DEVELOPMENT OF THE GERONTOLOGICAL COUNSELING COMPETENCIES
SCALE: A SELF-REPORT MEASURE OF COUNSELOR COMPETENCE WITH
OLDER ADULTS

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DEVELOPMENT OF THE GERONTOLOGICAL COUNSELING COMPETENCIES
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Dissertation

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ABSTRACT

With the projected older adult population increase and the prevalence of older adults whose mental health needs are not being met, it is more important than ever that counselors possess the basic knowledge and skills to work with older adults. In order to meet the increasing demand for counselors with the knowledge and skills to work with older adults, an instrument needs to be developed to assess the current competence level of counselors and counselor educators in the field as well as counselor trainees. The purpose of the present study was to develop a reliable and valid measure of counselor competence when working with older adults. Items for the Gerontological Counseling Competencies Scale (GCCS; O’Connor Thomas, 2012) were generated using the rational/theoretical approach to scale construction. Feedback from an expert panel and focus group were used to formulate the initial 50-item GCCS and provide support for its validity (content/face validity). The initial scale was disseminated online via listservs and 268 counselors, counselor educators, and counselor trainees across the United States agreed to participate in the study. The data obtained from these participants was analyzed through a series of Principal Component Analyses and resulted in a final 21-item Gerontological Counseling Competencies Scale (GCCS) comprised of three subscales: Knowledge & Skills, Attitudes, and Bio-Cognitive Knowledge. Reliability analysis indicated that the GCCS and its subscales had good to excellent internal consistency reliability. Furthermore, results revealed that prior educational experience,
prior work experience, and prior training significantly predicted counselor perceived competence when working with older adults. In addition, correlations of the GCCS full scale and subscales with social desirability, as measured by the Balanced Inventory of Desirable Responding (BIDR), indicated that the GCCS was not influenced by socially desirable responding. Overall, the findings of the present study demonstrate that it is important that counselor education programs provide not only coursework in gerontology but also clinical experience with older adults and additional training opportunities such as seminars and/or workshops. The present study also discussed recommendations for future research in the area of counselor competence when working with older adults.
DEDICATION

This dissertation is dedicated to my family, friends, and especially my daughter, Doris. Doris is one of the main reasons why I persisted throughout this process, despite all of the obstacles. I want her to know that anything is possible with perseverance. Never give up on your dreams!

I would also like to dedicate this dissertation to the memory of my grandparents, Doris and John DeRose and Norma O’Connor. I was so lucky to have such loving role models in my life. They helped to develop my respect for older adults and my passion for gerontology.
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Scree Plot from Principal Components Analysis
CHAPTER I
INTRODUCTION

Statement of the Problem and Need for the Study

With the “baby boom” generation (those born between 1946 and 1964) beginning to reach the age of 65 in 2011 together with the increase in average life expectancy, the older adult population (those aged 65 years and older) is predicted to increase from 35 million in the year 2000 to 40 million in 2010 and then to a startling 55 million in the year 2020 (Administration on Aging, 2009; Federal Interagency Forum on Aging-Related Statistics, 2008). Not only is the population aged 65 and older growing, but also the “oldest old,” those 85 years and above, are expected to more than double from 4.2 million to 8.9 million from the year 2000 to 2030 (Administration on Aging, 2006). With a majority of older adults suffering from one or more chronic health and mental health conditions (e.g., hypertension, arthritis, depression) and the rise of prescription medication use, coupled with below basic health literacy, it is imperative that health care professionals are competent to work with and knowledgeable about a variety of issues unique to this population (Federal Interagency Forum on Aging-Related Statistics, 2008). According to the American Psychological Association (2008), “the demand for mental health practitioners with expertise in older adult care will expand as the older population grows” (p.2).
Health has been defined by the World Health Organization as a state of complete mental, physical and social well-being (Centers for Disease Control & Prevention, 2008). Further, “Because mental health is essential to overall health and well-being, it must be recognized and treated in all Americans, including older adults, with the same urgency as physical health. For this reason, mental health is becoming an increasingly important part of the public health mission” (p.1). In fact, mental health has been identified as a priority by the Surgeon General (1999), the White House Conference on Aging (2005), and the 2010 Healthy People objectives. Older adults will be in great need for personal counseling and with their numbers growing so rapidly, their concerns will inevitably move higher on the national agenda (Finn Maples, 2006).

Even though these important organizations have identified the mental health of older adults as a priority, approximately two-thirds of older adults with a mental disorder do not receive the necessary mental health services (American Psychological Association, 2008). This figure increases the estimates noted by Rabins (1996) who reported that the mental health needs of nearly 63% of adults aged 65 and older were not being met. With the rapid increase in the older adult population discussed previously, this number will continue to climb. As a result of the population demographics, the benefits of mental health interventions will become more prominent; and “as the number of older people grows, progressively more older people in need of mental health treatment—especially the very old—are expected to be suffering from greater levels of comorbidity or dealing with the stresses associated with disability” (U.S. Department of Health & Human Services, 1999, p.345-346).
Despite the importance of having well-trained, competent counselors and psychologists for working with older adults, this unique population still remains overlooked in the training of both counselors and psychologists at the master’s and doctoral level. Therefore, as Myers argued, for “counselors to be prepared to meet the demands of our graying population, it is imperative that all counselors graduate with some knowledge of the needs of older persons and the skills to provide effective helping interventions to meet those needs. It is incumbent upon counselor educators to provide the needed training and to do so in a manner which will provide an assurance to the public that newly trained counselors have at least a minimum level of competence” (http://www.uncg.edu/ced/jemyers). A similar issue faces the training of psychologists. According to the American Psychological Association’s (1998) work entitled What Practitioners Should Know about Working with Older Adults, because of the impending demographic changes, many psychologists who have never received formal instruction to work with older adults will be faced with providing services to this fast growing population. Thus, because practitioners in all settings may expect to encounter older adults in need of assistance, the American Psychological Association (2008) recommends that training in the psychology of aging should be included in education to address the mental health needs of the rapidly growing older adult population.

Likewise, federal government policy makers have indicated that “As the older population grows, it will also grow more diverse” and “By 2050, programs and services for older people will require greater flexibility to meet the needs of a more diverse population” (Federal Interagency Forum on Aging-Related Statistics, 2008, p.4). Thus,
the mental, physical, social and economic well-being of older adults are intertwined and impact many facets of our society. As noted in *Older Americans 2008: Key Indicators of Well-Being*, “The growth of the population age 65 and over affects many aspects of our society, challenging policymakers, families, businesses, and health care providers, among others, to meet the needs of aging individuals” (Federal Interagency Forum on Aging-Related Statistics, 2008, p.2).

In summary, with the projected population increase associated with the “graying” of the baby boom generation coupled with the prevalence of older adults whose mental health needs are not being met, all counselors should possess the basic skills and knowledge to work with older adults (Schwiebert & Myers, 2001). A major challenge to the counseling profession today is that despite the fact that “competencies for gerontological counseling have been established (Myers & Sweeney, 1990), there remains a vast disparity between counselors trained to work with older persons and the need for counselors to work with older persons” (Schwiebert & Myers, 2001, p.320). In order to meet the increasing demands for counselors trained in working with older adults, we need to develop an instrument to assess the current competence level of counselors in the field as well as student trainees to identify gaps in their knowledge and training.

**Purpose of the Study**

The primary purpose of the present study was to develop a reliable and valid self-report measure of counselor perceived competence in working with older adults. In developing the measure, items were generated that assess knowledge, skills, and attitudes
regarding identified areas of gerontological counselor competence. Then, the underlying factor structure, reliability, and validity of the measure were established. Finally, the measure was used to explore the current status of the field with regards to counselors’ perceived competence in working with older adult clients. The study provided information on factors that predict counselor perceived competence when working with older adults such as prior work experience with older adults (including practicum and internship), education (e.g., coursework) in gerontological issues, and training in working with older adults (e.g., workshops, seminars). It was hoped that the findings from this initial study would help guide future research in the area of gerontological counselor competency, a much needed focus in multicultural competence research.

**General Research Questions**

The present study addressed the following research questions:

1. Is the Gerontological Counseling Competencies Scale (GCCS; O'Connor Thomas, 2012) a reliable measure of perceived counselor competence when working with older adult clients?

2. Is the GCCS a valid measure of perceived counselor competence when working with older adult clients? Specific questions addressed included:
   
   (a) Does the GCCS have face validity (content validity)?
   
   (b) What is the underlying factor structure of the GCCS?
   
   (c) Does the GCCS demonstrate construct validity?
1) Does prior work experience, prior educational experience, and prior training predict counselor perceived competence when working with older adults? (Note: prior work experience includes supervised and unsupervised work experience with older adults, prior educational experience pertains to coursework with topics related to older adults, and prior training experience includes things such as workshops and seminars dealing with gerontological content).

3. Is the Gerontological Counseling Competencies Scale (GCCS) influenced by socially desirable responding?

**Definitions of Important Terms**

The following section will briefly define a few of the important terms for the present study.

**Older adults.** For purposes of this paper, the term older adult is used to denote adults aged 65 years and older.

**Multicultural.** Multicultural is a term denoting the diversity of racial, ethnic, and cultural heritage; socioeconomic status; age; gender; sexual orientation; and religious and spiritual beliefs, as well as physical, emotional, and mental abilities (Council for Accreditation of Counseling and Related Educational Programs, 2009).

**Multicultural/Cultural competence.** Cultural competence is “a set of cultural behaviors and attitudes integrated into the practice methods of a system, agency, or its
professionals that enables them to work effectively in cross cultural situations” (Administration on Aging, 2001, p.9). It includes awareness of one’s own cultural beliefs and practices, and the recognition and acceptance that people from other cultures may not share them. Cultural competence is rooted in validation, openness and respect towards those with different cultural and social perceptions and expectations (Administration on Aging, 2001; American Psychological Association, 2009). Multicultural competence is a capacity whereby counselors possess cultural and diversity awareness and knowledge about self and others, and how this awareness and knowledge is applied effectively in practice with clients and client groups (American Counseling Association, 2005).

**Counselor competence.** Counselor competence involves having the capacity to function effectively within the context of the cultural beliefs, behaviors, and needs of clients (American Psychological Association, 2009).

**Competencies.** Competencies are the areas in which a professional should be capable of performing to a certain standard and that standard typically is set by the profession (Myers, 1992). They include specific knowledge, skills, and attitudes (Myers & Sweeney, 1990).

**Overview of the Remainder of the Present Study**

Chapter II includes a review of the literature examining theoretical and empirical research relating to the older adult population including population characteristics, special concerns, barriers to treatment, and presenting problems with treatment effectiveness. Most importantly, this chapter thoroughly discusses current and past
research on gerontological counselor competencies and multicultural competence assessment. Chapter III discusses the methodological framework of the present study, including the general research design, research questions, hypotheses, participants, instrument development and data collection procedures, and, finally, data analysis procedures. Chapter IV reports the results of the statistical analyses used in this study to test the hypotheses stated in Chapter III, including descriptive and inferential statistics. Lastly, Chapter V includes a summary, conclusion, and discussion of the results reported in Chapter IV. Further, the limitations and contributions of the present study will be discussed as well as the implications for the counseling profession and recommendations for future research in this area.
CHAPTER II
REVIEW OF LITERATURE

Older Adult Population Characteristics

Approximately one in every eight Americans, 12.6% of the U.S. population, is aged 65 or older. This is a remarkable 37.9 million persons (Administration on Aging, 2009). The older adult population increased 11.2%, or 3.8 million, since 1997 and will continue the increase to approximately 38% in the next two decades as those currently aged 45-64 years old, the “baby boom” generation, reach and surpass the age of 65. Furthermore, “since 1900, the percentage of Americans 65+ has tripled (from 4.1% in 1900 to 12.6% in 2007), and the number has increased twelve times (from 3.1 million to 37.9 million). The older population itself is getting older. In 2007, the 65-74 age group (19.4 million) was over 8.8 times larger than in 1900, but the 75-84 group (13.0 million) was 17 times larger and the 85+ group (5.5 million) was 45 times larger” (Administration on Aging, 2009, p.2). One reason for the increase in the older population has been that over the last few decades, the life expectancy for older adults of all age groups, including those age 85 years and older, has been on the rise. Currently, life expectancy is approximately 78.1 years; roughly 30 years more than a person born in 1900 “Census estimates showed an annual net increase of 634,893 in the number of
persons 65 and over” (Administration on Aging, 2009, p.2). Older adults aged 100 years or older in 1997 represented an increase of 117% since 1990 from 37,306 to 80,771.

In looking at the older adult population in terms of the women to men ratio, women outnumber men 137 to 100 and this ratio increases with age to a staggering 210 to 100 for persons aged 85 and older (Administration on Aging, 2009). Older men are outnumbered by older women 21.9 million to 16 million. Due to this discrepancy in the women to men ratio of older adults, women are more likely to be widowed and this increases with age. “Widowhood is more common among older women then older men. Women age 65 and over were three times as likely as men of the same age to be widowed, 42 percent compared with 13 percent. The proportion widowed is higher at older ages, and the proportion widowed is higher for women than men” (Federal Interagency Forum on Aging-Related Statistics, 2008, p.5). To further exemplify this point, in 2007 76% of women compared to 34% of men aged 85 years and older were widowed.

In addition to the above statistics, there are significant differences in the ethnic and minority make-up of the older population. Thus, when examining the minority older population, it was found that 19.3% of persons aged 65 years and older in 2007 were minorities (8.3% African-American, 6.6% Hispanic origin, 3.2% Asian or Pacific Islander, less than 1% American Indian or Native Alaskan, 0.6% identified as two or more races) (Administration on Aging, 2009).

Another noteworthy trend characterizes the living and financial conditions of older adults. As identified in the 2008 Profile of Older Americans, it was reported that
about 10.9 million (30 percent) of older persons live alone. Forty-nine percent of women aged 75 years and above live alone (Administration on Aging, 2009). In 2007 the median income of those aged 65+ was $14,021 for females and $24,323 for males. Further, in 2007, households containing families headed by older adults reported a median income of $41,851. Primary sources of income for older adults as reported in 2006 were social security (89%), assets (55%), private pensions (29%), wages/earnings (25%), and government pensions (14%). *A Profile of Older Americans: 2008* states that approximately 9.7% or 3.6 million older adults were below poverty level in 2007.

In order to support the need for the present research, it is not only important to take a look at the current characteristics of this special population, it is even more important to take a look ahead. As the next section of this paper will address, the older adult population is the fastest growing segment of the population. As the “baby boomers” come of age and the oldest old dramatically increases, knowledge about this population becomes even more important in providing the necessary health and mental health care services required by this diverse group.

**The outlook for the future older population.** The older population will continue to grow significantly and it is projected to increase from 35 million in 2000 to 40 million in the year 2010 (a 15% increase) further to 55 million expected in 2020 (a 36% increase for the decade) and finally 71.5 million by the year 2030; a shocking 20% of the total U.S. population (Administration on Aging, 2009; Federal Interagency Forum on Age-Related Statistics, 2008). The 2008 *Profile of Older Americans* reports that people aged 65 and older represented 12.6% of the population in the year 2007 but are
expected to grow to be 19.3% of the population by the year 2030 (Administration on Aging, 2009).

The oldest older adult population, those aged 85 years and above, is also projected to increase dramatically. It is expected that is group will continue to increase from 4.2 million in 2000 to 5.5 million in the year 2007 and further to 5.7 million in 2010 (a 36% increase) and then to 6.6 million in 2020 (15% increase for that decade) (Administration on Aging, 2009). Another source indicates that the population aged 85 and over is projected to grow from 5.3 million in 2006 to nearly 21 million by 2050 (Federal Interagency Forum on Age-Related Statistics, 2008).

When looking at the population characteristics of the older adult population, it is also important to note that this population will continue to have greater ratio of women to men. “As in most countries of the world, older women outnumber older men in the United States, and the proportion that is female increases with age” (Federal Interagency Forum on Age-Related Statistics, 2008, p.3). In 2006, women comprised 58% of the population 65 and older and this number increased to 68% for those 85 years and older. Further, it is important to note that the income of older women is substantially lower than that of older men.

With the aging of the “baby boom” generation, the older adult population is also becoming more diverse and better educated. “Minority populations are projected to increase from 5.7 million in 2000 (16.3% of the elderly population) to 8.0 million in 2010 (20.1% of the elderly) and then to 12.9 million in 2020 (23.6% of the elderly)” (Administration on Aging, 2009, p.3).
Special Concerns for Older Adults

Based on the aforementioned statistics, there are numerous special concerns confronting this segment of the American population. These special concerns have been identified by researchers and are briefly highlighted below.

Physical health. The majority of older adults have one or more chronic health conditions. The five most frequently occurring health conditions among older adults are hypertension, arthritis, heart disease, cancer, and diabetes (Administration on Aging, 2009). Furthermore, in 2007, more than half the population aged 65 and older (52%) reported having one or more sensory, physical, or mental disability; and, in 2005, over one third (37%) of adults aged 65 and older reported their disability as being “severe.” Reported disability increases with age, approaching 56% of adults aged 80+. Research shows a “strong relationship between disability status and reported health status. For example, among those 65+ with a severe disability, 64% reported their health as fair or poor. Among the 65+ persons who reported no disability, only 10 % reported their health as fair or poor. The presence of a severe disability is also associated with lower income levels and educational attainment” (Administration on Aging, 2009, p.14). This indicates that severe disability has significant negative consequences for older Americans.

Another important finding by scholars is related to a decline in the ability of older Americans to carry out the activities of daily living (ADLs) (e.g., eating, bathing, dressing, getting around the house). For example, a recent study of noninstitutionalized older adults reported in A Profile of Older Americans: 2008 found that in 2006 27% of
adults aged 65 and older had difficulty in performing one or more ADLs (Administration on Aging, 2009). In addition, problems with one or more instrumental activities of daily living (IADLs) such as shopping, preparing meals, managing money, doing housework, and taking medications was reported by 12.5% of older adults. As with chronic conditions, limitations in ADLs and IADLs increase with age. The inability of older Americans to carry out these activities also negatively impacts their quality of life and health.

**Healthcare.** Older adults average more doctor’s office visits and hospital stays than the younger adult population. “In 2006 older consumers averaged out-of-pocket health care expenditures of $4,631, an increase of 62% since 1996. In contrast, the total population spent considerably less, averaging $2,853 in out-of-pocket costs. Older Americans spent 12.7% of their total expenditures on health, more than twice the proportion spent by all consumers (5.7%). Health costs incurred on average by older consumers in 2006 consisted of $2,770 (60%) for insurance, $859 (18%) for drugs, $844 (18.5%) for medical services, and $159 (3%) for medical supplies” (Administration on Aging, 2009, p.13). It is noteworthy that approximately 93% of adults aged 65 and over were covered by Medicare in the year 2007 and that 58% carried additional private health insurance. Moreover, Medicaid covered 9% of noninstitutionalized adults aged 65+ and 52% of Medicare beneficiaries residing in nursing homes in the year 2007.

In addition, “About 11% (3.7 million) of older Medicare enrollees received personal care from a paid or unpaid source in 1999. Almost all community resident older persons with chronic disabilities receive either informal care (from family or friends) or
formal care (from service provider agencies). Over 90% of these older persons with chronic disabilities received informal care and/or formal care; and about two thirds received only informal care. About 9% of this chronically disabled group received only formal services” (Administration on Aging, 2009, p.15). Hopefully, with the new Health Care Legislation passed by Congress in 2010, more older Americans will be covered for the aforementioned services. Currently, however, it is important to note that the loopholes in Medicare and Medicaid prevent many older adults from being able to pay for their prescription medications or to obtain medically necessary services from physicians or mental health professionals. This adds to the current underutilization of mental health services by older adults.

**Mental health.** According to the Surgeon General’s 1999 report, *Older Adults and Mental Health: Chapter 5*, close to 20% of the population aged 55 and older experience specific mental disorders such as depression, alcohol and/or drug abuse, anxiety, and Alzheimer’s disease (U.S. Department of Health & Human Services, 1999). Another factor that complicates matters is that “many older people, disabled by or at risk for mental disorders, find it difficult to afford and obtain needed medical and related health care services. Late-life mental disorders also can pose difficulties for the burgeoning numbers of family members who assist in caretaking tasks for their loved ones” (U.S. Department of Health & Human Services, 1999, p.336). Past and current older adults have been reluctant to seek counseling because of the worldviews in which they became adults. This, however, is changing with the aging of the baby boomers. The baby boomers are more familiar with and open to counseling. This will pose an increased
need for trained counselors armed with an arsenal of counseling techniques and interventions effective for this growing group of seniors (Finn Maples, 2007).

**Barriers to Treatment for Mental Health Concerns**

There are many reasons that older adults underutilize psychological services. Among these reasons are lack of identification of psychological problems by primary care physicians, reluctance of therapists to treat older adults, and incorrect diagnosis of depression as dementia resulting in a low rate of referral to mental health treatment (Myers & Harper, 2004). Other barriers include physical and cognitive deficits, presentation differences (e.g., somatic rather than mental health complaints), limits of healthcare system, comorbidity, stereotypes and misconceptions, financial and economic problems, treatment compliance, and polypharmacy. According to the U.S. Department of Health and Human Services (1999), “the large unmet need for treatment of mental disorders reflects *patient* barriers (e.g., preference for primary care, tendency to emphasize somatic problems, reluctance to disclose psychological symptoms), *provider* barriers (e.g., lack of awareness of the manifestations of mental disorders, complexity of treatment, and reluctance to inform patients of a diagnosis), and mental health delivery *system* barriers (e.g., time pressures, reimbursement policies)” (p. 341).

**Physical and cognitive deficits.** Physical and cognitive deficits can also impede the mental health diagnosis and treatment of older adults. Visual and auditory impairments can be a challenge for mental health professionals. In 2006 approximately one-half older men and one-third older women reported trouble hearing; and this number
increases with age (Federal Interagency Forum on Age-Related Statistics, 2008). Visual impairment was reported by approximately 17% of the older population; and this rises to 27% for those aged 85 years and older.

Whether normal or pathological, cognitive decline can impede the identification and assessment of mental disorders in older adults. For instance, accurate patient histories can be difficult to acquire due to the normal decline in long-term memory correlated with aging and even further with the more severe deficits that occur with dementia (U.S. Department of Health & Human Services, 1999).

**Unique characteristics.** Older adults also possess several unique characteristics that affect assessment and diagnosis of mental disorders. First, the presentation of mental disorders in older adults may be different than that of younger adults making recognition more complicated (U.S. Department of Health & Human Services, 1999). “For example, many older individuals present with somatic complaints and experience symptoms of depression and anxiety that do not meet the full criteria for depressive or anxiety disorders. The consequences of these subsyndromal conditions may be just as deleterious as the syndromes themselves” (U.S. Department of Health & Human Services, 1999, p.340). Similarly, when focusing specifically on depression in older individuals, many things can hinder diagnosis and treatment. First, the signs and symptoms of depression can be mistaken for other physical or mental disorders such as atherosclerosis and Alzheimer’s disease, and can even be attributed to “normal aging” (U.S. Department of Health & Human Services, 1999). In addition, psychosocial issues (e.g., loss, bereavement), sensory difficulties, and physical health problems can create and
exacerbate depression. At the same time, the psychosocial antecedents such as loss, combined with decrements in physical health and sensory impairment can lead the professional to focus attention away from depression and focus on these factors instead. Further obstacles to the diagnosis of depression involves the older adults themselves. As mentioned previously, older individuals are less likely to report symptoms such as worthlessness and dysphoria because of the stigma older Americans may feel is attached to the diagnosis. Hoyert, Kochanke and Murphy (1999) noted that older men, who have the highest rates of suicide in later life, are particularly unlikely to report the symptoms of depression. In summary, older adults, as well as their service providers, may be distracted by the physical symptoms experienced with depression.

**Healthcare system.** The failure to detect individuals who truly have treatable mental disorders is indicative of a serious public health problem (National Institutes of Health, 1992; U.S. Department of Health & Human Services, 1999). Unfortunately this situation is exacerbated by the healthcare system that limits the time spent caring for patients so that mental health concerns are forced to compete with co-occurring physical health concerns.

**Comorbidity.** As noted earlier in this paper, older adults experience many of the same mental disorders as other adults; however, the frequency, nature, and course may be very different. For example, many psychological issues in late life are similar in nature to the difficulties occurring at earlier life stages. On the other hand, other unique issues such as age-related physical changes and comorbidity may be more specific to late life (American Psychological Association, 2004). The high prevalence of coexisting mental
and somatic disorders or comorbidity makes detecting mental disorders in older adults more complex especially when somatic disorders look similar to or conceal psychopathology. The diagnosis of mental illness is further complicated because older adults tend to report somatic symptoms more readily than psychological symptoms (U.S. Department of Health & Human Services, 1999). For example, a recent study found that only two percent of older adults reported having psychological related symptoms in the last 30 days (Administration on Aging, 2009). In contrast, because of this willingness to report somatic symptoms, primary care physicians tend to focus on physical symptoms rather than mental symptoms. Yet primary care physicians are largely responsible for diagnosing mental disorders in older adults. As a result, primary care physicians may fail to detect depression and other mental disorders (U.S. Department of Health & Human Services, 1999).

**Treatment compliance.** Treatment compliance is another barrier to effective treatment for both physical and mental symptoms. Treatment compliance can be exacerbated by cognitive deficits that can hinder a client’s ability to remember treatment plans (U.S. Department of Health & Human Services, 1999). It has been widely noted that working and long-term memory declines with age (Baltes, Sowarka & Kliegl, 1989; U.S. Department of Health & Human Services, 1999). Thus, recall, information processing, problem solving, selective attention, and fluid intelligence may be affected as one ages requiring a slower pace and a greater need for repetition when presented with new information. Furthermore, if noncompliance does happen, it may be harder to detect and remedy because, according to chapter five of the Surgeon General’s report entitled
Older Adults and Mental Health, noncompliance may be mistakenly identified as “old age” (U.S. Department of Health & Human Services, 1999).

Health literacy. An issue also related to noncompliance of mental health (as well as physical health) treatment is health literacy. The U.S. Department of Health and Human Services Office of Disease Prevention and Health Promotion published The Quick Guide to Health Literacy and Older Adults to educate individuals who serve older adults on health (mental and physical) and aging issues. The guide defined health literacy as “the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions” (p.1). In general, health literacy involves a person’s understanding of and ability to use health information to act on their own behalf in regards to their physical and mental health. It includes not only the ability to read and write but also to follow directions, understand basic math, listen, fill out forms, and interact well with health care providers. Making sense of jargon or unfamiliar ideas is encompassed under health literacy. Health literacy requires critical thinking skills for health-related topics.

Health literacy difficulties can complicate mental and physical health problems and this will become even more of a problem with the fast growing older adult population. Health literacy is influenced by a variety of factors such as the communication skills of the health provider, basic literacy skills of the patient, and the unique situations one faces within the health care system. These factors affect how a patient reads instructions for medication, finds a doctor/mental health practitioner, and adheres to treatment. People with low health literacy skills lack understanding of mental
and physical health in general. Older adults have well-established problems with health literacy. A 2003 national assessment of health literacy found that older adults (age 65 and over) have lower health literacy scores than other age groups with only three percent measured as proficient. This is important because physical as well as mental health outcomes are related to health literacy.

