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# The Relationship Among Counselor Demographic, Training, and Employment Variables and Self-Reported Multicultural and Gerontological Counseling Competence

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**THE RELATIONSHIP AMONG COUNSELOR DEMOGRAPHIC,  
TRAINING, AND EMPLOYMENT VARIABLES AND SELF-REPORTED  
MULTICULTURAL AND GERONTOLOGICAL COUNSELING COMPETENCE**

by

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**ABSTRACT****THE RELATIONSHIP AMONG COUNSELOR DEMOGRAPHIC,  
TRAINING, AND EMPLOYMENT VARIABLES AND SELF-REPORTED  
MULTICULTURAL AND GERONTOLOGICAL COUNSELING COMPETENCE**

Rebecca G. McBride  
Old Dominion University, 2010  
Dissertation Chair: Dr. Danica G. Hays

As the “Baby Boom” population ages, the geriatric population will grow to be the largest cohort in history. Elders are considered to be members of a diverse population and, therefore, topics related to older adulthood should be addressed within multicultural training. The purpose of this study was to understand the relationship among counselor demographic variables, training variables, employment variables, attitudes toward the geriatric population, and self-reported multicultural counseling competence. Participants consisted of graduate students in both CACREP and non-CACREP accredited counseling programs, master’s and doctoral level practitioners, and counselor educators. No statistically significant relationship was found between demographic, training, or employment variables and participants’ self-reported multicultural counseling competence. No statistically significant relationship was found between training or employment variables and participants’ attitudes regarding the geriatric population. A statistically significant relationship was found between the demographic variable of race/ethnicity and participants’ attitudes regarding the geriatric population. A statistically significant negative correlation was found between participants’ attitudes regarding the geriatric population and their self-reported multicultural counseling competence.

Implications for future research and considerations counselors, counselor trainees, and counselor educators are discussed.

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## CHAPTER ONE

### STATEMENT OF THE PROBLEM

Approximately 76 million individuals who were born between 1946 and 1964 encompass the “Baby Boom” population (Maples & Abney, 2006; U.S. Census Bureau, 1993). As this population ages, the geriatric population will grow to be the largest cohort in history. According to the U.S. 2000 Census, 35 million individuals comprised the geriatric population (U.S. Census Bureau, 2004). Within this cohort, 53% were ages 65 to 74, 35% ages 75 to 84, and 12% ages 85 and older (U.S. Census Bureau, 2004). In addition, this cohort grew to approximately 36.8 million individuals by 2008 (U.S. Census Bureau, 2010) and researchers expect this cohort to continue to grow (Van Gerpen, Johnson, & Winstead, 1999). By 2030, researchers project the geriatric population will increase to include 21% of the U.S. population or 76.4 million individuals (Van Gerpen et al.).

With the rapid increase of the geriatric population, greater attention to mental illness within the population is likely as counselors may be treating individuals of this population at higher rates. Currently, older adults face mental health disorders (e.g., anxiety, depression, substance abuse) at a similar rate as younger age cohorts (Kelley, 2003). Unfortunately, symptomology is often misdiagnosed or underdiagnosed. For example, the Centers for Disease Control and Prevention (CDC, 2008) reported that 80% of depression cases seen within the geriatric population are highly treatable, but many times depression is under-detected and, therefore, left untreated or mistreated. In fact, older males have the highest suicide rates of any age cohort (Kelley, 2003), with 45.23 suicides per every 100,000 males age 85 and older (CDC, 2008).

There are also age-specific mental health considerations: 11% of individuals over age 65 and 36% age 85 and older suffer currently from some form of dementia such as Alzheimer's Disease (Kelley, 2003). Making mental and physical health care even more complex, elders with mental health disorders often have comorbid medical disorders such as arthritis, diabetes, and cardiac disease (Kelley, 2003). Therefore, counselors need to be adequately prepared to treat clients of this population as they may have increased contact with elders with a variety of physical and mental health disorders.

In order for counselors to be better prepared to treat clients of the geriatric population, multicultural counseling needs to be addressed within counselor education programs and continuing education. It is important for counselors to increase their multicultural competence so that they may be sensitive to the unique needs of each of their clients whether those needs be on dimensions of race, ethnicity, age, disability, sexual orientation, or gender. As multicultural competency increases, counselors will be able to treat their clients in a more ethical manner.

### **Multicultural Counseling**

Multiculturalism has progressively become of interest within the counseling field due to demographic changes in the United States. For instance, in 2000, 25%-30% of the U.S. population self-identified as minorities and by the end of 2010, this population will increase to 32.7% (LaRoche & Maxie, 2003; Yali & Revenson, 2004). Sue (2003) defined multicultural counseling and therapy as:

A helping role and process that uses modalities and defines goals consistent with the life experiences and cultural values of clients, recognizes client identities to include individual, group and universal dimensions, advocates the use of universal

and culture specific strategies and roles in the healing process, and balances the importance of individualism and collectivism in the assessment, diagnosis, and treatment of client and clients systems. (p. 16)

Therefore, Sue's definition of multiculturalism includes individual, group, and universal dimensions of identity such as race, ethnicity, sexual orientation, gender, age, socioeconomic status, and disability.

In order to increase counselor trainee overall multicultural counseling competence, research indicates that various training strategies may be implemented (Boysen & Vogel, 2008; Holcomb-McCoy & Myers, 1999). For instance, training variables such as completing a class in multicultural counseling or engaging in cross-cultural experiences are well-warranted (Holcomb-McCoy & Myers, 1999; Neville et al., 1996). Boysen and Vogel (2008) measured counselor trainees' multicultural competence within three groups: counselor trainees who had never completed a multicultural counseling course, counselor trainees who were currently completing a multicultural counseling course that semester, and counselor trainees who had completed a multicultural counseling course during the previous semester. Results indicated that counselor trainees who had completed a multicultural counseling course during the previous semester had the highest multicultural competence followed by those who were currently completing a multicultural counseling course, and those who had not completed a course. Therefore, in order to increase multicultural competence, completing multicultural courses is warranted.

Holcomb-McCoy and Myers (1999) found that, overall, American Counseling Association (ACA) members who had graduated from counselor preparation programs

perceived themselves as being multiculturally competent. However, results indicated that postgraduate study or cross-cultural experiences may influence counselors' self-report of multicultural competence even more so than education (Holcomb-McCoy & Myers). These findings indicate the need for not only completion of multicultural courses but, also, additional training opportunities. Converse to the role of increased training in increased overall MCC, other research indicates that the more time employed within the counseling field, the more the mental health practitioner is likely to judge elders as being less competent. Therefore, more time within the field may be associated with decreased MCC (Danzinger & Welfel, 2000). It is important to note that the aforementioned studies pertain to overall MCC rather than competence when working with just one multicultural group.

One aspect of increased MCC is minimal prejudice and discrimination and, specific to this population, is acknowledgement and dismantling of ageism. Ageism, the belief that elders are "senile, sad, lonely, poor, sexless, ill, dependent, demented, and disabled" (McGuire, Klein, & Chen, 2008, p. 11), manifests, for example, through the use of patronizing and overaccommodated language (e.g., loud, more pronounced, simplified speech) with older individuals (Nelson, 2005) or the attitude that they become unproductive as they age (Rayle & Myers, 2003). Unfortunately, due to ageism, elders frequently face institutionalization and loss of rights and power (Nelson, 2005).

Unfortunately, educators, counselors, and other health professionals may be just as likely as the general population to hold stereotypes against the geriatric population (Ivey, Wieling, & Harris, 2000). Mental health professionals may believe that elders are rigid, ill, tired, deteriorated, and lack interest in social interaction. As a result,

professionals may deem elders as not being fit for counseling (Ivey et al., 2000). These stereotypes and biases may also cause clients who are individuals of the geriatric population to be misdiagnosed, underdiagnosed, or given a poorer prognosis when compared to young and middle aged individuals (Dearman, Waheed, Nathoo, & Baldwin, 2006; Helmes & Gee, 2003). Therefore, counselors may not be competent in working with individuals of the geriatric population.

In order to remediate biases and stereotypes of mental health professionals against the geriatric population and increase competence in working with this population, Grant (1996) suggested that counselor preparation programs (1) encourage students to assess their attitudes towards the aging population, (2) integrate additional training opportunities such as advanced skill development to better prepare students to work with clients of the geriatric population, and (3) provide a supportive environment where students can test out their new behaviors. In addition, as another option for training, it may be worthwhile for counselor educators to develop more gerontological counseling programs in order to better serve the needs of this population.

### **Counselor Preparation Programs**

Preceding the 1970's, counselor preparation programs had a main focus of educating counselor trainees to work with young, school-age children (Myers, Loesch, & Sweeney, 1991). However, since the mid 1970's counselor preparation programs began to give increased attention to the issues of adults and older adulthood. In 1975, only 6% of counselor preparation programs offered an elective course in gerontology, however, eight years later 37% of counselor preparation programs offered this course (Myers et al., 1991).



Even though programs were still placing much emphasis on gerontological counseling, this emphasis seemed to level off by the 1990's (Myers et al., 1991). For example, Myers et al. surveyed all 458 counselor preparation programs that existed at that time and found that out of 237 responding programs 102 (43%) offered a course to educate counselors on topics of adulthood and 74 (31%) offered a course specifically geared towards geriatrics, which was fewer than the number of these courses being offered in 1983. At this time, 9 responding programs (4%) offered a specialization in gerontological counseling and 35 programs (15%) indicated that they offered a focus area in gerontological counseling as a part of their community or mental health counseling programs. Also, 53% of programs indicated that gerontological counseling was infused into human growth and development courses, 41% infused these topics into lifestyle and career development, 19% in sexuality courses, 18% in substance abuse courses, 17% in social and cultural foundations, and 15% in appraisal courses (Myers et al.).

Overall, 72 programs (31%) indicated that they had gerontology centers or institutes on aging (Myers et al., 1991). In addition, 72 programs indicated that they had students in their departments who had completed a thesis or dissertation related to gerontological counseling within the previous five years, as there were 254 total theses or dissertations completed and 66 in progress. Therefore, the amount of theses and dissertations related to gerontological counseling greatly increased from 1983 where only 61 individuals completed theses or dissertations regarding gerontological counseling and 39 were in progress. In 1983, only 8.5% of departments offered practicum or internship opportunities in geriatric settings compared to 80% in 1991. Also, in 1991, 25% of programs indicated that they wanted to offer additional coursework on gerontological

counseling in the future. The programs that did not plan to do so indicated that lack of resources such as faculty (56%), other priorities (40%), lack of student interest (28%), lack of faculty interest (18%), and lack of curricular resources (10%) were the main reasons for not offering additional courses (Myers et al., 1991). Limited literature exists regarding the prevalence of these topics addressed in counseling programs. Therefore, this current study may help to provide more up to date statistics on the number of individuals exposed to gerontology courses.

Overall, elders are considered to be members of a diverse population and, therefore, topics related to older adulthood should be addressed within multicultural trainings and courses. However, even though older adults are a diverse population, in 1991 when focus on the geriatric population was at its peak, only 17% of counselor preparation programs address topics surrounding gerontology (Myers et al., 1991). Therefore, one could assume that due to the decrease in focus on this population, there also may be a decrease in the percentage of counselor preparation programs addressing gerontology. Due to this, counselor preparation programs may want to consider addressing topics regarding age such as ageism, specific mental health disorders, and elder abuse. Counselor preparation programs may do this by infusing gerontological topics into core classes, offering a separate course, or offering gerontology as a specialization (Myers, 1992). To date, there are only two Council for Accreditation of Counseling and Related Educational Programs (CACREP) accredited gerontological counseling programs in the United States (CACREP, 2009a). As a result, because specialized training is so limited, infusion of these topics within counseling programs is

at utmost importance in order for counselors to have the opportunity to increase their competence in working with this population.

Since 1977, the American Counseling Association (ACA) conducted five major research projects in order to develop models and resources for counselor trainees to better work with elders (Myers, 1992). Overall, four models were investigated: the integrated or infuse model-where content is infused into current courses, the separate course model-where a separate course is created, the area of concentration model-where several courses surrounding gerontological counseling are taught, and the interdisciplinary model-where students complete courses regarding geriatrics in other departments. The ACA ultimately chose the integrated model because the CACREP core course areas could serve as the basis for infusion. In addition, this model was thought to be the most successful in reaching students, as they would all be exposed to topics regarding geriatrics during their coursework (Myers).

Subsequent to the ACA choosing the integrated model in order to educate counseling trainees about issues in gerontological counseling, five workshops were held in order to develop, review, critique, and revise competencies for training counselors in gerontological issues (Myers, 1992). The ACA and the CACREP adopted these gerontological competencies in order to assist with the integration of gerontological topics into counseling programs (Myers, 1995). Overall, these competencies contain two areas: competencies for all counselors and competencies for counselors specializing in work with older adults (Myers, 1992). These competencies outline that gerontological counselors must have minimum competency in both areas and counselors who are not

specializing in geriatrics are expected to be at least minimally competent in the generalist area (Myers, 1995).

### **Significance of the Study**

Due to the Baby Boom population, the geriatric population will increase at a significantly high rate throughout the next couple of decades (Van Gerpen et al., 1999). With this growth there will be an increase in issues pertaining to elder's mental health such as anxiety, depression, and suicide. In return, there may be more individuals of this population seeking counseling. Therefore, counselors must be knowledgeable and comfortable working with individuals of this population. It will be imperative that mental health professionals work to diminish any stereotypes they hold against the geriatric population in order to be competent in working with this population. In addition, there is much research within the healthcare literature pertaining to physicians and nurses stereotypes and biases of the geriatric population however, there is very limited research within the counseling field pertaining to this issue.

CACREP in its 2001 standards cited that counselors need to have specialized skills and techniques that go beyond the skills and techniques used by the "generalist" counselor in order to effectively work with the geriatric population (CACREP, 2001). However, as indicated by low infusion with counseling preparation programs, many of these programs are not emphasizing the specialized skills and techniques that counselor trainees need to acquire in order to be competent in working with this population (Myers et al., 1991). In addition, the CACREP 2009 standards eliminated the program area for Gerontological Counseling further indicating a lack of interest in these issues (CACREP, 2009b).

By integrating concepts about aging and the needs of older adults into each core course required for counselor preparation, counselor trainees are able to gain knowledge, skills, and awareness regarding the geriatric population and, therefore, become more competent in working with this population (Rayle & Myers, 2003). Ultimately, counselor trainees may not realize the extent to which they are needed within the geriatric counseling field. In addition, because of ageism and stereotypes, many counselor trainees may not have any interest in gerontological counseling courses even if they were to be offered as electives. Therefore, if these counselors never complete these courses or participate in educational experiences regarding geriatrics, negative biases and stereotypes they may hold against this population may remain the same.

Due to the fact that there are currently only two CACREP accredited gerontological programs and little infusion of gerontological topics into counselor preparation program coursework (CACREP, 2009a; Myers et al., 1991), a current lack of emphasis on gerontological counseling within counselor education programs may be fueling counselor stereotypes and biases of this population. In addition, counselors may believe they are multiculturally competent and not recognize their biases and stereotypes against the geriatric population (Stuart-Hamilton & Mahoney, 2003). Therefore, programs may need to integrate activities to reduce biases and stereotypes into the program curricula and ultimately increase counselor competence.

Within the current literature, there is limited research of how demographic, training, and employment variables are associated with working with individuals of the geriatric population. Research and assessments pertaining to MCC mainly focus on issues of race/ethnicity rather than including other multicultural populations such as

sexual minorities, the elderly, and those who have disabilities. Therefore, there is little understanding of how demographic, training, and employment variables relate to age competency. As a result, it is imperative that age competency is focused upon in future research because it is such an integral part of MCC and knowledge in this area is very limited.

### **Purpose of the Study**

The purpose of this study was to understand the relationship among counselor demographic, training, and employment variables for attitudes of the geriatric population and self-reported multicultural counseling competence. Counselor demographic variables included gender, age, and race/ethnicity. Training variables included whether or not the participant is currently enrolled in or graduated from a CACREP accredited program (CACREP status), number of gerontology counseling courses completed, number of courses gerontological topics were infused into, and number of years of counselor training within a graduate program. Employment variables included proportion of geriatric clients seen, time within the counseling field, licensure obtained, and primary work setting. Attitudes of the geriatric population was measured by the Fraboni Scale of Ageism (FSA; Fraboni, Saltstone, & Hughes, 1990). Finally, self-reported multicultural counseling competence was measured by the MCKAS (Ponterotto, Gretchen, Utsey, Rieger, & Austin, 2002). Multicultural counseling competence assessment has traditionally not addressed ageism or competency with the geriatric population, hence the first research question investigated the relationship between MCC and ageism.

## Research Questions

This study was guided by the following research questions:

- Is there a significant relationship between counselor and counselor trainee self-reported multicultural counseling competency as indicated by the total score on the MCKAS (Ponterotto et al., 2002) and counselor and counselor trainee attitudes as indicated by their scores on the FSA (Fraboni et al., 1990)?
- What is the relationship between counselor and counselor trainee demographic variables and attitudes toward older adults and self-reported multicultural competence?
  - Is there a significant relationship between counselor and counselor and counselor trainee demographic variables (i.e., gender, age, race/ethnicity) and attitudes towards older adults as measured by the FSA (Fraboni et al., 1990)?
  - Is there a significant relationship between counselor and counselor trainee demographic variables (i.e., gender, age, race/ethnicity) and self-reported multicultural counseling competence as measured by the MCKAS (Ponterotto et al., 2002)?
- What is the relationship between counselor and counselor trainee training variables and attitudes toward older adults and self-reported multicultural competence?
  - Is there a significant relationship between training variables (i.e., CACREP status, number of gerontology counseling courses

completed, number of courses gerontological topics were infused into, and number of years of education pertaining to counseling) and counselor attitudes towards older adults as measured by the FSA (Fraboni et al., 1990)?

- Is there a significant relationship between training variables (i.e., CACREP status, number of gerontology counseling courses completed, number of courses gerontological topics were infused into, and number of years of education pertaining to counseling) and counselors' self-assessment of multicultural counseling competence as measured by the MCKAS (Ponterotto et al., 2002)?
- What is the relationship between counselor employment variables and attitudes toward older adults and self-reported multicultural competence?
  - Is there a relationship between counselors' employment variables (i.e., proportion of geriatric clients seen, time within the counseling field, licensure obtained, and primary work setting) and counselors' attitudes towards older adults as measured by the FSA (Fraboni et al., 1990)?
  - Is there a significant relationship between counselors' employment variables (i.e., proportion of geriatric clients seen, time within the counseling field, licensure obtained, and primary work setting) and counselors' self-assessment of multicultural counseling competence as measured by the MCKAS (Ponterotto et al., 2002)?



### **Assumptions of the Study**

There were multiple assumptions when designing this study. This researcher believed that results would indicate a negative relationship between participants total score on the MCKAS and their score on the FSA as the lower the score on the MCKAS (indicating lower MCC) the higher the score on the FSA (indicating ageist beliefs). This researcher believed that participants from diverse racial populations would report fewer stereotypes and biases towards the geriatric population and higher levels of self-reported multicultural competence. In addition, this researcher believed that participants who are women would report fewer negative attitudes towards the geriatric population as females are typically “caretakers” within Western society and within the literature, increased contact with the geriatric population leads to fewer negative attitudes. This researcher believed that the relationship between age and attitudes towards the geriatric population would be curvilinear as younger and older participants report the most negative attitudes towards the geriatric population.

This researcher also believed that participants from CACREP accredited programs would rate themselves as being more multiculturally competent than participants from non-CACREP accredited programs. This researcher believed this because multicultural training is a core requirement of the 2009 CACREP standards and, therefore, this type of training is more standardized within CACREP accredited programs. However, this researcher anticipated that there would be no statistically significant difference between CACREP accredited and non-CACREP accredited participants and their scores on the FSA. This researcher believed that there would be no statistically significant difference because basic multicultural training may not be

enough to change inherent biases and stereotypes that counselor trainees may hold. In addition, gerontological education is not standardized across programs. However, it was believed that the more gerontological courses participants completed and the number of courses gerontological topics were infused into would lead to fewer ageist attitudes. This researcher also assumed that individuals who have worked with more geriatric clients in the past would hold fewer stereotypes and biases against this population. In addition, it was believed that time within the counseling field would lead to higher self-reported multicultural counseling competence as they may have more exposure to diverse populations throughout time.

This researcher believed participants would respond in a socially desirable way and, therefore, may not be completely honest when responding to the FSA (Fraboni et al., 1990) and The MCKAS (Ponterotto et al., 2002). It was believed that this may skew results and give the impression that participants hold fewer stereotypes and biases against the geriatric population than they really do. In addition, it was believed that participants would also give the impression that they are more multiculturally competent than they actually are. This was noted as a limitation of this study.

### **Definitions of Key Terms**

- *Ageism* is an irrational prejudice against older adults or the aging process (Stuart-Hamilton, 2006). Due to ageism, older adults are often labeled as being as “senile, sad, lonely, poor, sexless, ill, dependent, demented, and disabled” (McGuire, Klein, & Chen, 2008, p. 11). Ageism is not always intentional, as individuals often do not even know they hold ageist beliefs

(McGuire et al.). Ageism can occur on the individual, institutional, and societal levels.

- *Ethnicity* is defined as a person's affiliation with a particular ethnic group such as Irish, Italian, Chinese, and African American (Glauser, 2009). These individuals share nationality, language, common values, beliefs, and customs (LaRoche & Maxie, 2003).
- *Geriatric Population* is comprised of individuals age 65 and older (Stuart-Hamilton, 2006). These individuals account for the largest growing segment of the U.S. population.
- *Gerontology* is "a multidisciplinary field that includes sociology, biology, medicine, nursing, psychology, and social work, and there is a large body of knowledge that informs professional counselors about the difficult aspects of aging" (Smith, 2009, p. 210). However, very few training programs exist primarily for the preparation for working with the geriatric population.
- *Multicultural Counseling Competence* is defined as the capability to comprehend and constructively relate to the individuality of each client in light of the diverse cultures that affect each person's perspective (Stuart, 2004). Therefore, counselors must be competent in incorporating client's cultural traits into counseling sessions (Malott, 2009). The need for multicultural counseling was noticed in the 1950's and has continued to increase since that time. Ponterotto (1997) put forth the tripartite multicultural counseling competencies, which outline the skills,

knowledge, and awareness counselors need in order to effectively work with diverse cultural groups.

- *Multiculturalism* is a “social, intellectual, and moral movement” (Flowers & Davidov, 2006, p. 581). This movement has taken place in order for counselors to act ethically and reduce harm of diverse and minority clients during the counseling process.
- *Race* is defined as selected physical characteristics, criteria, or permanent attributes. Skin color and facial characteristics are often used in order to determine race (LaRoche & Maxie, 2003). The 2000 Census revealed that individuals identified with 165 racial combinations (Henriksen, 2009).

### **Overview of Methodology**

#### **Participants**

Participants consisted of graduate students in all stages of both CACREP and non-CACREP accredited counseling programs in order for participants’ scores from both CACREP accredited programs and non-CACREP accredited programs to be compared. Participants also consisted of master’s and doctoral level counselors working in the counseling field so that these individuals may be compared to counselor trainees. Participants were selected at random and were current members of the American Counseling Association. In order to complete the survey, participants were required to be currently enrolled within a counselor preparation program or must be a practitioner who graduated from a masters or doctoral in counseling program. Assuming a moderate effect size at  $P=.80$ , a minimum sample of 360 participants was sought to assume that

hypotheses are tested at the .05 alpha level (Cohen, 1992). In order to achieve this response rate, 2000 participants were surveyed.

### **Data Collection Methods**

The researcher contacted the ACA and requested a random selection of its members e-mail addresses. The researcher asked that half of the email list comprise ACA members who identify themselves as students and the other half who identify themselves as practitioners. In addition, it was requested that school counselors be excluded from this list. Data were collected by using the online service called SurveyMonkey ([www.surveymonkey.com](http://www.surveymonkey.com)). Upon obtaining the email addresses, an email was sent explaining the purpose of the study with a link to materials placed on SurveyMonkey. Participants were asked to complete the survey by filling in the appropriate answers. The survey packet included the following: The Fraboni Scale of Ageism (Fraboni, et al., 1990; Appendix B), The Multicultural Counseling Knowledge and Awareness Scale (Ponterotto et al., 2002; Appendix C), the Multicultural Training Questionnaire and Demographic Sheet (Appendix D), and informed consent information (Appendix E). Participants were able to answer the questions within the packet at their leisure, as there were no time constraints. In order to reduce ordering bias, three separate links were created with the survey ordered differently in each. In order to increase participation, reminders were sent to participants once weekly over a period of three weeks.

### **Data Analysis**

Data were analyzed using SPSS 16.0. Frequency distributions were utilized to report data such as gender, age, race/ethnicity, counselor trainee and number of years of

education pertaining to counseling, licensure information, and time in the counseling field (in years). In addition, a correlation was completed in order to analyze research question one and ANOVAS were completed in order to analyze research questions two, three, and four.

### **Summary**

Currently, there is a large gap in the scholarly research regarding gerontological counseling. It is vital that counseling professionals have access to up to date information regarding this population. In order to further explore counselors' possible stereotypes and biases against the geriatric population, there is a need for additional research.

## **CHAPTER TWO**

### **LITERATURE REVIEW**

In this chapter, the researcher will first outline the research that provides a description of the changing demographics of the United States by presenting relevant statistics and trends. Multicultural training will then be addressed, including the acquisition of multicultural competence and how multicultural competence is assessed. Mental health practitioners' attitudes regarding gender, age, race/ethnicity, sexual orientation, and socioeconomic status will be explored. An overview of the research regarding the geriatric population including aging trends and statistics will be then addressed. Physical, psychosocial, and psychological considerations will be presented including the aging process, physical and mental health, substance use, elder abuse, and occupational considerations. The researcher will then give an overview of positive aging, clinical implications and outcome research. Following, the researcher will discuss ageism including mental health practitioners attitudes regarding the geriatric population. Finally, the researcher will examine the ACA gerontological counseling competencies and previous research studies completed with individuals of the geriatric population.

#### **Changing Demographics**

The United States is considered the third most populous country in the world behind China and India (U.S. Census Bureau, 2002c). America's population tripled between 1900 and 2000 from 76 million to 276 million individuals (U.S. Census Bureau, 2002c). As a result, demographics of the U.S. population have changed and will continue to change immensely. Therefore, with increased diversity comes an increased focus on intersection of oppressed identities. In the year 2000, 25% - 30% of the U.S. population self-identified as minorities, and by the end of 2010, researchers expect this population to

increase to 32.7% (LaRoche & Maxie, 2003; Yali & Revenson, 2004). In 1900, 1 in 8 individuals identified themselves as a minority, however, in 2000, this number grew to 1 in 4 individuals (U.S. Census Bureau, 2002c). In addition, a growing body of literature indicates that by the year 2050, at least 50% of the U.S. population will be comprised of individuals from non-European backgrounds, particularly those from Latino and Asian populations (Hays, 2008; Yali & Revenson). From 1980 to 2000, the Hispanic population in the United States more than doubled (14.6 million to 35.3 million) and minorities of races other than Hispanic increased by 88% (U.S. Census Bureau, 2002c). Researchers project that the number of minorities will continue to increase well past 2050 (Yali & Revenson).

Currently, 1 in 10 Americans are foreign-born and 1 in 3 are considered to be minorities (Stuart, 1994). From the years 1900-2000, 40 million people immigrated into the United States (U.S. Census Bureau, 2002c). Most foreign-born individuals who arrived to the United States in the 1960's were from countries in Europe and most immigrants who arrived after 1970 were from countries in Latin America and Asia (U.S. Census Bureau, 2010). In 1980, 39% of individuals who were foreign-born originated from Europe, and 52% originated from Latin American or Asia (U.S. Census Bureau, 2010). Currently, 80% of foreign-born individuals were born in either Latin America or Asia (U.S. Census Bureau, 2010). This increase of foreign-born individuals has resulted in rapid growth of the Hispanic and Asian populations within the United States. Not only are these populations greatly increasing but, also, the non-Hispanic population is rapidly decreasing. For instance, in 1970 83% of the total population was White and 76% by 1990 (U.S. Census Bureau, 2010). By the year 2007, only 66% of the total population



was White. In addition, the majority of the population in Hawaii, New Mexico, California, and the District of Columbia are comprised of racial and ethnic minorities (Stuart, 1994).

