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Pro-Aging vs. Anti-Aging: A Comparative Study of Attitudes Toward Older Adults

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PRO-AGING VS. ANTI-AGING: A COMPARATIVE STUDY OF ATTITUDES TOWARD OLDER ADULTS

Vanessa Lee Benavidez, B.A.

An Abstract Presented to the Faculty of the Graduate School of Lindenwood University in Partial Fulfillment of the Requirements for the Degree of Master of Art

2001

ABSTRACT

A comparative study was conducted on the attitudes toward older adults between Counselors and Non Counselors. The participants included 50 Licensed Professional Counselors from the state of Missouri, who are registered members of the American Counseling Association (ACA), and 33 Graduate students from Lindenwood University in Saint Charles, Missouri, who are enrolled in graduate programs unrelated to professional counseling. The participants completed a demographic questionnaire and the Facts on Aging Quiz[1] (FAQ1). The demographic questionnaire contained personal data, and the FAQ1 measured attitudes and knowledge in five areas: correct answer, negative bias, positive bias, neutral, and don't know. The data was statistically analyzed to determine differences in each of the five areas. There were significant differences found in the specific areas of correct answers and positive bias between Counselors and Non Counselors. However, there were no significant differences found in the remaining three areas of negative bias, neutral, or don't know responses.

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2001

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DEDICATION

To my daughters, Emily Louise Gebert and Allyson Mae Graham. Be proud of who you are and what you become. Upon acceptance of oneself, accomplishments are endless. Thank you for your patience and believing in me ~ I love you.

To my husband, James Gregory Benavidez (Julio Jesus). Words cannot express my gratitude for your patience, emotional and unconditional loving support, and expertise throughout the process of this thesis. I could not have accomplished this without you. Mi amante para usted…sin fin.

In memory of the most incredible, intelligent, and determined woman, I have ever had the privilege and pleasure to know.
Carolyn Davis Scott 1/26/37 – 5/12/00
You will always remain in my prayers. May God bless and keep you.

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You are truly an inspiration.

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CHAPTER I

INTRODUCTION

Gerontologists view the process of aging as a multiplicity of elements, dividing the series of human development into three categories. Biological aging explores and defines the physical decrease and deterioration in bodily functions (Saxon & Etten, 1994). Social aging pertains to the change in one's status within the family unit, the absence of career and employment opportunities, and the dynamics of peers which may change from couples to single individuals (Abrams, Beers, Berkow, & Fletcher, 1995). Psychological aging relates to changes in individuals' mental health and level of cognitive process (Butler, Lewis, & Sunderland, 1991).

Some people might assume that as individuals age, commonalities exist within the aging population. Yet Saxon and Etten (1994) believe that within the realm of biological, psychological, and social aging, an individual's state of functions, such as cognitive abilities, physical routines and habits become extraordinary rather than similar to a phase in their lives as younger adults. Schlossberg (1990) also comments on comparative studies presented to the American Psychological Association, whereas, ongoing research on aging affirms that individuals age in various ways.

Biological aging focuses on certain physical changes that take place within the aging process. Various research reveals that sensory perceptions, such as touch, taste, smell, sight, and hearing decline as individuals age (Butler et al., 1991). Even though people of all ages have the potential for

contracting physical illnesses, Blair, Jacobs, and Quiram (1996) affirm, there are specific afflictions more prevalent within the elderly population. For example, two conditions that strike a large portion of older adults are arthritis and osteoporosis. Furthermore, Saxon and Etten (1994) acknowledge various age-related symptoms and the decline of the respiratory (lungs) and neurological (strength and reflexes) systems of the body.

Erik Erikson pioneered one of several psychosocial theories of human growth and developmental stages, whereby from birth until death, individuals were categorized into eight unique entities. The eighth stage relates to individuals 65 years of age until death, describing maturity, old age, or later adulthood, and is known as the "Ego Integrity versus Despair" stage of psychosocial crisis. Erikson interprets this final developmental stage as a time of reflection upon one's life. Through this particular psychosocial crisis, individuals who equate their lives as inadequate and discouraging, with many failures, and who continue to feel a sense of regret, may fear death due to the loss of closure relating to the troubling issues. However, people fortunate enough to positively reminisce on meaningful relationships, career successes, and have an overall sense of peace, most often will display acceptance of death (Hergenhahn & Olson, 1999, p. 177).

The deterioration of older individuals' physical health and psychosocial crises surrounding the loss of a spouse or family members and employment can bring about psychological effects. A long-lived myth that depression is a natural part of aging has plagued older adults for decades.

Often times, concerns expressed by elderly people to healthcare professionals can be overlooked and clinical depression may be undetected and ignored, which may increase the potential of isolation for older adults (Blair et al., 1996).

Butler and his colleagues suggest that the majority of older persons may experience many changes or losses in marital, housing, employment, financial, or societal status (Butler et al., 1991). These types of stressors may produce emotional problems that over time may warrant therapeutic intervention; however, Warnick (1995) asserts that a minimal proportion of older adults seek counseling. One of the reasons older adults may be reluctant to seek professional help is because of the misconceptions and attitudes toward this aging population. There are perceptions held by some mental health professionals that older adults are incapable of benefiting from counseling. However, in 1982, Wellman and McCormack reviewed a number of research studies, (as cited in Myers & Schwiebert, 1996) and cited supporting evidence that older adults are able to respond as effectively to therapy as all other age groups.

Ponzo (1992) believes that today's society promotes biased attitudes toward older adults, perceiving young adults as a population to be admired and valued. Older adults continue to be looked upon as a burdensome and futile portion of society, no longer capable of worthy contributions. However, the process of aging is a reality that will affect every individual in the future. Negative stereotypes depicting older adults as having poor recollection,

inattentiveness, and the inability to adapt to change have circulated through the healthcare system for decades and continue to plague the aging population (Matyi & Drevenstedt, 1989). In the past few decades, researchers have begun to explore the attitudes and perceptions of healthcare professionals within the field of psychology relevant to working with older adults (Danzinger & Welfel, 2000; Herrick, 1983; Shmotkin, Eyal, & Lomranz, 1992). There are a number of factors that may influence counselors' negative attitudes and perceptions of aging, thus producing a reluctance or fear of counseling older adults. This may be caused by their [counselors'] own personal upbringing, such as the lack of intergenerational interaction, perceptions of their own grandparents, being subjected to negative behavior displayed by their parents toward older adults, and counselors' views of their own mortality (Qualls, 1998; Woolfe, 1998; Woolfe & Biggs, 1997).

Personal perceptions and biases may not be the only factor influencing this resistance to working with older adults. Studies continue to reveal the significant lack of gerontological training for psychology students at universities within the United States (Ryan & Agresti, 1999). Although ongoing research has provided evidence of the absence of adequate gerontological training, little has been done and there continues to be an insufficient number of qualified therapists to counsel older adults (Garcia, Metha, Perfect, & McWhirter, 1997). With demographic projections of the rapid increase in the aging population, Galambos and Rosen (1999) believe that there is a critical need for all health care professionals to seek further

education about the process of aging and training related to working with older adults. All health care professionals should have a better understanding of the physiological, psychosocial, and psychological aspects of aging in order to provide adequate and appropriate medical and psychological treatment for the elderly population.

Statement of Purpose

The purpose of this study is to compare counselors' attitudes and perceptions about older adults with a sample of graduate students in non-counseling related master's programs with no experience or training in counseling, using the Facts on Aging Quiz[1] (FAQ1) multiple-choice format.

Research Questions

The following research questions were approached in this comparative study:

1. Do counselors exhibit a level of pro-aging bias toward older adults that is higher, lower, or equal to non-counselors with no experience or training in professional counseling?
2. Do counselors display a degree of anti-aging bias toward older adults that is greater, lesser, or equal to non-counselors with no experience or training in professional counseling?
3. Are counselors more knowledgeable about the process of aging compared to non-counselors with no experience or training in professional counseling?

Hypotheses

The null hypothesis is that there are no significant differences in attitudes and perceptions of pro-aging or anti-aging bias toward older adults as measured by the FAQ1 multiple-choice format between trained counselors and a comparable sample of graduate students with no training or experience in professional counseling. The alternative hypothesis, if accepted, is that there are significant differences in attitudes and perceptions of pro-aging and anti-aging bias toward older adults between trained counselors and graduate students with no training or experience in professional counseling.

CHAPTER II

REVIEW OF LITERATURE

Demographics Related to Aging

In 1900, the norm for prediction of longevity was 47 years. In 1996, The United States Bureau of Census, (as cited in Scharlach, Damron-Rodriguez, Robinson, & Feldman, 2000) confirmed that a majority of the population at the beginning of the 20th century consisted of "the youngest members of society" (p. 521). However, the current increase in life expectancy and increase in the population of older adults has brought about a proclamation by the United Nations General Assembly dedicating 1999 as the "International Year of Older Persons" (p. 521). In fact, Scharlach and his colleagues further stated that the 1996 United States Census Bureau confirmed that this substantial increase of the elderly population worldwide is viewed as the most monumental demographic transformation in history (Scharlach et al., 2000).

With the significant increase in this specific population, many people may believe that the elderly population will inevitably account for a majority of residents in long-term care institutions. Yet, an interesting fact is that within the past decade, older adults comprised only five percent of the population in long-term care institutions, such as nursing homes and hospitals (Myers & Schwiebert, 1996; Scharlach et al., 2000). In addition, Qualls (1998) points out another misconception about older adults, and suggests that the proportions of older adults residing in mental hospitals are continuously

exaggerated. In fact, Cooper's commentary (1997) agrees that contrary to common misconceptions of the aging population and myths that all older adults eventually become senile, thus requiring hospitalization, the percentage of older adults has actually been decreasing in mental hospitals within the past 10 years. Gelfand (1993) also attests to the fact that while there are over one million beds available in nursing homes, individuals who are 65 years of age and older continue to account for less than six percent of the elderly population in these nursing homes.

Within the beginning phase of the 21st century, significant demographic shifts continue to take place. In the United States alone, it is projected that the population of individuals 65 years of age and beyond will exceed 20 percent by the year 2030 (Scharlach et al., 2000). It is feasible to predict that increased life expectancy may persist as long as medical technology advances, providing cures for past and present chronic illnesses and diseases (Skala, 1996).

