LONGEVITY:
IMPLICATIONS FOR COUNSELING

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ABSTRACT

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By

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Master of Science in Marriage Family Therapy

“Old age is not a status we choose to become; it is a status that we inherit simply by the virtue of living, not dying” (as Utz & Nordmeyer paraphrase Holstein, 2007, p. 706).

This project aims to raise awareness about an age demographic that has been largely neglected by marriage family therapy. Population trends in the 21st century indicate an increase in diversity among clients that includes older aged individuals, couples, and families.

In the United States, public attitudes and social values reflect an ageist bias that is widely taken for granted by the dominant culture as normative. The American Counseling Association’s (2005) ACA Code of Ethics states:

Counselors are aware of their own values, attitudes, beliefs and behaviors and avoid imposing values that are inconsistent with counseling goals. Counselors respect the diversity of clients (p. 4-5). Counselors gain knowledge, personal awareness, sensitivity, and skills pertinent to working with a diverse client population (p. 9).

The American Psychological Association’s Guidelines for Psychological Practice with...
Older Adults state that “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” (APA Guidelines for psychological practice with older adults, 2004, p. 237). Knowledge and skill competencies written for geropsychologists adopt the same approach in its core attitudes for practice with older adults (Knight, Karel, Hinrichsen, Qualls, & Duffy, 2009). Such considerations are not found in the academic or professional literature of family counseling, however. To date, education about normal, healthy aging is not a mandated part of the curriculum for MFT programs, and there are no resources designed to help counselors evaluate their own age-related prejudices, fears, and cognitive distortions associated with old age.
CHAPTER I

Introduction

The Population Division of the United Nation’s Department of Economic and Social Affairs (2009) reports that population aging is affecting the world’s demographics. This unprecedented phenomenon is caused by below-replacement fertility rates and increasing life expectancy. It is causing global populations to change so rapidly that most countries “will require far-reaching economic and social adjustments” (United Nations, 2010, pp. xxiv-xxvi).

In the United States, this rapid rate of change has seen the number of people aged 65 and older grow from 3.1 million to 35 million within the short span of a single century (Humes, 2005). “Three quarters of all increases in life expectancy for at-birth and adult longevity have occurred since 1900” (Sheets, Bradley & Hendricks, 2010, p. 214). At the start of the century, a person could expect to live an average of 47.3 years (Centers for Disease Control, 2011) compared to today’s average, which is currently 78.7 years (Hoyert & Xu, 2012). The rapidity and scope of this change will have an impact on mental healthcare needs as well as the role and functions of mental health professionals (Okun & Kantrowitz, 2008; Karel, Gatz, & Smyer, 2012; Laidlaw & Pachana, 2009; Yorgason, Miller, & White, 2009).

Gerontological science of the past 50 years has made huge strides in deciphering genetic determinants and age-related diseases (Nagy, Bernard, Hodes, 2012; Schaie & Willis, 2011). Longevity researchers have come to realize “the critical importance of environmental factors that modulate and even supersede genetic predispositions” (Schaie
& Willis, 2011). Their work points to a much more optimistic perspective on aging and wellness (Baltes & Baltes, 1990; Schaie & Willis, 2011; Hertzog & Jopp, 2010; Fry & Keyes, 2010), but cultural beliefs about aging operate apart from science, as if the historical conditions and human experiences of earlier times still prevail (Angus & Reeve, 2006; Butler, 2008; Palmore, 1999).

The aging of society has not significantly changed our perceptions of aging and [older people]. Ageism . . . is widespread, generally accepted and largely ignored . . . Stereotypes are so embedded in our perceptions of human life that they are taken for granted and have become unexamined tacit assumptions (Angus & Reeve, p. 138).

Within this social context, a more than doubling of the population labeled “older adults” continues on course to reach its projected target of 72.1 million by 2030 (Administration on Aging [AoA], 2011, p. 3) when one in every five American citizens will be aged 65 or older (Humes, 2005). At present, one in every eight Americans accounts for an age group that just one century ago made up only 4.1% of the total population (AoA, 2011, p. 2).