Racial and ethnic populations are not the only multicultural groups projected to grow (Yali & Revenson, 2004). Greater numbers of individuals who self-identify as gay, lesbian, or bisexual are expected. In 2000, 594,000 same-sex partners cohabitated (U.S. Census Bureau, 2003b). Overall, 301,000 were male partners and 293,000 were female partners. The states with the highest number of same-sex partners cohabitating include California, Vermont, and New York (U.S. Census Bureau, 2003b).

Individuals with chronic diseases and disabilities are also projected to increase. In 2000, 49.7 million individuals or 19.3% of the U.S. population reported having a disability (U.S. Census Bureau, 2003a). In addition, 46.3% of these individuals reported multiple disabilities. Overall, 21.2 million individuals reported a condition limiting physical activity, 18.2 million reported a condition making it difficult to go outside of the home, 12.4 million reported difficulty learning, remember, or concentrating, 9.3 million reported a sensory disability such as sight or hearing, and 6.6 million reported difficulty with self-care such as dressing or bathing (U.S. Census Bureau, 2003a). In addition, 21.3 million individuals aged 16-64 reported a condition that affected their ability to work a job (U.S. Census Bureau, 2003a). For individuals under the age of 64, males reported having a disability at a significantly higher rate than females. However, for individuals ages 65 and older, women reported significantly higher rates of disabilities. Individuals who indicated they were Asian had the lowest overall disability rate at 16.6% and Whites had a disability rate of 18.5% (U.S. Census Bureau, 2003a). Individuals who indicated

they were Black or American Indian reported the highest disability rates at 24.3% each. Among all of the states, the disability rate was highest in the state of West Virginia followed by Kentucky and Arkansas (U.S. Census Bureau, 2003a).

According to the 2000 Census, 12.4% of the U.S. population reported they were living in poverty (U.S. Census Bureau, 2003c). Therefore, 33.9 million people were living below the poverty threshold. Poverty rates were highest in the southern region of the United States at 13.9% (U.S. Census Bureau, 2003c). Mississippi, Louisiana, and New Mexico reported the highest poverty levels. Non-Hispanic Whites had the lowest poverty rate at 8.1% followed by Asians at 12.6%, Pacific Islanders at 17.7%, Hispanics or Latinos at 22.6%, Blacks at 24.9%, and American Indians at 25.7% (U.S. Census Bureau, 2003c).

Due to the Baby Boom population, the geriatric population has grown and will continue to do so (Maples & Abney, 2006). In 1900, half of the United States population was less than 22.9 years old, however, by 2000, half of the population was more than 35.3 years of age (U.S. Census Bureau, 2002c). During the 20<sup>th</sup> century, individuals ages 65 and older increased from 3.1 million to 35 million (U.S. Census Bureau, 2002c & 2004). The states whose populations currently comprise the highest amount of Baby Boomers are Alaska (32%), New Hampshire (31%), Vermont (31%) and Maine (30%; U.S. Census Bureau, 2001). Therefore, these states can expect to see a rapid growth of geriatric individuals (Van Gerpen et al., 1999). In addition, there are 70 males to every 100 females within this population (20.6 million to 14.4 million, respectively; U.S. Census Bureau, 2004). Moreover, 56% of individuals within this cohort are married, 32% were widowed, 7% are divorced, and less than 5% have never been married (U.S.

Census Bureau, 2004). Furthermore, 18% of this cohort has some college or an associate's degree and 15% has completed a bachelors or other higher degree, however, almost half of the population over age 85 has not completed high school (U.S. Census Bureau, 2004). In addition, 9.9% of this population lives in poverty (U.S. Census Bureau, 2004).

### **Multicultural Training**

The changing demographics of the United States have required counselor preparation programs to increase their emphasis on multicultural competency and training. However, even with the greater emphasis on multicultural counselor education, counselors may still not be exhibiting sufficient multicultural competence (Hill, 2003). Therefore, counselors may not be adequately prepared for these population increases. Further, research indicates that individuals of minority populations often face many barriers that prevent them from seeking mental health treatment (U.S. Surgeon General, 2001). For instance, cost, lack of adequate services, mistrust and fear of treatment, racism, and differences in communication may all prevent individuals of minority populations from seeking treatment (U.S. Surgeon General, 2001).

Counseling training programs integrate multicultural training in a variety of ways. For instance, some programs require a separate multicultural course whereas others utilize the integration model by integrating multicultural issues into courses already in place (Toporek & Pope-Davis, 2005). However, even though many programs are increasing their focus on multicultural issues, counselors may actually be *less* prepared to work with clients who are culturally diverse than they were two decades ago (Coleman, Morris, & Norton, 2006). This may be due to the rapid growth of multicultural

populations and counselor education programs may not be able to keep up with the changing knowledge, skills and techniques needed to effectively work with these diverse populations.

Research indicates that the completion of multicultural training experiences is significantly connected to higher self-reported multicultural knowledge but not with multicultural awareness (Holcomb-McCoy & Myers, 1999). In addition, Allison, Crawford, Echemendia, Robinson, and Knepp (1994) indicated that counseling psychologists reported low levels of competence when working with minority clients. However, 50% of participants reported that they perceived themselves as competent when working with Whites, women and economically disadvantaged clients. Holcomb-McCoy and Myers (1999) found that overall ACA members who had graduated from counselor preparation programs perceived themselves to be multiculturally competent. They believed they were most competent on awareness and skills and perceived themselves to be less competent on both the knowledge and racial identity dimensions. In addition, they believed that their multicultural training had been less than adequate indicating that postgraduate study or cross-cultural experiences may influence counselors' self-report of multicultural competence more than education.

Therefore, even though many counselor preparation programs have incorporated multicultural courses and increased integration of multicultural topics within current courses, this may not be enough for counselors to become multiculturally competent as they may gain more from field experiences (Holcomb-McCoy & Myers, 1999). Thus, field experiences such as immersion exercises can be infused into multicultural courses as well as additional courses. Holcomb-McCoy and Myers found there was no difference

between self-perceived multicultural competence between counselors from CACREP accredited programs and counselors from non-CACREP programs.

Counselor educators may have a difficult time training future counselors in becoming more multicultural as these students may be resistant to the process (Jackson, 1999). Oftentimes, students may feel angry, avoidant, or exhibit passivity towards the process of learning about multicultural issues. Students also may feel very uncomfortable and, therefore, become resistant when required to analyze their own race, ethnicity, gender, disability, socioeconomic status, sexual orientation, or age. Specifically, counselor preparation programs need to place more focus on exploring counselor's own personal values and assumptions and ability to recognize that their client's may acquire their values from a completely different worldview and, therefore, may be very different (Yali & Revenson, 2004). In addition, not only is it important for students to be comfortable in analyzing their own multicultural variables, but it is imperative that professors of multicultural courses engage in this process as well. If not, students may become very distrustful of multicultural training (Jackson, 1999).

Several factors have been found to affect the acquisition of multicultural competence among counselors. One hindrance is that many counselor educators often do not have adequate training in multicultural counseling (Hill, 2003). Therefore, these individuals may not be sufficiently prepared and may be uncomfortable with taking on the task of teaching a multicultural course. This may lead to an extremely uncomfortable learning atmosphere that is not conducive for beginning counselors. Counselor trainees may not be comfortable learning about multicultural issues as they reported feelings of defensiveness and guilt when discussions containing multicultural topics arise within the

classroom (Hays, 2008). Even though some discomfort is expected, it would be worthwhile for counselor educators to attempt to minimize defensiveness and feelings of guilt. Ultimately, because counselor educators may not be prepared to do this, counselor trainee competence may suffer.

It is often assumed that multicultural knowledge ultimately leads to multicultural skills. However, counselors may know a great deal about different cultures but they may not know how to appropriately use multicultural skills when counseling clients who are diverse and, therefore, they may not be effective. Although there is some overlap between general counseling skills and multicultural counseling skills, there are some differences. According to Cates, Schaeffle, Smaby, Maddux, and Lebeauf (2007), multicultural skills include but are not limited to “seeking consultation with traditional healers or religious leaders consistent with a client's cultural values and attending to or working to eliminate biases, prejudices, and discriminatory practices” (p. 27).

Another deficiency that may exist in counselor education programs is that counselor self-awareness is often not stressed (Coleman et al., 2006). Self-awareness of biases, stereotypes and racial identity are imperative when counseling diverse clients. Examining biases, stereotypes and racial identity can be an uncomfortable process and, therefore, may cause some anxiety in both counselor trainees and counselor educators. As a result, some counseling programs may not emphasize self-reflection as much as they should. Therefore, counselor preparation programs need to place greater emphasis on helping counselor trainees reflect upon their own lives as well as preparing counselor educators to facilitate this difficult process.

## **Multicultural Competence**

Multicultural competence is defined as the “ability to understand and constructively relate to the uniqueness of each client in light of the diverse cultures that affect each person’s perspectives” (Stuart, 2004, p. 6). In order to guide this process, Sue, Arredondo, and McDavis (1992) introduced 31 multicultural competencies for counselors. Originally, these competencies referred to four main groups: African Americans, American Indians, Asian Americans, and Hispanics and Latinos, however, these competencies and standards are now applied to many different oppressed populations. The standards address counselor awareness of their own assumptions, values, and biases, understanding of the worldview of the culturally different client, and development of appropriate intervention strategies and techniques. The ACA endorsed these 31 multicultural competencies in 2003. However, although multicultural counseling competence has increased in theory, it has not increased in assessment. Therefore, additional oppressed populations other than racial minorities are rarely addressed within multicultural competence assessments.

In 1982, Sue et al. put forth a tripartite model for characteristics which culturally skilled counselors need to possess in order to increase multicultural counseling competence. This model laid the groundwork in which counseling professionals utilized in order to develop the standards and competencies that are currently in place today (Sue et al., 1992). The overall goal of Sue et al.’s (1982) model was to provide counselors with competencies in order to increase successful and ethical counseling of individuals from diverse populations. The three competencies within this model include beliefs/attitudes, knowledge, and skills. The beliefs/attitudes competency states that

culturally skilled counselors are aware of their own cultural heritage and value and respect differences (Sue et al., 1982). Therefore, these counselors move away from ethnocentrism and begin to respect differences of their clients. In addition, counselors should also be aware of their own values and biases and understand how they may affect clients who are of minority populations. Culturally skilled counselors are comfortable when there is a difference between them and their clients in regards to race and beliefs and they are also sensitive to their own limitations are willing to refer a client to a counselor of his or her own race or culture.

The knowledge competency of this model states that culturally skilled counselors understand the sociopolitical system within the United States and recognize how this may affect clients who are minorities (Sue et al., 1982). The culturally skilled counselor is also knowledgeable about the particular cultures their clients present from and understands the generic characteristics of counseling. In addition, the culturally skilled counselor is knowledgeable about the institutional barriers, which may prevent minorities from accessing or using mental health services. The skills competency of this model asserts that culturally skilled counselors must be able to appropriately generate, use, send, and receive verbal and nonverbal responses. Finally, the culturally skilled counselor must be able to use institutional intervention skills with their clients when needed.

Stuart (2004) proposed multiple guidelines in order for counselors to become more multiculturally competent. The first is to assist clients in describing their own unique cultural outlook. If this is done appropriately, counselors may be able to better understand their client's worldviews and more effectively work with them. Counselors should also work to control their own personal biases by exploring their own worldviews.



In addition, counselors are to match psychological tests to client characteristics and need to be careful that assessments are normed in the culture of their client. Counselors should also always consider clients' cultures when they select interventions and methods when working with clients.

### **Assessment of Multicultural Competence**

There are numerous instruments that may be utilized in order to assess counselor's multicultural competence (Cartwright, Daniels, & Zhang, 2008). However, these assessments mainly only assess for competence in working with multiple race/ethnicities and fail to include other multicultural populations. For instance, the Multicultural Counseling Inventory (Sodowsky, Taffe, Gutkin, & Wise, 1994), the Multicultural Awareness, Knowledge, and Skills Survey-Counselor Edition (Kim, Cartwright, Asay, & D'Andrea, 2003), and the MCKAS (Ponterotto et al., 2002) are instruments that are utilized in order to measure counselor's multicultural competence. However, because these instruments employ a self-report method, they may not sufficiently measure multicultural competence due to social desirability and, therefore, inflation of scores (Cartwright et al., 2008). For instance, Cartwright et al. found that counselor trainees continually rated themselves as being more multiculturally competent than observers rated them as while counseling a client with multicultural concerns. Therefore, counselor trainees perceived themselves to be more competent than they really were.

The Multicultural Counseling Inventory contains 42 items and is scored on a 4-point Likert scale (4=very accurate and 1=very inaccurate; Ponterotto et al., 2002). This scale measures counselors' self-reported multicultural awareness (10 items), knowledge

(11 items), skills (11 items), and relationship (8 items; Sodowsky et al., 1994). The internal consistency reliabilities totaled .80 for Multicultural Awareness, .80 for Multicultural Counseling Knowledge, .81 for Multicultural Counseling Skills, .67 for Multicultural Counseling Relationship, and .86 for the scale as a whole (Sodowsky et al., 1994).

The Multicultural Awareness, Knowledge, and Skills Survey-Counselor Edition contains 60 items and measures awareness, knowledge, and skills based on Sue et al.'s (1982) model of cross-cultural counseling (Kim et al., 2003). This assessment utilizes three different 4-point Likert scales (1=very limited, 4=very aware; 1= very limited, 4=very good; 1=strongly disagree, 4=strongly agree) for each of the three subscales. The higher an individual scores on each of these subscales the greater their competence. The reliability coefficients alphas for this scale are .75 for Awareness, .90 for Knowledge, .96 for Skills, and .88 for the entire scale.

The MCKAS is a 32-item scale, which measures counseling competence (Kim et al., 2003). This scale consists of two subscales including a Knowledge scale, which is 20 items, and measures participants knowledge related to multicultural counseling, and an Awareness scale, which is 12 items and measures worldview biases and attitudes (Kim et al., 2003). Both subscales have a coefficient alpha of .85 (Ponterotto et al., 2002) and in a study conducted by Kim et al. (2003) the Knowledge scale yielded a coefficient alpha of .90 and the Awareness scale yielded a coefficient alpha of .86.

The MCKAS will be utilized in this study in order to assess counselor and counselor trainee self-reported multicultural counseling competence. This scale was chosen because of its succinctness as other scales that were evaluated were fairly lengthy.

In return, this may encourage participation and completion of the survey packet. In addition, this scale has been deemed both reliable and valid and, therefore, is superior to many other scales that were reviewed. However, all of the previous scales do not address age as a cultural group and mostly concentrate on race and ethnicity. Therefore, it is important to explore the relationship between multicultural counseling competence scales and ageist attitudes scales.

### **CACREP Standards**

The CACREP was established in 1981 and became the primary accrediting body for the counseling field (Schmidt, 1999). At that time, 44 counseling programs became accredited (Bobby & Kandor, 1992). Today the CACREP currently accredits 504 masters and 55 doctoral counseling programs (CACREP, 2009a). The standards put forth by the CACREP in 1981 have been revised numerous times in order to address the needs of the continuously changing counseling field. In 2001, the CACREP recently revised their standards in order to better address multicultural competency (Cates et al., 2007). This revision emphasized the importance of multicultural counseling as it requires diversity to be addressed as one of the eight core areas. The 2001 CACREP standards also required counselor trainees to be given the opportunity to counsel diverse individuals during practicum and internship experiences.

The revisions made in the 2001 CACREP standards pertaining to multicultural counseling remained in place during the revisions for the 2009 standards. Overall, within the 2009 CACREP standards there are eight core areas that each accredited program must focus upon when considering courses and course requirements (CACREP, 2009b). According to the 2009 CACREP standards “Common core curricular experiences and

demonstrated knowledge in each of the eight common core curricular areas are required of all students in the program” (p. 9). Social and cultural diversity is 1 of the 8 core areas within the 2009 CACREP standards (CACREP, 2009b). This area focuses on educating counselor trainees to better understand “the cultural context of relationships, issues, and trends in a multicultural society” (p. 9). This includes but is not limited to understanding multicultural and pluralistic trends, experiential learning activities, theories of multicultural counseling, identity development, and social justice, strategies for working with and advocating for diverse populations, the development of cultural self-awareness, and the elimination of biases and prejudices.

Even though the standards for multicultural counseling remained the same between the 2001 and 2009 CACREP standards, some important changes were made pertaining to the gerontological specialty (CACREP, 2001, 2009b). In 2001, gerontological counseling was recognized as a specialty within the counseling field, however, the standards were revised and in 2009 this specialty was dropped (CACREP, 2001; CACREP, 2009b). In addition, currently there are only two CACREP accredited gerontological counseling programs in the United States (CACREP, 2009a). One program is at the University of North Carolina at Greensboro and the other at San Francisco State University.

CACREP accredited programs incorporate multicultural training in several different ways. For instance, they can either provide a separate course on multiculturalism, infuse multicultural topics into courses that are already in place, or do a combination of both (Cates et al., 2007). Although the CACREP standards do not require

accredited programs to have a course in multiculturalism, many programs choose to require this course in order to fulfill this core requirement (Cates et al., 2007).

### **Mental Health Practitioners Attitudes Regarding Diverse Populations**

Regardless of the multicultural training that is in place within many counselor preparation programs, counselors still may hold stereotypes and biases toward certain populations. For instance, stereotypes against women have been found to hinder the diagnostic process as women are often labeled with a mental illness at a higher rate than men (Eriksen & Kress, 2008). In addition, mental health practitioners may also hold stereotypes and biases against the elderly, individuals from diverse races, sexual minorities, and individuals of low socioeconomic status (Danzinger & Welfel, 2000; Fisher, Matthews, Robinson, & Burke, 2001; Garnets, Hancock, Cochran, Goodchilds, & Peplau, 1991; Toporek & Pope-Davis, 2005).

### **Gender**

Even though many counseling training programs offer multicultural training and courses, counselors may continue to hold stereotypes and biases against multiple populations (Toporek & Pope-Davis, 2005). Gender bias in counseling can cause clients to be misdiagnosed as well as misunderstood (Cook, Warnke, & Dupuy, 1993). Even though men and women experience mental illness at comparable rates, women are often thought to have a higher incidence of mental illness (Eriksen & Kress, 2008). In addition, Cook et al. (1993) indicated that mental health professionals tend to label clients as being disturbed if their behavior does not match the professional's gender ideals. Mental health professionals may also diagnose males and females differently even when these clients present with identical symptomology (Becker & Lamb, 1994). For instance,

Becker and Lamb indicated when clients presented with identical symptomology, clinicians diagnosed female clients with Borderline Personality Disorder more than male clients. In addition, a study completed by Danzinger and Welfel (2000) found that mental health professionals viewed female clients as less competent to make autonomous decisions when compared to male clients. In order to reduce gender bias in counseling, counselors should perform a comprehensive diagnostic process and seek to understand the environmental context in client's lives by incorporating gender issues into the counseling session (Cook et al., 2003).

### **Race and Ethnicity**

In the overall health care field, 23% of Blacks and 15% of Hispanics believe they would receive better health care if they were a different race or ethnicity (LaVeist, Rolley, & Diala, 2003). Research indicates that the client's race may bias counselors' evaluations of them (Fisher et al., 2001). Tomlinson-Clarke and Camili (1995) revealed that female counselors, when compared to male counselors, tend to diagnose African American and White clients with more severe mental illnesses. In addition, counselors also utilize distinctly different treatment interventions with each of these groups. Fisher et al. (2001), stated counselor trainees identified European American male clients as being the most lazy/slovenly, followed by the Mexican American and African American clients. Male clients who were Mexican American were perceived as the most aggressive/unreliable, followed by male clients who were European American and the African American. Rosenthal (2004) indicated that White rehabilitation counselors judged Black clients more negatively than they judged White clients.

## **Sexual Orientation**

In 1973, the American Psychiatric Association, depathologized homosexuality (Pearson, 2003). Therefore, homosexuality was no longer considered to be a mental illness. However, many of those biases and stereotypes continue to persist within the counseling profession. Individuals of this population have an increased risk of distress due to living in an oppressive society and, therefore, counselors should not view this distress as a result of being lesbian, gay, bisexual, transsexual, or questioning. Garnets et al. (1991) indicated that 58% of mental health professionals who were surveyed knew of negative incidents in which clients were biased or given inappropriate care. One therapist stated that he knew of practitioners who defined lesbians or gay men as being “sick” and in need of change. In addition, one therapist stated that he believes that homosexuality is a form of psychopathology and that it could be considered to be narcissistic personality disorder. In this same study, a participant who identified as being lesbian reported her negative experiences in counseling. She stated that her therapist inappropriately challenged her by saying “If you have a uterus, don’t you think you should use it?” (p. 967).

In order to more effectively work with this population and reduce the possibility of stereotypes and biases, counselors are encouraged to use gender-neutral language when clients are discussing their intimate relationships and do not specify a gender of their partner (Pearson, 2003). In addition, counselors are encouraged to use terms such as lesbian, gay, and bisexual when their clients use them to describe their relationships. Counselors should not ignore these clients’ problems and should not assume that all problems relate to their client’s sexual orientation. On the other hand, counselors should

not ignore the possibility that their client's sexual orientation may influence their problems. Finally, counselors should not overly focus on their client's sexual orientation unless that is the wishes of their client.

### **Socioeconomic Status**

Overall, in the health care field, living in poverty was positively correlated with perceived racial and ethnic bias in health care (Stepanikova & Cook, 2008). More specifically, previous research shows that counselors may hold stereotypes against individuals from low socioeconomic status (Toporek & Pope-Davis, 2005). Auwarter and Aruguete (2008) indicated that professional school counselors perceived students from low SES backgrounds as having lower abilities in mathematics and having less potential in their future endeavors.

### **Age**

Danzinger and Welfel (2000) indicated that mental health professionals often hold the assumption that elderly clients are less able than younger clients to make autonomous decisions. In addition, the prognosis of older clients was viewed to be more negative when compared with younger clients. This same study indicated that the longer the mental health practitioner was in practice, the more likely they were to judge elders as being less competent, which is counterintuitive. However, this may be because as mental health professionals grow older, they may find it difficult to face their own aging process and, therefore, view elders in a negative manner. Finally, licensed counselors were less likely to judge older clients as being less competent when compared to non-licensed counselors. A more comprehensive review of mental health professionals attitudes towards older clients follows below.



It is imperative that counselors focus on the other identities presented above (gender, race/ethnicity, sexual orientation, and socioeconomic status) when working with individuals of the geriatric population. Elders may not only be stereotyped due to their age but also may be stereotyped due to their gender, race/ethnicity, sexual orientation, and socioeconomic status. Therefore, when they reach older adulthood, these individuals may be considered to be a double minority for the first time throughout their lives. In return, this may cause them even greater psychological distress. In addition, counselors should be aware of their stereotypes and biases against different populations and work to break these stereotypes and biases down. Being more aware of counselor's stereotypes and biases of other cultures may assist them in becoming more aware of the stereotypes and biases they may hold against the geriatric population. Issues pertaining to the geriatric population will be further examined in the following sections.

### **The Geriatric Population**

Characteristics of geriatric population include aging trends of this population and physical, psychological, and psychosocial considerations. In addition, counselors should also explore and gain knowledge of occupational considerations for the geriatric population and be prepared to incorporate these considerations when providing counseling to individuals of this population.

#### **Aging Trends and Statistics**

During the seventeenth century, reaching old age was unusual as only approximately 1% of the population reached the age of 65 (Stuart-Hamilton, 2006). Throughout the nineteenth century, approximately 4% of the population reached the age of 65. Currently, there are 35 million individuals who comprise the geriatric population,

or 12.4% of the United States population (U.S. Census Bureau, 2004). In the United States, approximately 82% of the current geriatric population is White, 8.2% are Black, 6% are Hispanic, 2.9 are Asian or Pacific Islander, and less than 1% were American Indian or Native Alaskan (USDHSS, 2005). In addition, 21.1 million individuals of the geriatric population are females and 15.2 million are males. Therefore, there are approximately 139 women to every 100 men. Forty-two percent of older women compared to 72% of men are married (USDHSS, 2005). Approximately 43% of all older women are widowed compared to 14% of men (USDHSS, 2005).

In 2011, the first Baby Boomers will reach the age of 65 and, therefore, researchers expect the geriatric population to grow rapidly for the next two decades (U.S. Census Bureau, 2002c). By the year 2030, researchers project that the geriatric population will increase to include 70 million individuals. This growth is in part due to the large Baby Boom generation as approximately 76 million individuals make up this aging population (Maples & Abney, 2006). The Baby Boom population comprises 40% of the overall adult population. Due to better public sanitation, personal hygiene, and scientific and medical technology, researchers expect the life expectancy for this generation to be longer than that of any generation preceding it (U.S. Census Bureau, 2002c). In 1930, life expectancy was just 58 years of age and by the year 1988, life expectancy had increased to 75 years of age (Maples & Abney, 2006). By 2003 life expectancy reached 80 years of age. In addition, in 1900, there were only 122,000 individuals over the age of 85, however, in 2000, 4.2 million individuals were over the age of 85 (U.S. Census Bureau, 2002c).

Individuals of the Baby Boom generation are predicted to live to be 85 years of age or older due to better healthcare, higher education and, therefore, increased financial stability than preceding generations (Maples & Abney, 2006). However, for instance, between 1970 and 1999 the percentage of older adults who had completed high school rose from 28% to 68% and 15% of older adults had four or more years of college education (Rayle & Myers, 2003). However, even though many individuals have completed educational milestones to enhance their financial stability, 11% of this population is still living below the poverty level and over 20% of this population is considered to be poor. In addition, longer life expectancy is often correlated with increased suffering (Stuart-Hamilton, 2006). For instance, according to the World Health Organization's *World Health Report* (2000), 10% of the final years of life are often spent suffering from a disability.

Today's society has been described as a rectangular society where there are fairly equal numbers of individuals alive in each decade (Stuart-Hamilton, 2006). However, in 1900, society was described as a pyramidal society where there are progressively fewer individuals in older decades. Research shows that 70% of today's population can expect to live past 65 years of age and 30 to 40% can expect to live past 80 years of age (Stuart-Hamilton, 2006). Consequently, not only is this the largest geriatric population ever but it will also persist longer than earlier generations. Therefore, counselors are and will continue to have increased contact with individuals of the geriatric population.

In 2011 the first individuals of the Baby Boom population will turn 65 years of age (Sheets, Bradley, & Hendricks, 2006). As these individuals begin to retire and continue to age, this will affect health care, pensions, housing, and terminal care. Therefore, the

Baby Boom generation is dealing with unique problems that generations before it did not experience (Dixon, Richard, & Rollins, 2003). A few of these unique issues include diminishing social security income, long-term care needs and more prevalence of age discrimination. For instance, due to discrimination, women and minorities of this generation are often not and will not be financially secure. The U.S. Census Bureau found for the year 2001, 8.1% of age 65 or older Whites are living in poverty compared to 21.9% of elderly African Americans and 21.8% of elderly individuals of the Latino population (U.S. Census, 2002a & 2002b).

One important issue is that not only will the geriatric population increase greatly over the next 50 years but also minorities that comprise the geriatric population will grow by 500% (Dixon et al., 2003). Therefore, in order for counselors to be competent in working with the geriatric population, they must be aware of the unique issues that minorities of the geriatric population will experience, as they will be different from those of the majority population. Life experiences of both the majority and minority populations heavily influence clients of the geriatric population and counselors must be prepared to be able to work with these differing experiences.

### **Physical, Psychosocial, and Psychological Considerations**

It is imperative for counselors to be aware of the unique physical, psychosocial, and psychological conditions elders may face. For instance, 80% of this population reports having at least one chronic condition such as arthritis or high blood pressure (Rayle & Myers, 2003; USDHHS, 2010). In addition, elders are more at risk for developing Alzheimer's disease and dementia than any other age cohort (Zank, 1998). Another issue counselors must be aware of when working with the geriatric population is

elder abuse. Counselors must be able to identify the signs and symptoms of an elder who is being abused and be aware of different resources that may assist these individuals. Finally, counselors must be aware issues surrounding occupation and the transition of retirement when working with individuals of the geriatric population (Gallo, 2000).

