THESIS

PSYCHOLOGIST TRAINEE CLINICAL JUDGMENTS OF OLDER ADULT CLIENTS

Submitted by

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ABSTRACT

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With the steady growth of the population of older adults in the U.S., there is an ever-growing need to prepare more mental healthcare providers to work with older adult clients. However, decades of research indicate that clinicians may hold clinical biases toward older adults. The present study sought to explore current doctoral trainee clinical judgments of older adult clients. Results indicated that trainees rated themselves as less competent working with older clients than compared to younger clients. A positive relationship was also found between attitudes and trainees' perception of an older adult client's ability to form a therapeutic relationship. Additionally, increased training in aging-related topics was correlated with more positive attitudes toward older adult clients. Trainees' reports indicate a need for training programs and agencies to develop an emphasis on working with older adult clients in order to meet the mental health needs of this growing population.

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Following the Second World War there was a population surge in the United States (U.S.) with 76 million births between 1946 and 1964 (Maples & Abney, 2006). This cohort, known as the baby boomers, continues to make up a large portion of the U.S. population and they are beginning to reach their later years of life. In 2010, adults 65 and older represented 13% of the U.S. population and this proportion is projected to increase to 16% by the year 2020 (Karel, Gatz, & Smyer, 2012). The baby boomer generation is in many ways healthier and more independent than past generations; however many older adults have mental heath concerns, with approximately 20% meeting diagnostic criteria for a mental disorder (Karel, Gatz, & Smyer, 2012). Unfortunately, the current mental healthcare workforce may not be adequately prepared to serve the needs of this population given twice the number of psychologists are required to meet this growing demand (American Psychological Association, 2014). There are several factors, including biased clinical judgments and graduate education geared toward working with older adult clients, which must be assessed and addressed in order to ensure that these older adults receive fair and competent care.

Clinicians' Biases Toward Older Adult Clients

Ageism is a social phenomenon consisting of prejudiced attitudes, discriminatory practices, and stereotypic beliefs that negatively affect older adults (Butler, 1980). Unfortunately, mental health professionals are not immune to biases against older adults and negative age-related clinical judgments often persist even within the treatment setting and therapeutic relationship. Clinical biases have been explored in a variety of ways over the past several decades with the most recent of these studies finding that clinical biases and negative attitudes toward older clients are still prevalent amongst today's practicing clinicians (Tomko & Munley,

2013). Previous analyses of this phenomenon have focused on assessing participant knowledge of older populations, attitudes toward older adults, and clinical judgments of older clients in therapy; with participant samples ranging from psychologists, psychiatrists, other mental health professionals, and trainees.

Over the past several decades, researchers have been exploring the age-related biases of mental health providers across a number of clinical ratings and judgments (Appendix A. Table A.1.). For example, decades of research show that older adults are consistently rated as having a poorer prognosis than their younger counterparts with identical symptomology (Ford & Sbordone, 1980; Settin, 1982; Ray, McKinney, & Ford, 1987; Meeks, 1990; James & Haley, 1995; Danzinger & Welfel, 2000; Helmes & Gee, 2003). Clinicians also seem to consistently exhibit a preference for younger clients and decreased willingness to work with older clients (Dye, 1987; Settin, 1982; Zivian, 1992; Uncapher & Arean, 2000; Helmes & Gee, 2003). Additionally, there is a pattern of clinician misconception of the effectiveness of therapy for older adult clients (Dye, 1978; Ford & Sbordone, 1980; Settin, 1982; Ray, McKinney, & Ford, 1987; James & Haley, 1995; Helmes & Gee, 2003), despite decades of research indicating that psychological interventions are equally effective for older adults as they are for younger adults (Thompson, Gallagher, & Breckenridge, 1987; Scogin, 1994; Knight & McCallum, 1998; Myers, 2004). This body of research suggests a pervasive negative clinical bias toward older adult clients, persisting across decades of practice and various types of mental health professionals (e.g., social workers, psychiatrists, psychologists, etc.).

However, other types of biased clinical judgments are less consistent across the literature base. For example, some studies indicate that clinicians are more likely to underdiagnose clinically significant symptoms in older clients as compared to their younger counterparts

(Perlick & Atkins, 1984; Ivey, Wieling, & Harris, 2000) while other studies have found no significant age-related diagnostic differences (James & Haley, 1995). The literature also exhibits varied results regarding the impact of client age on treatment recommendations. Some studies indicate that mental health professionals are less likely to recommend therapy (Ford & Sbordone, 1980) and antidepressant medications (Perlick & Atkins, 1984) for older versus younger clients whereas other studies showed no difference in treatment recommendations based on a client's age (Hillman, Stricker, and Zweig, 1997; James & Haley, 1995). Although these particular biases are more variable across research studies they are still indicative of the possibility of differential clinical judgments based solely on client age.

The Role of Experience, Training, and Knowledge

Throughout the literature, preferences for working with older adults appear to be related to clinical experience and knowledge of working with an aging population (Dye, 1978; Zivian, 1992; Hillman, Stricker, & Zwieg, 1997; Damron-Rodriguez, Kramer, & Gallagher-Thompson, 1998; Hinrichsen & McMeniman, 2002). Some researchers hypothesize that therapist reluctance to treating older clients might be related to a lack of perceived competence and self-efficacy working with aging populations (Helms & Gee, 2003). Additionally, a recent study by Tomko and Munley (2013) has shown that higher levels of self-rated multicultural competence among psychologists significantly predicted less clinical bias toward older clients. This indicates that preferential client selection may be amenable to change with increased emphasis on multicultural education and training. There is also evidence of a cohort shift with trainees holding more positive views of working with older clients, although trainees continue to endorse some level of ageist beliefs (Lee, Volans, & Gregory, 2003). Current trainee cohorts may be more open and willing to learn about working with older adult clients than past generations of psychologists and

therefore increased emphasis on geropsychology can likely foster a decrease in age-related clinical biases. If biased preferences and clinical judgments are malleable then appropriate exposure, education, and training in this area can be a critical avenue of continuing the positive attitude shift toward working with older adult clients.