**Pharmacology.** The U.S. Department of Health and Human Services (1999) noted that while the pharmacological and psychosocial interventions used to treat mental health problems and specific disorders may be identical for older and younger adults, characteristics unique to older adults may be important considerations in treatment selection and the use of medications that are related to the effectiveness of treating mental health concerns. Some of the special issues to consider when selecting the proper medication for older adults include the following: age-related physiological changes, increased susceptibility to side effects, polypharmacy, comorbid conditions, and noncompliance issues. Another problem is that adults aged 65 years and over fill approximately three times the number of prescriptions that younger people fill per year (Chrischilles et al., 1992; U.S. Department of Health & Human Services, 1999). Because they often take multiple medications (polypharmacy) to treat their medical and mental symptoms, the treatment of mental disorders in the older adult population is seriously complicated due to the interaction possibilities among these medications, their increased side effects, and their decreased efficacy. Related to these problems is that often research is lacking that can alert physicians and mental health professionals to all the side effects and drug interactions (U.S. Department of Health & Human Services, 1999).
Stereotypes and misconceptions about aging and older adults can impede the proper diagnosis and assessment of mental disorders in later life. One such example is the belief that “senility” is a normal part of aging (American Psychological Association, 2004). This belief may affect the seeking of treatment. Another example is that older adults and/or their families may believe that hopelessness and depression are normal with older age again delaying or preventing the individual from receiving care (U.S. Department of Health & Human Services, 1999). Other widely held erroneous stereotypes such as the belief that the rate of mental illness is greater in older adults, or that the majority of older adults are ill and frail, or that older adults are not interested in intimacy and sex, and the belief that older adults are set in their ways negatively impact the treatment of the elderly in our society (American Psychological Association, 2004). The American Psychological Association (1998) and Hinrichsen (2006) discussed seven other commonly held myths about aging and older adults that also negatively impact their treatment. These include the belief that (1) older adults are a homogenous group; (2) older adults are lonely; (3) older adults are frail, sick and dependent on others; (4) older adults are cognitively impaired; (5) older adults are depressed; (6) with aging comes rigidity and stubbornness; and (7) older adults experience an inability to cope with the declines associated with aging. The fact is that older adults are a very diverse group who maintain close contact with family and friends. In addition, they commonly live independently with only little decline in intellectual abilities and their depression rates are lower than those for younger adults. Research has shown that personality remains relatively consistent throughout the lifespan and that most
older adults successfully cope with age-related challenges and with the exception of cognitive impairments, experience fewer diagnosable psychiatric disorders than other age groups (American Psychological Association, 1998; Hinrichsen, 2006).

Unfortunately, older adults have been the object of stereotypes from not only the general public but also health professionals (Hinrichsen, 2006). A major misconception is related to ageism. Ageism has been defined as “a form of culturally based age bias that involves (a) restrictiveness of behavior or opportunities, negative attitudes based on age, age-based stereotyping, and distorted perception in the service of maintaining such stereotypes, positive or negative; (b) a cultural belief that age is a significant dimension by definition and that it defines a person’s social position, psychological characteristics, or individual experience; or (c) the untested assumption that data from one age group generalize to others, or conversely that age is always relevant to variables studied by psychologists” (Schaie, 1993, p.49). In summary, ageism includes stereotyping of, prejudice toward, and/or discrimination against older adults because of their age (Butler, 1969; Schaie, 1993; American Psychological Association, 2004).

As noted, ageism has been identified as a problem in research on older adults. For example, Schaie (1993) specifically examined ageist language in psychological research within the context of four major themes: 1) description of the research topic, 2) language used in describing study designs, 3) descriptions of methodology and choice of participants, and 4) language used in the analysis and interpretation of research findings. In reviewing the existing literature, Schaie (1993) concluded that, first, ageism occurs when the research topic focuses on the problems of aging, relies on biological models of
decline, neglects participants’ health status, assumes age is the cause of differences without considering extraneous variables, and focuses on older adults as care needing (dependent) rather than care providing. Second, the design of the study can include ageist language when failing to distinguish between normal age-related changes and disease, relying on chronological age, and ignoring age-sex-culture interactions. This includes failure to describe other potential relevant demographics where differences can occur (e.g., culture/ethnicity, gender, sexual orientation) that may influence the data. Third, the methodology can also be flawed through inadequate operational definition of age and the use of inappropriate research instruments. Finally, the description of the analysis and conclusions reached by the researcher can use ageist language (e.g., age differences confused with age changes, individual differences overlooked, age change magnitude ignored, the absence of differences relevant to ageist stereotypes not reported, and reporting age differences that are found accidentally). As a result of the difficulties caused by the impact of ageism on research in older adults, some of the findings regarding them may be erroneous or misleading.

Presenting Problems and Treatment Effectiveness

A major question regarding the delivery of mental health services to older adults is “Does counseling work with older adults?” The answer is YES! Several studies have supported the efficaciousness of a variety of psychotherapeutic approaches used with older adults (Roth & Fonagy, 1996; Myers & Harper, 2004). Furthermore, older adults can benefit from interventions to the same degree as younger adults, though often more
slowly (American Psychological Association, 1998; 2004; Pinquart & Soerensen, 2001). However, evidence has been found that older adults may need more sessions (a longer involvement in therapy) and age-related adaptations for the interventions to be most effective (Myers & Harper, 2004).

In addition it has been found that individual and group interventions are both effective when working with older adults (Pinquart & Soerensen, 2001). Individual therapy is useful for building trust and also for adapting the intervention to the client’s specific needs, whereas group interventions can help clients to build supportive social networks. The American Psychological Association (1998; 2004) has described numerous examples of effective interventions for older adults. These include but are not limited to cognitive-behavioral, psychodynamic, interpersonal, and reminiscence approaches.

In the past ten years numerous studies have identified evidence-based approaches for older adults. For example, Pinquart and Soerensen (2001) found that both psychotherapeutic interventions and psychosocial interventions were effective with depression and psychological well-being in older adults. Specifically, they found that cognitive-behavioral therapy, psychodynamic therapy, and supportive treatments were effective treatments for depression and subjective well-being (SWB).

A few of the most frequent psychological problems experienced by older adults are depression and suicide, anxiety, substance abuse and dependence, sleep disturbances, Alzheimer’s disease and dementia, and loss and bereavement. Several studies have supported that treatment for these mental health issues is effective for older adults.
Individual or group psychosocial interventions alone or combined with antidepressant medication have been found to be very effective for treating depressive symptomatology in older adults, with a response rate between 60-80% (U.S. Department of Health & Human Services, 1999). For example, Scogin and McElreath (1994) meta-analysis of 17 studies found cognitive, behavioral, brief psychodynamic, interpersonal, and reminiscence therapies to be effective for relieving late-life depression. Further support for the efficaciousness of cognitive-behavioral, problem-solving, interpersonal, and brief psychodynamic approaches has been noted by various researchers (e.g., Arean et al., 1993; Gallagher-Thompson, Hanley-Peterson & Thompson, 1990; U.S. Department of Health & Human Services, 1999). Using the American Psychological Association’s Criteria for Empirically Validated Treatments (Chambless et al., 1996), Gatz et al. (1998) meta-analysis also found individual and group cognitive, behavioral, problem solving, and reminiscence therapies to be effective treatments for older adults with depression. Additional support for these therapies has also been reported by Myers and Harper (2004).

Likewise for anxiety, psychosocial interventions alone or with pharmacological treatment have been shown to be effective (Wolitzky-Taylor, Castriotta, Lenze, Stanley & Craske, 2010). For example, Roth and Fonagy (1996) found support for the use of cognitive-behavioral therapy for treating anxiety in older adults (Myers & Harper, 2004). Further support came from Ayers, Sorrell, Thorp and Wetherell (2007) review of literature which found that cognitive-behavioral therapy, relaxation training, cognitive therapy, and supportive therapy alone or in combination with pharmacotherapy are
effective in alleviating anxiety symptoms. Sheikh and Cassidy (2000) also found cognitive and behavioral techniques to be effective in treating anxiety disorders in older adults.

Psychosocial interventions are also effective for treating substance abuse and dependence problems in older adults with three components specifically enhancing the effectiveness of this treatment: (1) age-segregation, (2) a less confrontational style, and (3) the use of reminiscence (Blow, Walton, Chermack, Mudd & Brower, 2000; U.S. Department of Health & Human Services, 2002; Gatz et al., 1998; Myers & Harper, 2004). Further, individual or group cognitive-behavioral approach and socialization, educational, and self-help groups have been found to be effective for use with older adults (U.S. Department of Health & Human Services, 2001; Stewart & Oslin, 2001).

There is also a growing body of evidence that a variety of therapies have been shown to be successful in treating sleep disturbances in older adults. According to Gatz et al. (1998) meta-analysis, several studies show cognitive-behavioral treatment to be effective for insomnia. Edinger, Wohlgemuth, Radtke and Quillian (2001) also support the use of cognitive-behavioral interventions in treating sleep problems in older adults. Morin, Culbert and Schwartz (1994) and Murtagh and Greenwood (1995) meta-analyses found positive and significant treatment effects for behavioral approaches to treating insomnia. Furthermore, relaxation methods have been found effective with sleep problems (Friedman, Bliwise, Yesavage & Salom, 1991; Myers & Harper, 2004; Roth & Fonagy, 1996).
Treatment efficacy for the alleviation of symptoms associated with Alzheimer’s Disease and other dementias has also been supported by many researchers. For example, Gatz et al. (1998) found that behavioral approaches are successful in diminishing behavioral problems associated with dementia. Behavioral interventions such as stimulus control procedures can also be effectively applied at the environmental level. Memory and cognitive retraining programs are effective for slowing the “decay in skills” of clients suffering from dementia. Furthermore, training in the use of memory aids (e.g., mnemonics, notetaking) can help clients with mild dementia. Roth and Fonagy (1996) examined studies that support the effectiveness of the reality orientation treatment approach for dementia and found significant results in the areas of memory, information/orientation, and cognitive abilities. Psychosocial interventions have not only been found to be effective with patients but also with their caregivers (U.S. Department of Health & Human Services, 1999). Moreover, because depression and anxiety often accompany dementia, it is important to focus interventions on these issues. Cognitive and behavioral therapies have been found to be effective in treating these associated problems (Teri & Gallagher-Thompson, 1991; Teri & Uomoto, 1991; U.S. Department of Health & Human Services, 1999).

“Loss—whether of significant persons, objects, animals, roles, belongings, independence, health, or financial well-being—may trigger problematic reactions, particularly in individuals predisposed to depression, anxiety, or other mental disorders” (American Psychological Association, 2004, p.241). Treatment has been shown to be effective in alleviating these reactions (Currier, Neimeyer & Berman, 2008). Further,
Currier, Neimeyer and Berman’s (2008) review of 61 outcome studies found that bereavement interventions using group, individual, and/or family therapy modalities are equally effective. Allumbaugh and Hoyt’s (1999) meta analysis of 35 studies also revealed support for the effectiveness of grief interventions. In particular, cognitive-behavioral therapy was found by Boelen, de Keijser, van den Hout and van den Bout (2007) to be an effective form of treatment for complicated grief.

**Counselor Competencies with Older Adults**

While there is increasing evidence documenting the effectiveness of therapy with older adults, there is a gap in our knowledge regarding training and competence of mental health professionals specializing in working with older adults. This is a major challenge confronting the counseling profession today (Finn Maples, 2006). Due to the fast growing older adult population, increased numbers of highly skilled counselors will be needed to address the physical, spiritual, emotional and mental issues of older adults. Furthermore, current practitioners with an interest in working with older adults must find programs that will increase their competence in counseling this population. A major stumbling block in providing cutting edge training in this area has been the slow pace of identifying and assessing competencies needed for working with older adults. Only when competencies have been identified, and measures are developed to assess them, can scholars assess the level of expertise guiding practitioners today. In order to develop relevant competencies and assessment instruments, this paper will first discuss the standards, laws, codes, and multicultural competencies for the counseling profession (the
Council for Accreditation of Counseling and Related Educational Programs-CACREP; the American Counseling Association-ACA; the Association for Multicultural Counseling and Development-AMCD). These governing bodies provide counselors with the expectations and guides for the profession and provide the impetus for developing competencies and setting up academic programs that teach them.

**CACREP.** The Council for Accreditation of Counseling and Related Educational Programs (CACREP) describe the knowledge and skills that counselors should acquire in their education. According to CACREP (2009), the Standards “are written to ensure that students develop a professional counselor identity and master the knowledge and skills to practice effectively” (p.2). A few sections of the Standards relevant to this research will be summarized. For CACREP 2009 guidelines in their entirety, please visit the CACREP website at (http://www.cacrep.org). Perhaps the most relevant section of the CACREP guidelines related to working with older adults are the multicultural competencies put forth in the last fifteen years.

**Multicultural competence addressed by the Council for Accreditation of Counseling and Related Educational Programs.** The recent 2009 Standards put forth by CACREP require that counseling programs must reflect the current knowledge and projected needs for counselors to effectively function in a “multicultural and pluralistic” society. Therefore, they specify that courses must include information that enables students to understand how cultural factors are related to the issues, relationships, and practices characteristic of our multicultural society today. The Standards state that in addition to didactic learning experiences, students should be offered “specific
experiential learning activities designed to foster students’ understanding of self and culturally diverse clients” (Council for Accreditation of Counseling and Related Educational Programs, 2009, p.11).

The Standards have identified the knowledge areas that courses must emphasize in order for students to gain an understanding of how culture influences individual development and interpersonal relationships. Thus courses must teach theories of individual and family development across the lifespan, as well as models of identity and self-concept development. In covering these topics, courses must provide information regarding how cultural differences are related to these models of development. In addition, the Standards state that courses must provide training in all aspects of assessment and diagnosis of multicultural clients. Finally, in order to counsel diverse clients, courses must also cover the current literature discussing approaches, strategies, techniques, and theories shown to be effective when counseling specific populations. This includes the ability to modify existing theories, techniques, and interventions to make them culturally appropriate for diverse clients.

**Failure of the CACREP Standards to emphasize competence in working with older adults.** Despite the under arching theme of the need to provide training in multiculturalism and diversity issues, the CACREP Standards (2009) are vague when it comes to age and do not specifically address the older adult population. It is ironic that at a time when increased training of counselors working with older adults is warranted, the 2009 Standards have completely omitted the Standards for Gerontological Counseling Programs which was a part of the 2001 Standards. Finn Maples (2007) warned the
profession of the dire consequences if training programs neglect to train counselors to be competent in working with the large numbers of older adult clients now and especially in the future. Finn Maples (2006) noted that “we are neither prepared nor trained for the onslaught of the Silver Tsunami. Some graduate programs offer individual courses in aspects of gerontological counseling, but if practitioners are to meet the rapidly increasing counseling needs of baby boomers, more attention must be given to training these professionals, and current counseling practitioners must become alert to the concern” (p.41). The failure of the 2009 CACREP Standards to specifically demand that counselors be trained to work with older adults indicates a serious shortcoming by the leadership that can have adverse consequences if the Standards are not refined to specifically state the need for academic programs to provide relevant knowledge and skills training for their students to be competent in meeting the needs of older adult clients.

**ACA Code of Ethics.** In addition to the CACREP 2009 Standards, the current American Counseling Association (ACA) 2005 Code of Ethics impacts the training of counselors. The purposes of the ACA Code of Ethics are to: (1) identify the ethical responsibilities of the members; (2) establish principles that define ethical behavior and best practices; (3) serve as an ethical guide to assist members in constructing professional course of action; and (4) serve as the basis for processing of ethical complaints initiated against members of the association (Glosóff & Kocet, 2005). The ACA Code of Ethics is divided into eight sections that focus on: (a) the counseling relationship; (b) confidentiality, privileged communication, and privacy; (c) professional responsibility;
(d) relationships with other professionals; (e) evaluation, assessment, and interpretation; (f) supervision, training, and teaching; (g) research and publication; and (h) resolving ethical issues. For purposes of the present paper, only a few of the items relevant to counselor competence, as related to this research, will be addressed. A complete copy of the ACA Code of Ethics can be located on the American Counseling Association webpage at (http://www.counseling.org).

**Multicultural competence addressed in the American Counseling Association’s Code of Ethics.** The ACA Code of Ethics also addresses issues related to multicultural competence. For example, it states that counselors should acquire sensitivity, personal awareness, knowledge and skills appropriate for working with diverse populations. In addition, they should be open to new procedures and keep current with the relevant literature and research related to the diverse populations with whom they work. Next, in the realm of assessment, counselors should use caution when selecting assessment instruments to use with diverse populations and must administer, score, and interpret the assessment instruments that are relevant to the needs of older clients. This includes exercising caution when using assessment techniques that were normed on populations other than that of the client and recognizing the effects of age, color, culture, disability, ethnic group, gender, race, language preference, religion, spirituality, sexual orientation, and socioeconomic status on test administration and interpretation.

**Failure of the ACA Code of Ethics to emphasize competence in working with older adults.** Like the 2009 CACREP Standards, the ACA 2005 Code of Ethics uses vague terms such as “diverse populations,” “diverse groups,” and “specific populations”
when describing counselor competencies. Therefore, these references leave questions for the counselor/counselor trainee such as “what is meant by diverse populations or groups?” and “what is a specific population?” Thus, the ACA Ethics Code leaves it to the reader to interpret it as not only including race, ethnicity, and sexual orientation but also age, specifically older adults, as a “diverse group” or “specific population.” This is a reach for many counselors who have not been trained to look at older adults through a multicultural lens.

**AMCD.** Similar to the multicultural training required by CACREP and the ACA Code of Ethics, the Association for Multicultural Counseling and Development (AMCD) has listed multicultural competencies needed by counselors (Sue, Arredondo & McDavis, 1992). The following discussion will look at a few of the competencies most relevant to this paper. A complete list of the competencies can be found on the AMCD webpage at (http://www.amcd-aca.org). It is important to note that the competencies focus on race and ethnicity but can and should be generalized to other populations such as older adults.

*Multicultural competence addressed by the Association for Multicultural Counseling and Development.* A major tenet to the document is that culturally skilled counselors should be aware of the limits of their competence to counsel diverse clients as well as their preconceived stereotypes that they hold regarding other racial and ethnic minority groups. Counselors should be well-read and should be familiar with the relevant research and the latest findings about the mental health of ethnically and racially diverse groups. They should be aware of their client’s cultural heritage, life experiences, and historical background and understand how these factors impact their clients’ functioning.
In order to achieve this familiarity, counselors should seek out educational, consultative, and training experiences that foster their knowledge and understanding of culturally different populations and that helps to improve their counseling effectiveness. Further, the competencies state that counselors should not be tied down to only one approach to counseling but also recognize that helping styles and approaches may be culture bound. In regards to assessment, culturally skilled counselors should possess knowledge about the potential bias in assessment procedures and instruments and training is the use of traditional assessment and testing instruments with culturally diverse clients.

**Failure of AMCD to emphasize competence in working with older adults.** In summary, the aforementioned competencies are similar to those put forth by CACREP and ACA. Consistent with those documents, the AMCD multicultural competencies focus for the most part on the needs of racial and ethnic minority groups without specific mention of the needs of older adults or other special populations. This omission is significant because by not clearly articulating older adults as a cultural subgroup with unique needs that counselors must be knowledgeable of in order to assess, diagnose, and treat them ethically and effectively, training programs are not mandated to include this knowledge in their curriculum and are not required to document that their graduates are competent to work with this rapidly expanding population.

**Gerontological competencies for counselors and human development professionals.** The need to develop specific competencies to address the training required by counselors working with older adults came to the forefront of the counseling profession at the fifth national ACA aging project (1989-1990) which featured the
seminal research of Jane Myers and colleagues. Under the direction of Dr. Jane Myers and funded by the U.S. Administration on Aging (AoA) and the American Counseling Association (ACA), this series of five national projects on aging stimulated interest in the counseling needs of older adults and resulted in the development of a division focused on adult development and aging (Myers, 1995). At the culmination of this series of five national workshops and with input from professional counselors, counselor educators, gerontologists, practitioners, administrators, researchers, and other personnel working in the aging network, competencies for working with older adults were defined and later adopted by the Association for Adult Development and Aging (AADA), a division of ACA (http://www.uncg.edu/ced/jemyers). Specifically, a 38-page document entitled *Gerontological Competencies for Counselors and Human Development Professionals* (Myers & Sweeney, 1990) was developed and provided a series of gerontological counselor competencies divided into two areas: those for all counselors (generic competency statements) and those for counselor’s specializing in work with older adults (specialty competency statements). It was expected that these competencies would be infused into existing curricula and that additional knowledge and skills for working with older adults would further be honed during the counselor's employment.

The competency statements are based in the eight core areas of counselor preparation as defined in the Standards of the Council for Accreditation of Counseling and Related Educational Programs (CACREP), the national accrediting body for training in the counseling and human development professions and include: Human Growth and Development; Social and Cultural Foundations (later changing its name to Social and
Cultural Diversity); Helping Relationships; Groups (later called Group Work); Lifestyle and Career Development (Career Development); Appraisal (Assessment); Research and Evaluation (Research and Program Evaluation); and Professional Orientation (now known as Professional Orientation and Ethical Practice). Competency statements were written for each of these entry-level content areas and an area entitled Practica and Internship was also included. The competency statements were developed reflecting Knowledge, Skill, and Attitudes considered important to each of the above areas and were intended to assist counselor educators in developing curricula and other training experiences to assure adequate counselor preparation in gerontological issues (http://www.uncg.edu/ced/jemyers; Myers, 1995).

Due to its lengthy size and to further promote dissemination and use of the competency statements by counselor educators, the document described above was summarized into a “short form” consisting of ten minimum essential gerontological competencies for all counselors and 16 minimum essential competencies for gerontological counseling specialists (http://www.uncg.edu/ced/jemyers). Note: for purposes of this paper only the complete list of competency statements for all entry-level counselors (generic) and the minimum essential gerontological competencies will be discussed further.

**Gerontological competencies for all entry-level counselors (generic).** The generic competencies described by Myers (http://www.uncg.edu/ced/jemyers) for each of the eight CACREP domains are listed in the next few pages.
Human growth and development. The counselor can demonstrate KNOWLEDGE of human development for older persons. This includes the ability to: 1) identify and discuss major psychological theories of aging; 2) identify and discuss physiological aspects of “normal” aging; 3) distinguish between normal and dysfunctional behaviors of older persons; 4) describe myths and stereotypes associated with human growth and development as applied to older persons; 5) describe the sensory changes that occur in later life and how these changes influence the perceptions and behavior of older persons; and 6) describe the impact of losses on older persons. The counselor can demonstrate SKILLS in the use of human development knowledge for older persons. These skills include: 1) arranging the interview situation to accommodate for the physical and sensory limitations of older persons and 2) applying effective communication skills, exhibiting sensitivity to sensory problems, and environmental modifications to assist older persons. The counselor can demonstrate positive, wellness-enhancing ATTITUDES toward the human development needs of older persons. These attitudes include: 1) being receptive and responsive to older persons who seek counseling and 2) recognizing and valuing positively the experience of aging in themselves and their families.

Social and cultural foundations. The counselor can demonstrate KNOWLEDGE of social and cultural foundations (currently known as social and cultural diversity) of older persons. This includes the ability to: 1) identify common societal attitudes -- positive and negative -- which have an impact on older persons; 2) summarize implications of major demographic information about older persons (e.g. numbers, gender, life expectancies, living arrangements, health, and economic status); 3) identify
and discuss the contributions of older persons to society (e.g., expertise, special talents); 4) explain the changes that have occurred in gender roles in today's society and the resulting problems and opportunities for older persons; 5) identify and discuss social aspects of aging (e.g., social relations, family ties, education, and role expectations of older persons); 6) identify and discuss major causes of stress for older persons; and 7) describe age and cohort differences in those who seek/accept assistance from human service professionals. The counselor can demonstrate SKILLS in the use of knowledge of social and cultural foundations for older persons. These skills include: 1) recommending prevention approaches to counter negative stereotypes of older persons; 2) demonstrating counseling skills for dealing with stress experienced by older persons; 3) demonstrating awareness of the needs of specific cultural groups within the older population; 4) referring older persons experiencing abuse and their abusers to appropriate community resources; and 5) recognizing and ameliorating the misuse and abuse of drugs in treating maladaptive behavior of older persons. The counselor can demonstrate positive, wellness-enhancing ATTITUDES toward the social and cultural foundation needs of older persons. These attitudes include: 1) imparting awareness of the positive nature of older persons' contribution to society; 2) demonstrating genuine respect and regard toward older persons; 3) accepting and respecting the moral, spiritual and social values of older persons; 4) demonstrating advocacy for older persons; and 5) identifying attitudes regarding drug misuse and abuse in treatment of older persons.

Helping relationship. The counselor can demonstrate KNOWLEDGE of the helping relationship for older persons. This includes the ability to: 1) identify differences
which may distinguish older persons from other age groups in establishing and sustaining a helping relationship; 2. distinguish the theoretical approaches which are most effective when counseling with older persons; 3) identify factors which facilitate the counseling process (e.g., overcoming reluctance to seek counseling or express feelings); and 4) discuss the impact of later-life transitions on older persons. The counselor can demonstrate *SKILLS* in the use of helping-relationship knowledge for older persons. These skills include: 1) applying effective communication skills with older persons of both genders; 2) demonstrating the ability to conduct psychosocial needs assessment with older clients; 3. demonstrating the ability to help an older person cope with major life transitions; and 4) adapting to sensory losses of older persons (e.g., modifying the counseling environment, using appropriate communications patterns). The counselor can demonstrate positive, wellness-enhancing *ATTITUDES* toward the helping relationship needs of older persons. These attitudes include: 1) recognizing the unique worth and value of older individuals; 2) showing sensitivity to individual differences (e.g., social, cultural, economic and spiritual preferences of older persons); 3) recognizing personal age-related biases which may affect helping relationships with older persons; 4) expressing the value of a holistic approach in counseling older persons; and 5) identifying personal attitudes toward sexuality and aging.

*Groups.* The counselor can demonstrate *KNOWLEDGE* of groups (now known as group work) for older persons. This includes the ability to: 1) describe the importance of group involvement for older persons; 2) describe special considerations for group work with older persons (e.g., physical, physiological, emotional); 3) identify leadership issues
relevant to group work with older adults (e.g., working through authority issues, expressing feelings); 4) describe topics appropriate for groups of older persons (e.g., widowhood, reminiscence, wellness, assertiveness training, transitions); and 5) identify ethical issues for group work with older persons. The counselor can demonstrate SKILLS in the use of group knowledge for older persons. These skills include: 1) applying general group principles to work with older persons; 2) addressing effectively common concerns of older persons through a group (e.g., isolation, loss of self-esteem, loneliness); and 3) demonstrating appropriate techniques for conducting all phases of group sessions with older persons. The counselor can demonstrate positive, wellness-enhancing ATTITUDES toward the group needs of older persons. These attitudes include: 1) communicating a belief in the challenges and opportunities for personal growth across the lifespan through group involvements; 2) exhibiting patience in working with older persons in groups; and 3) recognizing those needs of older persons and their adult children which can be dealt with in group settings.

