THE INFLUENCE OF CLIENT AGE AND THE PROFESSIONAL DISCIPLINE OF THE THERAPIST ON SELECTED CLINICAL JUDGMENTS

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TABLE OF CONTENTS

Chapter Page

I. INTRODUCTION 1

Statement of the Problem 9
Significance of the Study 10
Definition of Terms 12
Statement of Hypotheses 13
Research Objectives 15
Assumptions of the Study 15
Limitations of the Study 15
Organization of the Study 16

II. REVIEW OF LITERATURE 17

Theoretical Approaches to Aging 17
The Importance of Therapists' Attitudes 21
Therapists' Attitudes Toward the Elderly Client. 23
Elderly Socioeconomic Status and Clinical Judgment 30
Clinical Judgments and Treatment Options
for the Elderly 36
Professional Preparation. 43
Professional Discipline and Clinical Judgments with the Elderly 46
Physicians 48
Psychologists 51
Summary 54

III. METHODS 56

Subjects. 56
Instrumentation 57
The Modified SCVQ 59
Reliability 60
Validity 61

Chapter Page

III. METHODS. 55

Ethical Considerations. 61
Procedure. 62
Research Design/Data Analysis 62

IV. RESULTS. 64

Hypothesis 1. 66
Hypothesis 2. 67
Hypothesis 3. 68
Hypothesis 4. 69
Hypothesis 5. 70
Hypothesis 6. 70
Hypothesis 7. 71
Hypothesis 8. 72
Hypothesis 9. 73
Summary. 73

VI. SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS. 76

Summary. 76
Conclusions 78
Recommendations for Research 84
Recommendations for Professionals. 86

REFERENCES. 88

APPENDIXES QUESTIONNAIRE. 107

Appendix A - Simulated Young Client Vignette Questionnaire 108
Appendix B - Simulated Old Client Vignette Questionnaire 112

LIST OF TABLES

Table		Page
I.	Correlation Matrix for Dependent Variables.	63
II.	Means and Standard Deviations of Therapists' Responses on Clinical Ratings of Clients.	63
III.	ANOVA Summary Table of Therapists' Responses Regarding the Severity of the Client's Impairment.	65
IV.	ANOVA Summary Table of Therapists' Responses Regarding the Prognosis for the Client's Illness.	69
V.	ANOVA Summary Table of Therapists' Responses Regarding Psychotheraphy as an Appropriate Treatment Option.	70

LIST OF FIGURES

Figure Page

I. Therapists' Perception of the Severity of Impairment. 69

This study is dedicated

to

My Grandmas
Alma and Ludy

and

My Grandpaw Wallace

CHAPTER I

INTRODUCTION

Mead (1960) called old people "immigrants in time" (p. 33), and Fontana (1977) described the aging process as a journey into "the last frontier" (p. 10). Catton (1972) reiterated the metaphor when he said, "Early youth is exactly like old age; it is a time of waiting before a big trip to an unknown destination. The chief difference is that the youth waits for the morning limited and the aged wait for the night train" (p. 22). Literature from all fields is replete with similar images, and indeed, most perceptions of aging include fears that past those mythical gates of middle age lies a wasteland of emptiness where pilgrims spend their days grimly waiting for nothing, waiting for death, waiting for waiting itself.

Negative, prejudicial attitudes toward the elderly are nothing new. In fact, Aristotle (Loomis, 1943) believed that vindictiveness, resentment, and senile avarice were inherent to the aging process. Some of the earliest empirical research concerning attitudes toward the aged was conducted by Tuckman and Lorge (1953). Their work, along with that of Ginzberg (1952), determined that negative views of the aged were common among younger individuals. Steffe (1978) suggests that early studies as a whole confirmed the conclusions of

Tuckman and Lorge and Ginzberg:

> Early research described characteristics of the aged as congregated in poor farms, nursing homes, and state hospitals, leading to a general picture of impaired elderly and . . . created pity and revulsion [which] certainly added to the development of negative attitudes toward the aged in our youth-oriented society (p. 33).

A 1975 survey (Harris & Associates, 1975) for the National Council on Aging suggests that prejudice toward the elderly continues to be a part of modern society. Harris polled the general public and found old people generally described as not particularly bright or capable, often closed minded, inflexible, and slow, ". . . a miserable, problem-ridden segment of society . . . merely another of [its] problems" (1975, p. 9). Erikson, Erikson, and Kivnick (1986) contend that the cruelest aspect of the United States culture's youth orientation is that it automatically makes elders vulnerable to stereotyping. In a country that has prided itself on independence rather than dependence, on zestful enthusiasm rather than cautious deliberation, and on agility rather than firmness, it is no surprise that the predominant value should be youthfulness rather than maturity. It is also not surprising that ageism poses such a problem in our society.

Butler (1975b) coined the term ageism and defines it as:

> . . . a process of systematic stereotyping of and discrimination against

> people because they are old, just as racism and sexism accomplish this with skin color and gender. Old people are categorized as senile, rigid in thought and manner, old-fashioned in morality and skills . . . Ageism allows the younger generations to see older people as different from themselves; thus, they subtly cease to identify with their elders as human beings (p. 894).

That young is beautiful and old is ugly seems to be a stereotypical attitude deeply ingrained in the United States culture and economy. As Toffler (1970) suggests, in a throw-away society old things are discarded: They are too difficult to mend. And indeed, United States culture often relegates the elderly to the status of outdated, obsolete products. They are discarded and ignored. Butler (1975b) suggests that such dehumanization breeds a comfortable neglect of the elderly among those who are not old. It is no wonder that older people often perceive themselves as unattractive, dull, or unlovable. He further asserts that ageism may come to parallel racism (if not replace it) in the next 20 to 30 years. Merrill (1982) compares the process of growing old in a youth-centered America to a racist who must helplessly watch himself turn into a Black. As people age in modern American society they are actually placed in a difficult dilemma: Tradition characterizes elders as venerable and wise, deserving of respect and honor, while many older people reach their golden years only to be treated as second class citizens who are no longer productive and worthwhile.

Fontana (1977) suggests that when the elderly comply with the stereotypical mind-set of an ageistic society, they become "cultural dopes" (p. 28) who hide in dark corners so that they do not disturb the young. In fact, experts believe that the most insidious problem the elderly face is the stereotype they hold of themselves (Butler, 1973; Neugarten, 1968; Talley, 1980). Self-imposed stereotypes most often include ideas about being old fashioned, lonely, and infirm. The reality is that quite often elderly people hold the same stereotypes of themselves as do the young--- they decide what is bad about themselves, their lives, their circumstances; and go about reinforcing it in various ways (Talley, 1980). Hence a self-fulfilling prophecy fuels the problem of ageism.

Fontana (1977) labels the aging issue inherently complex; "An elusive enigmatic, intricately dialectic interplay of perception and conception, being and becoming, existing and beholding . . ." (p. 9). Ambivalence, confusion, fear, and anger are all feelings that most people experience when they think about growing old. Such emotions are no doubt based largely on stereotypical conceptions and beliefs.

While ageism may have been more acceptable in the past since only a small minority of our population was elderly, this is no longer the case. America is growing older. According to the Statistical Abstract of the United States (1986), 28 million Americans are 65 or older. This figure accounts for 12% of the population. By 2030 it is estimated that the over 65 population will increase by

two thirds (Goldstrom, Burns, Kessler, Feuerberg, Larson, Miller, & Cromer, 1987).

Cox (1985) credits this shift in composition to the declining birth rate combined with medical technology which keeps people alive and healthy well into retirement years. In fact, as the burgeoning ranks of the World War II baby boom approaches their later years the existential meanings of age and aging are likely to be stretched and strained so that current definitions seem quaint and anachronistic. Furthermore, as this segment continues to grow, the concomitant social changes must be addressed. In fact, the rapidly increasing number of older people has already made many of the problems of aging quite visible. Since most middle aged people expect to live to retirement age and beyond, interest continues to be generated in the quality of life for older people. General agreement seems to be that it is desirable to grant the elderly a secure and comfortable status (Cox, 1985). But intention does not always translate easily into action and the difficulties associated with this issue are likely to persist, if not intensify (Butler, 1983).

Research by Gunter (1971) not only underscores the prevalence of negative stereotypes of elderly people, but points out that such mind sets tend to be ". . . even stronger among health care personnel" (p. 469). Traditionally, psychotherapy is not common among the elderly population. At least one explanation of this situation is that psychotherapists are likely to fall prey to

some of the ageistic attitudes that exist in American society as a whole and health care personnel in particular. In fact, Freud (1904) insists that patient age is an important consideration when choosing candidates for psychoanalysis. He concludes that patients 50 years and older are not educable and lack the mental flexibility necessary for successful treatment. Pfeiffer (1971) suggests that traditionally, therapists have accepted such myths not because they are true or even because they are rooted in the foundations of the psychotherapy movement, but because such concepts fit their own personal prejudices. Noting that professionals often exhibit an unreasonable fear of the aging process, Comfort (1976) labels this reaction as gerontophobia.

Medicine and behavioral sciences have, in reality, mirrored social attitudes by considering and presenting old age as a litany of physical and emotional suffering. Neglect is an apt description for the general course of treatment for many of the elderly who are in need. Until after 1960, most of the medical, psychological, and social work literature was based on institutionalized populations (Butler, 1974). Since only five percent of the elderly in this country fall into this category (Dychtwald, 1986), there was an obvious gap in information. The situation is improved, but far from adequate. Ganikos (1979) points out a continuing need to better understand the concerns of the aged population. Hoyer, Raskind, and Abrahams (1984) suggest that indeed the field of gerontological research is on the rise in the United States. In particular, they

cite 747 studies dealing with the psychological aspects of aging between the years of 1975 and 1982, compared with only 263 such studies between 1963 and 1974.

While research indicates that health services in general have not focused on the needs of the elderly, the discrepancy between need and use has been particularly glaring in the area of mental health (Beattie, 1976). In 1986, the 28 million Americans 65 or older, nearly one fifth of the population, accounted for 29% of all hospital discharges and 33% of individual health care expenditures (Statistical Abstract of the United States, 1986). While there are conflicting views about the rates of mental disorders among the elderly, with many researchers asserting that they experience higher incidence (Cohen, 1976; Hankin & Oktay, 1979), and others suggesting they are no more likely than younger adults to have mental problems (Haug, Belgrave, & Gratton, 1984); there is virtually no disagreement that elderly people are underrepresented in mental health care (Goldstrom et al., 1987; Nissenson, 1984). In 1969, when elderly people constituted over 10% of the population, only 4% of total community mental health center services went to those 65 and older (Redick, Kramer & Taub, 1973). The last data available on community mental health care use by age, over a decade later in 1978, pointed to a remarkably similar situation. Despite the disproportionate increase in this segment of the population, only 4.3% of the case load were elderly. Less than 3% of private hospital or clinic

clients are over 65, and 70% of clinical psychologists report they do not see a single elderly client (Goldstrom et al., 1987).

With respect to private psychiatry, there is a similar picture. Only 4% of office-based visits are from elderly patients though this group accounts for almost one fifth of primary care office visits (Goldstrom et al., 1987). An even more alarming consideration is that many elderly patients visit a psychiatrist primarily for assessment rather than treatment (Hall, 1982). Butler (1975b) suggests that psychiatrists, because of their medical background, are often disposed to a disturbing point of view, ". . . that the emotional and mental disorders of old age are not bonafide "mental illnesses" and that psychiatric diagnosis and treatment are therefore unnecessary" (p. 895). Instead, professionals with medical educations are more likely to view elderly people as candidates for social assistance and ultimately custodial care than are other mental health care professionals. That most MD's conceptualize and treat exclusively within the medical model exacerbates problems with appropriately addressing the concerns of older patients. In an effort to delineate the powerful and sometimes harmful influence the biomedical model can have on patient care, Engel (1980) encourages the medical profession to recognize the ". . . crippling flaw of a model. . .that does not include [viewing] the patient as a [whole] human being" (p. 536). For the elderly, a reductionistic approach can be particularly harmful

and ineffective and may indeed be a factor in their being undeserved by mental health professionals.

Results clearly indicate a disproportionately lower use of mental health services by the over 65 sector both in comparison with other adults and in relation to the proportion of the U.S. population (Goldstrom et al., 1987). This state of affairs points to the need for mental health professionals to address the implications of these facts. Two paramount issues emerge: Do biases exist among mental health professionals toward the elderly, and if they do exist, in what ways do these biases influence professional assessment and decisions?

