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## Age And Health Stereotypes In Practicing Clinical Psychologists.

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AGE AND HEALTH STEREOTYPES IN PRACTICING  
CLINICAL PSYCHOLOGISTS

by

JOSEPH WILLIAM JAMES

A DISSERTATION

Submitted in partial fulfillment of the requirements for  
the degree of Doctor of Philosophy in the Department of  
Psychology in the Graduate School,  
The University of Alabama at Birmingham

BIRMINGHAM, ALABAMA

1995

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ABSTRACT OF DISSERTATION  
GRADUATE SCHOOL, UNIVERSITY OF ALABAMA AT BIRMINGHAM

Degree Ph.D. Major Subject Medical Psychology  
Name of Candidate Joseph William James  
Title Age and Health Stereotypes in Practicing Clinical  
Psychologists

Limited study has examined the effect of a potential client's age on treatment impressions and recommendations made by mental health professionals. Previous work suggests that clinicians make differential treatment recommendations and offer poorer prognoses on the basis of a client's age (i.e., mental health professionals exhibit a professional bias against older people). However, evidence for ageism suffers from important methodological limitations.

Beyond methodological concerns, a second body of work suggests that age may not exert as powerful an effect as indicated above. This literature suggests that, within the general population, poor physical health is a more powerful activator of negative interpersonal biases (the attribution of negative personality characteristics to a person on the basis of ancillary factors) than is age. However, no studies have identified the effect of physical health on professional and/or interpersonal biases among mental health professionals. The impact of a client's physical health is an especially important factor to examine among clinical psychologists as

many elderly people present with physical problems having little or no relation to their appropriateness for professional services or personality characteristics.

Thus, it is presently unknown if practicing clinical psychologists harbor professional and/or interpersonal biases towards potential clients secondary to that client's age and/or physical health status. To answer this question, a 2 (age, 35 years/70 years) X 2 (good health/poor health) between subjects investigation was conducted. Detailed vignettes of a client presenting with symptoms of depression were mailed to 800 practicing doctoral level psychologists (200 per cell), with responses received from 371 potential participants. Respondents were requested to complete a rating scale assessing for professional and/or interpersonal biases towards the hypothetical client on the basis of that client's age and/or health status.

Results revealed evidence for professional biases on several items as a function of age, and consistent main effects for health on items measuring both professional and interpersonal biases. These findings suggest that psychologists are not judging potential clients on an individual basis when forming initial impressions. Potential underlying processes, training implications of the findings, and directions for future research are discussed.

Abstract Approved by: Committee Chairman

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8/27/95

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Jan Herd

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Now I understand why those Academy Award speeches are so drawn out! I would have never been able to do this without the help of many people. I would first like to express my thanks to the respondents of this project for taking the time to complete the survey. Very warm gratitude is extended to the members of my committee, Drs. Boll, Duke, Lagory and Wright, for the generous donation of their time, advice, and support in seeing this project to its completion. Very special thanks is in order for my chair, Dr. William E. Haley, who has been an incredibly patient and supportive mentor the past 5 years. You sir, are one heck of a guy and will continue to be a role model to me throughout the coming years. I would also like to thank Dr. Ron Meredith, my friend and teacher, who has helped me to see all that life has to offer. A very big thank you goes to all my classmates, in particular Dr. G. E. (that's Genius Extraordinaire!) Steele, the brother I never had, for making it fun. Last, but most certainly not least, my love and appreciation go to my mother and late father who believed in me when no one else did, and Dr. Leila "snooty chicky" Swanson whose love has made my life fuller than I ever thought possible.



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## CHAPTER 1

### Introduction

#### Are Mental Health Professionals Ageist?

The term ageism was originally coined by Butler (1969) to refer to a societal pattern of widely held devaluative attitudes and stereotypes about aging and old people. Like racism and sexism, ageism is presumed to be responsible for social avoidance, segregation, and discriminatory practices (Gatz & Pearson, 1988).

It has been estimated that between 15 and 20% of the elderly in the United States may be in need of mental health care (Gurland & Cross, 1982). However, despite comprising approximately 12% of the population, the last known available national survey suggested that the elderly comprise only 4% of the average clinician's caseload (Dye, 1978). While recent regional surveys have indicated that there are increasing numbers of psychologists treating the elderly, it is generally thought that this population remains underserved (Gatz, Karel, & Wolkenstein, 1991). A myriad of factors including relatively poor insurance coverage, reticence on the part of the elderly to seek mental health services, and ageism on the part of service providers has been hypothesized to account for the relatively low proportion of elderly receiving treatment for

mental health concerns (Gatz & Pearson, 1988). Because of the broad range of potential contributory factors to this phenomenon, the present investigation explores only one facet of the problem: ageism among practicing clinical psychologists.

The question of ageism among some professionals is not a new one. From a historical perspective, the mental health field as a whole has often viewed old age as a stage of life of limited intrapersonal growth, not amenable to professional intervention. For example, Freud (1904/1956) advised against the admission of elderly persons to psychoanalysis:

Near or above the fifties the elasticity of the mental processes, on which treatment depends, is as a rule lacking...old people are no longer educable...and on the other hand, the mass of material to be dealt with would prolong the duration of treatment indefinitely.  
(p. 258)

Despite Freud's contention, recent treatment outcome studies have demonstrated that depressed elderly clients respond positively to individual psychotherapy regardless of orientation (e.g., Areean et al., 1993; Thompson, Gallagher, & Breckenridge, 1987) and to group psychotherapy (e.g., Steurr et al., 1984). Unfortunately, despite the proven efficacy of its services and the large segment of the population available to it, the practice of clinical gerontology has not grown at the same rate as other nascent subspecialties, such as neuropsychology. This has led some to theorize that mental health professionals are "reluctant therapists" in treating the elderly (Garfinkel, 1975; Kastenbaum, 1963).

Empirical demonstration of ageism among mental health professionals is limited, however. Taken as a whole, the available results seem to suggest that such a bias does indeed exist. However, as will be shown, methodological concerns make the external validity of the existing data questionable. Because the available data is so limited each study will be individually presented and critiqued.

One of the earliest investigations into ageism by psychologists was conducted by Wilensky and Barmak (1966), who requested doctoral students in several clinical programs to rank the attractiveness of potential patient populations. In this survey, geriatric patients were rated 24/24, viewed by respondents as less appealing to work with than were criminals and patients with mental retardation.

Little appears to have changed in the almost 30 years since Wilensky and Barmak's (1966) investigation. Garfinkel (1975) presented a scale measuring attitudes toward aging to a small ( $N = 38$ ), regional sample consisting of a mixture of mental health professionals (psychologists, psychiatrists, social workers, and students). Qualitative analysis of responses indicated that these professionals generally felt older people to be "well adjusted." Unfortunately, no measure of professional recommendations was utilized, so it is not known how these clinicians would actually diagnose or treat older patients.

Dye (1978) conducted a national mail survey of clinical psychologists' attitudes regarding elderly clients. Of those

responding, 20% expressed a desire to actively avoid working with patients in this age group. Compared to younger patients, older patients were viewed as significantly more rigid, unable to learn as rapidly, and as having less energy available for therapy. Pertinent to the present investigation, Dye asked respondents to rank order their desire to treat 12 potential clients whose descriptions were varied according to gender (male and female), age (young, mature, old), and diagnosis (neurotic, psychotic). Not surprisingly, a main effect was found for diagnosis, such that psychotics were seen as less desirable to treat than were neurotics. A more important finding was that, within each diagnostic category, as age increased, desirability to treat decreased. These findings have been replicated elsewhere.

Settin (1984) used a mail survey to present psychologists with descriptions of potential patients that included only age, socioeconomic status (SES), and gender (e.g., 72 year old, working class male with reactive depression, 46 year old, middle class female with reactive depression) and asked them to rate the target on a number of dependent variables tapping attitudinal (e.g., usefulness of intervention), symptomatological (e.g., disorientation) and diagnostic dimensions. Older clients were rated as being significantly less desirable to provide treatment to, rated as significantly less likely to benefit from intervention, and viewed as having a poorer prognosis than were younger clients. The results of this study again demonstrate that, in the absence of other

salient information, psychologists may exhibit a bias in the way in which they may treat potential older clients.