*Lifestyle and career development.* The counselor can demonstrate KNOWLEDGE of lifestyle and career development (now known as career development) for older persons. This includes the ability to: 1) identify and describe the major career and lifestyle theories related to aging; 2) describe the effect of age-related physical, psychological, and social changes on career development of older persons; 3) explain the importance of balancing work, leisure and relationships as they apply to older persons; 4) describe factors affecting the retirement decisions of older persons (e.g., economic, social, psychological); and 5) discuss major demographic changes in American society
related to work, leisure, and retirement. The counselor can demonstrate *SKILLS* in the use of lifestyle and career development knowledge for older persons. These skills include: 1) identifying employment problems of persons subjected to age discrimination in the labor market (e.g., older workers, displaced homemakers, discouraged workers); 2) identifying age discrimination in employer selection and retention procedures; 3) facilitating retirement for older persons and their families; and 4) facilitating alternative careers in retirement for older persons. The counselor can demonstrate positive wellness enhancing *ATTITUDES* toward the lifestyle and career development needs of older persons. These attitudes include: 1) viewing older persons as viable members of the work force and 2) supporting the concept of a leisure life style as an opportunity for self expression, development and socialization in later life.

*Appraisal.* The counselor can demonstrate *KNOWLEDGE* of appraisal (now known as assessment) of older persons. This includes the ability to: 1) describe the rationale for using appraisal instruments and techniques with older persons; 2) identify psychological and physical factors which may affect the use of standardized assessment instruments with older persons (e.g., visual, auditory, mental and physical impairments; learning and reading abilities; issues related to culture and experience); 3) describe the uses and misuses of appraisal instruments related to older persons; and 4) describe ethical implications of appraisal of older persons. The counselor can demonstrate *SKILLS* in the use of appraisal knowledge for older persons. These skills include: 1) selecting and using appropriate appraisal techniques in work with older persons and 2) demonstrating appraisal techniques to ensure appropriate counseling interventions with older persons.
The counselor can demonstrate positive, wellness-enhancing *attitudes* toward the appraisal needs of older persons. These attitudes include: 1) recognizing the value of appraisal techniques in work with older persons and 2) valuing appropriately appraisal information in a holistic assessment for older persons.

*Research and evaluation.* The counselor can demonstrate *knowledge* of research and evaluation (now known as research and program evaluation) of older persons. This includes the ability to: 1. describe research methods and techniques which are effective with older persons; 2) describe sources of literature reporting research about older persons; 3) identity topics appropriate for researching older persons; and 4) describe ethical issues in researching older persons. The counselor can demonstrate *skills* in the use of research and evaluation knowledge for older persons. These skills include: 1) adjusting research approaches based on characteristics of older persons; 2) using effectively research data bases related to older persons; and 3) designing a proposal appropriate to researching older persons. The counselor can demonstrate positive wellness enhancing *attitudes* toward the evaluation and research needs of older persons. These attitudes include: 1) recognizing the need for researching and evaluating older persons and 2) maintaining respect for older persons in the process of conducting research.

*Professional orientation.* The counselor can demonstrate *knowledge* of professional orientation (now known as professional orientation and ethical practice) for older persons. This includes the ability to: 1) describe unique roles and skills of gerontological counselors and 2) describe organizations relevant to working with older
persons. The counselor can demonstrate \textit{SKILLS} in the use of professional orientation knowledge for older persons. These skills include: 1) demonstrating ethical behavior when working with other professionals serving older persons and 2) demonstrating awareness of the referral network for helping older persons. The counselor can demonstrate positive wellness-enhancing \textit{ATTITUDES} toward the professional orientation needs of older persons. These attitudes include: 1) perceiving counselors as advocates for the needs of older persons and 2) showing sensitivity to the individual rights of older persons.

\textit{Practica and internship.} The counselor can demonstrate \textit{KNOWLEDGE} of gerontological issues in practica experiences with older clients. This includes the ability to: 1) understand the structure of the formal and informal aging services network; 2) describe the appropriate steps to follow and types of agencies to contact for older clients in need of specialized services; and 3) working effectively with other helping professionals on behalf of older persons. The counselor can demonstrate \textit{SKILLS} in the application of gerontological issues knowledge in practica and internship experience with older persons. These skills include: 1) applying competencies associated with each of the eight core preparation areas when working with older persons and 2) involving family members and others in the informal support network in working with older persons. The counselor can demonstrate positive, wellness-enhancing \textit{ATTITUDES} toward older persons in practica and internship experiences. These attitudes include: 1) respecting older clients' abilities and desire to help themselves and 2) feeling comfortable consulting with other professionals in the field of aging.
Minimum essential gerontological competencies for all counselors. As mentioned above, due to its extensive length, the document detailed above was condensed into a short-form that lists the ten minimum level competencies that graduates of CACREP programs must demonstrate in order to work effectively with older adults.

The ten competencies state that the graduate should:

1. Exhibits positive, wellness-enhancing attitudes toward older persons, including respect for the intellectual, emotional, social, vocational, physical, and spiritual needs of older individuals and the older population as a whole.

2. Exhibits sensitivity to sensory and physical limitations of older persons through appropriate environmental modifications to facilitate helping relationships.

3. Demonstrates knowledge of the unique considerations in establishing and maintaining helping relationships with older persons.

4. Demonstrates knowledge of human development for older persons, including major psychological theories of aging, physiological aspects of "normal" aging, and dysfunctional behaviors of older persons.

5. Demonstrates knowledge of social and cultural foundations for older persons, including common positive and negative societal attitudes, major causes of stress, needs of family caregivers, and the implications of major demographic characteristics of the older population (e.g., numbers of women, widows, increasing numbers of older minorities).

6. Demonstrates knowledge of special considerations and techniques for group work with older persons.

7. Demonstrates knowledge of lifestyle and career development concerns of older persons, including the effects of age-related physical, psychological, and social changes on vocational development, factors affecting the retirement transition, and alternative careers and lifestyles for later life.

8. Demonstrates knowledge of the unique aspects of appraisal with older persons, including psychological, social, and physical factors that may affect assessment, and ethical implications of using assessment techniques.
(9) Demonstrates knowledge of sources of literature reporting research about older persons and ethical issues in research with older participants.

(10) Demonstrates knowledge of formal and informal referral networks for helping older persons and ethical behavior in working with other professionals to assist older persons.

**Minimum essential competencies for gerontological counseling specialists.** For those counseling students who wish to specialize in working with older adults and obtain the title “gerontological counseling specialist,” Myers (1995) describes a list of competencies that define an advanced level of preparation. It is assumed that a gerontological counseling specialist will first meet all the generic requirements for counselor preparation as defined in the CACREP standards. Like the generic gerontological counseling competencies described above, the specialty competencies are organized according to the eight CACREP core curricular areas for counselor preparation (with the addition of Practica and Internship) and further extended to include six other areas: (1) Normative Experiences of Aging; (2) Impaired Older Persons; (3) Needs and Services for Older Persons; (4) Older Population and Special Issues; (5) Techniques for Counseling Older Persons; and (6) Ethics.

The specialty competencies were also condensed into a short form consisting of sixteen competencies relating to specialty work in the field of gerontology. According to Myers and Schwiebert (1996), like the generic competencies, these competencies should also be met at the time of graduation and further developed through actual employment experiences in the aging network. Since the focus of the present paper is counselors in general rather than those in a gerontological counseling specialty, the following section...
only lists the minimum essential competencies for gerontological counseling specialists (Myers, 1995; Myers & Schwiebert, 1996; Schwiebert & Myers, 2001). The graduates specializing in gerontological counseling must:

(1) Demonstrate and actively advocate for positive, respectful, wellness-enhancing attitudes toward older persons and a concern for empowerment of persons throughout the life span.

(2) Demonstrate skill in applying extensive knowledge of human development for older persons, that includes an understanding of the major theories of aging, the relationship between physical and mental health and aging, the difference between normal and pathological aging processes, gender-related developmental differences, and coping skills needed for life transitions and loss.

(3) Demonstrate skill in applying extensive knowledge of social and cultural foundations for older persons, including the characteristics and needs of older minority subgroups, factors affecting substance and medication misuse and abuse, recognition and treatment of elder abuse, and knowledge of social service programs.

(4) Demonstrate the ability to function in the multiple roles required to facilitate helping relationships with older persons (e.g., advocate, family consultant) and to mobilize available resources for functioning effectively in each role.

(5) Demonstrate skill in recruiting, selecting, planning, and implementing groups with older persons.

(6) Demonstrate skill in applying extensive knowledge of career and lifestyle options for older persons, age-related assets and barriers to effective choices, and resources for maximizing exploration of career and lifestyle options.

(7) Demonstrate skill in appraisal of older persons, including identifying characteristics of suitable appraisal instruments and techniques and in using assessment results in developing treatment plans.

(8) Demonstrate skill in applying extensive knowledge of current research related to older persons and the implications of research findings for helping relationships.
(9) Demonstrate skill in applying extensive knowledge of the intellectual, physical, social, emotional, vocational, and spiritual needs of older persons and strategies for helping to meet those needs.

(10) Demonstrate skill in applying appropriate intervention techniques, in collaboration with medical and other care providers, for physical and mental impairments common to older persons, such as acute, chronic, and terminal illness, depression, suicide, and organic brain syndromes.

(11) Demonstrate extensive knowledge of the formal and informal aging networks, public policy, and legislation affecting older persons, and knowledge of a continuum of care that will allow older persons to maintain their highest level of independence.

(12) Demonstrate skill in applying appropriate intervention techniques for situational and developmental crises commonly experienced by older persons, such as bereavement, isolation, divorce, relocation, sexual concerns, illness, transportation, crime, abuse, and relationships with adult children and caregivers.

(13) Demonstrate skill in the use of a wide variety of specialized therapies to assist older persons in coping with both developmental and nonnormative issues, such as creative arts therapies, pet therapy, peer counseling, and family counseling.

(14) Demonstrate skill in applying extensive knowledge of ethical issues in counseling older persons, their families, and care providers.

(15) Demonstrate the ability to act as a consultant to individuals and organizations on issues related to older persons and their families.

(16) Demonstrate skill in program development for the older population, including needs assessment, program planning, implementation, and evaluation.

This “short form” of the 38-page document, the minimum essential gerontological competencies for all counselors, was developed into a 26 item self-assessment of competence in gerontological issues and disseminated as part of a National Board for Certified Counselors (NBCC) survey. The 346 respondents to the survey were asked to
complete a self-assessment of their competence for each of the 10 minimum essential gerontological competencies for all counselors (generic) and the 16 minimum essential competencies for gerontological counseling specialists (specialty) using a 5-point Likert scale as follows: 1 = very competent, able to perform at a high level; 2 = competent, able to perform adequately; 3 = somewhat competent, more training required; 4 = not competent, not able to perform at this time; and 5 = not able to judge competence. In terms of the generic competencies (the interest of this paper), the assessment resulted in a mean competency score of M = 1.8 with a standard deviation of SD = 0.82. Further, most of the respondents considered themselves to be “somewhat competent” in each of the areas addressed but to need more training if they were to become “very competent” in each area.

**Guidelines for psychological practice with older adults.** To thoroughly examine competencies when working with older adults, it is important to look at the progress of other disciplines in this area. Psychology is one such discipline that provides more recent insight to this area of study. In 1992, the National Conference on Clinical Training in Psychology for Improving Services for Older Adults was organized by the American Psychological Association (APA). This conference resulted in the recommendations that APA “aid professionals seeking to specialize in clinical geropsychology” and also “develop criteria to define the expertise necessary for working with older adults and their families and for evaluating competencies at both the generalist and specialist levels” (American Psychological Association, 2004, p.238). To follow up on these recommendations, Section II (Clinical Geropsychology) of APA Division 12
(Society of Clinical Psychology) and Division 20 (Adult Development and Aging) formed an Interdivisional Task Force on Practice in Clinical Geropsychology with the responsibility of addressing the need for guidance on appropriate preparation for clinical work with older adults. This Task Force included members with professional involvement and expertise in adult development and aging, representing the specialty of clinical psychology, health psychology, clinical neuropsychology, counseling psychology, and other related areas of interest such as rehabilitation psychology and community psychology. Licensed psychologists engaging in independent psychological practice with older adults and/or their families were also included.

In 2004 the Interdivisional Task Force on Practice in Clinical Geropsychology described above developed the Guidelines for Psychological Practice with Older Adults to “assist psychologists in evaluating their own readiness for working clinically with older adults and in seeking and using appropriate education and training to increase their knowledge, skills, and experience relevant to this area of practice” (American Psychological Association, 2004, p.237). The twenty proposed guidelines are divided into six sections: 1) attitudes, 2) general knowledge about adult development, aging and older adults, 3) clinical issues, 4) assessment, 5) intervention, consultation, and other service provisions, and 6) education. The goals of the guidelines are twofold; to provide a frame of reference for practitioners working with older adults, and to provide basic information and reference in pertinent areas of aging (e.g., clinical issues, intervention, assessment, attitudes). Please refer to Appendix A for a complete list of the APA Guidelines for Psychological Practice with Older Adults.
Guidelines for psychological practice with older adults: Attitudes. Guideline One encourages those who work with older adults to work within their scope of competence and to seek consultation and make referrals when necessary. Despite the fact that many problems older adults experience are similar to those of other age groups and respond well to a generic repertoire of skills and techniques; it is important for clinicians to understand that this is not always the case. The aging process and unique circumstances of later life may affect diagnosis and intervention efficacy for some older adults. “Clinical work with older adults may involve a complex interplay of factors, including developmental issues specific to late life, cohort (generational) perspectives and preferences, comorbid physical illness, the effects of taking multiple medications, cognitive or sensory impairments, and history of medical or mental disorders” (American Psychological Association, 2004, p.239). The complexities of aging, as listed above, can make it challenging when treating older adults. This verifies the importance of education and training in the aging process and related difficulties. If practitioners feel their scope of competence does not meet the older adult client’s needs, it is important to seek consultation or make appropriate referrals.

Guideline Two encourages service providers to recognize how their beliefs and attitudes about aging and older adults may affect their assessment and treatment of older individuals and to seek consultation and continuing education on these issues (American Psychological Association, 1998; 2004). As mentioned previously, prejudice, stereotyping, and discrimination of older adults due to their age are referred to as ageism.
Service providers are not immune to possessing these ageist beliefs and behaviors which can impede diagnosis and treatment of older adult clients.

**Guidelines for psychological practice with older adults: General knowledge about adult development, aging, and older adults.** The importance of gaining knowledge about theory and research in aging is described by Guideline Three. The American Psychological Association (2004) recommends that clinicians acquire familiarity with the psychological, biological, and social context of the normal aging process that includes knowledge of the stages of the life cycle, cohort differences, concepts of aging, longitudinal change, cross-sectional differences, and research design for adult development and aging.

Guideline Four promotes the awareness of the social/psychological dynamics of the aging process. As already described, many issues of late life are similar to earlier stages of life; however, some issues are more unique and significant to late life. One of the significant stressors of older adulthood is loss. Loss of such things as persons, independence, roles, and health among the elderly is often significant due to its “multiple” and “cumulative” nature (American Psychological Association, 2004).

The understanding of diversity in the aging process including sociocultural factors such as ethnicity, gender, socioeconomic status, physical environment/living conditions, and sexual orientation is critical as expressed by Guideline Five. “The psychological problems experienced by older adults may differ according to such factors as age, cohort, gender, ethnicity and cultural background, sexual orientation, rural/frontier living status, differences in education and socioeconomic status, religion, as well as transitions in
social status and living situations. Clinical presentations of symptoms and syndromes in older individuals often reflect interactions among these factors and specifics of the clinical setting (such as the nursing home or the homebound living context)” (American Psychological Association, 2004, p.242). These experiences may also impact research on older adults. According to Schaie (1993), when designing research it is important for psychologists to consider whether chronological age as opposed to other demographic variables (e.g., income, educational level, retirement, generational membership) is the most relevant. Furthermore, since older persons are more diverse, the limitations in generalizability of convenience samples should be clearly stated when interpreting data.

According to Guideline Six, familiarity with current information about biological and health-related aspects of aging is important (American Psychological Association, 1998; 2004). Clinicians need to be aware of the normal biological changes (e.g., hearing impairment, visual changes) as well as abnormal biological changes of aging. Further awareness of the effects of comorbidity (physical and mental health) and polypharmacy is important for proper diagnosis and treatment of physical and mental disorders.

*Guidelines for psychological practice with older adults: Clinical issues.*

Guideline Seven relates the importance of current knowledge about cognitive changes in older adults. It is important for mental health professionals to be aware of normal age-related cognitive change in order to recognize abnormality. Some common cognitive changes associated with age involve the slowing of information processing speed and reaction time and a decline in visuospatial and motor control (American Psychological Association, 1998; 2004). Retrieval processes and working memory are also influenced
by normal aging as well as the ability to deal with complex situations, shift focus, and divide attention.

The understanding of the problems in daily living of older adults is important as indicated by Guideline Eight. It is important for clinicians to understand how issues of daily living for many older adults “center around the degree to which the individual retains ‘everyday competence’ or the ability for independent function, or is disabled to such extent as having to depend on others for basic elements of self-care (American Psychological Association, 2004, p.44).

According to Guideline Nine, psychologists should strive to be knowledgeable about psychopathology within the aging population and aware of the prevalence and nature of that psychopathology when providing services to older adults. Approximately 20-22% of older adults meet the criteria for some type of mental disorder (Administration on Aging, 2001; U.S. Department of Health & Human Services, 1999; American Psychological Association , 2004). As mentioned previously, these issues may be the same as those in younger adults (e.g., depression, anxiety, chemical abuse) but also may be unique to the older population (dementia, loss and bereavement). Suicide is also a concern for older adults with the suicide rates being higher for this age group than any other.

Guidelines for psychological practice with older adults: Assessment. Guideline Ten recommends that psychologists gain familiarity with the research, theory, and practice of various methods of assessment with older adults. This includes knowledge about assessment instruments that are reliable and valid when used with older adults
Further, knowledge about the most effective ways of gathering and interpreting information is important.

The importance of understanding the problems of using assessment instruments with older adults that are created for younger adults is indicated by Guideline Eleven. Included in this is the ability to adapt assessments to the specific characteristics and contexts of older adults when appropriately validated and normed assessments are not available. Modifying the assessment environment to reduce the influence of sensory problems and taking into account the potential influence of medication use and somatic complaints are just a few of the accommodations that may be necessary (American Psychological Association, 1998; 2004). Other accommodations may include: (1) familiarizing the older adult with the purpose and procedures of testing; (2) ensuring optimal performance by allowing advanced preparation for testing and giving prior notice to bring all assistive devices necessary (e.g., eyeglasses, hearing aids), preparing in advance for testing; (3) creating a quiet and well-lit environment, minimizing glare, and arranging the space to accommodate devices of those with physical limitations (e.g., wheelchair); (4) ensuring understanding of test instructions which includes speaking clearly, using simple language, repetition, and large print materials; (5) adjusting the test time to suit the optimal functioning of the older adult which includes frequent rest, bathroom breaks, and resuming testing at another time if the person is fatigued; (6) using verbal reinforcement and encouragement; and (10) gauging how the older adult performs at different times of the day by using multiple testing sessions (American Psychological Association, 1998).
According to Guideline Twelve, psychologists should strive to develop skill at recognizing and assessing for cognitive changes in older adults. This ability to make accurate assessments of cognitive functioning and appropriate referrals when necessary depends upon knowledge of normal and abnormal aging which includes age-related changes in intellectual abilities. The American Psychological Association (1998) recommends that “any assessment of an older adult should include the client’s current mental status, cognitive ability, social supports available to the client, the client’s medical status, and, if cognitive impairment is suspected, interviews with family members and close friends” (p.3). The Mental Status Examination (MSE) and Mini Mental Status Exam (MMSE) are two widely used assessments of a client functioning (American Psychological Association, 1998; 2004; Schwiebert, Myers & Dice, 2000; Polanski & Hinkle, 2000). Conducted during an intake interview, the MSE and MMSE can provide counselors with a way to organize objective and subjective screening information in order to aid in diagnosis, treatment planning, and monitoring of treatment progress.

**Guidelines for psychological practice with older adults: Intervention, consultation, and other service provisions.** Guideline Thirteen states that psychologists should gain familiarity with the theory, research, and practice of various methods of interventions with older adults, including evidence about their efficacy with this age group. As mentioned previously, increasing evidence documents that older adults benefit from a variety of forms of psychotherapy to a degree comparable with younger adults.

Psychologists should be familiar with and develop skill in applying specific psychotherapeutic interventions and environmental modifications with older adults and
their families, according to Guideline Fourteen. This includes adapting interventions for use with older adults. These interventions often need to address medical issues and comorbidity (e.g., pain management, enhancing compliance). Kennedy and Tanenbaum (2000) review of literature found that “age-related adaptations of interventions might be necessary with older adults to optimize outcomes. These adaptations include special consideration for any medical comorbidity, regard for the older adult’s cognitive capacity, and recognition of the role of family members and caregivers” (Myers & Harper, 2004, p.209). Furthermore, psychologists should not only be familiar with psychological interventions that can be used for any age group but also with those techniques primarily developed for use with older adults, such as reminiscence therapy (American Psychological Association, 1998; 2004).

Guideline Fifteen promotes the understanding of the issues pertaining to the provision of services in the specific settings in which older adults are typically encountered. Some examples of these settings include homes, senior centers, elder day care, private practice offices, mental health clinics, hospitals, and nursing homes (American Psychological Association, 1998; 2004).

According to Guideline Sixteen, recognition of the issues related to the provision of prevention and health promotion services with older adults is important. Psychoeducational programs, prevention efforts, and advocacy within healthcare and political-legal systems are examples (American Psychological Association, 1998; 2004). As part of these prevention and health promotion services, psychologists can choose to engage in activities that “target the special problems or issues of particular communities
of older adults with the goal of preventing the onset of mental disorders or ameliorating them at early stages” (American Psychological Association, 1998, p.30).

Understanding of the issues pertaining to the provision of consultation services when assisting older adults is Guideline Seventeen. This consultation may be provided to families and other caregivers as well as to other professionals, especially on cases in which the older adult is presenting with maladaptive interpersonal behavior or complex behavioral problems (American Psychological Association, 1998).

As indicated by Guideline Eighteen, understanding the importance of interfacing with and/or making referrals to other disciplines is encouraged (American Psychological Association, 1998; 2004; 2009). This includes working in collaborative teams and across a range of sites. Other disciplines typically involved in these collaborative teams or referrals include psychiatrists, primary physicians, nurses, other associated health professionals, social workers, clergy, and lawyers. Knowledge about the services available from these other disciplines is important.

Psychologists need to understand the unique ethical and/or legal issues involved in providing care to older adults, according to Guideline Nineteen. These issues often include balancing considerations of the principles of autonomy (maximizing independence) and beneficence (preventing harm), informed consent, confidentiality, conflicts of interest between the client and their families, and abuse or neglect (Agresti, 1992; American Psychological Association, 2004; Schiebert, Myers & Dice, 2000).

**Guidelines for psychological practice with older adults: Education.** Guideline Twenty encourages psychologists to seek out continuing education, training, supervision
and consultation to increase their knowledge, understanding, and skills when working with older adults. A few examples of these include postdoctoral fellowships, workshops, in-service training seminars, distance learning, and self-study.

**Multicultural competency in geropsychology.** A second significant work on gerontological counselor competencies was published in 2009 by the American Psychological Association Committee on Aging and its Working Group on Multicultural Competency in Geropsychology. This report discusses key issues pertaining to multicultural competence in working with older adults. These key issues regarding the infusion of multicultural diversity throughout geropsychology includes: (1) the need to recognize age as a critical component of multicultural diversity; (2) the importance of competency in addressing the needs and supporting the strengths of the diverse older adult population; and (3) knowledge about the impact of ageism on cultural diversity efforts in geropsychology research, education, and practice.

The premise of the report is that “one critical aspect of culture is age itself and this culture also continues to evolve. Since older people from a given cohort have been exposed to events, conditions, and changes different from what was experienced by their counterparts from another cohort, one finds between-cohort differences in attitudes, values, and behaviors” (p.5). This premise is in agreement with Hinrichsen’s (2006) assertion that multicultural issues and aging are interwoven. Not only are there differences across cohorts but also considerable variability within each cohort. In other words, older adults are not only different from younger adults but they are also very different from each other. According to the American Psychological Association
Committee on Aging (2009), older adults comprise a group with diverse characteristics and needs that are often overlooked. It is therefore essential that those who work with older adults are equipped with multicultural competence” (p.5).

**Recommendations for Geropsychology Practice, Training, Research and Public Policy with Diverse Elders.** Because, “the paucity of training programs in professional geropsychology perpetuates the severe shortage of qualified mental and behavioral health professionals, including psychologists, to provide services to America's aging population and the growing number of racial and ethnic minority elders” and “these shortages will only become more troublesome as the population ages and the demand for specialized mental health services increases” (APA, 2009, p.13), the report provides twenty-five recommendations for working with older adults. These recommendations are categorized by the following topics: overarching recommendations, education and training recommendations, practice recommendations, research recommendations, and public policy recommendations (American Psychological Association, 2009).

The American Psychological Association Committee on Aging (2009) recommends that psychologists working with older adults should:

1. counter ageism in their professional and personal lives.

2. consider age to be a critical component of cultural diversity and to appreciate the diversity within the aging population itself.

3. consider both the individual aspects of diversity and the intersection of cultural identity within the aging population.

4. consider characteristics such as ethnicity and race that can affect adjustment and well being.
(5) view culture and difference/diversity as a strength and build upon the 
skills an older adult has developed over a lifetime of experience.

(6) insure that life-span development and aging is a vital component of 
diversity education.

(7) develop a plan of action to increase the number of graduate programs, 
internships, and post-doctoral fellowships with emphasis on 
geropsychology

(8) develop an ethnogeriatric curriculum for training in mental health and 
aging among diverse groups.

(9) seek independent learning opportunities in multicultural 
geropsychology and avail themselves of opportunities for training at 
professional meetings and through continuing education programs

(10) design and conduct a professional education campaign to increase 
understanding and awareness of the impact of diversity on health beliefs, 
behaviors, and outcomes.

(11) educate society about common mental disorders among older 
individuals to help eliminate stigma and discrimination, and reduce 
barriers to treatment services.

(12) recognize how their attitudes and beliefs about aging and about older 
individuals may be relevant to their assessment and treatment of older 
adults, and to seek consultation or further education about these issues 
when indicated.

(13) tailor mental health services such as screening, assessment, and 
intervention to the needs and preferences of older adults.

