</i>	Std. Error	Beta	<i>t</i>
1 (Constant)	94.56	6.69		14.14
Age	-.12	.12	-.06	-1.07
Gender	-4.70	1.97	-.13	-2.38*
2 (Constant)	95.54	6.83		13.98
Age	-.12	.117	-.05	-.98
Gender	-4.68	1.97	-.13	-2.37*
Clinical Experience	-.11	.16	-.04	-.70

Note. Model 1: Multiple $R = .138$; $R^2 = .019$; Adjusted $R^2 = .013$; R^2 Change = .019; $F_{\text{Change}}(2, 347) = 3.36$; $p = .036$. Model 2: Multiple $R = .143$; $R^2 = .020$; Adjusted $R^2 = .012$; R^2 Change = .001; $F_{\text{Change}}(1, 346) = .50$; $p = .482$. For the Gender variable, women were coded "1" and men were coded "2."

* $p < .05$. ** $p < .01$.

($t = -.70$, $p = .482$). Null hypothesis 2a failed to be rejected.

Null Hypothesis 2b

After controlling for age and gender, participants' clinical experience with older adults will not contribute significant unique variance to predicting participants' professional clinical judgment in a case vignette involving an older client.

To test null hypothesis 2b, a second hierarchical multiple regression analysis was performed with participants' clinical judgment concerning the case vignette serving as

the criterion variable. The variable of participants' clinical experience with older adults was entered in the second model for the analysis. Results of this regression analysis are presented in Table 6. Participants' clinical experience with older adults did not account for significant additional variance in participants' clinical judgment concerning the case vignette after controlling for age and gender (Multiple $R = .210$; $R^2 = .044$; Adjusted $R^2 = .036$; R^2 Change = .009; $F_{\text{Change}}(1, 360) = 3.25$; $p = .072$), and clinical experience with older adults was not a significant predictor of participants' clinical judgment concerning the case vignette ($t = -1.80$, $p = .072$). Therefore, null hypothesis 2b failed to be rejected.

Research Question 3: To what extent does fear of death predict attitudes toward elders and clinical judgment in work with older adults?

Null Hypothesis 3a

After controlling for age and gender, participants' fear of death will not contribute significant unique variance to predicting participants' global attitudes toward older persons.

In this analysis, the criterion variable was Polizzi's ASD. The variable of participants' fear of death was entered in the second model for this analysis. The results of this regression analysis are presented in Table 7. Fear of death did not account for significant additional variance in attitudes towards older adults after controlling for age and gender (Multiple $R = .145$; $R^2 = .021$; Adjusted $R^2 = .013$; R^2 Change = .002; $F_{\text{Change}}(1, 346) = .71$; $p = .400$) and fear of death was not a significant predictor of attitudes toward older adults ($t = .84$, $p = .400$). Null hypothesis 3a therefore failed to be rejected.

Table 6
Clinical Experience with Older Adults and Clinical Judgment

Model	<i>B</i>	Std. Error	Beta	<i>t</i>
1 (Constant)	15.39	1.33		11.58
Age	-.08	.02	-.18	-3.38**
Gender	.51	.39	.07	1.31
2 (Constant)	15.90	1.35		11.74
Age	-.07	.02	-.16	-3.15**
Gender	.53	.39	.07	1.35
Clinical Experience	-.06	.03	-.09	-1.80

Note. Model 1: Multiple $R = .189$; $R^2 = .036$; Adjusted $R^2 = .030$; R^2 Change = .036; $F_{\text{Change}}(2, 361) = 6.68$; $p = .001$. Model 2: Multiple $R = .210$; $R^2 = .044$; Adjusted $R^2 = .036$; R^2 Change = .009; $F_{\text{Change}}(1, 360) = 3.25$; $p = .072$. For the Gender variable, women were coded “1” and men were coded “2.”

* $p < .05$. ** $p < .01$.

Null Hypothesis 3b

After controlling for age and gender, participants’ fear of death will not contribute significant unique variance to predicting participants’ clinical judgment in a case vignette involving an older client.

To test null hypothesis 3b, a second hierarchical multiple regression analysis was performed with participants’ clinical judgment concerning the case vignette as the criterion variable. The variable of participants’ fear of death was then entered in the

Table 7
Fear of Death and Attitudes toward Older Adults

Model	<i>B</i>	Std. Error	Beta	<i>t</i>
1 (Constant)	94.56	6.69		14.14
Age	-.12	.12	-.06	-1.07
Gender	-4.70	1.97	-.13	-2.38*
2 (Constant)	90.62	8.16		11.11
Age	-.12	.12	-.05	-.99
Gender	-4.43	2.00	-.12	-2.22*
Fear of Death	.04	.05	.05	.84

Note. Model 1: Multiple $R = .138$; $R^2 = .019$; Adjusted $R^2 = .013$; R^2 Change = .019; $F_{\text{Change}}(2, 347) = 3.36$; $p = .036$. Model 2: Multiple $R = .145$; $R^2 = .021$; Adjusted $R^2 = .013$; R^2 Change = .002; $F_{\text{Change}}(1, 346) = .71$; $p = .400$. For the Gender variable, women were coded "1" and men were coded "2."

* $p < .05$. ** $p < .01$.

second model for this analysis. The results of this regression analysis are presented in Table 8. Fear of death did not account for significant additional variance in clinical judgment concerning the case vignette after controlling for age and gender (Multiple $R = .199$; $R^2 = .040$; Adjusted $R^2 = .032$; R^2 Change = .004; $F_{\text{Change}}(1, 360) = 1.52$; $p = .219$). Fear of death was not a significant predictor of clinical judgment concerning the case vignette ($t = 1.23$, $p = .219$). Thus, null hypothesis 3b failed to be rejected.

Table 8
Fear of Death and Clinical Judgment

Model	<i>B</i>	Std. Error	Beta	<i>t</i>
1 (Constant)	15.40	1.33		11.58
Age	-.08	.02	-.18	-3.38**
Gender	.51	.39	.07	1.31
2 (Constant)	14.27	1.62		8.83
Age	-.08	.02	-.17	-3.26**
Gender	.59	.40	.08	1.48
Fear of Death	.01	.01	.07	1.23

Note. Model 1: Multiple $R = .189$; $R^2 = .036$; Adjusted $R^2 = .030$; R^2 Change = .036; $F_{\text{Change}}(2, 361) = 6.67$; $p = .001$. Model 2: Multiple $R = .199$; $R^2 = .040$; Adjusted $R^2 = .032$; R^2 Change = .004; $F_{\text{Change}}(1, 360) = 1.52$; $p = .219$. For the Gender variable, women were coded "1" and men were coded "2."

* $p < .05$. ** $p < .01$.

Research Question 4: Does multicultural competence predict attitudes toward older adults and clinical judgment of older clients?

Null Hypothesis 4a

After controlling for age and gender, participants' multicultural competence will not contribute significant unique variance to predicting participants' global attitudes toward elders.

In this analysis, the criterion variable was Polizzi's ASD. The variable of participants' multicultural competence as measured by the MCKAS was entered in the second model. Results of this regression analysis are presented in Table 9. Multicultural competence did not account for significant additional variance in attitudes towards older adults after controlling for age and gender (Multiple $R = .155$; $R^2 = .024$; Adjusted $R^2 = .015$; R^2 Change = .005; $F_{\text{Change}}(1, 346) = 1.74$; $p = .188$) and multicultural competence was not a significant predictor of attitudes toward older adults ($t = -1.32$, $p = .188$). Null hypothesis 4a failed to be rejected.

