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First Elderly Client in Therapy: Factors that Influence Student Interest in Geropsychology

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by

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DISSERTATION

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Dedication

I would like to dedicate this doctoral dissertation to my parents, Birgitta Johansson Filippelli and Donald Francis Filippelli. Mom, thanks for your bottomless love and support through the years (particularly the past five or so)…now that this is over, I can finally read some of those books (novels! fiction!) that have been piling up. Dad, I thank you for your unequivocal support of my pursuit of this degree, emotionally and financially…and, of course, for your undying love and affection.

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Abstract

In the coming decades, the elderly population in United States (U.S) is expected to grow significantly (U.S. Bureau of the Census, 1996). Consequently, the number of older individuals seeking mental health services will be greater than at any other time in the history of the U.S. The field of clinical psychology, however, is unable to meet the mental health needs of the current elderly population, and this gap is expected to widen in coming years. There is an ongoing discussion within the field of professional psychology as to how to train more clinicians to work with the elderly population (Gatz & Smyer, 2001; Hinrichsen & Zweig, 2005; Norman, Ishler, Ashcraft, & Patterson, 2000; Qualls, Segal, Benight, & Kenny, 2005), and the present study set out to understand factors that may influence clinical psychology graduate students' interest in working with clients from this population. The direction of the research was informed by current aging theory, particularly life-span and successful aging theories, and was inspired by the ongoing multicultural competency movement. Currently enrolled PsyD students (N=7) in clinical psychology programs were interviewed regarding their experiences of working with their first elderly therapy client in a supervised setting (practicum or predoctoral internship). Semi-structured interviews paid particular attention to aspects of participants' professional and personal experiences that they identified as influential on their interest to seek out (or not) future opportunities to work, or to learn more about working with, elderly individuals. Using the qualitative methodology of interpretive phenomenological analysis (IPA), interview transcriptions were analyzed to the point of saturation and distilled into common themes. These themes fell within six overarching domains: (a) Expectations vs. Reality, (b) Subjective Experience, (c) Resources Drawn upon During Treatment, (d) Interest in Geropsychology: Pre vs. Post, (e) Factors Associated with Future Interest in Geropsychology, and (f) What Would Have Made the Experience Better? These six domains comprised a total of 31 themes and

subthemes (many themes stood on their own, while others contained two or more subthemes). While a majority of the themes confirmed what is already known in the literature, unique themes also emerged, as was expected from an IPA study, whose intent was to capture the subjective voices of individual clinician-trainees. One common theme already raised by previous researchers about clinical training in geropsychology was that having at least some experience with elderly individuals in a supervised training setting is a crucial avenue for nurturing trainees' interest in working with the population (Cummings & Galambos, 2002; Hegeman, Horowitz, Tepper, Pillemer, & Schultz, 2002; Hinrichsen, 2000; Kropf, 2002). One theme unique to the present study about training, which was not found in the available literature and has clear implications for how academic programs approach training, was that some participants described experiencing a shift in their understanding of the elderly, from a population with very specialized needs to be treated by specialists, to a population that is a part of the larger, general population, which can be adequately treated by generalists. Themes are illustrated and discussed with quotations drawn directly from participant interviews, adding richness and voice to the study's results and conclusions. On the basis of the study's results and on the literature reviewed herein, implications of the current status of geropsychology training and recommendations that others have made to improve it are discussed. Additional recommendations, based on this study's unique findings, are offered as well.

First Elderly Client in Therapy:

Factors that Influence Student Interest in Geropsychology

Chapter 1: Rationale and Conceptual Framework

The U.S. is experiencing tremendous growth in its population of older adults. In 1995, there were 33.5 million people living in the U.S. who were 65 years or older, representing nearly 13% of the country's total population. It is expected that by the year 2020 the population of older adults will rise to 20% of the total population, or at least 70 million people. Furthermore, the "oldest old" (i.e., individuals who are 85 years or older) will represent the fastest growing segment of this population, with 3.6 million people in 1995 and a projected 8.5 million by the year 2030 (American Psychological Association [APA], 2004; U.S. Bureau of the Census, 1996).

It is also widely recognized that the mental health needs of elderly individuals are underserved. Current estimates suggest that between 15% and 25% of adults over 65 have a mental disorder with serious symptoms, and the prevalence rate for mental disorders in nursing homes is much higher, approaching 60% (Norman, Ishler, Ashcraft, & Patterson, 2000). Not surprisingly, the occurrence of mental illness is expected to increase in accordance with the anticipated growth spurt of the elderly population. It is also expected that the Baby Boomer generation (those born between 1946 and 1964), a group that will be largely responsible for the growth of the elderly population in the coming years, will consume health care—including mental health care—at a higher rate than any previous cohort (Qualls, Segal, Benight, & Kenny, 2005). According to a study by Gatz and Smyer (2001), demand by elderly clients for psychological services can be calculated by multiplying the number of older adults by the percentage that is in need of mental health services, which is estimated at 20% to 28%.

According to this calculation, 14 to 19.6 million elderly individuals may be seeking mental health services just a decade from now.

Considering the limited number of psychologists who currently specialize in working with older adults, it is clear that meeting the mental health demands of this growing population will require a tremendous effort. According to Qualls, Segal, Benight, and Kenny (2005), in 1995, the number of psychologists who devoted at least half of their time in their practices to older adults was between 200 and 700 (that is, 0.2% – 0.9% of 76,000 active clinical psychologists). Moreover, less than one fourth of these psychologists had completed any specialty training in working with older adults. Qualls and colleagues also found that, on average, a typical practicing psychologist provided services to fewer than two older adults each week, representing a combined ability to meet less than 60% of demand at that time. The APA estimates that by 2020, 5,000 full-time doctoral level geropsychology practitioners will be required to meet the rising needs. Given these statistics, there is no question that the field is "clearly in need of additional training programs to produce geropsychologists" (Qualls et al., 2005, p. 23).

There is evidence that student interest in gaining proficiency in working with older adults is growing, as indicated by an increase in applicants to existing "aging tracks" within clinical psychology programs; the current applicant to acceptance ratio is 6:1 (Qualls et al., 2005). However, Qualls and colleagues point out that this ratio is much lower than those for generalist PhD programs, and state that it is highly unlikely that the field will be able to meet APA's estimated need of psychological care for the elderly by 2020. This means that psychology generalists, rather than geropsychology specialists, will deliver the bulk of services to older adults in the coming decades. Therefore, although working to increase the number of

geropsychologists will be a primary goal in the coming years, it is also crucial that the current generation of psychologists-in-training receives at least some exposure to working with older adults.

While the demographic data are compelling, this author's interest in geropsychology training was initially ignited by her own experience in a generalist PsyD program. In recent years, much professional emphasis has been placed on the importance of being aware of the therapeutic implications of working with clients who are culturally diverse. But what about the implications of doing therapy with an individual who is several decades older than the therapist? If working with a client who is a therapist's contemporary but is of a different race, ethnicity, culture, nationality, sexual orientation, and/or socioeconomic status warrants investigation by countless researchers and the publication of numerous comprehensive handbooks, then working with an individual who was alive for forty, fifty, or even sixty years before the therapist was born must warrant some attention as well. The APA shares this stance, as evidenced by several policy statements issued by APA's Public Interest Office on Aging (2002b, 2005, 2007). Additionally, the Association of Psychology Postdoctoral and Internship Centers' (APPIC) 2003 conference on training in competencies included knowledge, skills, and awareness of geropsychology in the competency domain of Individual and Cultural Diversity (Daniel, Roysircar, Abeles, & Boyd, 2004).

The current body of literature on student interest in geropsychology is small but evolving. However, to the present writer's knowledge, there has not been a qualitative inquiry into the ways in which a trainee's first clinical experience with an elderly client may shape his or her future interest in clinical work with elderly populations. The overall purpose of this study, therefore, was twofold. The first goal was to improve understanding of how clinical

psychologists-in-training experience their first therapy encounter with an elderly client. The second, equally important goal of this study was to identify features of participants' experiences that affected their interest in pursuing work with elderly clients in the future, and/or seeking out future academic opportunities to learn about clinical work with the elderly. Indeed, it is crucial that trainees become competent in working with older clients because, even if they choose not to specialize in geropsychology (which is true of most trainees), "most clinical and counseling psychologists…whether they are aware of it or not…will see older adults in clinical practice simply because of the sheer numbers" (Hinrichsen & Zweig, 2005, p. 2).

Overview of Current Efforts in Geropsychology Training

Many professionals have advocated for "interweaving ageing issues into existing course work" in training programs (Hinrichsen, 2000). Indeed, this approach has been widely applied in the ongoing movement to increase students' multicultural competencies, as seen in APPIC's 2003 recommendations for Individual and Cultural Diversity (Daniel et al., 2004). However, the extant literature on working with elderly clients tends to focus primarily on age-appropriate assessment techniques or specific interventions targeting particular diagnoses (e.g., depression or cognitive decline). This is likely a result of the current biomedicalization of health-related issues and the proliferation of subspecialties and research without concomitant efforts toward the integration of data and cross-disciplinary theory development within psychology. Additionally, courses in developmental psychology tend to fail to acknowledge that development extends beyond young adulthood (Hinrichsen, 2000). Yet, life-span research has suggested that the experience of becoming old is a process that is distinct, though not separate, from other stages in the cycle of life. In her later years, Joan Erikson, the widow and longtime collaborator of Erik Erikson, felt compelled to append her husband's landmark theory of human development by

adding a new stage of psychosocial development: the Ninth Stage, or *gerotranscendence* (Erikson & Erikson, 1997). However, there is little to be found in the practice literature that focuses on the actual experience of working with elderly clients.

This last point is an important one in light of the growing body of conceptual, empirical, and practice research on therapy with diverse clients. Numerous studies have revealed that there are important considerations to take into account when clinicians work with clients whose cultural backgrounds are different than their own (i.e., Gielen, Fish, & Draguns, 2004; Ponterotto, Casas, Suzuki, & Alexander, 2001). In response, training programs in recent years have made noticeable changes in their curricula in order to take into account the needs of such individuals, including the method of "interweaving," mentioned above, a practice that has been found to be effective (Smith, Constantine, Dunn, Dinehart, & Montoya, 2006).

It is important to note that APA's multicultural guidelines, however, focus exclusively on "ethnically and racially different" individuals (APA, 2003). Studies on doing therapy with clients who are disabled, living in poverty, gay, or lesbian, and so on are also numerous, and they seem to fall within the realm of multiculturalism—that is, working with clients who are different from the clinician in some significant way (Roysircar, Dobbins, & Malloy, 2009).

However, biases that may affect clinical psychologists in practice include biases toward the elderly. As mentioned in the opening paragraphs, we live in a society that marginalizes its elders. In *The Life Cycle Completed*, Joan Erikson (1997) laments, "the usual attitude toward elders in our society is bewildering. While historical, anthropological, and religious documents record that long-lived elders of ancient times were applauded and even revered, this century's response to aged individuals is often derision, words of contempt, and even revulsion" (p. 116).

Indeed, taking into consideration the "anti-aging," movement, (a multi-billion dollar industry in this country), it seems that the process of aging itself is all too often seen not as a natural part of life but rather as an unfortunate event that befalls us and must be fought every step of the way. It follows that when we hold something at arm's length, such as the idea of growing old, we learn little about it. Of course, we have learned that when we know little about another person, other than that he or she is different from us, biases emerge in order to maintain this person's "otherness." The lack of research into the implications of working with a client who may be 40 or 50 years older than the clinician serves only to maintain the tacit assumption that *old* means *other*. But, much in the same way that the literature on working with culturally different clients seeks to demonstrate important considerations to be taken into account by clinicians (Griner & Smith, 2006), it is important to gain a deeper understanding of how elderly clients are experienced by clinicians.

Conceptual Framework

The conceptual framework of this study was rooted in current aging theory, including *successful aging* and *life-span* theories, both of which suggest that, although old age is not a distinct stage in life requiring its own explanatory framework, it is accompanied by new tasks and evolving mental health concern and needs (Rowe & Kahn, 1997; VandenBos, 1998). It was also influenced by the spirit of the ongoing multicultural competency movement. As discussed above, aged people in this country are often marginalized and underserved by the health industry, much like so many ethnic minorities are, and it is crucial to prepare the current generation of clinician-trainees to meet the unique needs of these clients.

Research Questions

Based on the identified need to more fully understand how clinical psychologists-in-training experience their first elderly therapy client, the present study was guided by the following research questions:

1. Primary research question:
    - How do clinician-trainees (the participants of the study) experience their first elderly therapy client?
2. Issue subquestions:
    - What, if any, common themes emerge among the reported experiences of different participants?
    - Do participants experience their elderly clients differently than they do their other clients? If yes, how so?
    - Do participants feel any differently about working with elderly clients after having worked with one? What, specifically, contributes to this change?
3. Topical subquestions:
    - In what ways do participants think that their academic training did or did not prepare them adequately to work effectively with elderly clients?
    - What, if anything, in their training do participants find to have been particularly helpful (or unhelpful) in working with elderly clients?
    - What, if anything, about the context of the therapy experience (i.e., nature of the training site, supervision, peer support) do they find to have been particularly helpful (or unhelpful) in working with elderly clients?
    - What suggestions might they make to their own graduate program and/or training site about geropsychology training in order to better prepare future students?

Summary

The population of elderly individuals in the U.S. is undergoing a well-documented growth spurt. Based on current data, the field of professional psychology will be unable to meet

this population's growing mental health needs unless specific measures are taken. Not only must more clinicians be trained as geropsychology specialists, but generalists must, by necessity, be adequately trained to meet the basic mental health needs of older adults, as it is generalists who will find themselves bearing the brunt of this population expansion.

The goals of the current study were twofold: (a) to gain a richer understanding of how PsyD clinicians-in-training experience their first elderly therapy clients, and (b) to identify factors of their experiences that influenced their interest in clinical work with elderly individuals. Several findings of this study were aligned with recommendations that others have already made, regarding the preparation of clinical psychology students for work with older adults, thereby reinforcing the appropriateness of these recommendations. Novel findings, which were not identified in the extant literature, emerged as well, and provide new insights into how academic programs and field training sites might go about better preparing trainees and increasing trainee interest in working with elderly individuals in the future.

Chapter 2: A Review of the Literature

History of Theories of Aging and Current Theoretical Propositions

For as long as human beings have grown old and died, they have been interested in aging. Evidence that people have speculated about the way they age has been traced to ancient Greece's great philosophers, and even earlier (Birren & Schroots, 1996; Hendricks & Achenbaum, 1999). Therefore, an attempt to survey the current state of aging theory without first discussing its evolution would be shortsighted. Thus, this introductory section will provide an historical context of how we have arrived at the current state of theorizing about the way humans age.

Definitions of the term *theory* vary, ranging from "speculation" to "a plausible or scientifically acceptable general principle or body of principles offered to explain phenomena" (Merriam-Webster Online Dictionary, n.d.). For the present purposes, the following definition will be used: a theory is "the construction of explicit explanations in accounting for empirical findings" (Bengston, Rice, & Johnson, 1999, p. 5). By this definition, the function of any given theory is to make sense of observations and data in order to build knowledge and understanding. More specifically, theory not only allows for the integration and explanation of knowledge, but it also lays the groundwork for predictions about what is not yet known and paves the way for interventions to improve human conditions (Bengston et al., 1999; Birren & Schroots, 1996).

On the other hand, there is a growing sentiment that the field of aging research suffers from a lack of theory (Bengston et al., 1999; Kolb, 2008). There are, to be sure, countless models of aging. Models are not theories, however, and though they are useful to describe findings and relationships among findings, they do not move beyond the scope of description to explanation or integration, as theories do (Bengston et al. 1999; Birren & Schroots, 1996). Bengston and colleagues suggest that this lack of theory is an example of Thomas Kuhn's

critique, put forth in his influential *The Structure of Scientific Revolutions*, that "much of 'normal science' has been reduced to what [Kuhn] called 'mopping up': filling in the empirical details, solving relatively trivial puzzles, looking for practical applications of existing knowledge" (Kuhn, 1962, as cited in Bengston et al., 1999, p. 4). The result of the abundance of models of aging is that, essentially, the field of aging research is data rich but theory poor (Birren & Schroots, 1996). It is important to understand how we have arrived at this point, and how it appears that we may be beginning to move on from it.

The evolution of theories of aging. To understand how peoples' ideas about aging have evolved, one must appreciate that, although aging is one of the few universal human phenomena, its impact and meaning are always mediated by economic, structural, and cultural factors (Hendricks & Achenbaum, 1999). For example, there are certain ideas about aging that are prevalent today, such as that of *pathological aging*. However, it was only in the mid-19th century, after scientists had had at their disposal for some years instruments such as microscopes and x-ray machines, that Jean-Martin Charcot's *Clinical Lectures on Senile and Chronic Diseases* was published (in 1881) and gained wide popularity (Hendricks & Achenbaum, 1999). For countless generations prior, the concept of aging was couched in more moralistic, philosophical, and religious world views (Bengston et al., 1999; Hendricks & Achenbaum, 1999). For example, the ancient Israelites understood that the human lifespan did not exceed 120 years (see Gen. 6:3), but that certain individuals defied this law was seen as a sign from God rather than a violation of divine order. Moreover, obedience to God's commandments was the best predictor of longevity (Hendricks & Achenbaum, 1999).

With scientific and medical advancements of the 19th century gaining momentum, the focus of aging research shifted to more discrete, quantifiable data, paving the way for the

theoretical understanding of aging as pathology, a medical condition with distinct elements. In the early 20th century, there were a number of multidisciplinary efforts to arrive at a single, "grand" theory of aging (Bengston et al., 1999). By the late 1930s, however, the tide of interest in broad, interdisciplinary theories was ebbing. During the interwar period, medical and scientific advancements began to result in a decline in infectious diseases and the concomitant emergence of chronic health conditions that accompanied increasing lifespans (Birren & Schroots, 1996). Later, as the Second World War drew to a close and behaviorism came to dominate the social sciences landscape, research funding focused increasingly on the natural sciences, rather than on other areas (e.g., economics, sociology, history, etc.), making conditions still less favorable for interdisciplinary efforts (Hendricks & Achenbaum, 1999). With this shift in funding priorities began the era of medical models of aging, with a focus on the "normal" vs. "pathological" aspects of aging, and physicians interested in old age became more inclined to develop a medical subspecialty than to interact with psychologists, sociologists, or any other scientist (Hendricks & Achenbaum, 1999). Also at play in this shift was public pressure for tangible solutions. In the words of Maggie Kuhn (1983), a founder of the Grey Panther movement, "We have enough research! We have enough theories! What we need are more programs to help senior citizens in need!" (as cited in Bengston et al., 1999, p. 12).

With increasingly narrow areas of subspecialization and decreasing conversations across specialties (and disciplines), most aging research in the past half century might be considered "aspect studies" (Birren & Schroots, 1996). That is, countless aspects of aging have been studied but with little effort to integrate findings across disciplines. This phenomenon is not limited to psychological research, as it seems to be present in most fields of scientific research. Vincent Cristofalo for example, a cell biologist and renowned researcher on aging, lamented the

proliferation of aspect studies in his own field. To paraphrase a 1996 commentary, there is very likely a world of difference between the aging of cells in a Petri dish and aging in an organism (as cited in Hendricks & Achenbaum, 1999, p. 37).

In the social sciences, the search for solutions without regard for theory can lead to several problems. One drawback is that, without theoretical underpinnings, our ability to explain why some programs or interventions succeed while others fail is greatly hindered. Consider, for example, the relationship between social support and psychological well-being among older adults. For years, it was implicitly assumed among practitioners that increased social support resulted in increased well-being. However, explicit testing of this assumption revealed that too much intergenerational support can, in fact, undermine autonomy and cause distress (Bengston et al., 1999). Interestingly, this phenomenon could be explained by *social breakdown theory*, which posits that self-sufficiency among vulnerable older adults is eroded with excessive levels of support, resulting in psychological distress and decreased autonomy (Bengston et al., 1999). Thus, the relationship between social support appears to be curvilinear, to which the widely held assumption that "more is better" does not conform, suggesting that many family caregiving strategies and policy decisions may be based upon an incorrect, yet widely popular "theory."

Changing how research is done is no small task, and the momentum behind the status quo is significant. Young scientists, for example, eager to strike out in a new direction or part, in any way, from the current modus operandi, often encounter difficulty. The biomedicalization of gerontology (a relatively recent way of thinking, as outlined above), has become so widely accepted that it permeates the way we, as a society, think about aging. This hegemony of ideas renders it increasingly risky for individual researchers to depart from biomedical models and inherently narrows the range of what is possible. Yet, theorists necessarily circumscribe the

world to which they attend, and "it is through our terms of our definition of what is important that we envelop and exclude portions of the world" (Hendricks & Achenbaum, 1999, p. 35).

Aging research and theory in the social sciences. The social sciences have, however, done a somewhat better job at producing theories of aging than have the natural sciences. Hendricks and Achenbaum (1999) outline three generations of theorizing about aging in the social sciences (psychology and sociology in particular). The first generation arose in the 1950s and '60s, the era in which gerontology emerged as a field, and the theories that dominated this period were concerned with explaining adjustment (or maladjustment) to taken-for-granted declines in old age, with a focus on various forms of activity and life satisfaction. Theories put forth during this time (e.g., disengagement, activity, and continuity theories) stressed the individual as the appropriate unit of analysis, and each was offered as universally applicable, not dependent on social or cultural context (Hendricks & Achenbaum, 1999).

The pendulum swung the other way with the second generation of theories, which focused on the elderly as a collective category, and how the aging process was dictated by changing structural conditions in society (Hendricks & Achenbaum, 1999). These theories, which harkened back to the age old contention—a là Comte and Marx—that the whole is more than the sum of its parts, posited that the way people age is shaped by various forces, including societal organization, the political agenda, and the individual's location within social hierarchies (Hendricks & Achenbaum, 1999). According to these theories, then, the appropriate unit of analysis was a structural or systemic circumstance, not the individual.

In recent years, there seems to be a growing appreciation that aging is an experientially-based process unique to each individual and that it does not occur in isolation but is very much shaped by the conditions in which the process plays out (Hendricks & Achenbaum,

1999). These third-wave theorists seem to be "less concerned with parsimonious or even monolithic explanations as they seeks to bridge and to meld societal constraints, cultural meanings, individual meaning-giving, and the social forces that pattern the fabric of life" (Hendricks & Achenbaum, 1999, p. 32).

Current state of aging theory in psychology. Some have suggested that the metaphors employed by researchers shape their interpretation of data and the models and theories that result (Hendricks & Achenbaum, 1999; Kolb, 2008). This is evident in the ways in which we have become accustomed to thinking and speaking about the elderly. Consider the well-known *hill metaphor* in cognitive aging: sooner or later, every person will pass the apex of his or her abilities and slowly decline from there on in (Birren & Schroots, 1996). Countless models and theories have been based on the assumption that cognitive development and aging parallel biological growth and decline, a single-peaked function. And a pervasive metaphor it is—one would be hard pressed to find someone unfamiliar with the meaning of the phrase "it's all downhill from here," or "he's really over the hill." In recent years, however, the body of evidence that psychological change processes do not necessarily parallel biological processes of aging has become increasingly robust (Birren & Schroots, 1996). Wisdom, for example, a psychological attribute that emerges and increases through middle and late adulthood, does not reflect this metaphor of cognitive rise and decline (Birren & Schroots, 1996).

Nevertheless, it is difficult to escape the dominant metaphor that aging is a medical problem and the aged are a problematic group in society (Birren & Schroots, 1996). The biomedical language of decline that pervades the literature on aging is virtually inescapable, yet by labeling a circumstance in a particular way, consciously or not, "the meaning is managed even as attention is diverted from other plausible interpretations" (Hendricks & Achenbaum,

1999, p. 37). The biomedical concept of aging as pathology represents one of two poles (the dominant pole in recent decades) in the ongoing discussion about aging. At the other pole are those who consider aging a "natural process devoid of any particular pathology" (Hendricks & Achenbaum, 1999, p. 27). There is evidence that the tide may be turning as many contemporary researchers are choosing not to participate in the language of the dominant metaphor.

Current theories of aging. Three current trends reflect the shift away from the concept of aging as pathology. Briefly, these trends are: **(**a) the emergence of the theory of *successful aging*; (b) a shift away from conceptualizing "old age" as a discrete phase requiring its own framework toward a more holistic, *life-span approach*; and (c) the recent theory of *gerodynamics*, itself a response to the first two trends (Erikson & Erikson, 1997; Hendricks & Achenbaum, 1999; Kolb, 2008; Qualls, 2002).

***Successful aging*.** *Successful aging* is defined as having three interrelated main components: (a) low probability of disease and disease-related disability, (b) high cognitive and physical functional capacity, and (c) active engagement with life (Rowe & Kahn, 1997). Each component comprises a number of subparts. The first component refers to the absence or presence of disease itself in addition to the severity of risk factors for disease. The second component considers cognitive as well as physical capacities. However, though functional capacities tell us a good deal about person's potential, they reflect little about actual activity. The third component therefore goes beyond potential and considers peoples' activity, focusing primarily on interpersonal relations and productive activity (Rowe & Kahn, 1997).

Rowe and Kahn's (1997) theory was an effort to add to our understanding of what is possible in old age, a departure from the thinking that had dominated aging theory for many decades. Until recently, conversations about aging had clustered at two poles (i.e., pathologic vs.

nonpathologic aging), and the idea of successful aging was introduced as a complement to the nonpathologic pole. That is, "normal" aging vs. "successful" aging, as opposed to the dominant view that old people were either ill or were at constant risk of illness. This theory grew out of findings generated by the MacArthur Study of Successful Aging (1988-1996), whose benefactors and researchers were explicitly motivated to "move beyond a limited chronological perspective to clarify genetic, biomedical, behavioral, and social factors responsible for retaining and enhancing functioning in later life" (Kolb, 2008, p. 314). This study is considered to be a catalyst in an ongoing reorientation toward successful aging as a key theme in what some refer to as the "new gerontology" (Kolb, 2008, p. 315).

Thus, the theory of successful aging is based on a rapidly growing, interdisciplinary body of literature that is concerned not only with reducing the risk of adverse events but also with increasing resilience when such events do occur (Rowe & Kahn, 1997). As the research proliferates, the emergent data consistently indicate that many predictors associated with the three components of successful aging are more modifiable than previously thought, either by aging individuals themselves or by making changes to their immediate environments (Rowe & Kahn, 1997). This theory is a departure from the currently entrenched symptom-based orientation in which mental health is defined by the absence of symptoms known to impair functioning (e.g., the DSM-IV; Qualls, 2002). The way in which Rowe and Kahn have synthesized these emergent findings and harnessed the momentum behind them represents a sea change in terms of what has been, for many years, considered possible in old age, and offers countless entry points for interventions to geropractitioners of all kinds.