If attitude is “a psychological tendency that is expressed by evaluating a particular entity with some degree of favor or disfavor” (Eagly & Chaiken, 1993, p. 1), then it’s no secret that the broader culture in America puts a higher valuation on youth. Studies conducted on the implicit nature of age stereotyping indicate an automatic negatively biased attitude towards aging and old age among study participants (Perdue & Gertman, 1990) of all ages, including those older in age (Levy & Banaji, 2002). “Counselors are subject to the same negative perceptions and stereotypes of older persons that are common in our society” (Myers, 1990, p. 252). “Prevalent in this society [is] a
paradoxical view that to grow old well is to stay young . . . which is a denial of normal development” (Duffy, 1999, p. 316).

**Statement of Need**

There are insufficient numbers of mental health professionals educated and trained to work with older adults (Karel, Gatz, & Smyer, 2012, p. 184; Laidlaw and Pachana, 2009; Knight, 1996; Barber & Lyness, 2001; Yorgason, Miller, & White, 2009). America’s post-World War II generation is turning 65 years of age at a rate of 10,000 individuals per day (Sanders et al., 2010) and will continue doing so until 2030, when the youngest of all cohort members will have turned 65 (Humes, 2005). The sheer size of the “baby boom” generation is appreciable. “Seventy percent more people were born from 1946 to 1964 than during the preceding two decades” (Hobbs & Damon, 1996, chapter 2, p. 1). Mary Finn Maples, past president of the ACA and professor of Counseling in Higher Education at University of Nevada, Reno, expects that aging baby boomers will impact the work of all counselors ranging from mental health and couples counselors to career and addictions counselors (Rollins, 2008, para. 10). Carolyn Greer, president of the Association for Adult Development and Aging (a division of the ACA,) echoes this opinion: “More and more counselors are going to be faced with this person who is older and who is confronting concerns about aging” (Rollins, 2008, para. 7).

Jonathan Rollins, editor of Counseling Today, is optimistic that the nation’s largest generation in history is a likely potential consumer of services, but colleague, Christopher Johnson of ULM’s Institute of Gerontology is concerned over the fact that the profession is broadly lacking in even a minimal amount of gerontological education. His opinion is that counseling stands unprepared to handle the “demographic imperative”
being presented by the new cohort of older adults (Rollins, 2008, para. 4-6). Council for Accreditation of Counseling and Related Educational Programs (CACREP) directors stated that the reason Gerontological Counseling was deleted from its 2009 revision of CACREP Standards was that “few counselor education departments have sought accreditation for this specialization” (Rollins, 2008 para. 8).

Karel, Gatz, and Smyer (2012) stated that even though it isn’t necessary for all psychologists to specialize in geropsychology, “they do need to achieve the competencies required for ethical and effective practice with the older adults seen through their regular practice” (p. 187). Like psychology, marriage family therapy holds itself to the fundamental principles of beneficence and non-maleficence. Immediate implications that longevity has for counseling, then, will have to do with identifying the areas most in need for special skills and a knowledge base where, historically, there has been no prior experience (Flori, 1989; Van Amburg, Barber, & Zimmerman 1996; Lambert-Shute & Fruhauf, 2011; Yorgason, Miller, & White, 2009; Foster, Krieder, & Waugh, 2009). The Pike’s Peak Model for Geropsychologists (Knight, Karel, Hinrichsen, Qualls, & Duffy, 2009) reads: “recognizing how personal attitudes and beliefs about aging and older adults may affect one’s work with them” (p. 208).

Purpose

This project is intended to highlight an area of need for education and training for MFT’s. Research has been conducted to identify potential challenges that counselors may encounter with respect to their ability to recognize erroneous age-related biases and misconceptions common among society. Experienced psychologists and counselors provide evidence that having certain knowledge, skills, and awareness makes a difference
in knowing how to listen and respond to older clients in ways that would enable the practitioner to correct, rather than participate in, ageist beliefs and stereotypic thinking.

**Significance**

The age group “older adults” is a heterogenous population with an extremely broad range of individual needs and characteristics. Age may bring increasing variation and complexity to presenting issues (Laidlaw & Pachana, 2009; Piercy, 2005; Karel, Gatz, & Smyer, 2012). Even more poignant is that the younger therapist-older client dynamic introduces professional concerns about counselor awareness with respect to personal values, beliefs, and attitudes (Agronin, 2010; Knight & Poon, 2009; Yorgason, Miller & White, 2009). Certain ethical codes, particularly those found in Section A: The Counseling Relationship and Section C: Professional Responsibility (American Counseling Association, 2005), will be impossible to achieve without adequate education and supervised training and practice (see APPENDIX A).

