INFLUENCE OF COUNSELOR GENDER AND CLIENT AGE ON SELECTED CLINICAL RATINGS OF SIMULATED VIGNETTES

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CHAPTER I

INTRODUCTION

Attitudes toward the elderly age group are often negative and prejudicial in nature and frequently originate from widespread misinformation and half-truths (Epstein, 1977). Indeed, even in the time of Aristotle, prejudice toward the elderly existed. Aristotle (Loomis, 1943) contended that cowardice, resentment, vindictiveness, and senile avarice were inherent in the aging process. Research conducted by Harris and Associates (1975) suggests that in modern times systematic prejudices toward the elderly continue to exist. Harris surveyed the attitudes of the general public toward the aged and found the elderly described as not particularly bright, alert, open minded, adaptable, nor good at getting things done.

Butler (1975b) terms this basic prejudice toward the elderly as 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).

A common form of the negative stereotyping of the elderly may be seen through a look at media commercials, which not only tout the virtues of youth, but deplore aging as a principle. Commodities are offered as "...fountains of youth for the skin, hair, glands and bowels" (Goodstein, 1981, p. 220). Although the elderly comprise 12% of the total population, only 3% of the faces that are seen on television screens belong to older people (Dychtwald, 1981). Merrill (1982) states "...to grow old in youth-centered America is to be like a racist who sees himself inexorably turning into a black" (p. 31). The negative bias of the United States society toward aging as a whole is one which places elderly members in a dilemma; aging is an inevitable part of life and too often seems to be pushed out of conscious awareness in many individuals. Persons are often faced with the double-bind of traditional expectations of respect for the elderly and urged to anticipate the golden years, yet when they reach these latter years, they often are told they are "...over the hill, fading fast, and down the drain" (Butler, 1975a, 1-2).

In the past, the ageistic stance was a viable position due to the minority of the aged in the United States population; however, the number of elderly is rapidly undergoing transition. According to the Statistical Abstract of the United States (1986), 28 million Americans,

or nearly 12% of the population, are 65 or older. These abstracts also report that this age group accounts for 29% of all hospital discharges and 33% of the country's personal health care expenditures.

There is a probability that psychotherapists fall prey to some of the ageistic attitudes that exist in the United States society. Freud (1962) had statements on work with the elderly which reflect an ageistic bias, he writes

> ...the age of patients has this importance in determining fitness for psycho-analytic treatment, that on the one hand, near or above the fifties, the elasticity of mental processes, on which the treatment depends, is as a rule lacking--older people are no longer educable--and on the other hand, the mass of material to be dealt with would prolong the duration of treatment indefinitely (p. 264).

Comfort (1976) labels professional reactions to elderly clients as gerontophobic, exhibiting an unreasonable fear of the aging process. Barron (1953) indicates that the elderly may be categorized as a group possessing all the characteristics of an oppressed minority. Nissenson (1984) relates that the elderly are underrepresented in mental health care, for less than 3% of private hospital or clinic clients are over the age of 65, and almost 70% of clinical psychologists in the country report that none of their clients are elderly.

The field of gerontological research is one which is gaining interest in the United States. Hoyer, Raskind, and

Abrahams (1984) suggest that interest in the study of the aging process and the aged individual has increased markedly in the last two decades. Between the years of 1975 and 1982, the number of studies published in psychological aging research was 747, as compared with 263 published studies between the years of 1963-1974.

Although recent decades have witnessed an increase in gerontological research, serving the needs of the elderly has not been a primary focus. Beattie (1976) states that "...for the majority of professions and services, the aged are either the least served, or are not served at all" (p. 627). This lack of services indicates an important concern and need for the counseling professional to determine whether biases exist toward the elderly, and if they do exist, to determine in what ways these biases influence client assessment.

Theoretical Foundations of Aging

A common variable shared by any definition of aging is the factor of time. Thus, Busse (1977) contends that a distinction may be made between primary and secondary aging. Primary aging refers to time-dependent biological, heredity processes that operate autonomously of trauma, stress, and disease. The process of primary aging results in a decline in the productivity of various functions of the organism, eventually predisposing him/her to increased

probability of death. Secondary aging is conceptualized as decline resulting from trauma and loss.

Generally, aging theories may be classified into four categories: biological, sociological, psychological, and social-psychological (Blackburn & Lawrence, 1986). In the biological realm, many theories have been proposed and research studies performed. One concept offered to explain the phenomenon of aging is that of the "biological clock" (Verwoedt, 1976, p. 2). In a review of biological research, Verwoedt concludes that the biological clock may operate on the system-as-a-whole, or more specifically on sub-systems, i.e., the brain or the mitochondria. The biological theories are based upon physical changes that take place on the tissue, organ, cellular, and molecular levels (Barash, 1983; Finch & Hayflick, 1977).

The second classification offered by Blackburn and Lawrence (1986) is that of sociologically-based theories. This approach focuses on the importance of environmental factors which impact the individual, including demographic influences and external norms. This category includes theories related to socialization and role theory (Bozzetti & MacMurray, 1977; Lowenthal, 1977), integration and status theory (Maddox & Wiley, 1976), minority group theory (Barron, 1953; Palmore & Wittington, 1971) and age stratification theory (Riley, Johnson, & Foner, 1972). These theories examine the relationship of the aged

individual to society and examines their role within it. The perceived social role and status of the individual in United States society may influence the counselor's perception of the aged person in the client assessment process.

The third classification offered by Blackburn and Lawrence (1986) is that of psychological theories. These theories seek to examine both personality and intellectual functioning changes that occur with age. These theories span a wide range of functions and capacities and are more difficult to quantify due to the fact that "...scholars in the subdisciplines of psychology have greater difficulty creating research designs that account for aging effects" (Blackburn & Lawrence, 1986, p. 267). A number of life span psychologists have contributed in the psychological theory realm. Neugarten (1963) writes of the development of interiority, a psychological turning-inward, which occurs as the individuals' influence over outer life decreases. Neugarten describes a concept of passive mastery in which the elderly individual learns to cope with increasingly overwhelming outside requirements. Erikson (1959) theorizes about the individual's resolution of developmental crises which occur over the life span; the important one for the elder being integrity versus despair. Erikson describes integrity as the acceptance of one's life as it was and acceptance of responsibility for it. Despair

is described as the failure to obtain these same objectives.

Another important aspect of psychological theories is concerned with age-related changes in intellectual functioning, including learning and memory (Schaie, 1983; Walsh, 1983). Some experimental evidence exists that indicates there is a general decrease in the performance of simple, as well as difficult mental operations (Palmore, 1973). Verwoedt (1976) proposes that a difficulty inherent in psychological theory research concerns differentiating between historical and aging effects.

The final classification proposed by Blackburn and Lawrence (1986) is the social-psychological category, which incorporates aspects of both the social and psychological realm in reference to aging. This approach includes response to both internal and external factors and is referred to frequently as the life-course perspective. Blackburn and Lawrence further provide the key premises of the life perspective as follows:

> a) theoretical distinctions exist between biographical time (personal experiencing of the life span) and social time (institutional norms that structure the life cycle);
> b) characteristics of the individual and his/her social environment interact and result in change over the life course;
> c) changes in the environment affect the life-course patterns of individuals or cohorts; and
> d) the collective behavior of individuals results in changes in institutional norms (p. 268).

Rosow (1978) also examines the life course perspective and the effects of environmental changes.

The current study is based upon the social-psychological theoretical framework due to the consideration of both psychological and social factors in the therapeutic interview and assessment process. External norms of behavior are expected to impact the counselor rater through creating ageistic bias in the assessment of simulated clients, ages 25 years (young) and 75 years (old). It seems likely that biases may be reflected in the assessment process through more negative ratings of the elderly individual. It also seems likely that psychological factors may influence the client assessment process through the impact of individual experiences and exposure to the aging client and related information.

Significance of the Study

Counselor attitude has been demonstrated as an important factor in the therapeutic process and the reluctance to work with elder clients has been termed the "reluctant therapist" phenomena (Kastenbaum, 1963, p. 296). Although the elderly currently comprise 25% of all health care expenditures, less than 3% are receiving mental health care services (Nissenson, 1984). The lack of provision of mental health services to the elderly appears to be complex, and may include both counselor and client

variables. A recent study conducted by Waxman, Carner, and Klein (1984) suggests that the elderly often turn to physicians, friends, and families in times of stress. Their findings suggest that the more physical and the less mental the symptoms, the greater the likelihood that the elderly individual will seek professional help. This finding may be due to the reactions of these elderly clients to ageism on the part of counselors or simply due to a lack of knowledge ragarding available mental health services.