Clinical training and experiences with aging populations are also positively correlated with a specialization in geropsychology (Koder & Helmes, 2008). However, whether or not a mental health provider wishes to specialize in geropschology it is important for all clinicians to develop competence working with older adults (Karel, Gatz, & Smyer, 2012). Unfortunately the majority of practicing psychologists report having minimal training in geropsychology (Qualls, Segal, Norman, Niederehe, & Gallagher-Thompson, 2002; Tomko & Munley, 2013). A recent survey of APA accredited doctoral programs indicated that only 28.3% of respondents reported that their training program offered a course in geropsychology, with none of the programs requiring students to take a geropsychology course and 67.4% of programs failing to offer any specific courses in geropsychology (Pachana, Emery, Konnert, Woodhead, & Edelstein, 2009). Given the growing importance of addressing the mental healthcare needs of older adults, it is likely that clinical training programs will benefit from preparing trainees to competently work with this population.

Proposed Study: Current Trainees' Clinical Judgments of Older Adult Clients

The present study sought to examine current psychologist trainees' clinical judgments of older adult clients in therapy, therefore providing the opportunity to compare present-day outcomes to previous decades of similar literature (Appendix A. Table A.1.). Clinical judgments of older adults in therapy included participant's willingness to work with the client, perceived appropriateness of therapy for the client, client's diagnosis, primary treatment recommendation,

client prognosis as well as clinician judgment of client's level of functioning and clinician's level of self-perceived competence treating the client. Based on previous decades of research indicating age-related biases across counseling professionals, it was hypothesized that psychologist trainees' clinical judgments would similarly vary based on client age with older clients being 1) rated less desirable than younger clients, 2) rated less appropriate for therapy than younger clients, 3) given a poorer prognosis than younger clients, and 4) rated as lower functioning than younger clients. It is also hypothesized that trainees would report feeling less competent to work with an older client as compared to younger clients and that diagnosis and treatment recommendations would similarly vary according to client age. Trainees' reported level of exposure to diversity and geropsychology training and attitudes toward older adult clients were also examined in order to explore the potential impact of these experiences on clinical biases against older adults.

Method

Participants

The sample in the present study was obtained via a recruitment email sent to Counseling and Clinical Psychology listserves and to training directors of Counseling/Clinical Ph.D./Psy.D programs with accreditation from the American Psychological Association. The recruitment email asked training directors to forward the study description and survey access to their current doctoral students. Of the 83 respondents, two were excluded because they were enrolled in a non-target graduate program (e.g., school psychology). The remaining 81 participants ranged in age from 24 to 66 with an average age of 29 years old ($X = 28.75$; $SD = 6.17$). The majority of the sample was female (n=58) and Caucasian (n=54), although the sample also included Biracial

(n=7), Hispanic (n=6), Black/African American (n=5), and Asian Pacific Islander (n=6) individuals. See Table 1 for specific demographic information.

Given that the sample of trainees consisted of current graduate students, they had all earned a bachelor's degree with five individuals reporting that they had also earned a master's degree. The majority of participants reported currently being enrolled in a Counseling PhD program (n=71) although some trainees were enrolled in a Clinical PhD program (n=3), a Counseling PsyD program (n=5), or another type of doctoral program (n=2). Participants were asked to indicate which aging topics have been covered in their respective programs. Topics and percentages of participant endorsement included: Developmental stages of aging (64%); Neuropsychology of aging (33%); Clinical skills working with older adults (20%); Diversity with specific reference to older adults (52%); other topics included challenges faced by older adults, psychopharmacology, and vocational (1%), with 25% of trainees reporting that no topics related to older adults had been covered in their programs (Figure 1). Participants also rated their pre-graduate school education and experience working with older adults, with the majority of trainees indicating that they had limited exposure to aging education and experience prior to graduate school (ratings were on a 7 point Likert scale with 1 = *none* to 7 = *very extensive*; M = 2.30, SD = 1.39; M = 2.51, SD = 1.67, respectively).

Due to the clinical nature of the study stimuli, trainees were required to have at least one year of clinical experience in order to participate. Reported experience ranged from one to greater than five years, with the majority of participants reporting three to four years of clinical experience (n=21). Thirty-three percent of the trainee sample indicated that they have not had any clinical experience working with older adults. The majority of trainees (74%) reported that older adult clients made up less than 5% of their client caseload. Participants were also asked to

indicate the clinical settings in which that they gained clinical experience working with older adults. Settings and percentages of participant endorsement included mostly Community clinics (39%), followed by Hospitals (17%) and Long-Term Care facilities (11%) (Figure 2).

Procedure and Materials

Participants were randomly assigned to read one of four vignettes describing either a younger or older client exhibiting either depressive (adapted from James and Haley, 1995: also used in Helmes & Gee, 2003; Tomko & Munley, 2013) or anxious symptoms (adapted from James & Haley, 1995 to reflect anxiety according to *Diagnostic and Statistical Manual of Mental Disorders,* DSM-5; description of anxious symptoms). Following James and Haley's (1995) model and the majority of adults over 65 are female (Center for Disease Control and Prevention, 2013), the vignette clients were both female aged either 70 (older) or 35 (younger). Further, both clients were described as white in order to control for potential race-related biases and differences in clinician rating. After reading the vignette, participants were asked to respond to eight clinical judgment questions. The vignettes were as follows:

Depressed client vignette.