Null Hypothesis 4b

After controlling for age and gender, participants' multicultural competence will not contribute significant unique variance to predicting participants' clinical judgment in a case vignette involving an older client.

To test null hypothesis 4b, a second hierarchical multiple regression analysis was performed with participants' clinical judgment concerning the case vignette as the criterion variable. The variable of participants' multicultural competence was entered in the second model for the analysis after entering age and gender in the first model. Table 10 presents the results of this regression analysis. Multicultural competence as measured by the MCKAS total score accounted for an additional 4% of the variance in clinical judgment after controlling for age and gender (Multiple $R = .276$; $R^2 = .076$; Adjusted $R^2 = .068$; R^2 Change = .040; $F_{\text{Change}}(1, 360) = 15.71$; $p < .001$ [$p = .00009$]) and the MCKAS total score was a significant predictor of clinical judgment ($t = -3.96$, $p < .001$ [$p = .00009$]). Therefore, null hypothesis 4b was rejected.

Table 9
Multicultural Competence and Attitudes toward Older Adults

Model	<i>B</i>	Std. Error	Beta	<i>t</i>
1 (Constant)	94.56	6.69		14.14
Age	-.12	.12	-.06	-1.07
Gender	-4.70	1.98	-.13	-2.38*
2 (Constant)	108.69	12.61		8.62
Age	-.15	.18	-.07	-1.26
Gender	-5.38	2.04	-.15	-2.64**
Multicultural Competence	-.07	.05	-.07	-1.32

Note. Model 1: Multiple $R = .138$; $R^2 = .019$; Adjusted $R^2 = .013$; R^2 Change = .019; $F_{\text{Change}}(2, 347) = 3.36$; $p = .036$. Model 2: Multiple $R = .155$; $R^2 = .024$; Adjusted $R^2 = .015$; R^2 Change = .005; $F_{\text{Change}}(1, 346) = 1.74$; $p = .188$. For the Gender variable, women were coded "1" and men were coded "2."

* $p < 0.05$ ** $p < 0.01$

Research Question 5: To what extent does pre-doctoral training in aging, clinical experience with older adults, fear of death, and multicultural competence independently contribute to predicting attitudes toward older persons and clinical judgment of older clients?

Null Hypothesis 5a

After controlling for age and gender, participants' pre-doctoral training in aging, clinical experience with older adults, fear of death and multicultural competence as a

Table 10
Multicultural Competence and Clinical Judgment

Model	<i>B</i>	Std. Error	Beta	<i>t</i>
1 (Constant)	15.40	1.33		11.58
Age	-.08	.02	-.16	-3.38**
Gender	.51	.39	.07	1.31
2 (Constant)	23.63	2.45		9.64
Age	-.09	.02	-.20	-3.99***
Gender	.11	.40	.01	.27
Multicultural Competence	-.04	.01	-.21	-3.96***

Note. Model 1: Multiple $R = .189$; $R^2 = .036$; Adjusted $R^2 = .030$; R^2 Change = .036; $F_{\text{Change}}(2, 361) = 6.67$; $p = .001$. Model 2: Multiple $R = .276$; $R^2 = .076$; Adjusted $R^2 = .068$; R^2 Change = .040; $F_{\text{Change}}(1, 360) = 15.71$; $p < .001$. For the Gender variable, women were coded "1" and men were coded "2."

* $p < .05$. ** $p < .01$. *** $p < .001$.

block of variables will not contribute significant unique variance to predicting participants' global attitudes toward elders.

To examine the fifth research question and to test null hypotheses 5a and 5b, the variables of pre-doctoral training in aging, clinical experience with older adults, fear of death, and multicultural competence were entered together as a block of variables in the second model of the analysis to predict attitudes toward older persons. The results of this analysis are presented in Table 11. Pre-doctoral training in aging, clinical experience with older adults, fear of death, and multicultural competence did not account for

Table 11
Full Model Predicting Attitudes toward Older Adults

Model	<i>B</i>	Std. Error	Beta	<i>t</i>
1 (Constant)	94.56	6.69		14.14
Age	-.12	.12	-.06	-1.07
Gender	-4.70	1.97	-.13	-2.38*
2 (Constant)	110.29	14.20		7.77
Age	-.16	.12	-.07	-1.32
Gender	-5.29	2.07	-.14	-2.55*
Training in Aging	-.30	.26	-.08	-1.18
Clinical Experience	.02	.19	.01	.12
Fear of Death	.03	.05	.03	.59
Multicultural Competence	-.07	.05	-.08	-1.41

Note. Model 1: Multiple $R = .138$; $R^2 = .019$; Adjusted $R^2 = .013$; R^2 Change = .019; $F_{\text{Change}}(2, 347) = 3.36$; $p = .04$. Model 2: Multiple $R = .176$; $R^2 = .031$; Adjusted $R^2 = .014$; R^2 Change = .012; $F_{\text{Change}}(4, 343) = 1.06$; $p = .38$. For the Gender variable, women were coded "1" and men were coded "2."

* $p < .05$. ** $p < .01$.

significant additional variance in attitudes towards older adults after controlling for age and gender (Multiple $R = .176$; $R^2 = .031$; Adjusted $R^2 = .014$; R^2 Change = .012; $F_{\text{Change}}(4, 343) = 1.06$; $p = .377$) and were not significant predictors of attitudes toward older adults. Thus, null hypothesis 5a failed to be rejected.

Null Hypothesis 5b

After controlling for age and gender, participants' pre-doctoral training in aging, clinical experience with older adults, fear of death and multicultural competence as a block of variables will not contribute significant unique variance to predicting participants' clinical judgment in a case vignette involving an older client.

To test null hypothesis 5b, a second hierarchical multiple regression analysis was performed with the variables of pre-doctoral training in aging, clinical experience with older adults, fear of death, and multicultural competence were entered together as a block of variables in the second model of the analysis to predict clinical judgment. The results of this regression analysis are presented in Table 12. Pre-doctoral training in aging, clinical experience with older adults, fear of death, and multicultural competence as a block of variables accounted for significant additional variance in predicting clinical judgment (Multiple $R = .296$; $R^2 = .088$; Adjusted $R^2 = .072$; R^2 Change = .052; $F_{\text{Change}}(4, 357) = 5.10$; $p = .001$). However, among this set of variables added in the second model of this regression analysis, only multicultural competence was a significant predictor. Among all the variables in the second model, age and multicultural competence were identified as significant unique predictors of clinical judgment ($t = -3.56$, $p < .001$ [$p = .0004$]; $t = -3.95$, $p < .001$ [$p = .00009$], respectively). Therefore, null hypothesis 5b was rejected.