Further research into both client and counselor characteristics appears to be warranted to examine the lack of contact of mental health professionals with the elderly group, particularly with the increasing number and proportion of the aged in the United States population and with the lengthening of the life span. The need for counseling of the elderly will continue to grow (Glass & Grant, 1983; Waters, 1984). The results of the study have the potential of providing insights into possible biases which may occur, due to both counselor and client characteristics. The awareness of bias, in turn, may diminish the influence of stereotypes on professional attitudes (Wilson and Hafferty, 1983) through the counselor obtaining a greater appreciation of strengths, weaknesses, and complexities of the elderly group.

Problem Statement

The counselor brings to the therapeutic encounter certain attitudes and beliefs derived from past associations and beliefs about clients (Coe, 1967). This study will seek to provide information about the influence of both client and counselor factors in the assessment of the elderly client by addressing the following question: Do counselor gender and client age influence counselor perceptions of severity of client problems, appropriate treatment options, and client prognosis for mental-health related difficulties?

Research Hypotheses

The following hypotheses are included in the current investigation.

1. Male counselors will rate the older simulated client as having a worse prognosis, more severe problems, and will choose psychotherapy less frequently as an appropriate option than will female counselors.

2. Counselors will rate the same simulated elder client problems as more severe than problems of the simulated younger client.

3. Counselors will rate the simulated elder client as appropriate for psychotherapy less frequently than the simulated younger client.

4. Counselors will rate simulated elder client problems as having a less favorable prognosis than the simulated younger client.

Definition of Terms

The following are definitions of terms used in this investigation:

Stereotype.This term arises from the Greek word "hardcore" (Cox, 1984, p. 15) and is defined as the most frequent combination of traits assigned by one group to another. Cox describes stereotyping as a social perception process that allows one to live in a complex world without having to deal with the wealth of details and particular characteristics of each individual.

Elderly. Those who have attained the chronological age of 65 and older will be considered elderly. This age is based upon the Medicaid program standards of old age (U. S. Bureau of the Census, 1984).

Counselor. All sample subjects included in the study were enrolled in counseling and counseling-related courses and are considered counselors for the purposes of this investigation.

Limitations

The following limitations are inherent in this study

1. Only volunteer graduate students sampled from counseling and psychology-related classes are utilized in this study. Inherent differences between volunteer and randomly selected subjects could be an intervening factor in the outcome of the study.

2. This study includes students in a university setting and is generalizable to the population directly sampled due to the non-random selection of the participants.

3. This study includes graduate students and is not generalizable to the professional counselors in the community.

4. This study includes a case simulation, which may not actually reflect the counselor's reactions and beliefs in the reality of the counseling situation.

5. The case vignette used in this study includes only a female discription and may not reflect counselor reactions toward a male client.

6. The case vignette includes symptoms of depression and may not be generalizable to other types of client problems.

Organization of the Study

The contents of this chapter were designed to serve as an introduction to the topic of this research inquiry. The Statement of the Problem, Significance of the Study,

Definition of Terms, Limitations, and Research Hypotheses were presented. A Review of the Literature is presented in Chapter II. The investigation Methodology is presented in Chapter III. Results of the investigation are presented in Chapter IV, while a Summary, Conclusions and Recommendations are presented in Chapter V.

CHAPTER II

REVIEW OF THE LITERATURE

This chapter presents a discussion of the research and literature relevant to biases of health service professionals, in general, toward the elderly. This review then examines research which specifically addresses age biases of counseling professionals. This chapter also reviews literature concerning the influence of both client and counselor demographics on assessment ratings of clients in the clinical setting.

Professional Perspectives on Aging

The first body of literature to be examined in this investigation concerns the attitudes that professionals demonstrate toward the elderly. Elderly individuals are conceptualized by Seltzer (1983) as "time travelers" (p. 122) who often become "...temporal refugees, the butt of stereotypes, the product in part of an earlier times' socialization" (p.122). Butler (1975a), a prominent gerontologist, suggests that the elderly are victims of ageism, which is reflected in:

> ...stereotypes and myths, outright disdain and dislike, or simply subtle avoidance of contact...at other times ageism serves a highly personal objective of protecting younger (usually middle-aged) individuals often at high emotional cost--from thinking about things they fear (aging, illness, death) (p. 12).

Comfort (1976), another prominent gerontologist, views ageism as negative stereotyping of the elderly so that they cease to be viewed as the same people they were when younger, or as inferior simply due to living a certain number of years. This gerontologist concludes that ageism transcends the boundaries of gender and ethnicity, and is readily apparent in housing policies, hiring practices, mandatory retirement and "...creates an inhuman limbo perpetrated by the folklore of fearful propogators" (p. 35). Epstein (1977) concludes that ageistic biases stem from the insecurity of younger people when confronted with the elderly, who symbolize powerlessness, disability, and deterioration.

Defining old age has been difficult and no clear agreement has been attained (Straker, 1963). Butler (1975a), suggests that chronological aging is an inaccurate measure and suggests that the age of 65 has been chosen for convenience in our society for determining a point for retirement. Butler further contends that it is entirely possible to be at various ages at one and the same time in terms of mental ability, bodily health, endurance, creativity, and emotions. Similarly, Dychtwald (1981)

proposes that aging is a complicated phenomena and includes many facets of the individual's life, namely chronological, emotional, intellectual, social, physical, and spiritual aging.

Other professionals support the notion of aqeism's existence in society. Coe (1967) conducted a descriptive pilot study in which data was obtained from transcripts of tape-recorded discussions held separately with a group of dentists, physicians, physical therapists, nurses, and social workers. The transcript data reveal that professionals, on the whole, "...tend to view the aged as rigid, inadaptable, and slow to respond to treatment" (Coe, 1967, p. 116) and that a practitioner may enter a therapeutic relationship with a negative set about older patients even before actually seeing a particular aged patient. Coe further concludes that "...stereotypes influence professionals' perspectives on the problems of aging and of treating the aged patient" (p. 119).

A study conducted by Spence and Feigenbaum (1968) concerning attitudes of 138 medical students toward the elderly supports the assumption that the elderly are victims of prejudice in the professional arena. The study was designed in a way that students had to make a choice, or refuse to make a choice, to save one of two patients in the same hypothetical situation in which gender, age, and race of the patients were manipulated. The results

indicated that subjects chose to save the young over the old patient and to save the black over the old white patient. The findings indicated that in a situation in which age was a factor in the decision-making process, only 5% refused to make a choice. When both gender and race were the differentiating criteria, the proportion who refused to make a choice rose to 28% and 50%, respectively. These researchers conclude that subjects have less difficulty in making decisions to save patients based upon the age variable, than based upon client gender or race. The conclusions suggest that prejudice toward the aged was even stronger than toward race.

In an article addressing prejudice against the aged, Barron (1953) proposes that the elderly group have characteristics consistent with an oppressed minority group. This investigator proposes that "...attitudes of prejudice and stereotyping as well as discriminatory behavior against the aged by younger adults is easily discernible" (p. 478). This theorist also suggests that prejudice against the aged is not uncommon; stereotypes and rationalizations for discrimination by younger adults assume the same properties as in ethnic intergroup interactions.

Therapist Attitudes Toward the Elderly Client

This portion of the review examines literature relevant to the topic of ageism as found specifically in the counseling field. Counselors may be influenced by prevalent social values and attitudes toward aging, and research investigations which address this issue are presented.

In a study of trends in United States mental health services over a 25 year period, Redlich and Kellert (1978) suggest that an unequal allocation of services have been made to young, versus elderly patients. Their study utilized data gathered from a broad range of mental health care facilities, including inpatient psychiatric institutions, private practice, psychiatric wings of general hospitals, community mental health centers, and nursing homes during the years of 1950-1975. Data were obtained through the use of questionnaires and interviews with over 900 representatives of the mental health profession, including psychiatrists, psychologists, social workers, nurses, and clergy. The findings suggest a trend toward working with younger clientele, with 60% of the population served in the community mental health centers being between the ages of 20 and 35 years. The findings for the state hospital suggest that this same age group comprise only 32% of the patient population. Similarly,

current National Institute of Mental Health (NIMH) statistics (Taube & Barrett, 1985) conclude that the state mental hospital is the most frequent treatment facility utilized for the elderly, with the over 65 age group comprising 30% of the population, as compared to 4% of the community mental health center population. These conclusions suggest that the elderly are more frequently hospitalized for mental disorders while younger clients more frequently receive outpatient mental health care in the community.