Statement of Problem

The personality of mental health professionals has a direct impact upon their clinical practices that is rare in any other field. In a unique and powerful way, values, needs, and personal beliefs affect the therapeutic encounters in which they engage (Coe, 1967). Corey (1982) maintains that the ". . . personal attributes of the therapists is the single most important determinant of successful therapy" (p. 26). In addition, by its nature, the mental health profession is composed of clinicians from various professional disciplines. Professional background may contribute to attitudes of helping professionals.

The purpose of this study is to investigate the extent of age bias in therapists with psychology and medical backgrounds and how this might relate to professionals' decisions about the mental health of different age-targeted persons. Specifically this study will address the following question: Do professional discipline and client age influence perceptions of severity of client problems, appropriate treatment options, and client prognosis for mental health related difficulties?

Significance of Study

If the needs of the elderly are to be adequately addressed, it is important to understand strengths and problems associated with professionals who are potential service providers.

> The interest that has been shown by academicians, social workers, health care professionals and legislators in aging and the aged has increased greatly in the last decade. There can be little doubt that public awareness of the problems of the elderly has increased as well. However, there are certain problems that cannot be solved by merely raising issues and increasing public awareness. One such problem is that of attracting competent personnel to work with the aged (Winn, Elias, & McComb, 1978, p. 235).

Long before learning the role of therapist, clinicians have cultivated individual personalities which incorporate various attitudes and values. Since therapists' personhood, intricately intertwines with the therapeutic process, it seems important to examine attitudes that may influence clinical practices. Kastenbaum (1963) suggested that practitioners who avoid older client are suffering from the "reluctant therapist" (p. 297) syndrome. At the same time, Cyrus-Lutz and Gaitz (1972) imply that the elderly may react to real or perceived negative attitudes of younger clinicians and be reluctant to see a mental health professional. In any event there is a clear discrepancy between the percentage of elderly in the population and the percentage of mental health care services which goes to elderly (Nissenson, 1984). It is certain that this situation results from complex factors, and it appears that both therapist and client variables are involved.

Further research into the antecedents of this lack of services seems to be warranted, especially in view of the demographic picture. All indications appear to be that the entire human-service system, and its psychotherapy component in particular, needs to focus on the expanding elderly segment of society (Glass & Grant, 1983).

Furthermore, literature on age bias has suggested that helping professionals may subscribe to negative stereotypes of the elderly and that awareness of such biases may, indeed, help counteract its influence on professional attitudes

(Wilson & Hafferty, 1983). Thus, this study could generate important educational implications. By better understanding the extent and nature of age bias in helping professionals and how this bias might relate to various professionals' clinical decisions, educators and program directors could address current weaknesses and devise effective strategies for equipping students to deal with problems more productively.

Definition of Terms

The terms of particular significance to this study are defined as follows:

Elderly: Those people who have reached the chronological age of 65 or older. This age is consistent with Medicare program standards for old age (U.S. Bureau of the Census, 1984).

Psychological-Interns: Individuals currently involved in counseling and clinical psychology doctoral programs. These individuals have completed course work and are pursuing clinical training requirements of their respective programs.

Psychiatric-Residents: Medical students currently enrolled in a psychiatric specialty program. They have completed general requirements for the Doctor of Medicine degree and are pursuing specialty training in psychiatry.

Severity-of-Impairment: The degree to which the current condition of the client is likely to impair his/her life activity. It is operationalized in the present

study as scores on Section II, Item 1 of the Simulated Client Vignette Questionnaire (SCVQ). Responses will be made on a seven point Likert-type scale ranging from "little impairment" to "severe impairment."

Prognosis: The prediction of the probable course of an illness and the chances of recovery (Webster's New World Dictionary, 1962). In the present study prognosis is operationalized by scores on Section II, Item 2 of the SCVQ. Responses are recorded using a seven point Likert-type scale ranging from "likely to decline" to "complete recovery."

Statement of Hypotheses

In order to examine the relationship between selected therapist and client characteristics the following null hypotheses will be tested:

1. H_0: Therapists' clinical judgments concerning the severity of the client's illness are not related to the client's age.
2. H_0: Therapists' clinical judgments concerning the severity of the client's illness are not related to the therapist's professional discipline.
3. H_0: Therapists' clinical judgments concerning the severity of the client's illness are not related to the interaction of client age and the professional discipline of the therapist.

4. H_0: Therapists' clinical judgments concerning the prognosis for the client's illness are not related to the client's age.

5. H_0: Therapists' clinical judgments concerning the prognosis for the client's illness are not related to the therapist's professional discipline.

6. H_0: Therapists' clinical judgments concerning the prognosis for the client's illness are not related to the interaction of client age and the professional discipline of the therapist.

7. H_0: Therapists' clinical judgments concerning the recommendation of psychotherapy as an appropriate treatment option are not related to the client's age.

8. H_0: Therapists' clinical judgments concerning the recommendation of psychotherapy as an appropriate treatment option are not related to the therapist's professional discipline.

9. H_0: Therapists' clinical judgments concerning the recommendation of psychotherapy as an appropriate treatment option are not related to the interaction of client age and the professional discipline of the therapist.

Research Objectives

The following research objectives are also to be addressed in the study.

1. To determine professionals' interest in working with age-targeted individuals.
2. To determine factors that influence professionals' clinical judgments concerning age-targeted individuals.

Assumptions of the Study

Assumptions of the present study are that students drawn from counseling and clinical psychology programs will have a similar knowledge base and that medical students will have educational backgrounds similar to each other.

Limitations of the Study

Certain limitations of the study are recognized.

1. Due to the analogue nature of the study generalizability of the findings is limited.
2. Only volunteer doctoral psychology and medical students were sampled, thus the inherent differences between volunteer and

randomly selected students must be recognized as a possible intervening factor in the study outcome.

3. Findings should be generalized cautiously to professionals in the field, since the sample included only students.
4. The case vignette used in the study includes only female descriptions with symptoms of depression and may not be generalizable to male clients or to clients with other types of presenting problems.
5. Since subjects responded to only one case vignette, findings may reflect the subject's personal biases.

Organization of the Study

Chapter I includes a brief introduction to the study, statement of problem, significance of the study, definition of relevant terms, the research hypothesis, assumptions and limitations of the study, and the organization of the study. Chapter II consists of a review of the relevant literature in the area of interest. Chapter III presents the methods and procedures utilized in the study including instrumentation, design, procedure and data analysis. Results of the investigation are presented in Chapter IV, while the summary, conclusion and recommendations are presented in Chapter V.

CHAPTER II

REVIEW OF LITERATURE

This chapter contains a review of theoretical positions and empirical findings pertinent to the present study. First, various approaches to aging are presented. Next, an overview of the influence of therapists' attitudes and values on clinical judgments is provided followed by a more specific discussion concerning the impact of professionals' attitudes about aging and the elderly on therapeutic decisions with elderly clients.

Theoretical Approaches to Aging

That gerontology's legacy is by nature multidisciplinary is both a blessing and a curse. On one hand there are often confusing disagreements over the most basic assumptions concerning the nature of the aging process. On the other hand there is a wealth of resources at work to both understand and improve the journey through the last half of life. Aging theories can generally be classified in four categories: biological, sociological, psychological and social-psychological (Blackburn & Lawrence, 1986). The biological theories are based upon

physiological changes that take place during the later part of the mature adult's life cycle. These theories emphasize the decline in biological functioning of the body due to changes in skin, joints, muscles, bone, and organ systems (Barash, 1983; Birren & Renner, 1977; Finch & Hayflick, 1977; Schaie, 1977).

Senescence, the term used to describe these inevitable deteriorations, has been defined as ". . . the changes that occur generally in the post-reproductive period and that result in decreased survival capacity on the part of the individual organism" (Strehler, 1982, p. 15). Verwoedt (1976) explained aging as a "biological clock" (p. 56) that operates on sub-systems within the body. Although biological theorists have many unanswered questions, their ideas are of great importance to understanding physiological factors in a life-course perspective.

The second classification offered by Blackburn and Lawrence (1986) is sociologically-based theories. These approaches focus on changing roles and definitions of self within the environment including demographic changes and societal norms. Theories in this category include role and socialization theory (Cumming & Henry, 1961; Lowenthal, 1977; Riley, Johnson, & Foner, 1972; Rosow, 1978), status and integration theory (Maddox & Wiley, 1976; Neugarten & Hagestad, 1976; Streibe, 1976), minority group theory (Barron, 1953; Palmore & Wittington, 1971), and age stratification theory (Bird, 1973; Riley, Johnson, & Foner, 1972). Theories with sociological bases focus on the interface between the individual and society, resulting in social roles and social status. How mental

health professionals view these concepts is likely to influence their perceptions of elderly clients, in turn, and have an impact on the assessment process.

Another category of theories relative to aging include those with psychological bases. These theories focus on personality and intellectual functioning that have to do with aging. Theorists have a more difficult time operationalizing and quantifying research in this area (Blackburn & Lawrence, 1986). Life-span psychologists have, however, managed to make considerable contributions in the area of aging. Neugarten (1963), who pioneered the study of aging and the human life cycle, wrote of "interiority" (p. 42), a psychological turning inward as outward control decreases. Erikson (1959) delineates life stages of psychological development of which the last is old age. He suggests that this stage challenges the individual to remove the tensions and rebalance the resulting strengths of all the earlier stages in order to establish an integrity of the self. His most recent work, in connection with Erikson and Kivnick, is a follow-up study to determine how the elderly meet this challenge (Erikson, Erikson, & Kivnick, 1986).

Another group of psychologically-based theories deal with intellectual functioning. Schaie (1983), for example, has conducted research indicating that intelligence changes over time and several researchers suggest that memory functions tend to decline with age (Palmore, 1973; Perlmutter & List, 1982). Another important area of psychological theory addresses the way individuals

cope in the world and how they utilize psychological resources relative to age (Folkman & Lazarus 1980; Pearlin & Lieberman, 1977). Though still in its infancy, this concept should be particularly interesting to mental health professionals, despite the likelihood of inherent difficulty sorting out historical effects from aging effects (Verwoedt, 1976).

Finally, Blackburn and Lawrence (1986) suggest the category of social-psychological theories. This approach combines aspects of the psychological and sociological theories and particularly attends to the interaction between internal and external factors. This body of theory arose in reaction to less convincing psychological approaches. Troll (1982) notes the shift in research emphasis to life-course considerations where the effects of various external variables over the life span are taken into account. This theory also makes clear distinctions between biographical time (personal experiencing of the life span) and social time (institutional norms that structure the life cycle), and notes the tendency for collective behavior of individuals to result in changes for institutional norms (Blackburn & Lawrence, 1986).

The social-psychological framework is quite applicable to this study since it focuses on the processes inherent to the therapeutic interview and assessment. It seems likely that both external norms and psychological factors will influence clinical judgment of mental health professionals participating in the assessment of simulated clients in this study.

The Importance of Therapists' Attitudes

Individual attitudes have been demonstrated to affect how individuals interact with others. In fact, the potential for relating to others as separate individuals rather than as the embodiment of one's own biases and stereotypes may be either increased or lessened by personal attitudes (Mackey, 1969). Leake and King (1977), for example, posited that traditional stereotypes and attitudes about low motivation and apathy among the underprivileged actually serve as self-fulfilling prophecies of their poor performance. They insist that findings in medical, psychological, and educational research support the idea that in interaction between two or more individuals, one person's expectations for the behavior of another can become self-fulfilling. Furthermore, when individuals are provided with stigmatizing labels, negative stereotypic responses often follow (Wallston, Wallston, & DeVellis, 1976).

For years, experts insisted that since therapeutic relationships were value-free, the danger of stereotyping did not apply (Lewis & Walsh, 1980). However, recent findings have prompted most professionals to abandon the notion of value-free psychotherapy (Lewis & Lewis, 1985). In fact, Schwartz and Abramowitz (1975) have suggested that personal values of the therapist can and do bias the assessment and treatment of clients. For example, Graham (1980) points out that therapist expectancies about clients can actually determine

whether clients are accepted and how they are assessed. Szasz (1970) asserts that the wider the disparity between therapist and client values, the more likely the client is to receive a severe diagnosis and poor prognosis. Accordingly, Fahey (1983) advocates that professionals enter into a process of reflection on the values which influence their decisions.

Several studies have attempted to identify value-relevant variables that might influence clinical judgments (Beutler, 1981), but results are unclear. Perhaps more important to this research are those studies which have examined the influence of therapist attitudes on clinical judgments of specific populations. Lewis and Lewis (1985) for example, found that psychologists assessed religious clients to need fewer therapy sessions than non-religious clients. When Graham (1980) sampled 100 therapists in community mental health centers, results indicated that nonoffenders were consistently rated as more appropriate therapy candidates than were offenders. It is interesting to note that these studies looked at different aspects of the therapy process and identified them as dangerous areas; acceptance/appropriateness for therapy and perceived number of required sessions. While generalizability is not clear, in view of these findings, further examination of the influence of therapists' attitudes on clinical judgments on specific client populations is warranted.