Life-span theories of aging. The *life-span developmental* approach, which initially emerged in the 1980s, is a general theory of aging that is "concerned with the description,

explanation, and modification (optimization) of developmental processes in the human life from conception to death" (Baltes, Reese, & Lipsitt, 1980, p. 66). According to Baltes et al. the emergence and acceptance of a life-span theory of development was made possible by the convergence of three trends. These trends included: (a) the publication of a number of studies of adult males (who were original participants in a child development project begun before World War II); (b) the birth of gerontology as an interdisciplinary field; and (c) a commitment, made by several major U.S. and European universities, to a life-span approach.

Human development, according to this theory, is a lifelong process. Based on the biopsychosocial model, it assumes that change occurs in interrelated biological, psychological, and social domains (VandenBos, 1998). There is a particular appreciation that cohort effects (the social-cultural domain) are an important factor in understanding older adults as a group as well as individuals (VandenBos, 1998). In a review of several seminal writings, Schroots (1996) summarized seven propositions about the nature of aging inherent in the theoretical framework of life-span developmental psychology:

> (1) there are major differences between normal, pathological, and optimal aging, the latter defined as aging under development-enhancing and age-friendly environmental conditions; (2) the course of aging shows much interindividual variability (heterogeneity); (3) there is much latent reserve capacity in old age; (4) there is aging loss in the range of reserve capacity or adaptability; (5) individual and social knowledge (crystallized intelligence) enriches the mind and can compensate for age-related decline in fluid intelligence (aging losses); (6) with age, the balance between gains and losses becomes increasingly negative; and finally, (7) the self in old age remains a resilient system of coping and maintaining integrity. (p. 745)

Life-span theory is based on the idea that life events can occur *on time* or *off time* (VandenBos, 1998). There is, therefore, an implicit assumption of a "normal life course," though this notion remains purposefully vague in the literature, as there is nothing inherently good or bad about being on or off time. Instead, what is important about an individual being off time for a particular life event is that that person's experience is likely to be different than another's experience of a similar event that occurred at a more typical time in life. Outlined in the literature are four general types of potentially stressful life events: (a) biological factors, (b) psychological factors, (c) physical and environmental factors, and (d) social and cultural factors (VandenBos, 1998). It is the way that an individual approaches and resolves life events, on time or off, that shapes their psychological well-being throughout life.

What makes the life-span approach to theorizing about aging different is that it does not subscribe to the assumption that old age is "a period requiring its own explanatory framework," and instead sees it as "a transitory phase of life having a great deal in common with any other rite of passage" (Hendricks & Achenbaum, 1999, p. 37). However, the assumption that old age is somehow separate from other phases of life continues to color the geropsychology literature, even as it functions as a barrier to recruiting students into the field (which will be discussed later in this chapter). Indeed, in an essay written in his 75th year, Carl Rogers asks himself, "What is it like to be seventy-five years old? It is not the same as being fifty-five years old, or thirty-five, and yet, for me, the differences are not so great as you might imagine" (Rogers, 1980, p. 70).

Additionally, life-span developmental theory and successful aging theory are complementary. The concept of *selective optimization and compensation* is a strategy that can be used throughout the lifespan to handle most any life event (Baltes et al., 1980). It refers to a process of selection (of domains of functioning), optimization (engaging in behaviors that enrich

and augment a person's general reserves and maximize quality and quantity of life), and compensation (when specific behavioral capacities are reduced or lost). When utilized during late adulthood, selective optimization and compensation clearly fits into the framework of successful aging. In sum, life-span developmental theory provides a "nonclinical, nonpathological approach for considering the entirety of a person's life...it addresses strengths, not just weakness, and it is concerned with change and adaptation" (VandenBos, 1998, p. 13).

Gerotranscendence. *Gerotranscendence,* a developmental theory of positive aging, was conceived by Swedish gerontological sociologist Lars Tornstam out of concern that most developmental theories of aging do not adequately understand many older adults because they overlook certain developmental patterns (Kolb, 2008). Tornstam's (2005, as cited in Kolb, 2008) intent was not to nullify other theories, but to address the experiences of some individuals that had not yet been adequately understood. More specifically, he is critical of successful aging theories because "aging successfully most often is understood as continuing to be a Western-cultured, White, middle-aged, middle-class successful person, with the typical emphasis on activity, productivity, efficiency, individuality, independence, wealth, health, and sociability" (p. 336). The central tenet of gerotranscendence is that aging well is not just an extension of the patterns of middle adulthood, but that development continues into old age and the meanings and tasks of old age can differ substantially from those of mid-life (Kolb, 2008).

Empirically based on both quantitative and qualitative data, gerotranscendence refers to a "shift in meta perspective, from a materialistic and rational vision to a more cosmic and transcendent one, normally followed by an increase in life satisfaction" (Tornstam, 1993, as cited in Erikson & Erikson, 1997, p. 123). According to this theory, though gerotranscendence is not a universal experience, many older adults will develop along one or all of three dimensions that are

encompassed by gerotranscendence: (a) the cosmic dimension, (b) the dimension of the self, and (c) the dimension of social and personal relationships (Kolb, 2008).

The concept of gerotranscendence may seem similar to the idea of *wisdom* associated with Erikson's eighth stage of psychosocial development, which necessitates navigating the crisis of *integrity vs. despair and disgust*, the successful resolution of which leads to wisdom (Erikson & Erikson, 1997). However, gerotranscendence differs from Erikson's concept of wisdom in that it portrays development in old age as a looking beyond oneself and into the future, whereas Erikson's wisdom is reached by the aged individual who looks back over his or her life with satisfaction, having accepted death's inevitability without fear (Brown & Lowis, 2003). In an interesting twist, Joan Erikson, Erik Erikson's wife of 64 years and longtime collaborator, based on her own experience of old age (she died in 1997 at the age of 95), her observations of her husband's final years (who died at 91 in 1994), and her perusal of her husband's annotated copy of *The Life Cycle Completed* (initially published in 1987), compelled her to publish a posthumous, extended version of *The Life Cycle Completed*, including a new, ninth stage based on the idea of gerotranscendence. It seems that not until they had lived well into their own final years and confronted their own aging selves, did it become apparent to the Eriksons that development may continue beyond the eighth, and previously assumed final, stage, accompanied by continued life satisfaction that was not bound to a retrospective orientation to one's life already lived (Erikson & Erikson, 1997).

A final note on aging theory. If one thing has been made clear in the discussion above, it is that the momentum behind constructivist approaches to theory building is growing. Such approaches maintain that "knowledge and discovery are socially constructed, variable, and subject to differential interpretation" (Hendricks & Achenbaum, 1999, p. 33). Moreover, there is

an appreciation that "facts" are inseparable from the worldview of the scientist who peddles them. Put simply, knowledge is relative and theory can never be finalized.

This is not to say that the pursuit of theory is a futile effort, but it is a call for the producers and consumers of theory to be aware that *theory* is not a *thing* that can be created, sent out into the world, and taken at face value. With this constructivist caveat in mind, there is a clear call in the field of gerontology for more efforts at theory because, as discussed above, without theory the contributions of the countless recent, current, and future studies on aging will have little impact (Bengston et al., 1999). The "facts" discovered in such studies do not speak for themselves, though they are important building blocks in the development of understanding. Bengston and colleagues (1999) suggest that "researchers have a responsibility to also act as theorists, to interpret and explain their findings within a broader context of inquiry" (p. 17).

Ageism

The term *ageism* was coined in 1968 by Robert N. Butler, while he was chairman of the District of Colombia Advisory Committee on Aging. At that time, ageism was defined thus:

> Ageism can be seen as a systematic stereotyping of and discrimination against people because they are old, just as racism and sexism accomplish this with skin color and gender. Old people are categorized as senile, rigid in thought and manner, old-fashioned in morality and skills…Ageism allows the younger generation to see older people as different from themselves; thus they subtly cease to identify with their elders as human beings. (Butler, 1969, as cited in Butler, 1994, p. 138)

Ageism exists on many levels, and stereotyping people on the basis of old age persists, as can be seen, for example, in the success of the so-called "anti-aging" industry, which implies that old age (one of the few universals of human experience) is something to be avoided (APA,

2002c; Rosowsky, 2005).

The roots of ageism in America. A number of theories attempt to explain the evolution of ageism in this country. Some researchers point to important historical periods of technological advancement as instrumental in the emergence of ageism (Nelson, 2005). More specifically, the invention of the printing press enabled societies or tribes to record and reproduce their traditions and histories through printed material, resulting in a great loss of status and power once held by elders as village historians. Later, the industrial revolution demanded that families be more mobile, rendering the extended family structure less adaptive. Moreover, the jobs created by the industrial revolution were more suitable to younger, stronger workers, and experience in a position became less valuable to society than the ability to adapt to changing technology. Around the same time, the average life expectancy began to increase as great medical advances took place. Because society was not prepared to deal with the growing population of older adults, old age began to be associated with negative qualities, and the elderly came to be regarded as "non-contributing burdens on society" (Nelson, 2005, p. 209).

Other researchers see a close connection between ageism and the separation of age groups in post-industrial societies (Giles & Reid, 2005; Hagestad & Uhlenberg, 2005). In such societies, age serves as a criterion for participation in productive work that contributes to societies. Hagestad and Uhlenberg suggest that age segregation occurs on three dimensions: (a) i*nstitutional segregation*, which occurs when "the principles and norms that define a social institution include chronological age as an eligibility criterion for participation;" (b) *spatial age segregation*, which occurs when "individuals of different ages do not occupy the same space and hence cannot engage in face-to-face interactions;" and (c) *cultural age segregation*, which refers to the separation of individuals by age that is reflected and reproduced in cultural contrasts,

which can be seen, for example, in the ageist humor so often used in birthday cards (p. 349). Such differences are often capitalized upon by marketers and the mass media, which have an economic interest in maintaining them.

The above-mentioned segregation concepts are related to Cuddy, Norton, and Fiske's (2005) *stereotype content model* (SCM). The SCM is a framework that describes and predicts how different groups of people are "sorted," and posits that the stereotype of elderly people is evaluatively mixed. That is, based on the SCM's two primary dimensions of stereotypes, *warmth* and *competence*, the elderly are seen as being high in warmth and low in competence. As long as the elderly are seen as benign (i.e., not an economic threat), this stereotype will likely persist (Cuddy, Norton, & Fiske, 2005).

In light of the growing elderly population in this country, coupled with increasing life expectancy, it is possible that these individuals will begin to be seen as a threat as their demands on the health care system, social security, etcetera increase (Longino, 2005). Cuddy and colleagues (2005) found that when elderly individuals behaved in ways that confirmed their incompetence, feelings of warmth toward them increased. Might the reverse hold true should this population, as the Baby Boomers reach old age, begin to make more demands on the federal government?

Ageism in the helping professions. Ageism in this country manifests in countless ways, but what is of concern here is that research has revealed that those in the helping professions (e.g., educators, counselors, and other health professionals, including clinical psychologists) are just as likely as anyone else to be prejudiced against the elderly (Nelson, 2005; Rosowsky, 2005). For example, physicians often view elderly patients as "depressing, senile, untreatable, or rigid" (Reyes-Ortiz, 1997, as cited in Nelson, 2005, p. 211), and they frequently experience

feelings of frustration and futility when confronted with elderly clients with cognitive or physical limitations (Wilkinson & Ferraro, 2002, as cited in Nelson, 2005). Overall, the research in this area suggests that little value is placed on geriatric medicine, and that medical students receive the message that, because old age is unstoppable, the illnesses that often accompany it are not important as they are seen as a typical part of the aging process (Nelson, 2005).

Contact theory. At this point, it seems reasonable to conclude that both the emergence of and the persistence of ageism in this country may be, at least in part, due to a deeply embedded segregation of individuals by age. This, then, suggests that efforts to decrease this separation and increase intergenerational contact might lead to fewer stereotypes. Indeed, this hypothesis has received significant attention in the context of other forms of prejudice. *Intergroup contact theory*, as it is known, was initially researched as early as the 1940s by social scientists who speculated that contact between the races (i.e., white and black) might lead to "mutual understanding and regard" (Lett, 1945, as cited in Pettigrew & Tropp, 2006, p. 751).

In 1954, Gordon Allport offered a widely influential statement on contact theory in his *The Nature of Prejudice*. In reviewing the research available at that time, Allport (1979) came to the following conclusion:

> Prejudice…may be reduced by equal status contact between majority and minority groups in the pursuit of common goals. The effect is greatly enhanced if this contact is sanctioned by institutional supports (i.e., by law, custom or local atmosphere), and provided it is of a sort that leads to the perception of common interests and common humanity between members of the two groups. (p. 281)

Not surprisingly, Allport's conclusion prompted researchers to redouble their efforts into the effectiveness of contact at reducing intergroup tensions. These efforts were evaluated in a

recent meta-analysis, the results of which "clearly indicate that intergroup contact typically reduces intergroup prejudice" (Pettigrew & Tropp, 2006, p. 766). Furthermore, it was found that the effect of contact often generalized beyond participants in the studies, suggesting that the effects of contact may be "far broader than what many past commentators have thought" (Pettigrew & Tropp, 2006, p. 766). Pettigrew and Tropp also found that although the presence of Allport's optimal conditions (e.g., equal status, common goals, etc.) resulted in a higher mean effect size, they were not essential for contact to achieve some positive outcomes.

The body of research that evolved out of Allport's formulation of intergroup contact theory did include some investigations into negative attitudes toward the elderly. In a 1984 study (which was included in the meta-analysis discussed above), Caspi found that children who had sustained contact with elderly teaching aids at school not only acquired more accurate information about age distinctions, but also evaluated the elderly more favorably than children who attended an age-segregated school. It is clear that contact theory offers much food for thought in terms decreasing ageist attitudes among professional psychologists as well as improving efforts to increase student interest in geropsychology.

Help-Seeking Attitudes of the Elderly

It has been well-documented that the mental health needs of elderly populations are not being met (Brockett & Gleckman, 1991; Currin, Schneider, Hayslip, & Kooken, 1998; Ford & Sbordone, 1979; Lewis & Johansen, 1982). In fact, some have found that age is inversely predictive of seeking mental health services (Shapiro, 1986, as cited in Currin et al., 1998). It is no wonder that a number of researchers have investigated the reasons behind this pattern.

A number of researchers have identified negative attitudes toward mental health services held by older adults (Currin et al., 1998; Lundervold & Young, 1992). Some religious beliefs

have been found to negatively influence attitudes toward mental health services (Currin et al., 1998; Lundervold & Young, 1992). Stigma associated with seeking mental health services has also been identified. For example, older adults often prefer the term "counseling" to terms including the word "mental" (Currin et al., 1998). Researchers have also cited the strongly held values of self-sufficiency and independence among older populations as barriers to seeking services (Currin et al., 1998; Zank, 1998). Not only are older individuals more likely to associate mental disorders with personal failure and spiritual inadequacy, but they are also more likely to blame themselves for psychological problems than for medical problems (Currin et al., 1998). Furthermore, many older individuals assume that a psychotherapist who may be as much as 40 years their junior could not possibly understand their problems (Zank, 1998).

Older adults also tend to be less knowledgeable about mental health services than their younger counterparts (Currin et al., 1998; Lundervold & Young, 1992). There are particular knowledge deficits about psychopathology and aging (Lundervold & Young, 1992), and many older individuals assume that psychological problems are simply a part of aging and do not report them (Currin et al., 1998). Many older people associate psychological treatment with custodial care and fear hospitalization, which may make some individuals even less likely to seek mental health services (Currin et al., 1998). The role of knowledge is an important one, as researchers have found that increased knowledge is associated with more positive attitudes toward seeking mental health services (Currin et al., 1998).

Are attitudes changing? Despite the trend that older individuals are less likely to seek mental health services than younger individuals, there is evidence that this is changing (Currin et al., 1998; Zank, 1998). For example, Currin and colleagues found differences between cohorts of older adults, with younger cohorts reporting more openness to a variety of helping resources

and more positive attitudes toward mental health services. Later-born cohorts were also found to be more flexible in their thinking about mental illness, were less likely to hold rigid stereotypes, had more inclusive estimates of the range of problems that may be addressed by mental health professionals, and were more willing to seek help for a greater variety of issues. Moreover, those who had seen a mental health professional in the past had higher opinions of them and were more likely to seek their services again.

There are a number of possible explanations for this trend, and Currin and colleagues (1998) speculate whether the older cohorts, who were middle-aged before the concept of mental health and deinstitutionalization became prevalent, may have outdated ideas of psychological care. What is of critical importance is that this does appear to be a trend, and thus has significant implications for the field of clinical psychology as it prepares to meet the needs of the growing elderly population. That is to say, not only will there be a growing number of elderly people, but a greater number of individuals within the elderly population will seek mental health services.

Therapist Attitudes toward Working with Elderly Clients

The other side of this coin is concerned with the attitudes of therapists toward elderly clients. Some common assumptions and stereotypes are highlighted below, as well as a concerning phenomenon known as *professional ageism.*

Common assumptions and stereotypes. A good deal of research has been conducted into therapists' attitudes toward elderly clients. Some assumptions commonly held by therapists include: (a) that symptoms of psychopathology in elderly people are inevitable and irreparable, (b) that the elderly are reluctant or unable to change, (c) that the psychological problems of the elderly are too complex to treat effectively, (d) that care provided to elderly people is more palliative than curative, and (e) that elderly clients have poorer prognoses than younger clients

(Currin et al., 1998; Ford & Sbordone, 1979; Lewis & Johansen, 1982; Poggi & Berland, 1985). Such stereotypes reinforce the widely held belief that psychotherapy is something better spent on younger patients (Currin et al., 1998; Ford & Sbordone, 1979; Poggi & Berland, 1985; Zank, 1998). Furthermore, many psychotherapists associate working with older clients with lower professional status (Currin et al., 1998; Ford & Sbordone, 1979; Poggi & Berland, 1985). The fact that there is a lack of adequate training and research into the effectiveness of psychotherapy with older adults serves to maintain such erroneous assumptions (Currin et al., 1998).

Another important factor in therapist attitudes toward elderly clients is that, when working with such patients, therapists are confronted with the realities of aging and death, which may highlight their own existential anxieties (Currin et al., 1998; Ford & Sbordone, 1979; Zank, 1998). Fear of a client dying while in treatment has been cited as a reason for reluctance to work with older clients (Lardaro, 1988; Poggi & Berland, 1985).

In *The Functional Approach to the Theory of Attitudes*, Daniel Katz (1960) noted that "unless we know the psychological need which is met by the holding of an attitude, we are in a poor position to predict when and how it will change," (as cited in Schigelone, 2003, p. 37). Schigelone, in an attempt to identify the origin of health care providers' attitudes toward elderly clients as a precursor to modifying them, categorized attitudes by their function. Based on Katz' research, Schigelone identified four categories and offered suggestions for modifying the attitudes that fall within them.

The first category, *instrumental/utilitarian attitudes*, is shaped by the human drive to maximize rewards and minimize penalties (Schigelone, 2003). An example is the view of older patients as time-consuming (e.g., their paperwork is often lengthy and they are thought of as "talkers"). Moreover, older patients with chronic conditions or co-morbid disorders may be seen

as labor-intensive but offer little hope of "successful" treatment (i.e., they cannot be "cured"). Most instances of these types of attitudes have a financial component: the perception that treating elderly adults is less financially rewarding than treating other patients. In order for attitudes in this category to be modified, one of two conditions must prevail: the attitude and activities related to it are no longer satisfying, or the individual's aspirations have been raised. In terms of the first condition, avoiding working with elderly patients is becoming a decreasingly viable option, as the population continues to grow. In terms of the second condition there is hope that, as medical advances continue, providers may become more hopeful about the treatment outcomes of their elderly clients (Schigelone, 2003).

The second category includes *knowledge attitudes*. Though often inaccurate, these types of attitudes, also known as stereotypes, provide "order and clarity for a bewildering set of complexities" (Katz, 1960, as cited in Schigelone, 2003, p. 38). Knowledge attitudes are derived from myriad sources: other peoples' experiences, the media, and so on. Therefore, such attitudes are rarely based on experience, but rather on perceptions forged by secondary sources (Schigelone, 2003). It has been suggested that attitudes that serve this function are only modified if they become inadequate to deal with new and changing information. Therefore, if stereotypes about the elderly are based on limited experience, exposing individuals who hold such stereotypes to a wide range of older people may facilitate change. This suggestion is reasonable, in light of the research into intergenerational contact.

The third category, *value-expressive attitudes*, provides an individual with a "positive expression to his central values and to the type of person he conceives himself to be" (Katz, 1960, as cited in Schigelone, 2003, p. 41). This type of attitude is apparent in the phenomenon of *compassionate ageism*, which is based on a health care providers' self-concept as a helping

person but often results in a tendency to use a patronizing tone with elderly patients. Another example is rooted in the fact that health care providers are trained to cure, and interventions that do not return a patient to optimal health are often perceived as failures. Of course, a return to optimal health is unlikely for many older adults. The result of this ambition to cure each and every patient may cause providers to avoid working with the elderly in order to preserve their own self-concepts as competent professionals. For attitudes in this category to change, according to Schigelone, one of two things must happen. First, there must be some degree of satisfaction with one's self-concept or its associated values. As all health care providers begin to treat increasing numbers of elderly patients (as is expected to occur based on demographic data), they will be forced to modify their views of success, lest they experience failure after failure in unsuccessfully "curing" their elderly patients. Or, value-expressive attitudes may be changed if they become inappropriate to one's values. As discussed in Chapter 1, our culture currently subscribes to the belief that youth is attractive and that indications of aging are unattractive. It is possible that this will begin to shift as the elderly population continues to grow, and people will come to value all phases of the life span equally.

The fourth (and final) category, *ego-defensive attitudes*, protects individuals from recognizing thoughts or feelings that threaten their self-image or adjustment (Schigelone, 2003). The idea of growing old and dying can be threatening, and people who fear their own mortality often view the elderly negatively. There are three possible ways to modify attitudes in this category. The first is to remove the threat: if attitudes toward the elderly are based on fears of illness and dependency, providing resources to explore those fears my change the way we feel about people who are already ill and dependent. The second is to allow for catharsis of the relevant feelings by, for example, supporting discussions among providers of their own fears

associated with older adults (and their own old age). This paves the way for the third way in which ego-defensive attitudes may be changed, which occurs when the individual is able to gain insight into his or her own mechanisms of defense (Schigelone, 2003).

Professional ageism. The idea of *professional ageism* was put forth by Gatz and Pearson (1988), who proposed that the reluctance to treat elderly patients may be less attributable to ageism in general than to specific treatment biases, including (a) negative misconceptions (e.g., therapy for depression in the elderly is ineffective); (b) positive misconceptions (e.g., memory lapses in the elderly are normal and do not require a mental health evaluation); and (c) an overestimation of the frequency of Alzheimer's disease. In order to quell the proliferation of professional ageism, the authors call for increased education about normal ageing and reigning in the exaggeration of psychological problems in the elderly.

Common Issues in Transference and Countertransference

There are a variety of theories addressing issues of transference and countertransference that arise in therapy with an elderly client. Newton and Jacobowitz (1999), for example, suggest four sources of transferences in elderly clients: (a) early childhood experience; (b) experiences from all following developmental stages (i.e., after early childhood); (c) current stage-related developmental conflicts; and (d) other age-related factors. Newton and Jacobowitz also highlight three common categories of countertransference in therapy with elderly clients: (a) *general reactions* (unconscious dynamics that influence interactions with all clients); (b) *group specific reactions* (reactions to specific groups of people, often reflective of internalized cultural stereotypes); and (c) *individual-client reactions* (responses triggered by a particular client's personality dynamics and presentation).

In another approach to exploring countertransference reactions to elderly clients, Brockett and Gleckman (1991) turned to Karen Horney's *interpersonal styles*. Horney (1950, as cited in Brockett & Gleckman, 1991) identified three primary interpersonal styles: *moving away*, *moving toward*, and *moving against*. To these, Brockett and Gleckman added a fourth category, *not moving*. By conceptualizing countertransferential reactions in this way, Brocket and Gleckman offer a number of strategies for managing countertransference in work with elderly clients, including maintaining a receptive attitude, self-knowledge, and supervision.

In leading a newcomers' group at a retirement home, Poggi and Berland (1985) hit upon some recurrent themes. A common occurrence was for group members to refer to the facilitators as "boys," leading the authors to explore the meaning of working with clients so much older than them. There was also a repression, by group members and facilitators alike, of sexual feelings and of discussions with sexual content. Additionally, Poggi and Berland often experienced their own resistance to interpreting the transference, which often manifested as a wish to provide physical treatment (i.e., to cure) as a way to avoid addressing more complex psychological issues. In reviewing their work as leaders of this group, Poggi and Berland highlight three issues that any therapist working with elderly clients ought to explore: (a) inadequately understood existential issues, (b) the demand that the young validate the importance and value of the very old, and (c) the profound physical and psychological differences between the young and old.

Predictors of Student Interest in Geropsychology

As awareness of the shortage of clinicians to provide care for older adults grows, research into predictors of student interest in geropsychology has accelerated. There are a variety of assumptions about why student interest in working with elderly clients is low. These assumptions operate at the individual level, for example that negative stereotypes about older

people prevent interest in working with them (Hinrichsen & McMeniman, 2002), but that preexisting positive beliefs about older people based on prior experiences increase interest (Cummings & Galambos, 2002). These assumptions also operate at a systemic level, as in the hypothesis that training programs have been slow to adopt curricula in the area of aging, so students are less likely to see it as a career option. This, combined with a lack of role models in geropsychology, might make it a less attractive subfield (Hinrichsen & McMeniman, 2002).

The goal of this small but growing body of literature is to identify strategies to increase interest in this population. Because research in this area is still sparse, studies focusing on identifying predictors of interest in social work students and medical students have been included as well. It is important to note that findings thus far have been, for the most part, equivocal. However, the studies discussed below provide crucial insights into how the field might do a better job of increasing interest in working with this population.

Contact with elders. Personal contact with elderly individuals has been associated with interest in working with elderly clients (Cummings & Galambos, 2002; Koder & Helmes, 2008; Hegeman, Horowitz, Tepper, Pillemer, & Schultz, 2002). The quantity and quality of contact, however, are key factors, as minimal and/or random contacts have been found to decrease interest in working with elderly clients (Schigelone & Ingersoll-Dayton, 2004). More contact does not seem to be the solution, though the quality of contact is crucial (Schigelone & Ingersoll-Dayton, 2004). In a qualitative study of medical students' interest in geriatrics, Schigelone and Ingersoll-Dayton found that, while all subjects reported both positive and negative contacts with elderly patients, the ones who were interested in pursuing geriatrics reported that their positive experiences outweighed the negative ones. Additionally, students who had had more random contacts reported that they felt compelled to rely on stereotypes.