> Ms. James is a *(Age condition:* 35/70) year-old white female who arrives at your office on time for her first appointment. Her insurance offers full coverage for psychotherapy. Scanning the patient information sheet she completed while waiting for her appointment, you note that Ms. James's medical history is unremarkable. You learn from her that she is recently widowed and that her presenting complaint is depression secondary to her husband's death approximately 8 months ago. Ms. James is casually attired and presents with a somewhat flattened affect. She appears to respond to your questions openly, with little hesitation. She becomes tearful as she recounts her husband's death to you, a prolonged battle with cancer. She indicates that she has lost all interest in activities, which formerly gave her pleasure, that she frequently awakens at 2:00 a.m. and is unable to return to sleep, and that she has recently lost 15 pounds. Ms. James also states that she has begun to wonder if life is worth living anymore.

Anxious client vignette.

> Ms. Smith is a *(Age condition:* 35/70) year-old white female who arrives at your office on time for her first appointment. Her insurance offers full coverage for

> psychotherapy. Scanning the patient information sheet she completed while waiting for her appointment, you note that Ms. Smith's medical history is unremarkable. You learn from her that she is new to the area and has been experiencing a great amount of anxiety lately. Ms. Smith is casually attired and presents with a somewhat nervous affect. She appears to respond to your questions openly, with little hesitation. She appears fidgety as she tells you about her frequent worrying. She indicates that she has been feeling restless and irritable, that she is easily fatigued but has difficulty falling and staying asleep. Ms. Smith also states that she is often preoccupied with her thoughts and finds it difficult to control her worry.

Measures

Clinical judgments. Items were selected based on past research (Appendix A. Table A.1.) as well as the researcher's intention to best mirror clinical in-take procedures and considerations. James and Haley's (1996) original Survey of Professional Bias (SPB) was used as a model with some modifications and additions made. First, the diagnosis and treatment recommendation items were revised to request the participant's "primary" choice of diagnosis and recommended treatment. Six of the clinical judgment items used in the present study originated from James and Haley's (1996) SPB (Items 1, 2, 4, 5, 6, 7), item eight originated from Helmes and Gee (2003), and item three was included by the researcher as an assessment of client functioning for a total of eight clinical judgment items.

The eight clinical judgment questions were as follows: 1) "What do you think the most likely primary DSM 5 (*Diagnostic and Statistical Manual of Mental Disorders, 5th edition*) diagnosis is for Ms. James/Smith's presenting problem?", 2) "What would be your primary treatment recommendation for Ms. James/Smith?", 3) "How would you rate Ms. James/Smith's current level of functioning?", 4) "How do you view Ms. James's ability to develop an adequate therapeutic relationship with you?", 5) "How appropriate a candidate for psychotherapy do you see Ms. James/Smith as being?", 6) "With regard to her presenting complaint, how would you rate Ms. James/Smith's prognosis?", 7) "How competent do you feel treating Ms. James/Smith?",

and 8) “How willing are you to work with Ms. James/Smith?” For items 1 and 2 participants were asked to make a multiple-choice selection from a list of diagnoses and treatment recommendations, respectively. Items three to eight were rated on a 7-point Likert scale from 1 (more negative rating) to 7 (more positive rating) across the various clinical judgment areas.

Although some previous researchers (Tomko & Munley, 2013) have combined similar clinical judgment items into a scale, the researcher of the present study was not interested solely in a composite of clinical judgments. The researcher sought to examine current psychologist trainees’ domain-specific clinical judgments according to client age/symptom rather than a congregate of clinical bias.

Training and experience. Training and experience in diversity and geropsychology was assessed via an adapted version of Tomko and Munley’s (2013) 14-item Training and Experience Questionnaire (TEQ). The scale was adapted to contain only items that are applicable to current trainees (e.g., ratings of pre-doctoral training and experience). Similar to Tomko and Munley’s TEQ, the adapted measure consisted of Likert-scale items (1=*none*, 7=*very extensive*) that assessed the extent of pre-doctoral coursework, training, and experience in diversity (three items) and aging (three items). The six items on the adapted TEQ included: 1) “Please rate the extent of your pre-doctoral coursework on multiculturalism (i.e., specifically focused on developing awareness, knowledge and skills for working with racially/ethnically diverse clients)”, 2) “Please rate the extent of your pre-doctoral practicum and internship training in counseling and psychotherapy with racially/ethnically diverse clients”, 3) “Please rate the extent of your pre-doctoral practicum and internship training in assessment with racially/ethnically diverse clients”, 4) “Please rate the extent of your pre-doctoral coursework on aging issues and working with older adults”, 5) “Please rate the extent of your pre-doctoral practicum and

internship training in counseling and psychotherapy with older adults", and 6) "Please rate the extent of your pre-doctoral practicum and internship training in assessment with older adults". Reliability of scores on the current study sample for the three Diversity items (α=.75) and three Aging items (α = .79) was acceptable (Nunnally, 1978). Due to marked differences between ratings of diversity and aging scales these items were not combined into a single total training scale.

Attitudes toward older clients. Some studies have measured the impact of attitudes toward older adults in general on clinical ratings of older adult clients (James & Haley, 1995; Tomko & Munley, 2013). An extensive search for an existing scale offered no preexisting, comprehensive measure assessing specific mental health provider attitudes toward older adult clients in a therapeutic context, therefore the author created a measure to use within the present study. The scale was adapted from a questionnaire originally developed by Happell and Taylor (2001) to assess nurses' perceptions of clients with drug and alcohol problems. The resulting Attitudes Toward Older Clients (ATOC) scale included items specifically related to therapists' work with older adults in therapy. Example items include: "I consider working with older adults to be fulfilling", "I feel comfortable working with older adults", and "I believe therapy is an effective means of treatment for older adults." Similar to Happell and Taylor's measure, the adapted questionnaire items were developed to relate to clinicians' attitudes, competence, and perceived knowledge working with older adult clients; however, only a single factor emerged from an exploratory factor analysis. Reliability of scores on the current study sample for the resulting 15-item scale (α = .85) was acceptable (Nunnally, 1978).