**Terminology**

*Ageism* - A complex construct of many definitions used as an umbrella term to represent all manner of prejudicial thoughts, feelings and behaviors regarding older people (Lassonde, Surla, Buchanan, O’Brien, 2012; Eagly & Chaiken, 1993). Relative to sexism and racism, ageism is disproportionately under-studied (Nelson, 2005, p. 208). From a macro perspective, ageism is “a societal pattern of widely held attitudes and stereotypes” conveyed through a broad range of common social practices contributing to avoidance, discrimination, and negative cognitions that devalue older people and the concept of old age (Gatz & Pearson, 1988, p. 184). The original definition of ageism by Robert Butler (1975) suggests that aging and old age are stigmatized:
... ageism allows the younger generations to see older people as different from themselves, thus they subtly cease to identify with their elders as human beings (p. 12).

Okun and Kantrowitz (2008) define ageism as “imposing on other people our own beliefs and values about what can or should be done at different ages” (p. 289).

**Aging Self-Stereotype/Stereotyping** - Researchers including, Becca J. Levy (2001) have observed that younger people who have held aging stereotypes over many years eventually direct those stereotypes inwardly (p. 279). Levy & Banaji (2002) suggest that the implicit process of self-stereotyping may be activated by the prevalence of age stereotypes. For example, older individuals “often encounter an expectation that they are subject to memory loss. This expectation takes forms that range from enforced early retirement to casual references made by middle-aged individuals to their own “senior moments” when they have forgotten something” (p. 62).

**Attitude** - A settled way of thinking or feeling about someone or something, typically one that is reflected in a person’s behavior (*Oxford English Dictionary online*, 2013). Eagly & Chaiken (1993) established a triparte model that identifies three separate components of attitude: cognitive (beliefs or stereotypes); affective (prejudicial feelings one has toward a group); and behavioral (discriminatory actions). Cuddy and Fiske (2002) stated:

“Ageist attitudes may be thought of as a constellation of these three factors, each of which can have a positive or negative component: feelings due to a person’s age, stereotypes about what someone is like just because the person is “of a certain age,” and differential treatment due to a person’s advanced age” (p. 131).
**Stereotype/Stereotyping** - Derived from the original definition (1798) for the method of reproducing metal plates by casting an original form from a plaster mold. A stereotype is “A preconceived and oversimplified idea of the characteristics which typify a person, situation, etc.” (*Oxford English Dictionary online*, 2013). A standardized mental picture that is held in common by members of a group and that represents an oversimplified opinion, prejudiced attitude, or uncritical judgment (*Merriam Webster Dictionary online*, 2013). Stereotypes usually focus on negative or unfavorable characteristics, but not always. It is the perpetuation of assumptions and misconceptions about a group of people that when unnoticed by society at large, can have detrimental effects on the lives of those being falsely depicted (Angus & Reeve, 2012).

**Stigma/Stigmatization** - Derived from stigmata; a mark of social disgrace associated with a particular circumstance, quality, or person (*English Oxford Dictionary online*, 2013). According to Major & O’Brien (2005), evolutionary scholars define stigma as an attribute that marks people as different and leads them to be devalued in the eyes of others. In organized societies, “humans have developed cognitive adaptations that cause them to exclude (stigmatize) people who possess (or are believed to possess) certain attributes . . . . in order to survive, people need to know who is friend or foe . . . and who has higher status (competence)” (p. 395-396).

**Theoretical Framework**

**Ecological Systems Theory** (Bronfenbrenner, 1979) – Also known as *bioecological model of human development*; a developmental theory by which “the individual is viewed as an element of the primary [immediate] family, which is an element within larger systems . . . . such as school, work, and community” (Okun & Kantrowitz, 2008,
These systems are embedded within a greater macrosystem that contains ideologies, such as the ideology of productivism; and attitudes about empirical factors, including but not limited to, race, gender, age, social class, geographical region, and ethnicity (p. 2). The individual cannot be fully understood apart from an understanding of the influences of the intermediate and larger systems (p. 1). According to the ecological perspective, individual growth and learning involves an active process of responding to events experienced between proximal, mid-level, and macro-environmental factors; all of which are reciprocal influences occurring simultaneously among the social/cultural systems and the psychological/biological systems within the individual (Molinari, 2011).