Therapist Attitudes Toward the Elderly Client

This portion of the review examines the literature on ageism in the mental health field. Since therapists can be influenced by prevailing social values and prevalent attitudes toward the elderly, studies addressing these issues are presented.

In a study of psychotherapy with elderly individuals, Pfeiffer (1971) examined the effects of the widespread myth that older adults are untreatable. Butler (1969) used the term ageism to describe the prejudices and stereotypes applied to individuals solely on the basis of age. He describes this form of bigotry as a reflection of . . ."deep seated uneasiness on the part of young or middle-aged -- a personal revulsion to and distaste for growing old, disease, disability, and fear of powerless, uselessness, and death" (p. 244).

Comfort (1976) suggests that ageism is based on negative stereotyping which results in devaluing the elderly on the basis of accumulated years. Cultural attitudes reinforce stereotyping and mental health professionals share in ageistic attitudes which enable younger people to view older people as different. Epstein (1977) concludes that such biases reflect younger people's insecurity about their own eventual powerlessness, disability, and deterioration as they age. By systematically excluding the elderly from the mainstream of society, individuals

may feel more comfortable with personal neglect and dislike for the aged (Butler, 1969).

Noted gerontologist, Dychtwald (1986) insists that the American health care industry must adapt to meet the needs of a growing elderly population. Citing gerontophobia as the basis for the widespread exclusion of older people from wellness movement, Dychtwald chides professionals for viewing chronological age as definitive. Instead, he proposes that it is a multifaceted phenomena including chronological, intellectual, social, spiritual, and emotional components (Dychtwald, 1981). In fact, defining the term elderly has been too difficult for experts to arrive at an agreeable concept (Straker, 1963). While 65 is the typical marker age in our society, this is generally considered an arbitrary convenience to facilitate retirement policies (Butler, 1975a).

One early study which addresses societal prejudices toward the elderly suggests that they actually demonstrate many qualities of an oppressed minority (Barron, 1953): "The bitterness, resentment, and self-hatred of older workers who experience discrimination in employment represent minority group reactions" (p. 480). He further suggests that the elderly threaten the power structure of the majority group, causing younger people to assume prejudiced stances, stereotypical mind sets, and rationalization for the discrimination practice. Thus, interaction between young and old can mimic the dynamics between ethnic minority/majority groups.

That the elderly constitute a psychiatrically under served minority in the United States is clear. Although persons over 65 account for more than 25% of all public mental hospital admissions, research budget allocations for the National Institute of Health do not reflect a commitment to this age group (Butler, 1969). In 1970, it was estimated that about three million older people with significant mental health problems did not receive help (U.S. Senate Special Committee on Aging). In 1978, Redlich and Kellert conducted a study of the allocation of mental health services by age groups. Using data collected from more than 900 professionals including psychiatrists, psychologists, social workers, nurses, and clergy during the years of 1950-1975, they found that younger people are more often served in mental health centers and that, in fact, 60% of all clients in these agencies are between 20 and 35 years of age. In state hospitals, however, this same age group represents just 32% of those served. This glaring inequity is confirmed by the latest figures of the National Institute of Mental Health (Taube & Barrett, 1985) which report that most elderly are treated in mental hospitals, rather than mental health centers. This group comprises 60% of hospital population as compared to only 4% of outpatient community mental health client populations.

While 15% to 20% of the elderly need mental health care (Gurland & Cross, 1982), a study by Dye (1978) identified less than 400 psychologists serving the elderly. When 454 members of the Ohio American Psychological Association

and American Associations of Social Workers were polled, it was reported that only 3.5% of therapists' time was spent with elderly clients as compared to 43% with younger clients (Lust, 1978). Butler (1975b) reports that despite striking statistical indicators of need, only 2% to 5% of older Americans are on the rolls of mental health centers and public nonprofit clinics. He further indicates that no more than 2% of the time of psychiatrists in private practice is spent with elderly patients. The percentage of elderly being served by practicing psychologists appears to be similarly alarming, with clients over 65 accounting for only 2.7% of the total elderly population (Santos & VandenBos, 1982).

While the prevalence of psychological disorders seems to increase with age and individuals over 65 face an increased risk for developing mental illness (Butler & Lewis, 1982), the elderly's emotional and mental problems have been largely neglected within the mental health fields (Butler 1975b). Butler (1975b) characterizes the attitude of the psychiatric community as futile, a sense of "therapeutic nihilism" (p. 894) about aging. Ford and Sbordone (1980) suggested several factors influencing whether the elderly receive mental health care. Factors include the elderly's own motivation to seek help, their ability to pay for services, and their fear of being labeled "insane" (p. 572). Another consideration is the small number of mental health professionals trained to work with the unique concerns of older clients, which makes it difficult for those who do seek help to obtain satisfactory services. However, several studies suggest that one of

the most important factors in the lack of services is actually the attitudes of mental health professionals toward the elderly (Coe, 1967; Ford & Sbordone, 1980; Geiger, 1978; Kastenbaum, 1963). In exploring the reason why psychotherapists avoid working with the elderly, Kastenbaum (1963) postulated three major factors: (a) Fear that the therapist's own status may be affected by dealing with a low-status group; (b) the therapist's anxiety surrounding issues of personal aging and death; and (c) the therapist's value judgment that older clients are nearer death and not worth the time investment. Kastenbaum calls this pessimism about the elderly and resistance to working with older clients the "reluctant therapist" syndrome (p. 296).

Research findings indicate that students and practitioners in nursing (Campbell, 1971; Gunter, 1971; Kayser & Minnigerode, 1975), social work (Mutschler, 1971) and general medicine (Harvey, 1982; Lieff, 1982; Solomon & Vickers, 1979) show negative attitudes toward older adults. When 220 practitioners from these professions were surveyed, 80% of them preferred not to work with the elderly (Wolk & Wolk, 1971). In a study of beginning and senior medical students (Spence & Feigenbaum, 1968) results indicate that both groups clearly preferred treating younger patients. In fact, the negative attitudes of these medical students toward the elderly were of greater magnitude than their prejudices related to race and ethnicity.

Using a sentence completion approach, Cyrus-Lutz and Gaitez (1972) found psychiatrists' attitudes toward the elderly were characterized by boredom and resentment toward the physical and mental deterioration. This study indicated that as a group psychiatrists were reluctant to reveal personal attitudes about aging. The researchers speculated that psychiatrists might have difficulty relating to patients who were not economically productive. This possibility is consistent with the tendency among psychotherapists to regard therapy as palliative or custodial in individuals who are judged to be in various stages of deterioration; attitudes that may in fact become self-fulfilling prophecies (Coe, 1967).

Ford and Sbordone (1980) randomly surveyed 179 practicing psychiatrists regarding their opinions concerning four clinical vignettes. Results indicated that, when symptoms and histories were identical, psychiatrists consistently regarded elderly patients as less ideal to work with than younger ones. Despite data indicating otherwise (Straker, 1963), Ford and Sbordone's findings indicate that psychiatrists have poorer prognoses for older patients than for younger ones. Furthermore, this group of professionals was more likely to forego psychotherapy as a primary treatment modality for the elderly, in favor of somatic and chemo-therapeutic approaches. Recognizing the ramification of ageism lurking beneath professional trappings, a Group for the Advancement of Psychiatry (1971) offered the following explanations for psychiatric physicians' attitudes: (a) apprehensiveness about personal aging; (b) conflicts about the physician's

personal relationships with their parents; and (c) feelings of helplessness to help patients improve their lives. Although the majority of literature in the field seems to indicate that professionals' attitudes toward the aged are negative, there are a few studies yielding conflicting results. Campbell (1971) reports that registered nurses and licensed practical nurses as well as nurses aids who participated in her study generally exhibited positive attitudes toward the elderly. Winn, Elias, and McComb (1978) also report a ". . .realistic view of the elderly by nurses and physicians" (p. 238). They suggest that:

> There are some aspects of being old that are not very appealing, especially if one is sick. It is unrealistic that one should have a good attitude toward such a situation. This does not imply that negative attitudes toward the elderly should be or are generated [by nurses and physicians] (p. 239).

Panek (1983) conducted a study of counseling students to examine the influence of client age on assessment of clients. Data analysis indicated that participants were not significantly affected by the client's age in arriving at clinical judgments. These findings are in opposition to most other studies previously cited. Panek suggests that his results point toward two major areas for further research: (a) longitudinal studies to assess the attitudes of professionals across levels of training and experience to look for patterns; and

(b) more in-depth examinations of professionals' attitudes and their treatment of elderly individuals.

Studies with such findings are, however, the exception. Most research clearly indicates that there is attitudinal bias against older people among current and future health care professionals.

Thus, therapists' attitudes influence their willingness to treat elderly clients. This phenomenon is consistent with a recent global study to investigate the effects of patient labels and presenting problems on clinical judgments (Haller-Johnson, 1980). Results indicated that client categories assigned negative labels are treated differently than others, and in fact, are likely to receive custodial care rather than active, progressive treatment.

There is ample empirical support for the contention that therapists' values and attitudes influence the therapeutic process. Moreover, there is extensive documentation in the literature that mental health professionals hold negative attitudes toward the elderly. There is, however, a relatively smaller body of research investigating the impact of these negative attitudes on clinical judgment.

Elderly Socioeconomic Status and Clinical Judgment

Although recent literature is replete with studies of reciprocal influence of client and therapist on the therapeutic process (Atkinson & Schein, 1986), most

of the research has focused on personal variables or on characteristics such as gender or ethnicity. Haase (1964) points out the scarcity of research examining the influence of socioeconomic status (SES) as a possible variable in clinical judgments. Furthermore, most studies in this area are too dated to be of optimal value. In 1958, Hollingshead and Redlich conducted a survey of therapists and found that upper SES clients are most likely to receive intensive insight therapy, with lower SES individuals more apt to receive supportive types of therapy. While some of these discrepancies could be due to ability to pay for services, other studies conducted in outpatient clinics where finances were not a concern, came to the same conclusions. For example, it has been reported that upper SES clients are generally considered better candidates for treatment than lower SES clients (Brill & Storrow, 1960; Schaffer & Myers, 1954). Furthermore, Nash, Hoehn-Saric, Battle, Stone, Imber, and Frank (1965) found therapists' ratings of client attractiveness, ease of establishing rapport and prognosis was related to their socioeconomic status. These factors in turn, were associated with the likelihood that clients would remain in therapy.

A 1964 study of 75 psychologists (Haase, 1964) hypothesized that Rorschach protocols belonging to lower SES clients would be interpreted as reflecting poorer adjustment than those belonging to upper SES individuals. Four simulated pairs of protocols were presented to the 75 subjects, with the only

accompanying information being a social service history of each simulated client. Subjects responses indicated a bias in favor of the middle class.

Evidence of SES bias was also found by Lee (1968) in a study of psychiatric residents. Subjects were asked to read a case history of a patient which reflected a lower, middle, or upper socioeconomic status. Next, they listened to a tape recording of a simulated session between a therapist and a client. Results showed a clear tendency for psychiatric residents to rate clients they perceived as coming from lower SES backgrounds as having more severe psychopathology and poor prognoses. Routh and King (1972) sought to reexamine these findings by asking clinical psychologists and students to rate a series of paragraphs which described clients as either lower or middle SES as a function of occupational status. Again, a significant effect for SES was found. Results indicate that subjects judged simulated clients from middle SES backgrounds as more likely to need counseling. These results appear to be opposite to Lee's findings. One explanation for Routh and King's conclusions could be that therapists believe middle SES clients to be better candidates for therapy, that is they are more attractive to mental health professionals and more likely to benefit from the counseling process.

In a more recent study (Wright & Hutton, 1977), 16 counseling psychology graduate students were asked to interview an actor and actress posing as actual clients. The clients were presented as wealthy individuals to half of the subjects

and as working-class individuals to the other half. Frequent references were made to SES and accompanying problem during each interview. Results indicate that counselors more often judged clients as having similar personalities to themselves when the client was from higher socioeconomic backgrounds. Other significant correlations were found for self-reported liking of the client and for recommendations for long-term counseling. The researchers asserted that this study points to the idea that therapists employ different decision-making processes in arriving at recommendations for clients from low as opposed to high SES backgrounds.

These studies support the bias against lower SES clients among mental health professionals. There is, however, little information concerning the SES of the therapist as a variable in this bias. An exception is a study by Redlich and Kellert (1978) which suggests that there is a relationship between the SES of the mental health professional and that of the client in the process of arriving at clinical judgment. Still, findings are not definitive and further studies of interaction effects in this area are needed.