(14) include training in settings where diverse elders are served.

(15) promote the latest evidence-based treatments/interventions in 
working with older adults.

(16) address client language and knowledge barriers (e.g., health literacy).

(17) expand the research knowledge base related to the efficacy of 
psychological interventions for late-life mental disorders and in particular 
with respect to racially and ethnically diverse older adults.
(18) conduct culture-centered and ethical psychological research among persons from ethnic, linguistic, and racial minority backgrounds.

(19) help promote greater attention to the development of research focusing on the health and well-being of diverse elders by the NIMH and NIA.

(20) support federal initiatives to train mental health professionals to address the mental health workforce needs of our increasingly diverse population of elders.

(21) support existing and develop additional programs to recruit, develop and retain researchers sensitive to cultural diversity issues in geropsychology and skilled in methodologies for appropriately examining issues of cultural diversity.

(22) help increase funding for federal programs (including Medicare, Medicaid, and the Older Americans Act) to expand the availability of quality mental and behavioral health and related supportive services for older adults.

(23) support initiatives that integrate mental and behavioral health in primary care and other settings where racially and ethnically diverse older adults receive services.

(24) support federal initiatives to eliminate disparities in mental health status and mental health care of older adults through the use of psychological and behavioral research and services that are culturally and linguistically competent.

(25) advocate for increased federal funding for multicultural geropsychology research by the NIA and NIMH.

As the previous section addresses, the American Counseling Association (ACA) and more recently the American Psychological Association (APA) have been instrumental in providing competencies or guidelines for counselors and psychologists working with older adults. Through support by the ACA’s Fifth National Aging Project (1989-1990) and using CACREP’s eight core areas, Jane Myers and colleagues
developed the *Gerontological Competencies for Counselors and Human Development Professionals* which specify the competencies required by all counselors to work with older adult clients. Because, as seen in Chapter 1 of the present paper, the older adult population is growing at such a rapid rate and most counselors will work with older adult clients now or in the future, these competencies were developed with the intention of being infused into existing training programs to facilitate graduation of counselors competent to work with this age group. More recent insight into the need for training counselors and psychologists to work with older adults has come from the American Psychological Association with the 2004 publication of the *Guidelines for Psychological Practice with Older Adults* and the 2009 publication of the report entitled *Multicultural Competency in Geropsychology*. These publications add to Jane Myers seminal work and, more importantly, look at age as a culture in which multicultural competence is necessary. Because of this necessity, it is also important to examine previous research on multicultural counseling competency assessment. The next section will do just that.

**Multicultural Counseling Competency Assessment**

The seminal work of Sue et al. (1982) defined cross-cultural counseling as “any counseling relationship in which two or more of the participants differ with respect to cultural background, values, and lifestyle” (p. 47). Despite their focus on race and ethnicity, Sue et al. (1982) acknowledged that cross-cultural counseling includes counselors and clients that belong to different cultural groups as defined by not only race and ethnicity but also by other variables such as age. Sue et al.’s (1982) work was the
basis for the establishment of multicultural counseling competencies and these competencies were further defined by Sue, Arredondo and McDavies (1992). These multicultural competencies were conceptualized by Sue et al. (1982; 1992; 1998) as having three dimensions or factors. This tripartite model includes 1) knowledge, 2) skills, and 3) attitudes/beliefs.

As explained by Bromely (2004) and Schomburg (2007), Sue et al.’s (1992) work was also the foundation for several of the most commonly used multicultural counseling competency scales: (a) Multicultural Awareness/Knowledge/Skills Survey (MAKSS; D’Andrea, Daniels & Heck, 1991; (b) Multicultural Counseling Inventory (MCI; Sodowsky, Taffe, Gutkin & Wise, 1994); (c) Multicultural Counseling Knowledge and Awareness Scale (MCKAS; Ponterotto, Gretchen, Utsey, Rieger & Austin, 2002); and (d) Cross-Cultural Counseling Inventory-Revised (CCCI-R; La Fromboise, Coleman & Hernandez, 1991). These scales were created to assess students’ progress toward multicultural counseling competence and to evaluate multicultural training.

**Issues in Developing Measures to Assess Multicultural Counseling Competency: Social Desirability.** Numerous studies in the last 15 years have scrutinized the above mentioned multicultural counseling competency scales resulting in two major concerns. First, these assessments have been found by some researchers to be influenced by social desirability (Constantine & Ladany, 2000; Sodowsky, Kuo-Jackson, Richardson & Corey, 1998). For example, Constantine and Ladany (2000) found significant relationships between some subscales of self-report multicultural counseling competence scales and social desirability. Sodowsky et al. (1998) also found
significant positive relationship between the MCI full-scale score and social desirability. Further, Constantine and Ladany (2001) reported that several self-report instruments assessing multicultural counseling competency were significantly and positively related to social desirability resulting in a possible inaccurate reflection of a counselor’s multicultural competence. On the other hand, some studies examining the relationship between multicultural counseling competence and social desirability have resulted in nonsignificant findings (Ponterotto et al., 1996; Sodowsky, 1996; Sodowsky, Taffe, Gutkin & Wise, 1994). These mixed findings have led some researchers to question what is meant by social desirability (Paulhus, 1984; Paulhus & Reid, 1991; Worthington, Mobley, Franks & Tan, 2000).

Historically, social desirability has been defined as a unidimensional construct reflecting the degree to which people attempt to make a good impression and is typically measured using the Marlowe-Crowne Social Desirability Scale (SDS; Crowne & Marlowe, 1960). More recently, research has supported the conceptualization of social desirability as a multi-dimensional construct consisting of two components: self-deception (in which the respondent truly believes his/her self-report) and impression management (in which the respondent consciously distorts the truth) (Paulhus, 1984; Paulhus & Reid, 1991). For example, Paulhus (1984) conducted three studies including an exploratory factor analysis of over 150 items, a confirmatory factor analysis to verify the model, and an experimental study. He concluded that all three studies supported the two factor (self-deception and impression management) theory of socially desirable responding. Further, when compared with the SDS, results showed that the Marlowe-
Crowne scale loaded strongly on both the Self-Deception and Impression Management factors. This dual loading pattern is consistent with other studies examining the Marlowe-Crowne Social Desirability Scale (Edwards & Walsh, 1964; Liberty, Lunneberg & Atkinson, 1964; Paulhus, 1984). Based on the above findings, Paulhus (1984) concluded “attempts to preclude or control social desirability must attend to both factors” (p.607). In agreement, after finding mixed results when examining the relationship between social desirability as measured by the Marlowe-Crowne Social Desirability Scale and multicultural counseling competence, Worthington et al. (2000) concluded that these mixed findings could be attributed to the “dated assessment” used and suggested that “Future research should abandon unidimensional measures and adopt a two-dimensional measure (i.e., Paulhus, 1991), which better reflects the construct” (p.466).

Because many studies over the last 25 years (e.g., Bromley, 2004; Paulhus, 1984; 1988, 1991; Paulhus & Reid, 1991; Schomberg, 2007) have supported looking at social desirability as a multidimensional construct with the most recent evidence supporting two factors labeled self-deception and impression management, Paulhus (1988; 1991) developed the Balanced Inventory of Desirable Responding (BIDR) to measure these two constructs. Taking into account the suggestion of many researchers to include a measure of social desirability when assessing multicultural counseling competence (e.g., Constantine & Ladany, 2000; 2001; Paulhus, 1991; Sodowsky, 1996) and keeping with the conceptualization of social desirability as a two dimensional construct, the present study will examine socially desirable responding using the Balanced Inventory of Desirable Responding (BIDR), a 40 item self-report survey developed by Paulhus (1988;
that measures the two facets of socially desirable responding: Self-Deceptive Enhancement (SDE) and Impression Management (IM). People high in SDE provide self-reports that are honest but overly confident and positively biased. In other words, they actually believe in their overly positive self-reports. On the other hand, people showing high IM consciously present themselves in a positive way to others by self-reporting higher levels of desirable behavior and lower levels of undesirable behavior (Schomburg, 2007).

**Issues in Developing Measures to Assess Multicultural Counseling Competency: Underlying Factors.** A second major concern of multicultural counseling competency scales is that, although they have the common goal of assessing perceived competence, they differ in number of factors thought to comprise this construct and, complicating matters more, these factors are given different names (Constantine & Ladany, 2000; 2001, Pope-Davis & Dings, 1994; Schomburg, 2007; Worthington, et al., 2000). Schomburg (2007) writes, “the four commonly-used instruments to measure multicultural counseling competence according to the tripartite model (Sue et al., 1982;1992) differ in their number of subscales, their names for the subscales, and their methods of assessment” (p.38). For example, when examining the MCI, Sodowsky et al. (1994) found evidence in support of four factors. Three factors (skill, awareness, and knowledge) were comparable in substance to the three broad competency factors defined by Sue et al. (1982-- skills, beliefs/attitudes, and knowledge) but one additional factor entitled relationship also emerged. D’Andrea, Daniels and Heck (1991), on the other hand, concluded that the MAKSS offers a three-factor model labeled knowledge,
awareness, and skills. Further, the MCKAS presented a two-factor model (knowledge and awareness) and the CCCI-R is made up of three subscales: awareness, skill, and sensitivity (Ponterotto, Gretchen, Utsey, Rieger & Austin, 2002; La Fromboise, Coleman & Hernandez, 1991, respectively). Constantine and Ladany (2001) proposed an even broader conceptualization of multicultural counseling competence to include six dimensions: (1) counselor self-awareness, (2) general knowledge about multicultural issues, (3) understanding of unique client variables, (4) multicultural counseling self-efficacy, (5) multicultural counseling skills, and (6) an effective counseling working alliance. Overall, “although the multicultural scales have similar objectives, there seems to be lack of clarity about what they actually assess” (Constantine & Ladany, 2000, p.162).

Despite the concerns mentioned previously, many current self-report measures of multicultural counselor competence have successfully utilized the tripartite definition (knowledge, attitudes/beliefs, and skills) as their primary theoretical foundation (D’Andrea et al., 1991; La Fromboise et al., 1991). When reviewing multicultural counseling competence measures, Ponterotto, Rieger, Barrett and Sparks (1994) found that the measures adhere to the Sue et al. (1982; 1992; 1998) competencies (beliefs/attitudes, knowledge, and skills) to some degree as a conceptual basis for item development. Therefore, the present research will examine gerontological counselor competence using the same framework. As described previously, this model was supported by Myers and her colleagues’ original conceptualization of the competencies. Within this framework, Myers and Sweeney (1990) define Knowledge, when applied to
counselor competency, as the ability to accurately identify, list, define, distinguish, match, label, etc…, words, theories, facts or concepts believed to be important to the effective functioning of counselors with older adult clients. Further, Skills, as applied to counselor competency, are evidenced by producing, demonstrating, showing, manipulating, or acting in such a manner as to promote positive behavior, wellness, and/or effective services for older adults. Finally, when applied to counselor competency, Myers and Sweeney (1990) describe Attitudes as being evidenced by ethical views, moral perceptions, and values which underscore positive, open, growth/wellness enhancing behaviors toward older adult clients (as found on Jane Myers website www.unCG.edu

Summary of Chapter II

Despite the trend toward increasing concern for the mental health needs of older adults due to the graying of the “Baby Boomers,” there are only two CACREP accredited programs in gerontological counseling and the specialization has been omitted from the new 2009 CACREP Standards (Southern, Gomez, Smith & Devlin, 2010). Furthermore, despite their stance on the importance of multicultural and diversity issues, the CACREP Standards, ACA Code of Ethics, and the Association for Multicultural Counseling and Development are all vague in relation to counseling competencies for working with older adults. Without the guidance of these governing bodies, counseling programs will not be expected to infuse gerontological issues into their training programs and counselors will not be prepared to meet the mental health needs of this fast growing population.
The competencies needed to work effectively with older adults however, have been identified and articulated by both the American Counseling Association and the American Psychological Association. As noted previously, Jane Myers and associates’ work on defining gerontological counselor competencies is instrumental in providing a model for the counseling profession. The next step is to develop a reliable and valid measure that can pinpoint how counseling professionals in the field perceive their degree of competence in working with older adults as well as to assess how current counseling students perceive their level of competence. This information can identify if there are areas that need to be emphasized by training programs in order to graduate counselors who are prepared to work competently with older adults.

The aim of the current research project is to add to the existing literature on multicultural counselor competencies by developing a measure to assess counselor competence when working with this very diverse special population, older adults. As mentioned in Chapter I, the present research considered the following questions: (1) Is the Gerontological Counseling Competencies Scale (GCCS; O’Connor Thomas, 2012) a reliable measure of perceived counselor competence when working with older adult clients? (2) Is the GCCS a valid measure of perceived counselor competence when working with older adult clients? (3) Does the GCCS have face validity? (4) What is the underlying factor structure of the GCCS? (5) Does the GCCS demonstrate construct validity? (6) Does prior work experience with older adults; education in gerontological issues; and training in working with older adults predict counselor perceived competence
when working with older adults? and (8) Is the Gerontological Counseling Competencies Scale (GCCS) influenced by socially desirable responding?
CHAPTER III

METHODOLOGY

Purpose

As noted previously, with the changing demographics the need for counselors competent to work with older adults is eminent. The primary purpose of the present study was to develop a reliable and valid self-report measure of counselor perceived competence when working with older adults. In developing the measure, items were generated that assess knowledge, skills, and attitudes regarding identified areas of gerontological counselor competence. Then, the underlying factor structure, reliability, and validity of the measure were established. Finally, the measure was used to explore the current status of the field with regards to counselors’ perceived competence in working with older adult clients. The study provided information on factors that predict counselor perceived competence when working with older adults such as prior work experience with older adults (including practicum and internship), education (e.g., coursework) in gerontological issues, and training in working with older adults (e.g., workshops, seminars). It was hoped that the findings from this initial study would help guide future research in the area of gerontological counselor competency, a much needed focus in multicultural competence research.
Research Questions and Hypotheses

**Research Question One.** Is the Gerontological Counseling Competencies Scale (GCCS; O’Connor Thomas, 2012) a reliable measure of perceived counselor competence when working with older adult clients?

*Hypothesis One:* The GCCS will demonstrate adequate internal consistency reliability.

**Research Question Two.** Is the GCCS a valid measure of perceived counselor competence when working with older adult clients? Specific questions addressed included:

(a) Does the GCCS have face validity (content validity)?

(b) What is the underlying factor structure of the GCCS?

(c) Does the GCCS demonstrate construct validity?

1. Does prior work experience with older adults, education/coursework in gerontological issues, and training in working with older adults predict counselor perceived gerontological competence?

*Hypothesis Two (Part One):* The GCCS will demonstrate adequate face validity (content validity).

*Hypothesis Two (Part Two):* The GCCS will demonstrate adequate construct validity. Specifically:

(a) There will be three underlying factors to the GCCS: knowledge, skills, and attitudes.
(b) Prior work experience with older adults (including practicum and internship), education (e.g., coursework) in gerontological issues, and training in working with older adults (e.g., workshops, seminars) will significantly predict counselor perceived competence in working with older adults.

**Research Question Three.** Is the Gerontological Counseling Competencies Scale (GCCS) influenced by socially desirable responding?

**Hypothesis Three:** The GCCS will have a low correlation with social desirability as measured by the Balanced Inventory of Desirable Responding (BIDR; Paulhus, 1988; 1991).

**Measures**

The following measures were used in the study: a document of informed consent, a questionnaire regarding demographic and training characteristics, a scale assessing perceived gerontological counseling competence, and a measure of social desirability.

**Informed Consent Document.** An informed consent form was the first document provided to the participants (see Appendix B). The purpose of the informed consent document was to provide potential participants with written communication concerning their voluntary and informed choice to participate in the study. The informed consent document included pertinent information about the study such as the title and purpose of the study, information about the researcher, potential risks and benefits of the study, information about the right to refuse participation or withdraw from the study at
any time without consequences, and efforts taken to maintain participant anonymity and confidentiality of the data obtained. Should any questions arise from the participants, the informed consent document provided the researcher’s contact information. Finally, a statement regarding voluntary agreement to participate in the study was included.

**Demographic and Training Questionnaire.** The Demographic and Training Questionnaire, developed by the researcher, was used to gather demographic information such as gender, age, race, and level of education as well as training information. Training information included prior work experience, education/coursework, and training (e.g., workshops) in working with older adults. Refer to Appendix C for a copy of the questionnaire.

**Gerontological Counseling Competencies Scale (GCCS; O’Connor Thomas, 2012).** The Gerontological Counseling Competencies Scale was developed by the researcher to assess counselor perceived competence when working with older adults. Development of the scale was based on the rational-theoretical approach to scale construction. The construct of gerontological counseling competence and its possible underlying dimensions (knowledge, skills, and attitudes) were defined based on the psychological theory and prior research on the topic of multicultural counseling competence in general and, more specifically, gerontological counseling competence. Fifty items were formulated for the initial Gerontological Counseling Competencies Scale (GCCS) based on this prior theory and research as well as feedback from an expert panel and focus group. The 50-item GCCS was given to 268 participants and the resulting data was analyzed using a Principal Components Analysis as well as other
analyses. The results of these analyses revealed a final 21-item Gerontological Counseling Competencies Scale comprised of three subscales (Knowledge & Skills, Attitudes, and Bio-Cognitive Knowledge). See Chapter IV for a complete discussion of scale development as well as reliability and validity evidence.

**Balanced Inventory of Desirable Responding (BIDR; Paulhus, 1988; 1991).**

As mentioned previously, the BIDR is a 40 item self-report measure of social desirability reflecting both self-deceptive enhancement (self-deception) and impression management. People with high scores on self-deception actually believe in their overly positive self-reports, while people with high scores on impression management consciously present themselves in a favorable light. Each subscale consists of twenty items measured on a 7-point Likert scale (1 = Not True, 7 = Very True). First, items that are negatively keyed are reverse scored. Next, one point is added to all items that have a 6- or 7-point response. Finally, all other responses are given a score of 0. Therefore, total scores on the SDE and IM subscales can range from 0-20. Paulhus (1991) argued that this scoring procedure ensures that only respondents who give exceedingly desirable responses attain high scores, which “provides some assurance that style rather than content is being tapped” (Schomburg, 2007, p. 39).

Internal consistency reliability coefficients (alpha) for the full scale was .83, for the SDE subscale ranged from .68 to .80, and for the IM scale ranged from .75 to .86 (Quinn, 1989; Paulhus, 1988). Test-retest correlations across a 5-week time period were .65 and .69 for the IM and SDE subscaled, respectively (Paulhus, 1988). Concurrent validity has been established by a .71 correlation with the Marlowe-Crowne Social
Desirability Scale (Crowne & Marlowe, 1960) and a .80 correlation with the Multidimensional Social Desirability Inventory (Jacobson, Kellogg, Cauce, & Slavin, 1977). Discriminant validity was demonstrated when self-deception and impression management formed discrete factors in factor analyses (Paulhus, 1984, 1988).

For the present study, internal consistency reliability of the Balanced Inventory of Desirable Responding (BIDR; Paulhus, 1988; 1991) was assessed by calculating coefficient alpha (Cronbach, 1951). Overall, the total BIDR (full scale) and its two subscales (Impression Management and Self-Deception) had adequate reliability (Cronbach’s Alpha = 0.84, 0.83, and 0.72, respectively). The resulting reliability coefficients were consistent with those reported in the literature, as discussed previously (Quinn, 1989; Paulhus, 1988). A complete copy of the Balanced Inventory of Desirable Responding can be found in Appendix D.

**Description of Independent and Dependent Variables**

For Hypothesis Two (Part Two-b), when examining variables that predict perceived competence, the four dependent variables were level of perceived competence as measured by the Gerontological Counseling Competencies Scale (full scale) and its subscales (Knowledge & Skills, Attitudes, and Bio-Cognitive Knowledge). The independent variables included: (1) prior work experience with older adults, (2) education in gerontological issues, and (3) training with older adults.
Participants and Delimitations

The convenience sample of participants in the present study was recruited through e-mail posts soliciting volunteers from counseling related listservs. Each listserv is comprised of professional counselors, counselor educators, and counselor trainees as well as other related professionals and students. The participants recruited for the present study consisted of counselors, counselor educators, and counselor trainees across the United States of America. The sample population in this study was delimited to professional counselors, counselor educators, Doctoral level counselor trainees, and Master’s level counselor trainees. Participants were not delimited based on sex, age, race, marital status, SES, level of experience or other demographic factors. The total number of participants required for the study follows the rule of thumb of at least five subjects per item in the survey and/or a total of 250 participants for the results to be meaningful (Cattell, 1978; Comrey, 1978; Gorsuch, 1983; Hatcher, 1994).

A total of 268 counselors, counselor educators and counselor trainees were recruited for participation in this study. The majority of participants were female (78%) and White/Caucasian (80%). Sixty-two percent of the participants reported Master’s Degree as the highest degree held. Sixteen percent held a Doctoral Degree and 22% a Bachelor’s Degree. One hundred and sixty participants reported currently working in the counseling field as a counselor and/or counselor educator with 24% working in a University setting and 20% at a Mental Health Clinic/Agency. A majority of the sample had prior work experience with older adults (65%) and prior coursework in issues related
to older adults. Close to half of the participants (41%) had prior training in gerontological topics.

**Procedures**

First, approval was obtained from the Institutional Review Board at the University of Akron to conduct this study (See Appendix E). Once approval was granted, the present study was conducted utilizing an online survey format disseminated to seven counseling listservs: CE-MFT, CESNET, COUNSGRADS, OHCOUNSELED, OCA-L, DIVERSEGRAD L and GERONTOLOGY-CENTER. The total number of subscribers to these listservs and whether or not the online survey reached each subscriber was unknown. Therefore, a survey response rate was not possible to obtain. As noted above, the listservs that were used are intended for counselors, counselor educators, and counselor trainee use as well as professionals and students in other related areas of study. An email was circulated on the listservs to solicit voluntary participation in the study. This e-mail also included information about the study, a request for participation, and a link to the site hosting the study’s survey. Once the link has been accessed, the first page included a document of informed consent (Appendix B). As explained above, the informed consent consisted of a brief description of the present study, the risks and benefits of participation in the study, the participants’ right to refuse participation or withdraw at any time without negative consequences, and a description of how data will be handled and how anonymity and confidentiality will be maintained. If the volunteer agreed to participate in the study, he/she was taken to the online survey itself. The online
survey began with the Demographic and Training Questionnaire consisting of questions about age, sex, race, education level, status (student or professional), and prior training, education, and work experience including that with gerontology (please refer to Appendix C for a copy of the questionnaire). The next scale found was the initial Gerontological Counseling Competencies Scale (Appendix G). As described previously, the GCCS was developed by the researcher to assess counselor, counselor educator, and counselor trainee perceived competence when working with older adults. The GCCS will be discussed more thoroughly in Chapter IV. Finally, the Balanced Inventory of Desirable Responding (BIDR; Appendix D) was included to assess social desirability. The estimated time to complete the entire survey was approximately 10-15 minutes.

**Research Design and Data Analyses**

First, the data was screened for missing and incorrectly entered data, normality, and linearity. Descriptive statistics (specifically, frequencies) were examined for the demographic and training variables in the study, including information on participant characteristics (gender, age, race), education (highest degree held and current student status and level) and employment (years in counseling field, current position and place of employment). Frequencies for prior gerontological experience were also explored. This included: work experience with older adults, number of older adult clients seen, educational experience (coursework on gerontological issues) and training on topics related to older adults. Psychometric properties of the major study variables were described (e.g., mean, standard deviation, alpha, range, and skewness.)
Second, after descriptive statistics were reported for the demographic and training variables, the process of scale development was described including the theoretical foundation for item choice and the expert panel and focus group ratings. This provided support for initial content validity/face validity of the Gerontological Counseling Competencies Scale (Hypothesis Two: Part One).

Third, exploratory factor analyses (specifically, a Principal Component Analyses) of the Gerontological Counseling Competencies Scale (GCCS; O’Connor Thomas, 2012) were performed. These analyses examined the underlying factor structure of the GCCS (Hypothesis Two: Part Two-a) and revealed three factors. These factors (subscales) were labeled Knowledge & Skills, Attitudes, and Bio-Cognitive Knowledge. Then, intercorrelations among the total Gerontological Counseling Competencies Scale and the three subscales were examined using Pearson correlations. Next, internal consistency (alpha) of the GCCS total scale and the three subscales (Knowledge & Skills, Attitudes, and Bio-Cognitive Knowledge) was performed to assess reliability (Hypothesis One).

Fourth, to examine Hypothesis Two (Part Two-b), a simultaneous multiple regression was performed to assess if prior work experience with older adults (including practicum and internship), education (e.g., coursework) in gerontological issues, and training in working with older adults (e.g., workshops, seminars) significantly predicted counselor perceived competence when working with older adults.

Finally, Pearson correlations between the Gerontological Counseling Competencies Scale (GCCS) and the Balanced Inventory of Desirable Responding (BIDR) were performed to assess the influence of socially desirable responding on
perceived counselor competence when working with older adult clients (Hypothesis Three).

**Summary of Chapter III**

The purpose of the present study was to develop a reliable and valid scale to assess counselor perceived competence when working with older adults. Participants included 268 counselors, counselor educators, and counselor trainees recruited from seven counseling related listservs. The participants completed a Demographic & Training Questionnaire, the preliminary Gerontological Counseling Competencies Scale (GCCS), and the Balanced Inventory of Desirable Responding (BIDR). Preliminary data screening was performed to look for missing data and to test for normality and linearity. After data screening, Descriptive and Inferential Statistics were examined; the results of these statistics are reported in the next chapter (Chapter IV).
CHAPTER IV
RESULTS

The purpose of the present study was to develop a reliable and valid self-report measure of counselor perceived competence when working with older adults. The Gerontological Counseling Competencies Scale was developed by examining the underlying factor structure, internal consistency reliability and content and construct validity. This chapter presents the statistical findings related to the present study. The first part of the chapter presents the descriptive statistics of the variables examined in the present study, and the second part reports the inferential statistical findings as they relate to the study’s three hypotheses.

Pre-Analysis Data Screening

Before descriptive and inferential statistics were analyzed, pre-analysis data screening was conducted. This was performed to ensure the validity and accuracy of the data (Mertler & Vannatta, 2005). Through the use of Frequency Tables, data was screened for incorrectly entered and missing items. No incorrectly entered or missing data were found. This was expected since the computer program used for online data collection prevents this from happening. Normality and linearity were established through examination of Scatterplots, skewness and kurtosis, and the Kolmogorov-Smirnov Test.
Descriptive Statistics

Demographic Information. There were a total of 268 participants included in the present study. As shown in Table 1, the sample was predominately female (78%, n = 209) and White/Caucasion (80%, n = 214). The remainder of the participants self-identified as Black/African American (10%, n = 26), Hispanic/Latino (3%, n = 7), Asian (4%, n = 10), Native American/American Indian (1%, n = 2) and finally 3% (n = 9) described themselves as Other. There was a range of ages represented in the study: 20-29 years (24%, n = 65), 30-39 years (28%, n = 75), 40-49 years (19%, n = 52), 50-59 years (17%, n = 45), 60-69 years (9%, n = 24), and 70-79 years (3%, n = 7).