Ford and Sbordone (1980) conducted a regional mail survey with 179 psychiatrists, presenting them with brief vignettes describing the clinical picture of 4 potential clients whose age (under 45 and over 65) and diagnosis (agoraphobia, alcoholism, reactive depression, and mania) were varied, such that each condition contained two older and two younger clients. Subjects were asked to rate each client on a number of dimensions on visual analog scales. Regardless of diagnosis, older clients were seen as less ideal for the respondents' services. Older clients with the depression and alcoholic diagnoses were given significantly poorer prognoses than were their younger counterparts in those conditions. With regard to treatment recommendations, older depressed clients were viewed as less suitable for psychotherapy than were their younger counterparts.

Finally, Ray, McKinney, and Ford (1987) utilized the same mail paradigm as did Ford and Sbordone (1980) on a regional sample of clinical psychologists. In this investigation, older clients presenting with depression and agoraphobia were rated as less ideal for intervention than were their younger counterparts. Older clients presenting with depression and mania were given poorer prognoses than were their younger counterparts.

Based upon the literature reviewed to this point, two conclusions may tentatively be drawn: (a) Age may elicit



negative biases within clinicians, in particular when the client has diagnoses which are amenable to psychotherapeutic intervention; and (b) factors such as diagnosis may exert stronger effects than does age in eliciting negative biases. These latter findings have been cited as partial evidence that age is a relatively weak activator of negative biases (e.g., Gatz & Pearson, 1988). However, this argument appears tenuous in that diagnoses such as psychosis and mania are generally thought best treated via pharmacological intervention, rather than through the types of services typically offered by psychologists. Therefore, it is conceivable that the differences found to date are more representative of appropriate professional judgement than of the relative strength of an ageist bias. The relative impact of certain other potential moderating factors, such as client physical health, in activating these biases is at present unknown.

In addition to these concerns, there are methodological shortcomings which make any conclusions drawn from the available studies tentative at best: (a) Five of the six studies have utilized relatively small ( $N < 150$ ), regional samples (Ford & Sbordone, 1980; Garfinkel, 1975; Ray et al., 1987; Settin, 1984; Wilensky & Barmak, 1966); (b) all of these studies utilized overly brief descriptions of potential clients, which has been shown via meta-analysis to exaggerate potential biases in attitudinal research (Kite & Johnson, 1988; see "Type of design," below, for more detail); (c) a majority of these studies utilized within subjects designs

(which has also been demonstrated via meta-analysis to exaggerate potential biases in attitudinal research [Kite & Johnson, 1988], see "The advantages of utilizing vignettes," below, for more detail); (d) all of these investigations have chosen to focus only on treatment recommendations and diagnoses; none have attempted to measure professionals' perceptions of target personality characteristics, which may explain underlying factors behind the any biases; and (e) none of these studies have examined the effects of potential moderating factors, such as client health, in activating clinicians' biases.

To summarize, while there is some evidence suggesting that bias towards the aged exists among mental health professionals, all studies in this area suffer from serious methodological shortcomings which make it unreasonable to draw conclusions with any certainty at this point in time. In fact, this issue is one of some controversy as it has been suggested by some reviewers that the presence of bias among clinicians toward the aged has been greatly overstated and may be non-existent (Gatz & Pearson, 1988). These reviewers have based their arguments upon literature examining ageism among the general population, a body of work which has utilized a somewhat different methodology than that which has used mental health professionals as participants. This discussion now turns to this literature and its implications for the present investigation.

### Ageism Among the General Population

Investigation of ageism within the general population dates to the early fifties. The typical paradigm utilized at that time required respondents to think of a typical old and/or young person while completing a rating scale and/or listing traits believed to be attributable to that person. The majority of findings during that period indicated that attitudes towards older people were generally negative in comparison with those towards younger people (e.g., Eisdorfer & Altrocchi, 1961; Palmore, 1971; Tuckman & Lorge, 1952; Weinberger & Millham, 1975).

Beginning in the early 1980s however, the nature of this work began to shift towards the hypothesis that people hold multiple stereotypes of older (and younger) adults and that a person's attitude towards a target stimulus will vary as a function of the particular stereotype activated. Brewer, Dull, and Lui (1981) were the first to suggest that stereotyping occurs at a more specific level. They hypothesized that "older adult" is a general superordinate category, nested within which are subcategories representative of stereotypes of specific kinds of older people (e.g., grandmother, elder statesman, senior citizen). Empirical support for this hypothesis was found when subjects sorted photographs of older adults believed to be representative of each subcategory into the aforementioned three expected groupings. Brewer and Lui (1984) later replicated these findings with a group of elderly subjects.

Schmidt and Boland (1986) then demonstrated that young adults have more representations of the elderly than the three initially conceptualized by Brewer et al. (1981). Pertinent to the current inquiry, these investigators also presented subjects with a description of each of the stereotypes (e.g., "Think of an older adult who is tough, patriotic, wealthy, distinguished looking, Republican, and is frustrated about mandatory retirement." [Schmidt & Boland, 1986, p. 257]), and asked them to rate their attitudes toward that person on a semantic differential scale. Attitudes towards the stereotypes hypothesized a priori to be positive (e.g., perfect grandparent) were rated significantly more positively than those which were hypothesized in advance to be perceived negatively (e.g., shrew/curmudgeon). Thus, Schmidt and Boland (1986) extended the work of Brewer et al. (1981), by demonstrating that not only do multiple stereotypes of the elderly exist, but that perceiver attitude toward the target will vary as a function of the stereotype activated by the target.

More recently, Hummert (1990) presented subjects with a deck of 84 cards, each listing one trait. Participants were divided into two groups (sort traits typical of older adults\sort traits typical of younger adult) and instructed to put all the traits that would be found in the same older (or younger) person into one group. A subsequent cluster analysis revealed different groupings (i.e., stereotypes) for the young and old adults. When respondents attitudes towards the

stereotypes were examined, an effect was found for stereotype, such that attitudes towards those which were hypothesized a priori to be negative (e.g., red neck, invalid) were poorer than those hypothesized in advance to be believed to be more positive (e.g., perfect grandparent). Most importantly, no effect was found for age (e.g., old vs. young invalid). This work demonstrated that multiple and different stereotypes exist for young and old adults and that inclusion of information which activates these stereotypes may eliminate or reduce the age effect found in previous work. Unfortunately, the design of this investigation precluded examination of any interaction between age and other potential activating factors.

The work of Hummert (1990) demonstrated that personality traits may exert a more powerful influence upon a perceiver's attitude toward the target stimulus than age. Germane to the present investigation, this review now examines literature which suggests that target health may also either interact with or exert a more powerful influence on a perceiver's biases than does age.

#### Do People Exhibit Biases on the Basis of a Target's Health Status?

Wright (1980) has argued that the presence of a physical disability will "spread" to influence the judgements of characteristics having no necessary relationship with a person's disabling condition. Wright contends that spread can be positive to infer such features as wisdom, courage, or

persistence (such as Schmidt and Boland's above mentioned elder statesman), or can be negative and used to infer deficiency (such as Schmidt & Boland's [1986] curmudgeon).

Preliminary work examining the effects of both age and health on perceiver's attitudes towards the target has supported Wright's (1980) contention. In most cases, health factors have been found to exert more potent effects than age in activating negative biases within the nonprofessional population. However, similar to the literature examining mental health professionals' perceptions of older clients, this literature is also of limited breadth and suffers from methodological flaws.

Braithwaite (1986) presented Australian high school students with very detailed vignettes in which the target's age (21/76 years old), and cognitive (alert/impaired) and physical (active/ disabled) abilities were varied. No effects were found for age, but targets with impaired physical or mental abilities were perceived as being less concerned for others, less active, less sociable, and less responsible. Thus, Braithwaite found that age is not as powerful an activator of biases as is poor health. However, this investigator utilized a measurement instrument (Ways of Behaving Scale) whose reliability coefficients of the three subscales were poor (.51 to .72), which may limit the validity of the findings.

Austin (1985) asked students to hierarchally rank their preferences for various groups, including the elderly and the

physically impaired. Participants in this study ranked persons with various kinds of serious illnesses, such as stroke, cancer or epilepsy, more positively than "older persons." However, the validity of this study is limited by utilization of overly brief descriptions of the various groups, a factor shown via meta-analysis to exaggerate potential biases in attitudinal research (Kite & Johnson, 1988).