Physiological Aspects of Aging

From the time of conception, individuals experience physiological aging, encompassing stages of physical growth and development of the body. The physiological aspects of aging are focused on the normal processes of bodily functioning for specific ages. For example, Newman and Newman (1999) assert that between the ages of 12 and 18, known as early adolescence, physiological changes consist of the beginning of boys and girls attaining reproductive abilities (puberty) as defined in Taber's Cyclopedic Medical

Dictionary (1997). Yet, on the other hand, for individuals between the ages of 60 and 75, known as later adulthood, Saxon and Etten (1994) state that the amount of lung capacity lessens and the weight of the lungs is reduced by approximately 20 percent.

All systems of the body may experience significant changes within the aging process. The dermis (internal layer) and epidermis (external layer) are tissues that make up the human skin. Through the process of aging, these layers become thin with a decrease in elasticity, causing a higher susceptibility to skin tears, lesions, and infections. With the loss of pigment, hair turns grey, while "follicle atrophy" produces balding or thinning of hair. Nail disorders may also be a problem for the aging individual, whereas fingernails may become brittle and toenails may thicken, which in turn can bring about infections (Burnside & Schmidt, 1994; Saxon & Etten, 1994, p. 34).

According to the National Health Interview Survey, 1991, the National Center for Health Statistics, and Vital Health Statistics, (as cited in Abrams et al., 1995) data was provided on persons 65 years of age and older, and confirmed a significant loss of visual and hearing abilities. Saxon and Etten (1994) comment on the age-related decline and changes in sensory skills, such as taste, touch, smell, hearing, and vision. In addition, Burnside and Schmidt (1994) confirm that the deterioration of the five sensory skills, as well as the loss of muscle strength (musculoskeletal system) and reduction of reflexes (nervous system) is related to the normal process of aging. According to Newman and Newman (1999), Organic Brain Syndrome, commonly known as

Dementia, is the most frequent cause for placing elderly persons in institutions, such as nursing homes and long-term care facilities. Additionally, 50 percent of older persons with dementia suffer from Alzheimer's disease, which is considered the most frequent type of Organic Brain Syndrome (Newman & Newman, 1999).

Psychosocial Aspects of Aging

Erikson believed that there are links between the physiological, psychosocial, and psychological aspects of aging. As individuals grow and develop, these interactions broaden. Physical (physiological) competence and personal (psychological) requirements form a relationship with societal (psychosocial) demands. In 1950, Erikson proposed his theory of psychosocial development, which recognized eight separate stages, from infancy to old age. There are six concepts of organization that define Erikson's psychosocial theory, such as: (1) stages of development, (2) developmental tasks, (3) psychosocial crisis, (4) central process, (5) radius of significant relationships, and (6) coping behaviors, such as prime adaptive ego qualities and core pathology (Newman & Newman, 1999).

Erikson's stages of development encompass certain behaviors, characteristics, and aspects during specific periods of one's life. Each stage will produce new characteristics, which may differ from the preceding developmental stages, consisting of intellectual, emotional, and physical growth. The purpose of each developmental stage is to gain experience and knowledge from the previous stage that will be needed to assist individuals in

functioning at the appropriate level and dealing with the experiences and challenges within the next stage. These developmental tasks consist of age related intellectual, physical, and psychological functioning (Hergenhahn & Olson, 1999; Newman & Newman, 1999).

The psychosocial crisis deals with specific societal demands of a positive and negative nature that individuals face at certain stages of life. Within each stage of the psychosocial crisis, individuals combine intellect and emotions to achieve the appropriate outcome. The radius of significant relationships consists of the influence or guidance of people of importance within their lives. The most common significant relationship, especially during childhood is with the individual's parents. However, as individuals progress through the different developmental stages, changes occur within the scope of significant relationships (Hergenhahn & Olson, 1999; Newman & Newman, 1999).

Coping behavior and coping skills also enable individuals to meet societal demands, which Erikson described as the Central Process. Prime Adaptive Ego Qualities are the affirmative psychological qualities that result from appropriate coping skills related to the psychosocial crisis. The Core Pathology would be considered the opposite of adaptive ego qualities, in which the psychosocial crises are not resolved favorably, which in turn, may also bring about distorted cognitive processes (Hergenhahn & Olson, 1999; Newman & Newman, 1999; Saxon & Etten, 1994; Wade & Tavris, 1993).

The eighth stage known as Later Adulthood includes people between the ages of 60 to 75 years. The developmental tasks include taking on new roles, such as grandparenthood, which may involve a difference in responsibilities compared to raising one's own children. Certain activities may change depending on the amount of physical exertion involved. An example might be employing someone to shovel the snow from the primary areas of access of one's property instead of risking potentially adverse health-related effects from this extremely strenuous activity. Other developmental tasks include acknowledging and learning how to accept certain changes in one's life, such as the gradual slowing of cognitive thought process, memory, and sensory functions (Newman & Newman, 1999).

In addition to acknowledging these physical and mental changes, one might begin to acquire certain personal perspectives about death. Erikson considered the psychosocial crisis at this stage to be Integrity versus Despair. Simply stated, persons in later adulthood might be in a position to review a lifetime of successes and failures. Individuals who are capable of this life review with a positive attitude might be considered wise and intellectual with a prime adaptive ego. A negative outlook (core pathology) might be considered as the sense of loss and hopelessness arising from events, such as the death of a spouse or other family members, physical decline, or retirement; thus, there may be the potential for one becoming cynical, pessimistic, or depressed (Newman & Newman, 1999).

Newman and Newman (1999) contend that Erikson's psychosocial interpretations are well founded, but view his theory as becoming insufficient over the past five decades. Therefore, Newman and Newman established three additional developmental stages, one of which related to older adults. The stage of "Very Old Age" (p. 505) includes individuals, 75 years of age until death. The developmental tasks for this stage include learning how to cope with specific changes, such as the greater probability of declining health, chronic illnesses, loss of physical strength, noticeable changes in one's behavior, as well as sensory skills.

This life stage may produce perceptions by younger generations as a futile aging population. While the very old aged may decline in certain areas, such as physical strength, sensory perceptions and behavioral response, and experience the possible loss of independent functioning, research confirms the importance of loving and intimate relationships between elderly spouses. Furthermore, according to a report by Bretschneider and McCoy in 1988 (as cited in Newman & Newman), a large number of married couples between the age of 60 and 85 stated that sexual intimacy continued to be part of the relationship without any significant change. Unfortunately, negative attitudes and societal ignorance portray the elderly population as a less than sexually desired age group; perceptions such as this may adversely influence older adults in fulfilling their own sexual needs (Butler et al., 1991; Newman & Newman, 1999; Saxon & Etten, 1994).

For the very old aged, at times also considered as the "frail elderly," (p. 532) philosophical transformations may take place, allowing the very old the opportunity to become absorbed in reflecting upon the past, present, and future. There may be a greater sense of consciousness, such as the recognition and the acknowledgement that a relationship between the past, present, and future can exist, enabling a more innovative and positive means of coping with the reality of the psychosocial crisis of this stage, which is known as Immortality versus Extinction (Newman & Newman, 1999). At this stage in life, assumptions may be such that most individuals may have formed personal perspectives about the inevitable—death, or their extinction on this earth. While many individuals may have found peace with impending death, which relates to the prime adaptive ego, some individuals may hold on to the ideation of living forever, and to become immortal, thus developing perceptions that form the core pathology. Erikson believed that individuals must recognize, acknowledge, and accept each developmental stage to successfully continue onto the next psychosocial stage of life (Hergenhahn & Olson, 1999; Newman & Newman, 1999; Saxon & Etten, 1994; Wade & Tavris, 1993).

Psychological Aspects of Aging

According to Erikson's theory, physiological, psychosocial, and psychological elements are the interactive components of human beings. As transformations of the physiological and psychosocial aspects occur for older adults, psychological issues may become evident (Newman & Newman,

1999). Bernstein (1990) discusses several factors leading to depressive episodes in older adults, such as the sudden onset of physical limitations due to an illness, the loss of a spouse or loved ones, loss of independence, or feelings of helplessness or hopelessness. Warnick (1995) agrees that considerable crises in the lives of older adults often trigger episodic depression. Blair and his colleagues also state that as older adults retire from their jobs, this too can cause a sense of loss in their status in society, which can potentially lead to depression. In 1995, reports by scientists stated that older adults who suffer from depression are approximately three times more at risk of having a stroke. Other miscellaneous studies on aging and depression have determined a delay in the recovery rate from illnesses, such as heart attacks, pneumonia, and broken hips for older adults who suffer from depression. Furthermore, depression may produce changes in behavior and personal characteristics in older adults (Blair et al., 1996).

McDonald and Haney (1997) refer to the Berkely Growth Study on personality changes in the elderly, which identified the impact of five separate personality classifications and adaptations to the aging process. The three of the five personality groups who appeared well adapted to aging were: (1) the "mature" type, displaying a realistic and positive attitude to life, with a sense of self-fulfillment and satisfaction with personal accomplishments and relations with other people; (2) the "rockingchair" type who may have a history of dependency on others for satisfaction, thus justify older adulthood as a valid reason to depend upon others; and (3) the "armored" type who

choose to remain active in order to protect against the decrease in physical abilities and limitations.

The two remaining personality groups who experienced difficulty with the aging process were: (4) the "angry" type, who feel as though life consisted of nothing more than disappointments and a lack of accomplishments, and find fault with everyone else except themselves; and (5) the "self-haters" who like the angry type, view life in a negative manner, yet everything that has happened throughout life is perceived as no one else's fault but their own. Although McDonald & Haney (1999) report that, "these personality types are not viewed as totally age-related, one's style of adjustment in old age is related to one's previous personality" (p. 50). To attempt change for the negative personality types, it is critical for older adults to have someone to confide in, someone they feel comfortable with and trust when sharing feelings of loss that often times accompanies the process of aging.