Cummings and Galambos (2002) also found the quality of contact to be important. In a study of social work students, Cummings and Galambos concluded that if students are not adequately prepared for exposure to older adults, contact may leave them feeling incompetent and is not experienced as rewarding. However, those who perceived contact as having been rewarding were more interested in working with the elderly. On the other hand, in a study of Australian psychologists, Koder and Helmes (2008) found no association between rewarding contact and interest in working with older adults.

Researchers have looked to prior family experiences to explain why some individuals become interested in working with the elderly. Schigelone and Ingersoll-Dayton (2004) found that nearly all students who had an interest in geriatrics reported being (or having been) very close to at least one grandparent. These students generally reported that their interest in geriatrics was rooted more in values embedded in their nuclear family than in their cultural or ethnic background. (However, some ethnic and cultural backgrounds have a strong emphasis on family, so culture and ethnicity may in fact be moderator variables for interest in geriatrics). On the other hand, Koder and Helmes (2008) found no evidence of such a connection.

Attitudes toward elders. Evidence suggests that students' favorable attitudes toward the elderly may predict interest in working in the field (Hegeman et al., 2002; Hinrichsen, 2000; Schigelone & Ingersoll-Dayton, 2004). In a study of a service learning program in elder care for social work students, Hegeman and colleagues (2002) reported some encouraging findings. For example, prior to participating in the service learning project, 61% of students agreed with the statement, "Most older people are set in their ways and unable to change" (p.188), but only 44% agreed at posttest. Additionally, 84% agreed with the statement, "Older people become wiser with age" (p. 188), while 90% did at posttest. Feelings of competency increased as well, with

92% of students agreeing at pre-test with the statement, "I don't have the ability to work with older people" (p. 189), which decreased to 85%. Interestingly, more students agreed with the statement, "It would be very stressful to work with older people or people with chronic conditions" (p. 188) at post test (44%) than at pre-test (35%). These findings suggest that the experience fostered a more accurate understanding of the realities of working with this population. Though this program seems to have a number of positive effects on attitudes and competence, the authors found no significant change in students' desire to work with the elderly (Hegeman et al., 2002).

Schigelone and Ingersoll-Dayton (2004) found that students who were interested in geriatrics held beliefs that focused on what they thought would be enjoyable about the job. On the other hand, students not interested in geriatrics believed such work might lack excitement and be problematic and frustrating. Furthermore, students who were not interested in geriatrics were more likely to view older adults as perpetrators of their own illnesses, such as diseases often associated with lifestyle choices (e.g., lung cancer or diabetes). These same students felt that working with children would be more rewarding and do more good in the long run. The authors conclude that students not interested in geriatrics hold more rigid beliefs about what being a doctor "should" be like (i.e., fast-paced, exciting, and helping those who "deserve" it), while students who are interested in geriatrics may have a more complex view of medicine.

Attitudes toward aging. Researchers have looked for an association between students' attitudes toward aging in general and interest in working with older adults. Koder and Helmes (2008) found that the more negative one's attitude toward one's own aging, the more likely one is to specialize in geropsychology. Schigelone and Ingersoll-Dayton (2004) found a similar link, in that students interested in geriatrics had more fears about aging and death. Students interested

in geriatrics more often had personal experiences with death and dying, leading the authors to hypothesize that these students had a more nuanced understanding of the realities of these processes. The authors speculate that "their fears may represent a positive connection to older adults; these students can identify with older patients and fear for their older selves. The students who are not afraid of aging and death admit that they have had little experience with it" (Schigelone & Ingersoll-Dayton, 2004, p. 657). Cummings and Galambos (2002), however, found no significant link between attitudes toward aging and interest in working in gerontology.

Education. Academic experience may also be a predictor of interest in working with the elderly. Cummings and Galambos (2002) found that while a gerontology course increased knowledge, it did not influence students' career preferences. Koder and Helmes (2008), however, found specialized academic training to be a powerful predictor of interest in geropsychology. As already mentioned, students' perceptions of their own skills and competencies affect whether interactions with older adults are experienced positively or negatively, and exposure to aging-related coursework has been associated with an increase in skills and competence (Cummings & Galambos, 2002). Haley and Gatz (1995) noted that many students are first exposed to clinical work with the elderly on a practicum and then go on to take a course on aging, suggesting that field experiences may be more motivating than classroom experiences. Similarly, Koder and Helmes found that geropsychologists were more likely than generalists to have had clinical exposure to older adults during a practicum. Thus, clinical experience during training, along with high quality supervision, are highlighted as important factors

Goals and strategies. There seem to be two primary goals articulated by authors in this area, along with numerous strategies toward achieving these goals (the latter are reviewed

below). One goal is to increase the number of experts in clinical geropsychology (Haley & Gatz, 1995; Hinrichsen & McMeniman, 2002; Koder & Helmes, 2008). Haley and Gatz emphasize the importance of training more specialists not only to do clinical work, but also to take on roles in educating and training future providers in geropsychology.

The second goal is related to a compelling point made by a number of authors: it will be generalists, not geropsychologists, who will provide the bulk of mental health care to the elderly in the coming decades (Haley & Gatz, 1995; Hinrichsen & McMeniman, 2002). Although their study was on medical students, Schigelone and Ingersoll-Dayton (2004) came to the conclusion that producing geriatric specialists might in fact not be the most effective approach. Hinrichsen and McMeniman seem to agree, stating that it is "imperative that the current generation of psychologists-in-training has some exposure to clinical work with older adults" (p. 339). This is echoed in the call to the social work profession to create a "citizenry prepared for the challenges an aging society will bring" (Hegeman et al., 2002, p. 179).

Curricula. Researchers have proposed several strategies to help increase student interest in geropsychology. Merely encouraging students to seek training in geropsychology is insufficient, and a number of authors have called for an infusion of aging-related material throughout existing curricula (Haley & Gatz, 1995; Hinrichsen, 2000; Kropf, 2002). In this way all students, at the very least, would be exposed to fundamental principles of clinical work with older clients (Kropf, 2002). It is important that such course material not just impart knowledge but also address issues of skill-building (Haley & Gatz, 1995), considering the fact that these academic experiences will be the only exposure to aging-related material for many students. Such a measure is a crucial and imperative first step (Hinrichsen & McMeniman, 2002).

Curriculum infusion models have been proposed in a number of areas. Recently, the infusion of issues of diversity into curricula has received significant attention, and the APA has recommended this strategy in its *Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists* (APA, 2002b). Some authors have conceptualized aging as an aspect of diversity (Kropf, 2002). Thus, looking to models of weaving issues of cultural diversity into curricula is proposed as a strategy in this area (Kropf, 2002). Some suggest that an indirect approach such as this might be protective against inadvertently intimidating students, which is possible when too much emphasis is placed on how much there is to learn in order to be competent to work with the elderly, with too little emphasis on the universal human dynamics that transcend age (Haley & Gatz, 1995). On the other hand, some emphasize the importance of offering at least one geropsychology specialty course (Hinrichsen, 2000), particularly in light of Koder and Helmes' (2008) finding that exposure to such specialty training may be a strong predictor of going on to work with older adults.

Field training. Since rewarding interactions with older adults have been associated with a decrease in negative stereotypes, another approach is to include experiential learning opportunities early in training (Hegeman et al., 2002; Kropf, 2002). Because quality of experience has been found to be more important than quantity, structured learning exercises (e.g., service learning projects) may increase positive attitudes toward elders, which in turn has been linked with an increase in interest in working with older adults (Hegeman et al., 2002; Hinrichsen, 2000). It is important to note that service learning models are readily available and are adaptable to a wide variety of objectives and settings (Hegeman et al., 2002).

However, more formal training opportunities, such as practica and internships, must be created as well (Cummings & Galambos, 2002; Hinrichsen, 2000), and the current lack of such

formal opportunities speaks volumes of how this area is valued by training institutions. Additionally, training placements must be combined with supervision by individuals who are competent and experienced in adult development and late-life psychopathology (Hinrichsen, 2000). Moreover, because the mental health needs of older adults are often encountered in a number of non-traditional settings, increasing opportunities for students to be exposed to settings such as nursing homes and primary medical settings, as well as working with interdisciplinary teams, will better prepare students for the realities of working with this population (Haley & Gatz, 1995). The importance of ensuring that students are exposed to at least some healthy elders, in order to combat ageism and negative attitudes, has also been highlighted (Haley & Gatz, 1995; Schigelone & Ingersoll-Dayton, 2004).

Faculty. The lack of current geropsychology providers is reflected on the institutional side of clinical psychology, as there is also a lack of faculty expertise in this area (Kropf, 2002). Strategies aimed at faculty development might include co-teaching arrangements or partnering with other programs with a higher degree of geropsychology expertise among staff (Kropf, 2002). Research collaborations might increase faculty competence in this area as well as increase student interest (Kropf, 2002). Of course, there is always a concern when faculty members are asked to take on additional responsibilities. However, it is notable that faculty involved with a service learning model for clinical social work students were supportive of the project, and found it to be professionally rewarding as well as energizing (Hegeman et al., 2002).

Practical incentives. Another route to piquing student interest might be to invite guest speakers to present their research or discuss their work. This would help students develop a more realistic understanding of the realities of clinical work with older adults, as well as provide role models for students in this area, which might increase the likelihood that students will

consider geropsychology as a possible specialty (Haley & Gatz, 1995; Kropf, 2002). Such informal exposure to aging-related work might also increase faculty interest (Kropf, 2002).

Another practical incentive that influences students is money, and Haley and Gatz (1995) stress that if the field is serious about changing patterns or practice, it must "look beyond altruism as a way of motivating students…and provide positive incentives for programs and students to work with the elderly population" (p. 117). Such strategies might include increasing geropsychology-related fellowships and research grants (Haley & Gatz, 1995), and lobbying for increased government reimbursements or loan-forgiveness to encourage graduates to provide services in high-need settings, such as nursing homes (Koder & Helmes, 2008).

Supervision

The literature pertaining to the supervision of clinician-trainees working with elderly clients is sparse. This situation is unfortunate because, though field training placements (such as practica) have long been an important feature of graduate programs in clinical psychology, such experiences on their own do not bring about professional competency. Rather, good supervision is believed by many to be the key ingredient that fosters clinical expertise (Duffy, 1992; Duffy & Morales, 1997; Qualls, Duffy, & Crose, 1995). The body of literature on "good" supervision is considerable, and a brief overview of some of the more widely held concepts in this area follows.

Overall, two broad factors have emerged as necessary prerequisites for positive supervision experiences: (a) a good supervisory relationship and (b) attention to the task of developing counseling skills (Worthen & McNeill, 1996). Good supervisors foster relationships that consist of warmth, acceptance, understanding, and trust (Worthen & McNeill, 1996). In terms of skills development, trainees' needs tend to evolve as they develop as clinicians (Heppner & Roehlke, 1984). Trainees in their primary placements need more focus on intake and

counseling skills, as well as more time spent on the development of self-awareness; intermediate-level trainees require guidance to deepen their conceptualization skills and working within a cohesive theory, and desire more emphasis on personal development than technical skills. More advanced trainees, on the other hand, prefer to use supervision as a venue to examine more complex issues of personal development, transference-countertransference, parallel process, and client/counselor resistance and defensiveness (Worthen & McNeill, 1996). At each stage of development, trainees prefer supervisors who show interest in supervision, have experience in psychotherapy and are currently practicing, and are technically and theoretically knowledgeable (Nelson, 1978).

Good supervision is particularly important for trainees working in geropsychology settings (or with elderly clients in other settings), as students who are ill-prepared for work with this population or are inadequately supervised are more likely to adopt ageist attitudes and fail to become psychologically connected with their older clients (Qualls et al.,1995). Without this connection, trainees are unlikely to become interested enough to pursue further geropsychology training. Proper supervision is crucial to avoid this (Duffy & Morales, 1997; Qualls et al., 1995).

*"***Good" supervision in geropsychology.** Duffy and Morales (1997) advanced three propositions in terms of geropsychology supervision. The first, also highlighted by Qualls and colleagues (1995), is that the difference between experience alone and supervised experience is vast. Students in the former situation often do not realize what they are missing and frequently fail to connect with their older clients. Without this connection, therapeutic power is lost and students are apt to lose interest in working with this population.

The second proposition is that there tends to be a wide range in terms of the quality of geropsychology supervision (Duffy & Morales, 1997). The task of supervision is often

delegated to junior or adjunct faculty and is avoided by more experienced clinicians due do its labor intensive nature. Thus, Duffy and Morales (1997) lament that what is "perhaps the most critical task in clinical training is conducted by the least experienced supervisors" (p. 374). When this happens, not only does the experience of the trainee suffer, but it communicates something about how supervision is understood and valued. However, in light of the above discussion of "good" supervision, one might posit that a junior faculty member who is an active clinician might provide better supervision than a senior member of the faculty who is no longer engaged in clinical work and whose focus is primarily on research, as is often the case.

The third proposition put forth by Duffy and Morales (1997) is that "the quality of clinical supervision is the single most important ingredient in the quality of geropsychology training" (p. 375). By heeding these propositions, the authors hope that those involved in the clinical training of future geropsychologists will be able to quell the drift away from the field by facilitating trainees' experiences of success in psychotherapeutic work with older adults.

Common issues in geropsychology supervision. The literature identifies a number of salient issues in the supervision of geropsychology trainees, the processing of which in supervision can be of great benefit. For example, it is important that those who supervise trainees working with elderly clients have an understanding of theories of development because, though trainees are nearly always younger than their clients, the different ages and life stages of each will shape the therapeutic dyad (Duffy & Morales, 1997; Qualls et al., 1995). Martin and Prosen (1976) suggest that supervisors also maintain an awareness of their own developmental tasks at any given time, as this too will influence the therapeutic triad.

Countertransferential themes are often related to trainees' beliefs about their own future, aging, and death (Martin & Prosen, 1976), a dynamic that may manifest in myriad ways. The

issue of sexuality in old age is another area that many young trainees are reluctant to consider or discuss (Qualls et al., 1995). Indeed, it seems that the topics of death and sex are "much easier for older clients to talk about than they are for younger therapists" (Qualls et al., 1995, p. 126), and intensive supervision is very likely the only opportunity for trainees to address and process such crucial issues as they arise. Failure to do so may again have the effect of inhibiting the establishment of rapport and leading trainees to be disinclined to work with elderly clients.

Another common experience is for trainees to feel overwhelmed as they try to make sense of the complex physical, mental, emotional, and spiritual concerns of their clients (Hubbard, 1984). If such feelings are not managed appropriately in supervision, trainees may end up feeling hopeless and incompetent. A trainee who feels hopeless and incompetent will have significant difficulty establishing the all-important rapport, which will then lessen the odds of a successful therapy, thereby exacerbating feelings of incompetence. Experiences of this nature are unlikely to instill a desire to seek out more experiences with elderly clients.

What do trainees want? Many trainees would, in fact, like more supervision around difficulties such as those discussed above. In a 1996 study of supervisory relationships in geropsychology settings, Brant found that interns felt more dependent on their supervisors than was perceived by their supervisors. This suggests that supervisees may have experienced feelings of being overwhelmed, as described by Hubbard (1984), but that their supervisors perceived them as needing less guidance than they actually did. Duffy and Morales (1997) stress this area as important for supervision because of the mistake that trainees often make in assuming that "geriatric psychotherapy requires totally new and different skills" (p. 367), a belief that can contribute to becoming overwhelmed and may overemphasize feelings of dependence on supervisors. Good supervisors might counteract such feelings of incompetence by working from

(and thereby modeling) the stance that "older adults are much more similar than they are different from other age groups, and an overspecialized approach runs the risk of ignoring basic human dynamics that transcend age or gender or ethnicity" (Duffy & Morales, 1997, p. 367).

Additionally, Brant (1996) found that the components of geropsychological supervision that trainees had previously identified as "ideal" were not actually addressed in supervision to a significant degree. More specifically, trainees responded that skill areas (e.g., assessment and diagnosis) were addressed more frequently in supervision than were personal issues (e.g., countertransference and ageism), even though trainees had ranked the latter area as being an important feature of "ideal" supervision. This finding is concerning and suggests that the supervision received by many of the trainees in Brant's study was lacking. It also indicates that the uniqueness of conducting therapy with a client who may be several decades older than the clinician-trainee necessitates consideration of issues of personal development and transference-countertransference earlier in a trainee's professional development than is suggested by the broad understandings of "good" supervision outlined above.

Brant (1996) also found that supervisors reported greater levels of "aging acceptance" than their trainees. Additionally, interns who had completed rotations longer than six months endorsed higher levels of "examination of aging issues of self" (Brant, 1996, p. 100). This suggests that extended training experiences make it more likely that vital issues of ageism and countertransference will be discussed in supervision. Thus, longer-term placements may be of greater benefit to geropsychology trainees than more abbreviated placements, which is consistent with the literature on "good" supervision (Worthen & McNeill, 1996).

Models of geropsychology supervision. In any specialization, there are particular factors to be considered when discussing how supervisors might best meet their trainees' needs.

Qualls and colleagues (1995) suggest that, in geropsychology, the scope of supervision may be broader than in other subspecialty due to the diversity of the clients themselves, the diversity of settings in which clients may be seen, and the complex medical issues often involved. Thus, training in and supervision around working in interdisciplinary settings is considered to be of vital importance (Duffy & Morales, 1997; Qualls et al., 1995).

Multimethod supervision. Duffy (1992) proposed a training model that accounts for the often interdisciplinary nature of geropsychology. This multimethod supervisory model aims to optimize the learning opportunities that are available in nursing home settings. It calls for the creation of an apprenticeship relationship with trainees through a combination of process supervision, case conferences, and grand rounds (Duffy, 1992). The goal is to provide closely supervised experiences at a number of levels in order to increase supervisees' competence and confidence in psychotherapy skills as well as provide much-needed experiences in working closely in a team setting with professionals from a number of fields. Furthermore, and very importantly, this model is adaptable to a broad range of community sites (Duffy, 1992).

Current State of Geropsychology Training and Practice

In 1981, the Conference on Training Psychologists for Work in Aging was held in Boulder, Colorado, and it was the first conference to focus on issues of training to work with older adults (Hinrichsen & Zweig, 2005; Knight, Santos, Teri, & Lawton, 1995). The wide ranging discussions at this conference, referred to as "Older Boulder," resulted in a variety of recommendations. However, the political realities of the 1980s—primarily the shift of responsibility for planning and delivering mental health services from the federal to state level in combination with major cutbacks in federal funding for training in psychology under the Reagan administration—curtailed this enthusiasm (Knight et al., 1995).

A second conference, "Older Boulder II," held in 1992, was more oriented toward clinical service issues (Knight et al., 1995). This time, an ad hoc task force was created to ensure that the recommendations generated at the conference would be carried forward (Knight et al., 1995). Out of this conference emerged an applicable model of education and training in geropsychology, known as the "three E's": *exposure* of all doctoral students to issues of aging, *experience* with providing clinical services, and *expertise* in geropsychology for those interested (DeVries, 2005; Hinrichsen & Zweig, 2005). This meeting was followed up by an APA Division 20 (Adult Development and Aging) and Division 12 (Clinical Psychology), Section II (Clinical Geropsychology) Interdivisional Task Force on Practice in Clinical Geropsychology. The Task Force's recommendations were approved in 2003 by the APA in the *Guidelines for Psychological Practice with Older Adults* (APA, 2004). Ultimately, in 1998, Clinical Geropsychology was recognized by the APA as a proficiency (Hinrichsen, & Zweig, 2005). Section II (Clinical Geropsychology) of APA's Division 12 (Clinical Psychology) and APA's Division 20 (Adult Development and Aging).

Models of training in clinical geropsychology. DeVries (2005) presented a model of geropsychology training that may be adopted by generalist programs to prepare their students for work with older adults, without having to create a specialty program. Its approach is based on APA's *Three E* model, with the goal of moving students from the exposure level to the experience level (DeVries, 2005). The first of three components includes suggestions for increasing awareness of aging issues in existing assessment and therapy courses. This tactic not only communicates that this population is valued by the profession, but it ensures that all students would have exposure to basic knowledge of working with older adults (DeVries, 2005).

The second component involves an introductory geropsychology course, including more advanced assessment and intervention skills (DeVries, 2005). An experiential component is essential to such a course, as the intent is to move students to the experience level of competence. The competencies targeted by such a course are: (a) ability to differentiate normal from pathological aging, (b) knowledge of mental health disorders in older adults, (c) knowledge of clinical assessment issues and instruments, (d) knowledge of intervention approaches and issues, and (e) awareness of models of service delivery (DeVries, 2005). The third component pertains to methods of assessing learning outcomes through exams, a portfolio of clinical experiences, in-class exercises and presentations, and individual supervision (DeVries, 2005).

DeVries (2005) also emphasizes the importance of linking didactic experiences with field training opportunities (e.g., practica), and urges training programs to explore ways in which they might reach underserved older adult populations through field training placements or other outreach efforts. Potential barriers to the implementation of this training model are noted, as well as some suggestions for overcoming these. Potential barriers cited include lack of departmental interest, lack of qualified faculty, and lack of student interest (DeVries, 2005).

The University of Colorado at Colorado Springs (CU) launched the nation's first specialty PhD program in geropsychology in 2004 (Qualls et al., 2005). Based on the scientist-practitioner model, it offers broad-based training in clinical psychology, with supplemental specialized training in clinical geropsychology that functionally serves as a minor for all students (Qualls et al., 2005). Through this balance of specialization and breadth, the program recognizes that "foundational training in clinical psychology and the science of the field is critical, regardless of specialty" (Qualls et al, 2005, p. 36).

The specific clinical curriculum is designed to systematically build skills in each major domain required by clinical psychologists: clinical interviewing skills, assessment skills, case conceptualization, intervention skills, and professional functioning (Qualls et al., 2005; see Appendix A for a list of course sequence and skills by domain). There is a focus on research throughout, and each student is required to write a master's thesis as well as a doctoral dissertation (Qualls et al., 2005). Field training is provided primarily through CU's Aging Center, though trainees have opportunities to train with non-aging populations as well. A variety of rotations are in place to ensure a well-rounded experience including: (a) neuropsychology, (b) group psychotherapy, (c) caregiver, (d) in-home services, and (e) an advanced practicum in which students gain experience in primary and long-term care settings (Qualls et al., 2005).

Qualls and colleagues (2005) did address the hurdle of attracting both faculty as well as students to a program that is not assured of "political approval or accreditation" in the near future (p. 37), and state that truth in advertising (i.e., not promising anything that they cannot deliver) has been their guide in these areas. Finally, the authors address balancing the dual identity of being a training facility as well as a mental health center. In the present author's opinion, it is commendable that this program has been able to start a mental health clinic from the ground up, which required significant time and funds as well as community outreach and support, but it begs the question of how duplicable this model really is, given the degree to which it relies on the clinic as a venue for training.

Continuing education needs. Many have reached the conclusion that, in order to meet the mental health needs of the growing elderly population, not only will training programs have to better prepare their students, but current practitioners must also become better prepared for work with elderly clients (Norman et al., 2000; Qualls, Segal, Norman, Niederehe, &

Gallagher-Thompson, 2002). The literature in this area seems to focus on two questions. First, who is currently providing mental health care to elderly clients? Second, what do they think is needed in terms of continuing education (CE) opportunities?

Who is providing care? In a recent survey of doctorally trained clinicians, only about 3% of respondents reported geriatric patients as being their primary professional target, while 69% reported that they provided some psychological services to older adults (Qualls et al., 2002). Respondents who reported the greatest percentage of services to older adults worked in long-term care settings, independent practices, and hospitals.

Current providers reported informal clinical experiences and on-the-job training as primary sources of training for work with older adults. One quarter reported some exposure to aging-related material in their graduate coursework, while only 3% had had a specialized internship. Individuals who had reported some degree of formal training were more likely to be providing assessment services to older adults, as well as psychotherapy. Additionally, more recent graduates (within the past 18 years) were more likely to have been exposed to graduate-level coursework, practicum placements, and internship rotations related to aging than those who had graduated more than 18 years ago. Respondents with more formal training (i.e., the more recent graduates) spent a greater percentage of their time working with the elderly (Qualls et al., 2002).

Perceived need for additional training. Forty percent of respondents to Qualls and colleagues' (2002) survey wanted to increase time devoted to elderly; 50% said they needed additional training. The majority of those who reported a need for more training was currently providing the least amount of services to older adults and had received the least amount of formal training. The majority of respondents (70%) expressed interest in attending specialized

educational programs on geropsychology topics. Among the most frequently cited areas of interest were depression, dementia, medical illnesses, substance abuse, bereavement/grief, end of life decisions, caregiver stress, and healthy/normal aging (Qualls et al., 2002).

Norman, Ishler, Ashcraft, and Patterson (2000) explored opinions about credentialing in clinical geropsychology, and 61% of respondents expressed interest in obtaining a certificate if it were available. Those in support saw it as a way to gain an edge in the marketplace and establish identifiable expertise as well as a means of attracting more psychologists into the field of clinical geropsychology. However, the current lack of credentialing was not perceived as a barrier to providing services to older adults.

Qualls and colleagues (2002) concluded that, in order to meet the mental health needs of the growing elderly population, the field needs to "facilitate more practice by those currently most heavily invested in work with older persons" (p. 440). To this end, the authors suggest a more coordinated approach to CE, as the survey results indicated a need for at least two levels of CE training. An introductory level could target general topics likely to be encountered by generalists, while an advanced level could target complex issues and cases that are likely to be encountered by practitioners with more geropsychology experience. These recommendations are made in conjunction with an acknowledgment that increasing and enhancing geropsychology training opportunities for graduate students is also necessary (Qualls et al., 2002).

Current guidelines for geropsychology practitioners. With the continued expansion of literature on the mental health needs of the elderly, there are numerous resources available to practitioners who work with this population. These resources cover various aspects of clinical geropsychology, such as books that address the clinical application of various therapeutic modalities with elderly clients, as well as nuts-and-bolts types of handbooks on particular clinical

issues that are often encountered when working with elderly clients. Also among this body of literature are several documents whose primary goal is to outline what practitioners should know about doing clinical work with older adults. Three such documents will be discussed below.