Results

Clinical Judgments

The primary diagnosis for the younger depressed client was Uncomplicated Bereavement (17%) whereas the primary diagnosis for the older depressed client was Adjustment Disorder with Depressed Mood (22%). Diagnoses for the anxious client were more consistent across age groups with 38% and 29% of participants selecting the primary diagnosis of Adjustment Disorder with Anxious Mood for both the younger and older client. Primary Treatment recommendations were also consistent across client age and symptom with the majority (85% and 83%) of trainees recommending individual therapy for both younger and older clients regardless of symptom presentation.

The remaining clinical judgment items were rated on a 7-point Likert scale with higher scores indicating more positive ratings across the six clinical domains (e.g., higher scores are indicative of higher functioning, greater ability to form a therapeutic relationship, greater appropriateness for therapy, better prognosis, more self-rated clinical competence, and greater willingness to work with the client). In terms of the client's level of functioning, half of the trainees rated the anxious client as "Somewhat High Functioning" regardless of client age (younger = 50% and older = 52%) whereas the young depressed client's perceived level of functioning was equally split between a "Moderately Functioning" (4 out of 7) and "Somewhat High Functioning" (5 out of 7), with 43% of trainees selecting each rating option, and the older depressed client was rated "Somewhat High Functioning" (5 out of 7) by 45% of the participants. Both the younger and older anxious and the younger and older depressed clients were rated as having a "Good" (6 out of 7) ability to form an adequate therapeutic relationship by the majority of trainees (60%, 71%, 55%, and 60% respectively). Younger anxious clients were rated as either

"Appropriate" or "Very Appropriate" for therapy with 45% of respondents selecting each rating option while 57% of participants rated older anxious clients as "Very Appropriate" for therapy (7 out of 7). Over half of trainees (60%) rated depressed clients as "Very Appropriate" for therapy (7 out of 7) regardless of client age. The client's prognosis was rated relatively consistently for anxious clients with 70% of trainees rating the younger anxious client's prognosis as "Good" (6 out of 7) and 67% rating the older anxious client's prognosis as "Good" (6 out of 7). The prognosis for depressed younger and older clients was also rated at as "Good" by over half of participants (55% and 65% respectively). The majority of trainees rated themselves as "Competent" to treat the younger and older anxious clients (60% and 67%, respectively) and younger and older depressed clients (50% and 65%, respectively). Seventy percent of the trainees indicated that they were "Completely Willing" (7 out of 7) to work with the younger anxious client versus 62% of trainees endorsing that they were "Completely Willing" to work with the older anxious client. Similarly, 65% of trainees were "Completely Willing" to work with the younger depressed client and 55% were "Completely Willing" to work with the older depressed client.

Differential diagnoses and treatment recommendations according to client age and symptom were statistically assessed using chi-square analyses on the two categorical clinical judgment items (e.g., items 1 and 2). Neither of these analyses was found to be statistically significant however this could be a result of low participant numbers across the nine diagnosis options and six treatment recommendation options. Additional differential clinical judgments were assessed via a 2x2 (Age X Symptom) multivariate analysis of covariance (MANCOVA) conducted on the five continuous clinical judgment items (items 3-8), controlling for participant age, gender, and ethnicity. Reported years of clinical experience was also included as a covariate.

Both main and interaction effects of client age and client symptom-type were assessed. Analyses revealed a statistically significant multivariate effect for the combined dependent variables (e.g,. clinical judgment items 3-8) in respect to vignette symptom (Wilk's Lambda = 0.82, F (6, 64) = 2.34, p = .04). Multivariate effects were not found for the main effect of client age. Follow-up 2x2 (Age X Symptom) analyses of covariance (ANCOVA) on the five continuous clinical judgment items revealed that trainees rated depressed clients as lower functioning (F (1, 69) = 4.88, p = .03, η_p^2 = .064) than the anxious client, regardless of client age. Trainees also rated themselves significantly less competent to work with the older client versus their younger counterpart (F (1, 69) = 5.06, p = .028, η_p^2 = .069) across symptom presentations. No additional main effects were found for client age or symptom on the remaining continuous clinical judgment items (e.g., client level of functioning, client's ability to develop a therapeutic relationship, appropriateness of client for therapy, client's prognosis, and willingness to work with the client). No statistically significant interaction effects (Age X Symptom) were found. Participants' reported years of clinical experience significantly related to their level of competence working with the client regardless of age and symptom type (F (1, 69) = 2.64, p = .003, η_p^2 = .116). See Tables 2 and 3 for a summary of primary results.

Following these initial analyses the data set was split to examine the impact of training and attitudes on participants' rating of older clients only. See Table 4 for means, standard deviations, ranges, and alpha coefficients of the training and attitude measures.

Training and Clinical Judgments

Participants' self-reported level of training and experience ranged from 3 to 21 on the three diversity items (TEQ-D; M = 15.76, SD = 3.64) and from 3 to 18 on the three aging items (TEQ-A; M = 8.19, SD = 4.29), indicating that trainees reported receiving more diversity-related

training than aging-related training. A multivariate analysis of covariance (MANCOVA) regressing reported level of training in diversity (TEQ-D) and aging (TEQ-A) onto the clinical judgment items revealed that neither training/experience in diversity nor training/experience in aging significantly related to trainees' clinical judgments of older adult clients.