The preceding findings concerning the process of clinical judgment by mental health clinicians has direct bearing on older Americans. Kastenbaum (1963) asserts that an important factor in the under-representation of elderly among recipients of mental health services is related to perceived SES. This hypothesis suggests that professionals avoid the elderly because of a fear of contamination

by the low SES of the elderly cohort. This idea is in keeping with Redlich and Kellert (1978) conclusions that there is a relationship between therapist's status and the perceived socioeconomic/clinical status of the client.

Drummond (1980) reports that almost 15% of the elderly live in official poverty and 50% of those over 65 have a weekly income of about $75. The U.S. Senate Special Committee on Aging reports that in 1985/86, 16.7% of the elderly were below poverty level. Drummond characterizes the elderly's plight as absurd:

> The poorer you get the sicker you are, and the sicker you get the poorer you will become . . . While doctors like to make diagnoses of individual diseases, the real business of sickness among the elderly . . . . . .has to do with a synergestic interplay of forces that set up vicious cycles, eddys, and currents that eventually sweep [them] away in a massive whirlpool (p. 38).

Palmore (1969) suggests that one aspect of this complex picture is the relationship between poverty and mental illness in a group often left behind in decaying rural communities and disintegrating inner cities.

Closely related to their economic plight, is the elderly's status in relation to the rest of society (Babbie, 1980). Drummond (1980) suggests that it is characteristic of a capitalistic society to ". . .grind down the aged as useless non-producers" (p. 37). Busse (1971) asserts that, in fact, older people are only

valued in those societies where they perform useful functions. Past studies indicate a multiplicity of problems associated with retirement and exiting the workforce (Cox & Bhak, 1979; Epstein & Murray, 1967; Streibe & Schneider, 1971). Among these are the lowering of income, the loss of status, the loss of privilege and power associated with one's position in the occupational hierarchy. These changes necessitate a major reorganization of one's life. Babbie (1980) points out that older adults must go through a resocialization process where old roles are unlearned and new, often less prestigious roles replace them. Neugarten (1963) emphasized that role loss can be the catalyst for feelings of loneliness, isolation, and uselessness. Unfortunately, some factors which seem to make the elderly less attractive as prospective clients, also seem to put them at risk emotionally. . .

> emotional disturbance is most likely to surface when events adversely reshape important life circumstances with which people must contend over time. . . The impact of events, we submit, is largely channeled through problems of roles. (Pearlin & Lieberman, 1977, p. 235).

Butler (1975b) contends that the psychodynamic and medical contributions to treating the emotional and mental disturbances of the elderly seem to be overridden by the severe social and economic conditions of American's elderly.

This portion of the literature review addresses the inequities in the allocation of counseling services to the elderly. Evidence is presented that mental health

professionals are influenced by personal values and perceptions of clients based upon client age and related low SES of older people in this society. The preceding presentation supports the contention that client age is an important variable in therapist perception of clients. The following section reviews research concerning treatment options recommended by mental health professionals based upon client age for elderly individuals.

Clinical Judgments and Treatment Options for the Elderly

Research findings indicate that client age is an important variable in therapists' perceptions of client concerns. As early as 1958 researchers emphasized the role perspective client age plays in determining if that person will receive mental health services or not (Hollingshead & Redlich, 1958). Furthermore, client age also impacts upon clinical judgments and treatment options considered by helping professionals when working with older populations (Butler, 1975a). In fact, Butler continues that most elderly people who are seen in private mental health settings are there for assessment and consultation regarding institutionalization. They rarely come for psychotherapy.

Differential treatment according to client age was also noted in a study by Sue (1976) which suggests that elderly clients are victims of discriminatory

practices. By randomly reviewing 10% of all client data at 17 community mental health centers in the Seattle, Washington, area over a three year period, significant diagnostic differences were uncovered. Younger clients most often received non-psychotic labels and were assigned an individual therapist at the intake interview. Conversely, older clients tended to be assigned to paraprofessionals for group therapy at intakes and were more often diagnosed as psychotic. Ford and Sbordone's (1980) finding underscore this disparity by suggesting that client age is one of the most important determinates in treatment recommendations made by psychiatrists.

There is also research which suggests that mental health professionals regard younger clients experiencing emotional difficulties as having a better prognosis than older patients with similar disturbances (Ford & Sbordone, 1980; Ray, Raciti, & Ford, 1985). Why psychiatrists, the subjects in the two preceding studies, should regard younger individuals as having a better prognosis than older ones is unclear. Ford and Sbordone (1980) suggest that these findings are probably the result of ageism since they are not consistent with other studies which indicate that age is not a predictor of some conditions such as depression (Trainor, 1978). The researchers emphasize the need for further investigation into the influence of client age and the prognosis mental health professionals assign to clients.

Another study to investigate the relationships between client age and perceived prognosis was conducted by Karasu, Stein, & Charles (1979). In this research, psychiatric residents responded to clinical vignettes of simulated clients by rating their prognosis on a Likert-type scale. Results showed that patients described as elderly were consistently given less favorable prognoses than their younger counterparts. Ray, McKinney, & Ford (1987) also points to the preponderance of poorer prognoses for elderly clients. In their study, 407 questionnaires were mailed to practicing psychologists. One hundred ninety-two respondents ranged in age from 27 to 73. The instrument contained four clinical vignettes developed by Ford and Sbordone (1980), which presented identical cases with the exception of identified client age. Two clients were presented as below 45 years of age and two were above 65 years. Presenting symptoms included depression, mania, agoraphobia, and alcohol abuse. The researchers manipulated the client ages on alternate forms of the instrument and subjects were asked to rate client idealness and prognosis on a Likert-type scale ranging from "not well" to "very well." Treatment recommendations were also elicited. Results indicate that psychologists are inclined to view older clients as less ideal for their practices and to assign them poorer prognoses than younger clients. Their findings also corresponded with those of Ford and Sbordone (1980) in that they yielded statistically significant correlations between respondents' ratings of idealness and prognosis. Ray, McKinney, and Ford (1987) found significant

correlations for each of the four vignettes included in their study. And, while correlations cannot prove causality, these consistent findings suggest that estimates of prognosis may influence clinicians determination of client idealness.

Thus, if elderly clients have poorer prognoses, therapists may regard the elderly as less desirable for their case load. Such attitudes could directly effect virtually all aspects of mental health services including the type of treatment offered, the quality of the service provided, and the therapeutic outcome. Since early treatment is imperative for older people with emotional disturbances if they are to continue to live autonomously (Stotsky, 1972), the negative attitudes of mental health professionals can actually perpetuate a cycle leading to custodial care and passive resignation by elderly victims (Ford & Sbordone, 1980).

One of the most important yet problematic aspects of working with the elderly is differentiating between organic diagnoses and mental disorders. Perlick and Atkins (1984) suggest that the diagnosis of psychiatric problems in older people is a task fraught with complexities. Accordingly, they conducted a study to investigate possible professional bias in assessing organic versus depressive pathology. In the research, a simulated patient was described as having symptoms of depressive pseudodementia, with the patient age randomly varied among participants. Responses indicated that there was significant diagnostic bias among the subjects. Indeed, subjects most often attribute client symptoms to organic senile dementia, rather than depression, when the patient was

depicted as an older person. The results of Perlick and Atkins' study revealed the presence of three different diagnostic biases. First, a patient who is described as elderly tends to be judged as more severely organic than when the same patient is described as middle-aged. This bias is reflected in overall diagnostic impressions, in severity ratings of organic symptoms, and in over-all ratings of the level of organic impairment. The finding that diagnostically nonspecific cognitive deficit are more frequently ascribed to organic problems when the individual is perceived as old is consistent with other research which suggests that diagnostic error may operate through a tendency to attribute cognitive deficits with ambiguous etiology to organic brain disease if the patient is elderly (Post, 1975).

A second bias pointed out by Perlick and Aikins (1984) is that patients described as elderly are judged to be less severely depressed than when the same individual is described as middle aged. This judgment is made irrespective of the degree of organic impairment perceived to be present. Therefore, mental health professionals tend to view depressive symptoms as less pathological in elderly individuals than in their middle-aged counterparts. This view is consistent with Epstein's (1977) suggestion that depression is a natural or realistic response to life stresses which the elderly face.

A third bias suggested by Perlick and Atkins involves the use of psychotropic drugs. Practitioners in this study judged patients described as elderly to be poor

candidates for a drug trail of antidepressant therapy. The opposite was true for the same patient who was viewed as middle-aged. This finding is particularly striking in view of the research which indicates that the elderly as a group often have problems caused by over-medication and synergistic effects of polopharmacy (Ayd, 1973; Goodstein, 1981; Libow, 1977).

Marsden (1978) indicates that dementia is frequently the primary diagnosis of elderly individuals, accounting for one-fourth to one-third of elderly patients seen at acute-care outpatient and inpatient facilities in this country. This researcher also notes important problems with diagnostic practices in this area. In extended care psychiatric facilities, the problem is even more pronounced (Gurland, Mann, & Cross, 1979). Up to two-thirds of patients receiving such care are diagnosed as suffering from dementia. That relying on default diagnostic categories for older people is dangerous, even disastrous, is a major contention of several experts (Butler, 1975a; Goldstrom et al., 1987; Stotsky, 1972; Verwoedt, 1976). In fact, this research indicates that functional problems in the elderly may be reversed if diagnosed appropriately and treated accordingly. Unfortunately, such aggressive measures are usually the exception rather than the rule, and when professionals have disagreements over diagnostic decisions, there is some indication that the compromise category seems to be organic brain syndrome (Gurland & Cross, 1982).

Several researchers have pointed out the importance of early and accurate diagnosis and treatment for elderly patients. Straker (1963) conducted a study of 100 older clients seeing private practitioners for depressive symptoms. Findings indicated that prompt treatment of depressive reactions, even when organic cerebral deficits were present, could reverse the disease or at the very least, help many patients significantly reduce symptoms and experience marked improvement in daily functioning. Ernst, Beran, Safford, and Kleinhauz (1978) suggest that psychotherapy can and does effect improvement in some elderly individuals who have been diagnosed as having permanent mental deterioration. Since mental disturbances among elderly people is often accompanied by physical disorders, the process of diagnosis and treatment can become quite complex.

The research examined in this section of the review suggests that older clients receive poor prognoses and are less likely to be judged as good candidates for psychotherapy than are their younger counterparts. This section also attends to prevalent diagnoses and the problems with misdiagnosis where functional problems are often labeled organic. The following portion of the literature review considers the role mental health professional preparation programs play in the problems inherent to adequately serving elderly populations.

Professional Preparation

Because the needs are so critical and the plethora of problems so complex, comprehensive training should be a priority for mental health professionals planning to work with the elderly. Yet a recent statement issued by the National Academy of Sciences (Harris, 1979) emphasizes the glaring inadequacies in aging education across professional specialties including physicians, nurses, psychiatric social workers, counselors, psychologists, and paraprofessionals. The report charges that, with a few exceptions, medical instruction at all levels is plagued by serious deficits:

> At the undergraduate level there is no systematic approach to teaching about aging; at the graduate level, residency and continuing medical education programs offer few opportunities for training, aging research, and care of the elderly (p. 28).

Noting the failure of psychiatric physicians to successfully meet the needs of the growing elderly cohort, Sadavoy (1982) suggests that the problem is rooted in the fact that few psychiatrists have specialty training in geriatrics. This researcher asserts that a two-fold approach is needed to remediate the situation: (a) implement specialty programs to educate therapists, researchers, and teachers to work exclusively in the area of aging; and (b) incorporate psychiatric treatment of the elderly into the mainstream of the psychiatric profession.

The situation is no better among counseling and psychology based programs. Siegler, Gentry, and Edwards (1979) surveyed course offerings at all APA approved doctoral counselor-preparation and internship programs in clinical psychology in November, 1975. Results indicated that there was very little in the way of formal training in geropsychology. Only 1% of the programs responding offered a subspeciality in the clinical psychology of aging. Only 5% of respondents included at least two courses in their curriculum, but indicated that these courses were electives and most of those were classified as nonclinical in orientation.

Another survey was conducted by Lubin, Brady, Thomas, and Whitlock (1986) to explore the possibility that positive changes had occurred in the field of geropsychology during the eight year period since the Siegler, Gentry, and Edwards (1979) study. Results of the new survey showed only a very small increase in educational opportunities. Schools offering subspecialities in the psychology of aging had increased from 1% to 11%. Overall the percentage of schools whose curriculum included at least two courses in this area rose from 5% in 1975 to 20% in 1984. It should be noted also that 24% of respondents indicated plans to develop further course offerings in geropsychology. Perhaps this statistic is a reflection of the findings that most directors of training in clinical and counseling psychology programs believe that current educational opportunities in this area are inadequate to meet current or projected needs.