In a study of the availability of community mental health care services, Dye (1978) identified fewer than 400 professional psychologists providing services to older adults. Butler and Sulliman (1963) also conclude the existence of an unequal allocation of services with psychiatrists, on the average, devoting only 2% to 4% of their professional time in counseling the elderly. Epstein (1977) likewise reports that over half of psychiatrists do not treat aged patients, and those who are involved in their treatment spend less than 4% of their professional time with this age group. Lust (1978) concludes similarly, in a study of 454 members of the Ohio American Psychological Association and National Association of Social workers, that counselors spend a minimum of time per week (3.5%) in counseling the elderly, as opposed to younger clients (43%).

Similarly, Wilensky and Barmack (1966), conducted a study examining client preferences of 165 New York area second year clinical psychology students. The questionnaires for the study were designed to rate preferences on a likert scale format (0= most negative preference; 7= most positive preference). Results suggest that students demonstrated greater preference for working with young adults (mean rating of 5.4) than with those individuals 65 and older (mean rating of 2.0). Conclusions drawn from the study are that clinical students prefer to "...avoid direct personal contacts with older persons" (p. 411). These studies suggest that counselors provide fewer personal therapy contacts with members of the aged population. This information may be assessed in light of research findings of Gurland and Cross (1982), that 15 to 20% of the aged could benefit from mental health care.

Butler (1975b) believes that psychiatry has shown a futility and a sense of "therapeutic nihilism" (p. 894) about old age. Kastenbaum (1963) recognizes this pessimism and resistance to working with the elderly client and terms it the "reluctant therapist" (p.296) syndrome. This theorist concludes that

> ...the psychotherapist's reluctance to work with the elderly client is based largely upon attitudes and values that have been uncritically absorbed from views prevalent in our society. There is a belief that an aged person will not live long enough to pay back the therapist's investment. How long is long enough? To deny therapy to

> the aged because they do not have a long enough future would be self-deceit; either he/she is worth helping or not (p. 301).

The length of time the client lives is fast becoming a moot point. Cohen (1984) believes that therapists should realize that by the time individuals have lived to be 65 years of age, they are obviously survivors and have a remaining life span of almost 15 years for males, and almost 19 years for females. The researcher proposes that this provides more than ample time for treatment. Dychtwald (1981) relates that humans are now living well beyond the age of 70 years and have the possible capacity to live for 10, 20, or more years past their current life expectancies. This increased longevity attests to the importance of professionals examining the validity of their attitudes toward the clients in their charge.

In exploring the reasons that psychotherapists may shun the older patient, Kastenbaum (1963) proposes that the therapists' perceived status may be contaminated by serving the low-status elderly group. Redlich and Kellert (1978) suggest that there is a "...direct correlation between the status of the mental health professional and the socioeconomic and clinical status of the patient" (p. 27). The poor socioecomic status of many of the United States elderly is apparent, with those individuals over age 65 comprising 16.7% of the below poverty level, as compared to 9.6% of those individuals younger than age 65 (U. S. Senate

Special Committee on Aging, 1985-86). Palmore (1969) states that part of the explanation for the higher incidence of mental illness in the aged is likely due to the fact that many aged are left behind in disintegrating rural and central-city areas as a consequence of a lowered financial and social status.

A person's status in society is also a function of interactions with other persons occupying alternative statuses (Babbie, 1980). Merton (1957), terms this function as "role set" and defines this term as "...the compliment of role-relationships in which persons are involved by virtue of occupying a particular social status" (p. 110). Babbie (1980) proposes that the individual must, at times in life, go through a process of "adult resocialization", which he defines as "...the process wherein a change of social status requires that previously learned roles be unlearned and replaced by new ones" (p. 147). The role set must be changed and society provides little in the way of positive role set for later life. Palmore and Wittington (1971) suggest that old age has become the "roleless role" (p. 85) leaving the elder without meaningful functions in society. Busse (1971) proposes that the elder's social status has decreased in contemporary society due to the tendency for older people to be valued only in societies where their population is

scarce, where social change is slow, or where they perform useful functions.

A loss of many roles may occur, reduction in productive contributions through retirement, a loss of parental roles as children become independent, as well as reductions in other social roles, often resulting in perceptions of uselessness, hopelessness, isolation, and loneliness (Neugarten, 1963). Thompson (1973) suggests that passivity in response to the environment is realistic due to a waning influence over the environment. Thompson suggests that this loss of control may lead to a dependence on, rather than active manipulation of, the environment, which leads to a greater loss of control over external conditions. Beauvoir (1972), the French writer expresses the belief that the "...aged person is no more than a corpse under suspended sentence" (p. 217). This statement emphasizes the lack of a positive social role to which the elderly individual can aspire.

This portion of the literature review suggests that counselors provide greater allocation of services to young, as compared to elderly clients. Evidence is presented that counselors are influenced in their perception of clients based upon the age of the individual and the related low status of the elderly population seeking help. The literature review lends support for this investigation's consideration the client age variable as an important

factor in counselor perception of clients. The following segment of this review will examine treatment options recommended by counselors based upon the client age variable, particularly for the elderly individual.

Clinical Options for the Elderly

Research suggests that the client age variable is important in counselor perception of client problems. In a study of psychiatrists in the New Haven, Connecticut area, Hollingshead and Redlich (1958), conclude that, among other factors, "...age operates in the determination of who is and who is not receiving psychiatric care" (p. 201). Research suggests that the elderly are treated differentially in the prescription of treatment modalities, with psychotherapy being the least frequent option. For example, Butler (1975a) suggests that when the elderly are seen by psychiatrists in private practice, the most frequent referrals are for consultations regarding institutionalization, rather than psychotherapy. Gallagher, Sharaf, and Levinson (1965) findings suggest that 66% of psychiatric patients in a public hospital between ages of 15 and 29 years received psychotherapy, while only 15% of those between 40 and 65 years were served. Ray, Raciti, and Ford (1985), report similar results in a study of 200 randomly selected members of the

Southern California Psychiatric Society whose responses to clinical vignettes indicated that more than 50% of psychoanalytic psychiatrists and 8% of eclectic psychiatrists recommend psychotherapy without medication when the patient was young, but only 17% of the psychoanalysts and none of the eclectics recommend this type of treatment when the patient was old. Similarly, in a study of 122 volunteer members of the Philadelphia Society of Clinical Psychologists, Schwartz (1980) in a study of responses relating to clinical vignettes, that outpatient medical care, outpatient supportive services, and offering no intervention are judged more appropriate than psychotherapy for old rather than young clients. This no intervention option selection lends credence to the existence of the myth of the untreatability of the older adult (Pfeiffer, 1971).

Research conducted by Sue (1976) suggests that client age relates significantly in the diagnosis and treatment of clients. The study involved randomly selecting treatment data for 10% of all clients seen during a three year period at 17 community mental health centers in the Seattle area. Findings indicate that older clients tend to receive a diagnosis of psychosis, to be assigned to paraprofessionals at intake, and to receive group rather than individual psychotherapy. Younger clients tend to receive non-psychotic diagnoses, to be assigned to professionals at

intake, and to receive individual rather than group psychotherapy. Differential treatment was apparent in the study. Ford and Sbordone (1980) also conclude that client age is an important determinant of treatment modality. These researchers examined questionnaire responses of 179 randomly selected members of the Southeastern Psychiatric Society and concluded that 33% of the psychiatrists recommended individual psychotherapy without any medication for the younger depressed patient, but only 7.8% recommended this treatment for the older depressed patient.

In order to determine attitudes and reactions of psychiatrists and psychiatric students toward the elderly, Cyrus-Lutz and Gaitz (1972) devised a study of 175 psychiatrists in which a sentence completion procedure was utilized. Short sentence stems were used, the most relevant to the current investigation was "When I am with an old person, I___" (p. 164). Findings indicated that a large proportion (66.8%) of the responses to this item were rated as passive and/or evasive and a larger proportion of subjects responded with negative feelings (42.1%), as compared to the proportion who responded with positive feelings (37.4%). In a subjective examination of the response content, the investigators conclude that

> ...negative feelings expressed most often by psychiatrists were impatience and boredom with elderly patients and resentment of the physical and mental

> deterioration evident in so many of the aged (p. 167).

The literature cited thus far in the review emphasizes that client age is influential in the determination of mental health services provided to clients. The literature suggests that the elderly are recommended for psychotherapy less frequently than young clients. Research in this review implies that negative stereotyping of the individual based upon age may exist and concomitantly may influence the counselor's assessment on other clinical ratings. The following section of the review will examine whether differences exist in the assessment of client prognoses based upon the client age variable.