Attitudes and Clinical Judgments

Participant scores on the Attitudes Toward Older Clients (ATOC) scale ranged from 48 to 84 (M = 64.43, SD = 8.11), with lower scores reflecting a more negative attitude toward working with older adults as indicated by low endorsement of comfort, interest, and competence working with older adult clients. A multivariate analysis of covariance (MANCOVA) regressing ATOC onto the congregate of clinical judgments did not reveal a significant multivariate effect of attitudes on the clinical judgment items as a whole; however, there was a significant positive relationship between attitudes toward older adult clients and clinicians' rating of a client's ability to form a therapeutic relationship. Specifically, trainees who held more negative attitudes toward older clients were significantly more likely to rate older clients as less able to develop a therapeutic relationship and vice versa ($F(20, 11) = 3.29$, $p = .023$, $\eta_p^2 = .833$). See Table 5 for primary findings.

Training and Attitudes Toward Older Adult Clients

Correlations were calculated to examine the relationship between training and experience with aging (TEQ-A), attitudes toward older clients (ATOC), participant age, and years of clinical experience. Results show a moderate, positive relationship between ATOC and TEQ-A, $r(78) = .46$, $p < .001$. Thus, the more training received in aging-related topics the more positive attitudes trainees held toward older adult clients. Participant age was also positively correlated with attitudes toward older adult clients (ATOC) $r(80) = .38$, $p < .001$, indicating that

as participant age increased so did positive perceptions of older clients. See Table 6 for intercorrelations between primary independent and demographic variables.

Discussion

Results of the present study indicate that the extent of pre-doctoral training in aging-related topics and skills are poorly matched with the ongoing demand to work with this growing population. With 69% of the current trainee sample rating their pre-doctoral training and experience in aging as a three on a 7-point Likert scale (1 = *none*, 7 = *very extensive*), these low rates of endorsement of aging-related training is commiserate with Tomko and Munley's (2013) study in which 61% of their sample of practicing clinicians also rated their pre-doctoral training and experience in aging as a three on the same 7-point Likert scale. These comparable findings indicate that current trainees are reporting similar levels of pre-doctoral training and experience working with older adults as practicing psychologists signifying that the extent of pre-doctoral training does not vary across professional cohorts (e.g., trainees in the current study and practicing clinicians in Tomko & Munley's , 2013). This is counterintuitive given the field's increased emphasis on treating older adult clients and the development of professional guidelines specifically geared toward working with this population (American Psychological Association, 2014). Even the most commonly reported aging topic ("Developmental stages of aging") was only covered in 69% of the programs represented in the current sample with a quarter of the particpants reporting that their training program did not cover any topics related to aging. Twenty-seven percent of the present sample of trainees reported having no pre-doctoral training in aging as compared to 11% of practicing clinicians who reported having no pre-doctoral training in aging (Tomko & Munley, 2013). These low training-ratings may influence the ability to discern an impact of training on clinical judgments, as was similarly determined by Tomko

and Munley. Although interested students can actively self-select into clinical settings that serve older populations, with research indicating that exposure to geropsychology is correlated with later involvement within that field (Koder & Helmes, 2008) it is critical to provide some level of geropsychology training and education to all psychologists in training. More adequate and consistent coverage of aging topics within training programs would likely positively impact the number of future clinicians ready and willing to work with the growing population of older adult clients.

Based on previous decades of research demonstrating age-related biases across mental health professionals, the researcher hypothesized that psychologist trainees' clinical judgments would similarly vary based on client age. More specifically that older clients would be 1) rated less desirable than younger clients, 2) rated less appropriate for therapy than younger clients, 3) given a poorer prognosis than younger clients, and 4) rated as lower functioning than younger clients. It was also assumed that therapists would report feeling less competent to work with an older client as compared to their younger counterparts. Diagnosis and treatment recommendations were also hypothesized to vary according to age of the client. Surprisingly, and in contrast with much of the previous literature, only one of the abovementioned age-related judgment differences was exhibited by the sample of psychologist trainees assessed in the present study wherein trainees rated themselves less competent to work with older versus younger clients. These findings, or lack there of, as compared to previous and research (Appendix A. Table A.1.) may be indicative of a positive shift toward a less biased professional perception of older adults in therapy. In other words, the newest generations of psychologists may exhibit the least bias toward older adults as compared to practicing professionals, past and present. The fact that the only significant clinical difference between trainees' ratings of older

and younger clients was self-reported competence working with the older client also offers insight into a pressing area of emphasis on addressing age-related topics within psychologist training programs. Some progress has already been made toward addressing this area of need. One such development, the Pikes Peak Training Model (Knight, Karel, Hinrichsen, Qualls, & Duffy, 2009), could be used to develop training curriculums that will better prepare trainees to feel confident and competent working with older adult clients.

Additionally, although ratings of the client's ability to form a therapeutic relationship with the therapist did not significantly vary according to age, trainees' attitudes toward older adult clients predicted their clinical judgment of an older client's ability to develop a therapeutic relationship. Since the therapeutic relationship is generally thought to be a critical component of the therapeutic process across all forms of psychotherapy (Crits-Christoph, Gibbons, & Mukherjee, 2013), this biased view toward older adults could have dire consequences in a clinical setting. It is possible that individuals who hold negative attitudes toward older adult clients would opt out of working with this population, however with the growing numbers it is likely they will come into contact with older adults clients at some point in their careers. Fortunately, although not predictive, the present study found a positive relationship between more training in aging and more positive attitudes toward older adult clients. Thus increasing aging-related education and training within doctoral programs could offer an avenue to increase positive attitudes toward older adult clients that could ultimately positively impact clinicians' perceptions of those clients in therapy.