**The aging process.** From the moment an individual is conceived they begin the aging process. Biological aging refers to the body's degenerative process (Stuart-Hamilton, 2006). There are many theories as to why human bodies age. For instance, the programmed theory of aging states that over time cell replacement within the body becomes less efficient and, therefore, because cells are not adequately repaired or replaced, the body begins to age. The somatic mutation theory of aging asserts that cells are replaced but over time begin to contain many errors due to damaged DNA within the cells. The autoimmune theory of aging states that aging stems from errors in the human body's immune system. Therefore, the body is inadequately able to fight off infections and may actually mistake certain bodily cells as infections and begin to erroneously attack them. The cellular garbage theory states that aging occurs due to toxins within the human body from harmful byproducts of cellular activity. Whether one or a combination of these theories is responsible for the aging process, one thing is certain, every individual will experience aging throughout their lifespan (Stuart-Hamilton, 2006).

As the human body ages, skin and muscles become less resilient as mitochondria within the cell structures are lost (Stuart-Hamilton, 2006). Therefore, wrinkles become more apparent, muscles become weaker and many bodily systems become less efficient. For example, the gastrointestinal and urinary systems become less efficient at excreting toxins and waste. In addition, the respiratory system cannot take in as much oxygen as it

once could. Within the cardiovascular system, the heart becomes weaker and blood vessels and arteries begin to harden making the pumping of blood more difficult. As a result, brain function begins to decrease as the blood and oxygen it was once receiving is significantly reduced. Due to this, throughout the aging process, 10-15% of an individual's total brain mass is lost. In addition, the breakdown of bones and weakening of muscles may prevent elders from participating in activities and may result in depression. Vision also often deteriorates throughout time. One-third of people over the age of 65 have a disease affecting their vision such as glaucoma, macular degeneration, and diabetic retinopathy. The aging process typically also affects hearing. For instance, approximately 32 % of individuals ages 70-80 and 50 % of individuals over 80 have serious hearing loss (Stuart-Hamilton, 2006).

**Physical health.** Most older adults report having at least one chronic condition (USDHHS, 2010). Overall, 80% of older adults report one or more chronic diseases (Rayle & Myers, 2003). In addition, individuals of this population account for 25% of the United States health costs as well as 25% of all pharmaceutical drug costs. The most common complaint is arthritis (49%) followed by high blood pressure (41%), heart disease (31%), any cancer (22%), diabetes (18%), and sinusitis (15%; USDHHS, 2010). Approximately 85% of older adults live independently and only about 7% live in nursing homes (Rayle & Myers, 2003). Due to the increased longevity in addition to unbalanced gender distribution of older adults, more women will be diagnosed with chronic diseases such as arthritis (Yali & Revenson, 2004). Because there is no cure for arthritis and many other chronic diseases, it will be imperative that mental health professionals are

competent in psychosocial interventions that may be used to treat chronic pain as well as stress management techniques.

According to the 2000 U.S. Census, individuals of the geriatrics population were 3 times more likely to have a disability compared to total general population (U.S. Census Bureau, 2004). In addition, 47% of individuals ages 85 and older reported a disability which either prevented or made going outside of the home very difficult. Overall, 14.2% of the U.S. population older than 65 years of age reported a sensory impairment such as blindness or deafness. In addition, 28.6% of individuals reported a physical impairment such as difficulty walking, climbing stairs, or lifting. Roughly 11% of individuals reported a mental impairment such as difficulty learning, remembering, or concentrating and 9.5% reported impairment with self-care such as dressing or bathing (U.S. Census Bureau, 2004). Overall, 43% of women and 40.4% of men reported a disability (U.S. Census Bureau, 2003a). According to the U.S. Department of Health and Human Services (USDHHS; 2000) the leading causes of death for individuals ages 65 and older are heart disease, cancer, and stroke. In addition, individuals ages 75 and older have the second highest rate for motor vehicle deaths.

**Mental health.** Dementia, such as Alzheimer's Disease, is extremely prevalent during older adulthood. In fact, these diseases may be the most prevalent mental illness in older adults (Zank, 1998). Therefore, due to increased life expectancy rates, many individuals will face these illnesses (Selkoe, 2006). Overall, 5% of adults over the age of 65 are diagnosed with Dementia and 10% are diagnosed with Alzheimer's disease (Spira & Edelstein, 2007; Zank, 1998). In addition, individuals over the age of 80 years of age are diagnosed with Dementia at a rate of 20% and over half of individuals over the age of

85 are diagnosed with Alzheimer's disease. Currently, in the United States, 4 million people are living with Alzheimer's disease (Spira & Edelstein, 2007). These individuals often have progressive memory loss, language disruption, agitation, and personality, emotional, and behavior changes (Abraham, 2005; Chesla, Martinson, & Muwaswes, 1994; Spira & Edelstein, 2007). In addition, individuals of the geriatric population residing in nursing homes often have a higher prevalence of dementia with research indicating rates of 51% to 94% (Walsh, Currier, Shah, Lyness, & Friedman, 2008).

Depression is common in older adulthood but not as common as it is in young adults (Zank, 1998). According to the Centers for Disease Control and Prevention (CDC; 2008), depression may cause difficulty sleeping, persistent sadness, withdrawal from activities, and physical discomfort. In addition, depression can lead to impairments in mental, physical, and social functioning (CDC, 2009). Overall, 2.5% of older adults meet the Diagnostic Statistical Manual criteria for depression or dysthymic disorder. However, 27% of elderly adults have symptoms of depression but do not meet the full criteria for the disorder. In addition, 5.5% of older adults meet the criteria for an anxiety disorder and an additional 2.5% display symptoms of anxiety but do not meet the full criteria for the disorder. Older adults must often face the death of friends as well as partners and, therefore, bereavement becomes a focus of older adulthood. Due to this, elders may experience increased depression. In addition, depression may also be exacerbated by illness and accidents such as hip fractures or heart disease (USDHHS, 2000). For instance, 12% of older individuals who are hospitalized for illness and accidents such as these develop depression. In addition, elders in nursing homes are



particularly inclined to develop depression as 15% to 25% of these individuals develop symptoms of the mental health illness (USDHHS, 2000).

Suicide also greatly affects individuals of the geriatric population. Overall, 13 individuals ages 65 and older commit suicide each day in the United States (Walsh et al., 2008). In 2000, individuals ages 65 and older completed 18.1% of suicides. In addition, 57.5 per every 100,000 men ages 85 and older complete suicide, which is more than five times the national suicide rate. Overall, the Baby Boom generation had a higher suicide rate than any other generation. Therefore, suicide rates may increase as this generation ages.

Social support is important in order to effectively reduce mental health illness within the geriatric population. Social support includes emotional support, informational support, and instrumental support (CDC, 2008). Elders may acquire emotional support by being provided with a safe place for elders to share their problems and emotions. Informational support is given when the elder is offered advice and guidance and instrumental support is given when elders are assisted with rides or housekeeping. If the mental health professionals offer the appropriate amount of support to elders, elders may have a decrease of mental illness, physical illness, and mortality. However, individuals of the geriatric population are more likely to report that they rarely or never receive the support they need. In addition, one-fifth of Hispanic elders reported they are not receiving the support they need compared to one-tenth of White elders indicating more support should be offered to this population (CDC, 2008).

Mental health also varies by race and ethnicity. For instance, when controlling for demographic factors and socioeconomic status, African American elders have been

found to have higher levels of severe cognitive impairment when compared to individuals from other racial groups (U.S. Surgeon General, 2001). In addition, Black, Rabins, German, McGuire, and Roca (1997) found that 58% of black older adults with mental disorders do not receive services. Research also indicates that older adults who self-reported as American Indian may have a higher rate of depression when compared to other racial groups (Kramer, 1991). Tang et al. (1998) indicated that Hispanic Americans have a higher prevalence of Alzheimer's disease when compared with White Americans.

**Substance use.** Elders abuse alcohol at a lower rate than the general population (Benshoff, Harrawood, & Koch, 2003). Individuals ages 65 and older have been found to have the lowest rates of alcohol use out of any other age cohort. At this age, there are both early onset and late onset abusers. Early onset abusers typically start drinking alcohol at a young age whereas late onset abusers start abusing alcohol after the age of 65. Late onset abusers usually start abusing alcohol due to their response to a negative life situation such as a retirement, death of a spouse, or health concerns. One negative consequence of abusing alcohol or drugs in older age is that aging bodies typically absorb and excrete these substances at a slower rate and, therefore, drugs and alcohol stay in the body for longer duration and at a higher concentration. In addition, alcohol and drugs may cause an adverse reaction to any medications the user may be taking. Alcohol abuse may also lead to Korsakoff's syndrome in older adulthood which results in major cognitive deficits (Kelley, 2003). However, unfortunately, elders may be reluctant to seek help as they may feel they do not fit into programs such as Alcoholics Anonymous (AA) or Narcotics Anonymous (NA).

**Elder abuse.** Due to ageist beliefs, it may be easy for individuals to disregard the welfare of older adults (Nelson, 2005). In 2004 alone, 565,747 elders were abused (National Center on Elder Abuse, 2004). However, these numbers are not completely accurate as cases are often underreported. Overall, there are five types of elder abuse (Buzgova & Ivanova, 2009). The first form is physical abuse, which is purposefully causing pain or injury to the body. The second is psychological and emotional abuse, which includes the use of words to cause anguish, fear, or humiliation. Financial abuse is also a form of elder abuse and includes caregivers mishandling of elders finances or organizations taking advantage of elders. Neglect includes malnutrition, inadequate health care, and poor hygiene. The final form of elder abuse is violation of rights, which occurs when family members or employees do not respect the right to privacy or free choice.

Elder abuse may go undetected as physicians often have the most contact with elders yet, have little training on elder abuse. For instance, Jones, Veenstra, Seamon, and Krohmer (1997) conducted a survey of U.S. emergency room physicians and found that only 25% had training in elder abuse. However, they found that 63% had training on spouse abuse and 87% had training on child abuse. In addition, elders who are abused may be scared to reveal the abuse and, therefore, this may cause elder abuse to be even more undetectable (Nelson, 2005).

### **Occupational Considerations**

Retirement is typically viewed very positively, however, it is often a very difficult process for many individuals. For instance, Gallo (2000) found that involuntary retirement affected the mental and physical health of older individuals. However, when

they were re-employed, this had a significant effect on their mental and physical well-being. Retirement may be difficult for older adults because they may feel a reduced sense of worth (Stuart-Hamilton, 2006). In addition, it may decrease financial stability, which in return may cause individuals to become depressed. This may be the reason white-collar workers typically report a greater sense of well being after retirement when compared to blue-collar workers.

### **Positive and Successful Aging**

Due to the many physical, psychological, and psychosocial factors that may influence elders, many times individuals view aging as a very negative process. However, not every elder experiences aging in that way. Overall, life satisfaction is influenced by socioeconomic, health, and environmental factors, and life dissatisfaction is often associated with obesity, smoking, physical inactivity, and heavy drinking (CDC, 2008). Research often places much focus on issues surrounding life dissatisfaction as well as issues that are associated with aging (Flood & Scharer, 2006). Due to the rapid increase of the geriatric population, the number of older adults who age unsuccessfully also rapidly increases and, therefore, researchers often focus on the negative aspects of aging. However, older adults engage in successful aging when they effectively adapt to the physiological and other changes associated with growing old and feel a sense of meaning and purpose in life.

Creativity may be one of the most important variables in successful aging (Flood & Scharer, 2006). If elders have creative ability, this may help them effectively cope with life changes that occur while growing older. In addition, creativity may help elders to adapt to physiological changes as well as any deterioration that may occur during their

geriatric years. Flood and Scharer indicated that Black older adults were more creative than White older adults. This finding may possibly indicate that successful aging differs across races.

Rossen, Knafl, and Flood (2008) found in a qualitative study that 87% of participants believed that an individual's acceptance of changes in life circumstances is an important element in successful aging. In addition, 90% of participants identified engagement in life such as staying involved in meaningful activities was important in order to successfully age. Participants believed that social and self-care activities were essential. Finally, 83% of participants believed that comportment, which is the presentation of the self to the outside world, was an essential element in successful aging. In addition, overall these participants viewed successful aging as a conscious choice.

Phelan, Anderson, LaCroix, and Larson (2004) found for 1,890 Japanese and White older adults who were surveyed, 90% of Japanese and White older adults had put thought into aging and more specifically, aging successfully. In addition, 67% of Japanese Americans who were surveyed and 63% of Whites reported that their thoughts about successful aging had changed over the past 20 years. Respondents reported that dimensions such as physical health, functional health, psychological health, and social health were important elements in aging successfully. Therefore, older adults' views of aging successfully appear to be multidimensional.

Overall, it is imperative that mental health professionals understand the concepts of positive aging in addition to physical, psychological, and psychosocial considerations. Being aware of and understanding these concepts can lead to fewer issues such as misdiagnosis and underdiagnosis when diagnosing the geriatric population. In addition,

if elders feel that they are not understood this can lead to resistance within the counseling process.

### **Clinical Implications**

There are a variety of clinical implications which counselors need to be aware of when working with individuals of the geriatric population. For instance, mental health issues for this population are often misdiagnosed or under diagnosed. In addition, clients who are of the geriatric population may be resistant to seek or receive mental health treatment. Likewise, counselors may be resistant to working with individuals of this population and may need additional training in order to effectively and ethically do so.

### **Misdiagnosis and Underdiagnosis**

Primary care physicians are often the first professionals elders will contact when they are distressed. In fact, 50% of elders who are depressed had contact with their general practitioner in the previous month (Orrell, Collins, Shergill, & Katona, 1995). In addition, older adults consult their general practitioners 1.5-2 times more often than the general population (Collins, Katona, & Orrell, 1995). However, primary care physicians often misdiagnose or underdiagnose this population (Dearman et al., 2006). For instance, 1 in 7 individuals of the geriatric population has clinical depression but this often goes untreated and undetected by primary care physicians. Dearman et al. (2006) indicated that 87% of geriatric patients with depression were only being assessed and treated by their primary care physicians. Seventy percent of these patients were being treated with antidepressants and the other 30% were simply being monitored. Thirteen percent of patients with depression presenting to primary care physicians were referred to mental health providers due to treatment failure, psychosis, or suicidal ideation or attempts.

Referrals to counselors may be well warranted as primary care physicians may not be able to spend an appropriate amount of time with geriatric patients presenting with mental health concerns. In addition, 65% of older adults have been found to have a comorbid personality disorder as well, which would prove to be difficult to treat by a primary care physician (Hillman, Stricker, & Zweig, 1997).

In order to make diagnosis of certain conditions such as depression, dementia, and substance abuse more simplistic for primary care physicians, the use of brief screening instruments is well-warranted (Iliffe, Mitchley, Gould, & Haines, 1994). Iliffe et al. indicated that when physicians utilized the mini-mental state examination, the 15-item geriatric depression scale, and the alcohol quantity-frequency scale, physician's detected more mental health distress than they would have from clinical judgment alone. For instance, four times as many participants were diagnosed with dementia and twice as many with depression when physician's utilized the screening instruments than by physician's clinical judgment alone. Due to this, indication of underdiagnosis of mental health disorders by physicians, screening instruments should be utilized more frequently when working with the geriatric population.

Mental health professionals often show diagnostic and treatment biases against older adults (Hillman & Stricker, 1998). For instance, older adults are often given a poorer prognosis by mental health professionals than are younger or middle aged adults. However, older adults presenting with depression are often thought to be less severe cases than younger or middle aged adults. This may occur due to age biases where older adults are thought to naturally be depressed. In addition, even when full criteria are met, older adults are less likely to be diagnosed with personality disorders.

**Resistance by Clients**

Individuals of the geriatric population may deny symptoms of mental disorders such as memory loss or confusion out of fear of being institutionalized or belief that these symptoms are merely consequences of growing older (Collins et al., 1995). In addition, if geriatric clients do admit to these symptoms, many of these individuals of the geriatric population may be resistant to traditional “talk therapy” as these clients may be used to treatments from the medical model (Brodaty & Ansley, 1994). Therefore, it may be very difficult for mental health professionals to gain access to this population. In order to assist with this resistance, mental health professionals need to be prepared to offer more information to individuals of this population so that they may know what to expect from the counseling process. Providing structure and clear goals may be helpful in order to reduce confusion and ambivalence. In addition, it may be helpful to allow clients who are elderly to take notes or to tape sessions.

**Resistance by Mental Health Professionals**

There is a higher incidence of co-occurring disorders in the geriatric population, which may make mental health treatment more difficult (Zivian, Larsen, Knox, Gekoski, & Hatchette, 1992). Therefore, mental health professionals may be more reluctant to treat this population, as they may not feel confident that they have the skills they need in order to assist older clients. For instance, older adults often need specialized health care or may need assistance with networking with other unique services. Therefore, mental health professionals may have to exert more time and energy in assisting this population. In addition, Woolfe and Briggs (1997) suggested that counselors may be resistant in treating this population because they too will grow old one day and may fear death or the



unknown. In addition, Woolfe and Briggs stated there may be a high incidence of transference and countertransference when treating this population, which may make mental health professionals feel threatened and deter them from engaging in these relationships. For instance, clients may remind therapists of their own mother or father or grandparents. In return, this may encourage irrational anger or over commitment to the client. Therefore, mental health professionals often report less preference and motivation for working with older adults compared to working with young and middle aged adults (Hillman & Stricker, 1998).

### **Additional Training Warranted**

Job availability for counselors within the geriatrics field is limited even if counselors are trained in geriatrics (Myers, 1995). For instance, in most states legislation mandates that social workers be employed at long-term care facilities, which means that jobs for counselors in these facilities are limited. In order to increase job availability, more training for counselors may be well warranted in order to make them more marketable to this type of employment. In addition, counselors may also feel as if they need more training in order to competently treat individuals of the geriatric population. For instance, Zank (1998) administered a revised version of Palmore's Facts on Aging quiz to 215 psychotherapists. Results indicate that the mean level of correct answers was 13 out of 24. In addition, no difference in knowledge was found among the participants regarding their age, education, training experience, experience working with elderly clients, or interest in working with elderly clients. This low mean score may be an indicator that more training is needed among mental health professionals.

Much of the training research regarding geriatrics is limited and outdated. However, there is an increasing need to focus on this population due to mental health concerns and population trends. Therefore, additional research on training and attitudes needs to be completed.

### **Outcome Research on the Geriatric Population**

Outcome research regarding the treatment of the geriatric population is limited within the counseling literature. However, cognitive and behavioral therapies have been found to be extremely effective in treating clients of the geriatric population because they emphasize any current concerns elders may have (Brodaty & Ansley, 1994). In addition, Cognitive Behavioral Therapy (CBT) challenges biases and stereotypes that may hinder personal growth and self-efficacy of individuals of the geriatric population and prevents these stereotypes and negative expectations from becoming self-fulfilling prophecies (Brodaty & Ansley, 1994; Rayle & Myers, 2003). A meta-analysis of seven studies (Scogin & McElreath, 1994) indicated that CBT was an effective treatment for older adults presenting with depression. In addition, when coupled with CBT the medication desipramine has been shown to be more effective than when older adults were treated with desipramine alone (Thompson, Coon, Gallagher-Thompson, Sommer & Koin, 2001).

CBT may be effective in treating late life anxiety (Barrowclough et al., 2001). Barrowclough et al. found that individuals who participated in CBT reported lower levels of anxiety. In addition, Stanley et al. (2003) found that individuals who participated in CBT showed improvement on multiple measures of worry and anxiety when compared to

the control group. In addition, these individuals continued to report lower levels of worry and anxiety at the 12 month follow up.

Life review may be a very good technique to utilize when working with individuals of the geriatric population (Rayle & Myers, 2003). Counselors can assist clients in journaling as well as reviewing their life through photographs. This technique is particularly helpful to those struggling with questions such as “Who am I” and “Why am I here?” In order to be most effective when utilizing techniques such as this one, counselors need to be aware of the cultural, environmental, and value orientation differences between themselves and their clients (Maples & Abney, 2006). Chiang, Lu, Chu, Chang, and Chou (2007) indicated that when life review therapy was utilized in a group setting with geriatric clients, their self-esteem and life satisfaction scores significantly increased when compared with control groups. When participants in the experimental group were assessed one month after the termination of the group, these scores continued to be elevated compared to the control groups scores.

Within the medical field, researchers tested the benefits of elders using Ginkgo biloba (120MG/D) for six weeks in order to increase their cognitive functioning (Birks, Grimley, & Van Dongen, 2009). However, no significant improvement was shown between the ginkoba and placebo groups. Also within the medical field, researchers tested the effectiveness of providing collaborative treatment of depression with elders and found this type of treatment to be beneficial (Callahan, 2001). Elders within the treatment group were given access to a depression clinical specialist who was supervised by not only a psychiatrist but also a primary care expert. The depression clinical specialist provided education, antidepressant management, care management,

collaboration between the primary care expert and psychiatrist, and follow-up after treatment was terminated. Participants in the treatment group had a treatment response of at least 50% decrease from baseline in the 20 depression items in the Symptom Checklist. Therefore, this type of care was successful in the treatment of depression and greater quality of life in the geriatric population. However, it is often unavailable in the United States due to inadequate coverage by health insurance companies (Alexopoulos, 2005).

### **Ageism**

The concept of ageism was first introduced by Butler (1969) and is described as stereotypes, prejudice, or discrimination against the geriatric population due to their age (Iverson, Larsen, & Solem, 2009). Not only do members of the general population hold ageist beliefs but mental health practitioners may also discriminate against this population as well. This may ultimately affect the way they interact with clients of the geriatric population and therefore, may put client care at risk (Helmes & Gee, 2003).

### **General Population Attitudes and Biases of the Geriatric Population**

Individuals of the general population often hold ageist beliefs. One common stereotype is that individuals of the geriatric population become unproductive as they age (Rayle & Myers, 2003). However, in most cases, individuals of the geriatric population remain productive and are very dependable workers. Another common stereotype is that individuals of the geriatric population are inflexible and set in their ways. However, older adults may simply be more comfortable doing what is most familiar to them. In addition, individuals of this population are often stereotyped as not being able to learn new information, being senile, and having a decline of interest in participating in sexual activity (Rayle & Myers). These stereotypes and biases may lead to individuals

exhibiting ageism, which is an irrational prejudice against older adults or the aging process (Stuart-Hamilton, 2006). Younger age groups may also be targets of ageism, however, it is typically more prevalent within older populations. For instance, both groups are thought to be inferior and hold little power due to their age. However, as younger individuals grow older, ageist beliefs diminish, yet, in older adults, ageist beliefs never diminish (Iverson et al., 2009).

In order to further explore stereotypes and biases held against the geriatric population, Stuart-Hamilton and Mahoney (2003) held a half-day workshop to increase “age awareness” of aging and older adults. Prior to the workshop, participants were given two scales. The first scale that was administered was the Fraboni Scale of Ageism (FSA), which measures attitudes towards aging adults, and the second scale, Palmore’s Aging Quiz, measured knowledge of aging. One month after the workshop, these two scales were administered to participants again. Researchers found that even though knowledge of the aging process was improved as indicated Palmore’s Aging Quiz scores, attitudes towards this population remained unchanged as indicated by the unchanged scores on the FSA. Therefore, even though knowledge of the geriatric population increased, stereotypes and biases of this population were unaffected indicating that simply educating individuals about the geriatric population is not enough to affect their attitudes regarding elders.

Further, Hummert, Garstka, and Shaner (1997) showed participants photographs of individuals of multiple age groups and asked them to assign character traits to each photograph. They found that participants gave fewer positive attributes to pictures of older individuals. Thimm, Rademacher, and Kruse (1998) found that when participants

were asked to give a specific set of instructions to both younger and older individuals, they tended to use “baby talk” and a different style of speech when communicating with older adults when compared to when they gave the directions to younger individuals.

Ryff (1991) asked younger, middle age, and older adults to rate their past, present, and future selves according to six dimensions which included self-acceptance, positive relations with others, autonomy, environmental mastery, purpose in life and personal growth. Results indicated that younger and middle age adults felt as if they were better in the present than they were in the past. They also believed that they would improve in each of the six dimensions throughout their lives. However, older adults reported that they believed that their best selves were behind them and that they would remain stable in a few of the dimensions (autonomy, self-acceptance, and positive relations with others for men) and saw a decline in others their future years (environmental mastery, personal growth, purpose in life, and positive relations with others for women). Therefore, results may be reflective of age stereotypes suggesting that older adults may succumb to learned helplessness and, therefore, not set goals for their future selves.

### **Mental Health Professionals Attitudes and Biases of the Geriatric Population**

Ageism is a rampant phenomenon within Western society (Holroyd, Dahlke, Fehr, Jung, & Hunter 2009). The elderly are often undervalued and many times ignored within our society. In addition, the health care field is not exempt from this phenomenon. For instance, nurses, doctors, and counselors may not have enough knowledge base or expertise regarding the geriatric population and, therefore, appropriate client care may be at risk. In addition, due to ageist beliefs, health care professionals may not have the desire to take additional courses or attend learning opportunities related to the elderly

population and, therefore, will not be competent in working with this population (Holroyd et al., 2009)

Mental health professionals stereotypes and biases may also affect their prognosis of clients. For instance, Helmes and Gee (2003) presented a fictional description of two patients to psychologists and counselors. All factors in the descriptions were the same except for the patient's ages. One patient was presented as 72 years of age and the other was presented at 42 years of age. Results signified that when the patient was described as being elderly, prognosis for that patient was less optimistic than if the patient was not described as being elderly. Due to age alone counselors believed the older client to be less able to develop a therapeutic relationship, to be less appropriate for therapy, and they felt less competent treating the older client and less willing to accept the older client compared to the 42 year old client. Zivian et al. (1992) found that psychotherapists preferred to treat young clients over middle-aged clients and middle-aged clients over older clients. However, older clients received higher preference when psychotherapists reported that they were older themselves, were employed where older adults were the primary clients, had taken three or more courses on the geriatric population or had stated that 10% or more of their client base were individuals of the geriatric population.

Woolfe and Briggs (1997) asked counselors what special factors needed to be taken into consideration when working with clients of the geriatric population. Overall, counselors perceived that when working with the geriatric population they needed to talk louder and clearer, explain more carefully about the counseling process, lower their expectations about what could be achieved in counseling, take things slower, show consideration for health, avoid using slang words, reduce focus on the past, and not

challenge defenses. These results indicate possible biases and stereotypes counselors may hold against individuals of the geriatric population.

Overall, counselor biases and stereotypes against the geriatric population may negatively affect relationships they have with clients of this population as well as prevent competence in working with this population (Nemmers, 2004). It is imperative that counselors decrease their stereotypes and biases against the geriatric population as these attitudes may significantly influence the cognitive and physical functioning of the client and may ultimately affect their will to survive. Counselors must be knowledgeable about stereotypes and biases held against the geriatric population and be prepared to delegitimize them when working with clients of this population.

### **ACA Gerontological Competencies**

In 1972, the American Counseling Association (ACA) mandated that the association develop a curriculum for training counselors to work with individuals of the geriatric population (Myers, 1995). From this, the Commission on Adult Development and Aging was created and the U.S. Administration on Aging funded five major projects on aging. During the fifth and final project, the ACA gerontological competencies were developed by a team of counselors, gerontologists, practitioners, administrators, and researchers. Overall, these competencies contain two areas: competencies for all counselors and competencies for professionals specializing in work with older adults. Gerontological counselors are expected to have minimum competency in both areas and other counselors who are not specializing in geriatrics are expected to be minimally competent in the generalist area. These competencies are based on the model for infusion of topics in geriatrics into existing counselor preparation courses.



Myers and Sweeney (1990) mandated that within the minimum essential gerontological competencies all counselors should:

- Exhibit positive attitudes towards older adults; Be respectful of all of this population's needs including but not limited to emotional, social, physical, and intellectual;
- Be sensitive towards older adult's limitations and modify the environment to better meet their needs if possible;
- Be knowledgeable in many areas including establishing relationships with older adults, understanding human development, understanding social and cultural foundations, knowledge of techniques and special considerations for group work with older adults, knowledge of lifestyle and career development concerns, and knowledge of assessment of older adults; and
- Be knowledgeable of scholarly sources of literature reporting research about this population such as peer-reviewed journals and know community organizations and networks in which they may refer older adult clients.