Wade and Tavris (1993) believe that because of the common myths that equate depression with the aging process, some older adults may interpret symptoms of depressive episodes as nothing more than another sign of growing older, and, therefore not seek out therapy. However, Blair and his colleagues believe that another reason for today's older generation not seeking counseling may be that in the past, depression was viewed as a sign of psychiatric illness, and something people did not discuss with unfamiliar persons, such as counselors or family physicians. Older adults may choose to

hide their feelings of depression. Isolation may occur, causing the transition of mild depression into severe depression (Blair et al., 1996).

The number of older adults who suffer from depression may be far greater than imagined, and as Gintner (1995) states, depressive symptoms are frequently undetected. Most often, the symptoms that accompany depression are not as obvious in older adults. At the same time, depressive symptoms for older adults are more pronounced in areas, such as sudden changes in the patterns of sleep, any fluctuations in appetite, and the noticeable differences in one's level of energy. General practitioners may view these symptoms as physiological rather than psychological. However, Warnick suggests the complexity of diagnosing depression in older adults. In older adults, particularly extreme depression may take on the appearance of dementia, which can lead to a misdiagnosis. In addition, some symptoms of depression may be induced by adverse reactions to prescription drugs, over-the-counter medications, or alcohol. Depression, overwhelming stress brought on by a chronic or terminal illness, and alcoholism are contributing factors for suicide among the elderly population. While older adults may not display suicidal ideations, that does mean that suicide does not occur within this aging population. Over the past 20 years, there has been an increase in the rates of suicide among people who are 65 years of age and older (Warnick, 1995)..

Research on the Aspects of Aging

Badger and Collins-Joyce (2000) conducted a study of two groups of older adults (depressed and non-depressed). The purpose was to explore the

relationship between physiological, psychological, and psychosocial aspects of aging. The sample population consisted of 24 men and 54 women, ranging in age from 60 to 76 years. The Short Portable Mental Status Exam (SPMSE) and Center for Epidemiological Studies-Depression Scale (CES-D) was administered to all subjects. Two groups were formed based upon the results of the SPMSE and CES-D. Group 1 included 43 subjects displaying no symptoms of depression and Group 2 consisted of 35 subjects with test scores indicating depression. The Older Americans Resources and Services Multidimensional Functional Assessment Questionnaire was administered to measure physiological, daily functional, and social support factors. The Sense of Mastery Scale and Mastery were used to measure psychosocial issues.

The results confirmed significant differences between Group 1 (non-depressed) and Group 2 (depressed) in the areas of daily functional abilities, and psychosocial support, yet found no significant differences relating to the older adults' attitudes toward illnesses and basic physiological impairments. Badger believed that depression among older persons is low in comparison to younger people. However, while some may believe that chronic illness may cause older adults to become depressed, Femia, Zarit, & Johansson (1997); and Holahan (1998) suggest (as cited in Badger & Collins-Joyce, 2000) that there is evidence indicating that older adults' negative attitudes may aggravate additional poor health issues. Continuous research also provides favorable reports that social support for older adults empowers the person against premature inabilities to function independently. Badger and Collins-Joyce

concluded that the study indicates some degree of association between physiological, psychosocial, and psychological factors.

Segrin (1994) conducted a study of older adults who lose the ability to effectively communicating with others, such as through the loss of hearing or inadequate speech patterns. The purpose of this study was to determine whether the loss of these communicative skills were linked to perceptions of lowered self-confidence, thus leading to isolation and various psychosocial challenges. The sample populations consisted of 40 older adults, with a mean age of 72 years, and 39 younger adults, with a mean age of 23 years. Written assessments were given to all participants to complete before pairs of individuals were videotaped in a simulated conversation.

The first observation consisted of older adults paired together and younger adults paired together. The second observation took place within several weeks, and consisted of an older adult and a younger adult paired together. The same process of videotaped simulated conversation was used. Segrin concluded that there was no significant evidence that the older adults had experienced the loss of social skills; however, unlike the younger adults, the older adults expressed some feelings of depression and decreased self-regard.

Counseling Older Adults

The key element, Bernstein (1990) believes, to successful counseling of older adults is that counselors need to gain a sense of understanding of the physiological, psychosocial, and psychological challenges that the elderly

population must learn to cope with on a daily basis. Knight and McCallum (1998) suggest that therapy for older adults not only produces positive results, but also offers satisfaction to the therapist familiar with geriatric counseling. Gintner (1995) believes that based upon the vastly growing elderly population, counselors must become more diverse regarding alternative therapeutic interventions, such as a thorough assessment of the client's medical background, and administering the Mini-Mental Status Exam (MMSE).

Warnick (1995) firmly believes in a humanistic [Rogerian] approach when counseling older adults. Perceiving all human beings as good, the counselor will be more adept in offering his or her client unconditional respect and concern, which is a core requirement in the therapeutic process. Older adults' perceptions may become distorted (incongruent) with reality, due to stereotypic or negative attitudes from the community or even close relatives. As the counselor works with an elderly client from a humanistic standpoint and rebuilds the client's self-worth and self-confidence, the client has a greater chance of perceiving issues in a more realistic (congruent) manner.

There are various successful therapeutic interventions with older adults, such as the Adlerian techniques of Early Recollections (ER) and Life Style Assessments. ER can be beneficial, especially in initial sessions as a means of establishing a rapport with the elderly client. Considered as a form of reminiscence therapy, ER involves both general and specific memories. An

example of general memories might include the client talking about how as a child, he or she remembers the entire family taking a ride in the country every Sunday. Specific incidents in addition to the general recollections might include the memory of a particular Sunday when the family had to cut the trip short because the client's younger sister became car sick. The objective of ER is to allow clients to become specific within the recollections, from early childhood up through the present. Allowing clients to be as detail-orientated as possible will assist counselors in obtaining a better understanding of the client's lifestyle throughout their life span. It is recommended that counselors record the individual sessions, e.g., audiotape or videotape, which becomes an important part within the life style assessment (Sweeney & Myers, 1986).

Life style assessment enables the counselor a view of the elderly client's perception of his or her life, such as how the client's conduct was influenced and who might have patterned his or her life. Alder believed that people's lives are influenced and fashioned during childhood. As children grow, specific traits learned at an early age continue to develop, and set a pattern of how they will conduct themselves throughout the course of their lives. When counselors are able to distinguish certain patterns that may have produced negative effects for elderly clients, therapists can offer a therapeutic means of resolution, and, thus closure to specific unpleasant memories (Sweeney & Myers, 1986). Therapeutic interventions similar to ER and life style assessments have become popular for individual and group therapy sessions for older adults.

Burnside and Schmidt (1994) discuss the positive characteristics of reminiscence therapy and life review. Charatan (1980) suggests (as cited in Burnside and Schmidt, 1994) that reminiscence therapy can restore one's unique sense of individuality while providing a diversion from current limitations or what the elderly client might consider a mundane existence. Life review involves a more intense recall of positive and negative factors in one's life, and is recommended as an individual therapeutic intervention between the client and counselor. Similar to one on one therapy with other age groups, the amount of sessions for life review will vary between clients, depending upon the specific issues that the client and counselor choose to work towards resolution. Other issues to consider may be the cognitive and emotional state of the client, and what the client is able to process. Because some issues may be extremely painful for the client, the counselor must pace this form of therapeutic intervention accordingly.

Genograms may serve as a beneficial tool and can be helpful throughout the process of life review. The genogram is a form of a psychological family tree, retracing a client's family history. When therapists incorporate the use of a genogram, Sharf (2000) believes that it allows the client to tell his or her story and perceptions of the past, while offering the therapist a much greater insight of the client's family members, such as, parents, siblings, aunts, uncles, and grandparents. By obtaining information about the client's family, the genogram may assist the therapist in viewing certain family patterns, such as the possible history of substance abuse,

chronic or physical illnesses, mental illness of other family members, divorces, deaths of parents, grandparents, and siblings. The main purpose of a life review for older adults is that it provides a source of positive direction when confronting unresolved issues, such as unresolved grieving for the loss of loved ones, disappointments, and the sense of failure (Sharf, 2000; Wade & Tavris, 1993).

Insufficient Training and Knowledge

Knight and McCallum (1998) claim that therapeutic interventions for older adults have been a topic of discussion for eight decades. However, despite the aging population that is rapidly growing, there is continued evidence of inadequate or the lack of gerontological training and knowledge needed to work with older adults (Cooley, 1993; Galambos & Rosen, 1999; Gatz, 1995; Johnson & Rosich, 1997; Myers, 1992; Myers & Blake, 1986; Myers, Loesch, & Sweeney, 1991; Orel, 1998; Qualls, 1998; Ryan & Agresti, 1999; Scharlach, Damron-Rodriguez, Robinson, & Feldman, 2000; Schwiebert, Myers, & Dice, 2000). Cavallaro (1992) contends that within the last three decades, the American Counseling Association has been instrumental in initiating gerontological coursework to assist counselors in counseling older adults. When counseling older adults, it is essential for therapists to understand specific life circumstances that are more prevalent in the elderly population, such as physiological, psychosocial, and psychological impairments, and the need for additional resources.

Scharlach and his colleagues suggest that for the elderly, there is a greater possibility of various losses, such as the loss physical and mental abilities, family members and friends, independence and employment, Given the number of losses that older adults endure, it is understandable how they may experience depression. Yet, counselors working with older adults need to be aware of what may appear to be depression may actually be the onset of dementia, of which is often misdiagnosed (Scharlach et al., 2000).

Ryan and Agresti (1999) present combined evidence of the lack of gerontological training, internships, academic coursework on older adults, and research positions on aging available to students. In addition, this study provides an insight into the attitudes of counseling professionals that reflect inadequate training. The study involved a random sample of graduate program directors (n = 458) from all accredited counseling programs in the United States. Questionnaires were mailed to all program directors, including instructions and return mailing material. Explicit directives were expressed to all directors whose programs did not offer gerontological training coursework, to return the materials unanswered. The questionnaire primarily focused upon the specifics regarding gerontological training offered, investigative studies conducted, and the program directors' attitudes towards concerns expressed by faculty and students for increased gerontological training and research. Based on the inadequate response rate of completed questionnaires, the results may be considered inconclusive. However, Ryan and Agresti suggest that the conclusions based on completed data received indicated that there was a

continued lack of options available for gerontological training, internships, and research.