When a panel of experts appointed by the UCLA School of Medicine were asked to select topics for quality assurance activities focusing on older individuals, mental health concerns were among the areas they suggested could benefit from improved quality (Fink, Sui, Brook, Park, & Solomon, 1987). Recommendations included conducting formal evaluations of services and implementing remedial steps to improve deficiencies. Improvements in educational opportunities are an integral part of this process (Foland, 1984). Noted geropsychiatrist Waxman (1986) suggests that . . .

> the most important single step towards increased treatment for older persons with mental disorders involves increased colla boration between geriatric mental health specialist and [health care professionals] in general (p. 299).

This section of the literature review examines studies relevant to diagnoses assigned to elderly individuals and the prevalence of mental disturbances in the aged population as a group. Many of the problems related to diagnosis of and treatment recommendations for the elderly may be related to inadequacies in educational opportunities. Research suggests only minimal experiences and course work is available in professional human service preparation programs related to geropsychology and geropsychiatry.

Professional Discipline and Clinical Judgments with the Elderly

There have been numerous studies investigating various aspects of ageism among mental health professionals and the clinical ramifications of such negative views. Many of these studies simply select a single profession and investigate how members of this group approach older people. For example, Meunier and Meunier (1986) investigated the attitude of nursing home administrators, a group with major responsibility and influence in meeting the needs of some elderly people. Surprisingly, this group appeared to have a positive bias toward older people and have a better than average knowledge of the concepts of aging. Several researchers have studied nurses (Campbell, 1971; Gunter, 1971; Kayser & Minnigerode, 1975). The findings indicate that this group displays negative attitudes which may influence their judgments about older patients. In fact, in a survey of 220 practitioners which included nurses, 80% of those responding preferred not to work with the aged (Wolk & Wolk, 1971). Nonpsychiatric physicians also have been found to have negative attitudes toward the elderly, with ageism surfacing as early as the first year of medical school (Butler, 1975a; Spence & Feigenbaum, 1968). Belgrave, Lavin, Breslau, and Haug (1982) point out that negative stereotyping influences medical students decisions' about elderly patients; similar findings are documented among dental students (Geboy, 1982).

While there are many studies investigating the effects of ageism on the clinical practices of individuals in various professions, there are few studies focusing upon differences between disciplines within the mental health field and what role, if any, professional prospective may play in perpetuating the problems inherent to adequately serving the elderly. An investigation by Pirrello (1978) is, however, an exception. While numerous researchers have implicated students and professionals in the field of social work as contributors to the elderly's dilemma (Ferrer & Miller, 1979; Mutschler, 1971), Pirello's (1978) approach is somewhat different in that it compares the social work profession to the medical profession. Results show that medical doctors were more likely to diagnose organicity and infer more mental illness in elderly simulated clients than were clinical social workers, who more often recommended outpatient therapy. The most pronounced finding over all, however, was in treatment recommendations, where both physicians and social workers more frequently recommended psychotherapy for young patients than old ones. Thus while both professional discipline and client age are important factors influencing clinical judgments, client age is the more significant of the two. Of particular interest to this study are the professional perspectives of psychiatric physicians and counselors/psychologists.

Physicians

Ford and Sbordone (1980) conducted an investigation of psychiatric physicians' clinical judgments concerning older patients in comparison to younger ones. Responses to 179 questionnaires were obtained from members of the Southern Psychiatric Society in which each respondent supplied demographic information and ratings of four clinical vignettes. Findings revealed that patient age played a significant role in judging a patient as ideal for one's practice. Younger patients with agoraphobia, alcohol abuse, mania, and neurotic depression came significantly closer to an ideal rating than did older patients with the same problems. Younger patients with alcohol abuse and neurotic depression also were given significantly more favorable ratings for prognosis than their older counterparts. Treatment recommendations also were significantly different. Almost one third of the psychiatrists recommended psychotherapy without medication for the simulated 32 year old depressed patient; only 7.8% of subjects recommended this treatment for the 72 year old simulated counterpart. Although the study was not designed to probe underlying attitudes of this group, the strikingly significant correlations found between idealness and prognosis suggested to the authors that psychiatrists use prognosis as a criteria of idealness.

Karasu, Stein, and Charles (1979) conducted a study using 17 second year psychiatric residents. The purpose was to look at age as a factor in the

evaluation and treatment of psychiatric outpatients in several areas including motivation, symptomology, and prognosis. Two questionnaires aimed at eliciting judgments concerning symptom severity of patients were administered to the subjects. Results showed that therapists rated younger patients as having less severe psychopathology than older patients. Motivation for treatment, prognosis, and capacity for insight also were viewed less favorably among older patients as compared to their younger counterparts. Additionally, psychiatric physicians expressed a decided preference for treating young patients as compared to the older group. Thus, the data suggests that psychiatrists perceive older patients as sicker, but less treatable than younger patients.

In an effort to determine reactions of psychiatric students and practicing psychiatrists toward elderly patients, Cyrus-Lutz and Gaitz (1972) devised a study using a sentence completion method. A total of 175 subjects participated by completing sentence stems designed to elicit information concerning attitudes that might influence clinical judgments of psychiatry physicians in their work with the elderly. Only 37.4% of the responses were judged as positive. Negative responses accounted for 42.1% of the total and the largest proportion of subjects responded with passive and/or evasive answers (66.8%). The investigators concluded that impatience and boredom are common feelings which psychiatrists have about the elderly; it almost seems they have a type of resentment toward the mental and physical deterioration they represent.

Similar results were reported by Ray, Raciti and Ford (1985) in a study of 350 randomly selected members of the Southern California Psychiatric Society. Their responses were solicited to four clinical vignettes describing several diagnostic conditions. Results indicated that more than 50% of psychiatrists with psychoanalytic orientations and 8% of those with eclectic orientations recommended psychotherapy without medication when the patient was young. When the simulated patient was elderly, however, only 17% of the psychoanalytic physicians made the same recommendation and none of the eclectic-oriented psychiatrists made this recommendation. Sadavoy (1982) chides his colleagues for:

> rejecting the active participatory role often necessary in helping [elderly] patients cope with the frequent stress and crisis situations which they face . . . and [relying on] over utilization of medical and organic models of treatment . . . giving little value to underlying character structure and subsequent weakness and strengths of the individual (p. 32).

Sadavoy attributes much of the problem to the fact that psychiatrists often work alone and are frequently confronted by desperate families with realistic burdens associated with decompensation of their elderly loved ones. Accepting the challenge of working with such patients is often overwhelming and can also skew

the physician's perception of older people who, as a whole, have a broad range of less intense concerns and needs.

Psychologists

In an essay, psychologist Swensen (1983), is no more complimentary to his profession than is Sadavoy. He suggests that psychology's approach to working with the elderly is largely ad hoc, derived from working with younger populations, "We have scarcely begun to sketch the processes taking place in later life, much less develop a coherent means of helping older people cope with their problems" (p. 332). In fact, there are relatively few studies of attitudes and practices related to the elderly among students and professionals working in the field of psychology (Ray, McKinney, & Ford, 1987). An early investigation by Wilensky and Barmack (1966) found that most of the 165 doctoral candidates sampled in clinical psychology programs preferred to work with 19-24 year old clients. Furthermore, the older the client, the less interested subjects were in treating them. In 1978, Dye (1978) obtained similar results when surveying counseling and clinical psychologists.

Schwartz (1980) conducted a study of 122 members of the Philadelphia Society of Clinical Psychologists to determine the function of client age in clinical evaluation. Each subject was randomly assigned to receive one of two forms of

an especially designed instrument consisting of eight clinical vignettes and a rating sheet concerning the simulated client each one described. Results indicated that overall, old age was a salient factor in the subjects' ratings of clients. Significant differences were found in stated prognoses for younger and older clients with psychotherapy less likely to be recommended for the elderly.

Hine-Lynch (1987), using a modified version of Schwartz's (1980) instrument, surveyed 121 counseling students to examine the influence of therapist gender and client age on clinical judgments. Decisions about severity and prognosis of client problems and appropriate treatment options were considered. Hine-Lynch used two forms of an identical vignette where age was manipulated to reflect an older (75 years) and a younger client (25 years). No significant differences were noted, but the researcher suggests that such findings may be the result of the severity of the constructed vignettes.

Ray, McKinney, and Ford (1987), noting the preponderance of literature documenting ageism among other mental health professionals, conducted a study to explore this issue among psychologists. Their hypotheses were based largely on prior findings of psychiatrists attitudes toward the elderly as found by Ford and Sbordone (1980). They expected to find that psychologists have similar biases toward elderly individuals and tend to approach treatment of this population in much the same way as their psychiatric colleagues. Several variables were examined and while many aspects of the conclusions were

comparable, other findings were not analogous to those of Ford and Sbordone (1980). For example, Ray, McKinney, and Ford (1987) expected that younger psychologists who ostensibly had been exposed to recent, less rigid concepts of aging would approach older clients in a more positive way than older psychologists. Such was the case with those psychiatrists polled by Ford and Sbordone (1980). Findings did not bear this out, however, with older professionals regarding older clients more positively than younger psychologists.

Regarding the differences observed between psychologists and psychiatrists, the authors suggest that psychiatrists may share the psychodynamic features attributed to physicians in general: That entering medicine may actually serve as a defense against one's own fear of aging, death, and disease (Ford, 1983; Galloway, 1981). Accordingly, psychiatrists may tap into their own fears when working with older patients, while psychologists may, in contrast, gain a better understanding and appreciation of the elderly's plight. While Ray, McKinney and Ford (1987) did not conduct a statistical comparison of these two groups responses, they suggest that research into differences between psychiatrists and psychologists attitudes toward and approaches to elderly populations could prove fruitful in improving the quality and availability of mental health services for older people.

Summary

This chapter included a review of the literature relevant to this investigation. Theoretical positions and empirical finding suggest that ageistic biases exist across professional lines, extending to virtually all groups of mental health service providers. Specific studies indicate that therapists respond differently to clients based upon various aspects of the client age variable. Research findings indicate that the elderly cohort is inadequately served by mental health professionals, who generally prefer working with younger individuals. Furthermore, research also indicates that therapists render poorer prognoses for older clients and are less likely to recommend psychotherapy as a treatment of choice for this group.

This chapter also includes a review of studies which explore the difficulties and complexities involved in diagnosis and treatment of mental disturbances among the elderly. Findings suggest that differential assessment and treatment procedures are utilized by mental health practitioners based upon client age. An additional variable that has received little attention is the professional discipline of the service provider. There is limited information suggesting that therapists with medical background and training are likely to make clinical judgments concerning older patients that are even more negative than their colleagues with counseling backgrounds.

It is apparent upon review of the relevant literature that biases do exist relative to client characteristics, that in turn, influence clinical judgments. There is also a preponderance of information concerning biases toward the elderly among mental health professionals. There is, however, a need to investigate more fully the nature and the extent of such age bias among helping professionals and exactly how, if at all, educational background is related to this problem. There has been, in fact, very little research investigating the role of professional discipline in therapeutic judgments. More research is needed to examine this issue and possible interaction effects between professional discipline and client age on clinical decisions that affect the provision of mental health services for elderly individuals. The present study attempts to investigate the relationship between client age and professional discipline in arriving at crucial clinical judgments.

CHAPTER III

METHODS

The methods and procedures used for this study are presented in this chapter. The chapter is divided into the following section: (a) subjects, (b) instrumentation, (c) design, (d) procedure, and (e) summary.

Subjects

The subjects for this study were comprised of two groups of students. The first group included 40 doctoral students from counseling and clinical psychology programs from state-supported universities in the southwestern United States. Subjects were participating in pre-professional internship training programs. The second group of subjects consisted of 47 physicians involved in a psychiatric specialty program. The subjects were involved in residencies in psychiatry at state-supported university hospitals in the southwestern United States. A total of 87 volunteer respondents were recruited through their respective university or hospital program. Both males and females were included in the study (40 males and 47 females). Of Ph.D's responding, 20 were male and 20 were female. This

group ranged in age from 26 to 52 years, with a mean age of 35.2. Of M.D.'s responding, 19 were males and 27 were female. This group ranged in age from 25 to 60 years, with a mean age of 31.8. The total subjects' ages ranged from 25 to 60 years with a mean age of 33.37 years. The total number of respondents to receive the 25 year old client vignette was 41 (22 M.D.'s and 19 Ph.D.'s), with a total of 46 (25 M.D.'s and 21 Ph.D.'s) receiving the 75 year old client vignette.