Education Information. Table 2 displays information on the participants’ educational experiences. When looking at educational attainment, the majority of participants reported Master’s Degree as the highest level of education (62%, n = 166). Twenty-two percent (n = 60) of the participants sampled held at least a Bachelor’s Degree and 16% (n = 42) held a Doctoral Degree. Over half of the participants (58%, n = 154) are currently enrolled in school with 74 of those participants working on Master’s Degree and 80 working on a Doctorate.

Employment Information. Sixty percent (n = 160) of the participants reported currently working in the counseling field as a counselor and/or counselor educator. Of these, 55 reported having 1-5 years of experience working in the field. On the other end of the spectrum, 45 participants reported having more than 15 years of experience working in the field. The remaining participants reported the following years of
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*Note: N = 268.*
Table 2

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<td>42</td>
<td>15.7%</td>
</tr>
<tr>
<td>Current Student</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>154</td>
<td>57.5%</td>
</tr>
<tr>
<td>No</td>
<td>114</td>
<td>42.5%</td>
</tr>
<tr>
<td>Degree Sought (N = 154)</td>
<td></td>
<td></td>
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<tr>
<td>Master’s Degree</td>
<td>74</td>
<td>48.1%</td>
</tr>
<tr>
<td>Doctoral Degree</td>
<td>80</td>
<td>51.9%</td>
</tr>
<tr>
<td>Year in Program (N = 154)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Master’s Level (before Practicum)</td>
<td>40</td>
<td>26.0%</td>
</tr>
<tr>
<td>Master’s Level (during Practicum)</td>
<td>15</td>
<td>9.7%</td>
</tr>
<tr>
<td>Master’s Level (after Practicum)</td>
<td>21</td>
<td>13.6%</td>
</tr>
<tr>
<td>Doctoral Level</td>
<td>78</td>
<td>50.6%</td>
</tr>
<tr>
<td>Enrolled in Practicum or Internship N = 154)</td>
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<td></td>
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<tr>
<td>Yes</td>
<td>51</td>
<td>33.1%</td>
</tr>
<tr>
<td>No</td>
<td>103</td>
<td>66.9%</td>
</tr>
</tbody>
</table>

*Note: N = 268, unless otherwise stated.*
experience: 6-10 years (n = 32), 11-15 years (n = 24), and less than one year (n = 4). See Table 3 for a description of participants’ employment information.

**Gerontological Experience.** As depicted in Table 4, 175 (65%) of the participants reported having prior work experience with older adults. Of these 175 participants, close to half (n = 82; 47%) had worked with 11 or more older adults. Twenty-eight (16%) reported prior work experience with 6-10 older adults and 37% (n = 65) had worked with 1-5 older adults. When looking at whether or not the participants had prior coursework in gerontological issues, 69% (n = 186) reported yes they had prior educational experience. The majority of these 186 participants (n = 100; 53.8%) had only one class and out of the remaining participants 25% had two classes, 11% had three, 4% had taken 4, and 7% reported taking five or more classes that included gerontological content. Finally, 110 (41%) of the participants had prior training with issues related to older adults.

**Psychometric Properties.** The psychometric properties of the Gerontological Counseling Competencies Scale (GCCS) with subscales (*Knowledge & Skills*, *Attitudes*, and *Bio-Cognitive Knowledge*) and the Balanced Inventory of Desirable Responding (full scale, *Self-Deception* subscale, and *Impression Management* subscale) are included in Table 5. The GCCS full scale had a mean score of 54.39 and a standard deviation of 15.69. Total scores on the full scale can range from 21 to 105 with higher scores indicating a higher level of self-perceived competence when working with older adults. The BIDR full scale had a possible range of 0-40 with a mean of 13.30 and a standard
Table 3

Employment Information

<table>
<thead>
<tr>
<th>Variable</th>
<th>Frequency (n)</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Working in Counseling Field</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>160</td>
<td>59.7%</td>
</tr>
<tr>
<td>No</td>
<td>108</td>
<td>40.3%</td>
</tr>
<tr>
<td>Years in Counseling Field (N = 160)</td>
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<td></td>
</tr>
<tr>
<td>&lt;1</td>
<td>4</td>
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<tr>
<td>1-5</td>
<td>55</td>
<td>34.4%</td>
</tr>
<tr>
<td>6-10</td>
<td>32</td>
<td>20.0%</td>
</tr>
<tr>
<td>11-15</td>
<td>24</td>
<td>15.0%</td>
</tr>
<tr>
<td>&gt;15</td>
<td>45</td>
<td>28.1%</td>
</tr>
<tr>
<td>Current Position (N = 160; may choose more than one)</td>
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<td></td>
</tr>
<tr>
<td>Counselor</td>
<td>116</td>
<td>43.3%</td>
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<tr>
<td>Counselor Educator</td>
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<td>20.5%</td>
</tr>
<tr>
<td>Other</td>
<td>34</td>
<td>12.7%</td>
</tr>
<tr>
<td>Current Place of Employment (N = 160; may choose more than one)</td>
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<td></td>
</tr>
<tr>
<td>Private Practice</td>
<td>43</td>
<td>16%</td>
</tr>
<tr>
<td>Mental Health Clinic/Agency</td>
<td>53</td>
<td>19.8%</td>
</tr>
<tr>
<td>University</td>
<td>63</td>
<td>23.5%</td>
</tr>
<tr>
<td>Other</td>
<td>33</td>
<td>12.3%</td>
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</table>

*Note: N = 268, unless otherwise stated.*
Table 4

Gerontological Experience

<table>
<thead>
<tr>
<th>Variable</th>
<th>Frequency (n)</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work Experience</td>
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</tr>
<tr>
<td>Yes</td>
<td>175</td>
<td>65.3%</td>
</tr>
<tr>
<td>No</td>
<td>93</td>
<td>34.7%</td>
</tr>
<tr>
<td>Number of Older Adults (N = 175)</td>
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<td></td>
</tr>
<tr>
<td>1-5</td>
<td>65</td>
<td>37.1%</td>
</tr>
<tr>
<td>6-10</td>
<td>28</td>
<td>16.0%</td>
</tr>
<tr>
<td>11+</td>
<td>82</td>
<td>46.9%</td>
</tr>
<tr>
<td>Educational Experience</td>
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<td></td>
</tr>
<tr>
<td>Yes</td>
<td>186</td>
<td>69.4%</td>
</tr>
<tr>
<td>No</td>
<td>82</td>
<td>30.6%</td>
</tr>
<tr>
<td>Number of Classes (N = 186)</td>
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<td></td>
</tr>
<tr>
<td>1</td>
<td>100</td>
<td>53.8%</td>
</tr>
<tr>
<td>2</td>
<td>47</td>
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<tr>
<td>3</td>
<td>20</td>
<td>10.8%</td>
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<tr>
<td>4</td>
<td>7</td>
<td>3.8%</td>
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<tr>
<td>5+</td>
<td>12</td>
<td>6.5%</td>
</tr>
</tbody>
</table>

Note: N = 268, unless otherwise stated. Gerontological Experience includes Work Experience, Educational Experience, and Training with older adults.
Table 4

Gerontological Experience

<table>
<thead>
<tr>
<th>Variable</th>
<th>Frequency (n)</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Training</td>
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<td></td>
</tr>
<tr>
<td>Yes</td>
<td>110</td>
<td>41.0%</td>
</tr>
<tr>
<td>No</td>
<td>158</td>
<td>59.0%</td>
</tr>
</tbody>
</table>

*Note: N = 268, unless otherwise stated. Gerontological Experience includes Work Experience, Educational Experience (coursework), and Training (workshops, conferences, presentations, seminars) with older adults.*

deviation of 6.46. Higher scores on the BIDR represent a greater influence of social desirability. The means, standard deviations, and total score ranges of the GCCS subscales were as follows: *Knowledge & Skills* (M = 39.68, SD = 11.93, range = 13-65), *Attitudes* (M = 8.43, SD = 3.01, range = 5-25), and *Bio-Cognitive Knowledge* (M = 6.28, SD = 2.32, range = 3-15). Total scores on BIDR *Self-Deception* and *Impression Management* scales can both range from 0-20. *Self-Deception* and *Impression Management* had a mean of 5.38 (SD = 3.35) and 7.92 (SD = 4.29), respectively (See Table 5).

**Scale Development**

Development of the GCCS was based on the rational-theoretical approach to scale construction (also known as the deductive or intuitive approach) which involves choosing
Table 5

Psychometric Properties of the Major Study Variables

<table>
<thead>
<tr>
<th>Scale</th>
<th>n</th>
<th>M</th>
<th>SD</th>
<th>α</th>
<th>Skew</th>
<th>Kurtosis</th>
<th>Min.</th>
<th>Max</th>
</tr>
</thead>
<tbody>
<tr>
<td>GCCS FS</td>
<td>268</td>
<td>54.39</td>
<td>15.69</td>
<td>.96</td>
<td>-.11</td>
<td>-.73</td>
<td>21.00</td>
<td>91.00</td>
</tr>
<tr>
<td>GCCS KS</td>
<td>268</td>
<td>39.68</td>
<td>11.93</td>
<td>.96</td>
<td>-.12</td>
<td>-.61</td>
<td>13.00</td>
<td>65.00</td>
</tr>
<tr>
<td>GCCS A</td>
<td>268</td>
<td>8.43</td>
<td>3.01</td>
<td>.85</td>
<td>.60</td>
<td>-.69</td>
<td>5.00</td>
<td>16.00</td>
</tr>
<tr>
<td>GCCS BK</td>
<td>268</td>
<td>6.28</td>
<td>2.32</td>
<td>.87</td>
<td>.24</td>
<td>-.65</td>
<td>3.00</td>
<td>12.00</td>
</tr>
<tr>
<td>BIDR FS</td>
<td>268</td>
<td>13.30</td>
<td>6.46</td>
<td>.84</td>
<td>.34</td>
<td>-.40</td>
<td>.00</td>
<td>31.00</td>
</tr>
<tr>
<td>BIDR SD</td>
<td>268</td>
<td>5.38</td>
<td>3.35</td>
<td>.72</td>
<td>.51</td>
<td>-.39</td>
<td>.00</td>
<td>15.00</td>
</tr>
<tr>
<td>BIDR IM</td>
<td>268</td>
<td>7.92</td>
<td>4.29</td>
<td>.83</td>
<td>.13</td>
<td>-.80</td>
<td>.00</td>
<td>18.00</td>
</tr>
</tbody>
</table>

*Note:* GCCS = Gerontological Counseling Competencies Scale; FS = Full Scale; KS = Knowledge & Skills; A = Attitudes; BK = Bio-Cognitive Knowledge; BIDR = Balanced Inventory of Desirable Responding; FS = Full Scale; SD = Self-Deception; IM = Impression Management.

A construct and defining possible dimensions underlying the construct based on theory. Next, items that fit the definitions are written for these dimensions (Szymanski & Chung, 2001). In other words, according to Burisch (1984), choice and definition of constructs precede and govern the formulation of items. With this approach, the validation process begins with the formulation of construct definitions, which are derived from psychological theory and from prior research. Test items are then prepared to fit the construct definitions. Empirical item analysis follows, with the selection of the most valid items from the initial item pool (Anastasi, 1986; 1992).
**Initial Content Validity.** The Gerontological Counseling Competencies Scale (GCCS) was designed to assess counselors’ perceived competencies with regard to therapeutic practice with older adults. In following with the rational-theoretical approach described above, and keeping in mind the intended purpose of the GCCS, the literature on counseling older adults in general and, more specifically, gerontological counseling competency was reviewed to ensure that the measure would adequately sample the content that it was being designed to measure. Second, based on prior theory in gerontological counseling competency and multicultural counseling competency, the possible dimensions underlying the construct were defined.

The review of the literature (as described in Chapter II) generated the two principal publications used to develop the initial pool of items for the GCCS:

*Gerontological Competencies for Counselors and Human Development Professionals* (Myers & Sweeney, 1990) and *Guidelines for Psychological Practice with Older Adults* (American Psychological Association, 2004). The initial Gerontological Counseling Competencies Scale was comprised of many of the individual competency statements for all entry-level counselors (generic) found in the *Gerontological Competencies for Counselors and Human Development Professionals* (Myers & Sweeney, 1990) supplemented with the more recent guidelines developed by the American Psychological Association found in the *Guidelines for Psychological Practice with Older Adults* (American Psychological Association, 2004). Note: when necessary to avoid any confusion of having multiple topics covered under one statement, the individual competency statements of Myers and Sweeney (1990) and the guidelines of the American
Psychological Association (2004) chosen for purposes of this research were shortened and the wording of the statements were updated to reflect more current language. For example, Myers and Sweeney (1990) stated that “the counselor should be able to demonstrate skills in the use of appraisal knowledge for older persons including selecting and using appropriate appraisal techniques in work with older persons” and Guideline 11 stresses that “psychologists should strive to understand the problems of using assessment instruments created for younger individuals when assessing older adults, and to develop skill in tailoring assessments to accommodate older adults specific characteristics and contexts” (American Psychological Association, 2004). The current research used the following two statements “I am able to demonstrate understanding of the problems of using assessment instruments created for younger individuals when assessing older adults” and “I am able to tailor assessment instruments created for younger individuals to the special needs of older adults.”

The research on gerontological counselor competency, as well as the research on Multicultural Competency Assessment (also described in Chapter II), suggested that counseling competence with older adults and multicultural competence in general reflects three domains (Knowledge, Skills, and Attitudes). Using this conceptualization, Knowledge refers to the ability to accurately identify, list, define, distinguish, match, label, etc…, words, theories, facts or concepts believed to be important to the effective functioning of counselors with older adult clients. Skills are evidenced by producing, demonstrating, showing, manipulating, or acting in such a manner as to promote positive behavior, wellness, and/or effective services for older adults. Finally, according to Myers
and Sweeney (1990), *Attitudes* are evidenced by ethical views, moral perceptions, and values which underscore positive, open, growth/wellness enhancing behaviors toward older adults.

Based on the aforementioned theoretical definitions, as well as the review of the extant literature on gerontological counseling competencies (described in Chapter II), 47 statements were generated that attempted to assess the three dimensions of counselor competencies with regard to counseling older adults: *Knowledge, Skills,* and *Attitudes.* As mentioned previously, these areas were chosen because they are the categories most often addressed in the counseling literature in relation to multicultural counseling competence, in general, and gerontological counseling competence, more specifically. (A copy of these 47 statements can be found listed on the Table of Specifications in Appendix F).

**Expert Panel.** Initial content validity/fac validity (Hypothesis Two: Part One) was supported by having the scale reviewed by four experts in the areas of counseling, aging, multicultural counseling and/or test development based on their self-expressed interest, clinical/professional experience, and research interest/publications. Using the Table of Specifications found in Appendix F, the expert panel was asked to examine each statement for clarity and to rate the statement based on a 5-point Likert scale (1 = low degree of fit, 2 = moderate degree of fit, 3 = pretty good fit, 4 = good fit, and 5 = very good fit) the extent to which each statement represents the three dimensions: *Knowledge, Skills* and *Attitudes.* Definitions for the three dimensions were provided. The expert panel was also invited to provide any comments or suggestion that they may have about
the statements. The initial scale was formulated based on feedback from these expert raters. The criterion for retaining an item was 60% agreement that an item fit a particular dimension with at least a rating of four (good fit). All 47 statements reached this criterion.

In following the comments/suggestions provided by the expert panel, many of the original 47 statements were shortened further to increase clarity of the items. For example, statements that began with “I am able to demonstrate knowledge…” were changed to “I know…” and statements beginning with “I am able to demonstrate understanding…” were shortened to “I understand…” Examples were also provided for statements 2 (the biological aspects of aging), 3 (the cognitive changes in older adults), and 4 (psychopathology in older adults) based on the expert panel feedback. Finally, one item (statement 3: I am able to demonstrate knowledge of the cognitive changes in older adults) was changed into two statements--- one discussing normal cognitive changes and the other discussing abnormal cognitive changes. With this additional item, this stage of instrument development resulted in 48 items.

**Focus Group.** To further support content validity (Hypothesis Two: Part One), the resulting 48 item scale was administered to a focus group comprised of eleven doctoral level counselor trainees and one counselor educator. The directions required the focus group members rate their competence for each of the 48 statements using a 5-point Likert scale (Likert, 1932): 5 = I am very strong/competent in this area with all older adult clients—this comes naturally for me; 4 = I am generally strong/competent in this area, though it may be more difficult with some older adult clients; 3 = I am generally
competent in this area, but it is necessary for me to continue to work on this area; 2 = I am inconsistent in this area—sometimes I do well and sometimes this is a weakness; and 1 = This is a weakness for me: I require continued work in this area. The focus group was also asked to complete the Demographic and Training Questionnaire (created by the researcher) and the BIDR. After completing the questionnaires, the focus group responded to a series of six questions and subsequent open-ended probes into the questions based on the answers. The six questions were as follows: Were the directions for filling out the GCCS clear? Was the Likert scale clear (in other words, did you understand what was meant by each scale item)? Were the statements clear (in other words, did they make sense)? Were the statements easy to read and understand? Did you feel the statements covered the topic of counselor competence? and finally, Did the statements make you think about your own training? After discussion of the six questions, the focus group was prompted to provide further comments or suggestions about the questionnaires. Based on the feedback from the focus group, two additional statements were added to the survey. The two statements examined competency with end of life issues of older adults—“I know about the impact of grief and bereavement on older adults” and “I know how end of life issues impact older adults.” Next, based on the focus group discussion, the Likert scale was changed for ease of interpretation. The new 5-point Likert scale was as follows: 5 = Describes Me Well; 3 = Describes Me Somewhat; and 1 = Does Not Describe Me At All.

This stage of instrument development resulted in 50 items (See Appendix G). This initial 50-item Gerontological Counseling Competencies Scale (GCCS) was
electronically disseminated to counselors, counselor educators, and counselor trainees across the United States via Listserv. A total of 268 participants responded to the solicitation for participation. The directions for the GCCS required the respondents to rate their competence for each of the 50 statements by using the 5-point Likert scale described previously (5 = Describes Me Well; 3 = Describes Me Somewhat; and 1 = Does Not Describe Me At All). Three examples of the GCCS items included: 1) I know about evidence-based interventions with older adults; 2) I am receptive to older adults who seek counseling; and 3) I am able to apply effective communication skills with older adults. A complete copy of the initial GCCS used in the present study can be found in Appendix G.

The data obtained from this stage of scale development was analyzed to formulate the final version of Gerontological Counseling Competencies Scale (GCCS; O’Connor Thomas, 2012) found in Appendix H. The next section describes the results of these analyses.

Inferential Statistics

Factor Analysis. In order to identify the underlying factor structure of the Gerontological Counseling Competencies Scale (Hypothesis Two: Part Two-a), the 50-item GCCS was subjected to a Principal Component Analysis with Varimax rotation (Brown, 2009; Gorsuch, 1983; Kim & Mueller, 1978). The following criteria were then used for determining the number of factors to retain:
1. **Kaiser’s Criterion** (Kaiser, 1958; 1960). Factors with eigenvalues greater than one are retained.

2. **Scree Test** (Cattell, 1966). When examining the scree plot, factors corresponding to the last eigenvalue before they start to level off are considered.

3. **Percent of Variance Explained** (Tinsley & Tinsley, 1987; Stevens, 1996). There is disagreement in the literature as to how much total variance that the factors together should explain—ranging from more than 50% (Tinsley & Tinsley, 1987) to more than 70% (Stevens, 1996). Compromising, the present study set the criterion at 60%. In other words, the factors together must account for more than 60% of the total variance with each of the factors explaining at least 3% of that variance.

4. **Simple Structure and Item-Factor Loading** (Brown, 2009; Gorsuch, 1983; Hatcher, 1994; Pedhazur & Schmelkin, 1991; Thurstone, 1947). The rotated factor pattern demonstrates simple structure. In other words, items loading high on one factor and lower on the other factors are retained. Interpretation for item-factor loading is based on a 0.40 or greater loading on one factor but less than 0.40 on the other factors.

5. **Number of Items per Factor** (Costello & Osborne, 2005; Hatcher, 1994; Osborne & Costello, 2004). At least three items significantly load on a factor.

Principal Components Analysis revealed the presence of seven factors with eigenvalues greater than one, explaining 49.45%, 6.35%, 3.96%, 3.11%, 2.51%, 2.27%, and 2.06% of the variance, respectively. An examination of the Scree Plot (see Figure 1) suggested that factor solutions ranging from three to four factors might be considered. A four-factor solution was chosen because the four factors together accounted for 62.87% of the total variance, with each factor contributing at least 3% of that total. The rotated component matrix revealed that six items failed to load at 0.40 on any of the four factors and 12 items loaded at 0.40 or higher on more than one of the factors. These 18 items were eliminated leaving a total of 32 items. Refer to Appendix I for a list of the eliminated items.

A second Principal Component Analysis with Varimax rotation was used to analyze the remaining 32 items. The results of this analysis were scrutinized using the six criteria for retention of factors discussed previously. As expected, the analysis revealed the presence of four factors with eigenvalues greater than one, explaining 52.27%, 6.86%, 4.26%, and 3.57% of the variance, respectively. For a second time, the scree plot supported a three- or four-factor solution. Once more, a four-factor solution was chosen because the four factors combined accounted for 66.96% of the total variance, with each factor contributing at least 3% of that total. Upon examination of the rotated component matrix, nine items cross-loaded (in other words, loaded at 0.40 or higher on more than one of the four factors) and were removed. Factor 4 was comprised
Figure 1: Scree Plot from Principal Components Analysis.
of only two items, therefore did not meet the three item minimum and was eliminated (See Appendix I). The removal of the nine cross-loading items and the fourth factor resulted in three remaining factors with a total of 21 items.

A third and final Principal Component Analysis with Varimax rotation was performed on the remaining 21 items. Results of this analysis were consistent with the results of the second analysis with the three remaining factors meeting all six criteria for selection described previously. As shown on Table 6, the three factor solution was preferable because none of the remaining items cross-loaded or failed to load on any other factor (all 21 items yielded factor loadings greater than 0.58 on their respective factors and loadings less than 0.39 on any other factor). Moreover, each factor was comprised of three or more items. Upon inspection, the items composing each factor are logical and share conceptual meaning. The 21 items were also consistent with the initial conceptualization of gerontological counseling competency (Hatcher, 1994; Tabachnick & Fidell, 2007).

As displayed in Table 7, the above analyses resulted in the retention of 21 items for the final Gerontological Counseling Competencies Scale (GCCS), and a three-factor solution accounting for 68.16% of the total variance. The first factor (subscale), consisting of 13 items, explained 53.92% of the total scale variance. This subscale was labeled Knowledge and Skills because the items reflect a counselor’s knowledge about aging and the application of that knowledge in their counseling (skills). For example, “I know the assessment instruments that are psychometrically appropriate for use with older
Table 6
Factor Loadings for Principal Components Analysis

<table>
<thead>
<tr>
<th>Item</th>
<th>Factor 1</th>
<th>Factor 2</th>
<th>Factor 3</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>.807</td>
<td>.270</td>
<td>.237</td>
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<td>3</td>
<td>.778</td>
<td>.108</td>
<td>.251</td>
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<td>4</td>
<td>.772</td>
<td>.285</td>
<td>.258</td>
</tr>
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<td>5</td>
<td>.771</td>
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<td>.770</td>
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<td>.380</td>
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</tr>
<tr>
<td>11</td>
<td>.701</td>
<td>.301</td>
<td>.198</td>
</tr>
<tr>
<td>12</td>
<td>.684</td>
<td>.195</td>
<td>.240</td>
</tr>
</tbody>
</table>

*Note.* Factor loadings >.40 are in boldface.
Table 6

Factor Loadings for Principal Components Analysis

<table>
<thead>
<tr>
<th>Item</th>
<th>Factor 1</th>
<th>Factor 2</th>
<th>Factor 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>13</td>
<td>.628</td>
<td>.336</td>
<td>282</td>
</tr>
<tr>
<td>14</td>
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<td>.160</td>
<td>.797</td>
<td>.151</td>
</tr>
<tr>
<td>16</td>
<td>.156</td>
<td>.704</td>
<td>.266</td>
</tr>
<tr>
<td>17</td>
<td>.295</td>
<td>.680</td>
<td>.302</td>
</tr>
<tr>
<td>18</td>
<td>.386</td>
<td>.589</td>
<td>.285</td>
</tr>
<tr>
<td>19</td>
<td>.279</td>
<td>.214</td>
<td>.855</td>
</tr>
<tr>
<td>20</td>
<td>.292</td>
<td>.239</td>
<td>.827</td>
</tr>
<tr>
<td>21</td>
<td>.355</td>
<td>.306</td>
<td>.681</td>
</tr>
</tbody>
</table>

*Note.* Factor loadings >.40 are in boldface.
Table 7

Total Variance Explained for Principal Components Analysis

<table>
<thead>
<tr>
<th>Factor</th>
<th>Total</th>
<th>% of Variance</th>
<th>Cumulative %</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>11.322</td>
<td>53.916</td>
<td>53.916</td>
</tr>
<tr>
<td>2</td>
<td>1.778</td>
<td>8.466</td>
<td>62.382</td>
</tr>
<tr>
<td>3</td>
<td>1.214</td>
<td>5.780</td>
<td>68.163</td>
</tr>
</tbody>
</table>

Rotation Sum of Squared Loadings

<table>
<thead>
<tr>
<th>Factor</th>
<th>Total</th>
<th>% of Variance</th>
<th>Cumulative %</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>7.780</td>
<td>37.048</td>
<td>37.048</td>
</tr>
<tr>
<td>2</td>
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<td>54.930</td>
</tr>
<tr>
<td>3</td>
<td>2.779</td>
<td>13.232</td>
<td>68.163</td>
</tr>
</tbody>
</table>

adults” (Knowledge) and “I am able to tailor assessment instruments created for younger individuals to the special needs of older adults” (Skill).

The second factor or subscale (five items) accounted for 8.47% of the total variance and was named *Attitudes* because the item content focuses on counselors’ sociocultural attitudes about aging. Two examples of items in this scale are: “I demonstrate positive, wellness enhancing attitudes toward older adults” and “I understand how sociocultural factors can influence the mental health of older adults.”

The third factor (subscale) consists of three items and explains 5.78% of the total scale variance. This factor was labeled *Bio-Cognitive Knowledge* because the three
items reflect a separate knowledge base; a counselor’s knowledge about the biological and cognitive aspects of aging. For example, “I know about the normal cognitive changes in older adults (e.g., short-term memory deficits, slower processing speed).” Another example is “I know about the abnormal cognitive changes in older adults (e.g., dementia).” See Table 8 for a complete list of the 21 items by scale.