Qualls (1998) study posed questions relevant to issues of concern for an aging population, and provided conclusions by way of interpreting extensive prior research data. Qualls intended to provide sufficient evidence to support her perceptions of inadequate gerontological training. The author utilized the qualitative approach of historical research. She pooled the necessary information needed from several conclusive prior surveys and studies. Primary sources included original studies found in journals, such as The Canadian Study of Health and Aging, and Qualls own research.

Qualls claimed that despite gerontological training becoming more available, the percentage of mental health professionals who are entering this specialty field is still limited. Therefore, one may wonder if the lack of counselors working with older adults is influenced by their own personal perceptions of this particular population. Additional research into mental health professionals' attitudes towards working with older adults may be necessary in order to come to a better understanding of the shortage of professionals in this specialty field.

Ethical issues are being scrutinized in relation to the elderly population. As Schwiebert and her colleagues imply, the standard ethical guidelines of the American Counseling Association may not be appropriate for older adults. In particular, they are limited in addressing three critical areas, which include cognitive impairments, elderly abuse, and terminal

illness. Counselors are faced with challenging decisions in these critical areas. Should the counselor who believes the cognitively impaired elderly client can no longer live independently, be responsible for advising family members? If an elderly client discloses episodes of abuse from other family members, should the counselor be mandated to hotline the alleged abuse as counselors are mandated when working with other age groups? What are counselors' obligations regarding terminally ill elderly clients proposing to commit suicide? The major concern may be choosing between legal and moral beliefs or obligations (Schwiebert et al., 2000).

Erdman B. Palmore

Professor Palmore's reasons for developing the first Facts on Aging Quiz[1] (FAQ1) in 1976 was nothing more than to spark some enthusiasm from his students at Duke University where he was teaching a class on the "Social Aspects of Aging" (Palmore, 1998, p. ix). Palmore reviewed other tests previously in circulation, such as Tuckman-Lorge Attitudes Toward Old People Scale and Kogan's Attitudes Toward Old People Scale, but these did not meet his criteria and expectations.

Originally, the objective of the FAQ1 was to determine the extent of knowledge of his students. The FAQ1 consisted of 25 true and false statements of various facts pertaining to older adults. Because of such positive responses to the FAQ1, Palmore sent the quiz and data to "The Gerontologist" where it was accepted for publication in 1977 (p. viii). As Palmore received more recognition, he constructed a second Facts on Aging

Quiz (FAQ2), which he believed would be beneficial in comparing students' levels of knowledge of older adults before and after specialty classes on aging. Palmore proposed to give his students the FAQ1 before specific classes or workshops, and upon completion of this training, administer another quiz, this time using the FAQ2 (Palmore, 1998).

Palmore's interest continued, whereby a third Facts on Aging Quiz was developed, known as the Facts on Aging Mental Health Quiz (FAMHQ). The primary purpose for this quiz was to assist mental health care professionals to evaluate their knowledge regarding older adults with mental disorders. The final quiz known as the Psychological Facts on Aging Quiz (PFAQ) was constructed with the assistance of others, such as Lopata (1973); Earley and von Mering (1969); McCutcheon (1986); Neugarten and Gutmann 1964; Neugarten and Weinstein (1964), and based on the statements/questions from both the FAQ1 and FAQ2, and presented to students in beginning courses of psychology (as cited in Palmore, 1998).

Within the last decade, Harris and Changas (1994) reformatted the original FAQ1 true/false version into a multiple-choice pattern. Extensive testing of this instrument concluded that there was greater validity and reliability because persons taking the quiz have four specific answers to choose from; therefore, "guessing" the appropriate answer was reduced (p. 578). Furthermore, Palmore (1998) suggested going one step further by adding the option of "Don't Know" (DK) to each multiple-choice statement, further decreasing persons answering the items, using guesswork, which again

increased the validity and reliability of this particular instrument. Along with the newly formatted FAQ1 multiple-choice version, the true/false version of the FAQ1, FAQ2, FAMHQ, and PFAQ have also been revised with regard to appropriately updated wording, and the FAQ2, FAMHQ, and PFAQ have also been formatted into a multiple-choice version.

Although, over the past 19 years Palmore's FAQ1 gained recognition as a means of determining knowledge and attitudes towards older adults, this instrument did not escape criticism. The two major criticisms pertained to the actual intent of measurement and misleading or ambiguous wording of the statements in the quiz (Palmore, 1998). Based on the data analysis from a study of 202 adults, David Klemmack (1978), using the FAQ1 True/False version, believed that this quiz measured attitudes towards older adults, in contrast to Palmore's primary claim of measuring knowledge. Additionally, Miller and Dodder (1980) commented that the FAQ1 was a questionnaire intended to include statements of fact about the physical, mental, and social aspects of aging, as well as some common mistakes or biases people may have about older adults. Although Palmore (1998) originally implied that the primary intent was to measure knowledge, Miller and Dodder further stated that Palmore acknowledged (as cited in Miller & Dodder, 1980) other possible dimensions being measured, such as indirect assessment of attitudes or biases toward older adults.

Almost three decades later and "150 known studies using the quizzes," much debate continues regarding the actual intent of assessment using the

FAQ1 (Palmore, 1998, p. x). A large portion of the abstracts of prior studies cited in Palmore's book, The Facts On Aging Quiz include health care professionals, such as physicians, dentists and nurses. Other sample populations include teachers, adolescents, young adults, undergraduate, and graduate students in non-related fields of study, as well as geriatric and psychology programs. Of the 150 known studies, seven studies included helping professionals, such as social workers, psychologists, or counselors Palmore, 1998).

Barnet's study in 1979 included persons employed in psychology, social work, and counseling. The study compared and measured the participants' knowledge from the FAQ1, using age, gender, education, disciplinary background, and frequency of contact with older adults as variables. While there was no significance between knowledge and these variables, a positive correlation was noted (r=.18; p<.05) between knowledge and interaction with older adults. Barresi and Brubaker's study in 1979 focused on measuring the level of knowledge of social workers. The results concluded that based on the percentage of specific statements repeatedly answered incorrectly, additional training in sociology and demographics of aging would be needed for social workers (as cited in Palmore, 1998).

A study by Carmel, Cwikel, and Galinody in 1992 measured the effects on attitudes and areas of employment preferences after individuals completed coursework on older adults. Some of the subjects were social work students. The results stated that there was no significant relationship between

knowledge and attitudes, and employment preferences. In 1992, Dudley administered the FAQ1, the FAQ2, and the FAMHQ to counselors to determine if there was a relationship between death anxiety and biases toward older adults. The results produced no relationship between death anxiety and biases toward the elderly population. However, there was in fact a significant relationship between the counselors and their personal anxieties towards their own death (as cited in Palmore, 1998).

Kwan's study in 1982, examined the validity of the FAQ1 as a measure of age bias with a sample population of social work students, and concluded that the FAQ1 was inappropriate to measure age bias. Levy's study in 1985 included community-based older adults, ministers, physicians, and social workers. The purpose was to compare these groups on their knowledge of older adults by using the FAQ1. Overall, the social workers scored higher with the correct answers than the other participants. However, while the social workers having direct contact with older adults scored highest with the correct answers, they also scored higher in the area of negative bias, whereas the social workers who did not work directly with older adults also scored high with the correct answers, yet they scored higher in the area of positive bias. Singleton's study in 1993 examined a sample population consisting of dentists, nurses, activity directors, dental hygienists, and social workers. Singleton found that a large portion of nurses, doctors, and dental hygienists disagreed with 60 percent of the social workers that felt that physicians considered older adults as low priority (as cited in Palmore, 1998).

Attitudes Toward Older Adults

In 1971, Palmore expressed his views about negative biases toward older adults by compiling close to 300 jokes about growing old. Yet, two decades later, there was still the need to publish his book, Ageism: Negative and Positive concerning the ongoing biases, toward an aging population. In his book, Palmore stated that because of decades of elderly oppression, society maintains another prejudice equal to racist and sexist views known as ageist or ageism (Palmore, 1994). Mulley (1997) adds that individuals and societal negative biases are projected by labeling older adults with names, such as geriatric, feeble, old geezer, old-timer, decrepit, and senile. In the 4th edition of the publication manual, the American Psychological Association strongly suggested that the word "Elderly" was no longer acceptable as a singular definition of an older person (American Psychological Association, 1997, p. 48).

McConatha and Ebener (1992) gave a brief synopsis on a number of previous studies portraying negative attitudes and biases towards older adults. The studies McContha and Ebener cited include: (1) supporting evidence of psychiatrists' stereotypic negative perceptions toward older persons by Ray, Raciti, and Ford (1985); (2) evaluations of adolescents' negative attitudes of older adults by Doka (1986); (3) studies conducted by the Andrus Gerontology Center, which produced supporting evidence of negative attitudes toward older people, as reported by Schlossberg, Troll, and Leibowitz (1978); (4) Kite and Johnson's (1988) review of 43 individual

studies regarding specific negative perceptions of older adults; and (5) studies by Hickey, Bragg, Rakowski, and Holtsch (1979), which disclosed gerontologists having negative attitudes toward older people. Additional issues of countertransference that counselors face when counseling older adults may be the fear of confronting the reality about the counselors' own parents or grandparents (Bearden, & Head, 1986; Bernstein, 1990; Crose, 1992; Myers, 1990; Woolfe & Biggs, 1997).

Woolfe and Biggs (1997) conducted a study to determine counselors' lack of interest toward counseling older adults. A questionnaire regarding issues about older adults was sent to 42 postgraduate counseling students over a two-year period (21 students for the first year and 21 additional students for the second year). Because Woolfe and Biggs only received responses from 19 students, they chose to conduct a group meeting of the total sample population. What Woolfe and Biggs concluded was that most of the subjects had little or no experience in counseling older adults; therefore, they did not respond to the study as it did not apply to their specific field of counseling.