Gekoski and Knox (1990) presented college students with descriptions of targets which were varied according to age (younger vs. older) and health (poor/average/excellent for their age). Respondents were asked to rate their interpersonal perceptions of these targets on a semantic differential scale. Main effects for health were found across all dimensions, such that those in poorer health were rated more negatively than those in good health. Only one effect was found for age, with older people being rated as less effective than younger ones in dealing with everyday crises. Unfortunately, it appears that the authors of this study failed to examine the effects of the interaction between age and health. Furthermore, this study utilized an overly brief description of the target which has been shown via meta-analysis to amplify potential biases (Kite & Johnson, 1988). Thus, while the results of this study are consistent with those of Braithwaite (1986), their validity is equally questionable.

Milligan, Prescott, Powell, and Furchtgott (1989) divided study participants into three groups (29 years and younger/30-49 years/ 50 years and older) and presented them with highly

detailed vignettes varied across age (39/79 years) and health (healthy/several medical problems). Subjects were then asked to rate their interpersonal perceptions of the target on a well-validated semantic differential scale. Main effects for health were found across all dimensions measured within all three groups of participants. No main effects for age were found. The only interaction found between age and health indicated that hypothetical older persons in poor health were seen as less autonomous than were their younger counterparts. The findings of this study are of particular importance because it appears to be the only one which utilized appropriate methodology to assess for both age and health effects as well as their interaction.

The consistency of Milligan et al.'s (1989) findings with those previously detailed suggests two important conclusions: (a) The general population appears to exhibit what Gekoski and Knox (1990) termed healthism; that is they hold devaluative attitudes and stereotypes towards those in poor health; and (b) within the general population, health exerts a more powerful effect than does age in activating negative biases. Based on the information reviewed to this point, a rationale will now be presented for examining the relative impact of both age and health on psychologists' perceptions of potential clients.

#### Reconciling Ageism and Healthism in Psychologists

The question of whether or not practicing clinical psychologists hold negative biases towards older clients



remains unanswered. While the balance of available data suggests that such biases do exist, the body of literature is prohibitively small and methodological problems within it are so rampant that any conclusions are premature at best. Furthermore, the factors related to such a bias, if it does in fact exist, are unclear. Examining clinicians' perceptions of personal characteristics of potential older clients in conjunction with their professional impressions and recommendations would appear to be a logical place to continue investigation of this phenomenon.

Examination of respondents' perceptions of a target's personal characteristics has long been used by social psychologists in investigations of the general population's perceptions of older persons. This work has recently suggested that most people hold multiple stereotypes of both younger and older people and that one's initial attitude towards a particular person will vary as a function of the stereotype activated. Tentative evidence suggests that information regarding physical health may serve as a more potent activator of negative stereotypes than information regarding age.

While physical health appears to activate negative biases among the general population, it is not known if it has the same effect on clinical psychologists. Knowledge of the existence of a negative bias towards a potential client on the basis of his or her age, health status, or some combination of these factors by clinicians is important in that many clients may present with one or both of these conditions. Older

Americans are particularly likely to present with a chronic health problem. One recent estimate is that more than 4 out of 5 people aged 65 years and older suffer from at least one chronic health condition (U.S. Senate Special Committee on Aging, 1991). Elucidation of the existence (or nonexistence) of these biases and the factors underlying them may help to clarify what is required to address any underservice or misservice these populations may be receiving from mental health professionals.

To this end, it is apparent that a study is required which utilizes a large, national sample of doctoral level psychologists and which addresses the methodological concerns alluded to earlier. In recognition of the importance of these concerns in conducting such an investigation, a brief review will now be presented of the literature which addresses them.

#### Design concerns

Type of design. It has been suggested that utilization of a within subjects design in investigations such as the present one are likely to draw the respondents' attention to the dimensions being assessed (i.e., age and health) and increase the probability of demand characteristics. This is of critical importance in an investigation utilizing research-savvy participants, such as psychologists. To minimize these concerns, several investigators (e.g., Kogan, 1979) have advocated the use of a between subjects design to study the impact of ancillary factors on a perceiver's impressions of the target stimulus.

There is empirical support for this contention. For example, as described above, Ray et al. (1987) presented psychologists with 4 vignettes describing potential patients with differing diagnoses and two age conditions (under 45 and over 65) and found younger targets to be rated more favorably on a number of dimensions concerning desirability for treatment and prognosis than were older targets. In contrast to this, Gekoski and Knox (1990) divided subjects into four groups in which age and health were varied and found multiple effects for target health, but only one for age.

With regard to the literature as a whole, Kite and Johnson's (1988) meta-analysis of attitudes towards the elderly found older targets in within subjects designs to be rated significantly more poorly than when they were evaluated in between subjects designs. The authors hypothesized that this was because "age-related information does not affect ratings in the most natural of evaluative settings--in which one person rates only one person--but does affect ratings when other people of differing age are also rated" (p. 241).

Thus, utilization of a between subjects design will minimize the likelihood of demand characteristics relative to a within subjects design. As described above, a majority of studies utilizing mental health professionals as respondents have used within subjects designs (e.g., Dye, 1978; Ford & Sbordone, 1980; Ray et al., 1987; Settin, 1984) and may have therefore magnified the potential for finding an ageist bias.

The advantages of utilizing vignettes. The use of analogue experimental techniques such as vignettes has a long history within both clinical and social psychology. If carefully designed they are generally considered to offer sufficient external validity to be representative of the situations which they attempt to mimic. The advantages of using analogue designs include their ease of administration and the ability to control and manipulate variables which one is unable to control or manipulate in the natural environment.

It may be hypothesized that increasing the amount of information provided to a participant regarding a target (i.e., the more the target is personalized) will decrease the likelihood that he or she will rely on generalized stereotypes. There is empirical evidence supporting this contention. As described above, Settin (1982) presented psychologists with descriptions of potential patients that included only age, SES, and gender (e.g., 72 year old, working class male) and asked them to rate the target on a number of dimensions. Multiple main effects were found for age including interest in providing intervention and prognosis. In contrast to this, Braithwaite (1986) presented subjects with a paragraph length description of the target which included information regarding age, physical and mental ability, and social attractiveness (e.g., "Margaret was 71 years of age. She had an amazing ability to remember all sorts of things, particularly names. At meetings, she excelled herself...this made her an invaluable source of information to all who knew

her, etc..." [p. 355]). Unlike Settin (1984), this investigator found multiple effects for ability, but none for age.

With regard to the literature as a whole, Kite and Johnson's (1988) meta-analysis revealed that studies using detailed descriptions of target persons (such as Braithwaite, 1986) exhibited smaller differences in participants' attitudes towards the elderly versus attitudes towards the young when compared with studies using a general label (such as Settin, 1982). As mentioned above, it is worth noting that virtually all previous work utilizing mental health professionals as respondents have typically used general labels (e.g., Ford & Sbordone, 1980; Garfinkel, 1975; Ray et al., 1987; Settin, 1984), and thus may have magnified the potential for finding an ageist bias.

Potential dependent variables. The present investigation appears to be the first to distinguish between two types of biases which may be exhibited by clinicians: professional bias and interpersonal bias. Professional bias may be thought of as relatively negative professional judgements, actions or intentions (e.g., seeing a client as less appropriate for therapeutic intervention, differing treatment recommendations or prognoses) on the basis of a client's age and/or physical health status. Professional bias is the type of bias typically explored in previous investigations. Interpersonal bias may be defined as the attribution of negative personal characteristics (e.g., rigid, intolerant, ugly) to a person on

the basis of his/her age and/or health status and is the type of bias which has typically been explored in investigations utilizing nonprofessionals as participants.

There is no clear consensus in the literature concerning what variables are most appropriate to measure professional bias. In prior work, clinicians have typically been asked to rate potential clients on likert or visual analogue scales which assess factors believed representative of their willingness and desire to treat that client. Examples include diagnosis, appropriateness for intervention, treatment recommendations and prognosis. An argument for the validity of these measures is the general replication of findings across investigations (e.g., Dye, 1978; Ford & Sbordone, 1980; Ray, et al., 1987; Settin, 1982).