The results of the Principal Components Analyses partially supported Hypothesis Two (Part Two-a). As expected, a three factor solution was found with Attitudes being one of the underlying factors. Although measuring the same content as expected, the combination of Knowledge and Skills as one single factor departed from the original conceptualization of these two items being separate factors. It was expected that the three items comprising Factor 3 (Bio-Cognitive Knowledge) would fit into the original conceptualization of Knowledge but were separated out as a unique knowledge base. This factor solely dealt with knowledge about the biological and cognitive aspects of aging.

**Correlations.** Pearson Correlations were used to examine the relationship between the items of the total Gerontological Counseling Competencies Scale and its subscales (Knowledge & Skills, Attitudes, and Bio-Cognitive Knowledge). This analysis indicated high correlations between the total scale and the three subscales (*Knowledge and Skills = 0.98, Attitudes = 0.77, and Bio-Cognitive Knowledge = 0.75*).

Intercorrelations were also examined among the three subscales. It was expected that the three subscales would be intercorrelated since they are all facets or dimensions of a single concept, gerontological counseling competence (Pedhazur & Schmelkin, 1991). As
Table 8

Final Gerontological Counseling Competencies Scale Items

<table>
<thead>
<tr>
<th>Subscale</th>
<th>Item Number</th>
<th>Statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledge &amp; Skills</td>
<td>1</td>
<td>I know the theoretical approaches which are most effective when counseling older adults.</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>I am able to aid older adults in the use of memory-enhancing techniques to overcome cognitive deficits that may impact the counseling process.</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>I know the assessment instruments that are psychometrically appropriate for use with older adults.</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>I know about evidenced-based interventions with older adults.</td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>I am able to tailor assessment instruments created for younger individuals to the special needs of older adults.</td>
</tr>
<tr>
<td></td>
<td>6</td>
<td>I am able to facilitate the retirement process with older adults.</td>
</tr>
<tr>
<td></td>
<td>7</td>
<td>I am able to identify factors which facilitate the counseling process with older adults.</td>
</tr>
<tr>
<td></td>
<td>8</td>
<td>I am able to adapt psychotherapeutic interventions for use with older adults.</td>
</tr>
<tr>
<td></td>
<td>9</td>
<td>I am able to enhance health literacy skills of older adults.</td>
</tr>
<tr>
<td></td>
<td>10</td>
<td>I am able to facilitate the process of choosing alternative careers for older adults in retirement.</td>
</tr>
<tr>
<td></td>
<td>11</td>
<td>I know how to work in groups with older adults.</td>
</tr>
</tbody>
</table>

(continued)
<table>
<thead>
<tr>
<th>Subscale</th>
<th>Item Number</th>
<th>Statement</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Knowledge &amp; Skills</strong> (cont.)</td>
<td>12</td>
<td>I know about the formal and informal aging services network.</td>
</tr>
<tr>
<td></td>
<td>13</td>
<td>I am able to modify the therapeutic environment to overcome the physical limitations of older adults.</td>
</tr>
<tr>
<td><strong>Attitudes</strong></td>
<td>14</td>
<td>I demonstrate positive, wellness enhancing attitudes toward older adults.</td>
</tr>
<tr>
<td></td>
<td>15</td>
<td>I know the contributions of older adults to society.</td>
</tr>
<tr>
<td></td>
<td>16</td>
<td>I know the common stereotypes of older adults.</td>
</tr>
<tr>
<td></td>
<td>17</td>
<td>I understand how sociocultural factors can influence the mental health of older adults.</td>
</tr>
<tr>
<td></td>
<td>18</td>
<td>I am able to apply effective communication skills with older adults.</td>
</tr>
<tr>
<td><strong>Bio-Cognitive Knowledge</strong></td>
<td>19</td>
<td>I know about the normal cognitive changes in older adults (e.g., short-term memory deficits, slower processing speed).</td>
</tr>
<tr>
<td></td>
<td>20</td>
<td>I know about the biological aspects of aging (e.g., hearing changes, vision changes).</td>
</tr>
<tr>
<td></td>
<td>21</td>
<td>I know about the abnormal cognitive changes in older adults (e.g., dementia).</td>
</tr>
</tbody>
</table>
expected, moderate correlations between the three subscales were found (Knowledge and Skills with Attitudes = 0.64, Knowledge and Skills with Bio-Cognitive Knowledge = 0.64, and Attitudes with Bio-Cognitive Knowledge = 0.60). These results suggested that the three subscales were correlated, but that each factor also measured separate aspects of counselor’s perceived competence in working with older adults (See Table 9).

Table 9

<table>
<thead>
<tr>
<th>Scale</th>
<th>GCCS Full Scale</th>
<th>GCCS Knowledge &amp; Skills</th>
<th>GCCS Attitudes</th>
<th>GCCS Bio-Cognitive Knowledge</th>
</tr>
</thead>
<tbody>
<tr>
<td>GCCS Full Scale</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GCCS Knowledge &amp; Skills</td>
<td>.977**</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>GCCS Attitudes</td>
<td>.767**</td>
<td>.641**</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>GCCS Bio-Cognitive Knowledge</td>
<td>.746**</td>
<td>.636**</td>
<td>.595**</td>
<td>1</td>
</tr>
</tbody>
</table>

*Note:* GCCS = Gerontological Counseling Competencies Scale. ** indicates that correlation is significant at the 0.01 level (2-tailed).
Reliability Analysis. To examine Hypothesis One, Internal consistency reliability was assessed by calculating coefficient alpha (Cronbach, 1951). A general guideline for an acceptable level of internal consistency is alpha = 0.70 (George & Mallery, 2003; Nunnally, 1978). The size of the scale does affect the size of alpha with larger item scales more likely to have higher alpha levels (Cortina, 1993, Pedhazur & Schmelkin, 1991). Consequently, smaller scales with higher alpha levels indicate more internal consistency. Overall, as shown in Table 10, the total GCCS and its three subscales (Knowledge and Skills, Attitudes, and Bio-Cognitive Knowledge) had good to excellent reliability (Cronbach’s Alpha = 0.96, 0.96, 0.85, and 0.87, respectively). These findings provide support for the reliability of the Gerontological Counseling Competencies Scale and Hypothesis One.

Table 10
Internal Consistency Reliability of Gerontological Counseling Competencies Scale and Subscales

<table>
<thead>
<tr>
<th>Scale</th>
<th>Cronbach’s Alpha</th>
<th>N of Items</th>
</tr>
</thead>
<tbody>
<tr>
<td>GCCS Full Scale</td>
<td>.956</td>
<td>21</td>
</tr>
<tr>
<td>GCCS Knowledge &amp; Skills</td>
<td>.956</td>
<td>13</td>
</tr>
<tr>
<td>GCCS Attitudes</td>
<td>.849</td>
<td>5</td>
</tr>
<tr>
<td>GCCS Bio-Cognitive Knowledge</td>
<td>.865</td>
<td>3</td>
</tr>
</tbody>
</table>

Note: GCCS = Gerontological Counseling Competencies Scale
Multiple Regression. Standard Multiple Regression analysis was conducted to determine how accurately the independent variables (work experience, educational experience, and training with older adults) predicted self-perceived counseling competence when working with older adults as measured by the full scale Gerontological Counseling Competencies Scale (Mertler & Vannatta, 2005). Regression results indicated that the overall model significantly predicted self-perceived gerontological counseling competence, $R^2=.347$, $R^2_{adj}=.340$, $F(3,264,)=46.752$, $p<.001$. This model accounts for 34.7% of variance in counselor self-perceived competence when working with older adults. A summary of regression coefficients is presented in Table 11 and indicates that the three variables (work experience, educational experience, and training with older adults) significantly contributed to the model.

Next, separate Standard Multiple Regression analyses were conducted for each of the GCCS subscales (Knowledge & Skills, Attitudes, and Bio-Cognitive Knowledge) as the criterion/dependent variables and gerontological work experience, educational experience, and training as the predictor variables. Regression results were significant for all three analyses: (1) Knowledge & Skills, $R^2=.367$, $R^2_{adj}=.360$, $F(3,264,)=50.982$, $p<.001$, accounted for 36.7% of variance; (2) Attitudes, $R^2=.167$, $R^2_{adj}=.158$, $F(3,264,)=17.692$, $p<.001$, accounted for 16.7% of the variance; and (3) Bio-Cognitive Knowledge, $R^2=.132$, $R^2_{adj}=.122$, $F(3,264,)=13.352$, $p<.001$ accounted for 13.2% of the variance. A summary of the regression coefficients for these three multiple regressions are also included in Table 11. Similar to the full scale regression described above, the regression coefficients indicated that the three variables (work experience, educational experience, and training with older adults) significantly contributed to the model.
Table 11

Standard Multiple Regression Analyses Summary of Coefficients

<table>
<thead>
<tr>
<th>Model</th>
<th>B</th>
<th>β</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Full Scale</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Work Experience</td>
<td>.524</td>
<td>.334</td>
<td>6.288</td>
<td>.000</td>
</tr>
<tr>
<td>Education</td>
<td>.296</td>
<td>.183</td>
<td>3.588</td>
<td>.000</td>
</tr>
<tr>
<td>Training</td>
<td>.523</td>
<td>.345</td>
<td>6.433</td>
<td>.000</td>
</tr>
<tr>
<td><strong>Knowledge &amp; Skills</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Work Experience</td>
<td>.648</td>
<td>.337</td>
<td>6.436</td>
<td>.000</td>
</tr>
<tr>
<td>Education</td>
<td>.322</td>
<td>.162</td>
<td>3.232</td>
<td>.001</td>
</tr>
<tr>
<td>Training</td>
<td>.691</td>
<td>.371</td>
<td>7.029</td>
<td>.000</td>
</tr>
<tr>
<td><strong>Attitudes</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Work Experience</td>
<td>.355</td>
<td>.281</td>
<td>4.676</td>
<td>.000</td>
</tr>
<tr>
<td>Education</td>
<td>.207</td>
<td>.158</td>
<td>2.750</td>
<td>.006</td>
</tr>
<tr>
<td>Training</td>
<td>.216</td>
<td>.176</td>
<td>2.913</td>
<td>.004</td>
</tr>
<tr>
<td><strong>Bio-Cognitive Knowledge</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Work Experience</td>
<td>.267</td>
<td>.165</td>
<td>2.688</td>
<td>.008</td>
</tr>
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<td>Education</td>
<td>.331</td>
<td>.197</td>
<td>3.357</td>
<td>.001</td>
</tr>
<tr>
<td>Training</td>
<td>.308</td>
<td>.196</td>
<td>3.177</td>
<td>.002</td>
</tr>
</tbody>
</table>
experience, and training with older adults) significantly contributed to each of the models.

Forward Multiple Regression analyses were conducted to examine which independent variables (work experience with older adults, educational experience/coursework with older adult content, and/or training in gerontological issues) were the predictors of gerontological counseling competence as measured by the GCCS full scale and each of the three subscales (Knowledge & Skills, Attitudes, and Bio-Cognitive Knowledge) (Mertler & Vannatta, 2005). Results indicated that prior training (e.g., workshops, seminars with topics related to older adults) accounted for most of the variance explained in the full scale (23.2%), Knowledge & Skills subscale (25.5%), and the Bio-Cognitive Knowledge subscale (7.9%). For the Attitudes scale, on the other hand, prior work experience with older adults accounted for most of the variance explained (10.4%) by the model (see Table 12). A summary of the regression coefficients are included in Table 13.

**Correlation with Social Desirability.** A Pearson Correlation between the Gerontological Counseling Competencies Scale (GCCS) and the Balanced Inventory of Desirable Responding (BIDR) was performed to assess the influence of socially desirable responding on perceived counselor competence when working with older adult clients as assessed by the GCCS (Hypothesis Three). As displayed in Table 14, the correlations between the GCCS and BIDR full scales and subscales were all low, ranging from -.084 to -.253. The results of this correlation supported Hypothesis Three, providing evidence that the GCCS was not influenced by social desirability.
Table 12

Forward Multiple Regression Analyses Model Summary

<table>
<thead>
<tr>
<th>Model</th>
<th>$R^2$</th>
<th>$R^2_{\text{adj}}$</th>
<th>$R^2_{\text{change}}$</th>
<th>$F_{\text{change}}$</th>
<th>df</th>
<th>$p$</th>
</tr>
</thead>
</table>

**Full Scale**

| Training      | 1     | .232                | .229                   | .232                | 80.239 | 1,266 | .000 |
| Work Experience | 2     | .315                | .310                   | .083                | 32.256 | 1,265 | .000 |
| Education     | 3     | .347                | .347                   | .032                | 12.870 | 1,264 | .000 |

**Knowledge & Skills**

| Training      | 1     | .255                | .252                   | .255                | 91.111 | 1,266 | .000 |
| Work Experience | 2     | .342                | .337                   | .087                | 34.878 | 1,265 | .000 |
| Education     | 3     | .367                | .360                   | .025                | 10.448 | 1,264 | .001 |

**Attitudes**

| Work Experience | 1     | .104                | .101                   | .104                | 30.915 | 1,266 | .000 |
| Training       | 2     | .144                | .137                   | .039                | 12.197 | 1,265 | .001 |
| Education      | 3     | .167                | .158                   | .024                | 7.562  | 1,264 | .006 |

**Bio-Cognitive Knowledge**

| Training      | 1     | .079                | .075                   | .079                | 22.754 | 1,266 | .000 |
| Education     | 2     | .108                | .101                   | .029                | 8.668  | 1,265 | .004 |
| Work Experience | 3     | .132                | .122                   | .024                | 7.226  | 1,264 | .008 |
Table 13

Forward Multiple Regression Analyses Summary of Coefficients

<table>
<thead>
<tr>
<th>Model</th>
<th>B</th>
<th>β</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td><strong>Full Scale</strong></td>
<td>1.430</td>
<td>10.545</td>
<td>.000</td>
</tr>
<tr>
<td></td>
<td>Training</td>
<td>.730</td>
<td>.481</td>
<td>8.958</td>
</tr>
<tr>
<td>2</td>
<td><strong>Full Scale</strong></td>
<td>1.022</td>
<td>6.957</td>
<td>.000</td>
</tr>
<tr>
<td></td>
<td>Training</td>
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<td>.383</td>
<td>7.141</td>
</tr>
<tr>
<td></td>
<td>Work Experience</td>
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<td>.305</td>
<td>5.679</td>
</tr>
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<tr>
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<td>Training</td>
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<td>.345</td>
<td>6.433</td>
</tr>
<tr>
<td></td>
<td>Work Experience</td>
<td>.524</td>
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<td>Education</td>
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<td>.183</td>
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<tr>
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<td><strong>Knowledge &amp; Skills</strong></td>
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<tr>
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<td>.505</td>
<td>9.545</td>
</tr>
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</tr>
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<td><strong>Knowledge &amp; Skills</strong></td>
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<td>3.128</td>
<td>.002</td>
</tr>
<tr>
<td></td>
<td>Training</td>
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<td>.371</td>
<td>7.029</td>
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<td>Work Experience</td>
<td>.648</td>
<td>.337</td>
<td>6.436</td>
</tr>
<tr>
<td></td>
<td>Education</td>
<td>.322</td>
<td>.162</td>
<td>3.232</td>
</tr>
</tbody>
</table>

(continued)
Table 13

Forward Multiple Regression Analyses Summary of Coefficients

<table>
<thead>
<tr>
<th>Model</th>
<th>Variable</th>
<th>B</th>
<th>SE</th>
<th>T</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td><strong>Attitudes</strong></td>
<td>1.138</td>
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<td>.000</td>
</tr>
<tr>
<td></td>
<td>Work Experience</td>
<td>.408</td>
<td>.032</td>
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<td>.000</td>
</tr>
<tr>
<td>2</td>
<td><strong>Attitudes</strong></td>
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<td>.057</td>
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<tr>
<td></td>
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<td>.000</td>
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<td></td>
<td>Training</td>
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<td>.021</td>
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<tr>
<td>3</td>
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<td>.053</td>
<td>3.754</td>
<td>.000</td>
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<tr>
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<td>Work Experience</td>
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<td>.028</td>
<td>4.676</td>
<td>.000</td>
</tr>
<tr>
<td></td>
<td>Training</td>
<td>.216</td>
<td>.017</td>
<td>2.913</td>
<td>.004</td>
</tr>
<tr>
<td></td>
<td>Education</td>
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<td>.016</td>
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<td>.006</td>
</tr>
<tr>
<td>1</td>
<td><strong>Bio-Cognitive Knowledge</strong></td>
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<td>9.053</td>
<td>.000</td>
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<td>Training</td>
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<td>.044</td>
<td>4.770</td>
<td>.000</td>
</tr>
<tr>
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<td><strong>Bio-Cognitive Knowledge</strong></td>
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<td>.074</td>
<td>5.861</td>
<td>.000</td>
</tr>
<tr>
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<td>Training</td>
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<td>.025</td>
<td>4.309</td>
<td>.000</td>
</tr>
<tr>
<td></td>
<td>Education</td>
<td>.290</td>
<td>.017</td>
<td>2.944</td>
<td>.004</td>
</tr>
<tr>
<td>3</td>
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<td>.087</td>
<td>3.885</td>
<td>.000</td>
</tr>
<tr>
<td></td>
<td>Training</td>
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<td>.019</td>
<td>3.177</td>
<td>.002</td>
</tr>
<tr>
<td></td>
<td>Education</td>
<td>.331</td>
<td>.019</td>
<td>3.357</td>
<td>.001</td>
</tr>
<tr>
<td></td>
<td>Work Experience</td>
<td>.267</td>
<td>.016</td>
<td>2.688</td>
<td>.008</td>
</tr>
</tbody>
</table>
Table 14

Correlation of the Gerontological Counseling Competencies Scale with Balanced Inventory of Desirable Responding

<table>
<thead>
<tr>
<th>Scale</th>
<th>GCCS-FS</th>
<th>GCCS-KS</th>
<th>GCCS-A</th>
<th>GCCS-BK</th>
<th>BIDR-FS</th>
<th>BIDR-SD</th>
<th>BIDR-IM</th>
</tr>
</thead>
<tbody>
<tr>
<td>GCCS-FS</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GCCS-KS</td>
<td>.977**</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GCCS-A</td>
<td>.767**</td>
<td>.641**</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GCCS-BK</td>
<td>.746**</td>
<td>.636**</td>
<td>.595**</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BIDR-FS</td>
<td>-.198**</td>
<td>-.154*</td>
<td>-.251**</td>
<td>-.219**</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BIDR-SD</td>
<td>-.229**</td>
<td>-.199**</td>
<td>-.249**</td>
<td>-.253**</td>
<td>.797**</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>BIDR-IM</td>
<td>-.119</td>
<td>-.084</td>
<td>-.183**</td>
<td>-.132</td>
<td>.881**</td>
<td>.416**</td>
<td>1</td>
</tr>
</tbody>
</table>

Note: GCCS = Gerontological Counseling Competencies Scale; FS = Full Scale; KS = Knowledge & Skills; A = Attitudes; BK = Bio-Cognitive Knowledge. BIDR = Balanced Inventory of Desirable Responding; FS = Full Scale; SD = Self-Deception; IM = Impression Management. ** indicates that correlation is significant at the 0.01 level (2-tailed). * indicates that correlation is significant at the 0.05 level (2-tailed).
Summary of Chapter IV

Chapter IV began with preliminary data screening and descriptive statistics. The data screening indicated that the data had no incorrectly entered or missing items. Furthermore, the assumptions of normality and linearity were met. The descriptive statistics were divided into three sections. The first section reported participant demographic information including participant characteristics, education, and employment. Next, prior experience with older adults (educational, work, and training) was explored. Finally, the psychometric properties of the Gerontological Counseling Competencies Scale and the Balanced Inventory of Desirable Responding were reported.

The remaining part of Chapter IV reported the results of the hypothesis testing. Hypothesis One stated that the Gerontological Counseling Competencies Scale would demonstrate adequate internal consistency reliability. In support of this hypothesis, the GCCS full scale and subscales (Knowledge & Skills, Attitudes, and Bio-Cognitive Knowledge) all demonstrated good to excellent reliability.

Hypothesis Two dealt with the validity of the Gerontological Counseling Competencies Scale. Through the use of an expert panel and focus group, content (face) validity was demonstrated. Furthermore, by means of Principal Components Analyses, the underlying factor structure of the GCCS was revealed. The resulting version of the GCCS had 21-items and three subscales (Knowledge & Skills, Attitudes, and Bio-Cognitive Knowledge). In addition, Standard Multiple Regression analyses were conducted to support construct validity. Results revealed that prior gerontological experience (work experience, educational experience, and training) predicted counselor
perceived competence when working with older adults as measured by the GCCS full scale and subscales.

Finally, with Hypothesis Three in mind, Pearson correlations were computed between the GCCS full scale and subscales and the Balanced Inventory of Desirable Responding (BIDR) full scale and subscales (*Self-Deception* and *Impression Management*). Results supported Hypothesis Three, the GCCS had low correlations with social desirability as measured by the BIDR.

These results and their implications for multicultural training and perceived counselor competency when working with older adults are discussed in Chapter V. Chapter V also provides directions for future research in this area of study.
CHAPTER V
DISCUSSION

Overview

With the projected older adult population increase and the prevalence of older adults whose mental health needs are not being met, it is necessary that all counselors possess the basic knowledge and skills to work with older adults (Schwiebert & Myers, 2001). A major challenge to the counseling profession today is that although competencies for gerontological counseling have been established by both the American Counseling Association (ACA) and the American Psychological Association (APA), “there remains a vast disparity between counselors trained to work with older persons and the need for counselors to work with older persons” (Schwiebert & Myers, 2001, p.320). In order to meet the increasing demand for counselors with the knowledge and skills necessary to work with older adults, an instrument needs to be developed to assess the current competence level of counselors and counselor educators in the field as well as counselor trainees. The primary purpose of the present study was to develop a reliable and valid self-report measure of counselor perceived competence in working with older adults. The Gerontological Counseling Competencies Scale (GCCS; O’Connor Thomas, 2012) was developed using the rational-theoretical approach to scale construction. As described in Chapter IV, the review of literature generated 47 competency statements that represented counselor perceived competence when working with older adults. These
statements were modified and additional statements were added based on the feedback from an expert panel and focus group. This feedback resulted in a 50-item initial scale that was completed by 268 counselors, counselor educators, and counselor trainees. The data obtained from these participants resulted in a final 21-item Gerontological Counseling Competencies Scale comprised of three factors: Knowledge & Skills, Attitudes, and Bio-Cognitive Knowledge. Further analyses supported the reliability and construct validity of the GCCS. The remainder of Chapter V discusses the results and implications of the study. It is organized into five sections: (1) discussion of the statistical results and comparison of the results to prior research, (2) implications for clinical practice and counselor education and supervision, (3) limitations of the study and recommendations for future research, and (4) summary of the discussion and implications of the study.

Discussion of Statistical Results and Comparison of the Results to Prior Research

This section discusses the statistical results for the present study as well as the comparison of these results to prior research. There are three subsections: information pertaining to development of the Gerontological Counseling Competencies Scale (GCCS) including initial content validity and underlying factor structure (Hypothesis Two: Part One and Part Two-a), information concerning reliability of the GCCS (Hypothesis One), information regarding construct validity of the GCCS (Hypothesis Two: Part Two-b) and information concerning social desirability and the GCCS (Hypothesis Three). (Note: it is difficult to compare some of the findings from the present study with previous research.
Scale Development. This section provides an overview of the development of the Gerontological Counseling Competencies Scale (GCCS). Specifically, initial content validity and underlying factor structure will be discussed.

Initial Content Validity. Hypothesis Two (Part One) stated that the GCCS will demonstrate adequate content (face) validity. As described in Chapter IV, support for this hypothesis began with the initial construction of the scale which was based upon the rational-theoretical approach (Burisch, 1984) and continued through the expert panel and focus group phases (Anastasi, 1986; 1992). Based on the rational theoretical approach to scale construction (Burisch, 1984; Syzmanski & Chung, 2001), construct definitions were derived from prior theory and research on multicultural counseling competency and, more importantly, gerontological counseling competency. This prior research suggested that gerontological counseling competence reflects three domains: knowledge, skills, and attitudes.

The two principal publications used to develop the initial 47 competency statements for the scale were *Gerontological Competencies for Counselors and Human Development Professionals* (Myers & Sweeney, 1990) and *Guidelines for Psychological Practice with Older Adults* (American Psychological Association, 2004). These 47 statements were reviewed by four experts in the field. The expert panel was asked to examine the statements for clarity and to rate the statement based on the extent to which each statement represented the three dimensions found in prior research (knowledge,
skills, and attitudes). The expert panel was also invited to provide any comments or suggestions that they may have about the statements. The feedback from the expert panel resulted in the addition of one item and the shortening of many other items to increase clarity.

The resulting 48 items were administered to a focus group comprised of 11 doctoral level counselor trainees and one counselor educator. The focus group was asked to complete this 48-item Gerontological Counseling Competencies Scale and then to respond to a series of questions about their experience. The questions were used to illicit feedback about clarity of the directions, the Likert scale, and the statements. The focus group was also asked if they felt the statements covered the topic of counselor competence and if the statements made them reflect on their own training. Finally, the focus group was asked to provide any additional comments or suggestions about the scale. Based on the feedback from the focus group, two items were added and the Likert scale was changed for ease of interpretation. This stage of instrument development resulted in 50 items.

The 50-item Gerontological Counseling Competency Scale was electronically disseminated to counselors, counselor educators, and counselor trainees across the United States via Listervs. A total of 268 participants responded to this solicitation for participation and the resulting data was analyzed through a series of Principal Component Analyses to formulate the final 21-item GCCS.

**Underlying Factor Structure.** Hypothesis Two (Part Two: a) stated that the GCCS will demonstrate adequate construct validity. Specifically, there will be three
underlying factors to the GCCS: knowledge, skills, and attitudes. The results of the present study partially supported this hypothesis. Using a series of Principal Components Analyses, a 21-item three factor solution emerged.

As described in Chapter II, multicultural competencies were originally conceptualized by Sue et al. (1982; 1992; 1998) as having three dimensions or factors (knowledge, skills, and attitudes/beliefs). This tripartite model of multicultural competence was the foundation for the development of several of the most commonly used multicultural counseling competency scales: (a) Multicultural Awareness/Knowledge/Skills Survey (MAKSS; D’Andrea, Daniels & Heck, 1991; (b) Multicultural Counseling Inventory (MCI; Sodowsky, Taffe, Gutkin & Wise, 1994); (c) Multicultural Counseling Knowledge and Awareness Scale (MCKAS; Ponterotto, Gretchen, Utsey, Rieger & Austin, 2002); and (d) Cross-Cultural Counseling Inventory-Revised (CCCI-R; La Fromboise, Coleman & Hernandez, 1991).