Influence of Client Age on Clinical Ratings

Research on the topic of differential clinical prognoses ratings for younger and older clients experiencing mental disturbance is lacking in the psychological literature. Some research performed in the area suggests that younger and older psychiatric clients are, indeed, assessed differentially. Ford and Sbordone (1980) suggest that elderly patients receive poorer prognoses than younger patients in the area of depression. Similar tendencies are cited in the study for mania, agorophobia, and alcohol abuse problems. These researchers summarize that "...further work in the area of prognosis of

psychiatric illness as related to age of patient is a current and pressing need" (p. 575).

Another study which addresses the question of differential prognoses for young and old clients was conducted by Ray, Raciti, and Ford (1985). Their study included responses from 179 volunteer psychiatrists to self-administered questionnaires regarding clinical vignettes in which the client age variable was manipulated. When examining the responses of psychiatrists with differing theoretical orientations, it was found that younger patients were given significantly better prognoses than older patients by both psychoanalytic and psychodynamic psychiatrists. No significant differences were demonstrated for the eclectic psychiatrist group. Schwartz (1980), in a study of 122 members of the Philadelphia Society of Clinical Psychologists, found that responses to six out of eight simulated clinical client vignettes yielded significant differences between the younger and older simulated clients on prognoses, with the older clients receiving less favorable ratings. Similarly, a study conducted by Karasu, Stein, and Charles (1979) investigated the responses of 68 patients and 17 second-year psychiatric residents in a comparison of psychiatric evaluation ratings. The investigation concludes that on a four point scale (1= least favorable, 4= most favorable) therapists rated prognosis less

favorable for older clients (2.90) than the younger group (3.10).

The importance of counselors' rating older clients with a poorer prognosis than younger ones has serious ramifications for the care of the elderly. In a study of treatment options for the elderly client, Stotsky (1972) finds that "...prognosis for aged patients who receive early treatment and are assisted in maintaining themselves in the community is much better than for those in state hospitals" (p. 121). This statement highlights the importance that elderly individuals be treated rather than only receive the custodial care that so often has been their fate (Ford & Sbordone, 1980).

The research examined in this section of the review suggests that older clients receive poorer prognosis ratings than their younger counterparts in the mental health setting. A question arises as to whether the elderly do, in fact, have mental disturbances that are not amenable to treatment, or are classified as having organic brain syndromes rather than mental disturbances. The following section will address the literature relevant to this question.

Diagnostic Perspectives on the Elderly

The elderly are a demonstrated high risk group for the development of mental disturbance (Waxman, Carner, & Klein,

1984). For example, Butler (1975b) observes that individuals over age 65 are most susceptible to mental illness. This gerontologist relates that functional disorders--notably depressions and paranoid states--increase steadily with each decade, as do organic brain diseases after age 60. National Institute of Mental Health (NIMH) statistics (Taube & Barrett, 1985) reveal that out of the 29 million elderly individuals in the United States, 15-20% are in need of psychological services and that psychiatric disorders increase with age. Research conducted by Redick and Taube (1980) indicates that 10-30% of the elderly population experience mental health problems. For example, the rate of depression is estimated at 13% of the elderly population (Gurland, Golden, & Dean, 1980) and the rate of suicide, particularly of elderly white males, is alarmingly high (Atchley, 1980).

Marsden (1978) reports that dementia is frequently the primary diagnosis of the elderly, with one-fourth to one-third of all elderly persons seen in acute-care outpatient and inpatient psychiatric facilities in the United States receiving this diagnosis, but conclude that overdiagnosis of this disorder may be a problem. Gurland, Mann, and Cross (1979) conclude that the dementia diagnosis is also frequently made in extended-care psychiatric facilities, with two-thirds of elderly receiving this

diagnosis, and in nursing homes, with one-third receiving this diagnosis.

The Marsden (1978) and Gurland, Mann and Cross (1979) research results should be interpreted in light of the finding that functional problems in the elderly are often misdiagnosed or ignored, and may be reversible if detected and treated with appropriate treatment (Butler, 1975a; Stotsky, 1972; Verwoedt, 1976). For example, a study of 74 nursing home patients conducted by Teeter, Garetz, Miller, and Heiland (1976) revealed that official records failed to identify five cases of schizophrenia, 34 cases of depression, and 13 with chronic brain syndrome. Along a similar line of inquiry, Kelleher, Copeland, Gurland, and Sharpe (1976) conducted a study of 50 patients over 65 years old who were admitted to two psychiatric hospitals. The researchers agreed with 64% of the existing official hospital diagnoses. When disagreement occured, it was usually because the hospital diagnosis was organic brain syndrome, while the researchers believed a more accurate diagnosis was schizophrenia or affective disorder.

Elderly individuals, if not treated for a functional problem, may experience organic syndromes as a result. For example, Straker (1963), studied 100 patients in private practice and found the major stressors facing the elderly are losses and depressions often occur as a reaction to these losses. This researcher contends that in some

patients a rapid crystallization of a chronic brain syndrome may occur following an environmental trauma. The findings also suggest that in other patients, an earlier depressive reaction was not recognized and treated and had rapidly progressed into an irreversible organic brain syndrome. Findings indicated that when elderly patients were diagnosed with a functional problem, it was most often a diagnosis of depression, but that prompt treatment of these depressive reactions, even in the presence of organic cerebral deficit, could reverse the syndrome or result in marked improvement in an appreciable number of patients. This research suggests that even with existing organic involvement, elder patients have the potential for improvement with treatment for depressive reactions.

Ernst, Beran, Safford, and Kleinhauz (1978) suggest that what is often diagnosed as mental deterioration may not be a permanent loss if the individual receives therapy and stimulation. Libow (1977) theorizes that one way to ensure senility is to "...misdiagnose a case of reversible cognitive disorder...The medications and the mileau experienced by patients will certainly come to fulfill that prophecy" (p. 87). One common problem in work with the elderly is that the client may be experiencing numerous physical problems in conjunction with the psychiatric problems, which may confuse the diagnostic picture (American Association of Retired People, 1985). Gurland

and Cross (1982) report that there exists a strong and consistent relationship between the presence of depression and physical illness. Certain diseases and drugs are reported to

> ...predispose the individual to depression and conversely, depression may predispose to development of medical morbidity and mortality in the short- and long-term (p. 15).

Medication abuse tends to be a common problem in the elderly population, with clients collecting and taking higher dosages than prescribed of multiple medications and for a longer duration than medically appropriate (Goodstein, 1981). Medication side-effects also are common in the elderly, with seven times the number of significant side-effects of other age groups occuring in 25% of hospitalized elderly patients (Butler, 1978). Medication effects do present a confounding variable in the diagnosis and treatment of the elderly, with a reported 20% of psychogeriatric admissions precipitated by adverse reactions to psychotropic drugs (Ayd, 1973).

The importance of differentiating between organic diagnoses and mental disorders assumes great importance for the clinician involved in the care of the elderly individual. The practice of misdiagnosing and/or ignoring of functional mental disorders could originate in the lack of formal training in geropsychology that most mental health providers have available to them. Siegler, Gentry,

and Edwards (1979) conducted a survey of all APA approved doctoral counselor-preparation and internship programs in clinical psychology in November, 1975. The survey inquired about content in clinical psychology of aging- presence of geropsychology. Results of the survey indicate that only 5% listed at least two courses in the area and only 1% of the programs responding to the survey had a formal program or subspecialty in the clinical psychology of aging.

A follow-up survey was conducted by Lubin, Brady, Thomas, and Whitlock (1986) in 1984 to determine whether the type and amount of geropsychological educational experiences available to students in APA approved doctoral programs in clinical and counseling psychology had undergone changes since the previous 1975-76 data of the Siegler, Gentry, and Edwards (1979) study. Conclusions drawn from the survey suggest a very small increase in gerontological training opportunities, with the number of schools offering a formal subspecialty in the field of aging increasing from 1% to 11% and the number of clinical courses offered increasing from 38% in 1975-76 to 54% in 1984. Lubin, Brady, Thomas, and Whitlock (1986) report that most of the Directors of Psychology Training that returned surveys do not believe that the current training in geropsychology in APA-approved programs is adequate for the need for services. The topic of gerontology has

received little emphasis in published textbooks in clinical psychology (Garfield, 1974).