These variables are likely to have important implications with regard to the practice of psychology. Diagnosis is an important consideration in that clients presenting with the same psychological symptomatology should generally receive the same diagnosis, regardless of age or physical health factors. Appropriateness for intervention (typically measured by asking clinicians to rate a targets' appropriateness for psychotherapy or ability to develop an adequate psychotherapeutic relationship) would seem to have significant implications regarding treatment recommendations. Prognosis and treatment recommendations should not differ as a function of age or health factors in that, as mentioned above, depressed elderly clients have been shown to be responsive to

all major schools of psychotherapy (see Scogin & McElreath, 1994, for a meta-analysis and review). Finally, a variable which apparently has not been utilized in previous investigations is the client's potential for suicide. This is surprising in that it is an important component of the assessment of a depressed patient. Because of the external validity of these factors in everyday clinical practice, the present investigation elected to utilize similar measures to examine the construct of professional bias.

Despite evidence suggesting that clinicians exhibit a professional bias against the elderly, it appears that no one has attempted to investigate related factors which may suggest how to remediate this phenomenon. Examining for the presence of negative interpersonal biases appears to be a logical point to begin in uncovering these mechanisms, should a bias be found to exist. A demonstration of interpersonal bias toward a client on the basis of his or her age or physical health status may have treatment implications in that it may interfere in the development of therapeutic alliance, a factor repeatedly demonstrated to be essential for therapeutic gain from a variety of therapeutic models (see Hovarth & Laborsky, 1993, for a review). Thus, analysis of interpersonal bias factors appears essential in understanding any reticence on the part of psychologists to work with these populations.

Measurement of the construct of interpersonal bias has typically utilized semantic differential scales, which consist of a series of bipolar ratings of different personality

traits. However, a shortcoming of some of these studies is their reliance on scales which have questionable psychometric qualities and/or apparently little grounding in theory (e.g., Austin, 1985; Braithwaite, 1986).

In contrast to these measures is the Aging Semantic Differential Scale (Rosencranz & McNevin, 1969). This instrument has the advantage of being specifically designed for measuring perceptions of the elderly and has been widely utilized in investigations similar to the present one (e.g., Bell & Stanfield, 1973; Dooley & Frankel, 1990; Gekoski, Knox, Johnson, & Evans, 1984; Rasch, Crystal, & Thomas, 1977). The psychometric properties of this measure are presented in a later section of this document (see "Materials" below).

Other therapeutic issues which do not appear to fall under the rubrics of professional or interpersonal bias appear to be relevant and were included in the present investigation. These issues include subjective level of competence in treating the patient, comfort in treating the patient, and patient's openness to professional recommendations. For the present investigation, these variables have been identified as process issues. Although not a primary focus of this investigation, data concerning process issues were collected and analyzed in an exploratory manner in the hope it may point to concerns to be addressed in future work.

Finally, factors such as therapist age, gender, orientation, and level of experience with particular age groups would also seem to be variables which may impact upon



a clinician's professional and interpersonal feelings regarding an individual. Although not a major focus of the present investigation, data concerning these factors was collected and analyzed in an exploratory manner in recognition of their potential impact.

To summarize, the dependent variables selected for the present investigation will not only broaden the available literature regarding professional bias towards the elderly and those in poor health, but also assess for the existence of interpersonal bias and bias within several process issues. It is hoped that the findings of this study will provide direction for future training of clinical psychologists in their work with these populations. The discussion now turns to the specific models explored in this investigation.

## CHAPTER 2

### Models to be Investigated

Previous literature has demonstrated that health and age cues affect respondents' perceptions of the target stimulus. No work has been done which systematically manipulates both of these variables utilizing clinical psychologists as subjects. To clarify this issue, three models were explored.

#### Model 1

Practicing clinical psychologists exhibit professional and/or interpersonal biases which are activated by an interaction of age and health cues. Although apparently never tested among psychologists, it has been hypothesized that when an older person violates general negative stereotypes (e.g., is in good health), he/she may be viewed in a more positive light than an otherwise comparable younger target (Green, 1981).

Thus, it may be hypothesized that an older target in good health might be viewed most positively because of a positive violation of a negative stereotype. Under this model, the younger target in good health would be expected to be rated second most positively as she does not violate expectations in any direction. The target rated third most positively would be expected to be the younger target in poor health as it

violates the good health expectation. Finally, the older target in poor health might be expected to be viewed most negatively because of negative violations of both age and health factors. The implication of a finding consistent with this model is that the effect of age is not generalized; it may be positive or negative, depending upon what circumstances it is manifested under.

#### Model 2

Practicing clinical psychologists exhibit professional and/or interpersonal ageist biases. This is the perspective as suggested by the present literature in this area. Support for this finding would have the following implications: (a) A finding consistent with the existence of professional ageist bias among clinicians would suggest that they need to be made more aware of treatment outcome studies indicating that the elderly are responsive to a variety of therapeutic interventions (see Scogin & McElreath, 1994, for a review); and/or (b) a finding consistent with the existence of interpersonal ageist bias on the part of clinical psychologists would suggest that clinicians need to be more aware of literature demonstrating that older people are no more likely than younger people to have negative (or positive) personality characteristics (see Schulz & Ewen, 1988, for a review).

#### Model 3

Practicing clinical psychologists exhibit professional, and interpersonal healthist biases. This hypothesis is

consistent with the position of Gatz and Pearson (1988) and the findings of attitudinal literature utilizing the general public as subjects. Proponents of this perspective have suggested that age is a relatively weak activator of negative biases when additional factors (such as physical health) are included in the model. Support for this hypothesis would imply that clinicians may be operating on heuristic rules when faced with a patient in poor health, and that they might need to be made more aware of the need to consider each patient on an individual level.

Although not the main focus of the present investigation, other potential correlates of ageist and/or healthist bias were examined. These factors include process issues, participant demographic characteristics, amount of professional experience with particular age groups, subjective levels of comfort and competence in treating the hypothetical patient.

## CHAPTER 3

### Method

#### Participants

Eight hundred (200 per cell) practicing doctoral-level psychologists were randomly identified through The 1991-1992 Edition of the National Register of Health Service Providers in Psychology, an alphabetically arranged professional directory of approximately 16,000 practicing professionals. This directory also provides information such as age ranges served and when most providers received his/her doctorate.

Any psychologist who stated that his or her clinical practice was limited to those under 65 years of age was excluded from the present study. An examination of a randomly selected sample of 50 names in the register indicated that 6% of those listed would be excluded on the basis of this criteria. A large sample was recruited because the response rate for a study of this sort typically ranges between 40% and 60% (e.g., Ford & Sbordone, 1980; Ray et al., 1987, Settin, 1982).

#### Procedure

Potential participants were sent a packet including a cover letter explaining the project, one of four possible vignettes (see "Materials," below, for more detail), the

survey instrument (see "Materials," below, for more detail) and an addressed and stamped return envelope. In order to maximize response rate, each cover letter had a handwritten note at the bottom which identified each participant by name, thanked him or her again for participating, and was signed by the investigator. This has been demonstrated to increase response rates in studies utilizing professionals as participants by as much as 40.7% (Maheux, Legault, & Lambert, 1989). Each survey was marked with a 4-digit code for identification purposes and records were kept as to when each instrument was mailed out and returned. If a potential participant had not returned his or her survey after 3 weeks, a second packet was sent out, identical to the first with the exception of the cover letter. When available, data regarding the number of years since each potential participant received his/her doctorate was collected from the National Register. This data was utilized to conduct preliminary analyses comparing professionals who returned the questionnaires versus nonrespondents to ensure that the final sample was representative of the population as a whole.

### Materials

Vignette. The vignette was a paragraph-length description of a female client presenting at the clinician's office with symptoms of depression. These symptoms were described as being related to her husband's death from cancer approximately 8 months prior to the time of the vignette. Several factors regarding external validity impacted on the decision to make

the target a female: (a) Clinical lore suggests that the majority of therapy clients are female, (b) women are significantly more likely to be depressed than men (Myers et al., 1984), and (c) there are more older women than men (U.S. Senate Special Committee on Aging, 1991). A recent review of gender and therapeutic outcome indicates that there are no consistent differences between males and females in terms of responsiveness to treatment (see Garfield, 1986, for a review).

Depressive symptomatology was thought to be an appropriate presentation as it is frequently seen by clinicians and has been shown to be amenable to psychotherapy in both younger and older adults (see Scogin & McElreath, 1994, for a review). In keeping with DSM-III-R nosology, the target reported five symptoms: depressed mood, anhedonia, weight loss, sleep difficulties, and recurrent thoughts of death. Unfortunately, after a careful review of the vignette after data collection was complete, it was realized that no indication was made as to how long the patient had been experiencing symptomatology. This factor may have impacted upon the diagnostic choices made by respondents.