Although these multicultural competency scales have the common goal of assessing perceived competence, they differ in number of factors thought to comprise this construct and, complicating matters more, these factors are labeled differently (Constantine & Ladany, 2000; 2001, Pope-Davis & Dings, 1994; Schomburg, 2007; Worthington, et al., 2000). For example, when examining the MCI, Sodowsky et al. (1994) found evidence in support of four factors. Three factors (skill, awareness, and knowledge) were comparable in substance to the three broad competency factors defined by Sue et al. (1982-- skills, beliefs/attitudes, and knowledge) but one additional factor entitled relationship also emerged. D’Andrea, Daniels and Heck (1991), on the other
hand, concluded that the MAKSS offers a three-factor model labeled knowledge, awareness, and skills. Further, the MCKAS presented a two-factor model (knowledge and awareness) and the CCCI-R is made up of three subscales: awareness, skill, and sensitivity (Ponterotto, Gretchen, Utsey, Rieger & Austin, 2002; La Fromboise, Coleman & Hernandez, 1991, respectively). Constantine and Ladany (2001) proposed an even broader conceptualization of multicultural counseling competence to include six dimensions: (1) counselor self-awareness, (2) general knowledge about multicultural issues, (3) understanding of unique client variables, (4) multicultural counseling self-efficacy, (5) multicultural counseling skills, and (6) an effective counseling working alliance.

Despite these mixed findings, many current self-report measures of multicultural counselor competence have successfully utilized the tripartite definition (knowledge, attitudes/beliefs, and skills) as their primary theoretical foundation (D’Andrea et al., 1991; La Fromboise et al., 1991). When reviewing multicultural counseling competence measures, Ponterotto, Rieger, Barrett and Sparks (1994) found that most measures adhere to the Sue et al. (1982; 1992; 1998) competencies (beliefs/attitudes, knowledge, and skills) to some degree as a conceptual basis for item development. As a consequence of these findings and because Myers and her colleagues originally conceptualized the competencies as having three factors (knowledge, skills, and attitudes), the present research examined gerontological counselor competence using the tripartite framework. It was expected that the Gerontological Counseling Competencies Scale (GCCS) would have three underlying factors: knowledge, skills, and attitudes.
As mentioned previously, the results of the Principal Components Analyses revealed a three factor solution. The first factor was composed of 13 items that were originally conceptualized as both knowledge and skills items. These items together formed one factor that was labeled *Knowledge & Skills*. The *Knowledge & Skills* subscale reflected a counselor’s knowledge about aging and the application of that knowledge to their practice (skills). The second factor was made up of five items that were conceptualized as attitudes during scale development. This subscale was, of course, labeled *Attitudes*. The items on the *Attitudes* subscale focused on counselors’ sociocultural attitudes about aging. Finally, a third factor emerged that reflected a counselor’s knowledge about the biological and cognitive aspects of aging. This subscale, labeled *Bio-Cognitive Knowledge*, consisted of three items that were originally conceptualized as just knowledge but proved to be a separate (unique) knowledge base.

Thus, the results of the present study are consistent with findings in the multicultural domain in regards to the number of factors (three) but inconsistent in that knowledge and skills merged together to form one single factor. Another inconsistent finding was that knowledge about the biological and cognitive aspects of aging emerged as a distinct knowledge base (factor) highlighting the uniqueness of the field of aging from other diversity areas. Therefore, it supports the need for specialized training and coursework dealing with cognitive-biological aspects of aging and how to assess for normal and abnormal changes in cognition over time.

**Reliability.** This section provides an overview of the statistical results in relation to reliability of the Gerontological Counseling Competencies Scale (GCCS). Hypothesis
One stated that the GCCS will demonstrate adequate internal consistency reliability. The results of the study supported this hypothesis. The GCCS full scale and subscales (Knowledge & Skills, Attitudes, and Bio-Cognitive Knowledge) were found to have good to excellent reliability (0.96, 0.96, 0.85, and 0.87, respectively). The results of Hypothesis One are difficult to compare with prior research considering no other measures to date have been developed that assess self-perceived counseling competencies with older adults.

**Construct Validity.** This section provides an overview of the statistical results in relation to construct validity of the Gerontological Counseling Competencies Scale (GCCS). Hypothesis Two (Part Two: b) stated that the GCCS will demonstrate adequate construct validity. Specifically, prior work experience (clinical experience) with older adults (including practicum and internship), education (coursework) in gerontological issues, and training in working with older adults (e.g., workshops, seminars) will significantly predict counselor perceived competence when working with older adults as measured by the GCCS and its subscales (Knowledge & Skills, Attitudes, and Bio-Cognitive Knowledge). This hypothesis was tested by performing a series of standard multiple regression analyses for the full GCCS and its subscales. Results of these analyses indicated that prior experience with older adults, specifically coursework, work experience, and training, predict counselor self-reported gerontological competence. The three predictors together accounted for 34.7% variance of the GCCS full scale, 36.7% variance of the Knowledge & Skills subscale, 16.7% variance of the Attitudes subscale, and 13.2% variance of the Bio-Cognitive Knowledge subscale.
These results are consistent with prior research that examined predictors of multicultural counseling competence (e.g., Arthur & Januszkowski, 2001; Bellini, 2002; Dickson & Jepsen, 2007; Sodowsky et al., 1998). For example, Arthur and Januszkowski (2001) examined if age, gender, multicultural seminars, number of courses, minority client caseload, ethnicity, year of graduation and number of years practicing predicted multicultural counseling competence. Results showed that minority client caseload and completion of multicultural seminars were the strongest predictors of multicultural counseling competence as measured by the full scale Multicultural Counseling Inventory (MCI; Sodowsky et al., 1994). Sodowsky et al. (1998) also assessed multicultural counseling competence using the MCI full scale and found that social desirability, counselor race, feelings of social inadequacy and locus of control race ideology, and training (client load, number of research projects, and number of workshops) together predicted 34% of the variance in multicultural counseling competency. Furthermore, Dickson and Jepsen (2007) found that social desirability, program cultural ambiance, multicultural instruction (classes), and multicultural clinical experience, together accounted for significant variance in the Knowledge (15%), Skills (13%), Awareness (28%), and Relationship (26%) subscales of the MCI. Finally, when examining the multicultural competence of vocational rehabilitation counselors, Bellini (2002) found that demographic variables, multicultural experience (race and caseload), and multicultural training (multicultural classes, multicultural workshops and multicultural research projects) predicted 33% of the variance of the full scale Multicultural Counseling Inventory (MCI).
Follow-up analyses examined the unique contribution to counselor competence when working with older adults of each of the predictors. Forward multiple regression analyses were performed for the full Gerontological Counseling Competencies Scale and the three subscales (Knowledge & Skills, Attitudes, and Bio-Cognitive Knowledge) again using prior educational experience, work experience, and training as predictors. Results of these analyses indicated that prior training (e.g., workshop and seminars with topics related to older adults) accounted for most of the variance explained in the full scale (23.2%) as well as the Knowledge & Skills and Bio-Cognitive Knowledge subscales (25.5% and 7.9%, respectively). For the Attitudes subscale, prior work experience with older adults accounted for most of the variance explained by the model (10.4%). These results are also consistent with prior research in multicultural counseling competency (Bellini, 2002; Dickson & Jepsen, 2007; Sodowsky et al., 1998).

For example, Bellini (2002) found that multicultural training which included coursework, workshops, and research projects accounted for 9% of the variance in the full scale Multicultural Counseling Inventory (MCI; Sodowsky et al., 1994). In addition, Sodowsky et al. (1998) discovered that training variables (client load, number of research projects, number of courses, and number of workshops) contributed to 10% of the variance in multicultural counseling competency as measured by the MCI full scale. Finally, Dickson and Jepsen (2007) found that multicultural clinical experience accounted for significant unique variance in the Awareness (3%) and the Relationship (10%) subscales of the Multicultural Counseling Inventory.
The findings of the present study, as well prior studies on multicultural counseling competence (as discussed above), support the need for not only coursework but also clinical experience and other training opportunities such as workshops and seminars. According to Arthur and Januszkowski (2001), “Course work in counsellor education programs can provide important background information in the knowledge domain and encourage students to engage in a process of self-reflection. However, the results of this study suggest that theory alone may not be the best way to prepare counsellors for working with culturally diverse clients. Counsellor education programs need to expose students to members of culturally diverse groups and provide opportunities for skill development through practicum placements and cross-cultural supervision” (p.45).

**Social Desirability.** This section provides an overview of the statistical results in relation to the influence of social desirability on the Gerontological Counseling Competencies Scale (GCCS). Hypothesis Three stated that the GCCS will have a low correlation with social desirability as measured by the Balanced Inventory of Desirable Responding (BIDR; Paulhus, 1988; 1991). The results of the present study supported this hypothesis, providing evidence that the GCCS was not influenced by social desirable responding. These findings both contradicted and supported previous studies that examined multicultural counseling competency scales and their relation to social desirability.

This is true because prior studies on self-report measures of multicultural counseling competency have reported mixed findings on the influence of social desirability. First, some assessments have been found by researchers to be influenced by
social desirable responding (Constantine & Ladany, 2000; Sodowsky, Kuo-Jackson, Richardson & Corey, 1998; Worthington, Mobley, Franks & Tan, 2000). For example, Worthington et al. (2000) found a significant and positive correlation between the full scale and Relationship subscale of the MCI and social desirability as measured by the Marlow-Crowne Social Desirability Scale (SDS; Crown & Marlow, 1960). They also found a significant negative relationship between social desirability and the Cross-Cultural Counseling Inventory-Revised (LaFromboise, Coleman, & Hernandez, 1991). Further, Sodowsky et al. (1998) found a significant positive relationship between the MCI full-scale and social desirability as measured by the Multicultural Social Desirability scale. Finally, Constantine and Ladany (2001) reported that several self-report instruments assessing multicultural counseling competency (specifically the CCCI-R full scale, MAKSS Knowledge and Skills subscales, and the MCI Relationship subscale) were significantly and positively related to the Marlowe-Crowne Social Desirability Scale.

The results of the present study, on the other hand, did not find social desirability to be influential. The correlations between the GCCS and the Balanced Inventory of Desirable Responding (BIDR) full scales and subscales were all low, ranging from -.084 to -.253. Perhaps, one reason for this is that when dealing with other multicultural topics such as race, people are more sensitive to political correctness which may influence their responding. Nevertheless, these results do parallel the nonsignificant findings of other researchers who have examined multicultural counseling competency self-reports and social desirability (e.g., Bromley, 2004; Constantine, 2000; Schomburg, 2007). For
example, both Bromley (2004) and Schomburg (2007) examined multicultural counseling competence using the Multicultural Counseling Knowledge and Awareness Scale (MCKAS). The results showed that social desirability as measured by the Balanced Inventory of Desirable Responding (BIDR) was not significantly related to multicultural counseling competency. In addition, Constantine (2000) found nonsignificant relationships between multicultural counseling competency (as measured by the MCKAS) and the Marlowe-Crowne Social Desirability Scale.

**Implications for Clinical Practice and Counselor Education and Supervision**

The results of the present study have many implications for clinical practice and counselor education and supervision. As discussed in Chapter I, the older adult population is growing at a tremendous rate with the “graying” of the baby boom generation. Due to this population increase and because these baby boomers are more familiar with and open to counseling, counselors need to be trained to work with older adults. Despite the importance of having well-trained, competent counselors for working with older adults, this unique population still remains overlooked in the training of counselors at the master’s and doctoral level. Therefore, as Myers argued, for “counselors to be prepared to meet the demands of our graying population, it is imperative that all counselors graduate with some knowledge of the needs of older persons and the skills to provide effective helping interventions to meet those needs. It is incumbent upon counselor educators to provide the needed training and to do so in a manner which will provide an assurance to the public that newly trained counselors have
at least a minimum level of competence” (http://www.uncg.edu/ced/jemyers). Stickle and Onedera (2006) go so far as to state that “the need for counselor training in gerontology is daunting” (p.249).

There has, however, been models developed that can help current counselor education programs incorporate gerontology into their curricula (Myers, 1989; 1994; Myers & Blake, 1986; Zucchero, 1998). A variety of studies promote the infusion of gerontology into the existing curriculum of training programs (Myers & Sweeney, 1990; Stickle & Onedera, 2006; Zucchero, 1998). In fact, Myers and Sweeney (1990) developed the *Gerontological Competencies for Counselor and Human Development Professionals* (one of the main sources used in the present study to create the Gerontological Counseling Competencies Scale) with the intention of being infused into existing training programs. One model that does this is the Integration/Infusion Model. As described by Myers (1989; 1994), this model involves infusing concepts related to the counseling needs of older adults into each of the Council for Accreditation of Counseling and Related Educational Programs (CACREP) core areas. This model ensures that information relevant to counseling older adults is included in all core counseling preparation courses (Myers, 1994) and that all students are provided with the knowledge and skill base necessary to work with older adults (Myers & Blake, 1986). This model also has the advantage of being flexible in meeting the diverse needs of all students (Myers & Blake, 1986).

As indicated by the results of the present study, it is necessary that counselors acquire specialized knowledge about older adults in order to be competent to work with
this population. Furthermore, particular attention should be paid to knowledge about the biological and cognitive aspects of aging. As discussed above, the previous work of Myers and other researchers has offered useful recommendations for infusing this knowledge into the existing curricula (e.g., the Integration/Infusion Model). However, the results of the present study suggest that not only is coursework important but also additional training experiences (e.g., workshops, seminars) and clinical experiences with older adult clients (e.g., work experience, supervised practica and/or internships). The next model that will be discussed incorporates all of these important training experiences.

The Unique Training Model, developed by Zucchero (1998), integrates a variety of the training models found in the literature (e.g., Integration/Infusion Model, Separate-Course Model, Area-of-Concentration Model, and Interdisciplinary Model). The Unique Training Model not only infuses gerontological issues into the general curriculum but also provides opportunities for students to specialize in gerontological counseling. The curriculum would include knowledge acquisition, practice of skills, and experiences working with older adults. Students would also be encouraged to obtain additional experience through volunteer work. Students would have the opportunity to take gerontology courses across multiple disciplines (e.g., counselor education, sociology, psychology, anthropology, biology) to see relevant issues from various perspectives. Furthermore, the practice of skills would be provided within the supervised practicum and internship components since all students would be required to work with an older adult. Students who choose to specialize in gerontological counseling would also be required to participate in a specialized practicum. According to Zucchero (1998), “this
model provides exposure to the psychology of aging for all students, including those who are not initially interested in working with older adults but who may eventually work with them. The opportunity to learn about gerontological issues in an environment that reduces the level of anxiety, and increases the level of motivation, may increase the trainees’ interest in and knowledge of this area. It may also decrease their resistance to working with the older adult population” (p.274).

Regardless of the particular training model followed, many researchers agree that course work in counselor education programs which includes gerontological content can provide important background information in the knowledge domain and can also stimulate an interest in the area of gerontology (Myers, 1989; 1994; Myers & Blake, 1986; Myers & Sweeney, 1990; Stickle & Onedera, 2006; Zucchero, 1998). However, the results of the present study, as well as others (e.g., Arthur & Januszkowski, 2001; Dickson & Jepsen, 2007; Zucchero, 1998) suggest that theory alone may not be the best way to prepare counselors for working with diverse groups such as older adults. Counselor education programs need to provide other opportunities for knowledge and skill development such as additional training in the form of workshops and seminars. Furthermore, this study also indicates the need for and importance of clinical experience with older adults (e.g., supervised practica and/or internship experiences) in shaping counselor and counselor trainees’ attitudes toward older adults.
Limitations of the Study and Recommendations for Future Research

This section will identify the key limitations of this research study. It will also include recommendations for future research in the area of counselor competence when working with older adults.

First, the present study used an online survey method of data collection. Counselors, counselor educators, and counselor trainees were contacted via counseling related listservs and invited to participate in the study. The internet survey method using listservs for dissemination was chosen because it was considered to be a practical and effective way of targeting and inviting counselors, counselor educators, and counselor trainees across the United States to participate in the study. It is important to note, however, this method is not infallible. Using this method, it is impossible to determine whether an accurate representation of counselors in the United States was achieved because this method limited participation to members of the listservs.

A second limitation of the present study was that the sample was a sample of convenience. This can be a limitation for a variety of reasons (e.g., generalizability). For instance, the counselors, counselor educators, and counselor trainees who chose to participate in the study may not accurately reflect all counselors, counselor educators, and counselor trainees in regards to prior experience with older adults. Participants may have chosen to participate in the study because they already possessed and interest in gerontology and already had educational, training, and clinical experience with this population. This was evident in that 69% of the participants had taken coursework that addressed the needs of older adults, 65% of the participants reported having prior clinical
experience with older adults and 41% of the participants reported having prior training experiences with older adults (e.g., workshops, seminars).

A third limitation of the present study is related to the demographic characteristics of the participants. Although the sample did have a good representation in terms of age of the participants, other demographic variables did not provide much variation. For example, the sample was predominantly female (78%) and white (80%). This limitation is important to note because prior studies that examined multicultural counseling competence indicated that demographic characteristics can influence multicultural competence (e.g., Bellini, 2002; Constantine, 2001).

Despite the above mentioned limitations, the present study is important because the Gerontological Counseling Competencies Scale (GCCS; O’Connor Thomas, 2012) was the first scale developed that assesses gerontological counseling competence. The intent of this initial study was to stress the importance of examining the older adult population as a diverse group that should be included in the training of counselors. It was also intended to encourage future research on counseling competencies when working with older adults.

One area in which future research can expand the present study is to examine other predictors of counselor competence. One such predictor is the amount of experience. This includes the amount of educational experience and clinical experience. The present study did not directly examine this area. However, prior research in the area of multicultural counseling competency has found that the number of previous multicultural counseling courses taken significantly contributed to self-reported
multicultural counseling competency (e.g., Constantine, 2001; Sodowsky et al., 1998). Further, research has indicated that the number of training cases or the amount of clinical experience with individuals from a particular diverse group was a significant predictor of self-rated competence. A second predictor that future research can examine is supervision. Many prior studies that explored counselor multicultural competence have found that supervision focusing on multicultural issues as well as how much time spent receiving this supervision significantly predicted self-perceived multicultural counseling competence (Arthur & Januszkowski, 2001; Constantine, 2001; Lee & Khawaja, 2012). Third, another focus of future research in this area involves demographic characteristics of the counselor, counselor educator, or counselor trainee (e.g., ethnicity/race, gender). Prior research on multicultural competence has found that ethnicity/race and gender have contributed significantly to self-reported multicultural competence (e.g., Bellini, 2002; Constantine, 2001).

Another recommendation for future research has to do with assessment of gerontological counseling competence. Not only should future studies continue the validation process of the Gerontological Counseling Competencies Scale (GCCS; Karli O’Connor Thomas, 2012) but also expand on the present study by developing and using alternative measurement techniques such as observer rating scales. Many researchers in the area of multicultural counseling competencies measurement have supported the use of alternative methods of assessment (e.g., case conceptualization; supervisor rating scales) rather than relying solely on self-reports (e.g., Constantine, 2001; Constantine & Ladany, 2000, 2001; Ladany et al., 1997).
Summary of the Discussion and Implications of the Study

The purpose of the present study was to develop a reliable and valid measure of counselor competence when working with older adults. Items for the Gerontological Counseling Competencies Scale (GCCS; O’Connor Thomas, 2012) were generated using the rational/theoretical approach to scale construction. Feedback from an expert panel and focus group were used to formulate the initial 50-item GCCS and provide support for its validity (content/face validity). The initial scale was disseminated online via listservs and 268 counselors, counselor educators, and counselor trainees across the United States agreed to participate in the study. The data obtained from these participants was analyzed through a series of Principal Component Analyses and resulted in a final 21-item Gerontological Counseling Competencies Scale (GCCS) comprised of three subscales: Knowledge & Skills, Attitudes, and Bio-Cognitive Knowledge. Further analyses provided support for the reliability and construct validity of the GCCS full scale and subscales. In addition, correlations of the GCCS full scale and subscales with social desirability as measured by the Balanced Inventory of Desirable Responding full scale and Self-Deceptive Enhancement and Impression Management subscales were all low. Therefore, social desirability was not influential to the results of the present study.

Overall, the findings of the present study show that counselor education programs should not only include coursework in gerontology but also clinical experience with older adults and additional training opportunities such as seminars and/or workshops. The
The present study has opened up many opportunities for future research in the area of counselor competence when working with older adults.

The present study also provides evidence that Counselor Education programs need to demonstrate that they are graduating students competent in specific areas. This is the first reliable and valid measure to assess the competency of student trainees and current practitioners when working with older adults. It is hoped that this measure will be an impetus to other researchers to develop and refine other types of scales (e.g., observer ratings) that assess gerontological counseling competencies. Counselors, counselor educators, and counselor trainees need to be accountable for the expertise necessary to work with older adults. Ultimately this protects the welfare of their clients.
REFERENCES


http://www.uncg.edu/ced/jemyers. Website of Dr. Jane Myers, Department of Counseling & Educational Development, the University of North Carolina at Greensboro.


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APPENDICES
Attitudes

Guideline 1. Psychologists are encouraged to work with older adults within their scope of competence, and to seek consultation or make appropriate referrals when indicated.

Guideline 2. Psychologists are encouraged to recognize how their attitudes and beliefs about aging and about older individuals may be relevant to their assessment and treatment of older adults, and to seek consultation or further education about these issues when indicated.

General Knowledge about Adult Development, Aging, and Older Adults

Guideline 3. Psychologists strive to gain knowledge about theory and research in aging.

Guideline 4. Psychologists strive to be aware of the social/psychological dynamics of the aging process.

Guideline 5. Psychologists strive to understand diversity in the aging process, particularly how sociocultural factors such as gender, ethnicity, socioeconomic status, sexual orientation, disability status, and urban/rural residence may influence the experience and expression of health and of psychological problems in later life.

Guideline 6. Psychologists strive to be familiar with current information about biological and health-related aspects of aging.
Clinical Issues

Guideline 7. Psychologists strive to be familiar with current knowledge about cognitive changes in older adults.

Guideline 8. Psychologists strive to understand problems in daily living among older adults.

Guideline 9. Psychologists strive to be knowledgeable about psychopathology within the aging population and cognizant of the prevalence and nature of that psychopathology when providing services to older adults.

Assessment

Guideline 10. Psychologists strive to be familiar with the theory, research, and practice of various methods of assessment with older adults, and knowledgeable of assessment instruments that are psychometrically suitable for use with them.

Guideline 11. Psychologists strive to understand the problems of using assessment instruments created for younger individuals when assessing older adults, and to develop skill in tailoring assessments to accommodate older adults’ specific characteristics and contexts.

Guideline 12. Psychologists strive to develop skill at recognizing cognitive changes in older adults, and in conducting and interpreting cognitive screening and functional ability evaluations.

Intervention, Consultation, and Other Service Provision

Guideline 13. Psychologists strive to be familiar with the theory, research, and practice of various methods of intervention with older adults, particularly with current research evidence about their efficacy with this age group.

Guideline 14. Psychologists strive to be familiar with and develop skill in applying specific psychotherapeutic interventions and environmental modifications with older adults and their families, including adapting interventions for use with this age group.
Guideline 15. Psychologists strive to understand the issues pertaining to the provision of services in the specific settings in which older adults are typically located or encountered.

Guideline 16. Psychologists strive to recognize issues related to the provision of prevention and health promotion services with older adults.

Guideline 17. Psychologists strive to understand issues pertaining to the provision of consultation services in assisting older adults.

Guideline 18. In working with older adults, psychologists are encouraged to understand the importance of interfacing with other disciplines, and to make referrals to other disciplines and/or to work with them in collaborative teams and across a range of sites, as appropriate.

Guideline 19. Psychologists strive to understand the special ethical and/or legal issues entailed in providing services to older adults.

Education

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

American Psychological Association (2004)
APPENDIX B

INFORMED CONSENT DOCUMENT

You are invited to participate in a dissertation research project being conducted by Karli O’Connor Thomas, a doctoral candidate in the Department of Counseling at the University of Akron in Akron, Ohio. This study will examine counselors’, counselor educators’ and counselor trainees’ perceived competence when working with older adults. If you agree to participate in the study, you will be asked a series of general demographic and training questions and then you will be asked to complete two questionnaires related to perceived competence when working with older adults. The surveys should take approximately 10-20 minutes to complete. You will not receive direct benefits or compensation for your participation in the study, however, your participation may add to the body of knowledge and understanding regarding gerontological counselor competencies.

Your participation in this study is voluntary, and you are free to refuse to participate or to withdraw your participation at any time, without negative consequences. No known risks or discomforts to research participants are expected. All information will remain anonymous with no identifying data collected. Your anonymity will be further protected by not asking you to sign and return an informed consent document. Confidentiality will be maintained through use of a number code system that will be
assigned to the online responses. Data collected for purposes of this study will be entered into a password protected computer and answers to the questionnaires will be stored on a secure website. If desired, you will be able to print a copy of this informed consent document for future reference.

If you have any questions about this study, please contact Karli O’Connor Thomas via e-mail karli@uakron.edu or phone (330)706-9336. You can also contact Dr. Sandra Perosa, Ph.D., Dissertation Chair, from the University of Akron, in Akron, Ohio, at sperosa@uakron.edu, or by calling her at (330)972-8158.

Clicking “I Agree” on the online cover page and beginning the study will serve as your acceptance of the information provided in this Informed Consent Document and your consent to participate in this study.
APPENDIX C

DEMOGRAPHIC AND TRAINING QUESTIONNAIRE

Directions: Read each question carefully. After each question, select the answer that best describes you.