In the social work discipline, though there has been an increase in the number of educational experiences available to students, the need for continued emphasis on gerontology remains (Nelson, 1983). According to Nelson's survey of graduate schools of social work in the United States, 14% offered no courses, 27% offered one course, and 39% offered three or more courses. The most common courses offered, according to the survey, were Therapeutic and Case Management Interventions (64%); Policy and Planning for the Elderly (53%); Introduction to Gerontology (42%); Death and Dying (13%); Urban Ecology and Aging (2%); and Aging and Mental Health (<1%). Nelson stresses the importance of increasing the gerontological emphasis of professional preparation programs.

This section of the review examines literature relevant to the prevalent diagnoses assigned to elderly individuals and the rate of mental disturbances found in the aged population on the whole. The tendency for counselors to misdiagnose functional problems in lieu of assuming organic diagnoses is discussed. Part of this tendency for misdiagnosis may relate to research suggesting that clinical texts and professional human service preparation programs offer minimal educational experiences in geropsychology.

Counselor Age and Clinical Ratings

This portion of the literature review examines a variable which has received little attention in the literature; the relationship of the therapist's age to that of the patient in psychiatric assessment and treatment. The interaction of individuals involved in the therapy setting is an important factor in behavior change. As Bordin (1959) proposes, "...the key to the influence of psychotherapy on the patient is in his relationship with the therapist" (p. 235). Specifically, the question the following literature will address is: Does counselor age influence clinical ratings of same age, younger, or older clients?

The process termed "age-role reversal" (p. 398) by Carkhuff, Feldman, and Truax (1964) may influence counselor perceptions in clinical settings. These researchers suggest that there is a reversal of the basic parent-child relationship where the older individual is seeking help from the younger individual and this process creates intrapersonal and interpersonal psychic conflicts. These researchers propose that age-role reversals may appear prominent, particularly in a situation where young clinicians interact with clients who are considerably older than themselves. They further theorize that younger therapists may perceive the greater age and experience of the client as threatening to their expertness in the

counseling role, in that the older client may challenge the therapist's competency. This age-role reversal process is so uncomfortable for young clinicians that it leads to their preference for working with their peers as clients, thus avoiding working with older individuals.

The influence of the counselor age variable was investigated empirically by Karasu, Stein, and Charles (1979). Their research involved obtaining clinical ratings of client problems by both the client and the therapist. The results of the study support the assumption that both client age and therapist age are important variables in clinical assessment. Therapists rated younger and same age patient's pathology and prognosis for treatment as significantly more favorable than that of older patients. In this study therapists also expressed a decided preference for treating the younger age group patients (97%), as compared with the same age group (33%). A total of 67% expressed no interest in treating the older group of patients. In terms of the relative age difference between therapist and patient, in the young (27 to 36 year-old) therapist group, the closer the age of therapist to the depressed patient, the greater the likelihood that the patient would remain in treatment. These researchers reported that 50% of younger clients, 87% of same age, and 37% of the older clients remained in treatment at a three month follow-up. The authors conclude that closer age

matching of therapist to client has an important effect on at least the longevity of the therapeutic encounter. The importance of a therapist-client match is consistent with other research findings, which suggest that greater therapeutic zeal and success is associated with a closer match of client-therapist characteristics (Rosenthal, 1955).

Another empirical study of the effect of counselor age in clinical client assessment was conducted by Ray, Raciti, and Ford (1985). This research suggests that as age of psychiatrists increase, ratings of idealness and prognosis for older clients decrease, which suggests that ageistic bias toward the older client may exist and continue into a therapist's own later years. This finding is consistent with research conducted by Ford and Sbordone (1980).

The variable of counselor age is one which has received little attention in clinical assessment and decision-making. The older counselor's perceptions and clinical ratings of clients have received little consideration in research. This portion of the review lends support to the inclusion of counselor age as a covariate in the current study. Another variable which merits investigation in the assessment of clients is the variable of counselor and client gender. Specifically, the question that arises is: Does negative stereotyping related to the gender of the counselor and/or client exist

in the therapeutic relationship? The following portion of the review will examine research related to this question.

Influence of Client/Counselor Gender on Clinical Ratings

The examination of the therapeutic relationship leads to a concern in the counseling field which relates to possible gender role bias and resultant prejudicial treatment of clients (American Psychological Association, 1975). Differing standards for the treatment of male and female clients have been highlighted by research (Broverman, Broverman, Clarkson, Rosencrantz, & Vogel, 1970; Haan & Livson, 1973). Research also suggests that counselors respond differently with clients based upon counselor-client gender pairings during the initial interviewing process (Hill, 1975).

The influence of counselor, rather than client, gender as a factor in the therapeutic interview process also has been investigated in the research. Maslin and Davis (1975) conducted a study in which the attitudes of counselor trainees toward clients were examined. The conclusions suggest that males hold more stereotypic standards of mental health for females than males. Female counselors were found in this study to possess approximately the same expectations for all mentally healthy persons, regardless of gender. These findings are consistent with those of

Laurence (1964), who conducted a study of the attitudes of undergraduate psychology students toward different combinations of gender and aged individuals. Clinical vignettes of different age and gender were rated by students as to their harshness on a questionnaire designed to tap judgments of categories of personality, insecurity, conservativism, and mental deterioration. Findings suggest that men were consistently more favorable in their ratings of other males than of females. A double standard was evidenced, in which the males were consistently harsher in their attitude judgments of women rather than men. In this study, however, women students were found to possess a single standard of evaluation for both males and females. The age, rather than the gender of the client seemed to be the important determinant in the female student raters' estimations. The findings suggest that female psychiatrists discriminate more than male psychiatrists based upon the age of the individual under assessment. This finding is consistent with other research conducted by Ray, Raciti, and Ford (1985), in which the gender influence of psychiatrists in evaluation of older and younger patients was examined.

Further research in the area of the influence of gender of counselor-raters on client assessment was conducted by Hill, Tanney, Leonard, and Reiss (1977). These researchers evaluated the attitudes of 88 subjects,

including graduate students in counseling-related fields, faculty, and staff members of a university counseling center. Responses were obtained to questionnaires regarding four videotaped clinical vignettes (two of young female, two of older female) which were produced to represent typical female client problems: feared rape, vocational-educational, and existential anxiety concerns. Subjects watched the videotapes and rated the clients using an empathy scale, counselor estimates of problem severity, ability to profit from counseling, attractiveness and number of expected sessions for problem resolution. The results indicate that female counselors perceived the younger woman's problem with existential anxiety as more serious than the older woman's. Female counselors were found more empathic and optimistic about the effects of counseling for the feared rape problem. Educational, vocational problem female counselors perceived the older woman with a social-work related problem as more serious than for the younger woman. Conclusions drawn from the findings were that counselor gender role bias was inconsistent across different problem types and no clear-cut effects were found. Suggestions were made that further research be conducted in the area of gender influence of both the counselor and the client.

This portion of the review focuses on the influence of counselor gender as it applies in the evaluation of

subjects in the therapeutic process. The conclusions from the research suggest that males tend to favor a double standard, although the results remain somewhat contradictory and further research is recommended in order to further examine this factor in professional relationships (Ray, Raciti, and Ford, 1985). The research examined in this portion of the review suggests that gender characteristics of both counselor and client may effect the therapeutic process.

Summary

Included in this chapter is a review of the literature relevant to this investigation. Examination of literature gathered from the general professional arena suggests that ageistic biases exist in professional practice. Further examination of research specifically in the counseling field suggests that counselors do respond differentially to clients based upon the client age variable. The research suggests that counselors provide unequal allocation of professional time to younger and older clients, with the older clients recommended for and receiving fewer therapeutic contacts. A preference for working with same age or younger clients is also suggested in the literature. Research also is presented which suggests that older client prognosis ratings tend to be less favorable than those of younger clients.

This chapter also includes an examination of literature relevant to the impact of counselor age in the therapeutic process. Literature in this area is sparse but does suggest that age-role reversal may occur when a young counselor is working with a considerably older client. Researchers suggest that the closer the age of the therapist and client, the greater is the likelihood that the client will remain in treatment.

This chapter concludes with an examination of the impact of counselor and/or client gender in the client assessment process. Findings suggest that differential responses exist in the treatment of male and female clients, with male counselors subscribing to a double standard in assessment. Specifically, the literature suggests that males tend to rate male clients more favorably than female clients. Research also suggests that female counselors tend to be more equitable in their clinical judgments of clients of either gender.