The minimum essential gerontological competencies for gerontological counselors are identical to the ones presented above but also include additional competencies (Myers & Sweeney, 1990). For instance, gerontological counselors must:

- Act as advocates for older adults and apply extensive knowledge of human development;

- Apply extensive knowledge of social and cultural foundations for older adults and demonstrate the ability to function in multiple roles such as advocate and family consultant;
- Have skill in the recruitment, selection, planning, and implementing groups with the geriatric population;
- Have extensive knowledge of career and lifestyle options and assessment of older adults;
- Have extensive knowledge of the current research pertaining to older adults and they must be able to implement strategies in order to meet adult clients' needs;
- Collaborate with medical providers in order to meet the needs of physical and mental impairments;
- Demonstrate extensive knowledge about legislation and public policy and be able to apply appropriate intervention techniques during crises;
- Have skill and understanding of the variety of specialized therapies in order to assist older clients and be knowledgeable about ethical issues that may affect this population;
- Be able to consult with organizations and individuals in order to discuss issues related to their clients; and
- Have skill in program development in order to develop and revise programs to better meet this population's needs.

Regardless of the development of the ACA Gerontological Competencies, there is a current lack of emphasis on gerontological counseling in counselor education programs

as indicated by the fact that there are only two CACREP accredited gerontological counseling programs in the United States and very few course offerings within counselor preparation programs (CACREP, 2009a; Maples & Abney, 2006). Some counselor education programs address this deficiency by offering a course on gerontological counseling, however, this course is typically offered only as an elective (Maples & Abney, 2006). Even though these courses are helpful, many times the emphasis is placed too heavily on diagnosing mental health disorders that are unique to the geriatric population such as Alzheimer's disease. Therefore, much needed skills and techniques counselors need to effectively work with the geriatric population may not even be included within the curriculum.

### **Previous Geriatric Research**

Within the counseling literature, there are numerous conceptual articles pertaining to the geriatric population. These conceptual pieces include topics such as incorporating different therapy techniques when working with elders (Westcott, 1983), effective ways of teaching gerontology in counseling (Stickle & Onedera, 2006), and overviews of evidence based practices when counseling older adults (Myers & Harper, 2004). However, there are a lack of descriptive studies exploring this population within the counseling literature. In addition, there have been very few qualitative studies completed with members of the geriatric population.

Many of the quantitative studies regarding attitudes of the geriatric population by students and professionals have been completed within the medical field. Therefore, this information is absent from the counseling literature. For instance, Fitzgerald, Wray, Halter, Williams, and Supiano (2003) indicated that first year medical students

knowledge of the geriatric population was low as they only answered 37% of the questions correct on the Revised Facts on Aging Quiz. However, the Maxwell-Sullivan Attitudes Scale was administered, results indicated that students had somewhat positive attitudes about individuals of the geriatric population with women having significantly more positive attitudes than men. Students who were interested in geriatrics as a career also reported more positive attitudes than students who were not considering this career path.

Krain, Fitzgerald, Halter, and Williams (2007) analyzed knowledge and attitudes of the geriatric population among surgical and medical subspecialty house officers. Attitudes and knowledge were assessed by using the Maxwell-Sullivan Test and the University of Michigan geriatrics Knowledge Test. Participants were shown to have positive attitude scores but low knowledge scores. This indicates that more educational programs in geriatrics are needed in order to further educate these professionals. Further, Kishimoto, Nagoshi, Williams, Masaki, and Blanchette (2005) assessed the knowledge and attitudes of medical students, internal medicine residents, and geriatric medicine fellows about the geriatric population. Results indicated that in regards to knowledge, first and second year medical students had lower knowledge compared to medical fellows. However, first year medical students and fellows had more favorable attitudes towards the geriatric population than advanced students and residents did. Finally, Hughes et al. (2007) indicated that more negative attitudes towards individuals of the geriatric population would develop as training progressed. In addition, students who had cared for older patients before did not have significant attitudinal differences when compared to students who had not previously cared for older patients.

## Conclusion

Diverse cultures within the United States are rapidly increasing (LaRoche & Maxie, 2003; Yali & Revenson, 2004). In response to this, multicultural counseling competencies were created in order to assure that counselors are minimally competent in treating clients who are diverse. However, many mental health professionals continue to hold stereotypes and biases of those who differ by gender, race, ethnicity, age, sexual orientation, and socioeconomic status (Becker & Lamb, 1994; Danzinger & Welfel, 2000; Garnets et al., 1991; Fisher et al., 2001; Stepanikova & Cook, 2008; Toporek & Pope-Davis, 2005). These stereotypes and biases may prevent these clients in receiving adequate care.

Issues pertaining to the geriatric population are limited within the counseling literature. More specifically, research regarding stereotypes and biases of the geriatric population among counselors was found to be remarkably limited. The geriatric population is increasing at such a rapid rate that it is critical that any stereotypes or biases held against this population by mental health counselors are addressed so that counselors may be able to effectively treat individuals of this population. Individuals of the geriatric population have many needs such as elevated suicide rates, depression, anxiety, and victimization. However, these clients may be resistant to receive much needed care (Collins et al., 1995) possibly due to stereotypes and biases held by mental health professionals. The intention of this research is to fill this gap by researching counselor's attitudes and knowledge of the geriatric population and offer recommendations for training in order to better educate counselor trainees.

## **CHAPTER THREE**

### **METHODOLOGY**

This chapter discusses the methodology that was used in researching counselor trainees and practitioners self-reported multicultural competence as well as their attitudes towards the aging population. Counselor demographic variables, which included gender, age, and race/ethnicity, are also examined. In addition, training variables which included whether or not the participant is currently enrolled in or graduated from a CACREP accredited program (CACREP status), number of gerontology counseling courses completed, number of courses gerontological topics were infused into, and number of years of education pertaining to counseling are explored. Finally, employment variables are examined which included the proportion of geriatric clients seen within the previous year, time within the counseling field, licensure obtained, and primary work setting. The purpose of this study is discussed below as well as the research design, research questions, instrumentation, data collection methods, data analysis, validity threats, and potential contributions.

#### **Methodology Overview**

##### **Purpose of Study**

This quantitative study seeks to understand the relationship among counselor demographic variables, training and employment variables, attitudes of the geriatric population, and self-reported multicultural counseling competence. Counselor and counselor trainee demographic variables included gender, age, and race/ethnicity. Training variables included whether or not the participant is currently enrolled in or graduated from a CACREP accredited program (CACREP status), number of

gerontology counseling courses completed, number of courses gerontological topics were infused into, and number of years of education pertaining to counseling. Employment variables included proportion of geriatric clients seen, time within the counseling field, licensure obtained, and primary work setting. Attitudes of the geriatric population also served as a variable and was measured by the FSA (Fraboni et al., 1990). Finally, self-reported multicultural counseling competence served as a variable and was measured by the MCKAS (Ponterotto et al., 2002).

This study examined counselor and counselor trainee demographic, training, and employment variables and how these variables may be associated with attitudes toward the geriatric population in addition to self-reported multicultural competence. Further, the relationship between counselors' self-report of multicultural competence and their attitudes towards the geriatric population were examined. Multicultural counseling competence assessment has traditionally not addressed ageism or competency with the geriatric population, hence the need to look at the relationship between the two constructs.

### **Research Design**

Nonexperimental research design was utilized for this study, which means that variables were not manipulated (Sheperis, Gardner, Erford, & Shoffner, 2008). This type of research "obtains data to determine specific characteristics of a group or to describe a phenomenon" (p. 143). More specifically, this study utilized cross-sectional survey research design. The sample was obtained from a predetermined population of counselors and counselor trainees and the survey was distributed via the Internet. Advantages of utilizing a nonexperimental research design include the ability to obtain a

large amount of information at one time from a large sample size and the ability to conduct research when researchers are unable to manipulate variables (Belli, 2009). However, disadvantages include no ability for researchers to randomize groups and little ability to explain cause and effect relationships.

A web-based survey was used to assess the variables in this study. One potential disadvantage to web-based survey research is a low response rate. This may have resulted in nonresponse bias because participants who responded may have different characteristics compared to those who did not respond (Sheperis et al., 2008). However, this may have been remedied and response rates may have increased as a reminder e-mail was sent to participants (Kaplowitz, Hadlock & Levine, 2004; Kwak & Radler, 2002; Sheperis et al.). Another disadvantage is that it may be difficult to generalize results as participants who lack computer literacy, those who may be weary of responding to web-based surveys due to confidentiality issues, and low socioeconomic status (SES) participants who may not have access to a computer may have been excluded making the sample less representative (Mitra, Jain-Shukla, Robbins, Champion, & Durant, 2008; Sax, Gilmartin, & Bryant, 2003) In addition, for some Internet surveys, researchers cannot control if respondents take a survey more than once or if the intended participant is even the person responding (Cobanoglu & Cobanoglu, 2003; Mitra et al., 2008).

Web-based surveys also offer many advantages. For instance, they are often more efficient than surveys that are mailed (Sax et al., 2003). Shannon and Bradshaw (2002) found an average response rate of 15.58 days for traditionally mailed surveys as compared to 10.95 days for web-based surveys. In addition, they also found that 45% of participants completed the survey within 24 hours. Another advantage of web-based



surveys is that research conducted through this format may also help to reduce the effects of social desirability that may occur during telephone surveys or surveys completed face-to-face (Greene, Speizer, & Wiitala, 2008).

### **Variables**

Demographic variables (i.e., gender, age, race/ethnicity), training variables (i.e., CACREP status, number of gerontology counseling courses completed, number of courses gerontological topics were infused into, and number of years of education pertaining to counseling) and employment variables (i.e., proportion of geriatric clients seen, time within the counseling field, licensure obtained, and primary work setting) served as the independent variables for this study. Counselor and counselor trainee's attitudes towards the geriatric population as measured by the FSA and their self-assessment of multicultural counseling competence as measured by the MCKAS served as dependent variables for this study.

### **Research Questions and Hypotheses**

*In order to investigate whether counselor's demographic, training, and employment variables are associated with attitudes toward the geriatric population as well as self-reported multicultural counseling competence, the following research questions were examined:*

Research Question 1: Is there a significant relationship between counselor and counselor trainee self-reported multicultural counseling competency as indicated by the total score on the MCKAS (Ponterotto et al., 2002) and counselor and counselor trainee attitudes as indicated by their scores on the FSA (Fraboni et al., 1990)?

- (H<sub>1</sub>) There is a significant negative relationship between counselor and counselor trainee's total score on the MCKAS and counselors' scores on the FSA.
- (H<sub>2</sub>) There is no significant relationship between counselor and counselor trainee's total score on the MCKAS and counselors' scores on the FSA.

Research 2: What is the relationship between counselor and counselor trainee demographic variables, and attitudes toward older adults and self-reported multicultural competence?

- Is there a significant relationship between counselor and counselor and counselor trainee demographic variables (i.e., gender, age, race/ethnicity) and attitudes towards older adults as measured by the FSA (Fraboni et al., 1990)?
  - (H<sub>3</sub>) There is a significant relationship between counselor and counselor trainee's demographic variables (i.e., gender, age, race/ethnicity) and their attitudes towards older adults. Females will have lower ageism scores than males, age will be a curvilinear relationship as younger and older participants will hold the most negative attitudes, and multiple interaction effects are hypothesized.

- (H<sub>4</sub>) There is no relationship between counselor and counselor trainee's demographic variables (i.e., gender, age, race/ethnicity) and their attitudes towards older adults.
- Is there a significant relationship between counselor and counselor trainee demographic variables (i.e., gender, age, race/ethnicity) and self-reported multicultural counseling competence as measured by the MCKAS (Ponterotto et al., 2002)?
  - (H<sub>5</sub>) There is a significant relationship between counselor and counselor trainee's demographic variables (i.e., gender, age, race/ethnicity) and their self-reported multicultural counseling competence. Participants who are not White will have higher scores on the MCKAS and multiple interaction effects are hypothesized.
  - (H<sub>6</sub>) There is no relationship between counselor and counselor trainee's demographic variables (i.e., gender, age, race/ethnicity) and their self-reported multicultural counseling competence.

Research Question 3: What is the relationship between counselor and counselor trainee training variables and attitudes toward older adults and self-reported multicultural competence?

- Is there a significant relationship between training variables (i.e., CACREP status, number of gerontology counseling courses

completed, number of courses gerontological topics were infused into, and number of years of education pertaining to counseling) and counselor and counselor trainee's attitudes towards older adults as measured by the FSA (Fraboni et al., 1990)?

- (H<sub>7</sub>) There is a significant relationship between training variables (i.e., CACREP status, number of gerontology counseling courses completed, number of courses gerontological topics were infused into, and number of years of education pertaining to counseling) and counselor and counselor trainee's attitudes towards older adults. Number of gerontology counseling courses completed and number of courses gerontological topics were infused into will both lead to fewer ageist attitudes. Interaction effects are also hypothesized.
- (H<sub>8</sub>) There is no significant relationship between training variables (i.e., CACREP status, number of gerontology counseling courses completed, number of courses gerontological topics were infused into, and number of years of education pertaining to counseling) and counselor and counselor trainee's attitudes towards older adults.
- Is there a significant relationship between training variables (i.e., CACREP status, number of gerontology counseling courses completed, number of courses gerontological topics were infused

into, and number of years of education pertaining to counseling) and counselor and counselor trainee's self-assessment of multicultural counseling competence as measured by the MCKAS (Ponterotto et al., 2002)?

- (H<sub>9</sub>) There is a significant relationship between training variables (i.e., CACREP status, number of gerontology counseling courses completed, number of courses gerontological topics were infused into, and number of years of education pertaining to counseling) and counselor and counselor trainee's self-reported multicultural counseling competence. Participants coming from CACREP programs will self report has having greater multicultural counseling competence than participants coming from non-CACREP programs and interaction effects are also hypothesized.
- (H<sub>10</sub>) There is no significant relationship between training variables (i.e., CACREP status, number of gerontology counseling courses completed, number of courses gerontological topics were infused into, and number of years of education pertaining to counseling) and counselor and counselor trainee's self-reported multicultural counseling competence.

Research Question 4: What is the relationship between counselor employment variables and attitudes toward older adults and self-reported multicultural competence?

- Is there a relationship between counselors' employment variables (i.e., proportion of geriatric clients seen, time within the counseling field, licensure obtained, and primary work setting) and counselors' attitudes towards older adults as measured by the FSA (Fraboni et al., 1990)?
  - (H<sub>11</sub>) There is a significant relationship between employment variables (i.e., proportion of geriatric clients seen, time within the counseling field, licensure obtained, and primary work setting) and their attitudes towards older adults. The higher the proportion of geriatric clients seen within a year will lead to fewer ageist attitudes. Interaction effects are also hypothesized.
  - (H<sub>12</sub>) There is no significant relationship between employment variables (i.e., proportion of geriatric clients seen, time within the counseling field, licensure obtained, and primary work setting) and their attitudes towards older adults.
- Is there a significant relationship between counselors' employment variables (i.e., proportion of geriatric clients seen, time within the counseling field, licensure obtained, and primary work setting) and

counselors' self-assessment of multicultural counseling competence as measured by the MCKAS (Ponterotto et al., 2002)?

- (H<sub>13</sub>) There is a significant relationship between employment variables (i.e., proportion of geriatric clients seen, time within the counseling field, licensure obtained, and primary work setting) and their self-reported multicultural counseling competence. Time spent within the counseling field as an employee will lead to greater self-reported multicultural counseling competence. Interaction effects are also hypothesized.
- (H<sub>14</sub>) There is no significant relationship between employment variables (i.e., proportion of geriatric clients seen, time within the counseling field, licensure obtained, and primary work setting) and their self-reported multicultural counseling competence.

### **Instrumentation**

#### **The Fraboni Scale of Ageism (FSA)**

The FSA measures attitudes towards aging and the geriatric population rather than knowledge of this population (Fraboni et al., 1990; see Appendix B). This scale was designed to measure an affective component such as avoiding and excluding members of this population in addition to a cognitive component of myths and beliefs about this population. The FSA was the first of its kind as previous scales measured only cognitive

components of ageism. In order to receive the total score for this scale, each response on the Likert scale is summed.

The FSA consists of 29 items and utilizes a 4-point Likert type format ranging from 1 (*strongly disagree*) to 5 (*strongly agree*; 3 is excluded) and assesses stereotypic behaviors and attitudes by measuring antilocution, discriminatory attitudes, and avoidance of individuals of the geriatric population (Rupp, Vodanaovich, & Crede, 2005). The Antilocution subscale measures the degree in which participants refer to older adults and aging negatively by assessing participants' "antagonism and antipathy fuelled by misconceptions, misinformation, or myths about older persons" (Fraboni et al., p. 59; Rupp et al.). A sample item from this subscale is "Many old people just live in the past." The Avoidance subscale measures avoidance or the degree in which participants avoid contact with the geriatric population by assessing participants' "withdrawal from social contact with older persons" (Fraboni et al., p. 59; Rupp et al.). A sample item from this subscale is "I don't like it when old people try to make conversation with me." The Discrimination subscale measures the degree in which participants discriminate against the geriatric population by assessing participants' "discriminatory opinions regarding the political rights, segregation, and activities of older persons" (Fraboni et al., p. 59; Rupp et al.). A sample item from this subscale is "Most old people should not be trusted to take care of infants." Each response on the Likert scale is summed in order to get the total score. Scores for this scale range from 29-145 and the higher the participant's score the greater the level of measured ageism (Fraboni et al.). Unanswered items are scored as a three.



The FSA was found to have adequate construct validity and high internal reliability. Cronbach's alpha for the total scale was .86, suggesting the scale is relatively homogeneous (Fraboni, et al., 1990). The scale was found to have adequate internal consistency reliability as Cronbach's coefficient alpha of the Antilocution, Avoidance, and Discrimination subscales were found to be .76, .77, and .65, respectively. The scale has been correlated with other measures and has showed significant correlations with these measures such as the Acceptance of Others scales ( $r = .40, p < .001$ ), and Facts on Aging Quiz ( $r = -.28, p < .001$ ).

Kalavar (2001) indicated that male respondents had a mean score of 70.60 and female respondents had a mean score of 62.94. The mean score for the entire sample was 65.34. This may be due to the lifespan developmental processes as well as females greater exposure to the geriatric population. Rupp et al. (2005) found that according to the Fraboni Scale on Ageism, younger participants were more ageist than older participants. This study also suggested that the relationship between participant age and ageism scores may be slightly curvilinear. Therefore, younger and older participants tended to be the most ageist.

The utilization of the FSA within this study is vital as it detects ageist beliefs counselor trainees and professionals may have regarding the geriatric population. One of the minimum standards for working with the geriatric population is that all counselors must exhibit positive towards attitudes older adults (Myers & Sweeney, 1990). Therefore, if ageist beliefs are detected, then these individuals may be deemed incompetent in working with elders.

### **The Multicultural Counseling Knowledge and Awareness Scale (MCKAS)**

The MCKAS is a 32-item scale, which measures multicultural counseling competence (Ponterotto et al., 2002; see Appendix C). This scale consists of two subscales including a Knowledge scale which is 20 items and measures participants knowledge related to multicultural counseling and an Awareness scale which is 12 items and measures worldview biases and attitudes (Kim et al., 2003; Ponterotto et al., 2002). Ten of the 12 items (items 1, 4, 7, 10, 11, 18, 20, 24, 25, and 30) on the Awareness scale are negatively worded so they need to be reversed scored before totaling the final score (Ponterotto et al., 2002). A sample question that is reversed scored from the Awareness subscale includes: *I think that being highly competitive and achievement oriented are traits that all clients should work towards*. Therefore, a higher score on this item would indicate lower multicultural awareness. A sample question from the Knowledge subscale includes: *I am aware of individual differences that exist among members within a particular ethnic group based on values, beliefs, and level of acculturation* (Ponterotto et al., 2002).

The MCKAS utilizes a 7-point Likert-type scale in order to assess competencies and provides subscale scores for Knowledge-Skills as well as Awareness. The Likert scale ranges from (1) *not true at all*, (4) *somewhat true*, and (7) *totally true*. The rating selected for each item on the subscale are reversed scored if necessary then totaled to reach the subscale scores. The higher individuals score on both subscales the higher their multicultural Knowledge and Awareness (Ponterotto et al., 2002). Both the Knowledge and Awareness subscales have a coefficient alpha of .85 (Ponterotto et al., 2002) and in a study conducted by Kim et al. (2003) the Knowledge scale yielded a coefficient alpha of

.90 and the Awareness scale yielded a coefficient alpha of .86. A previous study utilizing the MCKAS found that mental health professionals who indicated greater levels of racial ideology were correlated with lower self-reported multicultural counseling awareness and knowledge (Neville, Spanierman, & Doan, 2006).

### **Multicultural Training Questionnaire and Demographic Sheet**

Each participant answered questions pertaining to their history of gerontology training (Appendix D). Didactic training was assessed by the number of gerontology or adult development courses they completed and the number of other courses topics regarding the geriatric population were infused into. Practitioners were also asked to identify the percentage of clients who they have worked with in the past year who were of the geriatric population. Each individual participating in this study was asked to provide information on a demographic sheet. Information assessed included gender, age, race/ethnicity, highest degree obtained, licensure information, time in the counseling field as a practitioner or student (in years), what ACA divisions they are a member of, CACREP status of the they are enrolled in or graduated from, and primary work setting.

### **Data Collection Methods**

#### **Participants**

Participants consisted of graduate students in all stages of both CACREP and non-CACREP accredited counseling programs in order for participants' scores from both CACREP accredited programs and non-CACREP accredited programs to be compared. Participants also consisted of master's and doctoral level counselors working in the counseling field so that these individuals may be compared to counselor trainees. Participants were selected at random and were current members of the American

Counseling Association. (The ACA staff randomly selected the desired sample from the sampling frame.) In order to complete the survey, participants were required to be currently enrolled within a counselor preparation program or be a practitioner who graduated from a masters or doctoral counseling program. Assuming a moderate effect size at the  $P=.80$  level, a minimum sample of 360 participants was sought to test hypotheses at the .05 alpha level (Cohen, 1992). Overall, 2000 participants were surveyed.

### **Compliance**

Proceeding data collection, in compliance with Federal codes (Code of Federal Regulations Title 45 Part 46, [45CFR46]) and State of Virginia regulations (*Virginia Code 32.1-162.16 et seq.*), the Human Subjects Review Board at Old Dominion University reviewed the proposed procedures and instrumentation (see Appendix A). Data collection began once the researcher was approved by the Human Subjects Review Board. In addition, this information was placed on SurveyMonkey so that participants were made aware that this study was approved. The information participants provided by filling out the online survey was completely anonymous. No identifying information was collected. Data was compiled using the Statistical Package for the Social Sciences (SPSS) 16.0 and was stored on a password-protected computer. Only the listed researchers had access to the data. To assure anonymity, no information regarding participant Internet addresses was recorded. There were no foreseeable risks for participating in this research. Participants were asked to answer a series of questions and were able to refuse to answer any questions that they did not wish to answer. In addition,

they were able to terminate participation at any time without penalty. There was no cost to participants nor was any compensation provided for participation.

### **Procedures**

The ACA was contacted and a random selection of its members e-mail addresses was requested. It was asked that half of the email list comprise ACA members who identify themselves as students and the other half who identify themselves as professionals. In addition, it was requested that school counselors be excluded from this list. Data were collected by using the online service SurveyMonkey (www.surveymonkey.com). Upon obtaining the email addresses, an email was sent explaining the purpose of the study with a link to materials placed on SurveyMonkey. Participants were asked to complete the survey by filling in the appropriate answers. The survey packet included the following: the FSA (Fraboni, et al., 1990), the MCKAS (Ponterotto et al., 2002), the Multicultural Training Questionnaire and Demographic Sheet, and informed consent information (see Appendix E). Participants were able to answer the questions within the packet at their leisure, as there were no time constraints. In order to reduce ordering bias, three links were created with the surveys ordered differently in each. In order to increase participation, a weekly reminder was sent to participants over a period of three weeks.

### **Data Analysis**

After data collection was completed, the SPSS 16.0 for Windows was utilized in the data analysis phase. The data were downloaded from SurveyMonkey into Excel and then imported into SPSS. Data were analyzed in order to ensure that it was complete and entered correctly. Frequency distributions were utilized to report data such as gender,

age, race/ethnicity, counselor trainee and number of years of education pertaining to counseling, licensure information, and time in the counseling field (in years). Research questions, hypothesis and analysis strategies follow.

In order to investigate the relationship between counselors' training variables, employment variables, demographic variables and their attitudes of the geriatric population, and self-assessment of multicultural competence the following hypotheses were examined:

- (H<sub>1</sub>) There is a significant negative relationship between counselor and counselor trainee total scores on the MCKAS and counselors' scores on the FSA.

Hypothesis 1, (H<sub>1</sub>) was analyzed by using a correlation procedure. Counselor and counselor trainee's total scores on the MCKAS and their total scores on the FSA were correlated with each other.

- (H<sub>2</sub>) There is no significant relationship between counselor and counselor trainee's total score on the MCKAS and counselors' scores on the FSA.

Hypothesis 2, (H<sub>2</sub>) was analyzed by using a correlation procedure. Counselor and counselor trainee's total scores on the MCKAS and their total scores on the FSA were correlated with each other.

- (H<sub>3</sub>) There is a significant relationship between counselor and counselor trainee's demographic variables (i.e., gender, age, race/ethnicity) and their attitudes towards older adults. Females will have lower ageism scores than males, age will be a curvilinear relationship as younger and older

participants will hold the most negative attitudes, and multiple interaction effects are hypothesized.

- (H<sub>4</sub>) There is no relationship between counselor and counselor trainee's demographic variables (i.e., gender, age, race/ethnicity) and their attitudes towards older adults.
- (H<sub>5</sub>) There is a significant relationship between counselor and counselor trainee's demographic variables (i.e., gender, age, race/ethnicity) and their self-reported multicultural counseling competence. Participants who are not White will have higher scores on the MCKAS and multiple interaction effects are hypothesized.

Hypothesis 3, (H<sub>3</sub>), Hypothesis 4 (H<sub>4</sub>), and Hypothesis 5 (H<sub>5</sub>) was analyzed by using a separate three-way ANOVA procedures. Counselor and counselor trainee's demographic variables (i.e., gender, age, race/ethnicity) served as the independent variables.

Counselor and counselor trainee's attitudes towards older adults as measured by the FSA and Counselor and counselor trainee's self-assessment of multicultural counseling competence as measured by the MCKAS served as the dependent variables.

- (H<sub>7</sub>) There is a significant relationship between training variables (i.e., CACREP status, number of gerontology counseling courses completed, number of courses gerontological topics were infused into, and number of years of education pertaining to counseling) and counselor and counselor trainee's attitudes towards older adults.

Number of gerontology counseling courses completed and number of courses gerontological topics were infused into will both lead to fewer ageist attitudes. Interaction effects are also hypothesized.

- (H<sub>8</sub>) There is no significant relationship between training variables (i.e., CACREP status, number of gerontology counseling courses completed, number of courses gerontological topics were infused into, and number of years of education pertaining to counseling) and counselor and counselor trainee's attitudes towards older adults.
- (H<sub>9</sub>) There is a significant relationship between training variables (i.e., CACREP status, number of gerontology counseling courses completed, number of courses gerontological topics were infused into, and number of years of education pertaining to counseling) and counselor and counselor trainee's self-reported multicultural counseling competence. Participants coming from CACREP programs will self report has having greater multicultural counseling competence than participants coming from non-CACREP programs and interaction effects are also hypothesized.
- (H<sub>10</sub>) There is no significant relationship between training variables (i.e., CACREP status, number of gerontology



counseling courses completed, number of courses gerontological topics were infused into, and number of years of education pertaining to counseling) and counselor and counselor trainee's self-reported multicultural counseling competence.

Hypothesis 7 (H<sub>7</sub>), Hypothesis 8 (H<sub>8</sub>), Hypothesis 9 (H<sub>9</sub>), and Hypothesis 10 (H<sub>10</sub>) were analyzed using separate four-way ANOVA procedures. Counselor and counselor trainee's training variables (i.e., CACREP status, number of gerontology counseling courses completed, number of courses gerontological topics were infused into, number of years of education pertaining to counseling) served as the independent variables.

Counselor and counselor trainee's attitudes towards older adults as measured by the FSA and counselor and counselor trainee's self-assessment of multicultural counseling competence as measured by the MCKAS served as the dependent variables.

- (H<sub>11</sub>) There is a significant relationship between employment variables (i.e., proportion of geriatric clients seen, time within the counseling field, licensure obtained, and primary work setting) and their attitudes towards older adults. The higher the proportion of geriatric clients seen within a year will lead to fewer ageist attitudes. Interaction effects are also hypothesized.
- (H<sub>12</sub>) There is no significant relationship between employment variables (i.e., proportion of geriatric clients seen, time within the counseling field, licensure obtained,

and primary work setting) and their attitudes towards older adults.

- (H<sub>13</sub>) There is a significant relationship between employment variables (i.e., proportion of geriatric clients seen, time within the counseling field, licensure obtained, and primary work setting) and their self-reported multicultural counseling competence. Time spent within the counseling field as an employee will lead to greater self-reported multicultural counseling competence. Interaction effects are also hypothesized.
- (H<sub>14</sub>) There is no significant relationship between employment variables (i.e., proportion of geriatric clients seen, time within the counseling field, licensure obtained, and primary work setting) and their self-reported multicultural counseling competence.

Hypothesis 11, (H<sub>11</sub>), Hypothesis 12 (H<sub>12</sub>), Hypothesis 13 (H<sub>13</sub>), and Hypothesis 14 (H<sub>14</sub>) were analyzed by using separate four-way ANOVA procedures. Counselors' employment variables (i.e., proportion of geriatric clients seen, time within the counseling field, licensure obtained, and primary work setting) served as the independent variables. Counselors' attitudes towards older adults as measured by the FSA and counselors' self-assessment of multicultural counseling competence as measured by the MCKAS served as the dependent variables.

### Validity Threats

According to Creswell (2009), there are two types of validity threats: internal and external. Internal validity is the ability of the research design to rule out or make alternative explanation of the results (Marczyk, Dematteo, & Festinger, 2005). Internal validity threats include “experimental procedures, treatments, or experiences of the participants that threaten the researcher’s ability to draw correct inferences from the data about the population in an experiment” (p. 162). For this study, selection may be a threat to validity as participants who are selected for this study may have certain characteristics that predispose them to have particular outcomes. In attempt to control this, a random email list was obtained from ACA and the survey was distributed to individuals on this list. Instrumentation threats may also exist within this study. For instance, the measures may not be consistent over time and they may not measure what they are actually intended to measure (Marczyk et al., 2005). Ordering bias may also be an issue. In order to prevent this, SurveyMonkey displayed questions to each participant in a randomized order. In addition, even though this study is not longitudinal in nature, testing may also be a threat if participants have taken either the FSA or the MCKAS previously. Taking the same measure multiple times may affect scores as practice, memory, research expectations, and sensitization may develop.

External validity is how generalizable the results of the research study are (Marczyk et al., 2005). According to Creswell (2009), external validity threats “arise when experimenters draw incorrect inferences from the sample data to other persons, other settings, and past or future situations” (p. 162). These threats may be a problem due to characteristics of the participants, timing of the experiment, and uniqueness of

setting. Interaction of setting and treatment may also have been an issue in this study. For instance, characteristics of the participants may have prevented the results from being generalized to individuals in other settings. Therefore, results of this study may not be generalizable to other populations. In addition, participants may have been reactive to the assessment in that they were aware that their performance is being measured and, therefore, altered their answers from what they would have otherwise been (Marczyk et al., 2005). Participants will do this in order to please the researcher or appear “better” or more competent than they actually are. This may have been an issue in this research because it pertains to counselors’ attitudes regarding the geriatric population. Therefore, participants may have not been completely honest if they did hold biases and stereotypes against this population. In attempt to reduce this, confidentiality and anonymity was ensured for this research study.

### **Potential Contributions**

This study highlights counselors’ biases and stereotypes of the geriatric population and, therefore, suggests any changes that may be needed in counselor preparation programs regarding gerontological issues so that counselors may be better equipped to work with this population. It is imperative that counselors are equipped to work with this generation as they are dealing with unique issues that generations before did not experience such as diminishing social security income, long-term care needs and more prevalence of age discrimination (Dixon et al., 2003).

If counselor biases and stereotypes are identified, this study will encourage programs to focus more heavily on issues exclusive to the geriatric population and ultimately affect counselors who will work with these individuals. In addition, it will be

recommended that counselor preparation programs better educate counselors about this population in order to break down some of these biases and stereotypes. One practical way to encourage acceptance of populations is through activities such as immersion experiences.

Due to the extensiveness of this generation, it is imperative that counselors are educated regarding these unique issues and prepared to assist and advocate for individuals that comprise the geriatric population. This may be difficult as many individuals who are elderly are hesitant to seek counseling (Maples & Abney, 2006). Therefore, if counselors are not competent in working with this population they may further deter these clients from seeking counseling. If this happens, geriatric client care will suffer significantly. This study helps to bring much needed attention to the geriatric population. It will assist in producing systemic changes that are needed so the counselors may be more competent in working with this population.

Currently, there is a large gap in the scholarly research regarding gerontological counseling. Much of the research is from the late 1980's and early 1990's. Due to the breadth of the current geriatric population, it is significant that counseling professionals have access to up to date information regarding this population. This study will contribute to the limited literature in the counseling field regarding geriatrics and stimulate future research.

### **Summary**

This quantitative study seeks to understand the relationship among counselor demographic variables, training and employment variables, attitudes of the geriatric population, and self-reported multicultural counseling competence. By exploring these

variables, I hope to add to the current literature regarding counselor stereotypes and biases of the geriatric population. In addition, I hope to examine possible training recommendations regarding the geriatric population for counselor preparation programs.

## CHAPTER FOUR

### RESULTS

The purpose of this study was to explore whether variables are associated with counselors' and counselor trainees' self-reported multicultural counseling competence as well as ageist attitudes. These variables included demographic variables (i.e., gender, age, race/ethnicity), training variables (i.e., CACREP status, number of gerontology counseling courses completed, number of courses gerontological topics were infused into, and number of years of education pertaining to counseling) and employment variables (i.e., proportion of geriatric clients seen, time within the counseling field, licensure obtained, and primary work setting). This study used the nonexperimental survey method to obtain quantitative data regarding counselors' self-reported multicultural counseling competence and their attitudes towards the geriatric population. This chapter outlines the results of the study, beginning with demographic information about participants. Following the survey participants' demographic information, an overview of the results for the FSA and the MCKAS. Then the research questions and hypotheses are presented with the results of the statistical analysis.

#### **Demographics**

The target population for this study was practitioners within the counseling field as well as masters students in both CACREP and non-CACREP counseling programs. Participants were selected via a random sample from the American Counseling Association. In order to control for ordering bias, participants were randomly assigned to three groups. Each group was provided with a unique link in order to access the survey. On April 9, 2010, solicitation for participants was sent to the 2,000 participants provided

by the American Counseling Association. Overall, 38 emails were undeliverable, leaving 1,962 individuals who were potential participants in the study. These undeliverable emails accounted for 1.9% of the sample. During this initial solicitation, 152 out of 415 individuals participated in the survey. This accounted for 36.6% of respondents.

On April 13, 2010, the first reminder email was sent to the 2,000 participants. This email was standardized, thanked those who had already participated, and reminded potential participants to complete the survey. Overall, 41 emails were undeliverable, leaving 1,959 individuals who were potential participants in the study. These undeliverable emails accounted for 2% of the sample. During this reminder period, 128 of 415 individuals participated in the survey. This accounted for 30.8% of respondents.

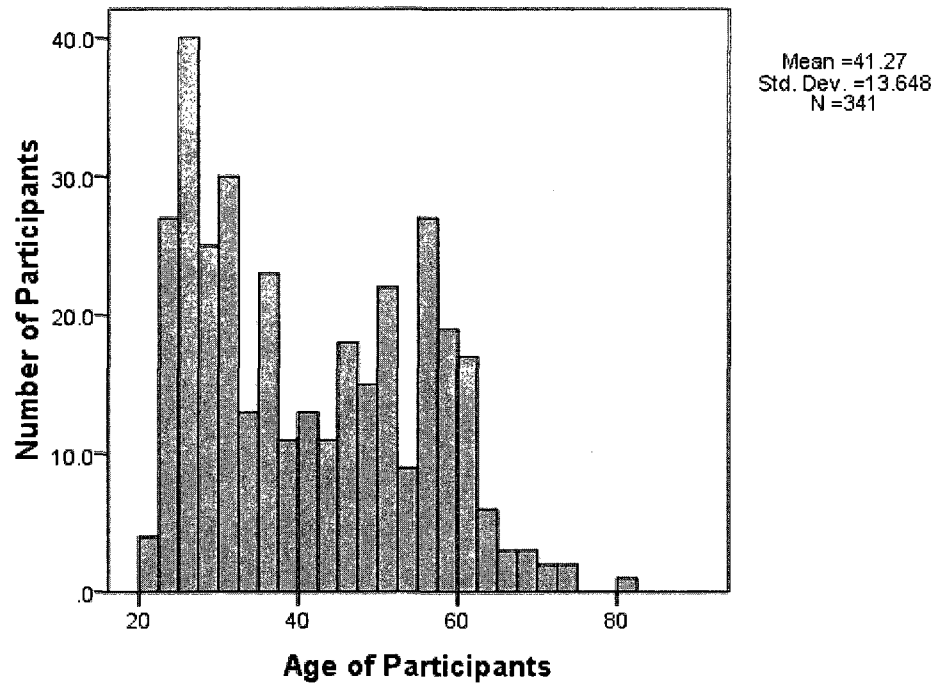
One week later, the second reminder email was sent to the 2,000 participants. The email was standardized, thanked those who had already participated, and reminded potential participants to complete the survey. Overall, 35 emails were undeliverable, leaving 1,965 individuals who were potential participants in the study. These undeliverable emails accounted for 1.7% of the sample. During this reminder period, 86 of 415 individuals participated in the survey. This accounted for 20.7% of respondents.

Several days later, the final reminder email was sent to the 2,000 participants. The email was standardized, thanked those who had already participated, and reminded potential participants to complete the survey. Overall, 31 emails were undeliverable, leaving 1,969 individuals who were potential participants in the study. These undeliverable emails accounted for 1.5% of the sample. During this final reminder period, 49 of 415 individuals participated in the survey. This accounted for 11.8% of respondents.



The overall return rate for the survey was 415 out of 1,962 potential respondents (21.1%). Participants did not have to complete the survey once they began it and, therefore, participants were allowed to drop out at anytime. Overall, 415 participants began the survey but only 361 participants completed it. Therefore, 54 participants dropped out and 86.9% of participants who started the survey completed the survey. However, not every participant who completed the survey fully answered every question. Out of the 61 FSA and MCKAS items, 41 questions (67%) had one or more blank spaces from participants who chose not to answer those particular questions. However, there was no question on either of these assessments with more than seven blank spaces. Therefore, every question on these two assessments had at least a 98.1% response rate by 361 participants.

Participants were asked to indicate their age in the survey demographics section. Out of the 361 participants, 20 participants chose to not report their age. The age range was 21 to 81 years. The mean age for participants in this study was 41.27 years of age, with a standard deviation of 13.64. This sample was bimodal (23,27) and the median age was 39. The ages of this entire sample were unevenly distributed, platykurtic (-1.07), and slightly positively skewed (0.329; see Figure 1).



*Figure 1.*

Distribution for the ages of participants in this study.

Participants were asked to identify their gender. All participants reported their gender and overall, 72 males (19.9%), 287 females (79.5%), and 2 transgendered (.005%) individuals participated. Participants also reported their race/ethnicity. Overall, 294 participants identified as being White, 25 identified as African American, 17 identified as Hispanic, 3 identified as Asian American, and 18 identified as other (see Table 1). Other races included participants who identified themselves as a combination of the above stated races, Native American, Bahamian, Persian, Pacific Islander, African, Welsh-Irish and Portuguese. In addition, four individuals chose not to report their race/ethnicity.

Table 1  
*Race/Ethnicity of Participants*

	Frequency	Percent
White	294	81.4
African American	25	6.9
Hispanic	17	4.7
Asian American	3	.8
Other	18	5.0

Participants were asked to indicate their membership within the divisions of the American Counseling Association. Overall, 181 (50.1%) participants indicated that they are not a member of any divisions. Descriptive data for participants' responses are shown below in Table 2.

Table 2  
*Participants' Membership in the Divisions of the American Counseling Association*

	Frequency	Percent
AACE	10	2.7
AADA	7	1.9
ACC	13	3.6
ACCA	12	3.3
ACEG	4	1.1

ACES	28	7.7
ALGBTIC	17	4.7
AMCD	12	3.3
AMHCA	40	11.0
ARCA	10	2.7
ASCA	25	6.9
ASERVIC	18	4.9
ASGW	6	1.6
C-AHEAD	5	1.3
CSJ	4	1.1
IAAOC	5	1.3
IAMFC	15	4.1
NCDA	10	2.7
NECA	3	.8
No Memberships	181	50.1

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Participants were asked to report any licenses or certifications they currently held. Overall, 97 participants indicated they were Licensed Professional Counselors (26.8%; LPC), 75 Nationally Certified Counselors (20.7%; NCC), 13 Licensed Marriage and Family Therapists (3.6%; LMFT), 8 Certified Rehabilitation Counselors (2.2%; CRC), and 3 Certified Substance Abuse Counselors (0.8%; CSAC). In addition, 171 (47.3%) participants indicated that they currently did not hold any licenses or certifications and 82

(22.7%) indicated they held other licenses or certifications than stated above. Some of the other licenses and certifications participants indicated they held included Licensed Clinical Professional Counselor, Licensed Mental Health Counselor, Registered Play Therapist, Certified Addictions Counselor, and Licensed School Counselor.

Participants were also asked to identify their highest level of education. Overall, 1 participant chose not to report, 102 participants indicated their highest level of education was a Bachelor's degree (28.3%), 214 indicated their highest level of education was a Masters degree (59.4%), and 44 participants indicated their highest level of education was a Doctorate degree (12.2%). However, all participants who identified their highest level of education as a Bachelor's degree were currently pursuing their Masters in Counseling.

Participants were asked to identify the number of gerontology courses they have completed. Overall, 220 (60.9%) participants indicated that they had not completed any gerontology courses, 84 (23.3%) indicated they had completed one gerontology course, 35 (9.7%) indicated they had completed two gerontology courses, 9 (2.5%) indicated they had completed three gerontology courses, 5 (1.4%) indicated they had completed 5 gerontology courses, and 3 (.8%) indicated they had other training experiences such as degrees in gerontology and extensive internships with the geriatric population.

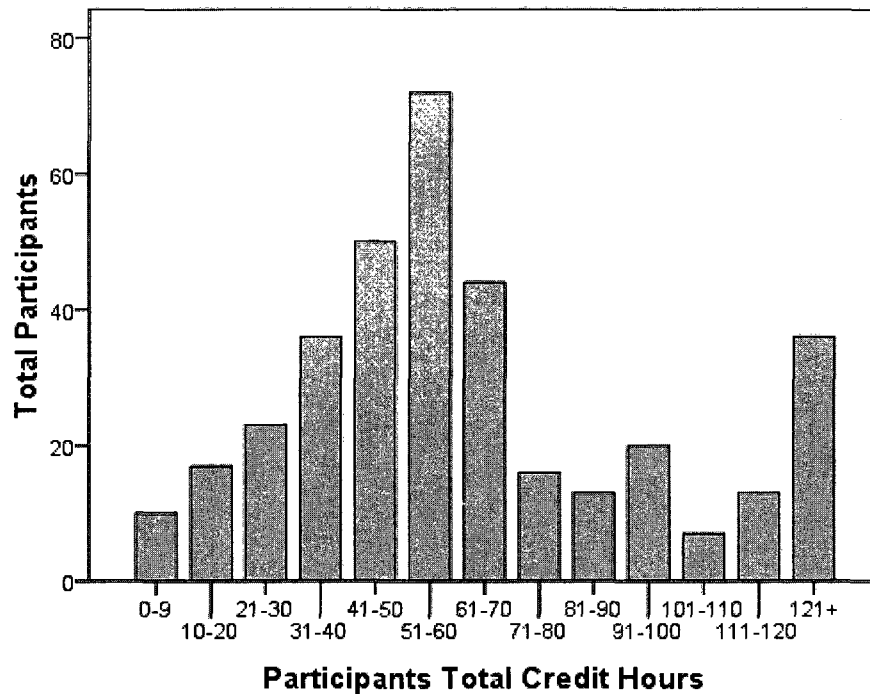
Participants were also asked to indicate whether their practicum and internship as well as the eight core CACREP courses addressed topics regarding geriatrics.

Descriptive data for participants' responses are shown below in Table 3.

Table 3  
*Courses Addressing Geriatrics*

	Frequency	Percent
Ethics	138	38.2
Career	106	29.4
Multicultural	213	59
Helping Relationships	74	20.5
Human Growth	278	77
Group Work	66	18.3
Assessment	75	20.8
Research and Program Evaluation	24	6.6
Practicum and Internship	85	23.5

Participants were asked to identify how many credit hours they have completed within master's and doctoral counseling programs. Overall, 4 individuals chose not to report the amount of credit hours they had completed. The mean range of credit hours completed was 61-70. Descriptive data for participants' responses are shown below in Figure 2.



*Figure 2.*

Distribution of participants total credit hours.

Participants were asked to identify their multiple roles within the counseling field. Overall, 164 (45.4%) participants identified themselves as practitioners, 161 (44.5%) identified themselves as masters-level students, 37 (10.2%) identified themselves as doctoral in counseling students, and 43 (11.9%) identified themselves as counselor educators. When asked to identify their primary role 31 (8.6%) participants identified themselves as counselor educators, 158 (43.8%) identified themselves as practitioners, and 172 (47.6%) identified themselves as masters or doctoral students.

Out of the 31 participants who identified their primary role as counselor educator, 16 of them indicated that they graduated from a CACREP accredited program, 13 participants indicated that they did not graduate from a CACREP accredited program,

and 1 participant indicated that they were unsure if they had graduated from a CACREP accredited program or not. In addition, one participant chose not to disclose whether or not they had graduated from a CACREP accredited program. When asked if they currently teach at a CACREP accredited university, 12 participants indicated that they did and 19 participants indicated that they did not. In addition, their years as counselor educators varied and are presented in Table 4 below.

Table 4  
*Participants Years as Counselor Educators*

	Frequency	Percent
0-2 Years	10	32.3
3-5 Years	5	16.1
6-8 Years	5	16.1
9-11 Years	4	12.9
12-14 Years	3	9.7
18-20 Years	2	6.5
30+ Years	1	3.2

Of those participants who primarily identified themselves as doctoral or masters students (172), 131 stated that they were currently enrolled in a CACREP accredited program, 28 stated that they were not currently enrolled in a CACREP accredited program and 13 stated that they were unsure whether or not they were enrolled in a



CACREP accredited program. In addition, 148 of these participants identified as masters in counseling students while 24 identified as doctoral in counseling students.

Of those participants who primarily identified themselves as practitioners (158), 107 indicated that they graduated from a CACREP accredited program, 42 indicated that they had not graduated from a CACREP accredited program, 8 were unsure whether or not they had graduated from a CACREP accredited program, and 1 chose not to disclose this information.

These participants were also asked to indicate the percentage of clients who are from the geriatric population they see per year. Seven participants chose not to disclose how many clients from the geriatric population they see per year. Descriptive data for participants' responses are shown below in Table 5.

Table 5  
*Percentage of Geriatric Clients per Year*

	Frequency	Percent
0-10%	103	65
11-20%	26	16.5
21-30%	10	6.3
21-40%	3	1.8
41-50%	6	3.8
51-60%	1	1.7
61-70%	3	1.8
71-80%	3	1.8
81-90%	2	1.2

Participants who identified themselves primarily as practitioners were asked to indicate their primary work setting. Overall, 75 participants indicated that their primary work setting is private practice, 12 indicated that their primary work setting is a hospital, 17 indicated that their primary work setting is a school, 52 participants indicated other settings as their primary work settings, and 2 participants chose not to disclose their work setting. The “other” primary work settings included community centers, in-home, early intervention programs, correctional facilities, hospice care, and rape crisis centers.

Finally, participants who primarily identified as practitioners were asked to indicate their years of experience as employees within the counseling field. One participant chose not to disclose this information. Descriptive data for participants’ responses are shown below in Table 6.

Table 6  
*Practitioners Years of Experience within the Counseling Field*

	Frequency	Percent
0-2	44	34.3
3-5	34	21.5
6-8	17	10.7
9-11	13	8.2
12-14	12	7.6
15-17	10	6.3
18-20	6	3.8
21-23	3	1.9

24-26	7	4.4
27-29	3	1.9
30+	8	5.1

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### **Summary of Participant Demographics**

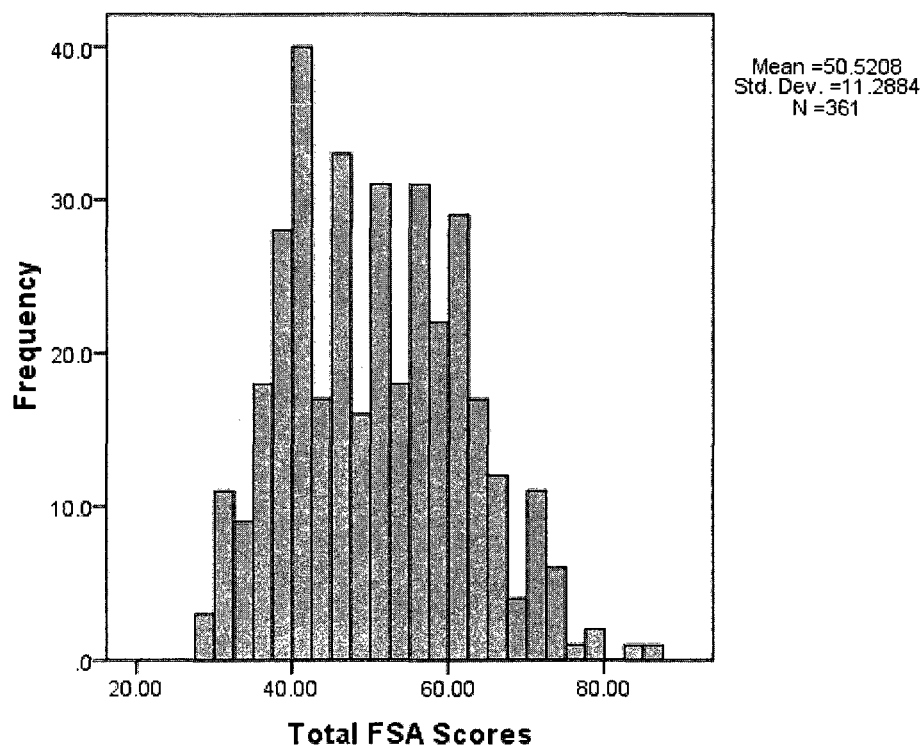
The majority of this sample consisted of White females. Participants had fairly equal memberships in the divisions of ACA with the majority as members of AMCHA (11%). However, 50% of the sample stated that they were not members of any divisions. Overall, the majority of participants had received their master's degree (59.3). In addition, the majority of the sample stated that they had never completed a course in gerontology (60.9%) however, 23.3% stated they had taken at least one gerontology course. The courses in which gerontology was primarily infused into were Human Growth and Development (77%) and Multicultural (59%).

Students made up 47.6% of this sample, followed by 43.8% practitioners, and 8.6% counselor educators. The majority of counselor educators were new in the field (0-2 years; 32.3%). Likewise, the majority of practitioners were also new within the field (0-2 years; 34.3%). In addition, 65% of practitioners stated that each year only 0-10% of their clients are those of the geriatric population. The majority of students were enrolled in CACREP accredited programs (76%).

### **Scoring Responses on the Instruments**

The scoring of the FSA was accomplished in SPSS, 16.0 for windows (SPSS, 2007). One of the variables collected for use in this research was the ageism score as

measured by the first instrument used in this study, the FSA (Fraboni et al, 1990). The complete FSA consists of 29 items (Appendix B). Seven of the items are reverse scored (Items 16, 19, 20, 21, 22, 25, and 27). The maximum score available of the FSA is 145 and the minimum is 29. Therefore, the maximum available range is 116. A higher score on the FSA indicates participants hold more ageist attitudes. All 361 participants in the study completed the FSA. The mean score for the FSA was 50.52 (with a standard deviation of 11.29), indicating very few ageist attitudes overall. The range of the FSA scores was 29-86. The FSA scores were unevenly distributed, platykurtic (-.505), and slightly positively skewed (0.313; see Figure 3).



*Figure 3.*

Distribution of participant's total FSA scores.

The Antilocution, Avoidance, and Discrimination subscales were also scored. The Antilocution subscale measures the degree in which participants refer to older adults and aging negatively by assessing participants “antagonism and antipathy fuelled by misconceptions, misinformation, or myths about older persons” (Fraboni et al., 1990, p. 59; Rupp et al., 2005). The Avoidance subscale measures avoidance or the degree in which participants avoid contact with the geriatric population by assessing participants’ “withdrawal from social contact with older persons” (Fraboni et al., p. 59; Rupp et al.). The Discrimination subscale measures the degree in which participants discriminate against the geriatric population by assessing participants’ “discriminatory opinions regarding the political rights, segregation, and activities of older persons” (Fraboni et al., p. 59; Rupp et al.). Table 7 provides means and standard deviations for the FSA subscale scores.

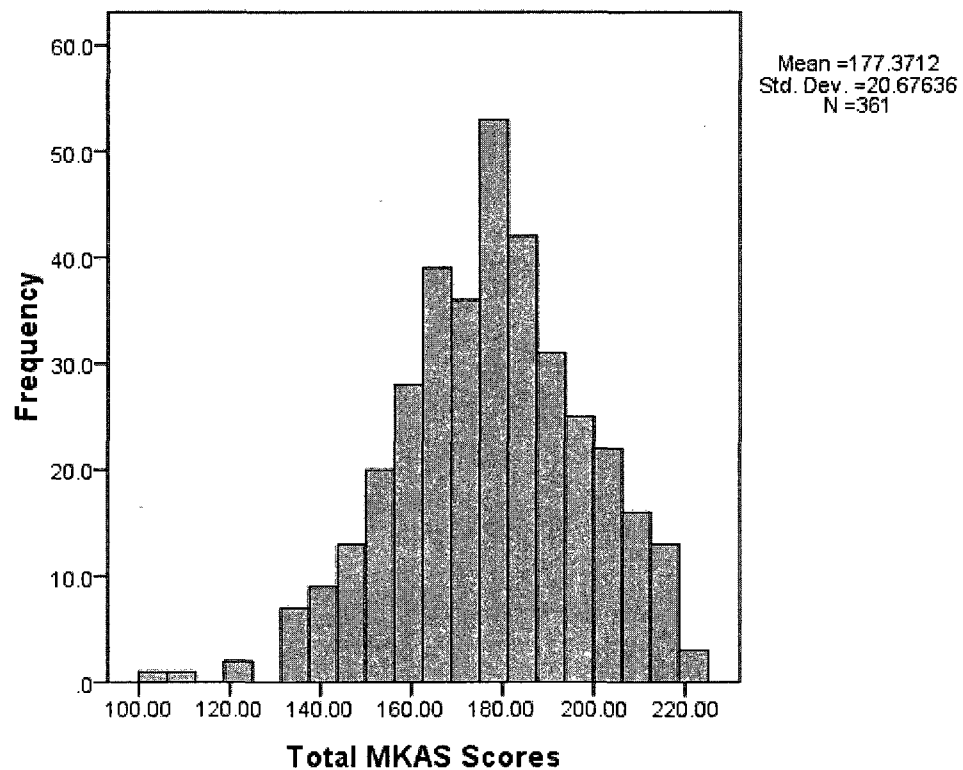
Table 7

*Means and Standard Deviations of the FSA Subscales*

	<i>M</i>	<i>SD</i>
Antilocution	18.02	5.05
Avoidance	17.04	4.55
Discrimination	15.09	3.57

Another variable of interest that was collected for use in this research was the total score on the MCKAS (Ponterotto et al., 2002). The complete MCKAS consists of

32 items (Appendix C). Ten of the items are reverse scored (Items 1, 4, 7, 10, 11, 18, 20, 24, 25 and 30). The maximum score available of the MCKAS is 224 and the minimum is 32. Therefore, the maximum available range is 192. A higher score on the MCKAS indicates more multicultural knowledge and awareness than lower scores. All 361 participants in the study completed the MCKAS. The mean score for the MCKAS was 177.37 (with a standard deviation of 20.67) indicating a self-reported highly competent sample with a range of 106-224. The MCKAS scores were evenly distributed, nearly mesokurtic (.095), and were not skewed (-.265; see Figure 4).