Instrumentation

The Simulated Client Vignette Questionnaire (SCVQ) was developed by Schwartz (1980) and consists of three sections. Section I includes a series of eight vignettes composed of brief descriptions of simulated clients with symptoms of various DSM III disorders. Each scenario describes an initial interview of a client in a psychologist's office. There are two forms of each vignette; in each case, the descriptions are identical except for the identified client age which was manipulated to reflect an elderly individual on form A and a young individual for form B. The simulated young clients have a mean age of 32 and simulated elderly clients have a mean age of 68. The instrument is designed so that subjects receive four young and four old cases.

The second part of the instrument (Section II) consists of a series of five questions calling for clinical judgments concerning the simulated client in each vignette. Items are as follows:

1. Severity of Impairment: This section asks "How severely impaired is this client/patient?" Responses are made on a Likert-type scale where 1 equals "little impairment" and 7 equals "severe impairment."
2. Prognosis: This section asks "How favorable is the prognosis for this client/patient?" Responses are made on a seven point Likert scale. (1="likely to decline"; 7="complete recovery").
3. Interest: This section is aimed at measuring the therapist's interest in working with this client/patient. Respondents are asked to rate "How interested would you be in working with this client?" on a seven point Likert-type scale. (1="interested"; 7="not interested").
4. Appropriateness for Case Management Options: By circling the appropriate number on a seven point Likert-type scale, respondents will indicate decisions concerning case management options for this client. (1="appropriate"; 7="not appropriate"). Choices are:

   a - outpatient medical care from a physician;

   b - outpatient therapy from a community mental health center;

c - inpatient care in a hospital or other institution; and

d - outpatient supportive services from a social service agency.

5. Client Age as an Influencing Factor: On this item, therapists are asked to give information concerning factors which influenced previous responses. Respondents are asked ". . . Which specific factors in the client influenced you when answering the previous questions? List important words in the summary" (p. 4). Responses here should reflect respondents' awareness of client age as a decision-making influence.

Finally, the SCVQ includes a demographic questionnaire. This section yields information concerning respondent's age, gender, professional specialty, and experience with various age groups.

Schwartz (1980) reported test-retest reliability as assessed by Pearson-product moment correlation coefficients ranging from .12 to .99. Validity for the SCVQ was not addressed by Schwartz (1980).

The Modified SCVQ

For the purposes of this study, the SCVQ (Schwartz, 1980) was modified to include only one of the original eight case descriptions. This approach was based on procedures followed in a study by Hine-Lynch (1987) and utilized

similar instrumentation and procedures. The vignette used in this investigation dealt with depression (See Appendices A and B). Sections II and III of the instrument remained the same as Schwartz's original version with the exception of Section, II, item 4 which deals with case management options. Since the variable of interest in this study is psychotherapy, this item was revised to ask, "How appropriate is psychotherapy as a treatment option for this individual?" Participants responded on a Likert-type scale where 1 equals "very appropriate" and 7 equals "not at all appropriate." Other minor wording change were made in all three sections of the instrument to reflect language appropriate for all subjects from both medical and counseling professions. For example, the word "psychologist" in the vignette was replaced by the more generic "psychotherapist." References to "client" were replaced by the term "client/patient." Finally, the vignette used described a simulated female client/patient, since gender was not considered as a variable in this investigation. In addition, the portion of the original vignette that labeled the client/patient as "incontinent of urine at night" was omitted. This modification was made in order to avoid suggesting severe physiological problems in the simulated clients that might bias subjects' judgment of the overall clinical picture.

Reliability. Prior to her study based on a modified version of the SCVQ, Hine-Lynch (1987) conducted a pilot study to establish test-retest reliability for that portion of the instrument dealing with depression, the same portion to be

used in the current study. Test-retest reliability estimates for individual items ranged from .13 to .89.

Validity. Because validity was not addressed by Schwartz (1980), Hine-Lynch (1987) used a panel of experts in the field of aging and mental health to establish face validity for that portion of the SCVQ used in her study. Since subjects for that study included only individuals with counseling backgrounds, another panel was assembled for the current study. It included two individuals with psychology backgrounds and two with medical backgrounds. All members were required to report some professional experience with elderly individuals in order to serve on the panel. Experts were instructed to review the instrument and the study proposal and report whether the modified SCVQ appeared to measure what it proported to measure. All members agreed that the instrument was face valid.

Ethical Consideration

Subjects were volunteers and were verbally notified at the time of administration that their participation in the study is not mandatory. They were free to withdraw from the study at any point. All data were confidential and a coding procedure was used for identification purposes. Supervisors of the

subjects involved in the study were mailed an abstract of the study including possible reasons for the outcome and recommendations for future research.

Procedure

Subjects within each group were assigned one of the two SCVQ forms (A or B). Each subject received a packet containing sections I, II, and III. Written instructions were included in each packet. Packets were completed individually and in groups, with all subjects being instructed not to talk while completing the packet. All materials were administered in university conference rooms or classrooms with no time limit for completing the packet. Subjects were informed verbally that results of the study would be made available to them when the investigation was completed.

Research Design/Data Analysis

This analogue study is a 2 x 2 factorial between-subjects design. The independent variables are client age (25 years, 75 years), and subjects' professional discipline (M.D.'s, Ph.D.'s). This design was selected so that each independent variable could be examined individually as well as the interaction between the two variables. Because only one of the independent variables was

manipulated (client age) and because it was impossible to control for all possible confounding variables, this study is a quasi-experimental design. The dependent variables are clinical judgments concerning the severity of the problem, the prognosis for the illness, and the recommendation of psychotherapy as an appropriate treatment option.

The statistical analysis proposed for this study was a multivariate analysis of variance (MANOVA). Independent variables were client age (2 levels) and subjects' professional discipline (2 levels). Dependent variables were the severity of the problem (as measured by the SCVQ), the prognosis for the illness (as measured by the SCVQ), and the appropriateness of psychotherapy as a treatment option (as measured by the SCVQ). After examining the correlation matrix, it was determined that the dependent variables under consideration did not appear to form a construct, and three univariate analysis of variance (ANOVA) were conducted. The data were analyzed using the SYSTAT statistical package (SYSTAT, 1986). The confidence level for the study was placed at .05.

CHAPTER IV

RESULTS

This chapter presents the results of the investigation. The study was designed to explore the relationship among therapist's professional discipline, client age, and selected clinical judgments.

An examination of the correlation matrix reported in Table 1 indicated that no values above .30 were present. The variables, therefore, did not appear to form a multivariate construct, and univariate analysis of variance (ANOVA) was then utilized to test each hypothesis. Three univariate analyses of variance (ANOVA) were calculated to determine the relationship between each of the dependent variables; (a) severity of the client's impairment, (b) prognosis for the client's illness, (c) appropriateness of psychotherapy as a treatment option; and the independent variables of professional discipline of the therapist and the age of the client.

Reported in Table 2 are the means and standard deviations for each of the three dependent variables. The number of subjects reported in the table reflect the number of usable protocols collected from each of the groups represented in

the study. An alpha level of .05 was used to evaluate the F ratios calculated to test the hypotheses.

Table 1

Correlation Matrix for Dependent Variables

Variables	Impairment	Prognosis	Psychotherapy
Impairment	1.00		
Prognosis	.20	1.00	
Psychotherapy	.29	.19	1.00

N = 87

Table 2

Means and Standard Deviations of Therapist's Responses on Clinical Ratings[a] of Clients

	Therapist	N	Impairment		Prognosis		Psychotherapy	
			M	SD	M	SD	M	SD
Young Client	M.D.	22	4.82	.91	2.37	.58	3.09	1.38
25 Years	Ph.D.	19	4.95	.78	2.63	.76	2.26	1.33
Old Client	M.D.	25	5.32	.75	2.80	1.50	3.76	1.76
75 Years	Ph.D.	21	4.71	.78	2.91	1.00	2.43	1.36
TOTAL:								
Young Client	All Therapists	41	4.88	.84	2.49	.68	2.71	1.40
Old Client	All Therapists	46	5.04	.82	2.85	1.28	3.15	1.71

[a]Ratings were made on a Likert-type scale of 1 to 7. On the variable of impairment, 1 equals "little impairment" and 7 equals "severe impairment." On the variable of prognosis, 1 equals "complete recovery" and 7 equals "likely to decline." On the variable of psychotherapy, 1 equals "appropriate" and 7 equals "not appropriate."

Based on the assumption of independence among the dependent variables, three separate analyses were utilized to test the hypotheses in this study. The hypotheses are divided into three groups each dealing with a different dependent variable and are addressed separately in the following section.

Hypothesis One

The first hypothesis postulated that the therapist's clinical judgment concerning the severity of the client's impairment is not related to the age of the client. Severity of impairment was operationalized by the score on Section II, item 1 of the Simulated Client Vignette Questionnaire (SCVQ).

A 2X2 factorial univariate analysis of variance (ANOVA) was performed to analyze the therapist's clinical ratings of the severity of the client's impairment as a function of client age (25 years, 75 years). Table 3 provides a summary table for the ANOVA. Results indicate a statistically significant effect for the main effect of client age [$F(1/83) = 4.53$, $p = .036$]. The mean score for the client described as 75 years of age (5.04) is significantly greater than for the client described as 25 years of age (4.88). The strength of association for client age as measured by omega squared is .038, which indicates that in this population approximately 3.8% of the variance in perceptions of impairment is related to client age. The power for this analysis is approximately .63.

Table 3

ANOVA Summary Table of Therapist's Responses

Regarding the Severity of the Client's Impairment

Source	df	SS	MS	F	P
Client Age	1	2.947	2.947	4.534*	.036
Profession Discipline	1	0.170	0.170	0.262	.610
Client Age X Profession Discipline	1	2.908	2.908	4.475*	.037
Error	83	53.946	0.650		

*$p < .05$

Hypothesis Two

The study's second hypothesis was that the therapist's perception of the severity of the client's impairment is not related to the professional discipline of the therapist (M.D., Ph.D.).

Results of the 2X2 factorial analysis of variance (ANOVA) presented in Table 3 above indicated no significant ($p > .05$) differences among means. Thus, there is no evidence to suggest that therapists in this sample with medical backgrounds (M.D.'s) rate clients differently than do therapists with psychology backgrounds (Ph.D.'s). Thus, null hypothesis two was not rejected. The power for this analysis is approximately .26.

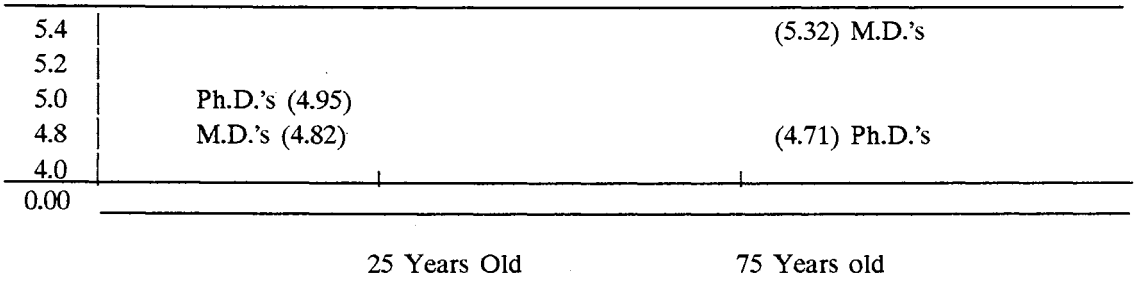
Hypothesis Three

The third hypothesis postulated that the therapist's perception of the severity of the client's impairment is not related to the interaction of client age (25 years, 75 years) and the professional discipline of the therapist (M.D., Ph.D.).

The 2X2 factorial analysis of variance (ANOVA) for the dependent variable of impairment as presented in Table 3 indicates a statistically significant interaction effect for client age and professional discipline of the therapist [$F(1/83) = 4.78$, $p = .037$]. The graph of the interaction is presented in Figure 1. For M.D.'s, the mean impairment score for the client described as 75 years of age is 5.32; and for the client described as 25 years of age, the mean is 4.82. For Ph.D.'s, the mean impairment score for the simulated 75 year old client is 4.71; and for the simulated 25 year old client is 4.95. Results of the Tukey's a for unconfounded means reveal a statistically significant difference between M.D.'s and Ph.D.'s ratings of the simulated 75 year old client. No other differences between pairs of means reached statistical significance. The strength of association for the interaction effect, as measured by omega squared is .037, which indicates that in this population, 3.7% of the variance in perceptions of impairment is related to the interaction of client age and professional discipline of the therapist. The power for this analysis is approximately .63.