Finally, in light of previous research examined, the following hypothesis is included in the current investigation: Male counselors will rate the older simulated client as having a worse prognosis, more severe problems, and will choose psychotherapy less frequently as an appropriate treatment option than will female counselors. This hypothesis is formulated based upon findings that males tend to demonstrate more negative

assessment of female than male clients (Maslin & Davis, 1975; Laurence, 1964; Ray, Raciti, & Ford, 1985). Hill, Tanney, Leonard, and Reiss (1977) and Ray, Raciti, and Ford (1985) suggest that further research in this area is warranted due to the complex nature and inconsistent investigation results concerning the influence of counselor gender in the client assessment process.

Hypotheses also are examined in the current investigation that counselors will rate the simulated elder client problems as more severe, as appropriate for psychotherapy less frequently, and with a less favorable prognosis than the simulated younger client. These hypotheses are included in the study due to the preponderance of the sampling of actively practicing professional psychiatrists or psychiatric residents (Butler & Sulliman, 1963; Cyrus, Lutz, & Gaitz, 1972; Epstein, 1977; Ford & Sbordone, 1980; Hollingshead & Redlich, 1958; Ray, Raciti, & Ford, 1985), and psychologists (Dye, 1978; Schwartz, 1980), and a lack of studies focusing on graduate psychology and counseling students (Hill, Tanney, Leonard, & Reiss, 1977). It would seem important that a determination be made of whether our society is producing ageistically biased counselors who will practice in the community upon completion of their respective graduate education programs. Perhaps the awareness of possible bias

will facilitate proper interventions and diminish their effects, as suggested by Wilson and Hafferty (1983).

CHAPTER III

METHODOLOGY

Included in this chapter is a description of the subject population and the procedures which were utilized in the study. The research and statistical design of the investigation also are discussed.

Subjects

The subjects for this study consisted of graduate students in the fields of counseling and clinical psychology sampled at four universities in one southwestern state. A total of 121 volunteer masters and doctoral student respondents were recruited through sampling university counseling and psychology classes. Both males and females were included in the study (51 males, age range of 21 to 58 years; mean age= 35.4; 70 females, age range of 21 to 56 years; mean age= 24.7). The total number of respondents who received the young client vignette was 57 (males= 26, females= 31) and the old client vignette was 64 (males= 25, females= 39).

The years of professional experience reported for the subjects ranged from 0-29 years (mean= 6.94 years; median= 4 years). The semesters of practicum experience reported

by the subjects ranged from 0-8 (mean= 1.82 semesters; median= 1 semesters). The marital status of the subjects was reported as follows: Married= 59%; Never married= 25%; Divorced= 16%.

Research Design

The design utilized in this study was a two-by-two factorial between-subjects design. The influence of demographic characteristics on clinical decisions made concerning simulated clients was examined. The independent variables used included the age of the client vignette (young, 25 years; old, 75 years) and the gender of the respondent. The dependent variable construct consisted of client clinical ratings (severity of client problem, prognosis of client problem, and psychotherapy selection as the appropriate treatment option). The respondent age was covaried in the study to exercise some control over this variable due to the preponderance of younger ages in the sample.

Instrument/Vignette

Simulated Client Vignette Questionnaire (SCVQ)

The SCVQ was developed by Schwartz (1980), and was modified for the purposes of this study to include only one of the original eight case descriptions. The case

description utilized for the investigation related to depression (See Appendixes A and B). After reading the case description, respondents were asked to complete a series of questions relating to the description, as well as a personal data questionnaire. The case vignette included a brief description of the simulated client, with symptoms, observable signs such as motor and speech behavior, and the client's gender and age. The vignette description described an initial client interview in the office of a psychologist. The vignette involved a female client showing signs of depression and anxiety. Client gender was not considered as a variable in the study, with the inclusion of only a simulated female client description. There were two forms of the vignette, which were identical in all sections with the exception of the manipulated age variable, which was reversed in a mirror fashion on the alternate forms (for example, the 25 year-old Mrs. Jones on Form I becomes the 75 year-old Mrs. Jones on Form II). Both vignette descriptions clearly stated Mrs. Jones' age in the narrative. Both vignette forms were printed on white paper.

After reading Section I of the SCVQ, respondents were asked to answer the following questions relating to the client description by circling the chosen response:

Severity of impairment. Respondents were asked to

rate "How severely impaired is this client?" on a 7 point likert scale (1= "little impairment"; 7= "severe impairment").

Prognosis. Respondents were asked to rate "How favorable is the prognosis for this client?" on a 7 point likert scale (1= "likely to decline"; 7= "complete recovery").

Interest. Respondents were asked to rate "How interested would you be in working with this client?" on a 7 point likert scale (1= "interested"; 7= "not interested").

Appropriateness for case management options. Responses to proper treatment decision on the case were rated on these options by circling the number on the likert scale (1= "appropriate"; 7= "not appropriate"):

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.
d. Outpatient supportive services from a social service agency.

Client age as an influencing factor. Respondents also were asked "Which specific factors in the client

influenced you when answering the previous questions? List the most important words in the summary." This question was included to determine subject awareness of client age as a factor which influenced their decision-making.

The third and final section of the SCVQ consisted of a respondent demographic questionnaire, regarding respondents' age, gender, degree level, and involvement with various client age groups. The age and gender of the respondents were obtained from this section, and were used as covariate and independent variable data, respectively. The remaining information was used to form a description of the respondent population.

Reliability. Test-retest reliability, as related by Schwartz (1980) in a pilot study, was assessed by Pearson-product moment correlation coefficient for questions two-five in a range from .12 to .99. Because of the vagueness of the reliability information in the Schwartz (1980) study, and the difference in subject groups which was used in the present investigation, a pilot study was conducted by this investigator. The ten subjects used for the pilot study were students in doctoral level Clinical and Counseling Psychology and master's level Community Counseling programs. The SCVQ was self-administered and a one week time period elapsed between administrations of the instrument, so that the total time period of the pilot study was eight days. The

Pearson product-moment correlations for the instrument were obtained to establish test-retest reliability for the likert items to be used in this study (See Appendix C).

Validity. Validity of the SCVQ instrument was not addressed in the Schwartz (1980) study. Face validity of the SCVQ was established for the present study by having a panel of experts in the mental health and aging fields examine the SCVQ instrument to determine whether the measure appears valid for the purposes of this study. One individual who examined and supported the use of the SCVQ received a Ph.D. in Social Psychology and has specialized in the gerontology field for 18 years. This individual is a member of the Midwest Council for Social Resources on Aging. Another individual who supported the use of the instrument received a Ph.D. in Counseling Psychology and has been employed in the mental health field for 12 years. Another individual who surveyed the instrument and lended support has functioned as the director of a mental health center for the last six years and holds a Masters degree in Clinical Psychology and has fulfilled all requirements, with the exception of the dissertation, for the Ph.D. in Clinical Psychology.

Procedure

The subject pool for this study included 121 students sampled from four universities in one southwestern state

and included students from psychology and counseling-related classes. Both master's and doctoral level university students were utilized in the study. These male (N= 51) and female (N= 70) students were invited to participate in the study on a volunteer basis through the investigator's contact with university classes.

Prior to administration, the two forms of the instrument were stacked in a manner so that each individual in the room would receive either Form I (young client vignette) or Form II (old client vignette); this procedure constituted random assignment to the age level for the clinical vignette. Section I, Section II and the first six items of Section III were administered to all participants. The full Section III demographic questionnaire was then administered on a separate sheet, following the investigator's receipt of the completed sections of the instrument, to minimize the possibility of student awareness of the purpose of the study. This procedure was followed to ensure that the subjects were not influenced in their responses through awareness of the study's independent variable of client age. The SCVQ was self-administered in the group and no time limit was given for completion. The student group data was collected over a period of three weeks. The data was then compiled and the multiple analysis of covariance procedure was performed on the data utilizing the SPSSX program (SPSSX, 1983).

Ethical Considerations

The subjects involved in the investigation were volunteer subjects and were verbally notified at the time of the SCVQ administration that their participation in the study was not mandatory and they were free to withdraw from the study at any point in the process. The data was anonymous, with a coding procedure used for identification. Initial debriefing was performed immediately following the receipt of the instruments in the classes. The purpose of the study was explained, as well as research hypotheses given. Any questions the counselor-students voiced were addressed at any point in the procedure. Follow-up debriefing was performed through an abstract mailing to each professor involved in the study, including a synopsis of possible reasons for the outcome and recommendations for future research.

Data Analysis/Statistical Design

The data obtained in this investigation was analyzed through the use of multiple analysis of covariance (SPSSX, 1983). The two-way mancova procedure was used to determine whether there exists a significant difference between counselor clinical ratings of young (25 year-old) and old (75 year-old) client vignettes on the dependent construct of severity of problems, client prognosis, and psychotherapy appropriateness as a treatment option. The

influence of counselor gender also was examined as it related to these same clinical client ratings. Counselor age was covaried to control for the preponderance of younger subjects in the investigation population.