What practitioners should know about working with older adults. In 1998, the APA Working Group on Older Adults published an article whose goal was to provide "information to dispel myths about older adults and raise practitioners' awareness of the facts of aging" (APA, 1998, p. 413). In seven sections, this article covers broad domains pertinent to clinical geropsychology practice. The authors also include a list of professional geropsychology resources as well as a bibliography of recent and current research. The seven domains outlined by the APA Working Group on Older Adults are (a) demographic realities of the increasing older population, (b) commonly held myths about older adults, (c) realities of aging for older Americans, (d) psychological problems some older adults experience, (e) assessment of older adults, (f) appropriate psychological interventions for older adults, and (g) broad professional issues of concern to psychologists working with older adults (APA, 1998).

Recommendations for knowledge and skills. More recently, eight clinical psychologists working in the Veterans Affairs (VA) system published a similar document (Molinari et al., 2003). Notably, two of the authors of this article were members of the APA Working Group on the Older Adult at the time that the 1998 article, discussed above, was published. The 2003 VA article is presented by its authors as a modification of the framework introduced at the 1992 National Conference on Clinical Training in Psychology (i.e., Older Boulder II). While the original 1992 framework was introduced as a model for education and training in geropsychology, the 2003 article (Molinari et al., 2003) is described as a "broad schema to

provide the groundwork for what should be accomplished in a licensed psychologist's training to prepare him or her for practice with older adults" (p. 435).

Molinari and colleagues (2003) collaborated with the VA Technical Advisory Group in Geropsychology (TAGG), "a vehicle of communication for geropsychologists within the VA system" (p. 436). This collaboration resulted in seven competency areas considered to be critical to geropsychology practice: (a) knowledge about normal aging, (b) assessment, (c) treatment, (d) prevention and crisis intervention, (e) consultation, (f) interfacing with professionals in other disciplines, and (g) knowing special ethical issues in providing services to the aged (Molinari et al., 2003). Each competency area is broken down into Levels 1 and 2, the former describing the knowledge and skills that all psychologists should have to work competently with older adults in general practice, and the latter describing the knowledge and skills required for practice and training as a more specialized geropsychology practitioner (Molinari et al., 2003).

APA 2004 guidelines. As described previously, APA has been involved in researching geropsychology best practices for many years. Its most recent product, *Guidelines for Psychological Practice with Older Adults* (2004), was developed by APA's Interdivisional Task Force on Practice in Clinical Geropsychology (a.k.a., the "Task Force"), a joint effort between APA's Division 20 and Section II of Division 12.

The formation of the Task Force was a response to Older Boulder II's call to "develop criteria to define the expertise necessary for working with older adults and their families and for evaluating competencies at both the generalist and specialist levels "(APA, 2004, p. 238). The Task Force included clinical geropsychologists we well as individuals experienced in clinical work with older clients within a variety of subspecialty areas, such as clinical neuropsychology, health psychology, rehabilitation psychology, and community psychology (APA, 2004). In all,

there are 20 guidelines, each of which fall under one of six broad sections: (a) attitudes; (b) general knowledge about adult development, aging, and older adults; (c) clinical issues; (d) assessment; (e) intervention, consultation and other service provision; and (f) education. Please see Appendix B for a complete list of the 20 guidelines put forth by the Task Force (APA, 2004).

Documents such as APA's 2004 guidelines and the others discussed in this section are tools that can be used by individual professionals as well as by training programs. For professionals, these types of guidelines can help them assess their own level of competence for work with elderly clients and identify areas where additional education, training, or supervision might be needed. For training programs, guidelines can help ensure that their trainees are being adequately prepared for clinical work with older adults. Producing documents of this type is an ongoing process, and any such guidelines are constantly being revised and updated in order to reflect the current research into and understanding of the mental health needs of older adults. Moreover, just as the field's understanding of the mental health needs of this population is constantly evolving, so are the individual clinicians who work with them. Thus, much as the guidelines will never be "final," so must individual clinicians submit themselves to periodic self-assessment to ensure that they are providing the most appropriate and current services.

Summary of the Literature Reviewed

The scope of the literature that grounds the current study is broad and varied. In reviewing this literature, it is clear that not only has theorizing about the way we age evolved significantly (and is continuing to evolve), but also that the way we think about aging and elderly individuals can profoundly shape the way we interact with and treat them. It is also clear that awareness of the shortage of geropsychology practitioners is growing, and potential approaches to addressing this problem are being discussed an implemented. One of the consistently

identified themes in this shortage is the lack of interest on behalf of clinical psychology students in working with elderly patients. There are several possible reasons for this, though research into how to increase interest has been equivocal. Using *Interpretive Phenomenological Analysis*, a qualitative methodology described in Chapter 3, it is hoped that the results of this study will shed some light into how particular factors of a student's first therapy experience with an elderly client might shape his or her future interest in working with similar clients.

Chapter 3: Methodology

The purpose of this study was to investigate clinical psychology trainees' subjective experience of working with their first elderly therapy client, with goals of gaining a richer understanding of their experiences, as well as identifying factors which may shape students' interest in geropsychology. The findings of this study have the potential to contribute to the ongoing debate of how to meet the future mental health needs of this country's growing elderly population.

Interpretive Phenomenological Analysis

Interpretive Phenomenological Analysis (IPA) is a qualitative research methodology that attempts to "explore personal experience and is concerned with an individual's personal perception or account of an object or event, as opposed to an attempt to produce an objective statement of the object or event itself" (Smith & Osborn, 2003, p. 51). IPA takes into account the two-stage interpretive process inherent in phenomenological research: "The participants are trying to make sense of their world; the researcher is trying to make sense of the participants trying to make sense of their world" (p. 51). With this definition of IPA, the primary researcher attempted to make sense of data provided by clinician-trainees, who were, in turn, trying to make sense of their own experiences of treating their first elderly clients.

Participants

IPA studies tend to recruit a relatively small sample, though there are no hard and fast rules on sample size—IPA studies have been published with samples ranging from one to fifteen (Smith & Osborn, 2003). For the present study, seven individuals from five different PsyD programs across the country were interviewed; interviews took place in March and April, 2010. Participants were at varying stages of their training at the time of the interviews: two were in

their second year of graduate school, two in their third year, two in their fourth year, and one participant was on internship.

Participants varied in age, from 24 to 42 years (average age was 30.6 years). Their first elderly clients ranged in age as well, from 66 to 92 years (average age was 77.1 years). The age difference between clinician-trainees and their clients ranged from 38 to 65 years (the average age difference was 47.1 years).

Of the seven participants, six were female and one was male. Six participants self-identified as Caucasian, and one as African American. Four were married, and three single, never married. Education prior to beginning work toward a PsyD varied: six participants had BAs in psychology (two had double majors: one with English, one with Theatre). One participant had two Master's degrees: one in Counseling Psychology, the other in School Psychology. Five were current members of various professional organizations: four were APA members, two were members of their state's psychological association, two were members of ABCT (the Association for Behavioral and Cognitive Therapies), two were member of Psi Chi (the International Honor Society in Psychology), and one was a member of the Society for Personality Assessment.

The settings in which participants encountered their first elderly clients varied, as did their clients' presenting problems. The youngest client was a 66-year-old Caucasian female who was seen on the geriatric unit of a psychiatric hospital. Her presenting problem was severe depression and mild suicidality, and she was seen twice weekly for two months. Next, in age-order, was a 68-year-old Caucasian male who was treated at an outpatient drug and alcohol facility for alcoholism. He was seen for three to four months, both in group and individual therapy. Next was a 69-year-old female from the Dominican Republic, who was seen at a

Community Mental Health Center (CMHC) in an urban setting. She presented in the early stages of dementia, and was seen for individual therapy (in Spanish) for four months. Next was a 78-year-old Caucasian female who was seen in an Alzheimer's treatment clinic. She presented in the early stages of dementia (eventually diagnosed as Lewy body dementia), and was seen for approximately seven months. Next was an 82-year-old Caucasian female of Swedish descent, who was seen in a multidisciplinary private practice. Her presenting problem was depression and anxiety, and she was seen for three to four months. Next, there was an 85-year-old female of Hawaiian descent who was seen in a CMHC, presenting with anxiety and "existential stuff." She was seen for only two sessions. Finally, there was a 92-year-old Caucasian male who was seen in a medical setting at a state hospital (having been admitted for pneumonia). He also had a diagnosis of Alzheimer's dementia, and was seen for approximately one month, at which time he passed away.

Procedures

Participants were recruited through an email invitation, sent to 20 PsyD programs in the United States. (See Appendix C for the recruitment email). In the proposal for the study, it was planned that the email invitation would be sent to 10 programs. However, due to difficulties recruiting an adequate sample, an additional 10 programs were targeted, with the approval of the primary investigator's dissertation chair.

Participants were emailed the study's Informed Consent Form (see Appendix D). Once signed forms were returned, interviews were scheduled. Six of the interviews were conducted by telephone, and one in person. At the outset of each interview, the Informed Consent Form was reviewed, and participants were asked to provide demographic information. Interviews lasted approximately 50 to 70 minutes, and participants were asked questions about various aspects of

their experience with their first elderly clients. The researcher simultaneously audiotaped the interviews and took notes. Occasionally, clarifying questions were asked to ensure that the researcher understood that which interviewees were intending to communicate.

Potential risks of participating in this study were minimal. However, as the study involved live interviews, the anonymity of participants could not be guaranteed. Therefore, the following steps were taken to ensure confidentiality. Participants' names were replaced with randomly generated codes, and all recorded interviews and resulting transcripts were identified by these codes. During data analysis, themes were developed across cases which cannot easily be linked to any particular interviewee. Quotations to substantiate themes were reported, but were not accompanied by any identifying information. Moreover, none of the quotations were unique enough so as to reveal a particular interviewee's identity. No mention of interviewees' names, or the names of the institutions they attend, are reported anywhere in this writing.

Throughout the study, all hard copies of data were stored in a locked file cabinet, and digital copies of interviews and transcripts were stored on a secure, password-protected laptop computer; only the researcher had access to the file cabinet or computer. After the dissertation is successfully defended, all recordings of interviews will be destroyed. The remaining data—hard and digital—will continue to be stored securely, at the home of the primary investigator, for an additional two years for verification, if requested, by third parties, after which the transcripts will be destroyed. These procedures were included in the Informed Consent Form, which was signed by the researcher and each participant.

The risk of emotional harm to participants was deemed minimal. One potential risk, identified in the Informed Consent Form, was the possibility that some of the interview questions may have resulted in subjective feelings of discomfort. It was made clear to each participant that

they were not required to answer every single question asked, and would not be penalized in any way if they chose to skip any questions. Questions were framed in a semi-structured manner that uncovered important information about participants' experiences working with their first elderly clients. The benefits of the study outweighed the risks described above.

Instrument

Data were collected through the use of a semi-structured interview, the gold standard data collection method in IPA (Smith & Osborn, 2003). Interview questions were developed based on the study's literature review and guided by its research questions:

1. Primary research question:
    - How do clinician-trainees (the participants of the study) experience their first elderly therapy client?
2. Issue subquestions:
    - What, if any, common themes emerge among the reported experiences of different participants?
    - Do participants experience their elderly clients differently than they do their other clients? If yes, how so?
    - Do participants feel any differently about working with elderly clients after having worked with one? What, specifically, contributes to this change?
3. Topical subquestions:
    - In what ways do participants think that their academic training did or did not prepare them adequately to work effectively with elderly clients?
    - What, if anything, in their training do participants find to have been particularly helpful (or unhelpful) in working with elderly clients?
    - What, if anything, about the context of the therapy experience (i.e., nature of the training site, supervision, peer support) do they find to have been particularly helpful (or unhelpful) in working with elderly clients?

- What suggestions might they make to their own graduate program and/or training site about geropsychology training in order to better prepare future students?

The interview consisted of nine demographic questions and 30 open-ended questions. (See Appendix E for the interview protocol). The demographic questions established background information about participants, including name, city of residence, age, race/ethnicity, sexual orientation, marital status, and stage of doctoral training. Two other questions were professional in nature, inquiring about prior education and work experience, and membership in professional organizations. The remainder of the interview consisted of semi-structured and open-ended questions. Some questions were factual in nature, related, for example, to the amount of exposure participants had to topics on geropsychology in their academic training. Most questions, however, were self-reflective in nature, as the goal of the study was to learn about students' subjective experiences of working with their first elderly clients.

Data Analysis

The goal of IPA research is to learn something about the participant's psychological world. Smith and Osborn (2003) caution, however, that "while one is attempting to capture and do justice to the meanings of the respondents to learn about their mental and social world, *those meanings are not transparent* [italics added]" (p. 64). Thus, in an IPA, data analysis and later interpretation require a consistent and exhaustive interaction of the researcher with the transcripts.

The process of analysis involved numerous steps, and resulted in the identification of domains and themes that emerged across data sets (i.e., interview transcripts). More specifically, the data analysis included the following steps:

Step one. Each interview was transcribed by the primary investigator, including all verbal language, false starts, pauses, etcetera. Prior to any transcription, each interview was listened to in its entirety. This was followed by the transcription of the interview, followed then by another complete listen, to ensure accuracy.

Step two. One by one, each transcript was read through in its entirety a number of times, ensuring familiarity with each respondent's experience. During these readings, the right margin of each transcript was used to make notes on significant or interesting things that the respondent said (Smith & Osborn, 2003). As each transcript was read and reread, the researcher began to take notes in the left margin, documenting emerging theme titles.

Step three. Once the transcripts ceased to yield new themes, all of the discovered themes were listed in a blank document, and connections among them were sought. As themes began to emerge from the data, some contained subordinate themes ("subthemes") within them. Other themes stood on their own ("terminal themes"), and did not contain any subthemes. During this process of distilling the information, the researcher constantly referred back to the text to check her own sense-making of the data against what the respondent actually said, as called for by IPA procedure (Smith & Osborn, 2003).

Step four. As themes were identified, they began to fall into several overarching domains, associated with various aspects of interviewees' experiences. This step represents a minor modification to IPA methodology, as grouping data into domains is not specifically called for. However, the interview questions inquired into several different areas of participants' experiences, and clustering the themes into domains appeared an appropriate strategy to infer broad meanings (Hill et al., 2005; Hill, Thompson, & Williams, 1997), and to treat the data with parsimony. Within each domain, themes were then clustered and categorized according to IPA

procedure as described in the prior step (Smith & Osborn, 2003).

Step five. Using this list of domains and themes, a table was produced. Each domain was given a name that clearly represented its contents. Within each domain, terminal themes and thematic clusters were named. Subordinate themes were named and listed within the clusters that contained them. This table presents the themes in such a way that each can be easily traced back to the interview (and page number) whence it originated. This step involved continued consultation with interview transcripts to ensure that emergent themes across cases indeed represented shared experiences among participants. As this phase of analysis unfolded, in consultation with the investigator's peer debriefer, Dr. Gargi Roysircar (also the dissertation chair), some themes were dropped, or absorbed into other themes. As specified by IPA procedure (Smith & Osborn, 2003), themes were included based on frequency, richness, and how well they expounded on or clarified other themes.

Step six. Using the table created in the previous step, a final table of themes was produced. This table clearly lists each domain, the terminal themes and thematic clusters within each domain, and all associated subthemes. Also included is the frequency with which each terminal theme and subtheme occurred across cases.

Step seven. A written narrative summary was prepared for the Results section of the study, guided by the final table of themes and using participant quotes where appropriate (Smith & Osborn, 2003).

Quality Control

Guba and Lincoln (1989) identify five criteria essential for judging the quality of qualitative research (as cited in Mertens, 2004). The following procedures were employed

throughout this research study to ensure its credibility, transferability, dependability, confirmability, and authenticity.

Credibility. Credibility, according to Guba and Lincoln (1989), is the criterion in qualitative research that parallels the internal validity of an experimental design (as cited in Mertens, 2004). Thus, "the credibility test asks if there is a correspondence between the way respondents actually perceive social constructs and the way the researcher portrays their viewpoints" (Mertens, 2004, p. 254). The researcher employed the following strategies to establish and ensure credibility throughout this endeavor:

Prolonged and sustained engagement. In this study, the in-depth semi-structured interviews constituted prolonged and sustained engagement. This criterion was deemed to have been met when themes and examples during interviews began to reoccur rather than expand (Mertens, 2004).

Peer debriefing. Peer debriefing involves engaging in discussions with a disinterested peer. The primary investigator's dissertation advisor served this role, as the study does not fall within her research program, teaching responsibilities, or area of expertise. Periodically, the researcher consulted with her peer debriefer to discuss her methods, findings, conclusions and hypotheses with said peer, whose task it was to ensure that the values of the researcher did not color the research endeavor (Mertens, 2004).

Member checks. In qualitative research, it is essential that the constructions that develop out of data that have been collected and analyzed be verified by the participants who supplied the original data. Member checks involve "checking" with participants to make sure that what the researcher has interpreted is indeed what the respondent had intended to communicate (Mertens, 2004). However, this procedure was modified for the current study because no additional

contacts were made with participants after the interviews were complete. As an alternative, ongoing, informal member checks were performed during interviews. This was achieved by summarizing what the researcher perceived to have been said and inviting the participant to comment or make clarifications as necessary. Additionally, at the conclusion of each interview, the investigator offered to share the results of the study's findings with the respondent (Mertens, 2004). Two participants accepted this offer.

Transferability. Transferability is to qualitative research what external validity is to quantitative research (Guba & Lincoln, 1989, as cited in Mertens, 2004). Mertens (2004) states that, "the burden of transferability is on the reader to determine the degree of similarity between the study site and the receiving context," while it is the responsibility of the researcher to "provide sufficient detail to enable the reader to make such a judgment" (p. 256). Providing *thick description* is a useful method of ensuring transferability. For this study, thick descriptions were provided by direct quotations from participants.

Dependability. Guba and Lincoln (1989, as cited in Mertens, 2004) identify dependability as the qualitative parallel to reliability. That is, in quantitative research, reliability means stability over time (especially for test-retest reliability), while in interpretive research change over time is expected, but it must be tracked in such a way that an outside observer could inspect it and understand the change process (Mertens, 2004). Keeping track of change in this way is called a *dependability audit*, which, for the current study, involved keeping an account of any changes to the methodology described herein, along with rationale for any changes.

Confirmability. Confirmability is the qualitative parallel to objectivity (Guba & Lincoln, 1989, as cited in Mertens, 2004). Within the context of qualitative research then, confirmability means that the data collected and the resultant interpretations are not mere

figments of the researcher's imagination (Mertens, 2004). To this end, a *confirmability audit* was maintained throughout the interpretation process, and demonstrates that the data can clearly be traced back to its original sources within the interview transcripts.

Authenticity. A qualitative study can be deemed "authentic" if the investigator has succeeded in a balanced and fair presentation of all perspectives, views, and beliefs (Lincoln & Guba, 1989, as cited in Mertens, 2004). There are two criteria relevant to this study that the investigator strived to meet in her efforts to achieve authenticity in the research process:

Fairness. Fairness answers the question, "To what extent are different constructions and their underlying value structures solicited and honored in the process?" (Mertens, 2004, p. 257). To this end, semi-structured interviews were utilized, which allowed the investigator to invite further information about participants' unique experiences. It also allowed participants to not answer any particular question, should they so choose.

Ontological authenticity. Ontological authenticity refers to the degree to which the participants' conscious experience of the phenomenon being studied becomes more informed (Mertens, 2004). In this study, an example of this was participants' evolving understanding, over the course of the interview, of their experience with their first elderly client. In order to ensure authenticity on this level, the researcher utilized member checks (as discussed above) to clarify and document transformations in the respondents' understanding of their experiences.

Summary

Employing IPA methodology, the investigator conducted a systematic, in-depth analysis of interview data gathered about clinical psychology students' first experience doing therapy with an elderly client. As a qualitative methodology, IPA had several advantages. The use of semi-structured interviews allowed for an in-depth examination of participants' inner

experiences, and the intensive process of analysis was aimed at ensuring that these experiences were understood and represented in an accurate and authentic manner.

According to Mertens (2004), the "key characteristic of phenomenology is the study of the way in which members of a group or community themselves interpret the world and life around them" (p. 240). This basic principle of phenomenological research guided data collection and analysis, in the effort to learn about the lived experience of a particular professional phenomenon by individuals within a particular phase of their clinical training.

Chapter 4: Results

This chapter begins with an overview of the methods used to analyze data, followed by the presentation of results, including summaries of overarching domains and comprising thematic clusters. These summaries are accompanied by direct excerpts from interview transcripts, providing thick descriptions of the phenomena under examination.

Overview of Methods and Results

Through the application of Smith and Osborn's (2003) Interpretive Phenomenological Analysis (IPA), domains, thematic clusters, and subordinate themes emerged from the data. IPA calls for themes to be clustered with similar themes, though grouping data into domains is not specifically called for. However, because the interview questions explored several different areas of participants' experiences, clustering the themes into domains was deemed an appropriate strategy to infer broad meanings (Hill et al., 1997; Hill et al., 2005) and to treat the data parsimoniously. Within each domain, themes were then clustered and categorized according to IPA procedure (Smith & Osborn, 2003).

Twenty themes emerged, which fell under a larger umbrella of six domains. While many of these themes stood on their own (terminal themes), eight of them comprised two or more subthemes. Overall, within the six domains were a total of 31 terminal themes and subthemes. See Table 1 for domains, themes, subthemes, and the frequency with which each occurred among the interviews. Additionally, Appendix F provides a detailed chart of domains, themes, subthemes, and representative excerpts drawn directly from the interview transcripts. In the remaining pages of this chapter, each domain is identified, and the themes and subthemes that emerged within each are described. Direct quotations from the interviews are included, as well, which best illustrate the meanings of the themes and subthemes.

Table 1

Domains, Themes, Subordinate Themes, and Frequency across Interviews

Domains	Themes	Subthemes	F*
Expectations vs. Reality	Connection	Fear of not being able to connect	7
		Difficulty establishing connection	4
		Connection *is* possible	6
	Nature of the work	It will be different in some way	5
		It's not *too* different	5
	Why bother?	Is treatment worthwhile?	5
		Treatment *is* worthwhile	4
	Existential concerns		4
Subjective Experience	Role confusion	What does a geropsychologist *do*?	3
		Role "reversal" (respect)	2
	Personal Confusion		5
	Did not feel competent		4
Resources Drawn Upon During Treatment	Academic preparation	Formal learning opportunities	3
		Informal learning opportunities	3
	Supervision		5
	Prior experiences	With diverse populations (clinical)	5
		Other (clinical)	4
		With elderly (non-clinical)	3
Interest in Geropsychology: Pre vs. Post	Pre: Ambivalent, but open		4
	Pre: Yes, interested		2
	Ambivalence / interest influenced by diverse variables:	Personal experiences	6
		Peer learning	3
		Self-concept as generalist	2
	Post: Increased interest / openness		6
Factors associated with Future Interest in Geropsychology	Positive experience		5
	Increased confidence		4
	Good supervision		4
	Shift to generalist frame		3
What Would Have Made the Experience Better?	Academic preparation	More / better	7
		Gero is neglected by schools	6
	More / better supervision		4

*Note: F (frequency) denotes the number of cases in which themes appears, not the overall frequency of occurrence.

Domain 1: Expectations vs. Reality

Connection

All of the clinician-trainees interviewed went into the experience of working with their first elderly client with some preconceived notions of what the experience would be like. After reflecting upon the experience, most participants reported notable differences between their expectations of the work and the reality of it. Four general themes, in terms of expectations and reality, emerged within this domain, which are presented in more detail below.

Fear of not being able to connect. This subtheme was the most frequently cited in terms of participants' expectations about what it might be like to work with their first elderly client in therapy. This, in fact, was one of only two themes cited by all seven interviewees. In several cases, this fear focused on the age difference between the clinician-in-training and the client, as seen in the following two excerpts:

> I imagined it'd be really hard, especially building up a good relationship. So if I'm 24, and this person could be 65, they could be 70 or even 80 years old…that's like a *50 year* gap. So that's…that's pretty hard to traverse, I'd say. (418.10)[1]

> There was a little bit of hesitation, a little bit of realization that this was somebody who is a *lot* older than me, who has years and years and years…y'know? So, there was a lot of history there that I won't connect with. (515.9)

For some participants, there was also a fear of whether or not their client would be accepting of *them*, based on age difference:

> …also wondering if she would accept *me*, as a *young* person. Y'know, would she trust me? Would she be open to talking to someone who *she* knew wasn't alive for the majority of her life? So, I think actually a lot of my fear was feeling that *she* may have issues with *me.* (515.9-10)

Difficulty establishing a connection. More than half of participants (4) did, in fact, describe having a hard time connecting with their client, when asked about their experiences of

[1] The first three digits indicate the interview from which the excerpt was drawn. The numbers after the period indicate the page of the interview transcript where the quote can be found.

the first few sessions with their first elderly client. For one participant, this difficulty contributed feelings of anxiety about the therapeutic encounter in general:

> I was feeling a little anxious, a little intimidated. He was also really quiet…very reserved. Especially at the beginning, it was kind of like pulling teeth with him a little bit. And so I think that reinforced…a little of the anxiety and intimidation that I was feeling. (240.9)

Another participant seemed to understand the difficulty connecting as an issue of the client's hesitation to trust the therapeutic relationship:

> She's not gonna trust me if I don't build the relationship, so nothing else is gonna work. So it was like…the very first job I had from then on, it was…build the relationship, build the relationship, build the relationship. (418.15)

Regardless of the way in which the fear of not being able to connect manifested itself, it was clear that four of the clinician-trainees interviewed did indeed experience difficulty connecting with their clients.

Connection is possible. All but one of the participants found that they were, in fact, able to establish solid relationships with their clients. For some, the point of connection centered on finding a common ground in the therapy, such as making an intervention that resonated with the client, as described in the following example:

> He really loved *learning* about drug and alcohol addiction, and so that was, like, our break-in point. And so then, I would say, once I realized that he found that beneficial…I would say I didn't really feel those feelings of intimidation or pulling teeth…anymore, it was just a great relationship, and I felt like it progressed really *well*. (240.10)

As evident in the above excerpt, the interviewees' relationships with their clients turned out to be rich and rewarding centerpieces of the experience for many of them. Having their fears of not being able to connect with their client dispelled was revelatory, as summed up by the following participant:

> And, just the fact that I *was* able to build a good relationship, even if at first it wasn't all that great, just the fact that I was able to build a good relationship really dispelled that

> thought that I had, like, "How can I connect with someone who's so much older?" Because we made that connection, it was like, "OK, so this isn't impossible." (418.26)

Nature of the Work

Another subtheme that came up among many participants, while they explored their expectations of what doing therapy with their first elderly client might be like, was that the nature or quality of the work would be different, in some way, than therapy with other clients they had encountered.