Table 12
Full Model Predicting Clinical Judgment

Model	<i>B</i>	Std. Error	Beta	<i>t</i>
1 (Constant)	15.40	1.33		11.58
Age	-.08	.02	-.18	-3.38**
Gender	.51	.39	.07	1.31
2 (Constant)	23.17	2.74		8.45
Age	-.08	.02	-.19	-3.56***
Gender	.19	.40	.03	.46
Training in Aging	.00	.05	.00	.03
Clinical Experience	-.06	.04	-.09	-1.50
Fear of Death	.01	.01	.05	1.01
Multicultural Competence	-.04	.01	-.21	-3.95***

Note. Model 1: Multiple $R = .189$; $R^2 = .036$; Adjusted $R^2 = .030$; R^2 Change = .036; $F_{\text{Change}}(2, 361) = 6.67$; $p = .001$. Model 2: Multiple $R = .296$; $R^2 = .088$; Adjusted $R^2 = .072$; R^2 Change = .052; $F_{\text{Change}}(4, 357) = 5.10$; $p = .001$. For the Gender variable, women were coded "1" and men were coded "2."

* $p < .05$. ** $p < .01$. *** $p < .001$.

The Aging Semantic Differential

As a secondary goal of the present investigation, both versions of the Aging Semantic Differential measure, the original published by Rosencranz and McNevin in 1969 and the refined version published by Polizzi in 2003, were included in the study.

The two measures were highly correlated, $r = .80$ ($p < .001$ [$p = 1.65 \times 10^{-74}$]). As reported previously, the mean of participants' attitudes toward older adults as measured by Polizzi's ASD were less than the neutral score of 96, thus in the positive range ($M = 81.72$, $SD = 17.86$, range = 24 – 122). For the original ASD, which is also scored on a scale from 1 to 7 with higher scores indicating less favorable attitudes, but with eight additional items, the mean of participants' scores were also in the positive range (a neutral score = 128) with a mean of 122.30 ($SD = 19.20$) and a range from 52 – 174.

Since the two versions of the ASD differed in terms of the number of items, an average score for each version of the ASD was calculated by taking the total score on each version and dividing by the number of items. Participants scored significantly higher on the original version of the ASD than on Polizzi's refined version of the ASD. The mean score across items for Polizzi's ASD was 3.41, while the mean score across items for the original ASD was 3.82 ($t = -17.31$, $p < .001$ [$p = 6.83 \times 10^{-49}$]). Correlations between study variables and Polizzi's ASD versus the Original ASD are presented in Table 13.

As seen in the correlation table, gender was significantly correlated with Polizzi's ASD ($r = -.13$, $p = .019$), but not with the Original ASD ($r = -.08$, $p = .126$). Fear of death was found to be significantly correlated with attitudes toward older adults as measured by the Original ASD ($r = .15$, $p = .005$), and was not significantly correlated with attitudes toward older adults when measured by Polizzi's ASD ($r = .07$, $p = .197$).

Table 13
Correlation Table for Polizzi's ASD and the Original ASD

	Polizzi's ASD	Original ASD
Age	-.05	-.09
Gender	-.13*	-.08
Training in Aging	-.07	-.09
Clinical Experience	-.05	-.06
Fear of Death	.07	.15**
Multicultural Competence	-.03	-.08

Note: For the Gender variable, women were coded "1" and men were coded "2." Pearson r for the table is based on $N = 350$.

* $p < .05$. ** $p < .01$

Summary

In summary, gender was found to be a significant predictor of attitudes toward older adults, as measured by Polizzi's Refined Version of the Aging Semantic Differential (Polizzi's ASD; Polizzi, 2003), while age, pre-doctoral training in aging, clinical experience with older clients, fear of death and multicultural competence did not predict attitudes toward older adults. In predicting clinical judgment concerning a case vignette about an older client, age and multicultural competence, the latter measured by the total score on the Multicultural Knowledge and Awareness Scale (MCKAS;

Ponterotto et al., 2002) were significant predictors. Gender, pre-doctoral training in aging, clinical experience with older clients, and fear of death were not identified as significant variables in predicting clinical judgment of an older client.

CHAPTER V

DISCUSSION

Introduction

Chapter V is a discussion of the findings and the implications of this study.

Chapter V includes sections on: 1) attitudes toward older adults and clinical judgment of an older client; 2) pre-doctoral training in aging and clinical experience with older adults; 3) fear of death; 4) multicultural competence; 5) implications of the study; and 6) limitations of the study. Finally, concluding remarks and directions for future research close the chapter.

The purpose of this study was to examine the factors that may predict counseling psychologists' attitudes toward older adults and clinical judgment of an older client. The present study was the first extensive survey of a sample of practicing counseling psychologists since Carol Dye's survey research in 1978. Among the primary aims of the study was the goal of exploring how several factors suggested by the literature may relate to attitudes toward older adults and professional bias in clinical judgment of an older client, which would directly impact gerontological competence. In particular, the factors of pre-doctoral training in aging, clinical experience with older adults, fear of death, and multicultural competence were investigated as predictors of attitudes toward older adults and professional bias in clinical judgment of an older client.

Previous research has indicated that the more training and clinical experience a professional has had with older adults, the more favorable their attitudes toward elders will be and the less bias they will demonstrate in their professional clinical judgment. For

example, Gregory Hinrichsen and his colleagues have consistently found that exposure to, knowledge of, and experience with older adults leads to more favorable attitudes and interest in working with older adults (e.g., Hinrichsen, 2000; Hinrichsen & McMeniman, 2002). Other studies have identified a relationship between professionals' fears of death and their attitudes toward older adults (Arnold, 2002; DePaola et al., 1992; DePaola et al., 2003; Martens et al., 2004). While to my knowledge, prior research has not specifically investigated multicultural competence and attitudes toward older adults and clinical judgments of older clients, I hypothesized that counseling psychologists' self-reported multicultural competence would be associated with more positive attitudes toward older adults and less bias in clinical judgment involving an older client.

The present study explored the relationship between pre-doctoral training in aging, clinical experience with older clients, fear of death, and multicultural competence and their relationship to global attitudes toward older adults and professional bias in clinical judgment of a specific older client presented via clinical vignette. Given the history of ageism among medical and mental health professionals, attitudes toward older adults and clinical judgment of an older client were chosen as dependent variables in order to develop an increased understanding of the extent to which pre-doctoral training, clinical experience, fear of death and multicultural competence may lead to more positive attitudes and less bias among counseling psychologists. Demographic information was collected and used in this study to investigate and control for the possible effects of age and gender.

Attitudes toward Older Adults and Clinical Judgment of an Older Client

Participants in the study had generally positive attitudes toward older adults as evidenced by the mean score on Polizzi's ASD falling in the positive range, 81.72 ($SD = 17.86$). In several recent studies (Karlin et al., 2005; Laditka et al., 2004; Maurer et al., 2006; Mueller-Johnson et al., 2007) employing Polizzi's ASD, means have fallen in a similar range (between 74.4 and 89.4). Polizzi and Millikin (2002) reported lower scores in their investigation of the effect of ageist language on the instrument (mean for man 70-85 years of age was 58.02 and mean for woman 70-85 years of age was 56.28). It should be noted, however, that Polizzi and Millikin utilized a version of the measure that was still in development, e.g., positive and negative adjectives were randomly reversed.

It appears that Polizzi's ASD scores in the present study may have been influenced by the number of participants who chose either to leave the measure blank ($n = 14$) or selected the neutral response ("4," which yields a total score of 96) for every adjective item on the measure ($n = 83$). A number of participants expressed concern about performing the rating of "a person 70-85 years of age," some refusing to complete the measure without any additional information. For example, participants made such comments as: "can't answer without a specific person in mind," "not enough info to know (age discrimination?)," and "??" – depends on the individual." This may be a limitation and concern about the measure when employed (using the target in the current study) with professional participants.