Limitations and Future Research

A potential limitation of the current study is the use of a vignette client stimulus versus an in-person client. The two dimensional nature of a client vignette may have failed to elicit biases that might exist when physically seated across from an older adult client in an actual therapeutic context. To examine this possibility, future research could explore age-related biases using confederate clients of varied ages. This level in vivo of engagement and interaction with an older versus younger client may offer a more in depth exploration and a more realistic view of attitudes and differential clinical judgments toward older adult clients.

As previously noted, the clients in the vignettes in the present study were white females. The gender and race/ethnicity of the clients was held constant in order to isolate the impact of client age and to protect against the influence of these factors on clinician clinical judgments. Unfortunately much of the research similarly focuses on older white females and therefore can miss critical components of the experiences of older males and older adults from diverse backgrounds. Future research may wish to examine the intersection of gender and race/ethnicity on clinical ratings of older adult clients.

The quantitative nature of this study, and the majority of previous literature, may also have limited the depth of information gathered regarding attitudes and potential biases toward older adult clients. Future research could qualitatively examine trans-cohort (e.g., present trainees and practicing psychologists) attitudes toward working with older adult clients in order to glean a more in depth view of potential attitudinal differences including gathering information regarding what may be contributing to differences in attitudes. Examining the attitudes of both novice psychologist trainees and experienced practitioners can also offer insight into how future educational and pre/post-doctoral trainings and programs can inoculate potential biases toward older adults and ideally encourage newer generations of psychologists to practice therapy with

older adult clients. Additionally, future research could qualitatively examine geropsychology training from the perspective of faculty members and decision-makers within psychologist training programs. The latter exploration could offer a more systemic view of the current state of clinical trainings aimed at preparing future psychologists to work with the ever-growing population of older adults.

Another potential limitation is that although there were several references made to the Pikes Peak Training Model (Knight, Karel, Hinrichsen, Qualls, & Duffy, 2009), a competency-based training and evaluation of knowledge and skills specific to working with older adults, the present study did not examine these competencies within the trainee population. Future researchers may wish to investigate these competencies within trainee and psychologist populations. Given the positive relationship found between aging-related training and attitudes toward working with older adult clients, training programs may want to incorporate more geropsychology training and educational opportunities in order to better prepare their students to meet the psychological needs of older adult clients. Since several predoctoral training curriculums have been develop based on the Pikes Peak Training Model (Qualls, Scogin, Zweig, and Whitbourne, 2010), future research could investigate the impact of these curricula already in progress or researchers within training programs could investigate the implementation of a Pikes Peak curriculum within their own programs.

Conclusions

The results of the present study indicate that current doctoral-level trainees do not exhibit the same marked negative biases toward older adult clients as frequently seen in the past literature. However, trainees did express less self-reported competency working with older versus younger clients. Further, general attitudes toward older adult clients impacted trainees'

ratings of the client's ability to form a therapeutic relationship, a critical component of successful therapy. Fortunately there seems to be a relationship between the level of aging-related training and attitudes toward older adult clients indicating that as the extent of training increases so do positive attitudes. Unfortunately, trainee reports suggest that there is limited aging-related coursework and training currently being offered to doctoral students. If the field of psychology hopes to meet the needs of the growing aging population then training programs and agencies must prioritize work with older adults and engender a culture of competence and willingness to serve these clients within newer cohorts of psychologist trainees.

Table 1

Demographic Characteristics of Participants (N =81)

Characteristic	M	SD	Range	n	%
Age (years)	28.75	6.17	24–66		
Gender					
Female				58	72
Male				23	28
Ethnicity					
Caucasian				54	69
Biracial				7	7
Hispanic				6	7
Black/African American				5	6
Asian Pacific Islander				3	4
Other				3	4
Highest Degree Earned					
Bachelor's (B.A., B.S.)				76	93
Master's (M.A., M.S., M.S.Ed., Psy.M.)				5	6
Type of Doctoral Program					
Counseling Ph.D.				71	88
Clinical Ph.D.				5	6
Counseling Psy.D.				2	2
Counseling Ed.D., combined				2	2
Clinical Experience (years)					
1-2				20	25
2-3				27	33
3-4				21	26
4-5				3	4
5+				10	12

Table 2

Means and Standard Deviations of Continuous Clinical Judgments by Client Age Symptom Type

	Younger Client		Older Client	
Clinical Judgment	Depressed[a] M (SD)	Anxious[b] M (SD)	Depressed[c] M (SD)	Anxious[d] M (SD)
Functioning	4.65 (.67)	5.00 (.73)	4.85 (.75)	5.19 (.68)
Therapeutic relationship	5.85 (.67)	6.05 (.76)	5.95 (.76)	6.19 (.51)
Appropriateness	6.60 (.50)	6.35 (.67)	6.45 (.83)	6.48 (.68)
Prognosis	5.90 (.79)	6.10 (.55)	5.65 (.75)	6.05 (.59)
Therapist Competence	6.00 (.73)	6.30 (.57)	5.75 (.55)	6.05 (.59)
Willingness	6.55 (.76)	6.65 (.59)	6.50 (.61)	6.62 (.50)

Note. Functioning = “How would you rate Ms. James/Smith’s current level of functioning?”; Therapeutic Relationship = "How do you view Ms. James's ability to develop an adequate therapeutic relationship with you?"; Appropriateness = “How appropriate a candidate for psychotherapy do you see Ms. James/Smith as being?”; Prognosis = “With regard to her presenting complaint, how would you rate Ms. James/Smith's prognosis?”; Therapist Competence = “How competent do you feel treating Ms. James/Smith?”; Willingness = “How willing are you to work with Ms. James/Smith?” All items were rated on a 7-point Likert scale with higher scores indicating more positive ratings (e.g., higher functioning, highly able to form a therapeutic relationship, more appropriate for therapy, better prognosis, more competence, and greater willingness to work with the client, respectively).
[a]*n = 20,* [b]*n = 20,* [c]*n = 20,* [d]*n = 21.*