Figure 1

Therapists' Perception of the Severity of Impairment



Hypothesis Four

The fourth hypothesis stated that the therapist's clinical judgment concerning the prognosis for the client's illness is not related to client age (25 years, 75 years). Prognosis is operationalized by therapists' ratings on Section II, item 2 of the SCVQ.

A 2X2 factorial univariate analysis of variance (ANOVA) was performed to test the hypothesis. Table 4 provides a summary of the ANOVA results and reveals no significant ($p > .05$) differences among means due to client age. Accordingly, null hypothesis four was not rejected. The power for this analysis is estimated to be less than .25.

Hypothesis Five

The fifth hypothesis postulated that the therapist's perception of the prognosis for the client's illness is not related to the professional discipline of the therapist (M.D., Ph.D.). The results of the 2X2 univariate analysis of variance (ANOVA), as presented in Table 4, indicate no significant ($p > .05$) differences among means due to professional discipline of the therapist. Thus, null hypothesis five was not rejected. The power of this analysis is estimated to be approximately .25.

Hypothesis Six

Hypothesis six stated that the therapist's clinical judgment concerning the prognosis for the client's illness is not related to the interaction of the therapist's professional discipline (M.D., Ph.D.) and the age of the client (25 years, 75 years). Table 4 presents the results of the 2X2 univariate analysis of variance (ANOVA) addressing the dependent variable of prognosis and indicates no significant ($p > .05$) interaction. Thus, null hypothesis six is not rejected. The power for this analysis is approximately .25.

Table 4

ANOVA Summary Table of Therapists' Responses

Regarding the Prognosis for the Client's Illness

Source	df	SS	MS	F	P
Client Age	1	2.228	2.228	2.025	0.158
Profession Discipline	1	0.732	0.732	0.665	0.417
Client Age X Profession Discipline	1	0.143	0.143	0.130	0.719
Error	83	91.321	1.100		

Hypothesis Seven

The seventh hypothesis postulated that there is no relationship between the therapist's clinical judgment concerning the recommendation of psychotherapy as an appropriate treatment option and the age of the client. The appropriateness of psychotherapy is operationalized as responses to Section II, item 4 on the SCVQ.

A 2X2 factorial univariate analysis of variance (ANOVA) was calculated to analyze the recommendation of psychotherapy as an appropriate treatment option as a function of the independent variable of client age (25 years, 75 years). Table 5 presents a summary of the result and reveals no significant ($p >$

.05) differences among means due to client age. Thus, null hypothesis seven was not rejected. The power for this analysis is approximately .25.

Table 5

ANOVA Summary Table of Therapists' Responses Regarding Psychotherapy as an Appropriate Treatment Option

Source	df	SS	MS	F	P
Client Age	1	5.239	5.239	2.373	0.127
Profession Discipline	1	6.985	6.985	3.165	0.079
Client Age X Profession Discipline	1	1.366	1.366	0.619	0.434
Error	83	183.205	2.207		

Hypothesis Eight

The eighth hypothesis stated that there is no relationship between clinical decisions to recommend psychotherapy as an appropriate treatment option and the professional discipline of the therapist (M.D., Ph.D.). Results of the 2X2 factorial univariate analysis of variance (ANOVA) for the dependent variable of psychotherapy are presented in Table 5 and reveal no significant ($p > .05$) differences among means due to the professional discipline of the therapist.

Therefore, null hypothesis eight is not rejected. The power for this analysis is approximately .25.

Hypothesis Nine

The ninth hypothesis stated that the interaction of client age (25 years, 75 years) and the professional discipline of the therapist (M.D., Ph.D.) does not influence the therapist's perception of psychotherapy as an appropriate treatment option. The findings summarized in Table 5 are the results of the 2X2 univariate analysis of variance (ANOVA) calculated to analyze the dependent variable of the recommendation of psychotherapy as a treatment option. No significant ($p > .05$) interaction effect was found. Accordingly, null hypothesis nine was not rejected. The power for this analysis is estimated to be less than .25.

Summary

This chapter presents the results of this investigation, including the statistical analyses. Results showed that client age significantly affected this sample of therapists' perceptions of the degree of impairment, with the simulated 75 year old client receiving higher impairment scores than the simulated 25 year old

client. The strength of association for client age and therapists' perception of impairment as indexed by omega squared is .038. This suggests that approximately 3.8% of the variance in perception of impairment is related to client age. No significant relationship was established between impairment and the main effect of professional discipline of the therapist (M.D., Ph.D.). Results did, however, indicate a significant interaction effect for client age (25 years, 75 years) and the professional discipline of the therapist (M.D., Ph.D.). Findings revealed statistically significant differences in the way Ph.D.'s and M.D.'s rated the simulated 75 year old client. In this sample, M.D.'s ranked the simulated 75 year old as significantly more impaired than did Ph.D.'s. The strength of association for the interaction effect and the dependent variable of impairment is .037 indicating that approximately 3.7% of the variance in the therapist's perception of impairment is related to the interaction of client age and the professional discipline of the therapist.

No statistically significant difference was found between the M.D.'s and Ph.D.'s perceptions of the prognosis for the client's illness, irrespective of the age of the client. Furthermore, no statistically significant difference was found between perceptions of the simulated 25 year old client and the simulated 75 year old, regardless of the professional discipline of the therapist. There also was no significant interaction effect of professional discipline of the therapist and age of the client on the dependent variable of prognosis.

Finally, for the recommendation of psychotherapy as an appropriate treatment option, no statistically significant differences were found between means due to the main effects of client age or the professional discipline of the therapists in this sample. Again, the interaction of client age and professional discipline of the therapists in this sample did not appear to be related to the dependent variable of the recommendation of psychotherapy as an appropriate treatment option.

CHAPTER V

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Summary

The purpose of this study was to investigate the extent of age bias among therapists with psychology and medical backgrounds, and how this might relate to professionals' decisions about the mental health of simulated age-targeted clients. Specifically, this study was designed to investigate the influence of client age and the professional discipline of the therapist on selected clinical judgments through the use of case vignettes. The clinical judgments examined included the severity of the client's impairment, the prognosis for the client's illness, and the recommendation of psychotherapy as an appropriate treatment option.

Subjects for this study included two groups of students. The first groups was comprised of 40 doctoral students from counseling and clinical psychology programs at state-supported universities in the southwestern United States. Subjects were participating in pre-professional internship programs through their respective schools. The second group of subjects consisted of 47 physicians involved in a psychiatric-specialty program. These subjects were fulfilling

residency requirements in psychiatry at state-supported universities in the southwestern United States. A total of 87 subjects participated in the study.

The Simulated Client Vignette Questionnaire (SCVQ) was self-administered, individually and in groups, in university conference rooms or classrooms. Subjects within each group were randomly assigned one of two forms (A, the simulated 25 year old client; or B, the simulated 75 year old client) of the SCVQ. All client symptoms and characteristics, with the exception of age, are the same. Limitations of the study are: a) due to the analogue nature of the study, generalizability of the findings is limited; b) only volunteer doctoral psychology and medical students were sampled, thus, the inherent differences between volunteers and randomly selected students must be recognized as a possible intervening factor in the outcome of the study; c) findings should be generalized with caution to professionals in the field, since this sample includes only students in M.D. or Ph.D. programs; d) the case vignette used in the study included only descriptions of a female with symptoms of depression and may not be generalizable to male clients or to clients with other types of problems; and e) since subjects responded to only one case vignette, findings may reflect the subject's personal biases.

After concluding that the dependent variables in this study did not form a construct, the proposed multivariate analysis of variance (MANOVA) was not appropriate. Thus, to investigate the study's nine hypotheses, three separate 2X2

univariate factorial analyses of variance (ANOVA) were conducted. The analyses examined the relationship between each of the dependent variables: a) Severity of the client's impairment, b) prognosis for the client's illness, and c) appropriateness of psychotherapy as a treatment option; and the independent variables of the professional discipline of the therapist (M.D. or Ph.D.) and the age of the client (25 years or 75 years). A significant interaction effect for client age and professional discipline of the therapists was found in the analysis for the dependent variable of severity of impairment. Furthermore, a significant main effect for client age also was found for the impairment variable, with the simulated 75 year old client being rated as significantly more impaired than the simulated 25 year old client. No other significant interaction effects or main effects were found for the dependent variables of prognosis and the recommendation of psychotherapy as an appropriate treatment option.

Conclusions

Based on the results of this study, the following conclusions are presented.

1. The results of the first 2X2 factorial univariate analysis of variance (ANOVA) indicated a statistically significant difference between therapists' perceptions of the severity of impairment for the simulated 25 year old client and the simulated 75 year old client. The mean impairment score for the

simulated 75 year old client was significantly greater than the mean impairment score for the simulated 25 year old client. However, this finding should be interpreted in light of the fact that the results also indicate a statistically significant interaction effect for client age and the professional discipline of the therapist on the dependent variable of impairment. Findings revealed that M.D.'s ranked the simulated 75 year old client as significantly more impaired than did Ph.D.'s.

These findings are consistent with earlier research (Butler, 1975b; Swartz, 1980), which suggests that elderly patients are generally judged as more impaired than their younger counterparts. The present findings also are consistent with a study by Sue (1976) who found that psychiatrists judged elderly patients as more impaired than younger patients with similar symptoms; and, in fact, were likely to assign psychotic labels to the elderly, while assigning non-psychotic labels to younger individuals. The current significant findings for M.D.'s may be explained by a phenomenon noted by several other researchers (Gurland & Cross, 1982; & Perillo, 1978) who found that when the patient is elderly, M.D.'s are likely to attribute symptoms to organic problems, rather than emotional difficulties. Perlick and Atkins (1984) found that suspected organic etiology is particularly likely when M.D.'s see elderly patients with depressive symptomology.

The findings in the current study seem to indicate that despite the trend toward a more holistic approach to over-all health care in this country (Engle,

1980), the psychiatric profession still lags behind professionals in other specialities. It seems that psychiatrists, perhaps due to the tradition of the medical model, still focus on symptomology rather than underlying, holistic frames of reference. Psychologists, on the other hand, may approach individuals with a broader, more systemic framework which allows them to conceptualize in alternate ways that are not strictly symptom focused.

2. The results of the second ANOVA calculated suggested that the therapists' clinical judgments concerning the prognosis for the clients' illness is not related to client age, the professional discipline of the therapist, or the interaction of client age and the professional discipline of the therapist. These results are not consistent with other studies (Karasu, Stein, & Charles, 1979; Ray, McKinney, & Ford, 1987) which found that clinicians routinely gave elderly patients poorer prognoses than younger individuals. In addition, studies by Ford and Sbordone (1980) and Ray, Raciti, and Ford (1975) indicate that psychiatrists in particular are likely to view elderly individuals as having poorer prognoses.

3. The results of the final ANOVA reveal therapists' clinical judgments concerning the recommendation of psychotherapy as an appropriate treatment option is not related to client age, the professional discipline of the therapist, or the interaction of client age and the professional discipline of the therapist. Again, these findings are not consistent with earlier findings (Ford & Sborne, 1980; Gurland & Cross, 1982; Swartz, 1980) which suggest that if the patient is

elderly, clinicians are likely to forego psychotherapy as a treatment modality in favor of somatic or chemotherapeutic approaches.

The non-significant results for the two previous ANOVA's will be discussed together in the following section. This approach was chosen due to the fact that the variables of prognosis and psychotherapy as an appropriate treatment option are generally considered together in the literature. Furthermore, the various interpretive comments in this section are applicable to both non-significant analyses.

An important consideration when interpreting the non-significant results of this study is the statistical power of the respective analyses. Despite a carefully designed study based on previous research (Gurland & Cross, 1982; Ray, Raciti & Ford; Schwartz, 1980), the dependent variables of impairment, prognosis, and psychotherapy as an appropriate treatment option did not form a construct in the current study. Thus, multivariate analysis of variance (MANOVA) was inappropriate for the current study; and, as a result, seven of the nine analyses had extremely low power (approximately .25). These nonsignificant findings, in reality, are inconclusive due to such low power (Cohen, 1977; Fagley, 1985). These findings may mean that there is no effect or that there is indeed a significant effect, but the current study was not sensitive enough to detect it. Thus, the research cannot answer the questions it set out to address regarding

the variables of clinical ratings of the prognosis for the client's illness and the recommendation of psychotherapy as an appropriate treatment option.

If, however, the nonsignificant results are viewed as valid, several possible explanations may account for discrepancies between these findings and previous findings. First, the current study included only students, while much of the earlier research was done by drawing subjects from the population of practicing mental health professionals (Karasu, Stein, & Chares, 1979; Ray, Raciti, & Ford, 1985; Schwartz, 1980). It is possible that clinical ratings of prognosis for the client's illness and the recommendation of psychotherapy as an appropriate treatment option may vary considerably due to actual clinical experience of the therapist. Students may judge the degree of impairment in a way that is relatively consistent with more experienced professionals, but be less certain concerning the prognosis and treatment recommendations. This explanation also could account for the discrepancy among findings for the dependent variables in the present study.