1. What is your gender?
   a) Male
   b) Female

2. What is your age?
   a) 20-29
   b) 30-39
   c) 40-49
   d) 50-59
   e) 60-69
   f) 70-79
   g) 80 or above

3. What is your race?
   a) White/Caucasian
   b) Black/African-American
   c) Hispanic/Latino
   d) Asian
   e) Pacific Islander
   f) Native American/American Indian
   g) Other (please describe) _______________________________

4. What is the highest level of education you have completed?
   a) Bachelor’s Degree
   b) Master’s Degree
   c) Doctoral Degree

5. Are you currently enrolled in school?
   a) Yes
   b) No
6. If you answered Yes to the previous question (question 5), please respond to the following:

What degree are you seeking?
   a) Master’s Degree
   b) Doctoral Degree

Which year are you in your program?
   a) Master’s level before practicum
   b) Master’s level during practicum
   c) Master’s level after practicum
   d) Doctoral level

7. Are you currently enrolled in a Practicum or Internship?
   a) Yes
   b) No

8. Are you currently a counselor or counselor educator working in the field?
   a) Yes
   b) No

9. If you answered Yes to the previous question (question 8), please respond to the following:

How many years have you been working in the field?
   a) Less than one
   b) 1-5
   c) 6-10
   d) 11-15
   e) More than 15

What is your current position? (Note: you may choose more than one, if appropriate)
   a) Counselor
   b) Educator
   c) Other (please describe) _______________________________

Where is your current place of employment? (Note: you may choose more than one, if appropriate)
   a) Private Practice
   b) Mental Health Clinic/Agency
   c) University
   d) Other (please describe) _______________________________
Are you currently being supervised?
   a) Yes
   b) No

What is the age of your current clientele/students? (Note: you may choose more than one, if appropriate)
   a) Children/Adolescents
   b) Young adults
   c) Middle-aged adults
   d) Older adults

10. Have you ever had the opportunity to work with an older adult client (aged 65 or older)?
    a) Yes
    b) No

11. If you answered Yes to the previous question (question 10), please respond to the following:

   How many older adult clients have you worked with?
   a) 1-5
   b) 6-10
   c) 11 or more

   Was this a supervised or unsupervised experience? (Note: you may choose both, if appropriate)
   a) supervised
   b) unsupervised

   Did you run into any problems/concerns with this client that you did not feel competent to address?
   a) Yes
   b) No

   If Yes, please describe the steps you took to remedy these problems (Note: you may choose more than one, if appropriate)
   a) Advice from supervisor
   b) Advice from peer
   c) Referral
   d) Education
   e) Other (please describe) _____________________
If yes, did you feel these concerns stemmed from lack of training with this age group?
   a) Yes
   b) No

12. Have you ever taken any coursework (classes) that addressed the needs of older adults as part of its content?
   a) Yes
   b) No

13. If you answered Yes to the previous question (question 12), please respond to the following:

   Do you feel that the class adequately addressed the needs of older adults?
   a) Yes
   b) No

   Was the class required as part of your program?
   a) Yes
   b) No

14. Have you ever taken any class that solely addressed the needs of older adults?
   a) Yes
   b) No

15. If you answered Yes to the previous question (question 14), please respond to the following:

   Is the class required as part of your program of study?
   a) Yes
   b) No

16. Are you aware of any classes that address the older adult population?
   a) Yes
   b) No

17. Are you planning on taking any class that addresses the needs of older adults?
   a) Yes
   b) No
18. Have you had any other training working with older adults? (e.g., workshops, conference presentations, seminars etc…)
   a) Yes
   b) No

19. If you answered Yes to the previous question (question 18), please respond to the following:

   Describe this training (Note: You may choose more than one, if appropriate)
   a) Workshop
   b) Conference presentation
   c) Seminar
   d) Other (please describe) _______________________________

   Did you seek out the training on your own or were you encouraged to take part through your department/advisor/mentor/professor?
   a) On my own
   b) With the encouragement from another

   Do you feel this training adequately addressed issues related to older adults?
   a) Yes
   b) No

20. Do you feel you could benefit from a class designed specifically to address issues related to older adults?
   a) Yes
   b) No

21. Do you feel you could benefit from a class in which the topic of older adults is infused into the lessons?
   a) Yes
   b) No

22. Do you think you will ever work with older adult clients in your career?
   a) Yes
   b) No

23. If an older adult client would come to you for services, would you feel competent to work with this client?
   a) Yes
   b) No
APPENDIX D

BALANCED INVENTORY OF DESIRABLE RESPONDING (BIDR)

Using the scale below as a guide, write a number beside each statement to indicate how much you agree with it.

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not True</td>
<td>Somewhat</td>
<td>Very True</td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

1. My first impressions of people usually turn out to be right.
2. It would be hard for me to break any of my bad habits.
3. I don’t care to know what other people really think of me.
4. I have not always been honest with myself
5. I always know why I like things.
6. When my emotions are aroused, it biases my thinking.
7. Once I’ve made up my mind, other people can seldom change my opinion.
8. I am not a safe driver when I exceed the speed limit.
9. I am fully in control of my own fate.
10. It’s hard for me to shut off a disturbing thought.
11. I never regret my decisions.
12. I sometimes lose out on things because I can’t make up my mind soon enough.
13. The reason I vote is because my vote can make a difference.

14. My parents were not always fair when they punished me.

15. I am a completely rational person.

16. I rarely appreciate criticism.

17. I am very confident of my judgments.

18. I have sometimes doubted my ability as a lover.

19. It’s all right with me if some people happen to dislike me.

20. I don’t always know the reasons why I do the things I do.

21. I sometimes tell lies if I have to.

22. I never cover up my mistakes.

23. There have been occasions when I have taken advantage of someone.

24. I never swear.

25. I sometimes try to get even rather than forgive and forget.

26. I always obey laws, even if I’m unlikely to get caught.

27. I have said something bad about a friend behind his or her back.

28. When I hear people talking privately, I avoid listening.

29. I have received too much change from a salesperson without telling him or her.

30. I always declare everything at customs.

31. When I was young I sometimes stole things.

32. I have never dropped litter on the street.

33. I sometimes drive faster than the speed limit.
34. I never read sexy books or magazines.
35. I have done things that I don’t tell other people about.
36. I never take things that don’t belong to me.
37. I have taken sick-leave from work or school even though I wasn’t really sick.
38. I have never damaged a library book or store merchandise without reporting it.
39. I have some pretty awful habits.
40. I don’t gossip about other people’s business.
APPENDIX E

IRB APPROVAL

NOTICE OF APPROVAL

September 20, 2011

Kurti Michelle O'Connor Thomas
3200 Glenrock Drive
Norton, Ohio 44203

From: Sharon McWhorter, IRB Administrator

Re: IRB Number 2011.0909 “Development of the Gerontological Counselling Competencies Scale: A Self-Report Measure of Counselor Competence with Older Adults”

Thank you for submitting your IRB Application for Review of Research Involving Human Subjects for the referenced project. Your application was approved on September 20, 2011. Your protocol represents minimal risk to subjects and matches the following federal category for exemption:

☐ Exemption 1 – Research conducted in established or commonly accepted educational settings, involving normal educational practices.

☐ Exemption 2 – Research involving the use of educational tests, survey procedures, interview procedures, or observation of public behavior.

☐ Exemption 3 – Research involving the use of educational tests, survey procedures, interview procedures, or observation of public behavior not exempt under category 2, but subjects are elected or appointed public officials or candidates for public office.

☐ Exemption 4 – Research involving the collection or study of existing data, documents, records, pathological specimens, or diagnostic specimens.

☐ Exemption 5 – Research and demonstration projects conducted by or subject to the approval of department or agency heads, and which are designed to study, evaluate, or otherwise examine public programs or benefits.

☐ Exemption 6 – Taste and food quality evaluation and consumer acceptance studies.

Annual continuation applications are not required for exempt projects. If you make changes to the study’s design or procedures that increase the risk to subjects or include activities that do not fall within the approved exemption category, please contact me to discuss whether or not a new application must be submitted. Any such changes or modifications must be reviewed and approved by the IRB prior to implementation.

Please retain this letter for your files. This office will hold your exemption application for a period of three years from the approval date. If you wish to continue this protocol beyond this period, you will need to submit another Exemption Request. If the research is being conducted for a master’s thesis or doctoral dissertation, the student must file a copy of this letter with the thesis or dissertation.

CC: Sistina Perera - Advisor
CC: Stephanie Woods – IRB Chair

Office of Research Services and Sponsored Programs
Akron, OH 44325-2102
330-972-7600 • 330-972-6281 Fax
This University of Akron is an Equal Education and Employment Institution

[Signature]

Approved consent form/s enclosed
APPENDIX F

TABLE OF SPECIFICATIONS

Directions:
Using the scale below, indicate the concept (Knowledge, Skill or Attitude) that each of the 47 statements seem to fit. Put a number 1 through 5 under the concept the statement comes closest to fitting. If a statement seems to fit more than one concept, put a number representing the degree of fit in each column that you feel applies. Please indicate any comments or suggestions you may have about the statement (e.g., clarity).

Definitions for the concepts are as follows:

**KNOWLEDGE** is a clear perception of a truth, fact, or subject. It is the ability to accurately identify, define, list, match, distinguish, label, etc., the words, concepts, theories, or facts believed to be important to the effective functioning of a person counseling older adults.

**SKILL** is practical ability, expertness, or aptitude. It is evidenced by demonstrating, producing, manipulating, showing or acting in such a manner as to promote wellness, positive behavior and/or effective services for older adults.

**ATTITUDE** is a mental position with regard to a fact or state. It is a feeling, emotion, or state. An attitude is an individual’s disposition toward things, facts, events, circumstances, or others. It is evidenced by values, ethical views and moral perceptions which undergrid open, positive, growth/wellness enhancing behaviors toward older adults.
**Scale:**

1 = low degree of fit;
2 = moderate degree of fit;
3 = pretty good fit;
4 = good fit;
5 = very good fit

<table>
<thead>
<tr>
<th>STATEMENTS</th>
<th>CONCEPTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Statement</td>
<td>Knowledge</td>
</tr>
<tr>
<td>1. I am able to demonstrate knowledge of the major psychological theories of aging.</td>
<td></td>
</tr>
<tr>
<td>2. I am able to demonstrate knowledge of the biological aspects of aging.</td>
<td></td>
</tr>
<tr>
<td>3. I am able to demonstrate knowledge of the cognitive changes in older adults.</td>
<td></td>
</tr>
<tr>
<td>4. I am able to demonstrate knowledge about psychopathology in older adults.</td>
<td></td>
</tr>
<tr>
<td>5. I am able to apply effective communication skills with older adults.</td>
<td></td>
</tr>
<tr>
<td>6. I am receptive and responsive to older adults who seek counseling.</td>
<td></td>
</tr>
<tr>
<td>7. I am able to demonstrate positive, wellness enhancing attitudes toward older adults.</td>
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</tr>
<tr>
<td>8. I am able to demonstrate knowledge of the contributions of older adults to society.</td>
<td></td>
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<tr>
<td>9. I am able to demonstrate knowledge about common stereotypes of older adults.</td>
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<tr>
<td>10. I am able to demonstrate understanding of how sociocultural factors can influence the mental and physical health of older adults.</td>
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<tr>
<td>11. I am able to demonstrate awareness of the needs of the specific cultural groups within the older adult population.</td>
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<tr>
<td>12. I am able to identify how interpersonal relationships impact older adults.</td>
<td></td>
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<tr>
<td>13. I am able to demonstrate knowledge about evidence-based interventions with older adults.</td>
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<tr>
<td>14. I am able to adapt psychotherapeutic interventions for use with older adults.</td>
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<tr>
<td>15. I am able to modify the therapeutic environment to overcome the physical limitations of older adults.</td>
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</tr>
<tr>
<td>16. I am able to demonstrate knowledge about the theoretical approaches which are most effective when counseling older adults.</td>
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<tr>
<td>17. I am able to identify factors which facilitate the counseling process with older adults.</td>
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<tr>
<td>18. I am able to demonstrate knowledge of how medications impact the physical and mental health of older adults.</td>
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<tr>
<td>19.</td>
<td>I am able to aid older adults in the use of memory-enhancing techniques to overcome cognitive deficits that may impact the counseling process.</td>
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<tr>
<td>20.</td>
<td>I am able to enhance health literacy skills of older adults.</td>
</tr>
<tr>
<td>21.</td>
<td>I am able to recognize how my attitudes and beliefs about aging and older adults may impact my counseling with them.</td>
</tr>
<tr>
<td>22.</td>
<td>I am able to demonstrate knowledge of how to work in groups with older adults.</td>
</tr>
<tr>
<td>23.</td>
<td>I am able to demonstrate knowledge about the ethical issues surrounding group work with older adults.</td>
</tr>
<tr>
<td>24.</td>
<td>I am able to demonstrate knowledge about the major career and lifestyle issues relevant to older adults.</td>
</tr>
<tr>
<td>25.</td>
<td>I am able to demonstrate knowledge about how age-related changes effect career development of older adults.</td>
</tr>
<tr>
<td>26.</td>
<td>I am able to facilitate the retirement process for older adults.</td>
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<tr>
<td>27.</td>
<td>I am able to facilitate the process of choosing alternative careers for older adults in retirement.</td>
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<tr>
<td>28.</td>
<td>I believe that older adults are viable members of the work force.</td>
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<tr>
<td>29.</td>
<td>I am able to demonstrate knowledge about the issues that influence retirement decisions of older adults.</td>
</tr>
<tr>
<td>30.</td>
<td>I am able to demonstrate knowledge about the assessment instruments that are psychometrically appropriate for use with older adults.</td>
</tr>
<tr>
<td>31.</td>
<td>I am able to demonstrate understanding of the problems of using assessment instruments created for younger individuals when assessing older adults.</td>
</tr>
<tr>
<td>32.</td>
<td>I am able to demonstrate knowledge about the ethical implications surrounding assessment of older adults.</td>
</tr>
<tr>
<td>33.</td>
<td>I recognize the value of using assessment when working with older adults.</td>
</tr>
<tr>
<td>34.</td>
<td>I am able to tailor assessment instruments created for younger individuals to the special needs of older adults.</td>
</tr>
<tr>
<td>35.</td>
<td>I am able to recognize cognitive changes in older adults that may affect the assessment process.</td>
</tr>
<tr>
<td>36.</td>
<td>I am able to conduct and interpret cognitive screening evaluations when necessary.</td>
</tr>
<tr>
<td>37.</td>
<td>I am able to demonstrate knowledge about theory and research involving older adults.</td>
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<tr>
<td>38. I am able to recognize the need for research which includes older adults.</td>
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<tr>
<td>39. I am able to demonstrate knowledge about literature sources that report research about older adults.</td>
<td></td>
</tr>
<tr>
<td>40. I am able to use research databases that provide information relevant to older adults.</td>
<td></td>
</tr>
<tr>
<td>41. I am able to demonstrate knowledge about the ethical issues pertaining to research with older adults.</td>
<td></td>
</tr>
<tr>
<td>42. I am able to adjust research approaches based on the special characteristics of older adults.</td>
<td></td>
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<tr>
<td>43. I am able to work within the scope of my competence and to seek consultation or make referrals when appropriate.</td>
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</tr>
<tr>
<td>44. I am able to understand the importance of collaborating with other disciplines when appropriate.</td>
<td></td>
</tr>
<tr>
<td>45. I am able to demonstrate knowledge about the formal and informal aging services network.</td>
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</tr>
<tr>
<td>46. I feel comfortable consulting with other professionals in the field of aging.</td>
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</tr>
<tr>
<td>47. I am able to understand the special ethical and/or legal issues involved when providing services to older adults.</td>
<td></td>
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</tbody>
</table>
APPENDIX G

INITIAL GERONTOLOGICAL COUNSELING COMPETENCIES SCALE

Directions: Using the 5-point Likert scale below, please read the following statements and select the answer that best describes you.

<table>
<thead>
<tr>
<th>Describes me well</th>
<th>Describes me somewhat</th>
<th>Does not describe me at all</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 ----------------</td>
<td>4 -------------------</td>
<td>3 ---------------------</td>
</tr>
<tr>
<td>2 -----------------</td>
<td>1 -------------------</td>
<td>1 --------------</td>
</tr>
</tbody>
</table>

1. I know the major psychological theories of aging.

   5 4 3 2 1

2. I know about the biological aspects of aging (e.g., hearing and vision changes).

   5 4 3 2 1

3. I know about the normal cognitive changes in older adults (e.g., short-term memory deficits, slower processing speed).

   5 4 3 2 1

4. I know about the abnormal cognitive changes in older adults (e.g., dementia).

   5 4 3 2 1

5. I know about psychopathology in older adults (e.g., depression, grief).

   5 4 3 2 1
6. I am able to apply effective communication skills with older adults.
   5  4  3  2  1

7. I am receptive to older adults who seek counseling.
   5  4  3  2  1

8. I demonstrate positive, wellness enhancing attitudes toward older adults.
   5  4  3  2  1

9. I know the contributions of older adults to society.
   5  4  3  2  1

10. I know the common stereotypes of older adults.
    5  4  3  2  1

11. I understand how sociocultural factors can influence the mental health of older adults.
    5  4  3  2  1

12. I know the needs of the specific cultural groups within the older adult population.
    5  4  3  2  1

13. I understand how interpersonal relationships impact older adults.
    5  4  3  2  1

    5  4  3  2  1
15. I am able to adapt psychotherapeutic interventions for use with older adults.
   5  4  3  2  1

16. I am able to modify the therapeutic environment to overcome the physical limitations of older adults.
   5  4  3  2  1

17. I know the theoretical approaches which are most effective when counseling older adults.
   5  4  3  2  1

18. I am able to identify factors which facilitate the counseling process with older adults.
   5  4  3  2  1

19. I know how medications impact the physical and mental health of older adults.
   5  4  3  2  1

20. I am able to aid older adults in the use of memory-enhancing techniques to overcome cognitive deficits that may impact the counseling process.
   5  4  3  2  1

21. I am able to enhance health literacy skills of older adults.
   5  4  3  2  1

22. I recognize how my attitudes and beliefs about aging and older adults may impact my counseling with them.
   5  4  3  2  1
23. I know how to work in groups with older adults.
   5 4 3 2 1

24. I know the ethical issues surrounding group work with older adults.
   5 4 3 2 1

25. I know the major career and lifestyle issues relevant to older adults.
   5 4 3 2 1

26. I know how age-related changes effect career development of older adults.
   5 4 3 2 1

27. I am able to facilitate the retirement process for older adults.
   5 4 3 2 1

28. I am able to facilitate the process of choosing alternative careers for older adults in retirement.
   5 4 3 2 1

29. I believe that older adults are viable members of the work force.
   5 4 3 2 1

30. I know the issues that influence retirement decisions of older adults.
   5 4 3 2 1

31. I know about the impact of grief and bereavement on older adults.
   5 4 3 2 1
32. I know how end of life issues impact older adults.
   5  4  3  2  1

33. I know the assessment instruments that are psychometrically appropriate for use with older adults.
   5  4  3  2  1

34. I understand the problems of using assessment instruments created for younger individuals when assessing older adults.
   5  4  3  2  1

35. I know the ethical issues surrounding assessment of older adults.
   5  4  3  2  1

36. I value using assessment appropriately when working with older adults.
   5  4  3  2  1

37. I am able to tailor assessment instruments created for younger individuals to the special needs of older adults.
   5  4  3  2  1

38. I am able to recognize cognitive changes in older adults that may affect the assessment process.
   5  4  3  2  1

39. I am able to conduct and interpret cognitive screening evaluations when necessary.
   5  4  3  2  1
40. I know about theory and research involving older adults.
   5  4  3  2  1

41. I know there is a need for research which includes older adults.
   5  4  3  2  1

42. I know the literature sources that report research about older adults.
   5  4  3  2  1

43. I am able to use research databases that provide information relevant to older adults.
   5  4  3  2  1

44. I know the ethical issues pertaining to research with older adults.
   5  4  3  2  1

45. I am able to adjust research approaches based on the special characteristics of older adults.
   5  4  3  2  1

46. I work within the scope of my competence and seek consultation or make referrals when appropriate.
   5  4  3  2  1

47. I collaborate with other disciplines when appropriate.
   5  4  3  2  1

48. I know about the formal and informal aging services network.
   5  4  3  2  1
49. I am open to consulting with other professionals in the field of aging.
   5  4  3  2  1

50. I understand the special ethical and/or legal issues involved when providing services to older adults.
   5  4  3  2  1
APPENDIX H

GERONTOLOGICAL COUNSELING COMPETENCIES SCALE
(GCCS; O’CONNOR THOMAS, 2012)

<table>
<thead>
<tr>
<th></th>
<th>Describes me well</th>
<th>Describes me somewhat</th>
<th>Does not describe me at all</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>I know the theoretical approaches which are most effective when counseling older adults.</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>2.</td>
<td>I am able to aid older adults in the use of memory-enhancing techniques to overcome cognitive deficits that may impact the counseling process.</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>3.</td>
<td>I know the assessment instruments that are psychometrically appropriate for use with older adults.</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>4.</td>
<td>I know about the evidenced-based interventions with older adults.</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>5.</td>
<td>I am able to tailor assessment instruments created for younger individuals to the special needs of older adults.</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>6.</td>
<td>I am able to facilitate the retirement process with older adults.</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>7.</td>
<td>I am able to identify factors which facilitate the counseling process with older adults.</td>
<td>5</td>
<td>4</td>
</tr>
</tbody>
</table>
8. I am able to adapt psychotherapeutic interventions for use with older adults.
   5  4  3  2  1

9. I am able to enhance health literacy skills of older adults.
   5  4  3  2  1

10. I am able to facilitate the process of choosing alternative careers for older adults in retirement.
    5  4  3  2  1

11. I know how to work in groups with older adults.
    5  4  3  2  1

12. I know about the formal and informal aging services network.
    5  4  3  2  1

13. I am able to modify the therapeutic environment to overcome the physical limitations of older adults.
    5  4  3  2  1

    5  4  3  2  1

15. I know the contributions of older adults to society.
    5  4  3  2  1

16. I know the common stereotypes of older adults.
    5  4  3  2  1

17. I understand how sociocultural factors can influence the mental health of older adults.
    5  4  3  2  1
18. I am able to apply effective communication skills with older adults.
   5 4 3 2 1

19. I know about the normal cognitive changes in older adults (e.g., short-term memory deficits, slower processing speed).
   5 4 3 2 1

20. I know about the biological aspects of aging (e.g., hearing changes, vision changes).
   5 4 3 2 1

21. I know about the abnormal cognitive changes in older adults (e.g., dementia).
   5 4 3 2 1
APPENDIX I

PRINCIPAL COMPONENTS ANALYSES DROPPED ITEMS

Principal Components Analysis #1

The following table depicts the twelve items that were dropped because they cross-loaded:

<table>
<thead>
<tr>
<th>Statement</th>
<th>Factor 1</th>
<th>Factor 2</th>
<th>Factor 3</th>
<th>Factor 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>I know about theory and research involving older adults</td>
<td>.670</td>
<td>.204</td>
<td>.265</td>
<td>.434</td>
</tr>
<tr>
<td>I am able to recognize cognitive changes in older adults that may affect the assessment process</td>
<td>.623</td>
<td>.023</td>
<td>.300</td>
<td>.409</td>
</tr>
<tr>
<td>I am able to adjust research approaches based on the special characteristics of older adults</td>
<td>.619</td>
<td>.161</td>
<td>.190</td>
<td>.511</td>
</tr>
<tr>
<td>I know the ethical issues surrounding group work with older adults</td>
<td>.568</td>
<td>.232</td>
<td>.158</td>
<td>.427</td>
</tr>
<tr>
<td>I know how medications impact the physical and mental health of older adults</td>
<td>.551</td>
<td>.091</td>
<td>.448</td>
<td>.207</td>
</tr>
<tr>
<td>I understand the special ethical and/or legal issues involved when providing services to older adults</td>
<td>.550</td>
<td>.225</td>
<td>.170</td>
<td>.542</td>
</tr>
<tr>
<td>Statement</td>
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<td>Score2</td>
<td>Score3</td>
<td>Score4</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
<td>--------</td>
<td>--------</td>
<td>--------</td>
<td>--------</td>
</tr>
<tr>
<td>I know the needs of the specific cultural groups within the older adult population</td>
<td>.534</td>
<td>.443</td>
<td>.114</td>
<td>.231</td>
</tr>
<tr>
<td>I know the major psychological theories of aging</td>
<td>.494</td>
<td>.298</td>
<td>.482</td>
<td>.191</td>
</tr>
<tr>
<td>I know about psychopathology in older adults (e.g., depression, grief)</td>
<td>.464</td>
<td>.248</td>
<td>.549</td>
<td>.202</td>
</tr>
<tr>
<td>I understand the problems of using assessment instruments created for younger individuals when assessing older adults</td>
<td>.407</td>
<td>.055</td>
<td>.236</td>
<td>.651</td>
</tr>
<tr>
<td>I know the ethical issues surrounding assessment of older adults</td>
<td>.574</td>
<td>.151</td>
<td>.180</td>
<td>.574</td>
</tr>
<tr>
<td>I know the ethical issues pertaining to research with older adults</td>
<td>.558</td>
<td>.261</td>
<td>.210</td>
<td>.571</td>
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</tbody>
</table>
The following table depicts the six items that failed to load on any factor:

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<th>Statement</th>
<th>Factor 1</th>
<th>Factor 2</th>
<th>Factor 3</th>
<th>Factor 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>I believe that older adults are viable members of the work force</td>
<td>.125</td>
<td>.317</td>
<td>.029</td>
<td>.144</td>
</tr>
<tr>
<td>I recognize how my attitudes and beliefs about aging and older adults may impact my counseling with them</td>
<td>.238</td>
<td>.231</td>
<td>.296</td>
<td>.167</td>
</tr>
<tr>
<td>I work within the scope of my competence and seek consultation or make referrals when appropriate</td>
<td>.144</td>
<td>.144</td>
<td>.105</td>
<td>.106</td>
</tr>
<tr>
<td>I collaborate with other disciplines when appropriate</td>
<td>.193</td>
<td>.187</td>
<td>.031</td>
<td>.083</td>
</tr>
<tr>
<td>I am open to consulting with other professionals in the field of aging</td>
<td>-.033</td>
<td>.158</td>
<td>.144</td>
<td>.115</td>
</tr>
<tr>
<td>I know there is a need for research which includes older adults</td>
<td>.087</td>
<td>.180</td>
<td>.098</td>
<td>.138</td>
</tr>
</tbody>
</table>
Principal Components Analysis #2

The following table depicts the nine items that were dropped because they cross-loaded:

<table>
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<th>Statement</th>
<th>Factor 1</th>
<th>Factor 2</th>
<th>Factor 3</th>
<th>Factor 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>I know the issues that influence retirement decisions of older adults</td>
<td>.669</td>
<td>.423</td>
<td>.243</td>
<td>.042</td>
</tr>
<tr>
<td>I know the major career and lifestyle issues relevant to older adults</td>
<td>.650</td>
<td>.429</td>
<td>.358</td>
<td>-.006</td>
</tr>
<tr>
<td>I know how age-related changes effect career development of older adults</td>
<td>.649</td>
<td>.424</td>
<td>.316</td>
<td>-.009</td>
</tr>
<tr>
<td>I am able to conduct and interpret cognitive screening evaluations when necessary</td>
<td>.626</td>
<td>-.027</td>
<td>.346</td>
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</tr>
<tr>
<td>I know the literature sources that report research about older adults</td>
<td>.588</td>
<td>.060</td>
<td>.229</td>
<td>.481</td>
</tr>
<tr>
<td>I know about the impact of grief and bereavement on older adults</td>
<td>.569</td>
<td>.409</td>
<td>.400</td>
<td>.082</td>
</tr>
<tr>
<td>I know how end of life issues impact older adults</td>
<td>.532</td>
<td>.354</td>
<td>.452</td>
<td>.193</td>
</tr>
<tr>
<td>I am receptive to older adults who seek counseling</td>
<td>.147</td>
<td>.719</td>
<td>.052</td>
<td>.435</td>
</tr>
</tbody>
</table>
I understand how interpersonal relationships impact older adults

<table>
<thead>
<tr>
<th>Factor</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am able to use research databases that provide information relevant to older adults</td>
<td>.300</td>
<td>.098</td>
<td>.249</td>
<td>.664</td>
</tr>
<tr>
<td>I value using assessment appropriately when working with older adults</td>
<td>.239</td>
<td>.253</td>
<td>-.006</td>
<td>.554</td>
</tr>
</tbody>
</table>

The following table depicts the two items that were dropped because they were the only two items that loaded on Factor 4: