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Counselor Demographics, Ageist Attitudes, and Multicultural Counseling Competence Among Counselors and Counselor Trainees

Rebecca G. McBride and Danica G. Hays

The purpose of this study was to understand the relationship among counselors' self-reported multicultural counseling competence and their attitudes of the geriatric population. A statistically significant negative correlation was found between participants' attitudes of the geriatric population and their self-reported multicultural counseling competence. Implications for training and practice are provided.

Approximately 75 million individuals who were born between 1946 and 1964 encompass the Baby Boom population (Goldstein & Damon, 1993). In the year 2011, these individuals began entering the geriatric population. As the Baby Boom population ages, the geriatric population, which includes those 65 years and older, will grow to be the largest cohort in history. By 2000, 35 million individuals composed the geriatric population (Gist & Hetzel, 2004), and researchers expect this cohort to continue to grow to include 21% of the U.S. population—or 76.4 million individuals—by 2030 (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 more of these individuals. 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 AND PSYCHOSOCIAL CONSIDERATIONS

Mental Health Considerations

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

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suicide are prevalent within this population. 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). Overall, 5% of adults over the age of 65 years 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 are diagnosed with dementia at a rate of 20%, and more than half of individuals over the age of 85 years 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).

Depression can lead to impairments in mental, physical, and social functioning for this population (Centers for Disease Control and Prevention [CDC] & National Association of Chronic Disease Directors [NACDD], 2009). Overall, 2.5% of older adults meet the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 2000) criteria for depression or dysthymic disorder. However, 27% of older adults have symptoms of depression 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. Because of this, elders may experience increased depression. In addition, depression may also be exacerbated by illness and accidents, such as hip fractures or heart disease (U.S. Department of Health and Human Services [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 because 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 65 years and older commit suicide each day in the United States (Walsh, Currier, Shah, Lyness, & Friedman, 2008). In 2000, individuals 65 years and older completed 18.1% of suicides. In addition, 57.5 per every 100,000 men 85 years and older complete suicide, which is more than 5 times the national suicide rate. In fact, older men have the highest suicide rates of any age cohort, with 45.23 suicides per every 100,000 men 85 years and older (CDC & NACDD, 2008). Overall, the Baby Boom generation has a higher suicide rate than does any other generation.

Elder Abuse

In 2004 alone, 565,747 elders were abused (National Center on Elder Abuse, 2006), although this statistic is likely underreported. 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 because physicians often have the most contact with elders yet have little training on elder abuse (see Jones, Veenstra, Seamon, & Krohmer, 1997). 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). Because of 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 because of demographic changes in the United States. For instance, in 2000, 25% to 30% of the U.S. population self-identified as minorities, and, by the end of 2010, this population increased to 32.7% (LaRoche & Maxie, 2003; Yali & Revenson, 2004). One aspect of increased multicultural counseling competence is minimal prejudice and discrimination and, specific to this population, the acknowledgment and dismantling of ageism.

The concept of ageism was first introduced by Butler (1969) and is described as stereotypes, prejudice, or discrimination against members of the geriatric population because of 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).

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 older clients are less able than younger clients to make autonomous decisions. This same study indicated that the longer the mental health practitioner was in practice, the more likely he or she was to judge elders as being less competent, which is counterintuitive. However,

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this may be because as mental health professionals grow older, they may find it difficult to face their own aging process, thus leading them to view elders in a negative manner. Finally, licensed counselors were less likely to judge older clients as being less competent when compared with nonlicensed 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. Helmes and Gee (2003) found that when the client was described as being an older adult, prognosis for that client was less optimistic than if the client was not described as being an older adult. Because of age alone, counselors believed the older client to be less able to develop a therapeutic relationship and to be less appropriate for therapy compared with a 42-year-old client, and they felt less competent treating the older client and less willing to accept the older client. However, older adults presenting with depression are often thought to be less severe cases than are younger or middle-aged adults. This may occur because of 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.

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 because these attitudes may significantly influence client cognitive and physical functioning and overall well-being. 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, because they may not feel confident that they have the skills they need 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 that 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 overcommitment to the client. Therefore, mental

health professionals often report less preference and motivation for working with older adults compared with working with young and middle-aged adults (Hillman & Stricker, 1998).

Although 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. Because 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 between counselors' and counselor trainees' 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; thus, there is a need to look at the relationship between multicultural counseling competence and ageism because it has not been explored. The following research questions guided this study:

Research Question 1: What are counselors' and counselor trainees' training and clinical experiences related to the geriatric population?