Woolfe (1998) firmly believes that counselors are hesitant toward working with older adults because of countertransference issues. Woolfe's examination of such countertransference included the counselors' personal uncertainties and anxiety of his or her own death, or fear of triggering unpleasant memories of the loss of a parent or grandparent. The fear of the older client's dependency upon the counselor may be another consideration, but can work both ways, such as the counselors becoming too attached to the

older client because of the client's similarities to a deceased parent or an authority figure. Counselors might be confronted with the death of the client, which may place an even larger projection on his or her own future, with the counselor coming to the realization of his or her own personal experiences of aging, eventually leading to a personal extinction.

Malamud (1994) insists that the countless articles and studies about counselors' negative attitudes towards an aging society might in fact have more to do with the counselors' own countertransference issues. Many counselors fear for themselves because one day, they too will become the older adult. Counseling older adults may force the counselor to evaluate his or her own feelings about growing old, losing a sense of independence, the loss of spouses and loved ones, and eventually his or her own death.

Unfortunately, older adults appear to be stereotyped by a majority of health care professionals. Greene, Adelman, and Rizzo (1996) discuss the importance of effective communication between medical practitioners and older adults, yet suggest that because of ageist attitudes within the medical profession, older patients' physical ailments and complaints at times may be minimized by some physicians. Some doctors may view various symptoms of older individuals as nothing more than just part of growing old. As people age, it is not uncommon to have multiple complications, such as arthritis, hypertension or hypotension, edema, vision or hearing loss, yet Greene and his colleagues suggest that physicians tend to spend less time with older patients compared to the younger clientele (Greene et al., 1996).

Ponzo (1992) summarizes and interprets successful aging in a manner that renders such simplicity; yet a large portion of society and health care professionals have not been able to grasp this basic concept, which Ponzo profoundly states

> We age and die, and in the process demonstrate many of the changes associated with aging: deficits in hearing and seeing; decreased efficiency for immune, cardiovascular, and nervous systems; decreased bone density, and increased joint inflammation. Although these changes seem inevitable for most people, the extent of loss is variable; how people adapt is critical--and very modifiable. Successful aging is not equivalent to people's staying young, because we do get old. It is helping people stay vital longer by emphasizing what is possible, instead of what is typical; it is helping people accommodate to the changes of aging--as we accommodate to changes throughout the life span (p. 210).

CHAPTER III

METHOD

Subjects

A combined total of 83 subjects participated in this study. The subjects were divided into two groups. The first group represented 50 licensed professional counselors who were registered members of the American Counseling Association in the state of Missouri. The second group represented 33 students from Lindenwood University who were in non counselor related graduate programs, and had no experience or training in the field of counseling.

Survey questionnaires were mailed to 100 randomly selected licensed professional counselors from the American Counseling Association's list of registered members in the state of Missouri, and 45 questionnaires were distributed to three classes of graduate students at Lindenwood University's Westport Campus in Missouri. Of the 100 packets mailed to the first group of counselors, 50 (50%) licensed professional counselors responded. Of the 45 packets distributed to the second group of Non Counselors, 33 (73%) responded. Therefore, the total sample in the study included 50 (60%) licensed professional counselors (Group I Counselors) and 33 (40%) graduate students (Group II Non Counselors).

Men and women participants were represented in both groups. In Group I (Counselors), 11 (22%) were men, ranging in age from 29 to 77 years, with a mean age of 47 years. There were 39 (78%) women, ranging in

age from 23 to 72 years, with a mean age of 49.6 years. The Group II (Non Counselors) consisted of 17 (52%) men, ranging in age from 21 to 52 years, with a mean age of 31.2 years. There were 16 (48%) women, ranging in age from 21 to 60 years, with a mean age of 31.2 years. The ethnicity of participants in Group I (Counselors) included two (4%) African Americans and 48 (96%) Caucasians. Whereas, ethnicity of participants in Group II (Non Counselors) consisted of nine (27%) African Americans, 23 (70%) Caucasians, and one (3%) Other (specified as Russian).

The educational status for participants in Group I (Counselors) included 25 (50%) with Master degrees, 14 (28%) with a Master degree + 30 credit hours, and 11 (22%) with a Ph.D. Whereas, for the participants in Group II (Non Counselors), 20 (61%) had a Bachelor degree, 11 (33%) had Master degrees, and two (6%) had a Master degree + 30 credit hours.

There were 14 (28%) in Group I (Counselors) with prior education on aging and 36 (72%) who reported no prior education on aging. In Group II (Non Counselors), four (12%) confirmed prior education on aging, whereas 29 (88%) denied any prior education on aging.

For Group I (Counselors), the length of practice in the field of counseling reported was within the range of three months to 30 years, with a mean length of practice of 11.5 years. Within Group I (Counselors), 27 (54%) worked with Adolescents, 27 (54%) with Young Adults, 35 (70%) with Middle-Aged Adults, and eight (16%) with Older Adults. Group II (Non Counselors) was not given this question, as it did not pertain to their field of

graduate studies. Table 1 illustrates the demographic data of the participants in this study.

TABLE 1 - Demographic Data of Participants

Variable	Counselors (n = 50)		Non-Counselors (n = 33)	
Gender				
Men	11	22%	17	52%
Women	39	78%	16	48%
Ethnicity				
African American	2	4%	9	27%
Caucasian	48	96%	23	70%
Other	0	0%	1	3%
Education				
Bachelor Degree	0	0%	20	61%
Master Degree	25	50%	11	33%
Master Degree + 30	14	28%	2	6%
Ph.D.	11	22%	0	0%
Prior Education on Aging				
Yes	14	28%	4	12%
No	36	72%	29	88%
Age				
Range	23 – 77		21 – 60	
Mean	49.1		31.2	
Mode	55		23	
Counselor Demographics				
Length of Practice				
Range	3 mos. – 30 yrs.		N/A	
Mean	11.5		N/A	
Mode	15		N/A	
Client Population				
Adolescents	27	58%	N/A	
Young Adults	27	58%	N/A	
Middle-Aged Adults	35	70%	N/A	
Older Adults	8	16%	N/A	

Instruments

Demographic. Each questionnaire packet delivered to the participants in the study included a demographic questionnaire (Appendix C) constructed by the researcher. The questions included items such as gender, age, ethnicity, education level, prior education on aging, length of practice in the field of counseling, and type of client population. The last two questions were applicable for the licensed professional counselors only.

The Facts on Aging Quiz[1] (FAQ1). The FAQ1 multiple-choice format (Appendix D) was designed to measure learning, knowledge, and attitudes towards older adults. Erdman B. Palmore (1998) designed the original version of the FAQ1 in 1977, which consisted of 25 true/false statements. Palmore's (1977) initial intent was to determine the extent of knowledge about older adults.

In 1996, the FAQ1 multiple-choice version was introduced, and was determined to have a greater reliability factor compared to the original FAQ1 true/false version. Further amendments were introduced to the FAQ1 multiple-choice version, so that participants were able to choose the response of "DK" (don't know) instead of guessing what might be the correct answer, thus increasing internal validity. The current version of the FAQ1 used in this study consists of 25 statements, with five multiple-choice responses, lettered (a) through (e). Each multiple-choice statement offers one correct answer. Additionally, there are four choices that may portray a: (1) negative bias, which indicates a less than favorable perception of older adults, (2) positive

bias, involves an unrealistic view (denial) of older adults, (3) neutral response, which indicates that an individual has no defined opinion, and (4) the letter "e" represents the optional answer of "I do not know" (Palmore, 1998).

There are three areas that can be measured when using the FAQ1. The first area is considered to be the measurement of learning by using the FAQ1 as a pre-test before specific classes or other forms of instruction, and then alternating with the FAQ2 as a post-test, however, this method has yet to be fully tested for its reliability due to the two different individual tests being used for the test re-test purpose. However, utilizing the multiple-choice versions with the "don't know" (DK) option has been found to lower the difference in the mean scores between the two tests, thus providing evidence of greater validity (Palmore, 1998).

The second area examines the overall measure of knowledge, misconceptions, or ignorance, and is beneficial for group comparisons. Once again, allowing the DK option in the multiple-choice format may eliminate the possibility of individuals guessing at the answers. Therefore, the revised multiple-choice version of the FAQ1 can measure varying degrees of knowledge by calculating the percentage of correct responses, the percentage of incorrect responses, and the percentage of responses using the DK option. The correct responses measure accurate knowledge, incorrect responses measure misconceptions (either negative or positive bias), and DK responses measure the lack of knowledge or level of ignorance. The higher proportion

of incorrect and DK responses indicate the need for further education and ongoing information regarding the aging process (Palmore, 1998).

A third area of measure involves assessing negative or positive bias. The formula for assessment was determined by the number of questions, in which a negative or positive bias response would be possible. There are 18 specific questions in which an individual can potentially respond, indicating a negative attitude. Therefore, to compute one's negative bias score the total number of negative bias responses are divided by 18, which then generates the negative bias score. There are 13 specific questions with a possible positive bias response; therefore, the total number of positive bias responses are divided by 13, which then gives the positive bias score. By subtracting one's negative bias score from his or her positive bias score, the researcher is able to compute a net bias result (Palmore, 1998).

Procedure

This study focused on two groups: licensed professional counselors (Group I Counselors) and students in a non-related graduate program with no experience or training in professional counseling (Group II Non Counselors).

The participants in Group I (Counselors) were contacted through the American Counseling Association membership listing of registered licensed professional counselors in the state of Missouri (n=354). The Group I (Counselors) were 100 randomly selected licensed professional counselors from the American Counseling Association membership listing, using a table of random numbers. Participants in Group II (Non Counselors) were chosen

by the researcher as a comparative sample for this study, and included a combination of three different graduate classes of Lindenwood University's individualized education program. The selected classes were Personnel Law, Financial Accounting, and Marketing Concepts, which are graduate-level courses for students seeking a Master Degree of Art in Business Administration (MBA). The chosen classes were non-related to the graduate program for professional and school counseling.

The questionnaire packets for Group I (Counselors) were delivered by mail and contained a cover letter (Appendix A) of introduction of the graduate student conducting the survey with specific instructions to complete the questionnaire, acknowledgement of anonymity of all returned questionnaires, and telephone numbers where the researcher could be contacted if participants had any further questions. The packet also included the Facts on Aging Quiz[1], a demographic questionnaire, and a self-addressed stamped return envelope. Additionally, a self-addressed stamped postcard was included with the individual's name, requesting their signature once the questionnaire was completed and returned separately from the questionnaire. The post card included an option for the named participant to indicate if they accepted or declined to participate in the study. This was done in order to keep track of those who had responded to the survey while maintaining anonymity of responses.