The investigation results indicated that a multivariate construct for the dependent variables (severity of problem, psychotherapy selection as appropriate treatment option, and prognosis of client) existed for the purposes of this investigation. This matrix also was examined to determine whether possible singularity or multi-collinearity was interacting to adversely effect the results of the study and it was determined that neither was present. The data was analyzed through the use of the SPSSX statistical package (SPSSX, 1983). The confidence level for the study was placed at .05, power at .80, and effect size of .20.

CHAPTER IV

RESULTS

This chapter presents the results of the investigation. A two way Multiple Analysis of Covariance statistical procedure (SPSSX, 1983) was used to analyze the data. The independent variables included counselor gender and client age (young or old). The covariate included in the investigation was counselor age. The dependent construct included clinical ratings of the client (severity of client problem, prognosis of client, and psychotherapy as a treatment option). The correlation matrix for the dependent variables (Table I), as well as the Bartlett test of Sphericity (>.02) suggest that a multivariate analysis is warranted.

Table I

Correlation Matrix for Dependent Variables

Variables	Severity	Prognosis	Psychotherapy
Severity	1.26		
Prognosis	.035	1.41	
Psychotherapy	-.033	-.30	1.33

Hypothesis 1. Male counselors will rate the older simulated client as having a worse prognosis, more severe problems, and will choose psychotherapy less frequently as an appropriate option than will female counselors.

Results of the two-way multiple analysis of covariance indicated no significant difference in clinical ratings according to the counselor gender and client age variables. A summary of means and standard deviations for counselors according to gender on the client clinical ratings of interest may be found in Table II.

Table II

Means and Standard Deviations for Counselors on Clinical Ratings of Clients

	Client Clinical Ratings					
	Severity		Psychotherapy		Prognosis	
Counselor Gender	Mean	SD	Mean	SD	Mean	SD
	Young Client (N= 57)					
Male Counselors	4.77	1.10	2.58	1.14	4.81	1.33
Female Counselors	5.06	1.24	2.39	1.58	5.09	1.60
	Old Client (N= 64)					
Male Counselors	4.44	1.04	3.00	1.66	4.73	.93
Female Counselors	4.23	1.48	2.18	1.23	4.95	1.32

Examination of the source table (Table III) indicated no significant difference between clinical ratings of clients based upon the counselor gender and client age variables (Multivariate F= 1.08, df= 3, 114, p. >.05). Counselor gender was not determined a significant variable in clinical ratings of young and old simulated clients.

Table III

Multiple Analysis of Covariance According to Counselor Gender by Client Age

Source	Univ df	Univ f	Hypo SS	Mult df	Mult F
Severity	1,116	.87	1.39	3,114	1.08
Psychotherapy	1,116	1.81	3.58	3,114	
Prognosis	1,116	.16	.28	3,114	

Hypothesis 2: Counselors will rate the same simulated elder client problems as more severe than problems of the simulated younger client.

Hypothesis 3: Counselors will rate the simulated elder client as appropriate for psychotherapy less frequently than the simulated younger client.

Hypothesis 4: Counselors will rate simulated elder client problems as having a less favorable prognosis than the simulated younger client.

The preceeding hypotheses relating to clinical ratings based upon the client age variable were addressed through the use of the two-way MANCOVA procedure. The means and standard deviations relating to the client age variable in the results are summarized in Table IV.

Table IV

Table of Means and Standard Deviations for Clinical Ratings Based Upon Client Age

	Young Client (N= 57)		Old Client (N= 64)	
Clinical Rating	Mean	SD	Mean	SD
Severity	4.93	1.18	4.22	1.37
Psychotherapy	2.47	1.39	2.50	1.46
Prognosis	4.96	1.48	4.88	1.18

Examination of the source table (Table V) indicated no significance for any of the three hypotheses relating to

the client age variable (Multivariate F= 2.24; df= 1, 116, p. >.05). Graduate student counselors did not significantly differ in their estimations of simulated clients on clinical ratings based upon the client age variable.

Table V

Multiple Analysis of Covariance According to Client Age

Source	Univ df	Univ F	Hypo SS	Mult df	Mult F
Severity	1,116	.48	10.31	3,114	2.25
Psychotherapy	1,116	.22	.44	3,114	
Prognosis	1,116	.10	.18	3,114	

Summary

Presented in the chapter were the results of this investigation, including the statistical analysis. A two-way multiple analysis of covariance was utilized for the analysis of the data. The statistical analysis resulted in failure to obtain significance for any of the four hypotheses included in the study. Specifically, the results suggested that graduate counseling and psychology

student gender was not a significant factor in clinical ratings of simulated clients. The results also suggested that counselors do not significantly differ in their clinical ratings of simulated clients based upon the client age variable.

CHAPTER V

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

Summary

The purpose of this research was to determine whether counselor gender and client age would significantly effect simulated client clinical ratings of severity of illness, psychotherapy as an appropriate treatment option, and prognosis of illness. Counselor age was covaried in order to exercise some control due to the preponderance of younger subjects in the sample population.

This study utilized data gathered from 121 students enrolled in psychology and counseling-related courses in four universities in a southwestern state during the Summer of 1986. Graduate students, both male (N=51) and female (N= 70), were sampled in the investigation. The Simulated Client Vignette Questionnaire (SCVQ) was self-administered on a group basis over a period of three weeks and students randomly received either Form I (young client) or Form II (old client) of the SCVQ. The limitations of the study were: a) volunteer graduate students were utilized and resulting data is only generalizable to volunteer graduate student subjects, b) the study included graduate students in a university setting and is generalizable to the

population directly sampled due to the non-random selection of the participants, c) the study included graduate students and is not generalizable to counselors in the community, d) the study included client simulations, which may not actually reflect the counselor reactions and subsequent clinical ratings in the actual counseling situation, e) the case vignette included only a female client description and may not reflect counselor reactions toward a male client, and f) the case vignette included symptoms of depression and may not be generalizable to other types of client problems.

The hypotheses utilized for the current study were as follows.

Hypothesis 1. Male counselors will rate the older simulated client as having a worse prognosis, more severe problems, and will choose psychotherapy less frequently as an appropriate option than will female counselors. This hypothesis was not supported by the statistical analysis.

Hypothesis 2: Counselors will rate the same simulated elder client problems as more severe than problems of the simulated younger client. This hypothesis was not supported by the statistical analysis.

Hypothesis 3: Counselors will rate the simulated elder client as appropriate for psychotherapy less frequently than the simulated younger client. This hypothesis was not supported by the statistical analysis.

Hypothesis 4: Counselors will rate simulated elder client problems as having a less favorable prognosis than the simulated younger client. This hypothesis was not supported by the statistical analysis.

The statistical analysis utilized for the research data was multiple analysis of covariance. A multivariate construct for the dependent ratings of client prognosis, severity of client problem, and psychotherapy selection as an appropriate treatment option existed. No multivariate statistical significance was demonstrated for the hypotheses tested, suggesting that no difference exists in counselor clinical ratings of severity of illness, prognosis of illness, or psychotherapy selection as appropriate treatment based upon counselor gender or client age.

Conclusions

The results of this study may be analyzed in comparison with results of prior studies in the same general area. Client age was not demonstrated a significant variable in client clinical ratings of appropriateness for psychotherapy in the current study. This finding is not consistent with prior studies in the area (Gallagher, Sharaf, & Levinson, 1965; Sue, 1976; Schwartz, 1980; Ford & Sbordone, 1980; Ray, Raciti, & Ford, 1985), which indicated that psychotherapy was judged more

appropriate for young than old clients. The findings of the current study also suggested that client age was not a significant factor in prognosis ratings, which differs from prior research conclusions (Karasu, Stein, & Charles, 1979; Schwartz, 1980; Ray, Raciti, & Ford, 1985). Possible explanation for the variance in conclusions may be that the subjects under examination in previous studies included actively practicing professionals in the community, whereas the current investigation included graduate students in counselor-preparation programs.