Table 3

Clinical Judgments by Client Age and Symptom Type

Clinical Judgment	Client Age		F	Client Symptom		F
	Young[a] M (SD)	Old[b] M (SD)		Depressed[c] M (SD)	Anxious[d] M (SD)	
Functioning	4.83 (.71)	5.02 (.72)	0.70	4.75 (.71)	5.10 (.70)	4.88*
Therapeutic relationship	5.95 (.71)	6.07 (.65)	0.62	5.90 (.71)	6.12 (.64)	1.89
Appropriateness	6.48 (.59)	6.46 (.75)	0.29	6.53 (.68)	6.41 (.67)	0.71
Prognosis	6.00 (.68)	5.85 (.69)	0.95	5.78 (.77)	6.07 (.57)	3.55
Therapist Competence	6.15 (.66)	5.90 (.58)	5.06*	5.88 (.65)	6.17 (.59)	2.34
Willingness	6.60 (.67)	6.56 (.55)	0.82	6.52 (.68)	6.63 (.54)	0.02

Note. Functioning = “How would you rate Ms. James/Smith’s current level of functioning?”; Therapeutic Relationship = "How do you view Ms. James's ability to develop an adequate therapeutic relationship with you?"; Appropriateness = “How appropriate a candidate for psychotherapy do you see Ms. James/Smith as being?”; Prognosis = “With regard to her presenting complaint, how would you rate Ms. James/Smith's prognosis?”; Therapist Competence = “How competent do you feel treating Ms. James/Smith?”; Willingness = “How willing are you to work with Ms. James/Smith?” All items were rated on a 7-point Likert scale with higher scores indicating more positive ratings (e.g., higher functioning, highly able to form a therapeutic relationship, more appropriate for therapy, better prognosis, more competence, and greater willingness to work with the client, respectively).

*$p < .05$

[a]$n = 40$, [b]$n = 41$, [c]$n = 40$, [d]$n = 41$.

Table 4

Mean, Standard Deviation, Range, and Alpha Coefficients of Measures Used

Measure	M	SD	Range	α
TEQ-D	15.76	3.64	3 – 21	.75
TEQ-A	8.19	4.29	3 – 18	.79
ATOC	64.43	8.11	48 – 84	.85

Note. TEQ-D = Training and Experience Questionnaire-Diversity items; TEQ-A = Training and Experience Questionnaire-Aging items; ATOC = Attitudes Toward Older Clients.

Table 5

Univariate Analyses of Variance F *Ratios for Training and Attitudes Effects on Clinical Judgments of Older Clients*

Clinical Judgments	TEQ-D	TEQ-A	ATOC
Functioning	1.46	2.14	0.41
Therapeutic Relationship	0.49	0.22	3.29*
Appropriateness	0.63	0.54	0.23
Prognosis	0.83	0.55	0.84
Therapist Competence	0.56	0.88	0.80
Willingness	0.53	0.05	0.94

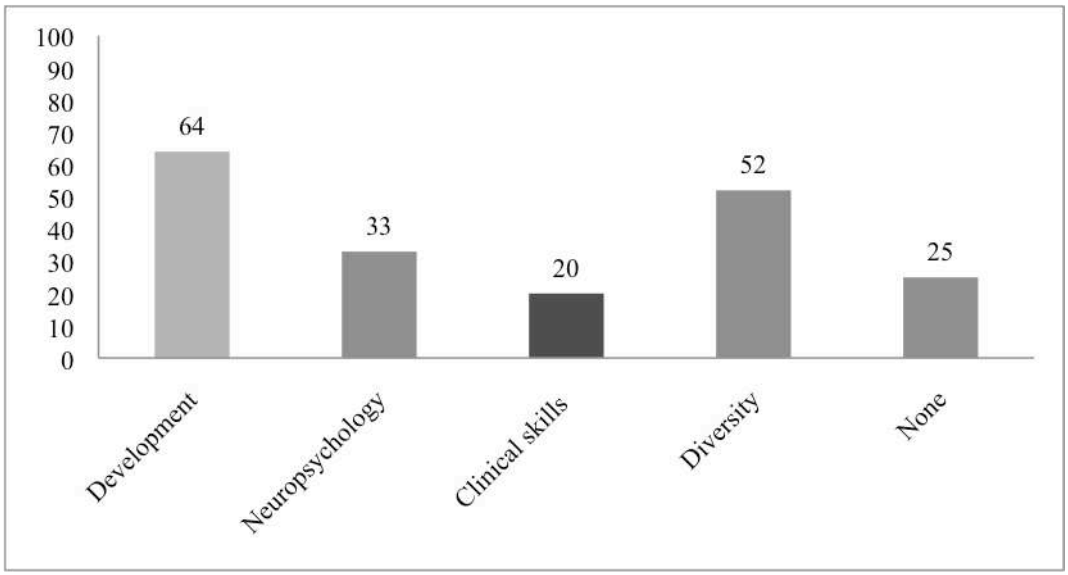
Note. Functioning = “How would you rate Ms. James/Smith’s current level of functioning?”; Therapeutic Relationship = "How do you view Ms. James's ability to develop an adequate therapeutic relationship with you?"; Appropriateness = “How appropriate a candidate for psychotherapy do you see Ms. James/Smith as being?”; Prognosis = “With regard to her presenting complaint, how would you rate Ms. James/Smith's prognosis?”; Therapist Competence = “How competent do you feel treating Ms. James/Smith?”; Willingness = “How willing are you to work with Ms. James/Smith?” All items were rated on a 7-point Likert scale with higher scores indicating more positive ratings (e.g., higher functioning, highly able to form a therapeutic relationship, more appropriate for therapy, better prognosis, more competence, and greater willingness to work with the client, respectively); TEQ-D = Training and Experience Questionnaire-Diversity items; TEQ-A = Training and Experience Questionnaire-Aging items; ATOC = Attitudes Toward Older Clients.
*$p < .05$