The researcher visited Lindenwood University's Westport Campus and hand delivered the questionnaire packets for Group II (Non Counselors) to the

three specific graduate classes. These packets included a cover letter (Appendix B) of introduction of the graduate student conducting the survey, instructions to complete the survey, the Facts on Aging Quiz[1], and a demographic questionnaire. The graduate students were instructed to complete the survey and personal data questionnaire and the researcher returned later during the class to retrieve the completed questionnaires. There were 15 questionnaire packets distributed to each of the three graduate classes. The final sample consisted of 12 (37%) Personnel Law students, 10 (30%) Financial Accounting students, and 11 (33%) Marketing students who completed the surveys.

Data Analysis

This study utilized a Causal-Comparative design and consisted of two pre-existing comparison groups of Counselors and Non Counselors. The independent variable is the subjects' status as a Counselor or a Non Counselor. The dependent variable is the attitude of the subjects towards older adults, and included five aspects, such as: (1) an accurate understanding of the aging process, (2) a pro-aging bias, considered to be a positive but unrealistic attitude, (3) an anti-aging bias, consistent with a negative perception, (4) a neutral position, indicative of no formed opinion, or (5) a DK [don't know] response, which would be appropriate if the participant was unsure of the correct answer.

Descriptive statistics were used to compare the two groups on demographic information. A *t* test was used to determine if there was

significant differences between Counselors and Non Counselors on the FAQ1 subscale scores.

CHAPTER IV

RESULTS

Descriptive statistics on the dependent variables of: (1) Correct Answer, (2) Negative Bias, (3) Positive Bias, (4) Neutral, and (5) Don't Know answers were computed in terms of the mean score, standard deviation, maximum and minimum scores for both Counselors and Non Counselors participants. The descriptive statistics are presented in Table 2.

TABLE 2 - Dependent Variables for Counselors and Non Counselors

Variable	Sample of Group	No. of Scores	Mean	SD	Min. Scores	Max. Scores
Correct Answer	Counselors	50	41.12	15.27	0.00	80.00
	Non Counselors	33	32.61	15.75	4.00	68.00
Negative Bias	Counselors	50	25.11	14.23	0.00	66.67
	Non Counselors	33	28.62	17.41	0.00	77.78
Positive Bias	Counselors	50	22.46	13.26	0.00	53.85
	Non Counselors	33	29.37	13.66	7.69	53.85
Neutral	Counselors	50	27.20	17.50	0.00	60.00
	Non Counselors	33	32.12	18.67	0.00	80.00
Don't Know	Counselors	50	22.96	21.77	0.00	100.00
	Non Counselors	33	25.09	24.15	0.00	68.00

To test for significant difference between the two groups, independent sample *t*-tests were run on the five dependent variables. The results of the *t*-tests are presented in Table 3.

TABLE 3 - Independent Sample *t*-tests of Dependent Variables

Dependent Variables	(n = 50) Counselors Mean	SD	(n = 33) Non Counselors Mean	SD	*t*-value	*p*-value
Correct Answer	41.12	15.27	32.61	15.75	2.445	0.016*
Negative Bias	25.11	14.43	28.62	17.41	-0.998	0.321
Positive Bias	22.46	13.26	29.37	13.66	-2.295	0.024*
Neutral	27.29	17.50	32.12	18.67	-1.221	0.226
Don't Know	22.96	21.77	25.09	24.15	-4.180	0.677

$*p < 0.05$

The results support significant difference between the Counselors and Non Counselors in terms of: Correct Answers ($t = 2.46$, $df = 81$, $p = 0.016$) and Positive Bias ($t = 2.295$, $df = 81$, $p = 0.024$). Counselors scored significantly higher on Correct Answers (Mean = 41.12, SD = 15.27), compared to the Non Counselors (Mean = 32.61, SD = 15.75) with the mean difference of 8.51. However, Counselors scored significantly lower in Positive Bias (Mean = 22.46, SD = 13.26), compared to the Non Counselors (Mean = 29.37, SD = 13.66), with the mean difference of - 6.91.

The results support no significant difference between Counselors and Non Counselors in terms of: Negative Bias (t = -.998, df = 81, p = 0.321), Neutral responses (t = -1.221, df = 81, p = 0.226), and Don't Know responses (t = -.418, df = 81, p = 0.677).

Based on data analysis supporting significant difference in the areas of: (1) correct answers, and (2) positive bias, and data analysis supporting no significant difference in the areas of: (1) negative bias, (2) neutral responses, and (3) don't know responses, the null hypothesis and the alternative hypothesis are partially supported

CHAPTER V

DISCUSSION

This study investigated differences in attitudes toward older adults between licensed professional counselors and graduate students (Non Counselors) in a non-related field of study with no training or prior experience in professional counseling. Interesting enough, the analysis of mean scores by *t*-tests provided evidence of significant differences in the proportion of correct answers and positive bias between Counselors and Non Counselors. However, no evidence supported significant differences in the remaining three areas of negative bias, neutral, and "don't know" answers between Counselors and Non Counselors.

The first question in this study addressed whether Counselors exhibit a level of pro-aging (positive) bias toward older adults that is higher, lower, or equal to Non Counselors with no experience or training in professional counseling. A Positive bias may be defined as an unrealistic perception, a sense, or state of denial concerning the aging process. Gadow (1980) suggests that positive biases can be just as damaging as negative biases toward older adults because of the extreme nature of what may be considered unreasonable perceptions. A positive bias may be a way for persons who refuse to come to terms with the process of aging to hold onto false beliefs that growing older is no different than other life stages. The implications of positive biases within the therapeutic setting may be such that the counselor's unrealistic perceptions about the normal process of aging may lead to minimizing or normalizing the

older clients issues, therefore not providing the client with appropriate or beneficial treatment. As Woolfe (1998) points outs, some counselors may choose not to counsel older adults due to their own personal fears of aging and death.

It is heartening to note that the Counselors in this study seemed to report a lower positive bias than the Non Counselors, suggesting that they did have a more realistic view of the aging process and were in less denial about aging than their Non Counselor counterparts. However, the evidence nevertheless suggests that the Counselors in this study did display a substantial level of positive bias towards older adults.

The second question in this study examined whether counselors displayed a negative bias toward older adults that would be greater, lesser, or equal to the non counselors without any prior training or experience in professional counseling. The implications of negative biases toward older adults can be equally oppressing as positive biases, if not possibly more detrimental to this specific population of human beings. Persons with negative biases include perceptions, such as categorizing all older adults into one stereotype, believing that this population is unable or incapable of functioning independently without the assistance and care of others. Older adults may also be viewed as grouchy, crabby, stubborn, and unwilling to accept change, therefore therapeutic interventions may not be as successful compared to younger age groups (Cooley et al, 1998; Knight & McCallum, 1998). If counselors perceive older adults in this stereotypical manner, it may

very well produce an unhealthy therapeutic relationship between the counselor and the client. For example, if the counselor perceives the elderly client as incapable of making his or her own rational decisions, the counselor may be inclined to direct the client by making suggestions as to what the client should or should not do, instead of actively listening to the client, and allowing the client the opportunity to process his or her own issues and possibly find positive resolutions. This type of negative bias may appear as though the counselor is being condescending or patronizing towards the older client in ways, such as the counselor's tone of voice, reflecting a sense of an authoritative or maybe even parental type of attitude (Malamud, 1996; Mulley, 1997; Myers, 1990).

The *t*-tests failed to find significant differences in the mean scores between Counselors and Non Counselors for negative bias toward older adults. However, the *t*-tests revealed a mean score of 25.11 for Counselors' negative bias responses in comparison to a mean score of 28.62 for Non Counselors. This study provides evidence that negative biases continue to exist in society, as well as within the mental healthcare settings.

In addition, Gatz and Pearson (1988); Kastenbaum (1963); Knight (1996); and Raue and Myers (1998) contend (as cited in Danzinger & Welfel, 2000) that the second most considerable barrier for older adults seeking counseling is the stereotypical attitudes and hesitance in mental health professionals. There remains to be inadequate counseling treatment for older

adults because of negative biases and misconceptions toward this aging population (Scharlach et al., 2000).

The third question in this study explored whether Counselors are more knowledgeable about the process of aging compared to Non Counselors with no experience or training in professional counseling. The *t*-tests provided a significant difference in the proportion of correct answers, with Counselors scoring reasonably higher than the Non Counselors did. The results might raise questions, such as does one's level of education influence the test scores specifically about aging, or does the level of education increase the overall average scoring on tests in general? Did the age of the participants play a role in the results of the test scores? Another consideration may be that the Counselors in this study were more knowledgeable of people in general based upon their field of expertise.

Nevertheless, Gatz and Finkel (1995) express concern about the sizeable proportions of older adults with mental health issues that may go undetected due to health care professionals who lack specialized training and additional education about the process of aging. With the growing number of studies and data about the process of aging that is accessible to mental and medical health care professionals, the need to become more knowledgeable about appropriate assessment and treatment plans for older adults is critical (Cooley et al., 1998). Everhart, Blieszner, and Edwards (1996) suggest that the future growth of the elderly population warrants programs that focus directly on the process of aging.

Limitations

There are limitations in this research that must be considered in interpreting the findings of significant differences. Firstly, the disproportionate gender representation of the participants in Group I (Counselors), which included 11 men and 39 women and Group II (Non Counselors), which consisted of 17 men and 16 women. Overall, there was a gender imbalance as there were twice as many women participants (n = 55, 66%) as there were men participants (n = 28, 34%) in this study.

Another extraneous factor not controlled for is age, as reflected in the difference in age between the two groups of participants. The range of age for Group I (Counselors) is 23 to 77 years, (Mean age = 49 years). The range of age for Group II (Non Counselors) is 21 to 60 years, (Mean age = 31 years). Here it is possible that the results may be attributed to the Counselor respondents being significantly older than the Non Counselors.