The vignettes were varied according to age and health. The ages 35 and 70 were chosen as they were thought to be representative of two distinct generations. Health was varied as either unremarkable, or with a detailed description of congenital heart disease which has necessitated several recent hospitalizations for the target. This medical diagnosis was

chosen for two reasons: (a) it appeared to be a valid diagnosis for both ages, and (b) it was thought that this presentation would effectively communicate that the patient was experiencing significant chronic health problems. The vignette is presented in its entirety in Appendix A of this document.

Survey instrument. The survey instrument was used to assess for all types of biases, as well as gather demographic information from respondents. It is presented in its entirety in Appendix B of this document. Professional bias was assessed via the following likert scale and categorical questions:

1. Diagnosis is a construct typically assessed via open-ended questions (e.g., Dye, 1978; Perlick & Atkins, 1984). Because of the relative ease of categorizing this variable, the present investigation continued in this tradition, with the question of interest being: "What do you think the most likely primary DSM-III-R diagnosis is for Ms. James' presenting complaint?" Responses were coded according to the various diagnostic categories offered by respondents.

2. The respondents' perceptions of the patient's ability to develop an adequate therapeutic relationship was assessed via the following question, "How do you view Ms. James' ability to develop an adequate therapeutic relationship with you?" Responses were coded on a 7-point likert scale ranging from very good (1) to very poor (7).

3. As noted above, clinicians' perceptions of the appropriateness of a particular patient for psychotherapy has



previously been examined by single item likert scales asking respondents to rate idealness for practice (e.g., Ford & Sbordone, 1980; Ray et al., 1987) or usefulness of intervention (e.g., Settin, 1982). However, these questions appear too broad to answer the specific question, is this person a good candidate for what you do? In recognition of this shortcoming, this investigation utilized the question "How appropriate a candidate for psychotherapy do you see do you see Ms. James as being?" Responses were coded on a 7-point likert scale ranging from very appropriate (1) to very inappropriate (7).

4. Treatment recommendations have in the past been measured by both multiple choice type questions (e.g., Ford & Sbordone, 1980; Ray et al., 1987) and open ended questions (e.g., Dye, 1978; Perlick & Atkins, 1984). Because of the inherent difficulties in categorizing open-ended questions, the present study chose to utilize categorized responses. The statement of interest read as follows: "Please rank order your treatment recommendations for Ms. James." Respondents were provided with the opportunity to write in their own choices or rank order the following: short-term psychotherapy, long-term psychotherapy, pharmacological intervention, hospitalization.

5. There is preliminary evidence suggesting that clinicians overestimate the probability of elderly clients having impairments which are due to organic mental disorders (e.g., Gatz & Pearson, 1988; Perlick & Atkins, 1984). To clarify this issue, the present investigation asked the

following question, "How likely do you feel the probability of Ms. James' presenting complaint being related to an organic mental disorder is?" Responses were coded on a 7-point likert scale ranging from very unlikely (1) to very likely (7).

6. Prognosis is a construct measured by single item likert scales in virtually all previous studies in this area (e.g., Dye, 1978; Ford & Sbordone, 1980; Ray et al., 1987; Settin, 1982). The present study utilized a similar measure, with the question of interest being "With regard to her presenting complaint, how would you rate Ms. James' prognosis?" Responses were coded on a 7-point likert scale ranging from very good (1) to very poor (7).

7. Respondent's perceptions of the probability of the patient committing suicide was assessed via the question, "How likely do you rate the probability of Ms. James attempting suicide in the near future?" Responses were coded on a 7-point likert scale ranging from very likely (1) to very unlikely (7).

Interpersonal bias was assessed via the 14-item Personal Acceptability-Unacceptability subscale of the Aging Semantic Differential Scale (Rosencranz & McNevin, 1969; see Appendix B). This subscale measures a respondent's perception of the social acceptability of a target stimulus. In addition to its relative brevity, this scale is designed in a likert scale format which makes it consistent with the above described items measuring professional biases. This scale was initially factor analyzed on a group of 287 respondents. As described

above, a survey of the literature in this area indicates that this instrument is the most widely used and accepted within this avenue of research (e.g., Bell & Stanfield, 1973; Dooley & Frankel, 1990; Gekoski & Knox, 1990; Gekoski et al., 1984; Milligan et al., 1989; Rasch et al., 1977). Only one subscale of the survey instrument has been chosen for use secondary to reasons of brevity and the present investigation's stated interest in perceptions of the target's personal characteristics.

As described above, the impact of age and physical health on therapeutic process issues appears to have not been assessed in prior work. Therefore, the following questions were designed as a preliminary investigation into this area.

1. Respondents' subjective levels of competence were assessed via the question, "How would you rate your subjective level of competence in treating Ms. James' presenting complaint?" Responses were coded on a 7-point likert scale ranging from very competent (1) to no competence (7).

2. Respondents' subjective level of comfort in treating the patient were assessed via the question, "How comfortable would you feel in treating Ms. James' presenting complaint?" Responses were coded on a 7-point likert scale ranging from very comfortable (1) to very uncomfortable (7).

3. The patient's perceived level of openness to the respondent's recommendations was assessed via the question, "How open to your treatment recommendations do you see Ms. James as being?" Responses were coded on a 7-point likert

scale ranging from completely open (1) to completely closed (7).

4. Respondents' perceptions of the locus of blame for the patient's problems were measured via the question "How much do you think Ms. James is to blame for her problems?" Responses were coded on a 7-point likert scale ranging from completely to blame (1) to completely blameless (7).

To ensure that the age and health manipulations were effective, the following questions served as manipulation checks.

1. The health manipulation check was assessed via a 7-point likert scale ranging from healthy (1) to unhealthy (7). This item was embedded within the items from the aging semantic differential scale in an attempt to mask its purpose.

2. The age manipulation check was assessed via a 7-point likert scale ranging from young (1) to old (7). This item was also embedded within the items from the aging semantic differential scale in an attempt to mask its true purpose.

Individual items were also included which were believed to be potential correlates of ageist and/or health biases, or useful in describing the sample. These items include participant demographic characteristics, amount of professional experience with particular age groups, subjective levels of comfort and competence in treating the hypothetical patient, and type of practice setting.

## CHAPTER 4

### Results

#### Response Rate

Prior to distribution of packets to the entire sample, 80 (20 per cell) were circulated during the pilot phase of this investigation. Of these, 38 completed forms were returned for a response rate of 47.5%. Analysis of this data indicated that the age and health manipulations were effective and that no changes were required in the protocol for further data collection.

In all, 800 packets (200 per cell) were distributed during the data collection phase of this study. Of these, 371 completed forms were returned for a 46.38% response rate. Of the returned forms, four did not have the questions pertaining to interpersonal bias completed. However, the remainder of the data from these questionnaires appeared to be valid and was utilized in all analyses except those related to interpersonal bias.

#### Typicality of Respondents

To ensure that the respondents did not differ from those who did not respond, the number of years since reception of doctorate was collected for each potential participant. This data was subsequently divided into two groups (respondents

versus nonrespondents) and compared via a student's  $t$  test. This analysis revealed no significant difference between groups on this variable (mean number of years respondents = 19.40, mean number of years nonrespondents = 18.91 years).

#### Equivalence of Groups

Several demographic and descriptive variables were analyzed to ensure that the respondents did not differ across groups. Chi-square analyses showed that the four groups did not differ significantly in gender, theoretical orientation, practice setting or type of degree. ANOVAs also indicated that the groups did not differ in age, number of years since receiving doctorate, or percentages of patients seen in various age groups. Demographic and descriptive information for the sample as a whole are presented in Table 1. It is noteworthy that the sample is generally highly experienced with nearly 20 years of practice since reception of doctorate. Also of interest is the relatively high percentage of clients seen over the age of 60.