Consistent with Polizzi's (2003) findings, the use of ageist language on the original ASD (Rosencranz & McNevin, 1969) with regard to the adjectives, the description of the target (e.g., "old man"), and the instructions ("rate the social object"

versus “rate the person”) may have contributed to less positive attitudes toward older adults on the original ASD for the present study. This is evidenced by scores on the original ASD being significantly higher (less favorable) than scores on Polizzi’s ASD for the same sample of participants ($t = -17.31, p < .001 [p = 6.83 \times 10^{-49}]$). Given the measure’s reported increased validity (Polizzi, 2003) from the original, the present study provides additional support for the use of Polizzi’s Refined Version of the Aging Semantic Differential in terms of the significantly lower average item score. These lower scores seem to be associated with less ageism and bias in the revised adjective set, the description of the target, and the instructions included in Polizzi’s versus the original version of the ASD.

The second criterion variable for the study, professional bias in clinical judgment of an older client as measured by six items from James and Haley’s (1995) survey of professional bias, ranged in scores from 6 to 24, with a mean of 12.07 ($SD = 3.65$). Given that scores were in the lower half of the scoring range (midpoint = 15), as well as the mean item score being 1.99 ($SD = .64$) the results revealed that most participants (83.2%) saw Ms. James as generally having a good ability to form a therapeutic relationship, appropriate for psychotherapy, and having a good prognosis. Furthermore, participants generally felt they were competent and comfortable in treating her presenting issue and they saw Ms. James as being open to their treatment recommendations.

The survey of professional bias by James and Haley (1995) has been used in previous research (Ford & Elliott, 1999; Helmes & Gee, 2003), yet its psychometric properties have not been reported. The present study is the first investigation to use select items from the survey of professional bias in a composite score and to examine the

reliability of these items. Three survey items from three prior studies: ability to form a therapeutic relationship, appropriateness for psychotherapy, and prognosis, were hypothesized to relate and therefore planned to be used as the criterion measure of professional bias. Following data analysis, it was determined that the inclusion of three additional items from the survey (level of competence in treating the presenting issue, level of comfort in treating the presenting issue, and Ms. James' openness to treatment recommendations) was appropriate to increase the internal consistency of the measure. Cronbach's alpha for the six items from the survey of professional bias was .73. This six-item version shows promise as a measure of professional bias for therapists working with older adults and future research is indicated to continue to explore its use.

Compared to James and Haley's (1995) results, participants in the present study scored similarly on the six items (ability to form a therapeutic relationship, appropriateness for therapy, prognosis, level of competence in treating, level of comfort in treating, and client's openness to recommendations) used to measure professional bias in clinical judgment of Ms. James. Comparison of the item scores for the present study and James and Haley are presented in Table 14.

James and Haley's (1995) participants were practicing doctoral-level psychologists ($N = 371$), identified through the *National Register of Health Service Providers in Psychology*. A majority of the sample was male (74.4%), the average age was 50.86, the most frequent work setting was private practice (71.6%), and the mean years since graduation was 19.40. For the present study, the majority of the sample was female (63.5%), the average age was 51.87, the most frequent work setting was

Table 14

Comparison of the Means of the Clinical Judgment Items Used in the Present Study

	Present Study ^a	James & Haley (1995) ^b
Relationship (2)	2.01 {0.85}	2.24 {0.94}
Candidate (3)	1.84 {1.22}	2.21 {1.14}
Prognosis (6)	2.13 {0.81}	2.30 {0.85}
Competence (8)	1.84 {0.88}	1.68 {0.66}
Comfort (9)	1.68 {0.86}	1.63 {0.63}
Openness (10)	2.58 {0.90}	2.55 {0.74}

Note. Numbers enclosed in parentheses correspond with the numbered question on the survey of professional bias. See “Clinical Judgments” section of the Methodology for the survey questions. Numbers enclosed in brackets are the standard deviations of the above means.

^a*N* = 364. ^b*N* = 82.

independent private practice (36.5%), followed by group private practice (19.2%), and the mean number of years in practice was 14.92.

It is worthwhile to highlight one additional finding regarding the criterion variables. As expected, attitudes toward older adults and clinical judgment concerning an older client each had a different relationship to the predictor variables, indicating their measurement of different constructs. For attitudes toward older adults, only gender was found to be a modest predictor of attitudes, while none of the other variables had

predictive value. For clinical judgment of an older client, age and multicultural competence were found to be significant predictors. This finding may offer support for Gatz and Pearson's (1988) claim that age bias is more problematic in the context of specific clinical judgments than global professional age bias, thus it is an important area for future research.

Demographic Variables: Age and Gender

The correlation between age and attitudes toward older persons (as measured by Polizzi's ASD) was not significant ($r = -.05, p = .311$). Age and professional bias in clinical judgment (as measured by scores on the criterion variable of six items from James and Haley's (1995) survey of professional bias) were significantly correlated and represented a negative relationship ($r = -.18, p = .001$). As age increased, professional bias as measured by the six clinical judgment items decreased; thus, older participants' responses indicated less professional bias toward the older client in the vignette.

Findings in the current study indicated that older practitioners demonstrated less professional bias toward the client presented in the clinical vignette. Although the relationship between age of the participant and global attitudes toward older persons was not significant in the present study, the finding of less bias among older participants seems similar to prior findings on the relationship between age and attitudes toward older adults. For instance, previous studies finding that older participants viewed an older adult more favorably attributed this to clinical maturity and experience and increased levels of empathy (Gellis et al., 2003; Ray et al., 1987; Zivian et al., 1992).

This finding is also consistent with social identity theory (Tajfel & Turner, 1979), in that persons rate another as more favorable if they perceive that person to be a member of their in-group or share a similar important dimension of identity. Thus, older counseling psychologists in the present study may have perceived Ms. James as a member of their in-group and made more favorable judgments about her than younger counseling psychologists. This effect may have been intensified given Ms. James' common clinical experience of grief and depression.

Meta-analysis results for the effect of gender on attitudes toward older adults are mixed (Kite et al., 2005). Specifically, Kite et al. found that for the 82 studies they examined which investigated evaluations of older adults (attitudes), the overall effect size was not significant for the gender of the participant. But, when the studies were examining competency rating of an older adult ($k = 63$), the overall effect was that men had more favorable ratings. Finally, when the behavior or behavioral intentions of the participant was the dependent variable, the overall affect was that women acted more favorably ($k = 27$). In reviewing the literature, several studies (e.g., Rupp et al., 2005; Thorson & Perkins, 1981) have found that women generally have had more positive attitudes toward elders, including recent studies using the original ASD to measure attitudes (Funderburk et al., 2006; Gellis et al., 2003). For the present study, gender and attitudes were significantly negatively correlated ($r = -.13, p = .019$), with lower scores on Polizzi's ASD (more favorable attitudes) being associated with male participants and higher scores with females.

In order to further explore this finding, men and women in the sample were compared for significant differences in age, testing the hypothesis that the sample of men

was significantly older than the sample of women. The mean age for men ($n = 133$) was 51.61 ($SD = 7.45$), while the women ($n = 231$) had a mean age of 52.03 ($SD = 8.66$). Thus, there was no significant age differences between the two groups ($t = .47, p = .642$). One possible explanation for the present study's findings relates to the difference in measures – previous studies used the original ASD while the present study used Polizzi's refined version.