It will be different in some way. For many (5), the expectation that the work itself would be different in some way centered around the content of the work. For example, one participant speculated whether, "Older folks maybe have…other types of psychological work to do" (954.9). For other participants, this expectation had more to do with wondering if *they* (participants) would have to *be* different in some way, carry themselves differently vis à vis this particular client. As one clinician-trainee put it, "Part of my reservation going in was, 'How do I relate to this person?' If I'm casual, will she be offended by that? Will I have to hold it together a little bit better? Be a little more tightly spun?" (515.25).

It is different, but not too different. Most participants (5) were pleased to discover that, while the nature of the work was in fact different in some way or ways, it was not *so* different as to be unmanageable. In one example, the experience disproved the participant's expectations of what older adults might be capable of in therapy:

> I think I needed to see that people, no matter what they're going through…are not as frail as I think they are. And you can…you don't *have* to treat them, like, with kids [sic] gloves, you *can* work with them, and work with them assertively, if you have to, and that they can also work very hard, too. (127.17)

Another participant discovered that the quality of doing therapy with an elderly person was not drastically different than working with other populations, which was experienced as reassuring:

> It was different, it was the first older gentleman that I had worked with. It was comforting, because…it wasn't really overly *different* than anything else, and I think it was good to know that I could, successfully, work with someone who was older. (240.13)

Why Bother?

Another theme within the domain of expectations vs. reality took the shape of speculation as to whether doing psychotherapy with an elderly person was worth the time and effort involved. In fact, while exploring their expectations of working with their first elderly client, most clinician-trainees (5) wondered whether doing therapy with this population was really worthwhile.

Is treatment worthwhile? A common manifestation of this theme was some level of doubt that older adults have enough of a capacity for change so as to make treatment worthwhile in the first place. As one participant speculated:

> Alright, so they're in their 70's…you might see them, and how much change can you really make? I mean, can you really make a change? And maybe the change only lasts a year or two before they die…was it really worth my time? (418.8)

Also evident in the above quotation is a recognition of the reality that, because these individuals are so much older, the benefits of therapy will necessarily be short-lived, only lasting as many years as the client had left to live. This awareness of the foreshortened utility of therapy with the elderly was common among participants, as exemplified by the following excerpt:

> I think a lot of elderly…I don't know that they would *need* something like that [mental health care], maybe because they've got it all figured out, or that there isn't much of a point to it, because they're not gonna be around for long. (240.7)

This excerpt also highlights an expectation that older people may simply have less need for psychotherapy because they have been around for so long that they have figured everything out. It is possible that, within this assumption lies an implicit fear of not being useful to the

client, and / or confusion about what exactly it is that a geropsychologist does. This confusion, in fact, was salient for many participants, and will be discussed under Domain 2.

Treatment is worthwhile. Despite their uncertainty about the utility and / or value of psychotherapy with the elderly, most participants (4) discovered it to be a very worthwhile endeavor: "It definitely showed me that there's a *lot* that can be done, and *how* to do those things" (127.17). Another participant observed, "So yeah, maybe she'll only be alive for a couple more years…but if you've got a couple more years to really, y'know, if you could make someone that much happier for that amount of time…" (418.25). One participant, whose client died (of natural causes) during the course of therapy, found the treatment to be of value, despite the extreme brevity of any beneficial effects: "I felt really honored to sit there with him, and help him reflect on his life, and to *be* that person who was really present at the end" (954.23).

Existential Concerns

A final theme identified by more than half of participants (4), as they talked about their expectations, focused on existential concerns, which manifested in various ways. One participant, (the participant whose client died), recalled wondering about that very possibility, before even having been assigned this particular client: "I had actually thought about, y'know, 'What if he died? What if one of my clients died? How do I think I'd respond to that?'" (954.16). Another participant expected that the content of the work itself would focus on existential issues: "I just keep coming back to, like, loss loss loss…loss of friends, loss of supports, loss of the ability to take care of yourself" (418.7). For others, this theme centered on their own anticipated feelings of sadness while working with an elderly person:

> If they're coming to see a psychologist it's likely because there are issues of depression, specifically dealing with losses, maybe death of a spouse or…I just think it would be a lot of really sad, death kinds of…or disability, or a lot of chronic pain, too, which I think would be very…psychologically draining. (863.9)

Another participant summed it up thus: “Honestly, my first perception was that, for whatever reason, I thought it would be sad <<laughs>> Like, my countertransference would just be a lot of sadness toward that person” (537.9).

Up to this point, all the themes that emerged within Domain 1 (“Expectations vs. Reality”) had a counterpart – that is, each expectation was tempered by a new understanding after have gone through the experience (referred to as “reality” in the domain name). However, there was no such counterpart to the theme “Existential Concerns” that emerged from the data. Despite this lack of a resolution, so to speak, because these concerns were shared by more than half of clinician-trainees interviewed, it seemed important to include in the presentation of results.

Domain 2: Subjective Experience

Role Confusion

More than half of the students interviewed (5) experienced some level of uncertainty about their role as a clinician working with an elderly individual. This theme clustered into to two subthemes. One centered on confusion as to what a geropsychologist’s role actually is, and the other had to do with concerns about a reversal of roles, of sorts.

What does a geropsychologist do? Confusion in this area was practical in nature. As in, there seemed to be a vague understanding of a geropsychologist as a psychologist who works with the elderly. Beyond that, almost half of clinician-trainees (3) reported being confused, when they were confronted with actually doing the work, as to what a geropsychologist *really* does. As one interviewee reported,

> I felt that the majority of the [gero]psychologist’s role would be in testing, like, dementia screenings, neuropsych testing, and…dealing with end of life issues. I thought…y’know, that’s probably about all that’s going on.[…] For instance, the gerospych intern, most of

> what she does *is* assessment. So, that tends to reinforce the belief about what a majority of what a geropsychologist does. (537.9)

For this participant, having the experience of actually being in the role of doing psychotherapy with an older adult was helpful in expanding the participant's understanding of the scope of geropsychology: "*But*, I guess I am now more aware that there might be more traditional roles, like therapeutic roles that could be involved. So, it wouldn't be so much an…assessment-filled role" (537.9).

Role reversal (respect). Another variation on the theme of *role confusion* had to do with a perceived reversal of roles. These concerns were based on the issue of respect for one's elders, and how to navigate a working relationship in which the (much) younger party was in the position of authority:

> Y'know, there's a tension of, like, *I'm* the professional here, but she's my elder, by a *lot*, and so I want to respect her and honor her, but I don't wanna let that take my authority away from me, or make me feel like less than the professional that I am. So, I think there was a little bit of role confusion. (515.10)

One participant linked this experience with her own personal experiences with elderly individuals in her past:

> Because of my upbringing, I was sort of nervous…because people that are older than you are held in the highest regard. So…I didn't want to be disrespectful in any way, and I didn't want to come across as condescending in any way. Y'know…sometimes in therapy there's, like, this *power* dynamic that happens in therapy sometimes, and I don't like that. So I wanted to make sure…I was *nervous* about that! (127.10)

This same participant, however, was pleased to discover that, although this reversal of roles was salient in the therapy, it was navigable, and did not impede therapy:

> It was much more normal as the therapy went on. I was pro*fess*ional, but I didn't have that, like, "Oh, I'm gonna be disrespectful" sort of feel anymore. And…when you say confidence, I felt like it was okay for me, even though I was younger, to be in a place of authority, because that's what my role was. You know what I mean? And I can execute that role in a respectful way. (127.14)

Personal Confusion

More than half of participants (5) cited feelings of confusion as being a prominent feature of their subjective experience of working with their first elderly client, particularly during the early stages of therapy. For some clinician-trainees, confusion was a salient feature of the first few sessions, as they navigated their role vis à vis their first elderly client, and confronted very novel presenting problems:

> I wasn't sure if it had to do with *me*, I wasn't sure if it had to do with him…just not really wanting, y'know, treatment so much, or…whether he was just, like, a silent kind of person. (240.9)

> [I was] a little bit confused [during the first session]. I went in to see him and he was lying in his hospital bed, and I introduced myself, and I started to tell him, y'know, who I was, what department I was from, why I was there, and he was <<laughs>> staring up at me, and then he said, "I love you." And I thought, "*Maaay*be I heard that wrong." (954.11)

Confusion was often directly related to particularly complicated presenting problems. For example, one individual had a very difficult time determining which factors of the client's situation were most salient to the presenting problem:

> It was difficult to gather all the information from her, but she *clearly* had an anxiety disorder of the OCD type. And…of course, intertwined with that was some pretty severe depression…but then there were also bereavement issues. [..] So, those were the presenting issues, but again, because of her very compulsive way of going about, y'know *thinking*, she was *very* difficult to work with. I felt that we circled around and around and around, and we made very little progress. And I don't know if that was *age*, or if that was, y'know, an obsessive-compulsive personality that was stuck in a thought process that was not going to budge. So…I'm not sure about that. (515.12)

Did Not Feel Competent

More than half of participants (4) had the unpleasant experience of simply not feeling competent to work with their first elderly client. For some, this self-doubt was present during the very early stages of therapy, and manifested in non-specific concerns about their ability to be helpful: "I thought, y'know, 'How am I gonna help her? What do I have to offer her?'" (863.15).

For one participant, feelings of incompetence were associated with the perception that the client was exceedingly accomplished in his life:

> That was a little intimidating to me…not just because of the life experience that he had, but also because he's a brilliant, incredibly brilliant person, and here I was, y'know, I had just started my 3rd year of graduate school, and…I was working with someone with, like, multiple doctoral degrees <<laughs>> Um, that was *really* intimidating for me. (240.9)

One participant linked feelings of incompetence with the brevity of the therapy (this particular client was only seen for two therapy sessions): "It was just…it was too short, and I didn't really feel <<laughs>> very competent in helping her" (863.18). Finally, another participant put the experience of not feeling competent very succinctly, summing up thus: "Well, I felt ill-equipped, and incompetent. I felt that…some of the negative expectations that I had were, in a sense, fulfilled" (515.20).

Domain 3: Resources Drawn upon during Treatment

Academic Preparation

Despite the difficulties many participants experienced in their work with their first elderly client, they drew upon a variety of resources in order to better understand and better treat their clients. A resource that many, not surprisingly, fell back on was their academic training, including both formal (i.e., through academic coursework) and informal (e.g., through peer presentations) learning opportunities.

Formal learning opportunities. Three interviewees cited formal academic opportunities as an important source of information in their work with their first elderly client. Some had already received fairly thorough exposure to topics related to geropsychology, as one participant reported:

> Well, there was a full, 3 credit course on geropsychology, and […] there was, uh, a 3 part seminar, where a psychologist from the geropsychology unit from the local psychiatric

> hospital came and did this 3 part seminar. (537.4) [NB, both courses were requirements.]

Another participant, who had had much less exposure to geropsychology in school, still found academic experience to be an important resource:

> Y'know, I don't know [if more academic preparation would have been helpful], because I *had* some classes where we had talked about that, and so it wasn't like I had never heard of it before. I don't know that a lot *more* education would've…made me feel particularly more prepared. (240.14)

Informal learning opportunities. Other clinician-trainees (3), who had had significantly less (or no) formal learning opportunities in geropsychology through their graduate programs, turned to informal sources of learning that they had access to. For one participant, a classmate with a preexisting interest in geropsychology was a significant resource:

> I feel that my biggest source of learning about it was in my Professional Seminar, because one of my classmates really focused a lot of her presentations and discussions on gerontology, or older adults. That was, like, *her* focus. So her presentations would all be on that kind of stuff. So I learned a lot from there. (418.4)

Another participant turned to a peer who had non-clinical work experience with elderly populations:

> Once, I consulted with a peer who volunteers in a nursing home. She wants to go into geriatric medicine, and I asked her, after that first session, I asked her about dementia […] So I did, sort of, have some questions that I brought to other people that added to my options, I guess. (954.14)

Supervision

Supervision was also an important resource that most participants (5) relied on in their work with their first elderly client. One interviewee reported that, "Getting therapy supervision from him [the supervisor] is very helpful, he's very insightful, and very able to point out issues, and suggest intervention ideas" (515.18).

Another interviewee was more specific in terms of how supervision was helpful:

> Yeah, he was able to offer me other case examples, or just, "This is what has happened in the past for some people," or he could say, "Here's a common pitfall that's happened to past practicum students here." He'll drop one of those, like if he sees you're trying to avoid something… But yeah, I definitely think that a big part of it was he could relate it to my experience, like, "This is helpful for some," just relating it to other practicum students who were also working with an older person. I found that really helpful. (418.21)

For this participant, that the supervisor had prior experiences supervising trainees working with their first elderly client was significant to the helpfulness of supervision.

Prior Experiences

Another rich resource area that participants referred to was prior experiences. A wide range of prior experiences was cited as being helpful in working with their first elderly client, and included both clinical and non-clinical experiences, professional and otherwise.

With diverse populations (clinical). Most clinician-trainees interviewed (5) cited prior clinical experiences working with diverse populations as being a very important resource which they drew upon to guide them in their work with their first elderly client. For some, the experience of having been challenged to work with a unique population, (and having it turn out to be a positive experience), was a source of confidence. As one participant explained,

> I had a job working with autistic children. It was my first real job […] after I got my first masters. And I was…coming into a population that I really had no background, no experience in […] and I think that helped me. I mean, knowing that I got through *that*. When you're new out of school, and you have a job opportunity, you're gonna *take* it. And it was really important for me to go through that. […] So, I had that, sort of, okay feeling to go in there, and I think that was…it was pretty similar, working with autistic children for the first time. And they turned out to be a population I loved, too. (127.21)

For the following participant, having had clinical experience with diverse populations was a very salient source of confidence, despite not being confident working with this *new* population (i.e., the elderly):

> In the past, with other types of diversity, I don't know…I guess just having *enough* positive experiences that I was willing to try this one. So, I *wasn't* confident in my

> ability to handle any kind of, y'know, old age issues. I was confident enough in myself as a therapist, that, "OK, I'll try this…and hopefully it'll go okay" <<laughs>>. (515.13)

For others, conceptualizing the elderly as a diverse population in and of itself was helpful, which allowed them to draw upon some of the universal touchstones of the therapeutic endeavor:

> When I've worked with other diverse populations in the past, my approach has always been just…well, just be highly empathic, just let them tell their story, show them you're interested, make them believe that you truly care—which I do, and…and they quickly trust, and then the relationship usually, but not always, but usually takes off. And so I thought, "Well, I can use those things," y'know, that same approach, and it actually did end up being effective. (515.10)

Other experiences (clinical). Nearly half of participants (3) cited prior clinical experience in general, (not specifically related to working with elderly populations), as an important resource. As one participant noted,

> I've worked with people, like, from 20 through 50, so it wasn't like I was going from, like, working with *kids* to the elderly. So, I think that helped a lot. But I think, that…yeah, I think if I *hadn't* had that, I think I probably would've felt less prepared (240.14)

Another, the one whose client died during the course of therapy, discovered that having had a few years of clinical experience had made the difficult situation of losing a client more manageable than it might otherwise have been:

> The fact that I have this experience with a client dying, I'm sure that it helps to have, y'know, 2 or 3 years of…other sorts of experience before. I had built up, sort of, a comfort level with therapy, and, just psychotherapy and all that stuff, before it happened. (954.26)

With elderly individuals (non-clinical). Finally, three participants referred to personal experiences with elderly individuals, at some time in their life, as being a resource that they drew from during the course of this experience. All examples of such experiences made reference to participants' grandparents, as seen in the following two examples:

> I had moments where I sat with him and he would tell me stories about his life, and it reminded me of sitting with my grandmother, and doing the supportive thing. But I was conscious of it, I guess, that I had been in that role before. (954.13)

> Well, like I said, I think I've had a *lot* of exposure to older adults, just based on my family, and being raised in, kind of, an older church, and things like that. So, I'm sure that that…helped me to feel more comfortable, and would help me to feel more comfortable with any gero patient. (537.18)

Domain 4: Interest in Geropsychology – Pre vs. Post

Pre: Ambivalent, but Open

Four participants explained that, while they may not have been particularly *interested* in doing clinical work with geriatric populations, they were, to some degree, open to giving it a try. As one participant explained very succinctly, "No, I wouldn't say that [working with elderly clients was an area of interest for me], but it wasn't *dis*interest, either, y'know? It wasn't something I would *never* want to do, but not particularly interested" (537.15). Another participant, despite stating prior disinterest in the work, purposely chose to complete a practicum at a facility that treats geriatric patients almost exclusively: "I was not interested in doing it prior to, um, coming into the clinic. I actually, like I said, I made myself work with this population because I didn't have any thought about them at all, prior to doing it" (127.20). This particular participant explained elsewhere in the interview that it was an awareness of the changing demographics of this country and the increasing mental health needs of the elderly populations that had informed the decision to seek out this training opportunity.

Pre: Yes, Prior Interest

Only two participants specifically reported having had a pre-existing interest in doing clinical work with older adults. One participant's interest was explained by an interest in a broader psychological topic: "I have a real interest in, like, existential issues…so I'm really intrigued by that stage of life" (954.22). The other stated simply, "It's been an area that I…I was

interested in it. I didn't think I wanted to specialize in it, but it was something I was interested in, just, working with older adults" (240.14).

Openness to treatment influenced by personal experiences. For the six clinician-trainees who reported either ambivalence to or actual interest in working with elderly populations prior to their first therapy experience with an older adult, there were a number of different influences that were cited as having shaped their prior interest. All six cited prior personal experiences with elderly individuals as having been a factor in shaping their interest. As one interviewee stated:

> I think, because of…people I have in my life who are elderly, I think I just have a strong appreciation for people in that stage of life…and for the life they've had. And so, I think that has, y'know, kept me kind of open, and interested in working with that population. I see it…I see it as a really wonderful part of life, with its own set of challenges, and, um, I think it's because I've been exposed to that, I think that's why I have that mentality. (240.16)

Another participant, with a very strong grandmother relationship, had not been completely aware of the degree to which this relationship had shaped her interest in working with older adults. For this individual, reflecting on the first elderly client seen for therapy was eye opening: "I guess it just sort of highlighted for me how much prior experiences with an older person can influence, like, our willingness or wantingness to work with older folks, um, clinically and professionally, later on" (954.26).

Openness to treatment influenced by peers. Nearly half (3) of the clinician-trainees interviewed cited a peer (or peers) as having been a factor in piquing their interest in working with this population. For one, this was in the form of conversations with classmates:

> I don't think I had much thought [about geropsychology], actually, before. That's why I actually chose this practicum, because of the conversations and things that started up [among classmates] during my first year, and I was like, "You know what? This is something that I need to go and think about." (127.10)

Another participant had a peer who worked with the bereaved, conversations with whom had sparked an interest in geriatric populations:

> I have a friend who does…he's a director of bereavement counseling at a hospital up here, and…I've heard a lot about a little bit of his work, and he works with a lot of elderly populations, and it always seemed interesting to me. (240.14-15)

Openness to treatment influenced by self-concept as a generalist. A final area that was cited (by two participants) as having been influential on prior interest was having a pre-existing professional self-concept as a generalist. One interviewee explained,

> Working in CMHC's, you really kinda *have* to be a generalist, just because of what gets thrown at you. It'd be *great* to specialize, but, just the population that I want to work with sort of has such a wide range of issues, that, in some ways, specializing gives you, like, a niche, makes you marketable…but in other ways you kind of pigeonhole yourself. […] In that particular setting, there are, like, so many people who work there, and if you limit yourself too much…you kinda have to be more open, because whoever you're seeing only has so many visits. (418.10)

Later on, this same participant described reacting to opening the elderly client's file for the first time: "When I first saw her file, and I saw her age, I was just like, 'Alright,' <<laughs>> 'I'm gonna have to do this eventually.'" (418.12)

Post: Increased Interest

All but one of the other clinician-trainees interviewed reported an increase in either openness to or interest in working with elderly clients, after having had their first therapy experience with one. For some, this was experienced more as an affirmation of prior interest or openness, as this individual reported: "I think it either increased it [the interviewee's interest in working with elderly clients], or…where it was a question, it kind of answered the question of whether this is something that I would like to do" (954.23).

Similarly, another interviewee stopped short of endorsing an increase in interest in working with geriatric populations, but reported a noticeable increase in how open this

interviewee felt to the idea: "I'm definitely more open…definitely. I don't know if I'll actively *pursue* working with the elderly […] So I guess my interest hadn't *grown* but my *dis*interest had definitely lessened. I'm definitely more open" (418.25).

Most, however, noted a definitive increase in their interest in working with geriatric populations in the future. One participant, reflecting on the experience of doing psychotherapy with an elderly client, stated, "I think it's made me more comfortable with it, and…encouraged my excitement for it" (240.15).

Domain 5: Factors Associated with Future Interest in Geropsychology

Positive Experience

As reported above, nearly all participants reported an increase in their interest in (or, at least, an increase in openness to) working with older adults. Inquiry into factors that were perceived to have been influential upon this change revealed a number of themes. One of the most frequently citied factors (cited by 5 interviewees), was having had an overall positive experience working with their first elderly client. As one participant reported:

> I hadn't really thought about working with this population at all. Then after I worked with this one lady, it…it really changed. I had such a *great* experience with her, and it *was* slow going at the beginning, but after we created this connection it was…it was really special to me. (418.11)

Another participant summed it up this way:

> I'd say it was really positive for me. I really enjoyed working with him, I…I liked experiencing myself when I was working with him, I liked being in that role. […] So in other words, meeting with him changed…yeah, I would say it has sort of shifted my perspective, or enhanced it, in a way that I would really want to go back for more. (954.19/23-24)

For some participants, having had a positive outcome to the treatment was related to an overall positive experience:

> Y'know, feeling that it was, overall, positive, both for she and I [sic]…so, I had my first geropsych therapy client, and didn't…ruin it or something, so of course it, like, makes me more open to do it again. (537.16)

Participants who had had some formal learning opportunities found them to be helpful, and contributed to their positive experience. One participant put it this way:

> The coursework that I've had helped me to open up, and to *see* things from a different way. […] What we did this past year really did help give me a, like…enough information to have a foundation of *some* kind to come in with. (127.18)

Increased Confidence

More than half of participants (4) reported an increase in their confidence in working with their first elderly client. This feeling of confidence, as one participant reported, had already had a positive impact on work with a second elderly client:

> I just started working, a few weeks ago, with my second elderly client, and…I think that the first experience that I had definitely, kind of, set up a level of, y'know, understanding and confidence, and some expectations for the second time. (240.15)

Another participant seemed surprised that having had a brief therapeutic encounter (2 months) still had a noticeable impact on the participant's confidence:

> I think just having that one encounter, therapeutically, made me feel a *little* more comfortable, because now, at least I've seen a patient on the gero unit, and I've had some experience and I guess it's kind of released some of the anxiety that I wouldn't know what to do. […] It was just very normalizing, the whole process. (537.13/15)

Good Supervision

Not surprisingly, good supervisory experiences were cited by more than half of participants (4) as having been important to their increase in interest or openness. One participant's supervisor was described thus, "Extremely, extremely supportive. Very open to hearing my side, very open to…helping me grow in my perspectives. […] Without it, I would not have had a good experience, at all" (127.16/20). Another participant summed up the positive supervisory experience this way:

> I don't think treatment would have gone as smoothly if I hadn't had the same help…it's hard to say. […] I think his help and supervision, in many ways, almost made the treatment a little bit shorter than if I hadn't had him as a supervisor. So…supervision definitely helped me overall in working with her. (418.21)

Shift to a Generalist Frame

A final theme that emerged in Domain 5 had to do with a shift in perception, on the part of those interviewed, from seeing the elderly as a very specific population to one that is more a part of the general population. Three participants articulated an increase in their awareness of the elderly as a population whose needs must be met by generalists, not by specialists alone. One participant summed it up this way:

> I mean, it's such a *huge* part of the population, how can you really, how can that be a specialty? Because it's such a huge segment, it *is* part of the general population. Maybe if it was just working, specifically, with elderly with certain memory problems, that would be more of a specialty. Or, if you were doing kid work, like specifically kids with MR, *that* would be a specialty. But, like, considering the entire elderly population as a specialty, looking at it that way…I can't see that as much. (418.23)

Domain 6: What Would Have Made the Experience Better?

Academic Preparation

When reflecting upon their experiences, participants were asked about what they thought could or would have made the experience of working with their first elderly client a better one. Two themes emerged among participants' answers to this question: academic preparation and supervision.

More / better formal academic training. Every single interviewee discovered their academic exposure to have been inadequate, after having encountered their first elderly therapy client. (This was one of only two instances when a theme was endorsed by all participants.)

Some interviewees focused on the Developmental Psychology classes that they had taken, indicating a general expectation that this particular class is a venue in which topics on

geropsychology ought to be covered, at least to some degree. This was not often the case, as one interviewee recalled, "I think I can remember the instructor saying, 'This is not my specialty.' […] And so…there was maybe one day on late life development" (537.5). Another participant described their school's Developmental Psychology class in this way:

> I think in a lot of ways, the class just kinda, like, focused a lot on the more earlier stages. Just the way the class was focused, there was a lot of focus on the early stages of life, and as soon as we started hitting adulthood, it just kind of…died off. […] It didn't even help prepare me at all…that idea of, "What is it like to be someone who's elderly?" I feel like I had no idea what they might be going through. Whatever I've learned has really been self-taught. (418.4-5)

Other interviewees likened geropsychology topics to general areas of diversity, like race and ethnicity. One participant seemed to expect geropsychology to be infused throughout the curriculum, as other diversity topics are, but instead had the following experience:

> I don't feel like my program even introduced us. Like, you asked about diversity, did they do a good job? Well, I think they did as much as what they could have done. With the elderly? No. We didn't even go there. At all. So, I think at the very least that would've been helpful. (515.21)

Another participant had the experience of geropsychology topics being lumped in with other areas of diversity in a way that was not experienced as helpful:

> [Referring to exposure to geropsychology topics in school]: I've gotta say, really, almost none. It's kind of brought up in terms of, y'know, "Hey, let's remember that diversity doesn't just, uh, have to do with ethnicity…there's age, and religious beliefs, and all these other types of things." Um…but we haven't really *talked* about elderly clients specifically. (863.7)

Many participants reported that having had more academic exposure to geropsychology topics would have made them feel more prepared going into their first therapy experience with a geriatric client. In referring to a class on developmental psychology, one participant reflected, "I think it would've been helpful [in feeling more prepared] if my program would've done…a *little* bit more with the end of the lifespan, than what they did" (515.20). Finally, another participant

summed up how more academic training would have been helpful: "I think there's definitely more I…I'd like to know going into it. […] So at least I'd have some tools in my toolkit to draw upon" (954.21).