**Limitations**

“Population aging will have an impact on economic growth, savings, investment, consumption, labor markets, pensions, taxation, and intergenerational transfers . . . family composition and living arrangements, housing demand, migration trends, epidemiology, and the need for healthcare services . . . voting patterns and political representation” (United Nations, 2010 p. xxv). This project will not be discussing any of these. “Aging is a gender issue” (Laidlaw & Pachana, 2009). However, discussion regarding the unique ways in which aging effects people of different genders does not fall within the scope of this project. Effects that different cultures have on attitudes toward aging will not be included.

**Bridge**

A review of the literature will examine ways in which attitude, beliefs, and expectations can affect therapeutic outcomes in counseling older adult clients. Following
a synthesis of the literature review, additional research will present the rationale for the development of this project and its intended audience. A project outline of the main issues will include some examples for the purposes of providing a starting place for learning and discussion in a class or group supervision or workshop. This information may point the individual therapist in a direction for further research. Concluding the project will be a summary and discussion followed by considerations for marriage family therapy that are pertinent now and will be in the coming years.
CHAPTER II

Literature Review

Introduction

Research will be conducted to explore ways in which negative attitudes about aging and older people can be a source of unwanted effects on the therapeutic relationship. Common causes of therapeutic failure, reasons for counselor anxiety, and false beliefs that underlie negative aging-related cognitions will be examined. Counselor attitude about working with older adults will be investigated, and evidence that there is a lag in the culture’s understanding of normal, healthy aging will be reviewed. The scope of the problem concerning training opportunities will also be considered.

Attitudes about Age and Aging in America

In America, the constructs of age and aging are in large part, products of societal structures and are a reflection of cultural norms and values. Therefore, it is important for counselors to conceptualize the impact of attitudes from a macro perspective as well as a micro perspective (Myers, 2007; Hagestad & Uhlenberg, 2005; Hagestad & Uhlenberg, 2006).

Effects of Language on Public Perception

Laidlaw and Pachana (2009) stated that “We are inflexibly tied to chronological age when working with older adults because so much of our language is tied up with age” (p. 603). Erdman B. Palmore (1999) and Robert Butler (1975) observed that casual semantics often reflect the cultural tendency to use the word “youthful” synonymously
with vital and energetic. The positive sensation of physical and mental wellness is automatically associated with chronological age (Palmore, 1999, p. 11).

Hendricks (2005) stated that “the way we use language, the way we characterize things, even if intended only as shorthand, evokes powerful connotations, and in all likelihood perceptions will follow suit” (p. 5). Attitudes about older people are often construed in the context of political discussions, in which “myths commonly relate to progressive physical and mental decline, social isolation, asexual behavior, lack of creativity, and economic and familial burden” (Angus & Reeve, 2006). “In this sense, the “older American” is created by social policy and by stereotypical thinking” (Knight, 1996 p. 31). Angus and Reeve (2006) asserted that “the more influential the group doing the labeling, the more widespread is the acceptance of largely unquestioned ageist stereotype[s]” (p. 139).

Angus & Reeve (2006) also suggested that over the course of time, society has sustained a “commonsense reality . . . a socially constructed space” that serves in maintaining a perceived sense of normalcy and daily predictability on the basis of tacit agreements about the world. Participants operate from “a set of unquestioned beliefs” and are often unaware that they are perpetuating ageist assumptions (p. 141). Hazan (1994) offered the following:

The information received about old people is often ambiguous, and because of this, the stereotype overrides our perception of them even in face-to-face interaction . . . . a stereotype is presumed universally applicable . . . . One of the most deeply rooted stereotypes of the aged is that they are conservative,
inflexible, and resistant to change. [They are] perceived as incapable of creativity, of making progress, of starting afresh (p. 28).

Thornton (2002) commented, “Myths . . . create images that inaccurately characterize everyday experiences of the majority of older people.” The circulation of these “found in our jokes and conversations expressed in the popular literature . . . subtly shape social, health, and work experiences in the presence of extraordinary knowledge to the contrary” (p. 304). A lag is evident by the broader culture’s outdated notions and misconceptions that stifle change in areas in need of updating. For example, educational programs that do not yet reflect what is now known about the social determinants of health and lifestyle practices that support wellness and development across the lifespan.

*Effects of Age Categorizing*

Respect for older adult clients involves respect for “interindividual variability” (Erber, 2010, p. 12). “One must not consider older adults as a single group, but as a broad category that contains many groups that share commonalities around some experiences, but also diverge in many ways” (Bates et al., 2012, p. 25).