*Figure 4.*

Distribution of participant's total MCKAS scores

## Findings

This study was designed with four research questions. The results of the detailed statistical analyses of those four questions appear in the following section. The analytical procedure for each question will be presented in this section and the results of the analysis upon the individual hypothesis formulated for each question will be presented in the following section.

### Research Question 1

Research question 1 states, “Is there a significant relationship between counselor and counselor trainee self-reported multicultural counseling competency as indicated by the total score on the MCKAS (Ponterotto et al., 2002) and counselor and counselor trainee attitudes as indicated by their scores on the FSA (Fraboni et al., 1990)?” Therefore, the relationship between the MCKAS as well as the FSA was analyzed.

### Test of Hypothesis 1

Hypothesis 1 stated that there would be a significant negative relationship between counselor and counselor trainee total scores on the MCKAS and counselors’ scores on the FSA. The analysis consisted of a Pearson product-moment correlation coefficient (Green & Salkind, 2008) computed using the participant’s MCKAS score and their FSA score. The correlation was statistically significant,  $r [359] = -.406$ ,  $p = .01$ , indicating that as the participant’s self-reported multicultural competence increases their ageist attitudes decreases. Hypothesis 1 was supported.

## Research Question 2

Research question 2 states, “What is the relationship between counselor and counselor trainee demographic variables, and attitudes toward older adults and self-reported multicultural competence?”

## Test of Hypotheses 3

Hypothesis 3 stated that there would be a significant relationship between counselors’ and counselor trainees’ demographic variables (i.e., gender, age, race/ethnicity) and their attitudes towards older adults. In particular, it was hypothesized that females would have lower ageism scores than males, age would be a curvilinear relationship as younger and older participants would hold the most negative attitudes, and multiple interaction effects would occur.

To explore the main and interaction effects of the independent variables (i.e., gender, age, race/ethnicity) on participant’s attitudes towards older adults as measured by the FSA, the dependent variable, a three-way ANOVA was conducted. Levene’s test of Equality of Error Variances was statistically significant,  $F(133, 204) = 1.909, p = .000$ . Therefore, variance was not normally distributed and the homogeneity of variance assumption was violated. There were no main effects for gender ( $F[2, 204] = 1.5, p = .23, \eta^2 = .01$ ) and age ( $F[50, 204] = .99, p = .49, \eta^2 = .20$ ). However, results were statistically significant for race/ethnicity ( $F[4, 204] = 2.78, p < .05, \eta^2 = .05$ ). Therefore, this main effect was analyzed further.

To control for Type 1 error, post hoc comparisons using the Fisher LSD test was used to evaluate pairwise differences among the five race/ethnicity types (White, African American, Asian American, Hispanic, and Other). This analysis revealed that Asian



American participants had statistically significantly more ageist attitudes than African American, White, and Other participants. Therefore, Hypothesis 3 was partially supported.

### **Test of Hypothesis 5**

Hypothesis 5 stated that there would be a significant relationship between counselor and counselor trainee's demographic variables (i.e., gender, age, race/ethnicity) and their self-reported multicultural counseling competence. In particular, it was hypothesized that participants who are not White would have higher scores on the MCKAS and multiple interaction effects would occur.

To explore the main and interaction effects of the independent variables (i.e., gender, age, race/ethnicity) on participant's self-reported multicultural counseling competence as measured by the MCKAS, the dependent variable, a three-way ANOVA was conducted. Levene's test of Equality of Error Variances was statistically significant,  $F(133, 204) = 1.710, p = .000$ . Therefore, variance was not normally distributed and the homogeneity of variance assumption was violated. There were no main effects for gender ( $F[2, 204] = .46, p = .64, \eta^2 = .004$ ), age ( $F[50, 204] = .81, p = .81, \eta^2 = .17$ ), or race/ethnicity ( $F[4, 204] = 1.4, p = .22, \eta^2 = .03$ ). In addition, no interaction effects were detected. Therefore, this hypothesis was not supported.

### **Research Question 3**

Research question 3 states, "What is the relationship between counselor and counselor trainee training variables and attitudes toward older adults and self-reported multicultural competence?"

### **Test of Hypothesis 7**

Hypothesis 7 stated that there would be a significant relationship between training variables (i.e., CACREP status, number of gerontology counseling courses completed, number of courses gerontological topics were infused into, and number of years of education pertaining to counseling) and counselor and counselor trainee's attitudes towards older adults. In particular, it was hypothesized that the number of gerontology counseling courses completed and number of courses gerontological topics were infused into would both lead to fewer ageist attitudes. Interaction effects were also hypothesized.

To explore the main and interaction effects of the independent variables (i.e., CACREP status, number of gerontology counseling courses completed, number of courses gerontological topics were infused into, and number of years of education pertaining to counseling) on participant's attitudes towards older adults as measured by the FSA, the dependent variable, a four-way ANOVA was conducted. Levene's test of Equality of Error Variances was statistically significant,  $F(198, 122) = 1.318, p = .049$ . Therefore, variance was not normally distributed and the homogeneity of variance assumption was violated. There were no main effects for CACREP status ( $F[2, 122] = .42, p = .66, \eta^2 = .01$ ), number of gerontology courses participants had completed ( $F[5, 122] = .86, p = .51, \eta^2 = .03$ ), total number of credit hours participants had completed ( $F[12, 122] = .299, p = .99, \eta^2 = .03$ ), or the amount of courses participants identified as infusing gerontological topics ( $F[8, 122] = .54, p = .82, \eta^2 = .03$ ). In addition, no interaction effects were detected. Therefore, this hypothesis is not supported.

### **Test of Hypothesis 9**

Hypothesis 9 stated that there would be a significant relationship between training

variables (i.e., CACREP status, number of gerontology counseling courses completed, number of courses gerontological topics were infused into, and number of years of education pertaining to counseling) and counselor and counselor trainee's self-reported multicultural counseling competence. In particular, it was hypothesized that participants coming from CACREP programs would self report as having greater multicultural counseling competence than participants coming from non-CACREP programs and interaction effects were also hypothesized.

To explore the main and interaction effects of the independent variables (i.e., CACREP status, number of gerontology counseling courses completed, number of courses gerontological topics were infused into, and number of years of education pertaining to counseling) on participant's self-reported multicultural counseling competence as measured by the MCKAS, the dependent variable, a four-way ANOVA was conducted. Levene's test of Equality of Error Variances was statistically significant,  $F(198, 122) = 1.775, p = .000$ . Therefore, variance was not normally distributed and the homogeneity of variance assumption was violated. There were no main effects for CACREP status ( $F[2, 122] = .008, p = .99, \eta^2 = .000$ ), number of gerontology courses participants had completed ( $F[5, 122] = .65, p = .66, \eta^2 = .03$ ), the total number of credit hours participants had completed ( $F[12, 122] = 1.02, p = .43, \eta^2 = .09$ ), or the amount of courses participants identified as infusing gerontological topics ( $F[8, 122] = .48, p = .87, \eta^2 = .03$ ). In addition, no interaction effects were detected. Therefore, this hypothesis was not supported.

#### **Research Question 4**

Research question 4 states, “What is the relationship between counselor employment variables and attitudes toward older adults and self-reported multicultural competence?”

#### **Test of Hypothesis 11**

Hypothesis 11 stated that there would be a significant relationship between employment variables (i.e., proportion of geriatric clients seen, time within the counseling field, licensure obtained, and primary work setting) and their attitudes towards older adults. In particular, it was hypothesized that the higher the proportion of geriatric clients seen within a year will lead to fewer ageist attitudes. In addition, interaction effects were also hypothesized.

To explore the main and interaction effects of the independent variables (i.e., proportion of geriatric clients seen, time within the counseling field, licensure obtained, and primary work setting) on participant’s attitudes towards older adults as measured by the FSA, the dependent variable, a four-way ANOVA was conducted. Levene’s test of Equality of Error Variances was statistically significant,  $F(88,66) = 1.613, p = .021, )$ . Therefore, variance was not normally distributed and the homogeneity of variance assumption was violated. There were no main effects for proportion of clients from the geriatric population ( $F[8, 66] = 1.147, p = .344., \eta^2 = .122$ ), years as a practitioner ( $F[10, 66] = .443, p = .92., \eta^2 = .063$ ), primary work setting ( $F[3, 66] = 1.17, p = .33, \eta^2 = .051$ ), or licensure status as a Licensed Professional Counselor ( $F[1, 66] = .001, p = .98, \eta^2 = .000$ ). In addition, no interaction effects were detected. Therefore, this hypothesis is not supported.

### Test of Hypothesis 13

Hypothesis 13 stated that there would be a significant relationship between employment variables (i.e., proportion of geriatric clients seen, time within the counseling field, licensure obtained, and primary work setting) and their self-reported multicultural counseling competence. In particular, it was hypothesized that time spent within the counseling field as an employee will lead to greater self-reported multicultural counseling competence. In addition, interaction effects were also hypothesized.

To explore the main and interaction effects of the independent variables (i.e., proportion of geriatric clients seen, time within the counseling field, licensure obtained, and primary work setting) on participant's self-reported multicultural counseling competence as measured by the MCKAS, the dependent variable, a four-way ANOVA was conducted. Levene's test of Equality of Error Variances was not statistically significant,  $F(88,66) = 1.184, p = .236$ , indicating an assumed homogeneity of variance, that is, variance for all dependent variables was normality distributed. There were no main effects for the proportion of clients from the geriatric population ( $F[7, 66] = 1.764, p = .100, \eta^2 = .18$ ), years as a practitioner ( $F[10, 66] = 1.19, p = .312, \eta^2 = .15$ ), primary work setting ( $F[3, 66] = .163, p = .92, \eta^2 = .01$ ), or licensure status as a Licensed Professional Counselor ( $F[1, 66] = 1.915, p = .171, \eta^2 = .03$ ). In addition, no interaction effects were detected. Therefore, this hypothesis was not supported.

### Summary

The results of this study indicated four main findings. First, findings indicate that the correlation between participant's scores on the FSA and the MCKAS is negative. Therefore, as participants rated themselves as being more multiculturally competent, their

ageist beliefs are significantly lower. Second, a statistically significant main effect for race/ethnicity on the FSA was substantiated. However, there were no other significant differences between participant's demographic variables and their scores on either the FSA or the MCKAS. Third, there were no significant differences between participants' training variables and their scores on either the FSA or the MCKAS. Finally, there were no significant differences between practitioners' employment variables and their scores on either the FSA or the MCKAS.

## CHAPTER FIVE

### DISCUSSION

The purpose of this study was to explore counselors' and counselor trainees' demographic, training, and employment variables and their self-reported multicultural counseling competence and ageist attitudes. Random sampling was used to obtain counselors, counselor trainees, and counselor educators. Three survey packets were placed on [www.surveymonkey.com](http://www.surveymonkey.com). These three links were then randomly distributed to 2,000 participants and 361 survey packets were completed. To minimize coercion, participants were not required to participate and could drop out at any time by closing their browser window.

Overall, 172 participants identified themselves as students (148 Masters, 24 Doctoral), 158 participants as practitioners, and 31 participants as counselor educators. The majority of participants were White (81.4%), leaving only 19% to represent other minority groups. Participants were also comprised of mostly females (79.5%). In addition, 26.8% were licensed as Licensed Professional Counselors. The majority of participants (60.9%) reported that they had never had a course in gerontology. Participants who identified as practitioners were primarily working in a private practice setting (47.4%).

The results of this study indicate that counselors and counselor trainees report lower ageist attitudes and rate themselves high in multicultural counseling competence. These two variables negatively correlated indicated that the higher participants rated themselves as being multiculturally competent, the lower their ageist beliefs. Therefore, perhaps increased multicultural education, which ultimately increases competence, may relate to a decrease in any previously held ageist beliefs.

It is important to note that in the analysis of research questions two, three and four, Levene's test was significant. Therefore, the variance between groups was unequal, or heterogeneous (Field, 2009). This means that at some levels of the variables, the spread of the scores greatly vary. Due to the factorial ANOVA design, there is no non-parametric counterpart for this test as there is for the one-way ANOVA. However, because ANOVA is robust, this violation may be potentially ignored (Lindman, 1974).

The findings of this study demonstrated that gender and age of participants were not significantly related to ageist attitudes. However, differences were found regarding how individuals of multiple race/ethnicities differ in the level of ageist beliefs held. Follow up analyses revealed that Asian American participants had statistically significantly more ageist attitudes than African American, Whites, and Other participants.

Participants of this study also did not hold ageist beliefs regardless of training variables. Therefore, whether or not participants were enrolled in or attended a CACREP accredited program made no significant difference in their ageist scores. In addition, it did not matter how many courses participants had completed in gerontology and made no difference how many courses participants had completed that infused these topics. Finally, it made no difference how many credit hours participants had completed. Therefore, perhaps no real curriculum differences in gerontology exist for CACREP and non-CACREP accredited programs.

The findings of this study demonstrated that practitioners did not hold ageist beliefs regardless of employment variables. Therefore, whether or not the majority of clients were from the geriatric population, there were no differences in ageist beliefs. In addition, there were no differences in ageist beliefs in practitioners who differed in



primary place of employment (e.g., private practice, hospital setting, and schools). Time within the counseling field as well as licensure status as a Licensed Professional Counselor also made no significant difference in ageist beliefs. However, there may have not been enough age variation in this sample of practitioners to detect any statistically significant differences as time within the counseling field directly relates with age, age may have masked these results.

Also in this study, participant's self-reported multicultural counseling competence did not significantly differ based on race/ethnicity, gender, or age. The findings of this study also demonstrated that participants had no difference in their self-reported multicultural counseling competence scores regardless of training variables. Therefore, whether or not participants were enrolled in or attended a CACREP accredited program made no difference in their MCKAS scores. In addition, it did not matter how many courses participants had completed in gerontology and made no difference how many courses participants had completed that infused these topics. Finally, MCKAS scores did not differ based on credit hours participants had completed.

Finally, the findings of this study demonstrated that practitioners had no difference in their self-reported multicultural counseling competence scores regardless of employment variables. Therefore, there were no differences in MCKAS scores in practitioners who differed in primary place of employment. Therefore, practitioners in private practice, hospital setting, and schools had no difference in perceived multicultural counseling competence. In addition, time within the counseling field as well as licensure status as a Licensed Professional Counselor made no difference in the MCKAS scores.

### **Relationship to Findings in Prior Studies**

As previously discussed in Chapters 1 and 2, empirical evidence exists to support the hypothesis that counselors and counselor trainees would demonstrate negative attitudes and biases against individuals of the geriatric population (Danzinger & Welfel, 2000; Helmes & Gee, 2003; Hillman & Stricker, 1998; Woolfe & Briggs, 1997). These biases and negative attitudes may be due to lack of training and knowledge regarding the geriatric population, fear of the aging process or death, and perception that individuals of the geriatric population are difficult to work with. This current study provided very little evidence to confirm that counselors and counselor trainees have negative attitudes towards individuals of the geriatric population. Overall, Fraboni et al. reports a mean of 57.89 on the FSA with a range of 30-91 when administering the FSA to 231 participants. This current study had a slightly lower mean of 50.52 and a similar range of 29-86.

Danzinger and Welfel (2000) found that the older the counselor, the more negative attitudes they had towards individuals of the geriatric population. In addition, Cummings, Kropf, and DeWeaver (2000) also reported a relationship between these two variables. However, this was also not substantiated in this study. Hughes and Heycox (2006) also did not find a relationship between the age of the participant and level of knowledge of individuals of the geriatric population, which may predict biases and negative attitudes towards the geriatric population.

Research suggests that males often hold more ageist attitudes than females (Fraboni et al., 1990; Kavalari, 2001; Rupp et al., 2005). Kavalari administered the FSA to 200 undergraduate students and found that males ( $M=70.6$ ) reported a statistically significant higher level of ageist attitudes than females ( $M=62.94$ ). Fraboni et al.

presented similar results as males (M=61.0) reported a statistically significant higher level of ageist attitudes than females (M=56.4). Results of this study concluded that males did have a slightly higher mean on their FSA scores (M=53.25) than females (M=49.93), indicating slightly more ageist beliefs, however, this difference was not statistically significant.

Regarding the MCKAS, Constantine et al. (2001) found the mean score for the MCKAS to be 162.63 when he administered it to 200 school counselors. In this current study, the mean score for the MCKAS was slightly higher at 177.37. In addition, Holcomb-McCoy and Myers (1999) did not find a difference in self-reported multicultural counseling competence between CACREP and non-CACREP graduates. This current study supports these findings. Holcomb-McCoy and Myers also analyzed the relationship between self-reported multicultural counseling competence and variables such as counselors work setting, educational level, ethnicity, gender, and age. Results determined that there were not statistically significant relationship between any of those variables and self-reported multicultural counseling competence except for ethnicity. Results of this current study also did not find relationships between any of those variables however, there was no relationship found between ethnicity and self-reported multicultural counseling competence.

The literature states that an emphasis on post-graduate, experiential training can facilitate MCC (Holcomb-McCoy & Myers, 1999). However, in this current study, post-graduate, experiential training was not included in the training variables explored. Results indicated that MCKAS scores did not differ based on credit hours participants

had completed. This may be due to post-graduate experiences that were unaccounted for within the variables.

Availability for counselors within the geriatrics field is limited even if counselors are trained in geriatrics (Myers, 1995). For instance, in most states, legislation mandates that social workers be employed at long-term care facilities, which means that jobs for counselors in these facilities are limited. In this current study, practitioners did not hold ageist beliefs regardless of employment variables. Therefore, whether or not the majority of clients were from the geriatric population, there were no differences in ageist beliefs. Perhaps since jobs for counselors within the geriatric field are limited, there is limited exposure to this population. In return, there may have been no difference in experience with working with individuals of the geriatric population among this sample of practitioners. As a result, no detected differences would be found because the majority of practitioners work with these individuals at a relatively low rate.

### **Limitations of the Study**

This study included multiple limitations that should be taken into consideration when interpreting the results. Internal validity is the ability of the research design to rule out or make alternative explanation of the results (Marczyk et al., 2005). Internal validity threats include “experimental procedures, treatments, or experiences of the participants that threaten the researcher’s ability to draw correct inferences from the data about the population in an experiment” (p. 162).

**Social desirability.** Social desirability may have affected participant’s responses on both the FSA and the MCKAS scale. Social desirability occurs when participants respond to instruments in socially acceptable ways rather than reporting their true feelings or beliefs (Vella-Broderick & White, 1997). Social desirable responses have

“the potential to attenuate, inflate, or moderate variable relationships depending on the measures being used and the model under consideration” (Fisher & Katz, 2000, p. 106). Participants in this study may have been reactive to the instruments in that they were aware that their performance was being measured and, therefore, altered their answers from what they would have otherwise been (Marczyk et al., 2005). Participants will do this in order to please the researcher or appear “better” or more competent than they actually are. In attempt to reduce this, confidentiality and anonymity was ensured for this research study.

The MCKAS required participants to self-report on a Likert scale of 1-7 whether or not they agreed or did not agree with 32 statements regarding multicultural counseling (Ponterotto et al., 2002). The higher the score participants received on the MCKAS, the higher they rated themselves as being multiculturally competent. Due to this, participants may have rated themselves as being more multiculturally competent than they really are. In addition, because multicultural counseling competence scales are self-report measures, their relationship to actual multicultural competence is questionable (Constantine & Ladany, 2000).

The FSA required participants to rate 29 statements on a Likert scale of 1-4 whether or not they agreed or did not agree with 29 statements regarding attitudes towards the geriatric population (Fraboni et al. 1990). The lower the scores on the FSA the lower participants ageist beliefs and negative attitudes towards the geriatric population. Due to this, participants may have rated themselves as holding fewer ageist beliefs than they actually do.

**Response rate.** Initially, 415 out of the 1,965 participants the survey was sent out to responded to it. However, only 361 participants who started the survey, completed it. Therefore, the response rate for those who fully completed the survey was 18.4%. This is a typical but fairly low response rate. However, even though the majority of participants did not respond, the estimated power calculation of 360 was met. It is also impossible to know if participants who did not respond have different characteristics than those who did.

It may be difficult to generalize results, as the Internet may not be readily available to all potential participants (Mitra et al., 2008; Sax et al., 2003). For instance some potential participants may lack computer literacy, be weary of responding to surveys due to confidentiality issues. In addition, low socioeconomic status (SES) participants may not have access to a computer. In addition, it is impossible to control if participants can take a survey more than once or if the intended participant is even the person responding (Cobanoglu & Cobanoglu, 2003; Mitra et al.).

**Selection.** For this study, selection may have been a threat to validity as participants who were selected for this study may have had certain characteristics that predispose them to have particular outcomes. For instance, all participants selected in this study were members of the American Counseling Association and, therefore, may have similar characteristics which prevents generalizability of results.

The majority of participants who comprised this sample were White (81.4%) and female (79.5%). Therefore, it is difficult to generalize these results to individuals who are not of these demographics. However, it is noteworthy that the demographics found in

this study are similar to those that comprise the entire population of counselors and counselor trainees.

Participants may have had difficulty answering some of the demographic questions. For instance, participants were asked to report the percentage of geriatric clients they see per year. This may have been difficult for some participants to assess. In addition, participants were asked whether or not they graduated or are currently attending a CACREP accredited program. Although, an “unsure” answer option was offered, some participants may have answered “yes” or “no” without knowing if they truly had graduated or were attending a CACREP accredited program. In addition, participants may have held more than one role creating uncertainty as they were forced to choose their primary role.

**Instrumentation.** Instrumentation threats may also exist within this study. For instance, the measures may not be consistent over time and they may not measure what they are actually intended to measure (Marczyk et al., 2005). In addition, even though this study is not longitudinal in nature, testing may also be a threat if participants have taken either the FSA or the MCKAS previously. Taking the same measure multiple times may affect scores as practice, memory, research expectations, and sensitization may develop. In addition, the FSA scoring may have impacted findings. For instance, unanswered items on this instrument are scored as a 3. Another concern with the FSA is that it does not measure behavioral items. In addition, attitudes towards the geriatric population beyond ageism were not measured. Overall, the FSA and the MCKAS scale may have been problematic. In addition, no real measure of age competency was utilized

in this study and, therefore, it is difficult to determine if participants are competent in working with individuals of the geriatric population.

**External validity threats.** External validity is how generalizable the results of the research study are (Marczyk et al., 2005). According to Creswell (2009), external validity threats “arise when experimenters draw incorrect inferences from the sample data to other persons, other settings, and past or future situations” (p. 162). These threats may have been problematic due to characteristics of the participants, timing of the experiment, and uniqueness of setting. Interaction of setting and treatment may also have been an issue in this study. For instance, characteristics of the participants may have prevented the results from being generalized to individuals in other settings. Therefore, results of this study may not be generalizable to other populations.

### **Implications for Counselors**

Although results of this study did not conclude that counselors have significant negative attitudes towards or about individuals of the geriatric population, implications may still be warranted. Previous research indicates that treatment of individuals of the geriatric population may be difficult due to a higher incidence of co-occurring disorders (Zivian et al., 1992). Due to this, mental health professionals may be more reluctant to treat this population. Therefore, if counselors are not comfortable treating individuals of this population, perhaps they should seek educational opportunities in order to become more competent in working with the unique issues this population faces.

Woolfe and Briggs (1997) suggested that counselors may be resistant in treating this population because they too will grow old one day and may fear death or the unknown. As a result, it may be well warranted for counselors to seek their own



individual counseling in order to work through some of these issues. In addition, Woolfe and Briggs stated there may be a high incidence of transference and countertransference when treating this population, which may make mental health professionals feel threatened and deter them from engaging in these relationships. Therefore, self-reflection may be important in order for counselors to gain a better understanding of what is occurring in counseling sessions with clients of the geriatric population.

### **Implications for Counselor Trainees**

Results of this study did not find any significant relationship between number of gerontological courses completed or number of courses these topics were infused into and counselor trainee self-reported multicultural counseling competence or negative attitudes towards the geriatric population. This could be a result of participants having had a gerontological course in addition to integration experiences as 40.1% stated they had completed at least one course and up to 77% experienced integration in other core courses. However, it may be well warranted for counselor trainees to enroll in at least one gerontological counseling course in order to learn more about the unique issues of the population. This is especially important if counselor trainees are not receiving much integration of these topics into their core classes.

Because a statistically significant negative correlation was found between participant's scores on the FSA and their scores on the MCKAS, it may be important for counselor trainees to seek educational opportunities that may assist them in becoming more multiculturally competent counselors. This is significant because in this current study, as self-reported multicultural competency increased, ageist attitudes decreased. However, it is important to note that correlation does not equal causation.

### **Implications for Counselor Educators**

This current study found that the mean score on the FSA was relatively low, which indicates few ageist attitudes and beliefs. In addition, the majority of participants stated that issues regarding geriatrics had been integrated into at least one of their core courses. Therefore, it is important for counselor educators to continue to integrate these topics into core courses to assure minimal competence in working with client of the geriatric population. Perhaps counselor educators may want to attempt to integrate these topics into courses in which participants identified very little integration such as group work, career, helping relationships, and assessment. For instance, counselor educators could discuss types of groups that may be appropriate for individuals of the geriatric population, retirement and career concerns of this population, as well as different assessments for this population.

Counselor educators should also encourage self-reflection of counselor trainees in order to challenge the biases and assumptions they may hold against minority groups such as the geriatric population. Self-awareness of biases and stereotypes are all imperative when counseling diverse clients. This may be an uncomfortable process and, therefore, may cause some anxiety in both counselor trainees and counselor educators. As a result, some counseling programs may not emphasize self-reflection as much as they should. Therefore, greater emphasis needs to be placed on helping counselor trainees reflect upon their own lives as well as preparing counselor educators to facilitate this difficult process. Immersion experiences and journaling may help to facilitate self-reflection by allowing students to challenge their biases and then journal about their

anxieties, discomfort, and victories. Additionally, counselor educators should suggest counselor trainees seek counseling if troubles arise.

### **Implications for Future Research**

In order to explore counselor's attitudes towards individuals of the geriatric population further, a qualitative or mixed methods study may be well warranted. Researchers could then determine patterns and themes based on participant's responses rather than quantitative data which offers very little exploration of responses. This type of research design would allow researchers to gain a better understanding of the attitudes counselors and counselor trainees have regarding individuals of the geriatric population.

In future research, a larger sample size may need to be utilized. If more participants were included, it could allow for more participants of different racial groups to be included. In the current study, participants of racial groups other than White only accounted for 18% of the sample. In addition, future research may warrant the use of different instruments. There are multiple self-report measures for multicultural counseling competence as well as attitudes towards individuals of the geriatric population. In addition, instead of using a self-report multicultural counseling instrument, it may be worthwhile for a panel of professionals to assess the multicultural competence of each participant. This can be done by presenting the participant with a standardized case study with a multicultural client and allowing professionals to rate how competently the participant works with the individual. This technique could be combined with a self-report measure.

In addition, because counselor's access to the geriatric population seems to be so low, it is important that additional research studies are completed on how counselors can

better access individuals of this population. Specifically, a qualitative study could be conducted with counselors who primarily work with individuals of the geriatric population. Access to the population could be explored as well as barriers to reaching this population. In addition, if counselors are choosing not to work with individuals of this population that may be worthwhile exploring as well.

Future research may also want to explore training on elder abuse among counselors. In addition, analogue studies may be utilized in order to determine the rate of diagnosis of mental health concerns such as depression, suicide, and dementia for the geriatric population. Finally, studies that explore what counselors actually do with these clients (e.g., theories, techniques, etc.) may be well warranted.

### **Conclusions**

This study sought to test and identify counselor, counselor educator, and counselor trainee's perceptions of individuals of the geriatric population. The relationship between demographic, training, and employment variables and their self-reported multicultural counseling competence and their ageist attitudes was explored. This study did not indicate that either counselor trainees, counselor educators, or practitioners hold biases against individuals of the geriatric population. In addition, this study did not indicate any differences between counselor trainees, counselor educators, or practitioners self-reported multicultural counseling competence scores.