Men did in fact score significantly lower (more favorable attitudes) on Polizzi's ASD ($t = 2.29, p = .023$). None of the studies published that utilized Polizzi's ASD have reported any significant difference between ratings by male and female participants (Karlin et al., 2005; Laditka et al., 2004; Maurer et al., 2006; Mueller-Johnson et al., 2007). Given the lack of evidence for a gender difference using Polizzi's ASD, paired with the history of an opposite relationship on the original ASD, the findings in the present study may be related to other factors. Although the order of measure presentation was counterbalanced in the present study to control for order effects, some male participants who rated Ms. James on the survey of professional bias first in their study packet may have referred to her specifically or been influenced by her clinical vignette when completing the ASD with the target of "a person 70-85 years of age." Research has shown that the gender of the target does affect participants' attitudes. For example, Laditka et al., utilizing Polizzi's Aging Semantic Differential, found that male participants rated female targets much more positively than male targets. Although the correlation obtained between gender and ASD scores in the current study was statistically significant, in view of the small magnitude of the correlation and the results of other prior

studies that have not found a relationship between gender and Polizzi's ASD scores; this specific finding requires additional study and replication.

Pre-doctoral Training in Aging and Clinical Experience with Older Adults

Since research suggests that both training and clinical experience with older adults decreases negative attitudes toward older adults, this study investigated participants' perceived extensiveness of pre-doctoral training in aging and clinical experience with older adults through a measure developed for the study, the Training and Experience Questionnaire (TEQ). Pre-doctoral training and clinical experience as measured by the TEQ did not predict either attitudes toward older adults or clinical judgment of an older client. These null hypotheses failed to be rejected.

Of the 364 counseling psychologists surveyed, only 1.6% ($n = 6$) of participants reported that their pre-doctoral training in aging (including coursework, practicum and internship training in psychotherapy, and practicum and internship training in assessment) was "very extensive." On a 7-point scale with 1 = "none" and 7 = "very extensive," over half of the participants (61.3%, $n = 223$) rated their pre-doctoral training in aging as a "3" or lower, with 11% ($n = 40$) of that group reporting their level of pre-doctoral training as "none." Of note, comparing the participants' training in aging and experience with older adults to their multicultural training and clinical experience with ethnic/racial minorities (measured in a parallel fashion), multicultural training and clinical experience were rated as much more extensive. The mean score for pre-doctoral training in multicultural issues was 13.00 ($SD = 4.07$) and clinical experience was 16.80

($SD = 4.92$), while training in aging averaged 9.13 ($SD = 4.60$) and clinical experience with older adults at 13.69 ($SD = 6.02$).

There was a significant difference between the participants' level of pre-doctoral training in aging and their post-doctoral clinical experience with older adults ($t = -5.07$, $p < .001$ [$p = .0000006$]). Thus, although a majority of participants had little to no formal pre-doctoral training, on a 7-point scale with 1 = "none" and 7 = "very extensive," 26.6% ($n = 124$) rated their post-doctoral clinical experience with older adults as a "5" or higher. Among the sample of psychologists studied by James and Haley (1995), participants reported what James and Haley deemed to be a relatively high percentage of clients over the age of 60 within their caseload ($M = 10.4\%$). Similar numbers were found in the present study: older adults (age 65 and over) made up 10.1% of counseling psychologists' caseload at the time of the study. Although one might expect the numbers to increase over time, at least one factor may have contributed to the numbers holding at around 10% – James and Haley included clients between the ages of 60 and 64. Therefore, this additional age group accounted for an unknown portion of the 10.4%.

There are a couple of possible explanations for the findings of the present study with regard to pre-doctoral training in aging and clinical experience with older adults. First, because most participants had little or close to no pre-doctoral training in aging, the possible effects of training on either of the criterion variables may have been limited or attenuated by the restricted range of pre-doctoral training among participants. Second, with regard to the possible effects on attitudes toward older adults as measured by Polizzi's ASD, participants had favorable global attitudes toward older adults despite overall having had little pre-doctoral training in aging, thus perhaps pre-doctoral training

and clinical experience among this professional group did not show an association with generally positive attitudes.

A closer look at the findings with regard to clinical experience revealed that two components of the items used to measure professional bias in clinical judgment score did correlate with clinical experience with older adults: comfort in treating Ms. James and subjective level of competence. Participants with more clinical experience with older adults in particular felt an increased level competence in treating Ms. James ($r = -.20, p < .001$ [$p = .0002$]) and clinical experience was correlated with increased comfort in treating Ms. James presenting problem ($r = -.15, p = .005$).

Failure to find a significant relationship between pre-doctoral training in aging and post-doctoral experience with older adults and the criterion variables may have also been related to the measurement approach used for these variables in the current study. The TEQ was developed specifically for this study in effort to quantify participants' pre-doctoral training in aging and post-doctoral clinical experience with older adults. This retrospective, general approach to trying to quantify the amount of pre-doctoral training in aging and post-doctoral clinical experience with older adults has limitations; and these limitations may relate to the failure to find significant relationships between these variables and the two criterion variables. Training in aging and clinical experience with older adults may be areas in need of further measurement development and quantification. Furthermore, measurement development can likely increase understanding of the complexities of constructs such as competence and how it relates to training and experience.

Fear of Death

The research question concerning fear of death for present study was partially based on the terror management theory of ageism. The terror management theory contends that negative attitudes toward older adults are derived from fears of death. Martens et al. (2004) designed several experiments that provided support for the theory by inducing fears of death and then indirectly eliciting participant's attitudes toward older adults. For example, participants viewed pictures of young adults in one group and young and elderly adults in the other group. Then, Martens et al. compared the results of a word-stem completion task for the two groups, for which some of the word-stems could be completed in a death-relevant way. The group that viewed the young and elderly pictures produced more death-related word-stems than the group that viewed only young adults.

In applying the perspective to real-life scenarios, there continues to be some evidence for the terror management theory. For example, DePaola et al. (1992) compared nursing home personnel with matched controls who did not work in a nursing home. Fear of the unknown (a subscale in DePaola et al.'s fear of death measure) and providing direct care to older adults were significant variables found to predict negative attitudes toward older adults. DePaola et al. (2003) also found that among older adults negative views of elders were significantly associated with death anxiety. Again, fear of the unknown as well as participant's age and anxiety about aging were significant predictors of negative attitudes toward older adults. In the current study, the Collett-Lester Fear of Death Scale Version 3.0 (Lester & Abdel-Khalek, 2003), a self-report measure of fear of death was used. Self-report measures concerning fear of death may yield different findings from

studies in which fear of death is experimentally or experientially induced. Also, different self-report measures of fear of death may yield different results.

Given that this is a relatively new area of research with limited investigation and some conflicting evidence (Gomez et al., 1991; Schigelone & Ingersoll-Dayton, 2004; Shmotkin et al., 1992), the present study aimed to examine the relationship between fears of death and attitudes toward older adults as well as participants' clinical judgment of an older client. Although fear of death was not found to predict either attitudes toward older adults or clinical judgment of an older client in the present study, some interesting findings related to scores on the fear of death measure were revealed. Fear of death was correlated with gender – women in the sample had higher levels of anxiety and unease related to death, which is consistent with prior findings (e.g., Cicirelli, 1999; Lester, 1990; Pierce, Cohen, Chambers, & Meade, 2007; Russac, Gatliff, Reece, & Spottwood, 2007; Salter & Salter, 1976).