The difference in the education levels between Group I (Counselors) and Group II (Non Counselors) may also have affected the survey results. All Group I (Counselors) members had at least Master degrees, with 28% having Master degrees + 30 credit hours, and 22% with a Ph.D., whereas Group II (Non Counselors) consisted of 61% with Bachelor degrees, and only 33% with Master degrees, and 6% with Master degrees + 30 credit hours. There were no Ph.D. level students in Group II (Non Counselors). It is possible that the counselors being a more educated sample, were likely to be more knowledgeable about the aging process.

Future Considerations

Within this study, the proportion of Counselors working with older adults was limited; similarly, the number of counselors who stated they had prior education on aging was few. A comparison study between counselors who work with older adults and counselors who work with other age groups (excluding older adults) may suggest if interactions with older persons may lead to a more realistic and supportive perspective in working with the elderly population. Future studies should also attempt to compare attitudes toward older adults between counselors who have had gerontological training and those who have not. An examination of counselors' concerns in working with older adults and possible countertransference issues could also be beneficial. Other considerations might be obtaining larger samples, which enhances validity within the study, and may allow for more generalization of the results.

As the aging population rises, the shortage of gerontological counselors becomes more apparent. Assessments of older adults can be a complex issue, yet Qualls (1998) states that counselors face the challenge of finding adequate training in the specialized field of gerontological counseling. Schlossberg (1990) agrees with Qualls regarding the complexity and diverse issues of the aging process, and urges counselors to seek additional gerontological training in order to obtain a better understanding when working with older adults. Furthermore, Myers (1995) and Myers and Salmon (1984) continue to declare the critical need for additional training in gerontology for counselors, whether or not they are working with older adults.

The continued efforts in assisting healthcare professionals to expand their knowledge base about the aging process may provide positive results within the coming years. However, Belsky (1984) declares an urgency in which people must realize that "ageism, even more than racism or sexism, is personally self-defeating. When we practice this prejudice, we are negating who, with luck, we must become" (as cited in Ponzo, 1992, p. 211). Upon the recognition of older adults as human beings worthy of living in a society free of age-related prejudice, future generations may transcend into the inevitable process of aging receiving acceptance, respect, and dignity, and in return leaving behind an invaluable legacy to those who remain—the wisdom acquired with age.

APPENDIX A

LETTER OF INTRODUCTION TO COUNSELORS

Dear Participant:

I am a graduate student at Lindenwood University, conducting a survey for my master's thesis. The enclosed questionnaire is designed to obtain information regarding gerontological issues within the field of licensed professional counselors. There are a total of 25 multiple-choice questions. Additionally, there are 7 questions, which will be used for demographic purposes only.

I would appreciate your completion of the questionnaire by March 23. I have provided a stamped, addressed envelope for you to use in returning the questionnaire. You do not need to put your name on the questionnaire, but I request that you sign your name on the enclosed postcard and mail it separately from the questionnaire. That way I will know you have replied and will not have to bother you with follow-up letters. Your responses on the questionnaire will be anonymous.

I realize that your schedule is busy and your time is valuable. However, I hope that you will take 15 minutes to complete the questionnaire that will assist me in concluding my thesis research.

Thank you in advance for your participation. If you have any questions about the study, you may contact me at 314-638-1238 or 314-638-9099.

Sincerely,

Vanessa L. Benavidez
Lindenwood University Graduate Student

APPENDIX B

LETTER OF INTRODUCTION TO GRADUATE STUDENTS

Master's Thesis Survey Instructions

I am a graduate student at Lindenwood University, conducting a survey for my master's thesis. The attached questionnaire is designed to obtain information regarding gerontological issues. There are a total of 25 multiple-choice questions. Additionally, there are 5 questions, which will be used for demographic purposes only.

Your cooperation in completing the questionnaire is greatly appreciated, as your participation will assist me in concluding my thesis research. Your responses on the questionnaire will be anonymous.

Thank you in advance for your participation. Upon completing the questionnaire, please place in the manila envelope located near your instructor.

Sincerely,

Vanessa L. Benavidez
Lindenwood University Graduate Student

APPENDIX C

DEMOGRAPHIC QUESTIONS FOR COUNSELORS AND NON-COUNSELORS

The following questions will be used for demographic purposes only

26. What is your gender?

    Male   Female   (Circle one)

27. What is your age? __________

28. What is your ethnicity?

    ( ) African-American   ( ) Asian-American   ( ) Caucasian

    ( ) Hispanic   ( ) Native American   ( ) Other______________

29. What is your educational level?

    ( ) Bachelor's   ( ) Master's   ( ) Master's + 30 credit hours

    ( ) Ph.D.

30. Did you receive any education on aging during your graduate studies?

    Yes   No   (circle one)

31. How long have you practiced in the field of counseling? ______*

32. What client population do you generally work with? *

    ( ) Adolescents   ( ) Young adults   ( ) Middle-aged adults

    ( ) Older adults

***Not applicable questions, such as 31 and 32 were omitted from the demographic questions for non-counselors.**

APPENDIX D

ORIGINAL INSTRUMENT WITH ANSWERS AND KEY

FAQ1 MULTIPLE-CHOICE FORMAT

Note that this version of the multiple-choice format changes the wording and correct answers to some of the items compared with the original 1996 version (Harris, Changas, & Palmore, 1996). The key to the symbols (+, -, *) is given at the end of this quiz. (Do not include the symbols in the form given the students.)

Instructions: Circle the letter of the best answer. If you do not know the best answer, you may put a question mark to the left of the answers instead of circling a letter. The revised edition suggests using "e. Don't Know (DK)" (Palmore, 1998).

1. The proportion of people over 65 who are senile (have impaired memory, disorientation, or dementia) is
    a. About 1 in 100 +
    b. About 1 in 10 *
    c. About 1 in 2 -
    d. The majority -
    e. I do not know

2. The senses that tend to weaken in old age are
    a. Sight and hearing +
    b. Taste and smell +
    c. Sight, hearing, and touch +
    d. All five senses *
    e. I do not know

3. The majority of old couples
    a. Have little or no interest in sex -
    b. Are not able to have sexual relations -
    c. Continue to enjoy sexual relations *
    d. Think sex is for only the young -
    e. I do not know

4. Lung vital capacity in old age
    a. Tends to decline *
    b. Stays the same among nonsmokers +
    c. Tends to increase among healthy old people +
    d. Is unrelated to age +
    e. I do not know

5. Happiness among old people is
   a. Rare -
   b. Less common than among younger people -
   c. About as common as among younger people *
   d. More common than among younger people +
   e. I do not know

6. Physical strength
   a. Tends to decline with age *
   b. Tends to remain the same among healthy old people +
   c. Tends to increase among healthy old people +
   d. Is unrelated to age +
   e. I do not know

7. The percentage of people over 65 in long-stay institutions (such as nursing homes, mental hospitals, and homes for the aged) is about
   a. 5% *
   b. 10% -
   c. 25% -
   d. 50% -
   e. I do not know

8. The accident rate per driver over age 65 is
   a. Higher than for those under 65 -
   b. About the same as for those under 65 -
   c. Lower than for those under 65 *
   d. Unknown **0**
   e. I do not know

9. Most workers over 65
   a. Work less effectively than younger workers -
   b. Work as effectively as younger workers *
   c. Work more effectively than younger workers +
   d. Are preferred by most employees +
   e. I do not know

10. The proportion of people over 65 who are able to do their normal activities is
   a. One tenth -
   b. One quarter -
   c. One half -
   d. More than three fourths *
   e. I do not know

11. Adaptability to change among people over 65 is
    a. Rare -
    b. Present among about half -
    c. Present among most *
    d. More common than among younger people +
    e. I do not know

12. As for old people learning new things
    a. Most are unable to learn at any speed -
    b. Most are able to learn, but at a slower speed*
    c. Most are able to learn as fast as younger people +
    d. Learning speed is unrelated to age +
    e. I do not know

13. Depression is more frequent among
    a. People over 65 -
    b. Adults under 65 *
    c. Young people **0**
    d. Children **0**
    e. I do not know

14. Old people tend to react
    a. Slower than younger people *
    b. At about the same speed as younger people +
    c. Faster than younger people +
    d. Slower or faster than others, depending on the type of test +
    e. I do not know

15. Old people tend to be
    a. More alike than younger people -
    b. As alike as younger people **0**
    c. Less alike than younger people +
    d. More alike in some respects and less alike in others *
    e. I do not know

16. Most old people say
    a. They are seldom bored *
    b. They are usually bored -
    c. They are often bored -
    d. Life is monotonous -
    e. I do not know

17. The proportion of old people who are socially isolated is
    a. Almost all -
    b. About half -
    c. Less than a fourth *
    d. Almost none +
    e. I do not know

18. The accident rate among workers over 65 tends to be
    a. Higher than among younger workers -
    b. About the same as among younger workers -
    c. Lower than among younger workers *
    d. Unknown because there are so few workers over 65 -
    e. I do not know

19. The Proportion of the U.S. population now age 65 or over is
    a. 3% **0**
    b. 13% *
    c. 23% **0**
    d. 33% **0**
    e. I do not know

20. Medical practitioners tend to give older patients
    a. Lower priority than younger patients *
    b. The same priority as younger patients +
    c. Higher priority than younger patients +
    d. Higher priority if they have Medicaid +
    e. I do not know

21. The poverty rate (as defined by the federal government) among old people is
    a. Higher than among children under age 18 -
    b. Higher than among all persons under 65 -
    c. About the same as among persons under 65 -
    d. Lower than among persons under 65 *
    e. I do not know

22. Most old people are
    a. Still employed +
    b. Employed or would like to be employed +
    c. Employed, do housework or volunteer work, or would like to do some kind of work *
    d. Not interested in any work -
    e. I do not know

23. Religiosity tend to
    a. Increase in old age **0**
    b. Decrease in old age **0**
    c. Be greater in the older generation than in the younger *
    d. Be unrelated to age **0**
    e. I do not know

24. Most old people say they
    a. Are seldom angry *
    b. Are often angry -
    c. Are often grouchy -
    d. Often lose their tempers -
    e. I do not know

25. The health and economic status of old people (compared with younger people) in the year 2010 will
    a. Be higher than now *
    b. Be about the same as now -
    c. Be lower than now -
    d. Show no consistent trend -
    e. I do not know

Key:
*** = Correct answer**
+ = Positive bias
- = Negative bias
0 = Neutral
e. = Don't Know (DK) revised/optional

REFERENCES

Abrams, W. B., Beers, M. H., Berkow, R., & Fletcher, M. B. (Eds). (1995). The merck manual of geriatrics (2nd ed.). Whitehouse Station, NJ: Merck & Co., Inc.