#### Age and Health Manipulation Check

To ensure the effectiveness of the age manipulation, a factorial ANOVA was conducted utilizing respondents' ratings of the target's age as the dependent variable and the manipulated age and health of the target as the independent variables. In this analysis, a main effect for manipulated age was found  $F(1,366) = 499.33, p < .0001$ , such that older targets were perceived to be significantly older than younger targets. A main effect was also found for manipulated health

Table 1

Sample Characteristics

## Gender

Percent male	74.39
Percent female	25.61

## Age

<u>M</u>	50.86
<u>SD</u>	9.65

## Setting

Percent private practice	71.62
Percent other	28.38

## Orientation

Percent cognitive/behavioral	32.97
Percent dynamic/humanistic other	41.08
Percent eclectic	25.95

## Degree

Percent Ph.D.	87.87
Percent Psy.D.	5.93
Percent Ed.D.	6.20

Number of years since reception  
of doctorate

<u>M</u>	19.40
<u>SD</u>	9.20

## Percent of clients by age

0 - 20 years old	18.90
21 - 40 years old	39.88
41 - 60 years old	30.79
over 60 years old	10.43

$F(1,366) = 18.09, p < .0001$ , such that the targets in poor health were perceived as significantly older than targets with no apparent health problems. The interactive term in this analysis was not significant.

To ensure the effectiveness of the health manipulation, a factorial ANOVA was conducted utilizing respondents' ratings of the target's health as the dependent variable and the manipulated age and health of the target as the independent variables. In this analysis, a main effect was found for health  $F(1,366) = 650.18, p < .0001$ , such that the targets in poor health were perceived to be in significantly poorer health than the targets in no apparent distress. No other significant effects were found in this analysis. The means, ranges and standard deviations for both these analyses are presented in Table 2.

#### Professional Bias Analyses

A MANOVA was conducted in which the target's age, health, and the interaction term were utilized as the independent variables and the continuous items measuring professional bias (target's ability to develop an adequate therapeutic relationship, appropriateness for psychotherapy, likelihood of presenting problem being organic in nature, likelihood of suicide, and prognosis) as the dependent variable. This analysis found significant main effects for age, Wilks'  $\lambda(5,359) = 6.82, p < .0001$ , and health, Wilks'  $\lambda(5,359) = 20.42, p < .0001$ . The interaction term was not significant.



Table 2

Means and Standard Deviations of Age  
and Health Manipulation Check Variables

	<u>Condition</u>			
	Young/ healthy (N = 82)	Old/ unhealthy (N = 100)	Old/ healthy (N = 99)	Young/ unhealthy (N = 90)
Perceived age <sup>1</sup>				
	M 5.55	5.90	3.44	3.88
	SD (0.82)	(0.84)	(0.82)	(1.05)
Perceived health <sup>2</sup>				
	M 3.05	5.62	3.00	5.75
	SD (1.09)	(1.00)	(1.10)	(0.88)

To further elucidate the findings of the MANOVA, univariate ANOVAs were conducted on each of the above mentioned items. A significant main effect was found for age on appropriateness for psychotherapy  $F(1, 366) = 11.03, p < .001$ , such that older targets were seen as being less appropriate candidates for therapeutic intervention. A significant main effect was also found for age on prognosis  $F(1,366) = 17.59, p < .0001$ , such that older targets were viewed as having a poorer prognosis than were their younger counterparts. The other analyses for age failed to reach significance.

Significant main effects were found for health on each

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<sup>1</sup>Note: lower values reflect perception of target as younger

<sup>2</sup>Note: lower values reflect perceptions of better health

item analyzed. The targets in poor health were rated as less able to develop an adequate therapeutic relationship  $F(1,366) = 14.43, p < .001$ , as being less appropriate for therapeutic intervention  $F(1,366) = 13.42, p < .001$ , as more likely to have their presenting complaint related to an organic etiology  $F(1,366) = 29.26, p < .0001$ , as having a poorer prognosis  $F(1,366) = 76.14, p < .0001$  and as being more likely to commit suicide  $F(1,366) = 18.52, p < .0001$  than were the targets in no apparent physical distress. None of the interactive terms were found to be significant. Data from these analyses are presented in Table 3.

A second series of analyses were conducted to examine for potential differences as a function of target age and/or health on the two categorical items utilized to measure professional bias: diagnosis and treatment recommendations. With regard to diagnosis, 48.27% of respondents diagnosed the target (regardless of condition) as having Major Depression. The other diagnoses included Adjustment Disorder (18.68%), Uncomplicated Bereavement (10.63%), Dysthymia (9.20%) and Brief Reactive Depression (1.44%). Of the respondents, 11.78% did not complete this item and thus were not included in this analysis. For the purpose of this analysis, responses were categorized as either "major depression" or "other" and compared via chi-square analysis across groups. No significant differences were found across groups.

Rather than following instructions to rank order their treatment recommendations, the vast majority of respondents

Table 3

Means and Standard Deviations of Professional Bias Items

	<u>Condition</u>			
	Young/ healthy (N = 82)	Old/ unhealthy (N = 100)	Old/ healthy (N = 99)	Young/ unhealthy (N = 90)
Lack of ability to develop a therapeutic relationship	M 2.24 SD (0.94)	2.64 (1.16)	2.19 (1.05)	2.62 (1.02)
Extent not an appropriate candidate for psychotherapy	M 2.21 SD (1.14)	2.52 (1.16)	1.71 (0.92)	2.27 (1.30)
Likelihood of complaint being due to an organic mental disorder	M 2.39 SD (1.27)	3.53 (1.66)	2.22 (1.80)	3.13 (1.63)
Poor prognosis	M 2.30 SD (0.85)	3.17 (1.13)	1.89 (0.94)	2.79 (1.02)
Likelihood of suicide	M 4.70 SD (1.24)	4.23 (1.28)	4.88 (1.18)	4.21 (1.35)

only offered one or two recommendations. Because of this, it was determined that the most appropriate analysis on this variable would be to examine for potential differences with which the different treatment recommendations were ranked as the first choice across groups. The treatment options were

categorized as either "short-term psychotherapy" (64.37%), "pharmacological intervention" (20.40%), or "other" (includes long-term psychotherapy, hospitalization, and other, 15.23%). Chi-square analysis revealed no significant differences across groups for any of these recommendations.

#### Interpersonal Bias Analyses

To examine the hypothesis that practicing psychologists hold interpersonal ageist and/or healthist biases, a MANOVA was conducted, utilizing the scores on each item from the Personal Acceptability-Unacceptability subscale of the Aging Semantic Differential Scale as the dependent variable and the target's age, health, and the interaction term as the independent variables. In this analysis, a significant main effect was found for health, Wilks' lambda(14,350) = 4.68,  $p < .001$ . However, neither the main effect for age nor the interactive term were found to be significant.

To further elucidate the findings of the MANOVA, univariate ANOVAs were conducted on each item of this scale. Significant main effects for health were found on the dimensions of handsome-ugly  $F(1,363) = 20.73$ ,  $p < .0001$ ; cooperative-uncooperative  $F(1,363) = 11.43$ ,  $p < .001$ ; optimistic-pessimistic  $F(1,363) = 13.46$ ,  $p < .001$ ; flexible-inflexible  $F(1,363) = 6.11$ ,  $p < .05$ ; hopeful-dejected  $F(1,363) = 7.68$ ,  $p < .01$ ; happy-sad  $F(1,363) = 6.88$ ,  $p < .01$ ; trustful-suspicious  $F(1,363) = 5.86$ ,  $p < .05$ ; tolerant-intolerant  $F(1,363) = 13.41$ ;  $p < .001$ ; pleasant-unpleasant  $F(1,363) = 20.02$ ,  $p < .0001$ ; and exciting-dull  $F(1,363) = 3.80$ ,  $p < .01$ .

In all these cases, the effect was such that the targets in poorer health were rated more negatively than those with no apparent health problems. Significant age X health interactions were found for the dimensions of tolerant-intolerant  $F(1,363) = 7.09, p < .01$ ; ordinary-exciting  $F(1,363) = 4.34, p < .05$ ; and exciting-dull  $F(1,363) = 5.57, p < .05$ ; such that the younger targets in poor health were viewed most negatively. The means and standard deviations of these variables are presented in Table 4.

#### Process Issue Analyses

Because these variables (subjective competence treating the target, comfort treating the target, the target's openness to treatment recommendations, and the amount the target is to blame for her problems) represent a somewhat more disparate group of measures than do those measuring professional and interpersonal bias, individual ANOVAs were conducted on each item. In these analyses, the scores from each item served as the dependent variable and the targets' manipulated age, health and the interaction term served as the independent variables.