Future research, including quantitative and qualitative studies are recommended to further explore counselor, counselor educator, and counselor trainee perceptions of the geriatric population and possible sources of counselor and counselor trainee bias. Even though this study did not identify any biases, it adds to the literature regarding effectively

working with the geriatric population and may help to stimulate important conversations and debates among counselor trainees, counselors, and counselor educators.

**Chapter 6**  
**Manuscript Submission**

Counselor Demographics, Ageism Attitudes, and Multicultural Counseling Competence  
among Counselors and Counselor Trainees

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### Abstract

Approximately 76 million individuals encompass the “Baby Boom” population (Maples & Abney, 2006). As this population ages, the geriatric population will grow to be the largest cohort in history. Elders are considered to be members of a diverse population and, therefore, topics related to older adulthood should be addressed within multicultural training. The purpose of this study was to understand the relationship among counselor and counselor trainee self-reported multicultural counseling competence and their attitudes of the geriatric population. A statistically significant negative correlation was found between participants’ attitudes regarding the geriatric population and their self-reported multicultural counseling competence. Implications for future research, training, and practice are provided.

**Keywords:** gerontology, multicultural counseling competence, Fraboni Scale of Ageism, Multicultural Counseling Knowledge and Awareness Scale

## Counselor Demographics, Ageism Attitudes, and Multicultural Counseling Competence among Counselors and Counselor Trainees

Approximately 76 million individuals who were born between 1946 and 1964 encompass the “Baby Boom” population (Maples & Abney, 2006; U.S. Census Bureau, 1993) and in the year 2011, these individuals will begin to enter into the geriatric population (U.S. Census Bureau, 2002c). As the “Baby Boom” population ages, the geriatric population, which includes those 65 and older, will grow to be the largest cohort in history. According to the U.S. 2000 Census, 35 million individuals comprised the geriatric population (U.S. Census Bureau, 2004). Within this cohort, 53% were ages 65 to 74, 35% ages 75 to 84, and 12% ages 85 and older (U.S. Census Bureau, 2004). In addition, this cohort grew to approximately 36.8 million individuals by 2008 and researchers expect this cohort to continue to grow to include 21% of the U.S. population or 76.4 million individuals by 2030 (U.S. Census Bureau, 2010; Van Gerpen, Johnson, & Winstead, 1999).

With the rapid increase of the geriatric population, greater attention to mental illness, elder abuse, and other psychosocial factors (e.g., ageism) within the population is likely, as counselors may be treating individuals of this population at higher rates. The purpose of this article is to review these salient characteristics for working with this population and to explore the relationship between two constructs indicating counselor competency in multicultural counseling and attitudes toward the geriatric population.

### **Mental Health Considerations**

There are many mental health considerations counselors must be aware of when counseling individuals of the geriatric population. Dementia, depression, and suicide are



prevalent within this population. In addition, elders may experience low social support and may be abused by caregivers. Counselors must be able to effectively work with individuals of this population as they often present with unique concerns.

### **Dementia**

Dementia such as Alzheimer's Disease is extremely prevalent during older adulthood and may be the most prevalent mental illness in older adults (Zank, 1998). With increased life expectancy rates, many individuals will face these illnesses (Selkoe, 2006). Overall, 5% of adults over the age of 65 are diagnosed with Dementia and 10% are diagnosed with Alzheimer's disease (Spira & Edelstein, 2007; Zank, 1998). In addition, individuals over the age of 80 years of age are diagnosed with Dementia at a rate of 20% and over half of individuals over the age of 85 are diagnosed with Alzheimer's disease. Currently, in the United States, 4 million people are living with Alzheimer's disease specifically (Spira & Edelstein). These individuals often have progressive memory loss, language disruption, agitation, and personality, emotional, and behavior changes (Abraham, 2005; Chesla, Martinson, & Muwaswes, 1994; Spira & Edelstein, 2007). In addition, individuals of the geriatric population residing in nursing homes often have a higher prevalence of dementia with research indicating rates of 51% to 94% (Walsh, Currier, Shah, Lyness, & Friedman, 2008).

### **Depression**

According to the Centers for Disease Control and Prevention (CDC, 2008), depression may cause difficulty sleeping, persistent sadness, withdrawal from activities, and physical discomfort. In addition, depression can lead to impairments in mental, physical, and social functioning (CDC, 2009). Overall, 2.5% of older adults meet the

Diagnostic Statistical Manual criteria for depression or dysthymic disorder. However, 27% of elderly adults have symptoms of depression but do not meet the full criteria for the disorder. In addition, 5.5% of older adults meet the criteria for anxiety disorder and an additional 2.5% display symptoms of anxiety but do not meet the full criteria for the disorder. Older adults must often face the death of friends as well as partners and, therefore, bereavement becomes a focus of older adulthood. Due to this, elders may experience increased depression. In addition, depression may also be exacerbated by illness and accidents such as hip fractures or heart disease (USDHHS, 2000). For instance, 12% of older individuals who are hospitalized for illness and accidents such as these develop depression. In addition, elders in nursing homes are particularly inclined to develop depression as 15% to 25% of these individuals develop symptoms of the mental health illness (USDHHS, 2000).

Unfortunately, symptomology is often misdiagnosed or underdiagnosed. For example, the Centers for Disease Control and Prevention (CDC, 2008) reported that 80% of depression cases seen within the geriatric population are highly treatable, but many times depression is under-detected and, therefore, left untreated or mistreated. In fact, older males have the highest suicide rates of any age cohort (Kelley, 2003), with 45.23 suicides per every 100,000 males age 85 and older (CDC, 2008).

### **Suicide**

Suicide also greatly affects individuals of the geriatric population. Overall, 13 individuals ages 65 and older commit suicide each day in the United States (Walsh et al., 2008). In 2000, individuals ages 65 and older completed 18.1% of suicides. In addition, 57.5 per every 100,000 men ages 85 and older complete suicide, which is more than five

times the national suicide rate. Overall, the Baby Boom generation had a higher suicide rate than any other generation. Therefore, suicide rates may increase as this generation ages.

### **Social Support**

Social support is important in order to effectively reduce mental health illness within the geriatric population. Social support includes emotional support, informational support, and instrumental support (CDC, 2008). Elders may acquire emotional support by being provided with a safe place to share problems and emotions. Informational support is given when the elder is offered advice and guidance and instrumental support is given when elders are assisted with rides or housekeeping. If mental health professionals offer the appropriate amount of support to elders, elders may have a decrease of mental illness, physical illness, and mortality. However, individuals of the geriatric population are more likely to report that they rarely or never receive the support they need. In addition, one-fifth of Hispanic elders reported they are not receiving the support they need compared to one-tenth of White elders indicating more support should be offered to this population (CDC, 2008).

### **Elder Abuse**

In 2004 alone, 565,747 elders were abused (National Center on Elder Abuse, 2004). Although this statistic is likely underreported. Overall, there are five types of elder abuse (Buzgova & Ivanova, 2009). The first form is physical abuse, which is purposefully causing pain or injury to the body. The second is psychological and emotional abuse, which includes the use of words to cause anguish, fear, or humiliation. Financial abuse is also a form of elder abuse and includes caregivers mishandling of

elders finances or organizations taking advantage of elders. Neglect includes malnutrition, inadequate health care, and poor hygiene. The final form of elder abuse is violation of rights, which occurs when family members or employees do not respect the right to privacy or free choice. Counselors are to be aware of these types of abuse as they attend to mental health considerations. For more information on counselors' role in preventing elder abuse, see Forman and McBride (2010).

Elder abuse may go undetected as physicians often have the most contact with elders yet, have little training on elder abuse. For instance, Jones, Veenstra, Seamon, and Krohmer (1997) conducted a survey of United States emergency room physicians and found that only 25% had training in elder abuse. However, they found that 63% had training on spouse abuse and 87% had training on child abuse. In addition, elders who are abused may be scared to reveal the abuse and, therefore, this may cause elder abuse to be even more undetectable (Nelson, 2005). Due to ageist beliefs among practitioners and society, it may be easy for individuals to disregard the welfare of older adults (Nelson, 2005).

### **Ageism**

Multiculturalism has progressively become of interest within the counseling field due to demographic changes in the United States. For instance, in 2000, 25%-30% of the U.S. population self-identified as minorities and by the end of 2010, this population will increase to 32.7% (LaRoche & Maxie, 2003; Yali & Revenson, 2004). One aspect of increased multicultural counseling competence (MCC) is minimal prejudice and discrimination and, specific to this population, is acknowledgement and dismantling of ageism.

The concept of ageism was first introduced by Butler (1969) and is described as stereotypes, prejudice, or discrimination against the geriatric population due to their age (Iverson, Larsen, & Solem, 2009). Ageist beliefs among mental health practitioners may ultimately affect the way they interact with clients of the geriatric population and therefore, may put client care at risk for mental health concerns and other psychosocial stressors (Helmes & Gee, 2003).

### **Counselor Perceptions of the Geriatric Population**

Ageism is a rampant phenomenon within Western society (Holroyd, Dahlke, Fehr, Jung, & Hunter 2009) as the elderly are often undervalued and many times ignored, including within the health care field. For instance, nurses, doctors, and counselors may not have enough knowledge or expertise regarding the geriatric population and, therefore, appropriate client care may be at risk. In addition, due to ageist beliefs, health care professionals may not have the desire to take additional courses or attend learning opportunities related to the elderly population and, therefore, will not be competent in working with this population (Holroyd et al.)

Mental health professionals stereotypes and biases may affect their prognosis of clients. For instance, Helmes and Gee (2003) presented a fictional description of two patients to psychologists and counselors. All factors in the descriptions were the same except for the patient's ages. One patient was presented as 72 years of age and the other was presented at 42 years of age. Results signified that when the patient was described as being elderly, prognosis for that patient was less optimistic than if the patient was not described as being elderly. Due to age alone counselors believed the older client to be less able to develop a therapeutic relationship, to be less appropriate for therapy, and they

felt less competent treating the older client and less willing to accept the older client compared to the 42 year old client.

Woolfe and Briggs (1997) asked counselors what were considerations when working with clients of the geriatric population. Overall, counselors perceived that when working with the geriatric population they needed to talk louder and more clearly, explain more carefully about the counseling process, lower their expectations about what could be achieved in counseling, take things slower, show consideration for health, avoid using slang words, reduce focus on the past, and not challenge defenses. These results indicate possible biases and stereotypes counselors may hold against individuals of the geriatric population.

Danzinger and Welfel (2000) indicated that mental health professionals often hold the assumption that elderly clients are less able than younger clients to make autonomous decisions. In addition, the prognosis of older clients was viewed to be more negative when compared with younger clients. This same study indicated that the longer the mental health practitioner was in practice, the more likely they were to judge elders as being less competent, which is counterintuitive. However, this may be because as mental health professionals grow older, they may find it difficult to face their own aging process and, therefore, view elders in a negative manner. Finally, licensed counselors were less likely to judge older clients as being less competent when compared to non-licensed counselors.

Mental health professionals often show diagnostic and treatment biases against older adults (Hillman & Stricker, 1998). For instance, older adults are often given poorer prognoses by mental health professionals than are younger or middle aged adults.

However, older adults presenting with depression are often thought to be less severe cases than younger or middle aged adults. This may occur due to age biases where older adults are thought to be naturally depressed. In addition, even when full criteria are met, older adults are less likely to be diagnosed with personality disorders.

Overall, counselor biases and stereotypes against the geriatric population may negatively affect relationships they have with clients of this population as well as prevent competence in working with this population (Nemmers, 2004). It is imperative that counselors decrease their stereotypes and biases against the geriatric population as these attitudes may significantly influence client cognitive and physical functioning and overall wellbeing. Counselors must be knowledgeable about stereotypes and biases, including their own, held against the geriatric population and be prepared to delegitimize them when working with clients of this population.

There is a higher incidence of co-occurring disorders in the geriatric population, which may make mental health treatment more difficult (Zivian, Larsen, Knox, Gekoski, & Hatchette, 1992). Therefore, mental health professionals may be more reluctant to treat this population, as they may not feel confident that they have the skills they need in order to assist older clients. For instance, older adults often need specialized health care or may need assistance with networking with other unique services. Therefore, mental health professionals may have to exert more time and energy in assisting this population. In addition, Woolfe and Briggs (1997) suggest that counselors may be resistant in treating this population because they too will grow old one day and may fear death or the unknown. In addition, Woolfe and Briggs stated there may be a high incidence of transference and countertransference when treating this population, which may make

mental health professionals feel threatened and deter them from engaging in these relationships. For instance, clients may remind therapists of their own mother or father or grandparents. In return, this may encourage irrational anger or over commitment to the client. Therefore, mental health professionals often report less preference and motivation for working with older adults compared to working with young and middle aged adults (Hillman & Stricker, 1998).

While there are mental health and psychosocial considerations and evidence of accompanying practitioner bias, there is little research examining counselor bias (counselor attitudes toward the geriatric population) and overall multicultural counseling competence. As age is considered a cultural variable, greater attention to counseling competency is needed to facilitate effective counselor interventions with this population. The purpose of this study was to understand the relationship among counselor and counselor trainee self-reported multicultural counseling competence and their attitudes of the geriatric population. Multicultural counseling competence assessment has traditionally not addressed ageism or competency with the geriatric population, the need to look at the relationship between multicultural counseling competence and ageism as it has not been explored. It was hypothesized that the lower the scores on the MCKAS (indicating lower MCC), the higher the scores on the Fraboni Score on Ageism (indicating ageist beliefs). In addition, this study also seeks to gain insight about the training and clinical experiences counselors and counselor trainees have regarding this population.



## Method

### Participants

Participants consisted of graduate students in both CACREP and non-CACREP accredited counseling program and master's and doctoral level counselors working in the counseling field. Participants were selected at random and were current members of the American Counseling Association. Assuming a moderate effect size at 2<sup>nd</sup> power of .80, a minimum sample of 360 participants was sought to assume that hypotheses are tested at the .05 alpha level (Cohen, 1992). The return rate for the survey was 21.1% and, overall, 415 participants began the survey but only 361 participants completed it. In order to achieve this return rate, 2000 participants were surveyed.

The age range was 21 to 81 years and the mean age was 41.27 years of age, with a standard deviation of 13.64 (20 participants did not report age). This sample was bimodal (23,27) and the median age was 39. With respect to gender, there were 72 males (19.9%), 287 females (79.5%), and 2 transgendered (.005%) participants. Also, 294 participants identified as being White, 25 identified as African American, 17 identified as Hispanic, 3 identified as Asian American, and 18 identified as other (4 participants did not report race/ethnicity).

### Procedure

Upon IRB approval, a random email list of members was requested from the American Counseling Association. It was asked that half of the email list be comprised of ACA members who identify themselves as students, the other half who identify themselves as practitioners and that school counselors be excluded. Data were collected by using the online service SurveyMonkey ([www.surveymonkey.com](http://www.surveymonkey.com)). Upon obtaining

the email addresses, an email was sent explaining the purpose of the study with a link to materials placed on SurveyMonkey and participants were asked to complete the survey by filling in the appropriate answers. The survey packet included the FSA (Fraboni, et al., 1990), the MCKAS (Ponterotto et al., 2002) a demographic sheet, and informed consent information. Participants were able to answer the questions within the packet at their leisure, as there were no time constraints. In order to reduce ordering bias, three separate links were created with the survey ordered differently in each. In order to increase participation, reminders were sent to participants once weekly over a period of three weeks. Participants did not have to complete the survey once they began it and, therefore, participants were allowed to drop out at anytime.

### **Measures**

**The Fraboni Scale of Ageism (FSA).** The FSA measures attitudes towards aging and the geriatric population rather than knowledge of this population (Fraboni et al., 1990). This scale was designed to measure an affective component such as avoiding and excluding members of this population in addition to a cognitive component of myths and beliefs about this population. The FSA consists of 29 items and utilizes a 4-point Likert type format ranging from 1 (*strongly disagree*) to 5 (*strongly agree*) (3 is excluded) and assesses stereotypic behaviors and attitudes by measuring antilocution, discriminatory attitudes, and avoidance of individuals of the geriatric population (Rupp, Vodanaovich, & Crede, 2005). A sample item from the FSA is *Many old people just live in the past*. Each response on the Likert scale is summed in order to get the total score. Scores for this scale range from 29-145 and the higher the participant's score the greater the level of measured ageism (Fraboni et al., 1990). Unanswered items are scored as a three.

The FSA has adequate construct validity and high internal reliability. Cronbach's alpha for the total scale was .86, suggesting the scale is relatively homogeneous (Fraboni, et al., 1990). The scale was found to have adequate internal consistency reliability as Cronbach's coefficient alpha of the Antilocution, Avoidance, and Discrimination subscales were found to be .76, .77, and .65, respectively. The scale has been correlated with the Acceptance of Others scale ( $r = .40, p < .001$ ), and Facts on Aging Quiz ( $r = -.28, p < .001$ ), indicating evidence of construct validity.

**The Multicultural Counseling Knowledge and Awareness Scale (MCKAS).**

The MCKAS is a 32-item scale, which measures counseling competence (Ponterotto et al., 2002). The MCKAS utilizes a 7-point Likert-type scale in order to assess competencies and provides subscale scores for Knowledge-Skills as well as Awareness. Scores for this scale range from 32-224 and the higher the participant's score the greater the participant's self perceived multicultural counseling competence (Ponterotto et al.). The Likert scale ranges from (1) *not true at all*, (4) *somewhat true*, and (7) *totally true*. The rating selected for each item on the subscale are reversed scored if necessary then totaled to reach the subscale scores. The higher individuals score on both subscales the higher their multicultural Knowledge and Awareness (Ponterotto et al., 2002).

Both the Knowledge and Awareness subscales have a coefficient alpha of .85 (Ponterotto et al., 2002) and in a study conducted by Kim et al. (2003) the Knowledge scale yielded a coefficient alpha of .90 and the Awareness scale yielded a coefficient alpha of .86. A previous study utilizing the MCKAS found that mental health professionals who indicated greater levels of racial ideology were correlated with lower self-reported multicultural counseling awareness and knowledge (Neville, Spanierman, &

Doan, 2006). Another study utilizing the MCKAS found that mental health professionals who indicated greater levels of colorblind racial ideology were correlated with lower self-reported multicultural counseling awareness and knowledge (Neville, Spanierman, & Doan, 2006).

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**Demographic sheet.** Each participant answered questions pertaining to their history of gerontology training. Didactic training was assessed by the number of gerontology or adult development courses they completed and the number of other courses topics regarding the geriatric population were infused into. Practitioners were also asked to identify the percentage of clients who they have worked with in the past year who were of the geriatric population. Each individual participating in this study was asked to provide information on a demographic sheet. Information that was asked included gender, age, race/ethnicity, highest degree obtained, licensure information, time in the counseling field as a practitioner or student (in years), what ACA divisions they are a member of, CACREP status of the program which they are enrolled in or graduated, and primary work setting.

## Results

To address research question 1, what are participants' training and clinical experiences related to the geriatric population, descriptive statistics were conducted. Participants were asked to indicate their membership within the divisions of the American Counseling Association and any licenses they currently held. Overall, 181 (50.1%) participants indicated that they are not a member of any ACA divisions, 97 participants indicated they were Licensed Professional Counselors (26.8%; LPC) and 75 participants indicated they were Nationally Certified Counselors (20.7%; NCC). In addition, 171 (47.3%) participants indicated that they currently did not hold any licenses or certifications.

Participants were also asked to identify their highest level of education and, overall, 1 participant chose not to report, 102 participants indicated their highest level of education was a Bachelor's degree (28.3%), 214 indicated their highest level of education was a Masters degree (59.4%), and 44 participants indicated their highest level of education was a Doctorate degree (12.2%). However, all participants who identified their highest level of education as a Bachelor's degree were currently pursuing their Masters in Counseling.

Participants were asked to identify the number of gerontology courses they have completed and, overall, 220 (60.9%) participants indicated that they had not completed any gerontology courses, 84 (23.3%) had completed one gerontology course, 35 (9.7%) completed two gerontology courses, 9 (2.5%) completed three gerontology courses, 5 (1.4%) completed 5 gerontology courses, and 3 (.8%) indicated they had other training experiences such as degrees in gerontology and extensive internships with the geriatric

population. Participants were also asked to indicate whether their practicum and internship as well as the eight core CACREP courses addressed topics regarding geriatrics. Overall, the majority of participants stated that topics regarding geriatrics were most addressed in multicultural (59%) and human growth and development (77%) courses.

Participants were asked to identify how many credit hours they have completed within master's and doctoral counseling programs. The mean range of credit hours completed was 61-70 (4 did not report). With respect to roles within the counseling field, 164 (45.4%) participants identified themselves as practitioners, 161 (44.5%) as masters in counseling students, 37 (10.2%) as doctoral in counseling students, and 43 (11.9%) as counselor educators. When asked to identify their primary role 158 (43.8%) identified themselves as practitioners, 172 (47.6%) as masters or doctoral students, 31 (8.6%) participants as counselor educators.

Out of the 31 participants who identified their primary role as counselor educator, 16 of them indicated that they graduated from a CACREP accredited program, 13 participants indicated that they did not graduate from a CACREP accredited program, and 1 participant indicated that they were unsure if they had graduated from a CACREP accredited program or not (1 did not report). In addition, their years as counselor educators varied and 32.3% of participants only had 0-2 years of experience as counselor educators. Of those participants who primarily identified themselves as doctoral or masters students (172), 131 stated that they were currently enrolled in a CACREP accredited program, 28 stated that they were not currently enrolled in a CACREP accredited program and 13 stated that they were unsure whether or not they were enrolled

in a CACREP accredited program. Of those participants who primarily identified themselves as practitioners (n=158), 107 indicated that they graduated from a CACREP accredited program, 42 indicated that they had not graduated from a CACREP accredited program, 8 were unsure whether or not they had graduated from a CACREP accredited program (1 did not report). These participants were also asked to indicate the percentage of clients who are from the geriatric population they see per year and overall, 65% of practitioners stated that 0-10% of their clients are from the geriatric population (7 did not report).

Participants who identified themselves primarily as practitioners were asked to indicate their primary work setting. Overall, 75 participants (47.4%) indicated that their primary work setting is private practice, 12 is a hospital (7.5%), 17 is a school (10.7%), 52 participants (32.9%) indicated other settings as their primary work settings (2 chose not to report). The “other” primary work settings included community centers, in-home, early intervention programs, correctional facilities, hospice care, and rape crisis centers. Finally, participants who primarily identified as practitioners were asked to indicate their years of experience as employees within the counseling field (1 chose not to report). Overall, 55.8% of practitioners stated that they had 0-5 years of experience as employees within the counseling field.

Research question 2 assessed the relationship between MCC and ageism, using the MCKAS and FSA. Higher scores on the FSA indicates participants endorsing more ageist attitudes. The mean score for the FSA was 50.52 (with a standard deviation of 11.29), indicating less ageist attitudes overall. The range of the FSA scores for this sample was 29-86. Another variable of interest that was collected for use in this research

was the total score on the MCKAS (Ponterotto et al., 2002). The mean score for the MCKAS was 177.37 (with a standard deviation of 20.67) indicating a self-reported highly competent sample with a range of 106-224.

A Pearson product-moment correlation coefficient was computed using the participant's MCKAS score and their FSA score and revealed a statistically significant relationship ( $r [359] = -.406, p = .01$ ) indicating that participants with fewer ageist attitudes had higher self-reported multicultural counseling competence.

### **Discussion**

The purpose of this study was to describe participants' training and clinical experiences related to the geriatric population and to understand the relationship among counselor and counselor trainee self-reported multicultural counseling competence and their attitudes of the geriatric population. The majority of this sample consisted of White females. Overall, the majority of participants had received their master's degree (59.3%). In addition, the majority of the sample stated that they had never completed a course in gerontology (60.9%) however, 23.3% stated they had taken at least one gerontology course. The courses in which gerontology was primarily infused into were Human Growth (77%) and Multicultural courses (59%). In 1991, Myers and Sweeny found that 53% of programs indicated that gerontological counseling was infused into human growth and development courses, 41% infused these topics into lifestyle and career development, 19% in sexuality courses, 18% in substance abuse courses, 17% in social and cultural foundations, and 15% in appraisal courses. Therefore, counselor training programs may be integrating gerontological topics more often than they did in the past.



Students made up 47.6% of this sample, followed by 43.8% practitioners, and 8.6% counselor educators. The majority of counselor educators were new in the field (0-2 years; 32.3%). Likewise, the majority of practitioners were also new within the field (0-2 years; 34.3%). In addition, 65% of practitioners stated that each year only 0-10% of their clients are those of the geriatric population. The majority of students were enrolled in CACREP accredited programs (76%).

The results of this study indicate that counselors and counselor trainees report lower ageist attitudes and rate themselves high in multicultural counseling competence. These two variables negatively correlated indicating that the higher participants rated themselves as being multiculturally competent, the lower their ageist attitudes. Therefore, perhaps increased multicultural education, which ultimately increases competence, may relate to a decrease in any previously held ageist beliefs.

Because a statistically significant negative correlation was found between participant's scores on the FSA and their scores on the MCKAS, it may be important for counselors and counselor trainees to seek educational opportunities, such as conferences, experiential activities, greater client contact, and additional courses, that may assist them in becoming more multiculturally competent counselors. This is important because in this current study, as higher self-reported multicultural competency was associated with lower ageist attitudes.

In addition, the majority of participants stated that issues regarding geriatrics had been integrated into at least one of their core courses with the most frequent integration in multicultural courses and human growth and development. Therefore, it is important for counselor educators to continue to integrate these topics into core courses to assure

minimal competence in working with client of the geriatric population. Perhaps counselor educators may want to attempt to integrate these topics into courses in which participants identified very little integration such as group work, career, helping relationships, and assessment. For instance, counselor educators could discuss types of groups that may be appropriate for individuals of the geriatric population, retirement and career concerns of this population, as well as different assessments for this population. In addition, 60.9% of this sample indicated that they had never completed a separate course in gerontology. Perhaps, these courses need to be offered more often in order to assist counselors and counselor trainees in gaining educational experiences regarding geriatrics.

Counselor educators should also encourage self-reflection of counselor trainees in order to challenge the biases and assumptions they may hold against minority groups such as the geriatric population. Self-awareness of biases and stereotypes are all imperative when counseling diverse clients. This may be an uncomfortable process and, therefore, may cause some anxiety in both counselor trainees and counselor educators. As a result, some counseling programs may not emphasize self-reflection as much as they should. Therefore, greater emphasis needs to be placed on helping counselor trainees reflect upon their own lives as well as preparing counselor educators to facilitate this difficult process. Immersion experiences and journaling may help to facilitate self-reflection by allowing students to challenge their biases and then journal about their anxieties, discomfort, and victories. Additionally, counselor educators should suggest counselor trainees seek counseling if troubles arise.

### **Limitations of the Study**

Social desirability may have affected participant's responses on both the FSA and the MCKAS. Social desirability occurs when participants respond to instruments in socially acceptable ways rather than reporting their true feelings or beliefs (Vella-Broderick & White, 1997). Social desirable responses have "the potential to attenuate, inflate, or moderate variable relationships depending on the measures being used and the model under consideration" (Fisher & Katz, 2000, p. 106). Participants in this study may have been reactive to the instruments in that they were aware that their performance was being measured and, therefore, altered their answers from what they would have otherwise been (Marczyk et al., 2005). Participants will do this in order to please the researcher or appear "better" or more competent than they actually are. In attempt to reduce this, confidentiality and anonymity was ensured for this research study.

The MCKAS required participants to self-report on a Likert scale of 1-7 whether or not they agreed or did not agree with 32 statements regarding multicultural counseling (Ponterotto et al., 2002). The higher the score participants received on the MCKAS, the higher they rated themselves as being multiculturally competent. Due to this, participants may have rated themselves as being more multiculturally competent than they really are. In addition, because multicultural counseling competence scales are self-report measures, their relationship to actual multicultural competence is questionable (Constantine & Ladany, 2000). Additional measures of MCC should be considered in future studies to minimize social desirability.

The FSA required participants to rate 29 statements on a Likert scale of 1-4 whether or not they agreed or did not agree with 29 statements regarding attitudes

towards the geriatric population (Fraboni et al. 1990). The lower the scores on the FSA the lower participants' ageist beliefs and negative attitudes towards the geriatric population. Due to this, participants may have rated themselves as holding fewer ageist beliefs than they actually do.