In examining the subscales of the Collett-Lester Fear of Death Scale Version 3.0 (Lester & Abdel-Khalek, 2003) for the current study, the largest correlation was found in relation to fear of your own dying and gender ($r = -.18, p < .001$ [$p = .0005$]). In other words, among the four subscales of the fear of death measure: fear of your own death, fear of your own dying, fear of others' death and fear of others' dying, the strongest relationship was women's higher scores on fear of your own dying. Another meaningful correlation found in the present study was that participants with less pre-doctoral training in aging tended to have higher levels of fear of death. ($r = -.13, p = .017$). Again, the fear of your own dying subscale had the largest correlation with pre-doctoral training in aging

($r = -.15, p = .002$). Participants with more extensive pre-doctoral training in aging reported less fear of their own dying.

One factor in the mixed findings in this area of research seems to be the fact that different measures have been used to study the variables and constructs of interest. For the present research, instruments were chosen to avoid ageist language and measure single constructs (fear of death, global attitudes toward older adults, specific clinical judgment of an older client) and failed to show a relationship between these variables among practicing counseling psychologists. Interestingly, fear of death had no significant predictive value in attitudes toward older adults as measured by Polizzi's ASD, but it was significantly correlated with attitudes toward older adults as measured by the original ASD ($r = .15, p = .005$). Because it has been argued that the original ASD contains more ageist language, perhaps it is ageism that is associated with fear of death rather than attitudes toward older adults (Polizzi, 2003). This area would benefit from additional studies exploring the complex relationship between fears of death, ageism, attitudes toward older adults, and training in aging.

Multicultural Competence

As theorized and hypothesized, a relationship between self-perceived multicultural competence, as measured by the Multicultural Counseling Knowledge and Awareness Scale (Ponterotto et al., 2002), and work with older adults was revealed. Higher levels of self-perceived multicultural competence were predictive of less bias in clinical judgment of an older client. Multicultural competence was not found to be predictive of attitudes toward older adults as measured by the ASD (Polizzi, 2003).

Current findings indicated that participants who had greater multicultural competence as evidenced by higher scores on the MCKAS, demonstrated less professional bias in their responses to the clinical vignette about Ms James, an older client. Although the pre-doctoral training in aging variable and the post-doctoral clinical experience with older adults did not emerge as significant predictors of less professional bias, multicultural competence was a significant predictor. The emergence of multicultural competence as a significant predictor suggests the importance of this variable for training in work with older adults. The absence of a relationship between pre-doctoral training in aging or post-doctoral clinical experience with older adults and professional bias with an older client, while surprising, may relate to the measurement approach used in the current study. Current findings do underscore the importance of multicultural training and competence in work with older adults.

Arredondo et al.'s (1996) model operationalizing the multicultural competencies and outlining a clear and sensible way to conceptualize multiple identities is entirely applicable to work with older adults, who, by virtue of their stage in the life cycle, have developed multiple identities. The Personal Dimensions of Identity (PDI) model describes identities and contexts in "A," "B," and "C" dimensions (e.g., age, gender and race are "A" dimensions, educational background and relationship status are "B" dimensions, and historical movements/eras is the "C" dimension). The PDI model is designed to recognize and honor the complexity of multiple identities across multiple contexts and encourage psychologists to do the same.

Current findings indicate that multicultural competence relates to less professional bias in responses to a clinical vignette about an older client. These findings would seem

to suggest that the development of multicultural competence may be relevant to multiple identities – each of the multiple dimensions of identity that are associated with sources of oppression as suggested by Arredondo et al.'s (1996) model. In this particular study, increased multicultural competence was associated with more informed, less bias clinical judgment of an older client. In applying the PDI model as a frame of reference for the case vignette for example, participants may have considered Ms. James' multiple identities and contexts in that she is an older woman (Dimension A), her relationship status recently changed from married to widowed (Dimension B), and she was raised in a time period in which mental health treatment was extremely stigmatized (Dimension C). Future research could examine how self-perceived levels of multicultural competence may relate to clinical judgment on other Dimension A characteristics e.g., lesbian, gay, and bisexual clients, clients with disabilities.

As expected, participants' self-reported ratings on the extensiveness of their multicultural pre-doctoral training and clinical experience was significantly correlated with total score on the MCKAS. More extensive pre-doctoral training in multiculturalism correlated with higher self-ratings of multicultural competence ($r = .21, p < .001$ [$p = .00006$]), as did more extensive post-doctoral clinical experience working with ethnically/racially diverse clientele ($r = .29, p < .001$ [$p = .00000002$]). Age and gender were also found to have a relationship with multicultural competence. Younger participants ($r = -.14, p = .01$) and women ($r = -.25, p < .001$ [$p = .000001$]) tended to have higher self-perceived multicultural competence. Younger participants also tended to reported more pre-doctoral training in multicultural issues ($r = -.22, p < .001$ [$p = .00001$]).

This finding raises the question, what is it about multicultural competence or multicultural training that differs from traditional training in aging? Perhaps there are differences in the way in which multiculturalism is taught in comparison to the ways in which aging is taught. One of the main thrusts in exposing students to multicultural competencies and dimensions of identity and context is to encourage exploration of their own identity, culture and personal biases. In fact, this is the first competency listed for both Sue et al. (1992) and Arredondo's models (1996). In contrast, training in aging has likely not been as consistent in encouraging students to examine their own identity, worldview, and biases that contribute to ageism and negative and/or stereotyped depictions of older adults. To illustrate this point, Judith Barker (1994) discussed the commonality of an incongruence between the therapist's and the older client's goals for therapy. Barker adds that this incongruity is often caused by differences in therapists' and clients' values and worldviews. These differences are obvious when one considers the topic of psychotropic medication to treat mental health disorders. Although there is a range of attitudes toward the use of medications among psychologists, most at least in part subscribe to their efficacy, while older clients, reared in the 1940s and 1950s before the widespread use of such medications, may be wary of the use of medication to treat mental disorders and may value what current providers consider "alternative" treatments such as family or spiritual interventions. Moreover, this point is even more important when one considers psychotherapy with racial/ethnic minority elders who may hold striking differences in worldviews and values than the therapist.

Implications of the Current Study

The current study found that self-perceived level of multicultural competence is a predictor of less professional bias in clinical judgment of an older client as measured in the current study. This finding suggests the importance of multicultural counseling knowledge and awareness training in exposing students to principles that are applicable to working with older adults. Current findings underscore the importance of multicultural training and competence in work with older adults and highlight the importance of multicultural training. Findings suggest that increasing knowledge and awareness of multicultural and diversity issues improves competence in working with older adults.