Research Question 2: What is the relationship between multicultural counseling competence and ageism, using Multicultural Counseling Knowledge and Awareness Scale (MCKAS; Ponterotto, Gretchen, Utsey, Rieger, & Austin, 2002) and Fraboni Scale of Ageism (FSA; Fraboni, Saltstone, & Hughes, 1990) scores?

Regarding Research Question 2, it was hypothesized that the lower the scores on the MCKAS (indicating lower multicultural counseling competence), the higher the scores on the FSA (indicating ageist beliefs).

METHOD

Participants

Participants consisted of graduate students in counseling programs accredited and not accredited by the Council for Accreditation of Counseling and Related Educational Programs (CACREP) 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 (ACA). Assuming a moderate effect size at power = .80, we sought a minimum sample of 360 participants to assume that the hypothesis was tested at the .05 alpha level (Cohen, 1992). The return rate for the survey was 21.1%, with 415 participants beginning the survey, but only 361 participants completing it. To achieve this return rate, we surveyed 2,000 participants. However, 35 e-mails were undeliverable; therefore, the actual number of participants surveyed was 1,965.

The age range was 21 to 81 years, and the mean age was 41.27 years, with a standard deviation of 13.64 (20 participants did not report). This sample was bimodal (23, 27), and the median age was 39 years. With respect to gender, there were 72 men (19.9%), 287 women (79.5%), and two transgender (0.6%) participants. Also, 294 (81.4%) participants identified as being White, 25 (6.9%) identified as African American, 17 (4.7%) identified as Hispanic, three (0.8%) identified as Asian American, and 18 (5%) identified as other (four participants did not report).

Procedure

Upon institutional review board approval, a random e-mail list of members was requested from ACA. It was asked that half of the e-mail list be composed of ACA members who identify themselves as students, with the other half being composed of ACA members who identify themselves as practitioners, and that school counselors be excluded. Data were collected through the use of a survey packet hosted on the online service SurveyMonkey (www.surveymonkey.com).

Measures

FSA (Fraboni et al., 1990). The FSA assesses attitudes toward aging and the geriatric population (Fraboni et al., 1990). This scale is 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 uses a 4-point Likert-type format ranging from 1 (*strongly disagree*) to 5 (*strongly agree*; 3 is excluded). Each response on the Likert-type scale is summed to obtain the total score, and scores range from 29 to 145 (higher scores indicate more ageism).

The FSA has adequate construct validity and high internal reliability. The Cronbach's alpha for the total scale was .86, suggesting that the scale is relatively homogeneous (Fraboni et al., 1990). The scale has been correlated with the Acceptance of Others Scale (Fey, 1955; $r = .40$, $p < .001$) and the Facts on Aging Quiz (Palmore, 1977; $r = -.28$, $p < .001$), indicating evidence of construct validity.

MCKAS (Ponterotto et al., 2002). The MCKAS is a 32-item scale that measures multicultural counseling competence (Ponterotto et al., 2002). The MCKAS uses a 7-point Likert-type scale that ranges from 1 = *not true at all*, to 4 = *somewhat true*, to 7 = *totally true*. Scores range from 32 to 224 (higher scores indicate higher self-perceived multicultural counseling competence). The Knowledge and Awareness subscales have a coefficient alpha ranging from .85 to .90 (Kim, Cartwright, Asay, & D'Andrea, 2003; Ponterotto et al., 2002). As evidence of construct validity, Neville, Spanierman, and Doan (2006) found that mental health professionals who indicated greater levels of racial/ethnic ideology were correlated with lower self-reported multicultural counseling competence.

Demographic sheet. Each participant answered questions pertaining to his or her history of gerontology training. Didactic training was assessed by the number of gerontology or adult development courses participants completed and the number of other courses into which topics regarding the geriatric population were infused. 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. In addition, participants were asked to identify their gender, age, race/ethnicity, highest degree obtained, time in the counseling field as a practitioner or student (in years), CACREP status of the program that they were enrolled in or had graduated from, and primary work setting.

RESULTS

To address Research Question 1 ("What are counselors' and counselor trainees' training and clinical experiences related to the geriatric population?"), we conducted descriptive statistics. Participants were asked to identify the number of gerontology courses they had completed. Two hundred twenty (60.9%) participants indicated that they had not completed any gerontology courses, 84 (23.3%) had completed one gerontology course, 35 (9.7%) had completed two gerontology courses, and 14 (3.9%) had completed three or more gerontology courses. Three participants (0.8%) indicated they had other training experiences, such as degrees in gerontology and extensive internships with the geriatric population. Five (1.4%) participants chose not to answer this question. Participants were also asked to indicate whether their practicums and internships, as well as the eight core CACREP courses, addressed topics regarding geriatrics. Overall, the majority of participants stated that topics regarding geriatrics were mostly addressed in multicultural (59%) and human growth and development (77%) courses.