American Psychological Association (1997). Publication manual of the American Psychological Association (4th ed.). Washington, DC: American Psychological Association.

Badger, T. A. & Collins-Joyce, P. (2000). Depression, psychosocial resources, and functional ability in older adults. Clinical Nursing Research, 9, (3), 238-255.

Beardon, L. J. & Head, D. W. (1986). Attitudes of rehabilitation professionals toward aging and older persons. Journal of Applied Rehabilitation Counseling, 17, (1), 17-19.

Bernstein, L. O. (1990). A special service: Counseling the individual elderly client. Generations, 14, (1), 35-38.

Blair, C., Jacobs, N. R., & Quiram, J. F. (Eds.). (1996). Growing old in America: 65+. Wylie, TX: Information Plus.

Burnside, I. & Schmidt, M. G. (1994). Working with older adults: Group process and techniques (3rd ed.). Sudbury, MA: Jones & Bartlett Publishers.

Butler, R. N., Lewis, M., & Sunderland, T. (1991). Aging and mental health: Positive psychosocial and biomedical approaches (4th ed.). New Jersey: Macmillan Publishing Company.

Cavallaro, M. L. (1992). A master's degree specialization in gerontological counseling. Counselor Education & Supervision, 32, (1), 70-77.

Cooley, S., Deitch, I. M., Harper, M. S., Hinrichsen, G., Lopez, M. A., & Molinari, V. A. (1998). What practitioners should know about working with older adults. Professional Psychology: Research and Practice, 29, (5), 413-427.

Cooper, B. (1997). Commentary. Key papers in old age psychiatry. International Journal of Geriatric Psychiatry, 12, (7), 708-711.

Crose, R. (1992). Gerontology is only aging, it's not dead yet! The Counseling Psychologist, 20, (2), 330-335.

Danzinger, P. R. & Welfel, E. R. (2000). Age gender and health bias in counselors: An empirical analysis. Journal of Mental Health Counseling, 22, (2), 135-149.

Everhart, D. E., Blieszner, R., & Edwards, T. M. (1996). Doctoral training in the psychology of adult development and aging: 1993-1994 survey results. Educational Gerontology, 22, (5), 451-466.

Gadow, S. (1980). Medicine, ethics, and the elderly. The Gerontologist, 20, (6), 680-685.

Galambos, C. & Rosen, A. (1999). The aging are coming and they are us. Health and Social Work, 24, (1), 73-77.

Garcia, Y. E., Metha, A., Perfect, M. C., & McWhirter, J. J. (1997). A senior peer counseling program evaluation of training and benefits to counselors. Educational Gerontology, 23, (4), 329-344.

Gatz, M. & Finkel, S. L. (1995). Education and training of mental health service providers. In M. Gatz (Ed.). Emerging Issues in Mental Health and Aging (pp. 282-302). Washington, DC: American Psychological Association.

Gelfand, D. E. (1993). The aging network: Programs and services (4th ed.). New York: Springer Publishing Company.

Gintner, G. G. (1995). Differential diagnosis in older adults: Dementia, depression, and delirium. Journal of Counseling & Development, 73, (3), 346-351.

Greene, M. G., Adelman, R. D., & Rizzo, C. (1996). Problems in communication between physician's and older patients. Journal of Geriatric Psychiatry, 29, (1), 13-32.

Harris, D. K., Changas, P. S., & Palmore, E. D. (1996). Palmore's first acts on aging quiz in a multiple-choice format. Educational Gerontology, 22, (6), 575-589.

Hergenhahn, B. R. & Olson, M. H. (1999). An introduction to theories of personality (5th ed.). New Jersey: Prentice-Hall, Inc.

Herrick, J. W. (1983). Interbehavioral perspectives on aging. International Journal of Aging & Human Development, 16, (2), 95-123.

Johnson, M. E. & Rosich, R. M. (1997). Gerontological training in APA accredited clinical and counseling psychology programs. Educational Gerontology, 23, (1), 29-35.

Klemmack, D. L. (1978). Comment: An examination of Palmore's facts on aging quiz 1. The Gerontologist, 18, (4), 403-406.

Knight, B. G. & McCallum, T. J. (1998). Adapting psychotherapeutic practice for older clients: Implications of the contextual, cohort-based, maturity, specific challenge model. Professional Psychology, 29, (1), 15-22.

McConatha, J. T. & Ebener, D. (1992). Relationship between client age and counselor trainees' perceptions of presenting problems, therapeutic methods, and prognoses. Educational Gerontology, 18, (8), 795-802.

McDonald, P. A. & Haney, M. (1997). Counseling the older adult (2nd ed.). San Francisco: Jossey-Bass.

Malamud, W. I. (1996). Countertransference issues with elderly patients. Journal of Geriatric Psychiatry, 29, (1), 33-41.

Matyi, C. L. & Drevenstedt, J. (1989). Judgments of elderly and young clients as functions of gender and interview behaviors: Implications for counselors. Journal of Counseling Psychology, 36, (4), 451-455.

Miller, R. B. & Dodder, R. A. (1980). A revision of Palmore's facts on aging quiz. The Gerontologist, 20, (6), 673-679.

Mulley, G. P. (1997). Myths of ageing. Lancet, 305, (9085), 1160-1161.

Myers, J. E. (1990). Aging: An overview for mental health counselors. Journal of Mental Health Counseling, 12, (3), 245-259.

Myers, J. E. (1992). Competencies, credentialing, and standards for gerontological counselors: Implications for counselor education. Counselor Education & Supervision, 32, (1), 34-42.

Myers, J. E. (1995). From "forgotten to ignored" to standards and certification: Gerontological counseling comes of age. Journal of Counseling & Development, 74, (2), 143-149.

Myers, J. E. & Blake, R. H. (1986). Preparing counselors for work with older people. Counselor Education & Supervision, 26, (2), 137-145.

Myers, J. E., Loesch, L. D., & Sweeney, T. J. (1991). Trends in gerontological counselor preparation. Counselor Education & Supervision, 30, (3), 194-204.

Myers, J. E. & Salmon, H. E. (1984). Counseling programs for older person: Status, shortcomings, and potentialities. The Counseling Psychologist, 12, (2), 39-53.

Myers, J. E. & Schwiebert, V. L. (1996). Competencies for gerontological counseling. Alexandria, VA: American Counseling Association.

Newman, B. M. & Newman, P. R. (1999). Development through life: A psychosocial approach (7th ed.). Belmont: Wadsworth Publishing Company.

Orel, N. A. (1998). Ethical considerations in assessing the competency of older adults: A provision of informed consent. Journal of Mental Health Counseling, 20, (3), 189-201.

Palmore, E. (1977). Facts on aging: A short quiz 1. The Gerontologist, 17, (4), 315-320.

Palmore, E. B. (1994). When is humor about aging 'good' and when is it 'ageist?' Perspective on Aging, 23, (3), 9-10.

Palmore, E. B. (1998). The facts on aging quiz (2nd ed.). New York: Springer Publishing.

Ponzo, Z. (1992). Promoting successful aging: Problems, opportunities, and counseling guidelines. Journal of Counseling & Development, 71, (2), 210-213.

Qualls, S. H. (1998). Training in geropsychology: Preparing to meet the demand. Professional Psychology: Research and Practice, 29, (1), 23-28.

Ryan, N. E. & Agresti, A. A. (1999). Gerontological training in the mental health professions: The results of a national survey. Journal of Mental Health Counseling, 21, (4), 352-370.

Saxon, S. V. & Etten, M. J. (1994). Physical change & aging: A guide for the helping professions (3rd ed). New York: Tiresias Press.

Scharlach, A., Damron-Rodriguez, J., Robinson, B., & Feldman, R. (2000). Educating social workers for an aging society: A vision for the 21st century. Journal of Social Work Education, 36, (3), 521-538.

Schlossberg, N. K. (1990). Training counselors to work with older adults. Generations, 14, (1), 7-10.

Schwiebert, V. L., Myers, J. E., & Dice, C. (2000). Ethical guidelines for counselors working with older adults. Journal of Counseling & Development, 78, (2), 123-129.

Segrin, C. (1994). Social skills and psychosocial problems among the elderly. Research on Aging, 16, (3), 301-321.

Sharf, R. S. (2000). Theories of psychotherapy & counseling: Concepts and cases (2nd ed.). Belmont, CA: Wadsworth Brooks/Cole Thomson Learning.

Shmotkin, D., Eyal, N., & Lomranz, J. (1992). Motivations and attitudes of clinical psychologists regarding treatment of the elderly. Educational Gerontology, 18, (2), 177-192.

Skala, K. (1996). American guidance for seniors…and their caregivers (Rev. ed.). Falls Church, VA: G & S.

Sweeney, T. J. & Myers, J. E. (1986). Early recollections: An Alderian technique with older people. Clinical Gerontologist, 4, (4), 3-12.

Thomas, C. L. (Ed.). (1997). Taber's cyclopedic medical dictionary (18th ed.). Philadelphia, PA: F. A. Davis Company.

Wade, C. & Tavris, C. (1993). Psychology (3rd ed.). New York: HarperCollins College Publishers.

Warnick, J. (1995). Listening with different ears: Counseling people over 60. Fort Bragg, CA: QED Press.

Woolfe, R. (1998). Therapists' attitudes towards working with older people. Journal of Social Work Practice, 12, (2), 141-147.

Woolfe, R. & Biggs, S. (1997). Counselling older adults: Issues and awareness. <u>Counselling Psychology Quarterly, 10,</u> (2), 189-194.