However, one important caveat should be stressed. In particular, multicultural competence alone does not prepare one for work with older adults. There are a number of complex issues (e.g., dementia, elder abuse, caregiver needs, interface with medicine, etc.) with which to contend when treating older adults. The complexity calls for specific training. Molinari et al. (2003) outlined recommendations for psychologists working with older adults, which have subsequently been adopted by APA (American Psychological Association, 2004). The authors delineated seven competency areas including normal aging, assessment, treatment, prevention and crisis intervention, consultation, interfacing with other disciplines, and special ethical issues. In the context of the prior discussion regarding the differences between multicultural and aging training, it is noteworthy that Molinari et al.'s article is focused on "knowledge and skills" and makes no reference to awareness or beliefs held by psychologists working with older adults. The authors do not discuss the importance of self-awareness of personal identity and culture and how that may be used to develop sensitivity to an older adult's worldview. Furthermore, the role of

psychologists as social justice agents in promoting ethical and fair treatment of older adults is not addressed.

Despite APA's 2004 adoption of recommendations for the knowledge and skills required to work with older adults, counseling psychologists in the present study had relatively little pre-doctoral training in aging. This finding is consistent with, and disappointingly seems not much improved from Johnson and Rosich's (1997) survey of clinical and counseling psychology programs. In 1997, out of 103 programs Johnson and Rosich surveyed, none required a course on aging. Over half of the participants in the current study (61.3%, $n = 223$) rated their pre-doctoral training in aging as a "3" or lower and only 1.6% ($n = 6$) of participants reported that their pre-doctoral training in aging was "very extensive." While counseling psychologists in the present study had few older adult clients on average (roughly 10% of their caseload) we should be reminded that this trend cannot continue with the number of Baby Boomers quickly reaching retirement and the mental health needs of this older adult cohort projected to exceed all other cohorts (Rosowsky, 2005).

The PDI model (Arredondo et al., 1996) emphasizes the importance of multiple identities, and multiple dimensions of identity in multicultural training. However, multicultural training and multicultural texts may vary in terms of the emphasis placed on each of the individual identity dimensions noted in the PDI model. An interesting question for future research is to explore the extent to which general multicultural training and multicultural knowledge and awareness increases competence in specific areas of diversity or dimensions of identity that may not have been emphasized in multicultural training, such as age. Also, findings suggest the possibility that

geropsychology training may learn from the apparent positive effects of multicultural training on work with older adults and possibly benefit by incorporating more emphasis on self-awareness, values, beliefs (e.g., beliefs about aging), as well as an understanding and appreciation for the older client's worldview.

Limitations of the Study

As in all analogue studies, one limitation of the present study is the use of a clinical vignette to predict how participants would behave in a real scenario (Kazdin, 1978). Although vignettes studies such as the present one are useful given that clinicians often have to make clinical decisions based on limited information, future research may examine actual therapist-client relationships and clinical judgments made by psychologists, studying them for any common themes. This information can be used to reveal how clinicians behave in real-life clinical scenarios as well as shedding light on the reported rationale for these decisions.

Another limitation of the present study is the instrumentation used and the reliance on counseling psychologists' self-report. As noted by the plethora of difficulties encountered by researchers attempting to measure attitudes toward older adults (Gatz & Pearson, 1988; Kite et al., 2005), they are complex and difficult to measure. It was especially difficult to find a measure appropriate to examine attitudes toward older adults that did not include stereotypical and ageist language. The use of Polizzi's Refined Version of the Aging Semantic Differential (Polizzi, 2003) seems appropriate for future studies given that Polizzi addresses many of the methodological problems faced by the original version of the Aging Semantic Differential (Rosencranz & McNevin, 1969).

However, it should be noted that a sizable percentage (26.6%) of the professional participants in the current study chose not to complete or not to waver from a neutral response on Polizzi's ASD, often indicating it was because they believed the measure was asking for generalizations or stereotypes.

On a related note, the measurement of training and experience in the present study was problematic. Given that the literature review suggested clear relationships between training and experience and the criterion variables, it may be that the retrospective technique used in the current study did not accurately assess the construct. Lastly, it is important to remember that the relationship found between multicultural competence and clinical judgment deserves further study given the complexity of the variables and, the variance accounted for by multicultural competence in the present study was small (4.0%). Further study of these variables to better understand the relationships is warranted. Following a better understanding of these relationships, training to prepare counseling psychologists to work with older adults can be enhanced.

Conclusions

In conclusion, this investigation into counseling psychologists' attitudes toward older adults and clinical judgment of an older client obtained some important findings. First, counseling psychologists had generally positive global attitudes of older adults. Second, this research suggests that both age and multicultural competence were important variables in predicting less professional bias in clinical judgment of an older client. The finding that age of professional participants predicted less professional bias seems consistent with earlier research findings on the relationship between age and attitudes

toward older adults and appears consistent with social identity theory (Tajfel & Turner, 1979). The finding that multicultural competence predicted less professional bias is new and significant, and highlights the importance of multicultural competence in work with older adults. Thus, training of counseling psychologists should continue to emphasize multicultural competence and diversity issues, and multicultural training and competence should be promoted as an important ingredient of a good foundation for students interested in working with older adults. While there is a considerable amount of research focused on attitudes toward older adults and correlates such as age, gender, training, professional and personal experience, this is the first investigation to examine the role of self-perceived multicultural competence. Third, Polizzi's Refined Version of the Aging Semantic Differential (Polizzi, 2003) was supported as an appropriate tool for the measurement of attitudes toward older adults and yielded significantly different results in comparison to the original version of the scale (Rosencranz & McNevin, 1969).

The present study offers several directions for future research. First, the failure to reject the null hypotheses related to the predictor variables of training, experience, and fear of death suggests the need for further research on these variables. As noted above, there may be limitations with the measurement of the constructs of training and experience in the present study. Similarly, the variable of fear of death needs further exploration given the initial findings of support for the terror management theory of ageism as well as the significant correlation found with the original ASD that was not found when measured by the updated ASD. Second, clinical judgments in the present study were measured as they related to treatment of an older woman experiencing grief-related depression. Future research should examine clinical judgments in the context of

other psychological disorders (such as Ford & Sbordone, 1980) to better understand how the characteristics of the older adult being rated may affect clinical judgments. Finally, given the consistent low levels of variance accounted for when studying attitudes and clinical judgments of older clients, future research should aim to explore other possible contributing factors. One strategy may be to conduct a qualitative investigation in which participants identify the important elements of their own journey in working with older adults. Given the growing demographic trends in our country, the area of training counseling psychologists to be competent in serving older adults is an important direction for future research.

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Appendix A

Human Subjects Institutional Review Board Approval Letter

WESTERN MICHIGAN UNIVERSITY

Human Subjects Institutional Review Board

Date: August 23, 2007

To: Patrick Munley, Principal Investigator
Jody Tomko, Student Investigator for dissertation

From: Amy Naugle, Ph.D., Chair

A handwritten signature in cursive script, appearing to read "Amy Naugle", written over the word "Chair" in the "From:" line.

Re: HSIRB Project Number: 07-08-13

This letter will serve as confirmation that your research project entitled "Training, Post-doctoral Experience, Attitudes and Clinical Judgments among Psychologists" has been approved under the exempt category of review by the Human Subjects Institutional Review Board. The conditions and duration of this approval are specified in the Policies of Western Michigan University. You may now begin to implement the research as described in the application.

Please note that you may only conduct this research exactly in the form it was approved. You must seek specific board approval for any changes in this project. You must also seek reapproval if the project extends beyond the termination date noted below. In addition if there are any unanticipated adverse reactions or unanticipated events associated with the conduct of this research, you should immediately suspend the project and contact the Chair of the HSIRB for consultation.

The Board wishes you success in the pursuit of your research goals.