Another possible factor which may have influenced the present findings could be the current public awareness of age-related issues (Lubin, Brady, Thomas, & Whitlock, 1986). The plight of the elderly has gained more public exposure and is, in some ways, a high-profile issue in the United States (Ray, McKinney & Ford, 1987). While age-related bias has not been eliminated, there is some indication that educational and professional experience opportunities

continue to increase (Seigler, Gentry & Edwards, 1979). Given this trend, current students may have been influenced by their exposure to such information and thus could conceivably become aware of age as a variable of interest. Such a sophisticated subject pool could strongly influence research findings.

Another factor which also must be considered when interpreting these results of this study is the fact that the present investigation was carried out through the use of case vignettes which described severe depressive symptoms. The subjects in this study possibly focused on the depressive symptoms to the exclusion of age as a variable. In fact, the subjective item on the SCVQ which asks for indications of factors that may have influenced the clinical ratings of the simulated client, seems to indicate as much. Responses on section II, item 5 indicate that the followings symptoms were most often the focus; a) crying 31%; b) anxiety, 25%; and c) bothersome 21%.

On the other hand, the age extremes (25 years and 75 years) included in the current study may in part account for the inconsistency between present results and previous findings. Because the simulated client was either very young or very elderly, the age variable may have been quite obvious to subjects. And, if therapists were aware of age as a variable, such awareness could result in socially desirable ratings; that is, rating the simulated clients in ways that do not reflect age bias, even if such were present. While age was not stated as a primary

factor on most protocols, it is quite possible that age-related characteristics may have been indirectly considered when arriving at clinical decisions.

Recommendations for Research

The following recommendations for future research are based upon the results of this study.

1. Future research should consider including subjects who are current professionals in the field to determine whether differences due to professional discipline are more or less pronounced for practicing professionals as opposed to students.

2. Future research could assess the role of therapist orientation in regard to how professionals approach the elderly. Rather than professional discipline, subjects could be group by theoretical orientation.

3. Further research could assess the role of the in-class education vs. on-the-job experience in regard to professionals' approaches to elderly individuals. Questions that might serve as research focuses would be: (a) what role did course work dealing with the elderly play in how therapist work with that population? and (b) how important were practicum experiences involving elderly clients in helping individuals develop personnel approaches to working with this group?

4. Further research should include both male and female client vignettes to assess possible differences in judgments due to client gender.

5. Future research should consider altering the ages of the simulated clients so that such a wide age discrepancy is replaced with a smaller age gap. Furthermore, a middle-age variable also might be included. A control group also could be included, where subjects were given a vignette with no age specified. Such an addition could provide important information concerning the consideration of client age when arriving at various clinical decisions.

6. Future research could include other disciplines such as social work and psychiatric nursing. Such studies could provide further information concerning training variables and their role in the formulation of clinical decisions.

7. Future research could include vignettes describing other presenting problems in order to assess the effects of the nature of the problem on the various clinical decisions.

8. Future research should attempt to gain a clearer understanding of specific factors which influence various clinical judgments. This task might be accomplished by providing a check list of symptoms and variables for subjects to consider before arriving at specific decisions about the simulated client.

9. Future research could include the use of videotapes rather than written vignettes. Such an approach could create a more reality-based study.

Recommendations for Professionals

1. Professionals should continue efforts to develop a comprehensive theoretical base regarding the elderly.

2. Professionals should endeavor to establish a proactive stance in the mental health field to assist clinicians in obtaining better opportunities for actual experience with elderly clients.

3. Professionals should further examine the role of professional programs in preparing individuals to work with the elderly population through a holistic approach to meet their multiple needs.

4. Educators should develop programs which provide opportunities for future mental health professionals from both medical and psychology backgrounds to share clinical experiences in order to enhance collegial relationships and thus become more effective in meeting the needs of all clients, especially the elderly.

5. Conclusions based on the present findings must obviously be limited. Certainly, it is appropriate to suggest that more research is in order to delineate further the relationship among client age, the professional discipline of the therapist, and critical clinical judgments. If the relationship is further supported, it would be important to consider how educational experiences might be altered

in order to impact positively on the professional's approach to working with elderly individuals.

6. As the numbers of older people increase, so will the need for adequate health care, including mental health services. Accordingly, both current and future mental health professionals need to better understand the concerns and needs of the elderly. An important part of that insight, must be an understanding of one's own attitude toward growing older.

7. Comfort (1976) suggests that personal exploration is an important aspect of professional preparation for adequately meeting the needs of the elderly:

> Unless we are old already, the next old people will be us. Whether we go along with the kind of treatment meted out to those who are now old, depends upon how far society can sell us the bill of goods it sold them. No pill or regime known could transform the latter years of life as fully as could a change in our vision of age and militancy in attaining that change (p. 33).

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APPENDIXES

APPENDIX A

SIMULATED YOUNG CLIENT

VIGNETTE QUESTIONNAIRE

This questionnaire contains three sections. Section I includes a summary of a client/patient interview. Section II includes questions and spaces for you to answer them. Section III includes questions on demographics.

Section I - Client/Patient Interview

This summary describes an initial client/patient interview. In all cases the setting is the office of a psychotherapist. Please read the summary and answer all the questions found in Section II. Even if you feel you would prefer to have more information, please answer fully.

Mrs. Jones

Mrs. Jones, a 25 year old homemaker, sat throughout the interview in a slumped position. When entering and leaving the office she maintained a slouched posture and walked slowly. During the interview she responded hesitantly to most questions and spoke in a low-pitched monotone; sometimes she did not respond at all. Mrs. Jones indicated that her husband arranged today's appointment. She reported that she "putters around the house" but generally feels unable to contribute to family activities. She feels she is a bother to those around her but also indicated that she dislikes being alone. She pointed out that sometimes she feels anxious and has difficulty making decisions. In addition, she sometimes cries for no apparent reason.

PLEASE TURN PAGE TO ANSWER QUESTIONS RELATED TO SUMMARY AND TO PROVIDE DEMOGRAPHIC INFORMATION. THANK YOU.

SECTION II

Please record your answer by circling the appropriate number below each question.

1. How severely impaired is this client/patient? Circle the number on the line below which best indicates the severity of the impairment.

1	2	3	4	5	6	7
little impairment		moderate impairment		severe impairment		

2. How favorable is the prognosis for this client/patient? Circle the number on the line below which best indicates the prognosis.

1	2	3	4	5	6	7
likely to decline		no change likely		complete recovery		

3. How interested would you be in working with this client/patient? Circle the number on the line below which best indicates your level of interest.

1	2	3	4	5	6	7
interested		neutral		not interested		

4. How appropriate is psychotherapy as a treatment option for this individual?

1	2	3	4	5	6	7
Very Appropriate		Moderately Appropriate		Not at all Appropriate		

5. Which specific factors in the client/patient interview influenced you when answering the previous questions? List the most important words in the summary.

_____

SECTION III

1. Sex _____ 2. Age _____

3. Years of professional experience _____
   Semesters practicum experience _____

4. Professional Speciality (psychology, psychiatry, etc.)

   _____

5. Highest degree held and major _____

6. Below are six client/patient age groups. Place an "x" next to those groups with which you feel you are quali fied to work.

   _____ birth to 5 years _____ 21-30
   _____ 6-12 _____ 31-60
   _____ 13-20 _____ 61 and older

7. What percent of your therapy experience has been spent with each of these age groups? Please report percentages so that they add up to 100%.

   _____ birth to 5 years _____ 21-30
   _____ 6-12 _____ 31-60
   _____ 13-20 _____ 61 and older

8. How interested are you in each of these client/patient age groups? If you were able to divide your professional time as you wished, what percent of your total time would you allocate to each age group? Please report percentages so that they add up to 100%.

   _____ birth to 5 years _____ 21-30
   _____ 6-12 _____ 31-60
   _____ 13-20 _____ 61 and older

9. Including both theoretical coursework and applied training (interships, practica, etc.), what percent of your professional education focused on each of the following age groups? Please report percentages so that they add up to 100%.

   _____ birth to 5 years _____ 21-30
   _____ 6-12 _____ 31-60
   _____ 13-20 _____ 61 and older

APPENDIX B

SIMULATED OLD CLIENT

VIGNETTE QUESTIONNAIRE

This questionnaire contains three sections. Section I includes a summary of a client/patient interview. Section II includes questions and spaces for you to answer them. Section III includes questions on demographics.

Section I - Client/Patient Interview

This summary describes an initial client/patient interview. In all cases the setting is the office of a psychotherapist. Please read the summary and answer all the questions found in Section II. Even if you feel you would prefer to have more information, please answer fully.

Mrs. Jones

Mrs. Jones, a 75 year-old homemaker, sat throughout the interview in a slumped position. When entering and leaving the office she maintained a slouched posture and walked slowly. During the interview she responded hesitantly to most questions and spoke in a low-pitched monotone: sometimes she did not respond at all. Mrs. Jones indicated that her husband arranged today's appointment. She reported that she "putters around the house" but generally feels unable to contribute to family activities. She feels she is a bother to those around her but also indicated that she dislikes being alone. She pointed out that sometimes she feels anxious and has difficulty making decisions. In addition, she sometimes cries for no apparent reason.

PLEASE TURN PAGE TO ANSWER QUESTIONS RELATED TO SUMMARY AND TO PROVIDE DEMOGRAPHIC INFORMATION. THANK YOU.

SECTION II

Please record your answer by circling the appropriate number below each question.

1. How severely impaired is this client/patient? Circle the number on the line below which best indicates the severity of the impairment.

1	2	3	4	5	6	7
little impairment		moderate impairment		severe impairment		

2. How favorable is the prognosis for this client/patient? Circle the number on the line below which best indicates the prognosis.

1	2	3	4	5	6	7
likely to decline		no change likely		complete recovery		

3. How interested would you be in working with this client/patient? Circle the number on the line below which best indicates your level of interest.

1	2	3	4	5	6	7
interested		neutral		not interested		

4. How appropriate is psychotherapy as a treatment option for this individual?

1	2	3	4	5	6	7
Very Appropriate		Moderately Appropriate		Not at all Appropriate		

5. Which specific factors in the client interview influenced you when answering the previous questions? List the most important words in the summary.

_____

SECTION III

1. Sex _____ 2. Age _____

3. Years of professional experience _____
   Semesters practicum experience _____

4. Job title _____

5. Professional specialties (school psychology, marriage counseling, psychiatry, etc.).

   _____

6. Highest degree held and major _____

7. Below are six client/patient age groups. Place an "x" next to those groups with which you feel you are qualified to work.

   _____ birth to 5 years _____ 21-30
   _____ 6-12 _____ 31-60
   _____ 13-20 _____ 61 and older

8. What percent of your counseling experience has been spent with each of these age groups? Please report percentages so that they add up to 100%.

   _____ birth to 5 years _____ 21-30
   _____ 6-12 _____ 31-60
   _____ 13-20 _____ 61 and older

9. How interested are you in each of these client/patient age groups? If you were able to divide your professional time as you wished, what percent of your total time would you allocate to each age group? Please report percentages so that they add up to 100%.

   _____ birth to 5 years _____ 21-30
   _____ 6-12 _____ 31-60
   _____ 13-20 _____ 61 and older

10. Including both theoretical coursework and applied training (interships, practica, etc.), what percent of your professional education focused on each of the following age groups? Please report percentages so that they add up to 100%.

    _____ birth to 5 years _____ 21-30
    _____ 6-12 _____ 31-60
    _____ 13-20 _____ 61 and older

VITA

Karen Huggins Lashley

Candidate for the Degree of

Doctor of Philosophy

THESIS: THE INFLUENCE OF CLIENT AGE AND THE PROFESSIONAL DISCIPLINE OF THE THERAPIST ON SELECTED CLINICAL JUDGMENTS

MAJOR FIELD: Applied Behavioral Studies

BIOGRAPHICAL:

Personal Data: Born in Muskogee, Oklahoma, December 29, 1947, the daughter of Mr. and Mrs. Clarence Huggins.

Education: Graduated from Fort Gibson High School, Fort Gibson, Oklahoma in May, 1966; received Bachelor of Arts in English from Oklahoma Christian College, Oklahoma City, Oklahoma in April, 1969; received Master of Education degree from Central State University, Edmond, Oklahoma in 1971; began doctoral program at Oklahoma State University in 1984, completed requirements for the Doctor of Philosophy degree at Oklahoma State University in July, 1989.

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