Geriatric population is neglected by training programs. Another variation on the theme of academic training was a general feeling that the programs training future clinicians are, in fact, neglecting the geriatric population. This opinion was voiced by 6 participants.

One interviewee felt strongly that schools need to be more proactive regarding geriatric populations: "Because there *are* more elderly clients out there, I think training programs need to at least open the door to students, to realize that this is part of the work that we do" (515.20). Another interviewee echoed this opinion:

> I just think that it's such a huge part of the population, and we have psychologists that work, y'know, specifically with children…and so I feel like we're acknowledging those age groups are specific populations. […] Just as important I think that there are…really important issues specific to that age group [the elderly]. (240.4)

Another participant reflected on what is communicated to future clinicians when schools take a passive stance regarding geropsychology:

> It could be communicating that it's not important. Or…in other ways, that it's a *specialty* area, so if you want to get into it you have to seek out specialization for it. Actually, I think in some ways that even just setting it up as a weekend class alone…we have weekend classes for sleep, there's a weekend class for hypnosis…so, it's like, "This is a specialty." […] So, I think that's kinda what it communicates, that it's not part of the general population who you work with, it's a certain specialty. (418.23)

Supervision: More / Better

A final area that more than half of participants (4) cited as something that would have made for a better overall experience was that of supervision. For one participant, supervision was adequate, but there was simply too little of it: "It [supervision] used to be an hour, which was really great…but now it's half an hour" (863.11).

Other participants, however, had unsatisfactory supervisory experiences. An experience shared by two interviewees was that their supervisor was not entirely unhelpful in terms of content related to geropsychology. What was lacking, however, was support for the trainee in terms of their own subjective experiences and needs to process. One interviewee put it this way:

> I know his style, and so I take certain expectations into my meetings with him. I know I'll get good…information and good feedback, and on that level he was very supportive. Was he willing to sit there and talk with me about my feeling inadequate? No, not really. (515.18-19)

Another participant had the following experience of supervision:

> He was the person who described to me how, um, with dementia, people can be less inhibited. […] But aside from that, in terms of psychologically, he didn't give me any insight into, like, what my client might be experiencing, and what he might need from me. (954.16)

Moreover, this participant was the one whose elderly client died during the course of therapy. The death of a client, of natural causes or otherwise, is widely acknowledged to be a difficult event, even for seasoned clinicians. This clinician-trainee was very unsatisfied with the supervisory support received in the wake of the client's death:

> He was sort of like, "Well, y'know, if you wanna go into health psychology this is something you're gonna have to deal with," and so on, and it didn't make me feel like I was part of something, but rather that this was something that *I* was going to have to deal with... And I wish he had helped me to explore my own feelings about it, rather than, like, present, "Well *I* had a client commit suicide once, and here's what that was like…" which I thought was a) insensitive, and b) completely different. <<laughs>> Yeah, completely different. (954.25-26)

This individual was able to seek out and obtain support from the post-doctoral fellow at the training site. The experience described in the above excerpt, however, highlights the need for supervisors who are able to provide more than just knowledge and skills to their trainees.

Summary

Data analysis identified a total of 31 terminal themes and subthemes, each of which fell within one of six overarching domains. The six domains identified were: expectations vs. reality; subjective experience; resources drawn upon during treatment; interest in geropsychology: pre vs. post; factors associated with future interest in geropsychology; and what would have made the experience better? The direct excerpts from the interview transcripts are a selection of the data that were collected from seven clinician-trainees. Appendix F provides a detailed chart of domains, themes, subthemes, and representative excerpts drawn directly from the transcripts.

Chapter 5: Discussion

The purpose of the study was to investigate how clinical psychologists-in-training experienced their first elderly therapy client. In conceptualizing the study, the investigator identified a need to more thoroughly understand the novel experience, with the hope of shedding light on aspects of this formative experience that influence future interest in working with elderly clients, and in turn provide insights into how geropsychology training might be improved. The following research questions guided the study:

1. Primary research question:

    - How do clinician-trainees (the participants of the study) experience their first elderly therapy client?

2. Issue subquestions:

    - What, if any, common themes emerge among the reported experiences of different participants?

    - Do participants experience their elderly clients differently than they do their other clients? If yes, how so?

    - Do participants feel any differently about working with elderly clients after having worked with one? What, specifically, contributes to this change?

3. Topical subquestions:

    - In what ways do participants think that their academic training did or did not prepare them adequately to work effectively with elderly clients?

    - What, if anything, in their training do participants find to have been particularly helpful (or unhelpful) in working with elderly clients?

    - What, if anything, about the context of the therapy experience (i.e., nature of the training site, supervision, peer support) do they find to have been particularly helpful (or unhelpful) in working with elderly clients?

    - What suggestions might they make to their own graduate program and/or training site about geropsychology training in order to better prepare future students?

These research questions were addressed using a qualitative methodology to analyze the interviews of seven PsyD trainees who had recently worked with their first elderly client in a training setting (practicum or internship). Implications of the results are discussed later in this chapter (please see Table 2 for a summary of the study's key findings, including novel findings as well as findings corroborated by existing literature).

The data were analyzed using IPA methodology (Smith & Osborn, 2003). One of the most valuable features of this method is that its ideal data-collection vehicle is the semi-structured interview, which provides an opportunity for in-depth exploration of an individual's subjective experiences and views. Additionally, IPA takes into account the two-stage interpretive process inherent in all phenomenological research: "The participants are trying to make sense of their world; the researcher is trying to make sense of the participants trying to make sense of their world" (Smith & Osborn, 2003, p. 51). The use of IPA was appropriate for this study because the author wished to gain insight into how trainees made sense of the experience under investigation in order to identify potential strategies not only to improve geropsychology training in general, but also to increase student interest in doing clinical work with older adults.

Finally, before launching into a discussion of the results, it is important to highlight the richness of data gathered. The trainees interviewed were exceptionally honest and open in discussing their experiences, to which they had clearly given much thought. They were admirable in their willingness to discuss unpleasant aspects of their experiences, including feelings of confusion, incompetence, and of not having been adequately trained. This level of insight and ability to self-reflect is, in the author's opinion, a positive reflection on the current state of PsyD training, and it was an honor to participate in every conversation.

Table 2

Key Findings

Novel findings

Participants worried about being able to connect with an older client.

Participants with pre-existing self-concepts as generalists were more likely to be interested in (or open to) clinical work with elderly individuals.

Prior clinical experience with diverse populations was an important resource.

After the experience, a shift to seeing older adults as part of the general population was associated with increased interest.

Participants expected aging-related issues to be covered in developmental psychology courses.

Participants expected their academic programs to address aging-related issues similarly to issues of diversity.

Participants were concerned that the elderly population is being neglected by graduate training programs.

Findings corroborated by prior research

Participants found that the experience did not require an entirely new set of skills.
- (Hendricks & Achenbaum, 1999)

Initially, participants questioned the point of therapy with elderly individuals.
- (Currin et al., 1998; Ford & Sbordone, 1979; Poggi & Berland, 1985; Zank, 1998)

Working with older clients raised existential issues in participants.
- (Currin et al., 1998; Ford & Sbordone, 1979; Lardaro, 1988; Poggi & Berland, 1985; Zank, 1998)

At times, participants felt confused and incompetent.
- (Cummings & Galambos, 2002; Hubbard, 1984; Qualls et al., 1995)

Initially, participants found high-functioning older clients to be intimidating.
- (Cuddy et al., 2005)

Participants experienced confusion about the role of a geropsychologist.
- (Haley & Gatz, 1995; Hinrichsen & McMeniman, 2002; Kropf, 2002)

Academic training positively affected feelings of competence and was related to overall positive experiences.
- (Cummings & Galambos, 2002)

Supervision was experienced as an important resource; good supervision was associated with future interest.
- (Duffy & Morales, 1997; Hubbard, 1984; Qualls et al., 1995)

After the experience of working with their first elderly client, participants felt more confident regarding future work with this population.
- (Hegeman et al., 2002)

Supervisors should have an understanding of the developmental tasks of late life.
- (Duffy & Morales, 1997; Qualls et al., 1995)

Participants wanted more support from supervisors, beyond the teaching of discrete skills.
- (Brant, 1996; Worthen & McNeill, 1996)

Domain 1: Expectations vs. Reality

Themes that were clustered into this domain were all related to expectations that participants had about the nature of doing clinical work with older adults, tempered by what they found to be the reality of the work, after having had their first experience with an elderly therapy client. There was an overall expectation that the work would be different in some significant way. But after the fact, participants found that although there *were* some differences, it was not very different from work with other populations.

The most commonly held expectation, cited by all seven students interviewed, was that being able to connect with a client who may be decades older than them would be difficult, if it were possible at all. Interestingly, this expectation was not something apparent in the literature reviewed on this topic. There is a body of literature on therapist attitudes toward working with the elderly (which was reviewed in Chapter 2 of this study); a fear a not being able to establish meaningful rapport with an elderly client was not found in the literature pertaining to assumptions about work with this population.

There is evidence, however, that many older adults expect that a psychotherapist who is decades their junior could not possibly understand their problems (Zank, 1998). For some interviewees, it seems that their fear of not being able to connect was based, at least in part, on the assumption that an elderly client would be skeptical of *their* comparatively young age: "Would she be open to talking to someone who *she* knew wasn't alive for the majority of her life? So, I think actually a lot of my fear was feeling that *she* may have issues with *me*." What is encouraging is that, while most trainees experienced some initial discomfort in terms of connecting with their first elderly client, they overwhelmingly discovered that connection was, in fact, possible.

There was also a general expectation that psychotherapy with older adults is simply not worth clinicians' time and effort. For interviewees, this belief emerged primarily in speculation about old age, and how long any benefits of therapy would last: "Alright, so they're in their 70's…how much change can you really make? I mean, can you really make a change? And maybe the change only lasts a year or two before they die…was it really worth my time?"

As evident in this excerpt, there was also skepticism of whether older adults are capable of meaningful psychological change. Statements such as these reflect a number of common stereotypes, all of which reinforce the widely held belief that psychotherapy is something better spent on younger patients (Currin et al., 1998; Ford & Sbordone, 1979; Poggi & Berland, 1985; Zank, 1998). Again, however, after having encountered just one older therapy client, trainees articulated a changed view of this work, many of them citing a new appreciation that there is valuable, meaningful psychological work to be done, even in the later years of life, and that this work is worthwhile regardless of how long the benefits might last (i.e., before the individual died). This is very similar to what Hegeman and colleagues (2002) found in a study of a service learning program in elder care for social work students.

Expectations such as these indicate that the dominant metaphor of pathological aging (Hendricks & Achenbaum, 1999) persists. This is not to say that clinical psychology training programs do (or do not) actively participate in this metaphor, or in the biomedical language of decline that maintains it, but it does suggest that introducing clinician-trainees to other, more current theories of aging would be appropriate. Successful aging (Rowe & Kahn, 1997), for example, is one departure from the metaphor of pathology, as discussed in this study's literature review. Introducing this, or other, theories on aging might be a useful approach to modifying trainees' expectations about what is possible, in terms of psychological growth and change in old

age. Exposure to the idea that old age is a period of life rich with opportunity for growth might mitigate trainees' expectations that psychotherapy with older adults is not a worthwhile endeavor, and possibly even increase interest in doing such work.

Overall, there were widely held expectations that therapy with an elderly client would be different than therapy with other clients. However, after having had the experience of working with an elderly client, participants found that, while there were some differences, the overall experience was really not *vastly* different than therapy with other clients they had worked with. This finding is important, because it reflects the widespread assumption that old age is a discrete phase of life, somehow separate from all the stages that came before. That trainees discovered this not to be the case suggests that it would be prudent for clinical psychology programs to adopt a life-span approach to theorizing about aging, as discussed in this study's literature review. This approach is unique in that it does not adhere to the assumption that old age is "a period requiring its own explanatory framework," and instead sees it as "a transitory phase of life having a great deal in common with any other rite of passage" (Hendricks & Achenbaum, 1999, p. 37). If trainees were to be exposed to a life-span approach to aging, it is possible that they will experience less apprehension at the idea of working with elderly clients, and possibly even increase their interest in working with individuals in this stage of life.

A final area, in terms of participants' expectations of the work, involved vague, existentially oriented ideation, for example that the work would be sadder than work with other clients: "Honestly, my first perception was that, for whatever reason, I thought it would be sad <<laughs>> Like, my countertransference would just be a lot of sadness toward that person." One participant voiced having wondered, "What if he died? What if one of my clients died? How do I think I'd respond to that?" Although this expectation had no corresponding

counterpart, as did the expectations discussed above, other researchers have found that therapists, when working with elderly clients, often find themselves confronted with the realities of aging and death, which may highlight their own existential anxieties (Currin et al., 1998; Ford & Sbordone, 1979; Zank, 1998). And, the fear of a client dying while in treatment is a commonly cited reason by therapists reluctant to work with older clients (Lardaro, 1988; Poggi & Berland, 1985). In light of this literature, the current finding indicates that quality supervision must be available to trainees, so that they may adequately process countertransferential themes related to any existential concerns about their own future and aging that may arise (Martin & Prosen, 1976). The existential concerns voiced by trainees may also be reflective of the continued influence of the idea of pathological aging, which may be combated by incorporating alternative, current theories of aging into curricula, as already suggested.

Domain 2: Subjective Experience

The themes that comprise this domain all have to do with participants' subjective experiences of actually doing therapy with their first elderly client. The most often cited features of participants' experiences had to do with feelings of confusion and incompetence. Feelings of confusion were primarily related to the complexity of presenting problems, which were often combined with overlapping medical issues.

As pointed out by Hubbard (1984), feelings of confusion are common as trainees strive to make sense of the complex physical, mental, emotional and spiritual concerns of their elderly clients. Hubbard highlighted the importance of supervision as a venue to appropriately manage confusion, as have Qualls et al. (1995) in their proposed model of geropsychology supervision. Indeed, Hubbard found that persistent feelings of confusion that went unaddressed in supervision can inhibit the establishment of rapport and affect the course of therapy.

While feelings of confusion were related to the overlapping complexities common to older adults, feelings of incompetence were more related to a perceived lack of academic training. Indeed, Cummings and Galambos (2002) found that exposure to aging-related coursework was associated with an increase in students' skills and confidence. Moreover, Cumming and Galambos found that students' perceptions of their own skills and competencies can affect whether interactions with older adults are experienced positively or negatively. This is an important point because, when asked about what aspect of their experience was most influential on feeling more interested in working with older adults in the future, participants of the present study most often reported that having had a positive experience was important.

Also related to feelings of incompetence was having encountered an elderly client who was perceived as being highly competent. That is, some participants found their clients to be much more competent than they had expected, and this discovery lead them to doubt their own competence in terms of being helpful. As one participant related, "she's kind of an exceptional elderly client in that, at 85, y'know, not only was her brain *extremely* sharp…*no* cognitive impairment…just a super-sharp, super-smart lady, and *very* involved in the community." This experience of surprise at encountering a high functioning elderly person is likely evidence of the perseverance of the myth of pathological aging.

It is also an example of Cuddy and colleagues' (2005) finding, according to their *stereotype content model*, that the elderly are seen as being high in warmth and low in competence, and therefore benign. For these participants, encountering an older adult who did not meet these stereotypical expectations seems to have thrown them off-kilter somewhat. The addition of current theories of aging into curricula, such as life-span and successful aging theories, could broaden students' understanding of what's possible in old age, and mitigate the

feelings of incompetence brought on by encountering older clients who are accomplished and high-functioning.

There was also some confusion among participants as to what exactly it is that a geropsychologist does, which clearly indicates a lack of role models in this area. In fact, to the best of participants' knowledge, none of the five academic institutions represented in the study had a core faculty member with geropsychology expertise, though two did have adjunct professors who taught specialized seminars. Indeed, Hinrichsen and McMeniman (2002) have identified a lack of geropsychology role models for clinicians-in-training, which they equate with a lack of awareness of geropsychology as a viable area of specialization.

In terms of the present study, the lack of role models not only shapes students' perception of the field, but also leaves students less prepared for their first encounter with an elderly client. This finding suggests that the strategy of inviting guest speakers, with expertise or experience in geropsychology, to present their research or discuss their work at clinical psychology graduate programs, as proposed by Haley and Gatz (1995) and Kropf (2002), might not only increase awareness of geropsychology as a field, but might also increase understanding of the roles of a geropsychologist, potentially mitigating trainees' feelings of confusion over what it is that a geropsychologist actually *does*.

Domain 3: Resources Drawn upon during Treatment

Participants accessed a variety of resources to aid them in their work with their first elderly client. As already pointed out, exposure to aging-related coursework is associated with an increase in students' skills and confidence (Cummings & Galambos, 2002). Indeed, the three participants who had had formal exposure to aging-related topics cited this training as being an important resource in their work with their first elderly client. Additionally, three other

participants, who had not had any formal exposure in graduate school but had had informal exposure (e.g., through conversations with classmates, or via classmate presentations), reported it to be helpful.

Supervision was also reported to have been an important resource in trainees' experiences with their first elderly client (despite the fact that most trainees interviewed voiced a desire for more and better supervision). This finding echoes Hubbard's (1984) suggestion that supervision is a crucial venue for trainees to be able to address feelings of confusion and overwhelm. One trainee's supervisor had experience in geropsychology supervision, which was found to be particularly helpful: "…a big part of it was he could relate it to my experience, like, 'This is helpful for some,' just relating it to other practicum students who were also working with an older person. I found that really helpful."

Participants frequently cited another resource, beyond academic training and supervision, which was not encountered in this study's literature review. Nearly every participant reported having drawn upon prior clinical experiences—particularly with diverse populations—as having been an important resource. This finding may reflect that current clinician-trainees, relative to prior generations of trainees, are more educated in multicultural psychology and have had more clinical experience with diverse clients, which provides them with a framework to approach elderly clients. With this in mind, the finding that trainees may view the elderly as a population of diversity is not surprising, and it has important implications for training. In 2002, APA (2002b) recommended a strategy of curriculum infusion in order to prepare students for work with diverse populations. The use of this strategy communicates to students the importance of being prepared to treat a wide variety of individuals. Because participants in the current study reported having drawn upon prior experiences with diverse populations while working with their

first elderly client, it is reasonable to conclude that including aging-related issues within diversity-infusion models would be appropriate.

The findings in this domain reinforce what some researchers have already found: that adequate academic preparation and good supervision are vital resources for trainees involved in their formative clinical experiences with elderly clients. Additionally, however, the findings of the current study reveal that trainees are a resourceful bunch. That is, participants who did not have adequate academic training or satisfactory supervisory experiences were able to access other resources, which were not identified in the extant literature. As one participant reported:

> When I've worked with other diverse populations in the past, my approach has always been just…well, just be highly empathic, just let them tell their story, show them you're interested, make them believe that you truly care—which I do, and…and they quickly trust, and then the relationship—usually, but not always, but usually takes off. And so I thought, "Well, I can use those things," y'know, that same approach, and it actually did end up being effective.

What this excerpt reveals is that some participants, in preparing to work with an elderly client for the first time, reasoned that clinical work with an older adult could not possibly require an entirely different set of skills than working with other populations, and thus used prior clinical experiences with diverse clients as a framework for approaching work with this new population. This finding offers support for the suggestion that some have made for the infusion of aging-related material into curricula, much in the same way that has been adopted for preparing trainees to work with diverse populations (Haley & Gatz, 1995; Kropf, 2002). More specifically, Haley and Gatz suggest that an indirect approach, such curriculum infusion, might be protective against inadvertently intimidating students, which is a hazard when too much emphasis is placed

on how much there is to learn, with too little emphasis on the universal human dynamics that transcend age. To this same end, including exposure to the lifespan theory of aging might neutralize the assumption that working with an individual toward the end of their life requires an entirely new set of skills.

Domain 4: Interest in Geropsychology – Pre vs. Post

Only one clinician-trainee interviewed for this study reported a specific disinterest in working with older adults, which persisted throughout the experience with their first elderly client. Of the other six participants, two reported a prior interest in working with elderly clients, and the rest reported that, while they were not specifically interested in this population, they were open to giving it a try. When asked about factors that were relevant to their prior interest in (or openness to) working with older adults, all six reported that personal experiences with elderly individuals (typically grandparents, or in the community, such as a church congregation) were a factor. Indeed, the relationship between personal experiences with older adults and interest in clinical work with them has been reported with some frequency (Cummings & Galambos, 2002; Koder & Helmes, 2008; Hegeman et al., 2002).

Another factor related to preexisting interest (or openness) was participants' perceptions of themselves as generalists, which, however, was not encountered in the literature reviewed for the present study. Although this was cited by only two participants, it has important implications for training. These participants approached their first elderly clients from a generalist stance, which shaped their understanding of the elderly as a population that generalists treat. This is a very realistic approach, because, based on Census data (U.S. Bureau of the Census, 1996), it will be generalists, not geropsychologists, who will necessarily provide the bulk of mental health care to the elderly in the coming decades (Haley & Gatz, 1995; Hinrichsen & McMeniman, 2002).

This finding suggests that curriculum infusion of aging-related material would not only be an appropriate step toward preparing students to do this work, but would have the likely effect of lessening prior disinterest that some students may have.

Reflecting back on their formative clinical experience with an elderly client, the only participant who did not report an increase in interest in working with this population in the future was also the only participant to report a prior disinterest. All other participants reported increased interest in (or, at the very least, increased openness to) working with elderly clients in the future: "I'm definitely more open…definitely. I don't know if I'll actively *pursue* working with the elderly […] my *dis*interest had definitely lessened. I'm definitely more open."

Domain 5: Factors Associated with Future Interest in Geropsychology

In exploring the aspects of their experiences that participants perceived to have been related to their increase in interest in (or openness to) working with elderly clients in the future, a number of factors were reported. The factor most frequently cited was having had a positive experience. Of course, it is difficult to identify exactly what made the experience positive, especially since nearly all of them had also reported having felt confused and/or incompetent. For some, having a positive treatment outcome was experienced as contributing to an overall positive experience. Another participant noted that there was something different, which was experienced very positively, about sitting with an elderly client:

> I really enjoyed working with him, I…I liked experiencing myself when I was working with him, I liked being in that role. […] So yeah, I would say it has sort of shifted my perspective, or enhanced it, in a way that I would really want to go back for more.

Two participants, who had reported at least some formal exposure to aging-related material in their coursework, felt that this preparation contributed to their overall positive

experiences: “Feeling like I did at least receive a good enough basis in my geropsych course, I guess that I […] felt like I was fairly competent.” This finding is important, and corroborates Cummings and Galambos’ (2002) finding that social work students who had received academic training for work with older adults were more likely to perceive contact with elderly clients during field training as rewarding, and they reported more interest in working with this population than classmates who had not received any academic training.

Several other participants in the current study reported that they felt more confident, having this first experience behind them, as though having been through it dispelled some of their preconceived notions and reassured them that the work was doable: “I guess it’s kind of released some of the anxiety that I wouldn’t know what to do. […]. It was just very normalizing, the whole process.” This increase in confidence was similar to that observed by Hegeman and colleagues in their 2002 study of social work students. These findings highlight the importance of field experience when it comes to generating student interest in geropsychology, a recommendation that many have already made (Cummings & Galambos, 2002; Hegeman et al., 2002; Hinrichsen, 2000; Kropf, 2002).

Another area that participants reported as being influential on future interest in elderly clients was supervision, which is not surprising considering the literature reviewed on this topic. Supervisors who had prior experience supervising students working with elderly clients were experienced as having been particularly helpful. Additionally, having a supervisor who was able to help students process, for example, feelings of confusion and incompetence, was also associated with increased interest. Not surprisingly, both of these features of participants’ experience have been cited as being key elements to good geropsychology supervision (Duffy & Morales, 1997; Hubbard, 1984).

A final note on the topic of increased interest, which was also related to preexisting interest (or openness), has to do with having a generalist frame. Three participants described experiencing a shift in their understanding of the elderly, from a population with very specialized needs, to be treated by specialists, to a population that is a part of the larger, general population, who can be adequately treated by generalists. As mentioned elsewhere, it will indeed be generalists, not geropsychologists, who will provide the bulk of mental health care to the elderly in the coming decades (Haley & Gatz, 1995; Hinrichsen & McMeniman, 2002). That some trainees reported that reconceptualizing older adults as part of the general population lead to increased interest in (or openness to) working with older adults in the future is an important finding. First, it once more underscores that field experience is invaluable. Moreover, it is another piece of evidence, not encountered in the extant literature, that supports existing recommendations that aging-related material be infused into graduate curricula, much in the same was as has been done in recent years with topics of diversity.

Domain 6: What Would Have Made the Experience Better?

The themes in the sixth domain are concerned with what the participants in this study felt would have contributed to making the overall experience more positive. Findings in this area are important because, as reported above, positive experiences were related to increased interest.

First and foremost, every single clinician-trainee interviewed voiced a desire for more and/or better academic preparation. Several participants seemed to expect aging-related issues to be addressed in a developmental psychology course, and they found themselves disappointed in this regard: “The class just kinda, like, focused a lot on the more earlier stages of life […] and as soon as we started hitting adulthood, it just kind of…died off. […] It didn’t even help prepare me at all.” This experience was shared by several participants, suggesting that a developmental

psychology class is most certainly an appropriate venue in which to introduce aging-related issues, and that some training programs are falling short in this regard. Furthermore, when a class such as this fails to address late-life issues, it may contribute to the perception that older adults are not a part of the general population. As earlier findings in this study have suggested, a useful approach to increasing students' competence and interest could be to integrate aging-related issues into training in such a way that it communicates that older adults are a population appropriately treated by generalists. To this end, programs must do a better job at addressing late life issues in developmental psychology classes.

Several participants also voiced expectations that aging-related issues ought to be addressed similar to the way in which diversity issues are addressed: "I don't think we spend as much time on [elderly populations] as we do on other diversity factors, like, say, racial diversity or socioeconomic diversity." This expectation again suggests that curriculum infusion of aging-related issues would be an appropriate step to increasing interest, as has already been called for (Haley & Gatz, 1995; Hinrichsen, 2000; Hinrichsen & McMeniman, 2002; Kropf, 2002).

Participants not only voiced a desire for more and/or better academic training, there was also a consensus that geropsychology is, in a sense, being neglected by training programs. Some participants had at least some awareness of the growing elderly population in the U.S., and felt that graduate programs have a responsibility to prepare students for work with older adults: "There *are* more elderly clients out there: I think training programs need to at least open the door to students, to realize that this is part of the work that we do." Other participants voiced an opinion that the way in which aging-related issues are addressed by some training programs communicates certain assumptions to students. On the lack of formal training opportunities, one participant noted:

> It could be communicating that it's not important. Or…in other ways, that it's a *specialty* area, so if you want to get into it you have to seek out specialization for it. Actually, I think in some ways that even just setting it up as a weekend class alone…we have weekend classes for sleep, there's a weekend class for hypnosis…so, it's like, "This is a specialty." […] So, I think that's kinda what it communicates, that it's not part of the general population who you work with, it's a certain specialty.