The recent increase of interest in the plight of the aged in U.S. society has been reflected in an increase in the number of education experiences available to graduate students in the area of gerontology (Seigler, Gentry, & Edwards, 1979; Lubin, Brady, Thomas, & Whitlock, 1986). Perhaps, on a positive note, during the process of current graduate education, some ageistic bias may be eliminated. This conclusion is supported by the findings of Hill (1975) that differences existed between experienced and inexperienced counselors in their therapeutic work with clients. The increased professional emphasis on the aged individual in society in recent years may have resulted in consciousness-raising of subjects in relation to aging issues. A related possible explanation for the difference in results of the current investigation and prior studies may be that graduate students have exposure to research

techniques and this may have resulted in a less naive subject pool, who may have become aware of aging as a variable of interest. If these students had actually become aware of the manipulated client age variable, they may have responded in the socially desirable way of not differentiating between the assessment of young and old clients.

Another difference in subject populations of past research and the current study involves professional discipline. A number of the studies sampled psychiatrists (Ford & Sbordone, 1980; Ray, Raciti, & Ford, 1985; Karasu, Stein, & Charles, 1979), who may by nature of their professional emphases, i.e., focus on medical aspects of working with the elderly, respond differently than would be expected for counselors in counselor-preparation programs.

Counselor gender was not determined a significant variable in client clinical ratings in the current study. The current investigation results differ from prior research conducted in the area (Laurence, 1964; Maslin & Davis, 1975) in which male counselors were determined harsher than female counselors in their judgments of female clients. The field of counselor gender research is complex and often yields results which are inconsistent and "...frequently contradictory and confusing due to the selection of different populations and the use of different instruments" (Tanney & Birk, 1976, p. 29). In the Laurence

(1964) and the Maslin and Davis (1975) studies, volunteer undergraduate counseling students were utilized, whereas the current study included only graduate students in psychology and counseling-related classes. A major difference of the current research and these studies was the inclusion of both client genders. Only a female client vignette was included in the current study. The inclusion of both client genders in case vignettes may provide a comparison between clients in a way that may influence clinical ratings. The complexity of the role of counselor-client gender pairings is well documented in the literature (Broverman, Broverman, Clarkson, Rosencrantz, & Vogel, 1970; Hill, Tanney, Leonard, & Reiss, 1977; Tanney & Birk, 1976) and further research in the area will be required before definitive statements may be made regarding the importance of this variable in client assessment and therapy.

Another factor which may account for the discrepancy in results from the current and prior studies may be that the current investigation involved the use of a vignette which described severe depressive symptoms. It is possible that the student-counselor responses reflected more of a counselor focus on the depressive symptomology, rather than simply the client age variable. This conclusion seems to be supported by evaluation of the subjective item of the SCVQ relating to awareness factors which influenced the

clinical ratings of the simulated clients. Responses obtained on this item suggested that a focus on depressive symptoms influenced the clinical ratings (crying, 31%; anxiety, 26%; feels like a bother, 24%). If this were the case, the instrument may have been measuring more of the consistency of the depression assessment perspective, rather than the difference between the young and old client vignettes. Perhaps it would have been more advantageous to utilize a more general client problem to circumvent this possible outcome.

Another aspect of the study should be considered in analyzing the inconsistency of results from the current research and prior research conducted in the area of counselor assessment of elder clients. The current study included an extreme age as the elder client age (75 years) and possible differences may have been masked by subjects' awareness of client age as a variable of interest. If awareness indeed existed, it would likely predispose the subject to rate according to social desirability; therefore, rating the simulated clients in a more equitable manner. However, from examination of the instrument item addressing awareness of factors which influenced the subjects in the decision-making process, it appeared that client age was not the primary factor in the clinical ratings, with only 2% of respondents reporting age as a factor which influenced the decision-making process. The

possibility exists that, although the respondents did not state awareness of the age variable, it is still likely that age-related characteristics may have intervened in the clinical ratings.

The overall results of the current investigation do not support the social-psychological framework theory offered by Blackburn and Lawrence (1986) since the impact of ageistic tendencies documented by other researchers did not appear to be present in this subject population. Perhaps our current emphasis on the plight of the aged and the increased opportunity for exposure to experience and coursework related to the aging process has influenced current society to the point that the theory should be expanded or revised. It seems apparent that further research in the influence of client age is appropriate to determine whether revisions to the theory are actually indicated.

Recommendations

Based on the non-significant findings of this study, the following recommendations are made for future research.

1. Future research should include male as well as female client vignettes due to possible differences in reactions to clients based upon client gender.

2. Future research should consider including both single and married simulated client vignettes due to

possible differences in assessment of these clients. There may have been a reaction to the female client being in a dependent role, requiring the spouse to refer for the assessment.

3. Future research should consider including client and counselor gender pairings in the client assessment process to determine whether differences exist between the reaction of male counselors to male clients, male counselors to female clients, and the converse for females.

4. Future research could possibly compare counseling graduate students with professional counselors in the community to determine whether differences exist between the two groups in the clinical ratings of clients.

5. Future research could be considered in which the older client age would not be as discrepant from the younger client; a smaller age gap may be more appropriate. It would also likely be advantageous to incorporate a manipulation check, in which students would be asked following the receipt of the instrument if they know the age of the client in the vignette. This would provide a good indication of whether awareness of the age variable existed.

6. Future research could include a middle age range client vignette due to the large discrepancy between the client ages presented. Important information was likely

lost by not including a median age variable in the current study.

7. Future research could include the disciplines of psychiatric social work and psychiatric nursing and related attitudes toward working with the elderly population. This type of research could provide valuable information on training variables in the formulation and/or alteration of attitudes toward working with the elderly individual.

8. Future research could consider the differences between the attitudes and clinical rating practices of psychiatrists, psychologists, counselors, social workers, and nurses in order to determine whether preparation program factors may have an effect on ageistic practices.

9. Future research could also examine the effects of different client problems as they relate to client assessment. Perhaps problems with varying severity could be used, i.e., low, moderate, high problem severity.

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APPENDIXES

APPENDIX A

YOUNG FORM OF SIMULATED CLIENT VIGNETTE QUESTIONNAIRE

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

Section I Client Interview

This summary describes an initial client interview. In all cases the setting is the office of psychologist. 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 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 described herself as a 25 year-old homemaker. 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. Recently she has become incontinent of urine at night.

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? 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? Circle the number on the line below which best indicate cates 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? 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 are each of the following case management options?

Circle the number on the line below which best represents your response.

a. outpatient medical care from a physician.

1	2	3	4	5	6	7
appropriate			neutral			not appropriate

b. outpatient psychotherapy from a community mental health center.

1	2	3	4	5	6	7
appropriate			neutral			not appropriate

c. inpatient care in a hospital or other institution.

1	2	3	4	5	6	7
appropriate			neutral			not appropriate

d. outpatient supportive services from a social service agency.

1	2	3	4	5	6	7
appropriate			neutral			not 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, etc)

_____

6. Highest degree held and major

_____

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

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

9. How interested are you in each of these client 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?

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

10. Including both theoretical coursework and applied training (internships, practica, etc.), what percent of your professional education focused on each of the following age groups?

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

APPENDIX B

OLD FORM OF SIMULATED CLIENT VIGNETTE QUESTIONNAIRE

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

Section I Client Interview

This summary describes an initial client interview. In all cases the setting is the office of psychologist. 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 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 described herself as a 75 year-old homemaker. 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. Recently she has become incontinent of urine at night.

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? 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? Circle the number on the line below which best indicate cates 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? 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 are each of the following case management options?

Circle the number on the line below which best represents your response.

a. outpatient medical care from a physician.

1	2	3	4	5	6	7
appropriate			neutral			not appropriate

b. outpatient psychotherapy from a community mental health center.

1	2	3	4	5	6	7
appropriate			neutral			not appropriate

c. inpatient care in a hospital or other institution.

1	2	3	4	5	6	7
appropriate			neutral			not appropriate

d. outpatient supportive services from a social service agency.

1	2	3	4	5	6	7
appropriate			neutral			not 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, etc)

_____

6. Highest degree held and major

_____

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

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

9. How interested are you in each of these client 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?

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

10. Including both theoretical coursework and applied training (internships, practica, etc.), what percent of your professional education focused on each of the following age groups?

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

APPENDIX C

PILOT STUDY TEST-RETEST RELIABILITY COEFFICIENTS

Pilot Study Test-Retest Reliability Coefficients

For The SCVQ Likert Items

Item	R Value
1. Severity of Impairment	.895
2. Prognosis	.776
3. Interest	.137
4a. Outpatient treatment, physician	.848
4b. Outpatient therapy, CMC	.856
4c. Inpatient hospital/institution	.605
4d. Outpatient/supportive services	.704
All items Pooled	.676
Items used for Dependent Variables Pooled (1, 2, and 4b)	.778

VITA

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Candidate for the Degree of

Doctor of Philosophy

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