Significant main effects were found for health on subjective competence  $F(1,366) = 33.48, p < .0001$ ; comfort in treating  $F(1,367) = 29.11, p < .0001$ ; and target's openness to treatment recommendations  $F(1,367) = 14.81, p < .0001$ . For all of these effects, the target in poor health was rated more negatively than was the target with no apparent health problems. No significant effects were found in these analyses

Table 4

Means and Standard Deviations of Interpersonal Bias Items

	<u>Condition</u>			
	Young/ healthy (N = 82)	Old/ unhealthy (N = 100)	Old/ healthy (N = 99)	Young/ unhealthy (N = 90)
Generous/ selfish	M 3.39 SD (0.80)	3.40 (0.90)	3.41 (0.90)	3.72 (0.83)
Handsome/ ugly	M 3.67 SD (1.14)	3.87 (1.16)	3.66 (0.92)	4.00 (1.30)
Cooperative/ uncooperative	M 2.49 SD (0.76)	2.73 (1.03)	2.56 (0.96)	2.88 (0.92)
Optimistic/ pessimistic	M 4.80 SD (1.03)	5.10 (1.15)	4.80 (1.11)	5.22 (1.05)
Flexible/ inflexible	M 3.91 SD (0.93)	3.98 (1.01)	3.93 (0.89)	4.27 (0.84)
Hopeful/ dejected	M 4.95 SD (1.35)	5.30 (1.19)	5.16 (1.18)	5.41 (1.13)
Happy/ sad	M 5.89 SD (0.97)	6.14 (0.84)	5.86 (1.17)	6.11 (0.82)
Friendly/ unfriendly	M 3.34 SD (0.90)	3.26 (0.87)	3.42 (0.88)	3.42 (0.85)
Neat/ untidy	M 3.30 SD (0.85)	3.43 (0.96)	3.41 (0.92)	3.55 (0.79)

Table 4 (continued)

Young/	<u>Condition</u>			
	Old/ healthy (N = 82)	Old/ unhealthy (N = 100)	Young/ healthy (N = 99)	Young/ unhealthy (N = 90)
Trustful/ suspicious	M 3.12 SD (0.83)	3.35 (0.89)	3.00 (0.77)	3.43 (0.99)
Tolerant/ intolerant	M 3.46 SD (0.72)	3.51 (0.79)	3.40 (0.79)	3.91 (0.88)
Pleasant/ unpleasant	M 3.07 SD (0.85)	3.36 (0.89)	3.04 (0.82)	3.66 (0.90)
Ordinary/ eccentric	M 3.30 SD (0.88)	3.22 (0.93)	3.20 (0.87)	3.54 (0.72)
Exciting/ dull	M 4.11 SD (0.68)	4.31 (0.73)	3.99 (0.78)	4.46 (0.87)

Note. lower values are associated with more desirable characteristic listed in each pair.

for age or the interactive term. The means and standard deviations of the variables used in these analyses are presented in Table 5.

#### Supplemental Analyses

Additional supplemental analyses were conducted to explore whether mental health professionals' age, proportion of clients 60 years of age and older, gender, setting and number of years since reception of doctorate were related to the

Table 5

Means and Standard Deviations of Process Issue Items

	<u>Condition</u>			
	Young/ healthy (N = 82)	Old/ unhealthy (N = 100)	Old/ healthy (N = 99)	Young/ unhealthy (N = 90)
Lack of subjective confidence in treating target	M 1.68 SD (0.66)	2.15 (1.06)	1.48 (0.58)	2.06 (0.99)
Lack of comfort in treating target	M 1.63 SD (0.63)	2.09 (1.11)	1.42 (0.63)	1.98 (1.00)
Client's lack of openness to treatment recommendations	M 2.55 SD (0.74)	2.91 (1.02)	2.57 (0.91)	2.93 (0.94)
Client's lack of blame for presenting complaint	M 5.57 SD (1.16)	5.89 (1.04)	5.80 (1.26)	5.85 (1.08)

dependent variables. No consistent pattern of significant relationships was found for these variables.



## CHAPTER 5

### Discussion

The main purpose of this study was to determine the impact of age on mental health professionals' perceptions of a presenting client when other salient factors, such as health, were carefully controlled. The findings that professionals continue to rate older clients as less appropriate for their services and see their prognosis as poorer than for younger clients are consistent with previous work in this area (e.g., Dye, 1978; Ford & Sbordone, 1980; Ray et al., 1987; Settin, 1984) and is unsettling in light of numerous published studies reporting successful treatment of depression with this population (see Scogin & McElreath, 1994, for a review).

It was hoped that inclusion of measures of interpersonal bias and therapeutic process issues would suggest what factors underlie such a bias, if one was found to exist. Interestingly, in contrast to the measures of professional bias, older targets were not rated significantly differently than their younger counterparts on these items. While this is a positive finding in that it indicates that practicing psychologists do not make negative inferences regarding personal characteristics on the basis of age, it leaves the mechanism of the professional ageist biases unclear.

A potential hypothesis for these findings may be found in the way in which aging has been covered in both popular and professional publications in recent years. It has been noted that this coverage has often focused on one of two extremes of a continuum--healthy, older adults actively engaged in exercise, recreation and gainful employment, or feeble, older adults suffering from major chronic dysfunctions such as Alzheimer's disease. Often overlooked are the vast majority of older adults who fall in between these two extremes (Gatz & Pearson, 1988). This widespread coverage may have helped to eradicate the attribution of negative personal characteristics on the basis of a person's age while at the same time perpetuating the erroneous impression that problems in older people signal the beginning of a irreversible downhill course. It is noteworthy that the older targets utilized in this study represented an individual falling somewhere between the two extremes. Thus, it is possible that respondents followed popular conceptions by viewing the older targets as interpersonally equivalent to their younger counterparts while at the same time exhibiting irreversible symptoms associated with aging. Supportive of this hypothesis are the items on which professional ageist biases were found--prognosis and appropriateness for psychotherapy.

A positive finding with regard to age was that those 60 years and older comprised approximately 10% of the average responding clinician's caseload. This is substantially higher than the 4% figure reported in the last known national survey

16 years ago (Dye, 1978) and is consistent with recent reports based upon regional samples indicating that a greater number of elderly are being treated by psychologists than commonly thought (Gatz et al., 1991). While the proportion is somewhat lower than what might be expected on the basis of population parameters (e.g., Gurland & Cross, 1982), it suggests that the elderly are not as underserved as previously thought.

Healthism on the part of service providers appears even more pervasive than ageism, leading not only to professional bias, but also to interpersonal biases for both older and younger targets. This is of particular concern for older adults. As noted above, older Americans are very likely to present with a chronic health problem, with recent estimates being that more than 4 out of 5 people 65 years and older suffers from at least one chronic condition (U.S. Senate Special Committee on Aging, 1991). This implies that if an older person is not viewed more negatively because of age factors by his/her psychologist, he/she is very likely to be viewed more negatively on the basis of health factors.

Several hypotheses may be forwarded to explain the healthist biases. One argument is that the majority of respondents to this project are in private practice and may not be familiar with the issues associated with a major medical illness. There appears to be some merit to this argument as respondents rated their level of subjective competence and comfort in treating targets in poor health significantly lower than for targets with no health problems.

Thus, it is possible that the health biases exhibited by respondents are reflective of a lack of experience with this type of patient.

This hypothesis fails to explain, however, why such consistent results were found on items measuring interpersonal bias. While an argument might be made for why a person in poor health is rated more negatively on a dimension such as handsome-ugly, no cogent argument can be made for rating that same person more negatively on dimensions such as tolerant-intolerant or flexible-inflexible. Because of this, the health effects found in this study appear more supportive of Wright's (1980) hypothesis that the presence of a physical disability may spread to influence judgements of characteristics having no necessary relationship with a person's disabling condition than of a hypothesis that respondents were simply recognizing their professional shortcomings.

The underlying mechanism of Wright's (1980) hypothesis may be found within social psychological literature. Researchers within this branch of psychology have documented that people often rely on heuristic or inferential rules as a means of reducing the cognitive effort required to encode a stimulus (e.g., Chiaren, 1980). Numerous experiments have shown that perceptions derived from meeting a new person can become entangled with previous memories of similar persons such that people frequently believe that they have seen features that they have in fact only inferred on the basis of previous experience (e.g., Hill, Lewicki, Czyzewski, & Boss, 1989).

Applying these findings to the present investigation, it is possible that a heuristic regarding the desirability and treatability of both physically impaired and older patients was operating and may in fact be operating in everyday clinical practice. Clearly, more work is needed to elucidate the mechanisms behind these biases.