When asked to identify their primary role, 158 (43.8%) participants identified themselves as practitioners, 172 (47.6%) as master's or doctoral students, and 31 (8.6%) as counselor educators. Of those participants who primarily identified themselves as practitioners (n = 158), 65% indicated that 0% to 10% of their clients were from the geriatric population (seven participants did not report). Practitioners were asked to indicate their primary work setting. Overall, 75 (47.5%) participants indicated that their primary work setting was private practice, 12 (7.6%) indicated a hospital, 17 (10.8%) indicated a school, and 52 (32.9%) indicated other settings as their primary work settings (two participants did not report). The other primary work settings included community centers, in-home care, early intervention programs, correctional facilities, hospice care, and rape crisis centers. In addition, 55.8% of practitioners stated that they had 0 to 5 years of experience as employees within the counseling field (one participant did not report).

Research Question 2 assessed the relationship between multicultural counseling competence and ageism, using MCKAS and FSA scores. The mean score

for the FSA was 50.52 (SD = 11.29, range = 29–86), indicating fewer ageist attitudes overall. The mean score for the MCKAS was 177.37 (SD = 20.67, range = 106–224). A Pearson product–moment correlation coefficient revealed a statistically significant relationship, $r(359) = -.41$, $p < .01$, 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 between counselors' and counselor trainees' self-reported multicultural counseling competence and their ageist attitudes. The majority of this sample consisted of White women. 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 that 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, Loesch, and Sweeney found that 53% of programs indicated that gerontological counseling was infused into human growth and development courses, whereas 41% infused these topics into lifestyle and career development courses, 19% in sexuality courses, 18% in substance abuse courses, 17% in social and cultural foundations courses, 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 practitioners (43.8%) and counselor educators (8.6%). The majority of counselor educators were new in the field (32.3% had 0–2 years of experience). Likewise, the majority of practitioners were also new within the field (34.3% had 0–2 years of experience). In addition, 65% of practitioners stated that each year only 0% to 10% of their clients are from 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 fewer ageist attitudes and rate themselves high in multicultural counseling competence, with a significant negative correlation between the two constructs. Therefore, perhaps increased multicultural education (e.g., conferences, experiential activities, greater client contact, and additional courses), which ultimately increases competence, may relate to a decrease in any previously held ageist beliefs.

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 and human growth and development courses. Therefore, it is important for counselor educators to continue to integrate these topics into core courses to ensure minimal competence in working with clients 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 to assist counselors and counselor trainees in gaining educational experiences regarding geriatrics.

Counselor educators should also encourage self-reflection of counselor trainees to challenge the biases and assumptions they may hold against minority groups, such as the geriatric population. Self-awareness of biases and stereotypes is 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 on 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 participants' 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-Brodrick & White, 1997). 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. Participants will do this to please the researcher or appear "better" or more competent than they actually are. In an attempt to reduce this, confidentiality and anonymity were ensured for this research study. Therefore, participants may have rated themselves as being more multiculturally competent than they really are or as holding fewer ageist beliefs than they actually do.

It may be difficult to generalize results, because the Internet may not be readily available to all potential participants (Mitra, Jain-Shukla, Robbins, Champion, & Durant, 2008; Sax, Gilmartin, & Bryant, 2003). For instance, some potential participants may lack computer literacy or may be weary of responding to surveys because of confidentiality issues. In addition, low socioeconomic status 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., 2008).

Sample demographics may have been another limitation. The majority of participants who composed 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 of 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 they were currently attending or had graduated from a CACREP-accredited program. Although an "unsure" answer option was offered, some participants may have answered "yes" or "no" without knowing if they were truly attending or had graduated from a CACREP-accredited program.

Implications for Future Research

As a way to explore counselors' attitudes toward 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 participants' responses rather than on quantitative data, which offer 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. Furthermore, because counselors' access to the geriatric population seems to be 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 future research, a larger sample size may need to be used to allow for more participants of different racial/ethnic groups to be included. In the current study, participants of racial/ethnic groups other than White accounted for only 17.5% of the sample.

Future researchers may also want to explore training on elder abuse among counselors. In addition, analogue studies may be used 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) may be well warranted.

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