Approval Termination: August 23, 2008

Appendix B
Reminder Postcard

Dear Psychologist,

Approximately 3 weeks ago you received a study packet in the mail inviting you to participate in a research project investigating training, experience, attitudes and clinical judgments of psychologists.

If you have already completed and returned your survey packet, I thank you for your help and please disregard this reminder. If you have not yet completed your survey packet, I would appreciate your consideration regarding participation in the study. The survey packet will only take approximately 15-20 minutes of your time. If you require additional information or another copy of the survey packet, please contact me at (269) 251-4240 or jody.tomko@wmich.edu.

Thank you,

Jody Tomko, M.A.
Doctoral Candidate
Western Michigan University

Appendix C

Anonymous Survey Research Consent Form

Dear Psychologist,

You are invited to participate in a research project studying training, post-doctoral experience, attitudes, and clinical judgments among psychologists. The study is being conducted by Jody Tomko under the supervision of Dr. Patrick Munley, both from Western Michigan University, Department of Counselor Education and Counseling Psychology. This research is being conducted as part of the dissertation requirements for Jody Tomko.

The purpose of this study is to gain a better understanding of how certain therapist variables may relate to clinical work with clients. Participation in the study involves completion of a study packet which includes a demographic form and five brief measures. The study packet takes approximately **15-20** minutes to complete.

This is an Anonymous Survey Research Project, so all information collected is completely anonymous and in no way linked to personal identifying information. Your replies will be completely anonymous, so please do not put your name anywhere on the forms. You may choose to not answer any question and simply leave it blank. If you choose to not participate in this survey, you may either return the blank survey or you may discard the survey materials. Returning the survey indicates your consent for use of the answers you supply.

In appreciation of your participation in this study, your name will be entered into a drawing to win one of two \$100 Discover gift cards. To be entered into the drawing, simply complete and return the enclosed postcard separately from your study packet. The estimated odds of being selected to receive a gift card are 1 in 150.

Although it is not anticipated that participation in this study will involve any risk with the exception of lost time, should you have any concerns or questions, please feel free to contact Jody Tomko at jody.tomko@wmich.edu or (269) 251-4240 or Dr. Patrick Munley at patrick.munley@wmich.edu or (269) 387-5100. If you have any questions about this research you may contact the above investigators or the Western Michigan University Human Subjects Institutional Review Board (HSIRB) chair at (269) 387-8293 or the Vice President of Research at (269) 387-8298.

This consent document has been approved for use for one year by the HSIRB as indicated by the stamped date and signature of the board chair in the upper right corner of this form. You should not participate if the stamped date is more than one year old or if the date is omitted.

Appendix D
Incentive Postcard

PLEASE BE SURE TO SEND THIS POSTCARD SEPARATELY FROM YOUR RESEARCH PACKET – by doing so, the researchers will have no way to connect your name to the study packet.

Dear Ms. Tomko,

☐ YES! I, _____ have completed and returned my survey packet. Please enter my name into the drawing to win one of two \$100 Discover gift cards.

If my name is chosen from the drawing, please send my gift card to:

☐ I would like to receive a summary of the results of the study.

☐ I chose not to participate in the study, please do not contact me any further.

Appendix E
Demographic Information Form

Demographic Information

1. Age: _____
2. Gender: _____ Female _____ Male _____ Transgender
3. Race/Ethnicity:
 - _____ American Indian or Alaskan Native
 - _____ Asian or Pacific Islander
 - _____ Black or African American
 - _____ Hispanic/Latino(a)
 - _____ Caucasian/White
 - _____ Bi-racial/Multi-racial
 - _____ Other, please specify: _____
4. Degree: _____ Ph.D. _____ Ed.D. _____ Psy.D.
5. Number of years practicing since receipt of doctoral degree: _____
6. What is your primary theoretical orientation?

_____ Behavioral	_____ Integrative
_____ Biological	_____ Interpersonal
_____ Cognitive Behavioral	_____ Psychodynamic/Psychoanalytic
_____ Eclectic	_____ Systems
_____ Humanistic/Existential	_____ Other _____
7. Current Primary Work Setting:

_____ Group Private Practice	_____ Outpatient Mental Health Center
_____ Individual Private Practice	_____ Psychiatric Hospital
_____ Medical Hospital	_____ University/College Counseling Center
_____ Other, please specify: _____	
8. Please estimate the number of clients you are presently seeing within the following age groups:

_____ Under 20 years	_____ 40-64 years
_____ 20-39 years	_____ 65+ years

Appendix F
Training and Experience Questionnaire

Training and Experience Questionnaire

The following statements relate to your pre-doctoral training and post-doctoral experience. For the purposes of this questionnaire, “*racially/ethnically diverse*” will be defined as persons with American Indian/Alaskan Native, Asian/Pacific Islander, Black/African American, Hispanic/Latino(a) or Bi-racial/Multi-racial racial/ethnic backgrounds, **who are also different from your own racial/ethnic background**. “*Older adult*” will be in reference to persons 65 years of age and older.

Please circle the response that best fits, using the following scale:

1	2	3	4	5	6	7
None						Very Extensive

1. Please rate the extent of your pre-doctoral coursework on multiculturalism (i.e., specifically focused on developing awareness, knowledge and skills for working with racially/ethnically diverse clients).

1 2 3 4 5 6 7

2. Please rate the extent of your pre-doctoral practicum and internship training in counseling and psychotherapy with racially/ethnically diverse clients.

1 2 3 4 5 6 7

3. Please rate the extent of your pre-doctoral practicum and internship training in assessment with racially/ethnically diverse clients.

1 2 3 4 5 6 7

4. Please rate the extent of your post-doctoral training in multiculturalism (e.g., workshops, conferences, post-doctoral fellowship, etc.).

1 2 3 4 5 6 7

5. Please rate the extent of your post-doctoral experience in counseling and psychotherapy with racially/ethnically diverse clients.

1 2 3 4 5 6 7

6. Please rate the extent of your post-doctoral experience in assessment with racially/ethnically diverse clients.

1 2 3 4 5 6 7

7. Approximately what percentage of your post-doctoral client caseload has consisted of racially/ethnically diverse clients?

less than 5%	5- 20%	21- 35%	36- 50%	51- 65%	66- 80%	more than 80%
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Please circle the response that best fits, using the following scale:

1	2	3	4	5	6	7
None						Very Extensive

8. Please rate the extent of your pre-doctoral coursework on aging issues and working with older adults.

1	2	3	4	5	6	7
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9. Please rate the extent of your pre-doctoral practicum and internship training in counseling and psychotherapy with older adults.

1	2	3	4	5	6	7
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10. Please rate the extent of your pre-doctoral practicum and internship training in assessment with older adults.

1	2	3	4	5	6	7
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11. Please rate the extent of your post-doctoral training in aging issues and working with older adults (e.g., workshops, conferences, post-doctoral fellowship, etc.).

1	2	3	4	5	6	7
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12. Please rate the extent of your post-doctoral experience in counseling and psychotherapy with older adults.

1	2	3	4	5	6	7
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13. Please rate the extent of your post-doctoral experience in assessment with older adults.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

14. Approximately what percentage of your post-doctoral client caseload has consisted of older adults?

less more 5%	5- 20%	21- 35%	36- 50%	51- 65%	66- 80%	more than 80%
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