Regardless of the underlying mechanism(s), mental health professionals should be aware of the potential for such biases and make appropriate adjustments according to the individual characteristics of each patient. The biases found in this investigation call into question the ability of psychologists to make these adjustments upon initial contact with older and/or chronically ill clients. This phenomenon does not appear to occur exclusively among mental health professionals. Within the medical profession, Hall, Epstein, DeCiantis and McNeil (1993) have shown that physicians' liking of their patients is significantly influenced by the physical and mental health of their patients, such that patients with chronic health problems are liked less by their physicians than those with occasional problems. Because of the compelling evidence suggesting that clinicians within several disciplines are no more immune to stereotyping those in poor health than society at large, an appropriate question for future researchers might be the extent to which these biases influence treatment implementation.

Tentative speculation may be made in this regard. It is noteworthy that age and health did not effect diagnosis or

treatment recommendations. This suggests that, while psychologists may harbor internal doubts and biases regarding these patients, their professional behavior remains unchanged. However, it is possible that clinicians may communicate their apprehension in treating these patients in a more subtle fashion than is indicated by these findings.

Seminal to all schools of treatment is the therapist's ability to form a strong therapeutic alliance with the patient (Horvath & Luborsky, 1993). It would appear difficult, however, to provide a physically impaired patient with as warm and trusting an environment as provided to an apparently healthy patient if one feels the former to be less handsome, cooperative, optimistic, flexible, hopeful, happy, trustworthy, tolerant, pleasant, and exciting than the latter. Thus, the biases noted in this study may result in the creation of a self-fulfilling prophecy, in which treatment outcome is adversely affected by the clinician's preconceived beliefs. As DeLoach and Greer (1981) wrote,

If a lack of knowledge or aversive reactions cause a professional to view a disability as an event which destroys one's chance for a happy, fulfilling life, it will be difficult for his/her clients to ever grow beyond the boundary of their situation. (p.44)

Others have warned of the potential to read unintended meanings into the actions of stigmatized individuals (Goffman, 1963).

A surprising finding was the number of diagnostic categories in which the targets were placed. The vignettes were designed with the intention that it would be clear that

the patient was experiencing a depressive episode. However, slightly less than half of the sample identified this as the primary diagnosis. This may be in large part due to the design of the vignette. As mentioned above, after completion of data collection it was realized that the vignette did not specify how long the target had been experiencing her symptomatology. Because of this, it is unclear whether or not the variety of the diagnoses offered by respondents are reflective of inappropriate professional judgement.

The purpose of the present study was to examine the impact of a presenting clients' age and health upon clinicians' initial impressions of that client. The project had a number of significant strengths. This appears to be the first investigation of its kind to utilize a large, national sample of doctoral-level clinical psychologists who specifically stated that they offered their services to those 65 years of age and older. It appears to have been the first study of its kind to attempt to control for a number of factors which have previously been shown to increase the likelihood of falsely inducing negative biases. These factors include overly brief descriptions of the target and a within-subjects design. This also appears to be the first study in this area to attempt to examine some of the factors which may co-exist with professional biases, such as interpersonal and process issues biases.

A precaution should be offered regarding the generalizability of the results. Despite speculation made

above, the impact of medical conditions other than congenital heart problems on the initial impressions of clinicians is unknown, as is the impact of negative initial impressions upon treatment implementation. Future research may be fruitfully directed towards examining at what level of severity of a particular medical illness is required to elicit the biases noted in the present investigation.

Most importantly, the results of this project should not be interpreted as an indication that psychologists and other mental health providers are unable to provide effective services for the elderly or the physically ill. There is overwhelming evidence demonstrating that clinicians are able to effectively treat depression in the elderly (see Scogin & McElreath, 1994 for a review), and that psychological intervention can be an effective component in the treatment of numerous and diverse somatic conditions including hypertension (e.g., Southam, Agras, Taylor, & Kraemer, 1982), diabetes (e.g., Epstein et al., 1981), headache (e.g., Adams, Feurstein, & Fowler, 1980) and insomnia (Lacks, 1987). There appears to be growing awareness within the medical field of the utility of psychology. A recent survey demonstrated that physicians who specialize in geriatric medicine believe that over 50% of their elderly patients would benefit from psychological assessment or intervention (Haley, Salzberg, & Barrett, 1993). There also appears to be growing awareness among the elderly of psychology's value as the proportion of elderly comprising the average respondent's caseload was 150%



greater than reported in the last known national survey (Dye, 1978).

This investigation has expanded upon the existing knowledge base by suggesting that the negative biases noted to be exhibited by psychologists when forming initial impressions of elderly clients may extend to other potentially underserved groups, such as those in poor health. These findings may be reflective of a larger problem facing the field of clinical psychology, in that the rapid expansion of knowledge has increased the need for psychologists to be trained in specific areas of mental health. To date, this debate has focused on the creation of a national certification board for the areas of substance abuse and psychiatric hospital practice (APA staff, 1994). The present results suggest that the American Psychological Association (APA) and state licensure boards may also need to become more attentive to qualifications of psychologists treating less recognized specialty populations, such as the elderly or those in poor physical health. At minimum, the data suggest that service providers should increase awareness of their internal reactions to these patients. Many psychologists spend a significant portion of their training and professional life learning to attend to their reactions to a client's emotional state. It may be appropriate for psychologists to devote equal time in attending to their reactions to other factors, at least when forming initial impressions of clients.

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**APPENDIX A**

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. (GOOD HEALTH CONDITION: Scanning the patient information sheet she completed while waiting for his appointment, you note that Ms. James' medical history is unremarkable. POOR HEALTH CONDITION: Scanning the patient information sheet she completed while waiting for her appointment, you note that Ms. James' medical history is remarkable for congenital heart disease which has necessitated several hospitalizations over the past five years. This severely limits the activities in which she can engage. You notice that her face is flushed and she appears out of breath as she shuffles to your office.) 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.



## APPENDIX B

2000







Instructions: The following items are different from those listed above in that they require you to make inferences regarding Ms. James's personality based on the information provided. However, the response format is the same. Please place a mark along each scale at a point which you feel best describes each personality characteristic for Ms. James. Please make each item a separate and independent judgement.

Generous	1	2	3	4	5	6	7	Selfish
Handsome	1	2	3	4	5	6	7	Ugly
Cooperative	1	2	3	4	5	6	7	Uncooperative
Healthy	1	2	3	4	5	6	7	Unhealthy
Optimistic	1	2	3	4	5	6	7	Pessimistic
Flexible	1	2	3	4	5	6	7	Inflexible
Hopeful	1	2	3	4	5	6	7	Dejected
Happy	1	2	3	4	5	6	7	Sad
Young	1	2	3	4	5	6	7	Old
Friendly	1	2	3	4	5	6	7	Unfriendly
Neat	1	2	3	4	5	6	7	Untidy
Trustful	1	2	3	4	5	6	7	Suspicious
Tolerant	1	2	3	4	5	6	7	Intolerant
Pleasant	1	2	3	4	5	6	7	Unpleasant
Ordinary	1	2	3	4	5	6	7	Eccentric
Exciting	1	2	3	4	5	6	7	Dull

How old are you? \_\_\_\_\_

Are you male \_\_\_\_\_ or female \_\_\_\_\_ ?

How would you describe your theoretical orientation?

\_\_\_\_\_

How many years have you had your doctorate? \_\_\_\_\_

Please estimate the percentage of clients you are presently seeing within the following age groups.

under 20 years \_\_\_\_\_

20-40 years \_\_\_\_\_

40-60 years \_\_\_\_\_

60+ years \_\_\_\_\_

Which of the following best describes your primary setting?

(please select only one)

\_\_\_\_\_ Individual private practice

\_\_\_\_\_ Group private practice

\_\_\_\_\_ University\College counseling center

\_\_\_\_\_ Psychiatric hospital

\_\_\_\_\_ Medical hospital

\_\_\_\_\_ Outpatient mental health center, free standing

\_\_\_\_\_ Other (please specify)

This concludes your participation. Thank you again for your time and effort, it is sincerely appreciated. Please return all completed forms in the enclosed postage paid envelope.

GRADUATE SCHOOL  
UNIVERSITY OF ALABAMA AT BIRMINGHAM  
DISSERTATION APPROVAL FORM

Name of Candidate Joseph W. James

Major Subject Medical Psychology

Title of Dissertation Age and Health Stereotypes in Practicing

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