Table 6

Intercorrelations Between Independent and Demographic Variables

Measure	1	2	3
1. TEQ-A	-		
2. ATOC	.46**	-	
3. Participant Age	.20	.38**	-
4. Clinical Experience	.01	.14	.40**

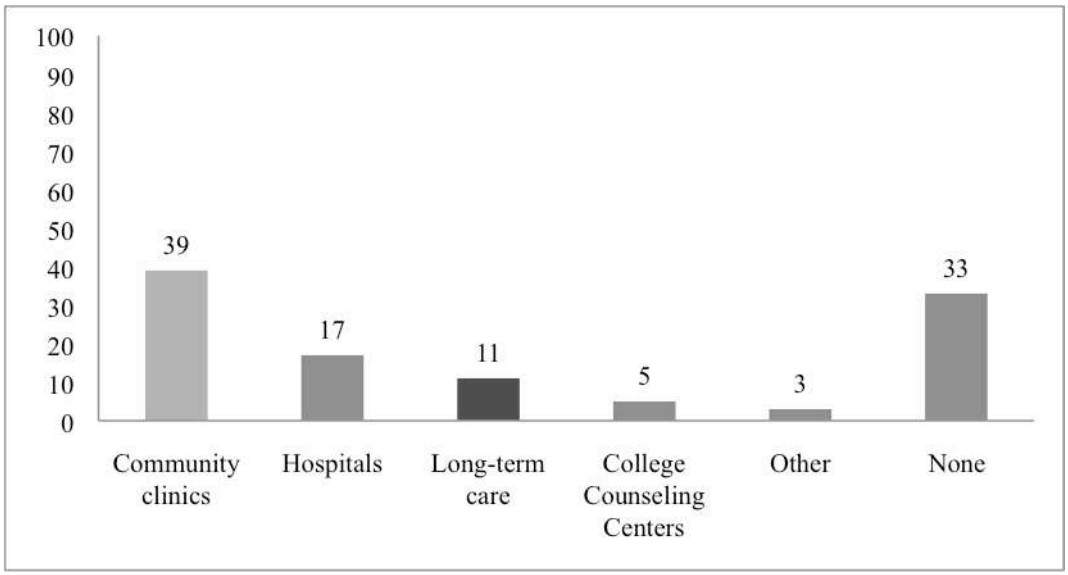
Note. TEQ-A = Training and Experience Questionnaire-Aging items; ATOC = Attitudes Toward Older Clients; Participant Age = Reported age of the participant; Clinical Experience = Reported years of trainees' clinical experience.
**$p < .01$



Note. Numbers indicate percentage of sample endorsing each aging topic.

Figure 1

Aging Topics Covered in Graduate Training Programs



Note. Numbers indicate percentage of sample endorsing each training setting.

Figure 2

Clinical Training Settings Working With Older Adults

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APPENDIX A

Table A.1.

Previous Studies' Research Methods, Populations, and Noteworthy Outcomes

Authors (date)	Method	Sample	Noteworthy outcomes
Dye (1978)	Survey of attitudes, knowledge, and clinical preference	Psychologists	▪ Preference for younger clients ▪ Older adult less appropriate for therapy than younger counterparts
Ford & Sbordone (1980)	Clinical vignettes	Psychiatrists	▪ Older clients less ideal clients ▪ Less likely to emphasize therapy for as treatment for older clients ▪ Older clients have poorer prognosis than younger counterparts
Settin (1982)	Clinical vignettes	Psychologists	▪ Less interest in providing therapy to older clients ▪ Therapy less useful intervention for older adults ▪ Older clients have poorer prognosis than younger counterparts
Perlick & Atkins (1984)	Patient interview	Psychologists	▪ Same symptoms seen as less severe for older clients ▪ Less likely to recommend anti-depressants to older clients
Ray, McKinney, & Ford (1987)	Clinical vignettes	Psychologists	▪ Psychotherapy is not beneficial for older adults ▪ Older clients have poorer prognosis than younger counterparts
Meeks (1990)	Clinical vignettes	Psychologists and Psychologist Trainees	▪ Older clients have poorer prognosis than younger counterparts
Zivian (1992)	Survey of clinical preferences	Psychiatrists and Psychologists	▪ Less interest in providing therapy to older clients
James & Haley (1995)	Clinical vignettes	Psychologists	▪ Older adults seen as less appropriate for therapy ▪ No significant difference in diagnosis ▪ No significant difference in recommendations ▪ Older clients have poorer prognosis than younger counterparts
Hillman, Stricker, & Zweig (1997)	Clinical vignettes	Psychologists	▪ Psychologists no less likely to recommend therapy and anti-depressants based on age ▪ Asked psychologists to provide GAF scores but found no significant differences between age groups
Danzinger & Welfel (2000)	Clinical vignettes	Psychologists, Social Workers, Psychiatrists	▪ Older clients have poorer prognosis than younger counterparts
Ivey, Wieling, & Harris (2000)	Clinical vignettes	Non-therapist university students, Marriage and Family Therapists, and MFT Trainees	▪ Same symptoms seen as less severe for older clients
Helmes & Gee (2003)	Clinical vignettes	Psychologists and Counselors	▪ Less interest in providing therapy to older clients ▪ Older adults less appropriate for therapy ▪ Older clients have poorer prognosis ▪ Clinicians feel less competent treating older adults
Tomko & Munley (2013)	Clinical vignettes; survey of attitudes, fear of death, training, and multicultural competence	Psychologists	▪ Total clinical judgment scale indicated more negative biases against older clients