Response rate may have been another potential limitation. Initially, 415 out of the 1,965 participants the survey was sent out to responded to it. However, only 361 participants who started the survey, completed it. Therefore, the response rate for those who fully completed the survey was 18.4%. This is a typical, but fairly low response rate. However, even though the majority of participants did not respond, the estimated power calculation of 360 was met. It is also impossible to know if participants who did not respond have different characteristics than those who did.

It may be difficult to generalize results, as the Internet may not be readily available to all potential participants (Mitra et al., 2008; Sax et al., 2003). For instance some potential participants may lack computer literacy, be weary of responding to surveys due to confidentiality issues. In addition, low socioeconomic status (SES) participants may not have access to a computer. In addition, it is impossible to control if participants can take a survey more than once or if the intended participant is even the person responding (Cobanoglu & Cobanoglu, 2003; Mitra et al.).

Sample demographics may have been another limitation. The majority of participants who comprised this sample were White (81.4%) and female (79.5%). Therefore, it is difficult to generalize these results to individuals who are not of these demographics. However, it is noteworthy that the demographics found in this study are similar to those that comprise the entire population of counselors and counselor trainees.

Participants may have had difficulty answering some of the demographic questions. For instance, participants were asked to report the percentage of geriatric clients they see per year. This may have been difficult for some participants to assess. In addition, participants were asked whether or not they graduated or are currently attending a CACREP accredited program. Although, an “unsure” answer option was offered, some participants may have answered “yes” or “no” without knowing if they truly had graduated or were attending a CACREP accredited program.

Instrumentation threats may also exist within this study. For instance, the measures may not be consistent over time and they may not measure what they are actually intended to measure (Marczyk et al., 2005). In addition, even though this study is not longitudinal in nature, testing may also be a threat if participants have taken either the FSA or the MCKAS previously. Taking the same measure multiple times may affect scores as practice, memory, research expectations, and sensitization may develop. Overall, the FSA and the MCKAS scale may have been problematic. In addition, attitudes towards the geriatric population beyond ageism were not measured.

External validity threats may also be a limitation of this study. According to Creswell (2009), external validity threats “arise when experimenters draw incorrect inferences from the sample data to other persons, other settings, and past or future situations” (p. 162). These threats may have been a problem due to characteristics of the participants, timing of the experiment, and uniqueness of setting. Interaction of setting and treatment may also have been an issue in this study. For instance, characteristics of the participants may have prevented the results from being generalized to individuals in

other settings. Therefore, results of this study may not be generalizable to other populations.

### **Implications for Future Research**

In order to explore counselor's attitudes towards individuals of the geriatric population further, a qualitative or mixed methods study may be well warranted. Researchers could then determine patterns and themes based on participant's responses rather than quantitative data which offers very little exploration of responses. This type of research design would allow researchers to gain a better understanding of the attitudes counselors and counselor trainees have regarding individuals of the geriatric population.

In future research, a larger sample size may need to be utilized. If more participants were included, it would allow for more participants of different racial groups to be included. In the current study, participants of racial groups other than White only accounted for 18% of the sample. In addition, future research may warrant the use of different instruments. There are multiple self-report measures for multicultural counseling competence as well as attitudes towards individuals of the geriatric population. In addition, instead of using a self-report multicultural counseling instrument, it may be worthwhile for a panel of professionals to assess the multicultural competence of each participant. This can be done by presenting the participant with a standardized case study with a multicultural client and allowing professionals to rate how competently the participant works with the individual. This technique could be combined with a self-report measure.

In addition, because counselor's access to the geriatric population seems to be so low, it is important that additional research studies are completed on how counselors can

better access individuals of this population. Specifically, a qualitative study could be conducted with counselors who primarily work with individuals of the geriatric population. Access to the population could be explored as well as barriers to reaching this population.

Future research may also want to explore training on elder abuse among counselors. In addition, analogue studies may be utilized in order to determine the rate of diagnosis of mental health concerns such as depression, suicide, and dementia for the geriatric population. Finally, studies that explore what counselors actually do with these clients (e.g., theories, techniques, etc.) may be well warranted.

### **Conclusion**

This study sought to determine a relationship between counselors' attitudes of the geriatric population and self-reported multicultural counseling competence. A negative relationship between the FSA and the MSCKAS was identified. Future research, including quantitative and qualitative studies are recommended to further explore counselor, counselor educator, and counselor trainee perceptions of the geriatric population and possible sources of counselor and counselor trainee bias and by correlating counselors' attitudes towards the geriatric population with their self-reported multicultural counseling competence.

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**Appendix A:**  
**Human Subjects Application and Approval**  
**OLD DOMINION UNIVERSITY**  
**APPLICATION FOR EXEMPT RESEARCH**

Note: For research projects regulated by or supported by the Federal Government, submit 10 copies of this application to the Institutional Review Board. Otherwise, submit to your college human subjects committee.

<b>Responsible Project Investigator (RPI)</b>		
The RPI must be a member of ODU faculty or staff who will serve as the project supervisor and be held accountable for all aspects of the project. Students cannot be listed as RPIs.		
<b>First Name:</b> Danica	<b>Middle Initial:</b> G.	<b>Last Name:</b> Hays
<b>Telephone:</b> 757.683.6692	<b>Fax Number:</b> 683-5756	<b>E-mail:</b> dhays@odu.edu
<b>Office Address:</b> ED 110-C, Darden College of Education		
<b>City:</b> Norfolk	<b>State:</b> Virginia	<b>Zip:</b> 23529
<b>Department:</b> Counseling and Human Services		<b>College:</b> Darden College of Education
<b>Complete Title of Research Project:</b> THE RELATIONSHIP AMONG COUNSELOR AND COUNSELOR TRAINEE DEMOGRAPHIC, TRAINING, AND EMPLOYMENT VARIABLES AND SELF-REPORTED MULTICULTURAL AND GERONTOLOGICAL COUNSELING COMPETENCE		<b>Code Name (One word):</b> Geriatrics
<b>Investigators</b>		
Individuals who are directly responsible for any of the following: the project's design, implementation, consent process, data collection, and data analysis. If more investigators exist than lines provided, please attach a separate list.		
<b>First Name:</b> Rebecca	<b>Middle Initial:</b> G.	<b>Last Name:</b> McBride
<b>Telephone:</b> 757.412.7816	<b>Fax Number:</b>	<b>Email:</b> rgmcbri@odu.edu
<b>Office Address:</b> 110 Education Building, Old Dominion University		
<b>City:</b> Norfolk	<b>State:</b> VA	<b>Zip:</b> 23529
<b>Affiliation:</b> <input type="checkbox"/> Faculty <input checked="" type="checkbox"/> Graduate Student <input type="checkbox"/> Undergraduate Student <input type="checkbox"/> Staff <input type="checkbox"/> Other _____		
List additional investigators on attachment and check here: <input type="checkbox"/>		

<b>Type of Research</b>	
<p><b>1. This study is being conducted as part of (check all that apply):</b></p> <p> <input type="checkbox"/> Faculty Research           <input type="checkbox"/> Non-Thesis Graduate Student Research  <input checked="" type="checkbox"/> <i>Doctoral Dissertation</i> <input type="checkbox"/> <i>Honors or Individual Problems Project</i>  <input type="checkbox"/> Masters Thesis           <input type="checkbox"/> Other _____         </p>	
<b>Funding</b>	
<p><b>2. Is this research project externally funded or contracted for by an agency or institution which is independent of the university? Remember, if the project receives ANY federal support, then the project CANNOT be reviewed by a College Committee and MUST be reviewed by the University's Institutional Review Board (IRB).</b></p> <p> <input type="checkbox"/> Yes (If yes, indicate the granting or contracting agency and provide identifying information.)  <input checked="" type="checkbox"/> No         </p> <p> <b>Agency Name:</b>  <b>Mailing Address:</b>  <b>Point of Contact:</b>  <b>Telephone:</b> </p>	
<b>Research Dates</b>	
<p><b>3a. Date you wish to start research (MM/DD/YY)</b>    <u>  </u>3/15/10</p> <p><b>3b. Date you wish to end research (MM/DD/YY)</b>    <u>  </u>3/14/11</p>	
<b>Human Subjects Review</b>	
<p><b>4. Has this project been reviewed by any other committee (university, governmental, private sector) for the protection of human research participants?</b></p> <p> <input type="checkbox"/> Yes  <input checked="" type="checkbox"/> No         </p> <p><b>4a. If yes, is ODU conducting the primary review?</b></p> <p> <input type="checkbox"/> Yes  <input type="checkbox"/> No (If no go to 4b)         </p> <p><b>4b. Who is conducting the primary review?</b></p>	

**5. Attach a description of the following items:**

X\_ Description of the Proposed Study

X\_ Research Protocol

X\_ References

X\_ Any Letters, Flyers, Questionnaires, etc. which will be distributed to the study subjects or other study participants

N/A If the research is part of a research proposal submitted for federal, state or external funding, submit a copy of the FULL proposal

Note: The description should be in sufficient detail to allow the Human Subjects Review Committee to determine if the study can be classified as EXEMPT under Federal Regulations 45CFR46.101(b).

**Exemption categories**

**1. Identify which of the 6 federal exemption categories below applies to your research proposal and explain**

**why the proposed research meets the category. Federal law 45 CFR 46.101(b) identifies the following EXEMPT categories. Check all that apply and provide comments.**

SPECIAL NOTE: The exemptions at 45 CFR 46.101(b) do not apply to research involving prisoners, fetuses, pregnant women, or human in vitro fertilization. The exemption at 45 CFR 46.101(b)(2), for research involving survey or interview procedures or observation of public behavior, does not apply to research with children, except for research involving observations of public behavior when the investigator(s) do not participate in the activities being observed.

\_\_\_\_(6.1) Research conducted in established or commonly accepted educational settings, involving normal educational practices, such as (i) research on regular and special education instructional strategies, or (ii) research on the effectiveness of or the comparison among instructional techniques, curricula, or classroom management methods.

**Comments:**

\_X\_(6.2) Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures or observation of public behavior, unless: (i) Information obtained is recorded in such a manner that human subjects can be identified, directly or through identifiers linked to the subjects; AND (ii) any disclosure of the human subjects' responses outside the research could reasonably place the subjects at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability, or reputation.

**Comments:**

**Participants will be selected via random sampling from a purchased email list from the American Counseling Association. In this study, participants will be asked to respond to a demographic questionnaire that includes personal information, however, the questionnaire will not solicit any identifying information (appendix B). Participants will also respond to the Fraboni Scale of Ageism (appendix C) and the Multicultural Knowledge and Awareness Scale (appendix D).**

**Each participant will receive and sign an Informed Consent form (appendix E). They will receive a copy of the informed consent for their records. Confidentiality of participant information will**

be strictly protected as no identifying information will be asked or collected at anytime throughout this study. The information participants provide by filling out the online survey is completely anonymous. Data will be compiled using computer SPSS and will be stored on a password-protected computer. Only the listed researchers will have access to the data. To assure anonymity, no information regarding participant internet addresses will be recorded. As soon as this study is completed, data files will be destroyed. Research findings may be presented at professional conferences and/or in scholarly journals. This study poses no risk of civil or criminal liability or any other damaging consequences.

\_\_\_\_(6.3) Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures, or observation of public behavior that is not exempt under paragraph (b)(2) of this section, if:

(i) The human subjects are elected or appointed public officials or candidates for public office; or (ii) federal statute(s) require(s) without exception that the confidentiality of the personally identifiable information will be maintained throughout the research and thereafter.

**Comments:**

\_\_\_\_(6.4) Research, involving the collection or study of existing data, documents, records, pathological specimens, or diagnostic specimens, if these sources are publicly available or if the information is recorded by the investigator in such a manner that subjects cannot be identified, directly or through identifiers linked to the subjects.

**Comments:**

\_\_\_\_ (6.5) Does not apply to the university setting; do not use it

\_\_\_\_(6.6) Taste and food quality evaluation and consumer acceptance studies, (i) if wholesome foods without additives are consumed or (ii) if a food is consumed that contains a food ingredient at or below the level and for a use found to be safe, or agricultural chemical or environmental contaminant at or below the level found to be safe, by the Food and Drug Administration or approved by the Environmental Protection Agency or the Food Safety and Inspection Service of the U.S. Department of Agriculture.

**Comments:**

**PLEASE NOTE:**

1. You may begin research when the College Committee or Institutional Review Board gives notice of its approval.
2. You MUST inform the College Committee or Institutional Review Board of ANY changes in method or procedure that may conceivably alter the exempt status of the project.

Responsible Project Investigator (Must be original signature)

Date



## **Appendix A**

### **Description of the Proposed Study**

**Study Title:**

THE RELATIONSHIP AMONG COUNSELOR AND COUNSELOR TRAINEE DEMOGRAPHIC, TRAINING, AND EMPLOYMENT VARIABLES AND SELF-REPORTED MULTICULTURAL AND GERONTOLOGICAL COUNSELING COMPETENCE

**Primary Purpose:**

The purpose of this study is to understand the relationship among counselor demographic variables, training and employment variables, attitudes of the geriatric population, and self-reported multicultural counseling competence. Counselor demographic variables will include gender, age, and race/ethnicity. Training variables will include whether or not the participant is currently enrolled in or graduated from a CACREP accredited program, number of gerontology counseling courses completed, number of courses gerontological topics were infused into, and number of years of education pertaining to counseling. Employment variables will include proportion of geriatric clients seen, time within the counseling field, licensure obtained, and primary work setting. Attitudes of geriatric population will also serve as a variable and will be measured by the Fraboni Scale of Ageism (FSA) (Fraboni, Saltstone, & Hughes, 1990). Finally, self-reported multicultural counseling competence will serve as a variable and will be measured by The Multicultural Counseling Knowledge and Awareness Scale (MCKAS) (Ponterotto, Gretchen, Utsey, Rieger, & Austin, 2002).

**Selection of Participants:**

Participants will consist of graduate students in all stages (first, second year, etc.) of both CACREP and non-CACREP accredited counseling programs in order for participants' scores from both CACREP accredited programs and non-CACREP accredited programs to be compared. Participants will also consist of master's and doctoral level counselors working in the counseling field so that these individuals may be compared to counselor trainees. Participants will be selected at random and will be current members of the American Counseling Association. In order to complete the survey, participants will be required to be currently enrolled within a counselor preparation program or must be a practitioner who graduated from a masters or doctoral in counseling program. Assuming a moderate affect size at the  $p=.80$  level a minimum sample of 360 participants will be sought to assume that hypotheses are tested at the .05 alpha level. Overall, 1000 participants will be surveyed.

**Data Collection Procedures:**

The American Counseling Association will be contacted and a random selection of its members e-mail addresses will be requested. It will be asked that half of the email list comprise ACA members who identify themselves as students and the other half who identify themselves as practitioners. In addition, it will be requested that school

counselors be excluded from this list. Data will be collected by using the online service called SurveyMonkey ([www.surveymonkey.com](http://www.surveymonkey.com)). Upon obtaining the email addresses, an email will be sent explaining the purpose of the study with a link to materials placed on SurveyMonkey. Participants will be asked to complete the survey by filling in the appropriate answers. The survey packet will include the following: The Fraboni Scale of Ageism (Fraboni, et al., 1990), The Multicultural Counseling Awareness Scale (Ponterotto et al., 2002), the Multicultural Training Questionnaire and Demographic Sheet, and informed consent information. Participants will be able to answer the questions within the packet at their leisure, as there will be no time constraints. In order to reduce ordering bias, SurveyMonkey will display questions to each participant in a randomized order. In order to increase participation, reminders will be sent to participants over a period of three weeks.

**Data Analysis:**

Data will be analyzed using SPSS. Frequency distributions will be utilized to report data such as gender, age, race/ethnicity, counselor trainee and number of years of education pertaining to counseling), licensure information, and time in the counseling field (in years). In addition, MANOVA's and correlations will be run the hypotheses of the research questions.

**Validity Threats:**

According to Creswell (2009), there are two types of validity threats: internal and external. Internal validity is the ability of the research design to rule out or make alternative explanation of the results (Marczyk, Dematteo, & Festinger, 2005). Internal validity threats include "experimental procedures, treatments, or experiences of the participants that threaten the researcher's ability to draw correct inferences from the data about the population in an experiment" (p. 162). For this study, selection may be a threat to validity as participants who are selected for this study may have certain characteristics that predispose them to have particular outcomes. In attempt to control this, a random email list will be obtained from ACA and the survey will be distributed to individuals on this list. Attrition may also be a threat to this study. For instance, participants may only take half of the survey then choose to drop out. Therefore, the researcher will not know outcomes for these participants. Instrumentation threats may also exist within this study. The measurements utilized in this study may not be reliable or valid. For instance, the measures may not be consistent overtime and they may not measure what they are actually intended to measure (Marczyk et al., 2005). In order to control this, previous studies which have used and validated these measures will be examined in order to determine validity and reliability of the measures. Ordering bias may also be an issue. In order to prevent this, SurveyMonkey will display questions to each participant in a randomized order. In addition, even though this study is not longitudinal in nature, testing may also be a threat if participants have taken either the Fraboni Scale of Ageism or the Multicultural Knowledge and Awareness Scale previously. Taking the same measure multiple times may affect scores as practice, memory, research expectations, and sensitization may develop.

External validity is how generalizable the results of the research study are (Marczyk et al., 2005). According to Creswell (2009), external validity threats “arise when experimenters draw incorrect inferences from the sample data to other persons, other settings, and past or future situations” (p. 162). These threats may be a problem due to characteristics of the participants, timing of the experiment, and uniqueness of setting. Interaction of setting and treatment may be an issue in this study. For instance, characteristics of the participants may prevent the results from being generalized to individuals in other settings. Therefore, results of this study may not be generalizable to other populations. In addition, participants may be reactive to the assessment in that they are aware that their performance is being measured and, therefore, alter their answers from what they would have otherwise been (Marczyk et al., 2005). Participants will do this in order to please the researcher or appear “better” or more competent than they actually are. This may be an issue in this research because it pertains to counselors’ attitudes regarding the geriatric population. Therefore, participants may not be completely honest if they do hold biases and stereotypes against this population. In attempt to reduce this, confidentiality and anonymity will be ensured for this research study.

**Potential Contributions:**

This study will highlight counselors’ biases and stereotypes of the geriatric population and, therefore, suggest any changes that may be needed in counselor training programs regarding gerontological issues so that counselors may be better equipped to work with this population. It is imperative that counselors are equipped to work with this generation as they are dealing with unique issues that generations before did not experience such as diminishing social security income, long-term care needs and more prevalence of age discrimination (Dixon, Richard, & Rollins, 2003).

If counselor biases and stereotypes are identified, this study will encourage programs to focus more heavily on issues exclusive to the geriatric population and ultimately impact counselors who will work with these individuals. In addition, it will be recommended that counselor training programs better educate counselors about this population in order to break down some of these biases and stereotypes. One practical way to encourage acceptance of populations is through activities such as immersion experiences.

Due to the extensiveness of this generation, it is imperative that counselors are educated regarding these unique issues and prepared to assist and advocate for individuals that comprise the geriatric population. This may be difficult as many individuals who are elderly are hesitant to seek counseling (Maples & Abney, 2006). Therefore, if counselors are not competent in working with this population they may further push these clients away. If this happens, geriatric client care will suffer significantly. This study will help to bring much needed attention to the geriatric population. It will assist in producing systemic changes that are needed so the counselors may be more competent in working with this population.

Currently, there is a large gap in the scholarly research regarding gerontological counseling. Much of the research is from the late 1980’s and early 1990’s. Due to the

breadth of the current geriatric population, it is significant that counseling professionals have access to up to date information regarding this population. This study will contribute to the limited literature in the counseling field regarding geriatrics and stimulate future research.

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## Appendix B

### The Fraboni Scale of Ageism

Instructions: Indicate how strongly you agree or disagree with each statement. For the purposes of this scale, elderly or old people are individuals who are 65 years of age or older.

1. Many old people are stingy and hoard their money and possessions.

1.....2.....3.....4  
Strongly Disagree Strongly Agree

2. Many old people are not interested in making new friends, preferring instead the circle of friends they have had for years.

1.....2.....3.....4  
Strongly Disagree Strongly Agree

3. Many old people just live in the past.

1.....2.....3.....4  
Strongly Disagree Strongly Agree

4. Most old people should not be trusted to take care of infants.

1.....2.....3.....4  
Strongly Disagree Strongly Agree

5. Many old people are happiest when they are with people their own age.

1.....2.....3.....4  
Strongly Disagree Strongly Agree

6. Most old people would be considered to have poor personal hygiene.

1.....2.....3.....4  
Strongly Disagree Strongly Agree

7. Most old people can be irritating because they tell the same stories over and over again.

1.....2.....3.....4  
Strongly Disagree Strongly Agree

8. Old people complain more than other people do.

1.....2.....3.....4  
Strongly Disagree Strongly Agree

9. I would prefer not to go to an open house at a senior's club, if invited.

1.....2.....3.....4  
Strongly Disagree Strongly Agree

10. Teenage suicide is more tragic than suicide among the old.

1.....2.....3.....4  
Strongly Disagree Strongly Agree

11. I sometimes avoid eye contact with old people when I see them.

1.....2.....3.....4  
Strongly Disagree Strongly Agree

12. I don't like it when old people try to make conversation with me.

1.....2.....3.....4  
Strongly Disagree Strongly Agree

13. Complex and interesting conversation cannot be expected from most old people.

1.....2.....3.....4  
Strongly Disagree Strongly Agree

14. Feeling depressed when around old people is probably a common feeling.

1.....2.....3.....4  
Strongly Disagree Strongly Agree

15. Old people should find friends their own age.

1.....2.....3.....4  
Strongly Disagree Strongly Agree

16. Old people should feel welcome at the social gatherings of young people.

1.....2.....3.....4  
Strongly Disagree Strongly Agree

17. Old people don't really need to use our community sports facilities.

1.....2.....3.....4  
Strongly Disagree Strongly Agree

18. It is best that old people live where they won't bother anyone.

1.....2.....3.....4  
Strongly Disagree Strongly Agree

19. The company of most old people is quite enjoyable.

1.....2.....3.....4  
Strongly Disagree Strongly Agree

20. It is sad to hear about the plight of the old in our society these days.

1.....2.....3.....4  
Strongly Disagree Strongly Agree

21. Old people should be encouraged to speak out politically.

1.....2.....3.....4  
Strongly Disagree Strongly Agree

22. Most old people are interesting, individualistic people.

1.....2.....3.....4  
Strongly Disagree Strongly Agree

23. I personally would not want to spend much time with an old person.

1.....2.....3.....4  
Strongly Disagree Strongly Agree

24. There should be special clubs set aside within sports facilities so that old people can compete at their own level.

1.....2.....3.....4  
Strongly Disagree Strongly Agree

25. Old people deserve the same rights and freedoms as do other members of our society.

1.....2.....3.....4  
Strongly Disagree Strongly Agree

26. Most old people should not be allowed to renew their drivers licenses.

1.....2.....3.....4  
Strongly Disagree Strongly Agree



27. Old people can be very creative.

1.....2.....3.....4  
Strongly Disagree Strongly Agree

28. I would prefer not to live with an old person.

1.....2.....3.....4  
Strongly Disagree Strongly Agree

29. Old people do not need much money to meet their needs.

1.....2.....3.....4  
Strongly Disagree Strongly Agree











## Appendix D

### Multicultural Training Questionnaire and Demographic Sheet

Age \_\_\_\_\_ Gender:  M  F  Transgender

**Race/Ethnicity (check one):**

- White  Native American  
 African American  Asian American  
 Hispanic  Other \_\_\_\_\_

**ACA divisions you are a member of (check as many as apply):**

- AACE  ALGBTIC  ASGW  
 AADA  AMCD  C-AHEAD  
 ACC  AMHCA  CSJ  
 ACCA  ARCA  IAAOC  
 ACEG  ASCA  IAMFC  
 ACES  ASERVIC  NCDA  
 NECA  None of the above

**Number of gerontology courses completed (check one):**

- 1  3  5  
 2  4  Other \_\_\_\_\_

**Courses in which geriatric content was addressed (check as many as apply):**

- Ethics  Career Development  
 Social and Cultural Diversity  Helping Relationships  
 Human Growth and Development  Group Work  
 Assessment  Research and Program Evaluation





21-30%

71-80%

31-40%

81-90%

41-50%

91-100%

**Primary Work Setting:**

Private Practice

School

Counselor

Educator

Hospital

Nursing Home/Assisted Living

Other \_\_\_\_\_

**Experience within the counseling field as an employee:**

1-5

21-25

6-10

26-30

11-15

31-35

16-20

Other \_\_\_\_\_

## Appendix E

### **Informed Consent**

#### **Title:**

The Relationship among Counselor Demographic, Training, and Employment Variables and Self-Reported Multicultural and Gerontological Counseling Competence

#### **Introduction:**

My name is Rebecca McBride, and I am the researcher for the study. I have a master's degree in Counseling, and I am currently pursuing my PhD at Old Dominion University. The project will be supervised by Dr. Danica Hays, an Associate Professor in the Department of Counseling and Human Services. With this form, I will provide you with information that will help you to decide whether you would like to participate or not.

#### **Criteria for Participation:**

In order to complete the survey, it is requested that you are currently enrolled in a counseling program (CACREP or non-CACREP) or a graduate of one of these programs.

#### **Description of the Study:**

You are invited to participate in a research project that examines counselors' knowledge and attitudes of the geriatric population in addition to their self-assessment of their multicultural counseling competence. If you agree to participate in this study, you will complete a series of questions that include demographic information (e.g., age, gender, race), the Fraboni Scale of Ageism, and the Multicultural Counseling Knowledge and Awareness Scale. Completing the survey should take approximately 15-30 minutes. You are free to refuse to answer any questions you do not wish to answer. You may withdraw from the study at any time by closing your browser window.

#### **Confidentiality:**

The information you provide by filling out the online survey is completely anonymous. No identifying information will be collected. Data will be compiled using SPSS and will be stored on a password-protected computer. Only the listed researchers will have access to the data. To assure anonymity, no information regarding participant internet addresses will be recorded. Research findings may be presented at professional conferences and/or in scholarly journals.

#### **Risks and Benefits:**

There are no foreseeable risks for participating in this research. You will be asked to answer a series of questions. You may refuse to answer any questions that you do not wish to answer and you may terminate participation at any time without penalty. You may benefit from this research in that the results may be released to the public. You may also choose to contact the primary researcher at the below listed email address for any resultant publications related to this research. In addition, you may benefit from a sense of helping the public at large by contributing to knowledge in this area of research.

**Withdrawal Privilege and Payments:**

There is no cost to you nor any compensation provided for participation. You do not have to participate in this study. You can choose to withdraw at any time. Even if you agree to participate and then later change your mind, there will be no negative consequences.

If you have any questions at any point during or after this study, please contact – Danica Hays at 757-683-6692, or dhays@odu.edu. Please feel free to send correspondence to Old Dominion University, 110 Education Building, Norfolk, VA 23529. You may also contact the IRB chair- George Maihafer at anytime at 757-683-4520, or gmaihafe@odu.edu.

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By clicking the "next" button below, you agree that you have read and understood the explanation provided and voluntarily agree to participate in this study.

## VITA

Rebecca G. McBride earned a Bachelor's of Science degree in Psychology in 2006 from Old Dominion University and a Master's of Art degree in Community Counseling from Regent University in 2008. She is a national certified counselor and is currently completing her residency requirements for licensure as a professional counselor.

Ms. McBride currently teaches undergraduate Human Services courses at Old Dominion University and is a supervisor for Master's students who are completing their practicum and internship experiences. She has worked in inpatient, residential, and private practice settings. Ms. McBride's research interests include the geriatric population, the homeless population, and social justice issues. She has published four articles in peer-reviewed journals and has contributed to a multicultural group work book. Ms. McBride has presented multiple times at state, regional, and national conferences. She also currently serves as the Assistant Editor for the *Journal of Human Services*.

Ms. McBride is an active member of several national professional organizations including the American Counseling Association (ACA), the Association for Counselor Education and Supervision (ACES), the Association for Adult Development and Aging (AADA), and Chi Sigma Iota (CSI).