As noted in this study's literature review, students' perception of the field of geropsychology is important (Haley & Gatz, 1995; Kropf, 2002), and a lack of training and role models affects this perception (remember, not one of the five graduate programs represented in this study had a core faculty member with expertise in geropsychology). One participant who was on internship offered an example of how training opportunities can affect perception: "I know a few graduate students who are specifically interested in geropsychology. We have a geropsychology-specific rotation, well, not a rotation but actually an entire *track* on our internship… So, yeah, I mean, it seems to be…blossoming." This participant was not completing the geropsychology track, but the fact of its existence communicated something to this participant about the viability of geropsychology now, and in the future.

Supervision was the other area that most participants highlighted as something they would have liked more of (in terms of quantity as well as quality). While a few participants did have satisfactory supervisory experiences (which were influential on increased interest), several had unsatisfactory supervisory experiences. This situation is unfortunate, because good supervision is believed by many researchers to be the key ingredient of field training that fosters clinical expertise (Duffy, 1992; Duffy & Morales, 1997; Qualls et al., 1995).

In supervision in general, two broad factors have emerged as necessary prerequisites for positive supervisory experiences: a good relationship and attention to the task of developing counseling skills (Worthen & McNeill, 1996). While most participants had supervisors who, at least, were able to provide knowledge and skills related to working with their first elderly client, many had supervisors who did not foster a warm and supportive relationship: "I know I'll get good…information and good feedback, and on that level he was very supportive. Was he willing to sit there and talk with me about my feeling inadequate? No, not really." This experience corroborates Brant's (1996) finding that geropsychology trainees felt that skill areas (e.g., assessment and diagnosis) were addressed more frequently in supervision than were personal issues (e.g., countertransference and ageism). It also echo's Brant's finding that interns felt more dependent on their supervisors than was perceived by their supervisors.

To increase competencies, supervisors working with clinician-trainees around aging-related issues must have an understanding of the developmental tasks of late life (Duffy & Morales, 1997; Qualls et al., 1995). Without this, trainees are left on their own to figure out what the psychological needs of their elderly clients are, which was the experience of one participant:

> He [the supervisor] was the person who described to me how, um, with dementia, people can be less inhibited. […] But aside from that, in terms of psychologically, he didn't give me any insight into, like, what my client might be experiencing, and what he might need from me.

This participant's experience offers evidence that the difference between experience alone and supervised experience is vast (Qualls et al., 1995), and underscores the reality that good supervision involves much more than the transmission of discrete skills. However, it is

important to acknowledge that doctoral level trainees are also accountable to their client populations by reading up about them, which could be encouraged and facilitated by supervisors.

Limitations of the Study

Based on the need to more fully understand how clinical psychology PsyD students experience their first elderly therapy client, the qualitative open-ended methodology of IPA was identified as the most appropriate means of data collection. However, there are limitations to the study. First and foremost, though the sample size was appropriate for a study of this nature, it was small and, therefore, generalizations about participants' experiences must be made with caution. Additionally, although specific inclusion criteria were used in an effort to recruit participants that had recently gone through working with their first elderly client, each participant's narrative was, of course, unique. Participants varied in age, were at different points in their training, and encountered their first elderly client in very diverse settings. This means that there are a number of potentially confounding factors that affected students' experiences that were not able to be controlled for—although this, of course, is a reality of conducting qualitative research.

Another limitation related to the use of IPA methodology is that it calls for one individual, the primary investigator, to analyze transcript data. Though this approach allows for a thorough analysis of the data through a prolonged immersion in the transcript data, it also limits the reader's view to a single lens: that of the primary researcher. Though a number of quality control methods were maintained throughout the course of the study, it is implicitly understood that the goal of qualitative research is not to arrive at objective facts. As summed up by Smith and Osborn (2003), the goal (of IPA specifically) is to "explore personal experience and is concerned with an individual's personal perception or account of an object or event, as

opposed to an attempt to produce an objective statement of the object or event itself" (p. 51). Smith and Osborn further acknowledge that this methodology necessarily involves a two-stage interpretive process: "The participants are trying to make sense of their world; the researcher is trying to make sense of the participants trying to make sense of their world" (p. 51). Thus, in the present study, personal factors unique to the primary investigator may have unconsciously influenced her interpretation of the data as she made efforts to understand participants' understanding of their own experiences.

It is also important to note that three of the study's participants were all students at the same PsyD program, which represents 43% of the sample. Though these participants were at different stages of their training and had diverse field training experiences, it is possible that the data, possibly even the interpretation of the data, were affected by the fact that three of seven participants were receiving training at the same program. Additionally, one of the seven interviews was conducted in person, on the grounds of the institution attended by the participant. It is possible that this face-to-face interview somehow shaped how the interview unfolded, in a way that was different from the other six interviews, each of which was conducted via telephone.

A final limitation of the study was the selection of 65 as the lower-bound age limit for participants' clients. People's definitions of "old" vary, and to one potential participant, "elderly" may mean over 60 and to another it may mean 85 years plus. In designating this cutoff age, the intention was not to impose an arbitrary definition of "old." Very simply, a cutoff age was necessary, and 65 was chosen in order not to rule out too many potential participants and to increase the likelihood of recruiting an adequate sample. Of course, as the human lifespan continues to increase and health during later years improves, the experience of growing old in

America is becoming ever more varied, which was reflected in the diverse characteristics of the clients with whom the study's participants had worked.

Future Directions

The present study's findings offer jumping-off points for a number of future areas of research. One area that seems particularly rich is that of supervision. Although the body of extant literature on the topic of supervision, per se, is not small, there is clearly more to be understood about the unique supervisory needs of clinician-trainees during their formative therapeutic encounters with elderly clients. For instance what, more specifically, makes for "good" geropsychology supervision? What needs are unique to students working with their first elderly clients, and how are they different from more universal supervisory needs, as identified in the general supervision literature (Heppner & Roehlke, 1984; Worthen & McNeill, 1996)?

Another rich potential area for research would be to focus on teasing out, with more specificity, the factors that contribute to an overall positive experience with geriatric clients. The present study confirmed that having had a positive experience was an influential factor on increasing future interest in working with older adults, and identified some elements that appeared to have contributed to participants' positive experiences (i.e., having a positive treatment outcome and having had some academic exposure to aging-related issues). A more thorough understanding of what makes this experience a positive one would be useful toward future efforts to ensure that more clinician-trainees have positive experiences, which would likely, according to the findings of the current study, leave them feeling more interested in (or at least open to) doing clinical work with older adults in the future. Of course, there are countless other areas related to this topic that are worthy of future investigation (e.g., exploration of existential issues, or how the setting in which an elderly client is encountered affects trainees'

experiences). The two areas highlighted above are simply suggestions, based on the findings of this study.

Researcher's Reflections

My interest in the topic of therapy with elderly individuals emerged as I immersed myself in studying clinical psychology (from 2006 to the present), and I soon became aware that this interest was, in large part, propelled by my own parents' aging. During visits home, which typically occur five or six times each year, I gradually realized that my father, for example, has become an old man—no longer is he the robust, energetic man I hold in my mind's eye. Somewhere along the way, without my really noticing it, he started growing old, and now each time I visit it seems I notice this more and more: his ever-thinning hair, his failing sense of taste and smell, the shuffling gait and tremors in his hand as he takes a phone message. Not long after I began noticing these things, he was diagnosed with Parkinson's disease.

During my training over the past several years, I find that I have been seeing my world, including my parents, through the newly acquired lens of a clinical psychologist-in-training. At some point it occurred to me, "What would I do if this person came to me for therapy?" I am a young, healthy woman, with my whole life ahead of me (as the saying goes). My father is an old man whose very body is failing him and who knows that his life is slowly but surely drawing to a close. What would his needs in therapy be? Would I be able to meet those needs?

So, there is a very personal layer to my interest in clinical work with older adults, and it has pushed me to seek out opportunities to learn about and gain clinical experience with elderly individuals. But, what about my classmates, who did not necessarily have an interest in, or even an awareness of, the work that can be done with this population? I kept expecting it to be addressed by my graduate program, in some way or another. Indeed, during my first two years

of school, I heard much about the importance of being aware of the therapeutic implications of working with clients who are culturally diverse, including in a semester-long required course, called Human Diversity and the Clinical Enterprise.

For the most part, the descriptor "diversity" seemed to include people who are of diverse races, ethnicities, or cultural backgrounds, or hail from foreign countries, and some of our classes have touched upon disabilities, socioeconomic status, and having been raised in rural vs. urban settings as issues of diversity, as well. There was a weekend course in gay, lesbian, bisexual, and transgender concerns in clinical work, and in the spring of 2010 our Department offered, for the first time, a weekend course on clinical work with the elderly, which I took during the last semester of my four-year academic program. In the spring of 2011, a core faculty member will provide an elective, semester-long course on this topic. However, during the first two years of my training, I kept finding myself wondering when we would talk about the implications of doing therapy with an individual who is several decades my senior.

My growing interest as I embarked on this research was propelled by a hunch that if working with a client who is your contemporary but is of a different race, ethnicity, culture, nationality, sexual orientation, and/or socioeconomic status warrants investigation by countless researchers and the publication of numerous comprehensive handbooks, then working with an individual who was alive for forty, fifty, or even sixty years before I was born must warrant some attention as well. Indeed, as I discovered in the early stages of my research, both APA and APPIC share this stance (APA, 2002b, 2005, 2007; Daniel, Roysircar, Abeles, & Boyd, 2004). These discoveries led me to wonder, Why is my program not introducing us to relevant issues pertinent to working with elderly individuals? How might this lack of attention affect my

classmates' interest in working with older adults? And, might there be a deficiency in our competencies as we enter the predoctoral internship phase in the fifth year of our training?

Since beginning this research in the fall of 2007, I have encountered a number of elderly clients in various training settings, and pursued any available opportunities to educate myself. I have been frustrated also by the pre-doctoral internship process and disappointed by how few sites have a formal focus on geropsychology (and still more disappointed, as I begin to survey post-doctoral fellowship opportunities). I have seen my parents continue to age: There was a moment—sometime in the past two or three years, though no one could possible pinpoint it—when my mother's blonde hair became "silver," as she likes to call it. It is a far cry from the long, blonde locks she prized as a young Swede, but still beautiful. It's gone at the moment though, as she undergoes chemotherapy for breast cancer.

In completing the study, I have come to a better understanding of how clinical psychology graduate students experience their first elderly clients, and of the unique challenges they face, both in anticipation of the work and during it. I have determined that many of the suggestions already put forth in the literature are well-founded, and I have discovered some new information, leading to some new suggestions. I have great hope that, as training programs begin to address aging-related issues more appropriately, more and more trainees will see this work as a natural part of their professional roles. I have also discovered that clinical psychology students are a remarkably resourceful bunch. Consider the participants in my study: if they did not feel prepared, they sought out other sources of knowledge, or referred back to other experiences to establish a map, something with which to orient themselves. If supervision was inadequate, they found other sources of support. They did not give up, and though not every treatment outcome

was positive, each participant felt that they had done some good for their client, even if only on a small scale.

Conclusions and Recommendations

The purpose of this study was to learn more about how PsyD clinicians-in-training experience their first elderly therapy client. Moreover, the primary researcher's hope was that learning about participants' lived experiences would shed light upon specific factors of the experience that increase future interest in working with, or learning more about working with, elderly individuals.

The study showed that, prior to the experience, participants' expectations about the nature of therapy with an elderly individual were telling. There were stereotypical assumptions about older adults, which have been identified elsewhere in the literature, indicating a need for more academic training in aging-related topics. There were widely held expectations that the work would be different, in any variety of ways, from work with other populations. Interestingly, there was one expectation, voiced by all participants, but which was not identified in the literature reviewed: a fear of not being able to connect (or of having great difficulty connecting) in a meaningful, therapeutic way, with an elderly client. This finding indicates that clinician-trainees may view old age a discrete phase of life, requiring a novel approach and skills. This misperception might be preemptively addressed by training programs through curriculum infusion models (Haley & Gatz, 1995; Kropf, 2002) and exposure to current theories of aging, such as life-span and successful aging theories (Hendricks & Achenbaum, 1999; Rowe & Kahn, 1997). It was also notable that the clinician-trainees in the present study were deeply invested in the therapeutic relationship, which may be particular to PsyD training.

Participants in the study also voiced, unanimously and unequivocally, a desire for more academic training in topics related to clinical work with older adults. Other researchers have already identified that trainees who have a positive overall experience with an elderly individual early in their training will be more likely to have a future interest in this population (Cummings & Galambos, 2002; Schigelone & Ingersoll-Dayton, 2004). Participants in the present study essentially divulged what, specifically, *they* would have wanted to make their experiences more positive. For example, they expected a class on developmental psychology to cover old age and were disappointed when this did not occur. They also expected aging-related topics to be covered in a similar way that topics related to diversity are: through curriculum infusion. This finding confirms the literature's call for curriculum infusion as an important first step to preparing trainees for work with older clients (Haley & Gatz, 1995; Kropf, 2002). Finally, several participants stated that their generalist orientation provided them an important framework for working with their first elderly client. This view was not something encountered in the literature, but offers support for an approach that frames the elderly as a part of the general population, with, of course, opportunities for more advanced study.

It is interesting to note that, although every single participant in this study felt unprepared, six out of seven reported an increase in interest in (or at least openness to) working with elderly individuals in the future. This finding begs the question: Does this mean that academic preparation is not, really, all that important? The answer is an unequivocal *no*. Every student felt that more would have been helpful. What it does mean is that trainees are very resourceful! If they did not feel prepared, they sought out other sources of knowledge. If their supervision was lacking, they identified and accessed other sources of support. This finding also suggests that, even for someone who is ambivalent about this work (which is likely most

students), exposure to at least one elderly client is critical in increasing future interest. Moreover, other findings elsewhere in the study suggest that better academic preparation might increase student interest in seeking out opportunities to gain experience with older adults. Academic exposure also increases the likelihood that, when a student does have his or her first experience, it will be a positive one, which is also associated with future interest.

Finally, participants in the study wanted more and better supervision. As has been highlighted many times over, supervision is perhaps the most crucial aspect of field training experiences (Duffy, 1992; Duffy & Morales, 1997; Qualls et al., 1995). The specific needs voiced by participants in the study aligned with current understandings of "good" supervision (Worthen & McNeill, 1996). Very simply, participants wanted skills and knowledge, with which they were provided (in most cases), but they also wanted much more support and opportunities to process feelings of confusion and self-doubt than were made available. This finding underscores not only a concerning situation, but also a need for continued research into discovering, with more specificity, the unique needs of trainees during their formative clinical experiences with older adults, and also of the unique challenges facing those who supervise them.

There was also awareness, among a few participants, that clinical psychology generalists will necessarily treat older adults, which, based on demographic data (U.S. Bureau of the Census, 1996), is a fact (Haley & Gatz, 1995; Hinrichsen & McMeniman, 2002). In this regard, there was a widely held view that clinical psychology programs are doing a disservice, both to trainees and to the elderly as a population, by not doing a better job of preparing students for work with this population. There is a great deal to be said about the current state of the field and how students' perceptions of it are shaped. The lack of attention to aging-related issues in clinical courses and the lack of faculty with expertise in geropsychology communicate to trainees

that the population is not important, and that geropsychology is not an area of specialization that is as viable, or as important, as others. The inadequacy of supervision also communicates that this work is, to a degree, an afterthought.

On a final note, the power of perception must not be underestimated (DeVries, 2005; Duffy & Morales, 1997). As one participant noted, the simple fact that her internship had an entire track devoted to geropsychology modified her perception of the field, and she came to see it as an important area of specialization. Another participant, at the close of our interview, noted that the fact that one of her peers was out there doing this specific research influenced her perception of the work: "Even just having participated in an interview, it might…spark my interest, and I might say, 'Oh! Hey, I should go do that.'"

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Appendix A

Clinical Curriculum of Geropsychology PhD Program
at the University of Colorado at Colorado Springs

Courses	**Skills**
	Clinical Interviewing Skills
Clinical Skills Lab	Basic listening skills Interview skills: paraphrasing, questioning, confrontation
Clinical Interviewing/ Personality Assessment	Directed Interviewing Mental status evaluation Social history
Psychotherapy	Interviewing in different theoretical frameworks
Clinical Practicum	Clinical interviews with clients
	Assessment Skills
Cognitive Assessment	Framing the assessment problem, choosing tests, administering and scoring tests, interpreting and conceptualizing data, report writing
Neuropsychological Assessment	Choosing tests, administering and scoring tests, interpreting and conceptualizing data, integrating findings from multiple tests, feedback in writing and orally
Clinical Practicum	Assessment of psychopathology, cognitive impairment, family systems, community systems
Clinical Interviewing and Personality Assessment	Objective assessment of personality and psychopathology, integrating testing results with clinical interview, report writing
	Case Conceptualization
Clinical Skill Lab	Conceptualizing information from behavioral observation and interview analysis
Psychotherapy	Knowledge of conceptual frameworks of major theoretical orientations, choosing framework match for client and therapist, conceptualizing cases from selected frameworks
Professional Development 2 —Diversity	Conceptualizing cases using social/cultural and family systems models, conceptualizing cases from practicum site
Clinical Geropsychology 1 —Settings and Contexts	Conceptualizing aging client cases in context of service network, housing, and health systems
Clinical Geropsychology 2 —Assessment/Treatment	Conceptualizing aging client issues using major theoretical frameworks and empirical research base, analyzing and evaluating ongoing treatment process with aging clients

Appendix A, continued

Clinical Practicum	Conceptualizing cases in clinical practice settings
	Intervention Skills
Clinical Skill Lab	Interview skills as interventions
Psychotherapy	Linking theoretical frameworks with intervention strategies
Clinical Geropsychology 2 —Assessment/Treatment	Intervention strategies for older clients associated with major theoretical frameworks
Clinical Practicum	Intervention skills in clinical practicum setting
	Professional Functioning
Clinical Skill Lab	Professional role development; ethics of interviewing
Professional Development 1	Ethics and standards of clinical practice
Professional Development 2 —Diversity	Cultural and family diversity
Clinical Geropsychology 1 —Settings and Contexts	Working in variety of settings relevant to older adults
Clinical Practicum	Functioning in clinical setting with appropriate ethics, standards of practice, and clinical skill while using supervision well

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Appendix B

APA Guidelines for Psychological Practice with Older Adults

Attitudes

1. Psychologists are encouraged to work with older adults within their scope of competence, and to seek consultation or make appropriate referrals when indicated.
2. Psychologists are encouraged to recognize how their attitudes and beliefs about aging and about older individuals may be relevant to their assessment and treatment of older adults, and to seek consultation or further education about these issues when indicated.

General Knowledge about Adult Development, Aging, and Older Adults

3. Psychologists strive to gain knowledge about theory and research in aging.
4. Psychologists strive to be aware of the social / psychological dynamics of the aging process.
5. Psychologists strive to understand diversity in the aging process, particularly how sociocultural factors such as gender, ethnicity, socioeconomic status, sexual orientation, disability status, and urban / rural residence may influence the experience and expression of health and of psychological problems in later life.
6. Psychologists strive to be familiar with current information about biological and health-related aspects of aging.

Clinical Issues

7. Psychologists strive to be familiar with current knowledge about cognitive changes in older adults.
8. Psychologists strive to understand problems in daily living among older adults.
9. Psychologists strive to be knowledgeable about psychopathology within the aging population and cognizant of the prevalence and nature of that psychopathology when providing services to older adults.

Assessment

10. Psychologists strive to be familiar with the theory, research, and practice of various methods of assessment with older adults, and knowledgeable of assessment instruments that are psychometrically suitable for use with them.
11. Psychologists strive to understand the problems of using assessment instruments created for younger individuals when assessing older adults, and to develop skill in tailoring assessments to accommodate older adults' specific characteristics and contexts.
12. Psychologists strive to develop skill at recognizing cognitive changes in older adults, and in conducting and interpreting cognitive screening and functional ability evaluations.

Appendix B, continued

Intervention, Consultation, and other Service Provision

13. Psychologists strive to be familiar with the theory, research, and practice in various methods of intervention with older adults, particularly with current research evidence about their efficacy with this age group.
14. Psychologists strive to be familiar with and develop skill in applying specific psychotherapeutic interventions and environmental modifications with older adults and their families, including adapting interventions for use with this age group.
15. Psychologists strive to understand the issues pertaining to the provision of services in the specific settings in which older adults are typically located or encountered.
16. Psychologists strive to recognize issues related to the provision of prevention and health promotion services with older adults.
17. Psychologists strive to understand issues pertaining to the provision of consultation services in assisting older adults.
18. In working with older adults, psychologists are encouraged to understand the importance of interfacing with other disciplines, and to make referrals to other disciplines and / or to work with them in collaborative teams and across a range of sites, as appropriates.
19. Psychologists strive to understand the special ethical and / or legal issues entailed in providing services to older adults.

Education

20. Psychologists are encouraged to increase their knowledge, understanding, and skills with respect to working with older adults through continuing education, training, supervision, and consultation.

The guidelines have been retrieved from:

American Psychological Association. (2004). Guidelines for psychological practice with older adults. *American Psychologist, 59,* 236-260.

Appendix C

Participant Recruitment Letter/E-mail

Hi, my name is Cristina Filippelli, and I am a student in the Department of Clinical Psychology at Antioch University New England. I, along with my supervisor, Gargi Roysircar, PhD, invite you to participate in a study on geropsychology education and training. This study, which constitutes my dissertation, will focus on how clinicians-in-training experience their first elderly therapy client.

- Individuals who are students in PsyD clinical psychology programs, and have recently (within the past 6 months) completed their first psychotherapy encounter with an elderly client (age 65 or older) are encouraged to participate.

- Participation entails a one-on-one interview with the researcher (approximately 60 to 90 minutes), preferably face-to-face or via telephone if necessary, to be scheduled at each participant's convenience.

- I understand that graduate students have very busy schedules, and so will offer an honorarium to all who participate, in appreciation of making time for my research. (Participants may choose a $20 gift card to either Dunkin' Donuts or Starbucks).

- Participation in this study is completely voluntary and confidential.

If you meet the above criteria and are interested in participating in this study, please contact me directly to confirm eligibility, review informed consent, and schedule an interview. If you know someone who meets the above criteria and who may be interested in participating, please forward this message to them.

If you have any questions about this study, please do not hesitate to contact me, the principal investigator, at the address below.

Thank you in advance for your interest in and support of my study.

Sincerely,

Cristina E.M. Filippelli, M.S.
Doctoral Candidate
Department of Clinical Psychology
Antioch University New England
40 Avon Street, Keene, NH 03134
603-283-2182
cfilippelli@antioch.edu

Appendix D

Informed Consent Form

Project Title: First elderly client in therapy: Factors that influence student interest in geropsychology

Principal Investigator: Cristina E. M. Filippelli, M.S., Clinical Psychology Doctoral Candidate

Address: Department of Clinical Psychology
Antioch University New England
40 Avon Street, Keene, NH 03134
Phone / Email: (603) 283-2182 / cfilippelli@antioch.edu

Advisor: Gargi Roysircar, Ph.D.
Address: Same as principal investigator's
Phone / Email: (603) 283-2186 / groysircar@antioch.edu

Thank you for considering taking part in this research project. By signing this consent form you indicate that you have been informed about the conditions, risks, and safeguards of this project.

- The purpose of this study is to gain understanding into how clinician-trainees currently enrolled in Psy.D. programs experience their first elderly therapy client. Questions will also focus on graduate training experiences with and exposure to diversity issues and geropsychology.

- Interviewees understand that their participation in this study is voluntary and that they may, at any time during or after the interview, discontinue participation.

- Potential risks of participation include the fact that some of the interview questions may result in feelings of discomfort. To minimize this risk, interviewees may decline to answer any question.

- Potential benefits to participants include having the satisfaction that the study will enrich the growing body of literature on geropsychology training and recruitment of trainees.

- Interviews (either face-to-face when possible or via telephone) are expected to last 60 to 90 minutes, and will be scheduled at each participant's convenience. All interviews will be audiotaped.

- After the data are collected, interviewee names will be replaced with codes. No specific mention of interviewees' names—or names of the institutions which they attend—will be made in any report of this study. Themes will be developed across cases and will not be linked to any particular interviewee. Quotations may be used to substantiate themes, but these will not be accompanied by any interviewee's name.

Appendix D, continued

- All hard copies of the data will be stored in a locked fireproof cabinet, and electronic data will be stored on a password-protected laptop computer; only the principal investigator will have access to either. All identifiers will be removed from transcriptions, which will be coded. After the project is completed, the tapes will be destroyed. Only the transcripts will be stored for an additional two years for verification, if requested, by third parties, after which the transcripts will be destroyed.

- Because the intended sample is small, it is possible that the primary investigator may recognize information about particular participants during analysis of the data. The researcher will, however, take every possible step to protect participants' confidentiality.

- Interviewees understand that, though they will not be compensated for their participation, they will receive a nominal honorarium (not to exceed $20), in appreciation for taking time out of their busy schedules to take part in this study.

- Interviewees have been given the opportunity to ask questions about this study, have asked them, and have received satisfactory responses.

- If interviewees would like to know the results of this study, they may contact the primary investigator after May, 2011.

- If interviewees have any further questions about the study, they may contact the primary investigator or her dissertation chair, Dr. Roysircar (groysircar@antioch.edu).

- If interviewees have any questions about their rights as a research subject, they may contact Dr. Kevin P. Lyness, Chair of the Human Research Committee (HRC), at (603) 283-2149, or via email at klyness@antioch.edu They may also contact Dr. Katherine Clarke, Vice President of Academic Affairs, at (603) 283-2416, or kclarke@antioch.edu

****

I, the interviewee, have read the information provided and agree to participate in this study.

_____ _____

Signature of the Participant Date

_____

Print Name of the Participant

_____ _____

Signature of the Researcher Date

Appendix E

Framework for Semi-Structured Interview

1. **Demographics**.
   - i. Name:
   - ii. City of residence:
   - iii. Ethnicity: How do you identify your ethnicity?
   - iv. Race: How do you identify your race?
   - v. Religious or spiritual affiliation:
   - vi. Marital status:
   - vii. Children (sex and age):
   - viii. Pre-doctoral educational experience and, if applicable, in which discipline(s):
     - Bachelors major
     - Masters discipline
     - Doctorate discipline
   - ix. Pre-doctoral work experience:
   - x. Membership(s) in professional organizations:
2. **General information**.
   - What has been your overall experience in graduate school so far as a clinical psychology doctoral student?
   - In brief, what have been the best parts of your academic experience? The worst parts?
   - Tell me about any prior experiences you've had with elderly individuals… (e.g., personal, family, work-related, volunteer work, etc.).
3. **Academic exposure related to older adult/diversity issues**.
   - Tell me about your exposure to issues of diversity in psychology…
   - How would you define "diversity" from your personal point of view?
   - Can you tell me how your program addresses (or does not address) your criteria or ideas of diversity?
   - How would you define "elderly"? What does this concept mean to you?
   - What sort of exposure have you had, in graduate school, to topics pertaining to elderly individuals?

Appendix E, continued

    - What about your exposure in graduate school to developmental theory?
  - Does your program have any faculty with expertise in geropsychology?
  - What are your thoughts on the field of geropsychology? Would you consider it a viable subspecialty? Why or why not?

4. **Experience of first elderly client**.
  - Tell me about the clinical training experience(s) you've had so far… (e.g., settings, populations worked with, treatment modalities, supervision received, supervisors' areas of expertise, etc.).
  - Tell me about the sort of setting you see yourself working in 5-10 years from now… (e.g., what populations, setting, treatment modalities, etc.).
  - Before beginning work with your first elderly client, what did you think it might be like to work with an elderly person?
    - Did you think it might be different to do therapy with an elderly person (as opposed to a younger client)? If yes, how so?
    - What were your thoughts about the elderly and mental health care? Have these changed at all since working with an elderly person?
  - Tell me about the first elderly client you saw for therapy... (e.g., age, reason for referral, length of therapy, client's prior experiences with therapy, etc.).
  - Before you met with the client, how were you feeling? (e.g., in terms of confidence, preparation for work with an elderly client, etc.).
  - Tell me about how you were feeling during the first session? As therapy progressed?
    - Issues of transference/countertransference?
    - Stumbling blocks/turning points?
    - Changes in feelings of competence/attitudes toward the client?
  - Tell me about any supervision that you received around this client…
    - Did your supervisor have experience/training in working with the elderly?
    - Was your supervisor knowledgeable about the needs of the elderly?
    - How responsive was the supervisor to your biases, need for support, self-efficacy?

Appendix E, continued

- Did your supervisor provide you with knowledge/skills training in terms of your work with this client? If "yes," please describe…
- What were your supervisor's own biases about the elderly?

5. **Reflections on first elderly client**.
   - Overall, how was this experience for you?
   - Did you feel prepared to work with this client?
     - If "yes," what was helpful? If "no," what would have been helpful?
   - Was working with elderly clients an area of interest for you, prior to seeing this client?
     - If "yes," why? If "no," do you think you will pursue further opportunities to work with/learn about geropsychology? Why or why not?
   - Can you tell me about any particular factors about this experience (e.g., supervision, course-related learning, positive/negative treatment outcome, etc.) that has influenced your desire to work with (or not to work with) elderly clients in the future?
   - Can you tell me about any personal experiences (i.e., not associated with your graduate training experience) with elderly people that you think may have affected your work with this client?
6. **Conclusion**.
   - Do you have any questions you'd like to ask me?
   - Is anything you'd like to add that has not been addressed?

Appendix F

Direct Excerpts from Interviews

Themes / *Subthemes*	
	Domain 1: Expectations vs. Reality
Connection	
Fear of not being able to connect	- For *me*, it's like, right now I'm 24…how could I talk to someone who's in their *70's*? How can I make that connection? (418.7) -I imagined it'd be really hard, especially building up a good relationship. So if I'm 24, and this person could be 65, they could be 70 or even 80 years old…that's like a *50 year* gap. So that's…that's pretty hard to traverse, I'd say. (418.10) -There was a little bit of hesitation, a little bit of realization that this was somebody who is a *lot* older than me, who has years and years and years…y'know? So, there was a lot of history there that I won't connect with, and…also wondering if she would accept *me*, as a *young* person. Y'know, would she trust me? Would she be open to talking to someone who *she* knew wasn't alive for the majority of her life? So, I think actually a lot of my fear was feeling that *she* may have issues with *me.* (515.9-10) -I guess I put myself a little bit in their shoes, and what it would be like to have this younger person come and say they're from psychology, and want to talk with them…? And I guess I was imagining them to have some skepticism about that. (954.8)
Difficulty establishing connection	-I was feeling a little anxious, a little intimidated. He was also really quiet…very reserved. Especially at the beginning, it was kind of like pulling teeth with him a little bit. And so I think that reinforced, like, a little of the anxiety and intimidation that I was feeling. (240.9) -She's not gonna trust me if I don't build the relationship, so nothing else is gonna work. So it was like…the very first job I had from then on, it was…build the relationship, build the relationship, build the relationship. (418.15) -He was seemingly a bit demented during [the first] session, I think, trying to place me. Trying to figure out who I was, and saying things like, "You had grandparents, and I think I knew them," and "You and I are connected somehow." So I would gently…probe that. Not saying, "No, you're wrong, that's not true," but just gently say, like, "Oh! How are we connected?" to see if he could sort of work it out for himself. And then I'd say things like, "You and I have never met before," and so he'd chew on that for a little bit. So, it was a little bit…tenuous, I guess. (954.12)

Appendix F, continued

Connection is *possible*	-And, just the fact that I *was* able to build a good relationship, even if at first it wasn't all that great, just the fact that I was able to build a good relationship really dispelled that thought that I had, like, "How can I connect with someone who's so much older?" Because we made that connection, it was like, "OK, so this isn't impossible." (418.26) -I felt like, she *did*, y'know, connect with me. I felt that she was trusting me, sharing a lot of personal information, which is, to me, a sign that she feels safe. So, on that level I was very pleased with how [the first session] went." (515.13) -He really loved *learning* about drug and alcohol addiction, and so that was, like, our break-in point. And so then, I would say, once I realized that he found that beneficial…I would say I didn't really feel those feelings of intimidation or pulling teeth or any of those anymore, it was just a great relationship, and I felt like it progressed really *well*. (240.10)
Nature of the Work	
It will be different in some way	-Part of my reservation going in was, "How do I relate to this person? If I'm casual, will she be offended by that? Will I have to hold it together a little bit better? Be a little more tightly spun?" (515.25) -Older folks maybe have…other types of psychological work to do. (954.9) -It's been a great professional growth experience for me, because this was more of a population that I was…wanting to handle with kids [sic] gloves.
It's different, but not too *different*	-I think I needed to see that people, no matter what they're going through…are not as frail as I think they are. And you can…you don't *have* to treat them, like, with kids [sic] gloves, you *can* work with them, and work with them assertively, if you have to, and that they can also work very hard, too. (127.17) -It was different, it was the first older gentleman that I had worked with. It was comforting, because…it wasn't really overly *different* than anything else, and I think it was good to know that I could, successfully, work with someone who was older, particularly with me being so young. (240.13) -I think, y'know, I don't think it was any different than any other therapy, in some ways, with another person, specifically referring to her age. (537.13-14)

Appendix F, continued

Why Bother?	
Is treatment worthwhile?	-I think a lot of elderly…I don't know that they would *need* something like that [mental health care], maybe because they've got it all figured out, or that there isn't much of a point to it, because they're not gonna be around for long. (240.7) -Alright, so they're in their 70's…you might see them, and how much change can you really make? I mean, can you really make a change? And maybe the change only lasts a year or two before they die…was it really worth my time? (418.8)
Treatment is *worthwhile*	-So yeah, maybe she'll only be alive for a couple more years…but if you've got a couple more years to really, y'know, if you could make someone that much happier for that amount of time… (418.25) -It definitely showed me that there's a *lot* that can be done, and *how* to do those things. (127.17) -I felt really honored to sit there with him, and help him reflect on his life, and to *be* that person who was really present at the end. (954.23)
Existential Concerns	-I just keep coming back to, like, loss loss loss…loss of friends, loss of supports, loss of the ability to take care of yourself. (418.7) -Honestly, my first perception was that, for whatever reason, I thought it would be sad <<laughs>> Like, my countertransference would just be a lot of sadness toward that person, if they're at…towards the end of their life and they're needing to come in for psychotherapy…I thought that might affect me. And, um, just have a *lot* of empathy, maybe *too much* empathy for them and, and maybe even becoming tearful. I mean, I could see myself doing that. (537.9) -I had actually thought about, y'know, "What if he died? What if one of my clients died? How do I think I'd respond to that?" (954.16) -If they're coming to see a psychologist it's likely because there are issues of depression, specifically dealing with losses, maybe death of a spouse or…I just think it would be a lot of really *sad, death* kinds of…or disability, or a lot of chronic pain, too, which I think would be very…psychologically draining. (863.9)

Appendix F, continued

Domain 2: Subjective Experience

Role Confusion		
	What does a geropsychologist do*?*	-I felt that the majority of the [gero]psychologist's role would be in testing, like, dementia screenings, neuropsych testing, and… dealing with end of life issues. I thought…y'know, that's probably about all that's going on. […] For instance, the geropsych intern, most of what she does *is* assessment. So, that tends to reinforce the belief about what a majority of what a geropsychologist does. *But*, I guess I am now more aware that there might be more traditional roles, like therapeutic roles that could be involved. So, it wouldn't be so much an…assessment-filled role. (537.9) -I just…I didn't know what to give her, if anything, and I just felt like I was just, kind of, listening, and nodding, and sometimes making process-type comments. (863.17)
	Role "reversal" (respect)	-Y'know, there's a tension of, like, *I'm* the professional here, but she's my elder, by a *lot*, and so I want to respect her and honor her, but I don't wanna let that take my authority away from me, or make me feel like less than the professional that I am. So, I think there was a little bit of role confusion. (515.10) -Because of my upbringing, I was sort of nervous, because people that are older than you are held in the highest regard. So…I didn't want to be disrespectful in any way, and I didn't want to come across as condescending in any way. Y'know…sometimes in therapy there's like this *power* dynamic that happens in therapy, sometimes, and I don't like that. So I wanted to make sure…I was *nervous* about that! (127.10) -It was much more normal as the therapy went on. I was pro*fess*ional, but I didn't have that, like, "Oh, I'm gonna be disrespectful" sort of feel anymore. And…when you say confidence, I felt like it was okay for me, even though I was younger, to be in a place of authority, because that's what my role was. You know what I mean? And I can execute that role in a respectful way. (127.14)
Confusion		-…it was difficult to gather all the information from her, but she *clearly* had an anxiety disorder of the OCD type. And…of course, intertwined with that was some pretty severe depression…but then there were also bereavement issues…she had lost her husband, and was grieving that. She had a *lot* of guilt around the way her life had been lived, about the way relationships had failed her…a lot of anger about the way relationships had failed her. So, some pretty classic stuff that you'd see often would exacerbate depression and

Appendix F, continued

	anxiety. [..] So, those were the presenting issues, but again, because of her very compulsive way of going about, y'know *thinking*, she was *very* difficult to work with. I felt that we circled around and around and around, and we made very little progress. And I don't know if that was *age*, of if that was, y'know, an obsessive-compulsive personality that was stuck in a thought process that was not going to budge. So…I'm not sure about that. (515.12) -It was negative in the sense that I really didn't feel like I understood what was going on with her. I felt confused by the presenting problem, and didn't feel that I really, fully—well, we don't ever *fully* grasp it—but did I even come close…to grasping, just, the level of pain, and probably confusion, that she was dealing with? (515.21) -I wasn't sure if it had to do with *me*, I wasn't sure if it had to do with him…just not really wanting, y'know, treatment so much, or…whether he was just, like, a silent kind of person. (240.9) -[I was] a little bit confused [during the first session]. I went in to see him and he was lying in his hospital bed, and I introduced myself, and I started to tell him, y'know, who I was, what department I was from, why I was there, and he was <<laughs>> staring up at me, and then he said, "I love you." And I thought, "*Maaay*be I heard that wrong." (954.11)
Did Not Feel Competent	-I felt ill-equipped, and incompetent. I felt that some of the negative expectations that I had were…fulfilled. (515.20) -It was just…it was too short, and I didn't really feel <<laughs>> very competent in helping her. (863.18) -That was a little intimidated to me…not just because of the life experience that he had, but also because he's a brilliant, incredibly brilliant person, and here I was, y'know, I had just started my 3rd year of graduate school, and…I was working with someone with, like, multiple doctoral degrees <<laughs>> Um, that was *really* intimidating for me. (240.9) -I thought, y'know, "How am I gonna help her? What do I have to offer her?" (863.15) -[On finding out the client had been admitted to a hospital for ECT]: It kind of surprised me, even though she had told me, during the course of therapy, that there had been some…consideration of that […] And so she didn't *know* if she was going for it, and she…she just mentioned it as a possibility. And I don't know if I just…if it was something that I just missed. It should have been some indication to me that…that maybe things are *more* severe than what I'm realizing. (515.15)

Appendix F, continued

Domain3: Resources Drawn upon During Treatment of First Elderly Client

Academic Preparation	
Formal learning opportunities	-Well, there was a full 3 credit course on geropsychology, and […] there was, uh, a 3 part seminar, where a psychologist from the geropsychology unit from the local psychiatric hospital came and did this 3 part seminar. [NB, both were required for all students] (537.4) -[On whether it was important to have had academic exposure to geropsychology] I'd say *definitely*. I'm the…anxious academic type, and I don't really like to work with populations if I haven't received formal training in them, so yeah, absolutely. -Y'know, I don't know, because I *had* some classes where we had talked about that, and so it wasn't like I had never heard of it before. I don't know that a lot *more* education would've…made me feel particularly more prepared. (240.14)
Informal learning opportunities	-I feel that my biggest source of learning about it was [in one of my classes], because one of my classmates really focused a lot of her presentations and discussions on gerontology, or older adults. That was, like, *her* focus. So her presentations would all be on that kind of stuff. So I learned a lot from there. (418.4) -Once, I consulted with a peer who volunteers in a nursing home. She wants to go into geriatric medicine, and I asked her, after that first session, I asked her about dementia […] So I did, sort of, have some questions that I brought to other people that added to my options, I guess. (954.14)
Supervision	-Yeah, he was able to offer me other case examples, or just, "This is what has happened in the past for some people," or he could say, "Here's a common pitfall that's happened to past practicum students here." He'll drop one of those, like if he sees you're trying to avoid something… But yeah, I definitely think that a big part of it was he could relate it to my experience, like, "This is helpful for some," just relating it to other practicum students who were also working with an older person. I found that really helpful. (418.21) -Um, he was really helpful. He's very validating and always gives great feedback. I would say that he didn't really focus too much on the fact that my client was elderly, but…he didn't really focus so much on that. I think he was more focusing on my…my feelings and reactions, and stuff like that. (240.12-13) -Getting therapy supervision from him is very helpful, he's very

Appendix F, continued

	insightful, and very able to point out issues, and suggest intervention ideas. (515.18)
Prior Experiences	
With diverse populations (clinical)	-When I've worked with other diverse populations in the past, my approach has always been just…well, just be highly empathic, just let them tell their story, show them you're interested, make them believe that you truly care—which I do, and…and they quickly trust, and then the relationship—usually, but not always, but usually takes off. And so I thought, "Well, I can use those things," y'know, that same approach, and it actually did end up being effective. (515.10) -I had a job working with autistic children. It was my first real job […] after I got my first masters. And I was…coming into a population that I really had no background, no experience in […] and I think that helped me. I mean, knowing that I got through *that*…when you're new out of school, and you have a job opportunity, you're gonna *take* it. And it was really important for me to go through that, y'know? […] So, I had that, sort of, okay feeling to go in there, and I think that was…it was pretty similar, working with autistic children for the first time. And they turned out to be a population I loved, too. (127.21) -In the past, with other types of diversity, I don't know…I guess just having *enough* positive experiences that I was willing to try this one. So, I *wasn't* confident in my ability to handle any kind of, y'know, old age issues. I was confident enough in myself as a therapist, that, "OK, I'll try this…and hopefully it'll go okay" <<laughs>>. (515.13)
Other (clinical)	-I've worked with people, like, from 20 through 50, so it wasn't like I was going from, like, working with *kids* to the elderly. So, I think that helped a lot. But I think, that…yeah, I think if I *hadn't* had that, I think I probably would've felt less prepared (240.14) -The fact that I have this experience with a client dying, I'm sure that it helps to have, y'know, 2 or 3 years of…other sorts of experience before. I had built up, sort of, a comfort level with therapy, and, just psychotherapy and all that stuff, before it happened. (954.26)
With elderly (non-clinical)	-Well, like I said, I think I've had a *lot* of exposure to older adults, just based on my family, and being raised in, kind of, an older church, and things like that. So, I'm sure that that…helped me to feel more comfortable, and would help me to feel more comfortable with any gero patient. (537.18)

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	-I had moments where I sat with him and he would tell me stories about his life, and it reminded me of sitting with my grandmother, and doing the supportive thing. But I was conscious of it, I guess, that I had been in that role before. (954.13)
	Domain 4: Interest in Geropsychology, Pre vs. Post
(Pre) Ambivalent, but Open	-I was not interested in doing it prior to, um, coming into the clinic. I actually, like I said, I made myself work with this population because I didn't have any thought about them at all, prior to doing it. (127.20) -No, I wouldn't say that [working with elderly clients was an area of interest for me], but it wasn't *dis*interest, either, y'know? It wasn't something I would *never* want to do, but not particularly interested. (537.15)
(Pre) Yes, Interested	-I have a real interest in, like, existential issues…so I'm really intrigued by that stage of life. (954.22) -It's been an area that I…I was interested in it. I didn't think I wanted to specialize in it, but it was something I was interested in, just, working with older adults. (240.14)
Ambivalent openness / interest influenced by:	
Personal experiences	-I think, because of…people I have in my life who are elderly, I think I just have a strong appreciation for people in that stage of life…and for the life they've had. And so, I think that has, y'know, kept me kind of open, and interested in working with that population. I see it…I see it as a really wonderful part of life, with its own set of challenges, and, um, I think it's because I've been exposed to that, I think that's why I have that mentality (240.16) -I guess it just sort of highlighted for me how much prior experiences with an older person can influence, like, our willingness or wantingness to work with older folks, um, clinically and professionally, later on. (954.26)
Peer learning	-I don't think I had much thought [about geropsychology], actually, before. That's why I actually chose this practicum, because of the conversations and things that started up [among classmates] during my first year, and I was like, "You know what? This is something that I need to go and think about." (127.10) -I have a friend who does…he's a director of bereavement counseling at a hospital up here, and…I've heard a lot about a little bit of his work, and he works with a lot of elderly populations, and it always seemed interesting to me. (240.14-15)

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Self-concept as generalist	-I would potentially be interested in it. I'm interested in working with clients across the age range, so I would love to work with children and adults, including older adults. I don't know if I'd take a job, y'know, working with *just* an older population, though. (863.8-9) -Working in CMHC's, you really kinda *have* to be a generalist, just because of what gets thrown at you. It'd be *great* to specialize, but, just the population that I want to work with sort of has such a wide range of issues, that, in some ways, specializing gives you, like, a niche, makes you marketable…but in other ways you kind of pigeonhole yourself. […] In that particular setting, there are, like, so many people who work there, and if you limit yourself too much…you kinda have to be more open, because whoever you're seeing only has so many visits. (418.10) -When I first saw her file, and I saw her age, I was just like, "Alright," <<laughs>> "I'm gonna have to do this eventually. (418.12)
(Post) Increased Interest / Openness	-[Referring to their first elderly client]: I think it's made me more comfortable with it, and…encouraged my excitement for it. (240.15) -I'm definitely more open…definitely. I don't know if I'll actively *pursue* working with the elderly. […] So I guess my interest hadn't *grown* but my *dis*interest had definitely lessened. I'm definitely more open. (418.25) -I think it either increased it [interviewee's interest in working with elderly clients], or…where it was a question, it kind of answered the question of whether this is something that I would like to do. (954.23)
	Domain 5: Factors Associated with Future Interest in Geropsychology
Positive Experience	-I hadn't really thought about working with this population at all. Then after I worked with this one lady, it…it really changed. I had such a *great* experience with her, and it *was* slow going at the beginning, but after we created this connection it was…it was really special to me. (418.11) -I'd say it was really positive for me. I really enjoyed working with him, I…I liked experiencing myself when I was working with him, I liked being in that role. […] So in other words, meeting with him changed…yeah, I would say it has sort of shifted my perspective, or enhanced it, in a way that I would really want to go back for more. (954.19/23-24)

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	-Y'know, feeling that it was, overall, positive, both for she and I…so, I had my first geropsych therapy client, and didn't…ruin it or something, so of course it, like, makes me more open to do it again. (537.16) -If I had had a poor outcome, like if she had ended at the point in time when all the yelling was going on, I'm sure I wouldn't have wanted to work with more older adults. I would've been like, "Alright, all my thoughts that I had before were totally true." (418.19) -Feeling like I did at least receive a good enough basis in my geropsych course, I guess that I…was able to…see her, and felt like I was fairly competent. (537.16) -The coursework that I've had helped me to open up, and to *see* things from a different way. […] What we did this past year really did help give me a, like…enough information to have a foundation of *some* kind to come in with. (127.18)
Increased Confidence	-I just started working, a few weeks ago, with my second elderly client, and…I think that the first experience that I had definitely, kind of, set up a level of, y'know, understanding and confidence, and some expectations for the second time. (240.15) -I think just having that one encounter, therapeutically, made me feel a *little* more comfortable, because now, at least I've seen a patient on the gero unit, and I've had some experience and I guess it's kind of released some of the anxiety that I wouldn't know what to do. […] It was just very normalizing, the whole process. (537.13/15) -I think I definitely learned more in terms of competence. How do I actually try and tell someone that…yeah, to some degree, you have dementia? It was really hard to hear. (418.18)
Good Supervision	-I don't think treatment would have gone as smoothly if I hadn't had the same help…it's hard to say. […] I think his help and supervision, in many ways, almost made the treatment a little bit shorter than if I hadn't had him as a supervisor. So…supervision definitely helped me overall in working with her. (418.21) -[Referring to supervisor] Extremely, extremely supportive. Very open to hearing my side, very open to…helping me grow in my perspectives. […] Without it, I would not have had a good experience, at all. (127.16/20) - My *supervisor* thought I was competent, and *she* [client] thought I was competent. (537.16)

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Shift to Generalist Frame	-I mean, it's such a *huge* part of the population, how can you really, how can that be a specialty? Because it's such a huge segment, it *is* part of the general population. Maybe if it was just working, specifically, with elderly with certain memory problems, that would be more of a specialty. Or, if you were doing kid work, like specifically kids with MR, *that* would be a specialty. But, like, considering the entire elderly population as a specialty, looking at it that way…I can't see that as much. (418.23)
	Domain 6: What Would Have Made the Experience Better?
Academic Preparation	
More / better	-I guess an analogy would be, like, with testing. If you haven't had much testing experience, are you really gonna wanna be doing assessments at a site? Not so much, 'cause you're a little scared about it, you're like, "I don't even really know what's going on here." Similarly…at least if you get exposed to it, probably you'll be like, "Okay, I have a *general* idea of what's going on here." (418.22) -I think it would've been helpful [in feeling more prepared] if my program would've done…a *little* bit more with the end of the lifespan, than what they did. (515.20) -I think there could always be more. I don't think we spend as much time on [elderly populations] as we do on other diversity factors, like, say, racial diversity or socioeconomic diversity. (240.3) -I don't feel like my program even introduced us. Like, you asked about diversity, did they do a good job? Well, I think they did as much as what they could have done. With the elderly? No. We didn't even go there. At all. So, I think at the very least that would've been helpful. (515.21) -I think in a lot of ways, the class [developmental psychology] just kinda, like, focused a lot on the more earlier stages. Just the way the class was focused, there was a lot of focus on the early stages of life, and as soon as we started hitting adulthood, it just kind of…died off. […] It didn't even help prepare me at all…that idea of, what is it like to be someone who's elderly? I feel like I had no idea what they might be going through. Whatever I've learned has really been self-taught. (418.4-5) -[Referring to developmental psychology class]: I think I can remember the instructor saying, 'This is not my specialty." (537.5) -[Referring to exposure to geropsychology topics in school]: I've gotta say, really, almost none. It's kind of brought up in terms of, y'know, "Hey, let's remember that diversity doesn't just, uh, have

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	to do with ethnicity…there's age, and religious beliefs, and all these other types of things." Um…but we haven't really *talked* about elderly clients specifically. (863.7)
Geropsychology is neglected by schools	-Because there *are* more elderly clients out there, I think training programs need to at least open the door to students, to realize that this is part of the work that we do. (515.20) -[On the lack of formal learning opportunities in geropsychology]: It could be communicating that it's not important. Or…in other ways, that it's a *specialty* area, so if you want to get into it you have to seek out specialization for it. Actually, I think in some ways that even just setting it up as a weekend class alone…we have weekend classes for sleep, there's a weekend class for hypnosis…so, it's like, "This is a specialty." […] So, I think that's kinda what it communicates, that it's not part of the general population who you work with, it's a certain specialty. (418.23) -I just think that it's such a huge part of the population, and we have psychologists that work, y'know, specifically with children…and so I feel like we're acknowledging those age groups are specific populations. […] Just as important I think that there are…really important issues specific to that age group [elderly]. (240.4) -I think it's becoming more of a…focus that we *have* to address. The needs of this population, the *Baby* Boomers, are coming up now, they're gonna be in that…there's gonna be a *huge* population that needs to be *served*. (127.7)
More / Better Supervision	-He was the person who described to me how, um, with dementia, people can be less inhibited. […] But aside from that, in terms of psychologically, he didn't give me any insight into, like, what my client might be experiencing, and what he might need from me. (954.16) -[Referring to the death of the client]: I did a lot of work by myself to process it, and figure out what *my* role was, and all of that. But I'm *sure* that getting more from the supervisor would have enriched the experience, in terms of what I could carry over to the next client. (954.25) -I know his style, and so I take certain expectations into my meetings with him. I know I'll get good…information and good feedback, and on that level he was very supportive. Was he willing to sit there and talk with me about my feeling inadequate? No, not really. (515.18-19) -It [supervision] used to be an hour, which was really great…but now it's half an hour. (863.11)

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-He was sort of like, “Well, y’know, if you wanna go into health psychology this is something you’re gonna have to deal with,” and so on, and it didn’t make me feel like I was part of something, but rather that this was something that *I* was going to have to deal with... And I wish he had helped me to explore my own feelings about it, rather than, like, present, “Well *I* had a client commit suicide once, and here’s that that was like,” which I thought was a) insensitive, and b) completely different. <<laughs>> Yeah, completely different. (954.25-26)