Bill Bytheway (2005) asserted that the practice of age categorizing has an unavoidable homogenizing effect. For example, referring to a group as “60 +” has serious implications for researchers, when the only criterion for being categorized is that members have all had their 60th birthday at some point in time. It is important to think about language when used in this way and what it means to group people over 100 with individuals who have just turned 60 and all ages in between (pp. 368-369) without regard for the vast range of individual differences.
The human tendency to categorize and create groups is explained by anthropological research as normal and innate (Hazan, 1994). “Observations from the cognitive sciences [reflect that] the mind inherently categorizes, conceptualizes, and frames perceptions and stereotypes social experiences . . . Categories and stereotypes are not the problem per se” (Thornton, 2002, p. 302). Cuddy & Fiske (2002) stated that human functioning involves some cognitive processes that employ stereotyping for memory purposes as well as reduction of data overload. Stereotyping can, however, become problematic in interpersonal situations because of the human impulse to “assign objects, events, and people to meaningful classes about which we have established beliefs and expectations.” Hence, whether accurate or not, such judgments can “govern the information we seek, heed, and remember” (p. 4) as well as act upon (Nussbaum, Pitts, Huber, Raup Krieger, & Ohs, 2005).

**Cultural Values**

During early civilization, younger citizens learned from and depended upon their elders, who were valued members of society, the owners of the land, and the historians of information necessary for survival (Butler, 2008; Nelson, 2005). Prior to the industrial revolutions of the 19th and 20th centuries, attitudes about the young and the old began to change. Following the revolution, America was on its way to becoming an “inner-directed” society that was focused on efficiency and in favor of independent achievement (Palmore, 1999). After the Civil War, the transition towards a modern society entailed the ability to compete for jobs. This meant moving away from the family business (Nelson, 2005) resulting in a literal distancing between the generations. According to Falk & Falk (1990), removing older adults from working status produced an immediate effect of
devalued social status. The U.S. rapidly evolved from an agrarian society to a national economy driven by innovation and change and a value system that places high appraisal on new technology that is constantly changing (Harbison, 1999).

**Age Segregation**

Laidlaw and Pachana (2009) advised that counselors “maintain a stance of non-assumption about aging” with older aged clients and to “retain a data-gathering perspective . . . age . . . may be the least important variable” (p. 603). However, age in America is anything but a neutral construct, so this type of awareness is an acquired one.

According to Hagestad and Uhlenberg (2005), people carry a great deal of expectation of themselves, their peers, and their world on the basis of “age grading” (p. 344). Americans tend to be very aware of where they are in their lives with respect to the “social clock” that helps people to determine for themselves where they stand with respect to the normal, expected life course (Nelson, 2005, p. 217). Hagestad and Uhlenberg (2006) explain that there is a side effect of the triparte (school, work, retired) structuring of society: “Individuals of different ages do not occupy the same space and hence cannot engage in face-to-face interaction.” Children are generally kept within “narrow bands of age peers,” while adults spend the majority of their workday away from the young and the old. Age-homogenous housing, such as university housing or retirement communities serve to maintain an “us versus them” arrangement between the ages, as does mass media, which use language to target consumers by age group identification. Marketing tactics maximize the mentality of differences and mutual exclusivity between age groups (p. 642).
Within Western developed societies there is a high valuation of youth [;] the knowledge and experiences of a lifetime is assigned lesser value than the newly acquired information of younger age groups . . . volunteerism [is] perceived to be of little value compared with those in the labor market where current income and heavy consumerism are [commended] (Harbison, 1999, p. 2).

Myers said (2007), “The media frequently remind us that the Social Security system is running out of money [and] today’s older person is living longer.” It is stated that they “are drawing a disproportionate share of Social Security funds.” Persons of younger generations are affected by the implications that competition for resources has for different groups. This kind of information feeds a negative attitude towards those who are living on pension funds that the young pay taxes for (p. 62).

In our society, youth is the standard held in the highest esteem . . . Without a doubt, messages conveying North American’s cultural unease with aging are everywhere—messages that are so well learned that people respond to them below the conscious level (Kite & Wagner, 2002, pp. 129-130).

Hagestad and Uhlenberg (2006) suggest that organizing society by age separateness promotes a consciousness of “otherness” by “blocking essential opportunities for individuals to meet, interact, and move beyond “us versus them” distinctions (p. 643).

People who grow up in an age segregated society are less likely to relate to a wide variety of older people, not having known them as family members, mentors, neighbors, friends or co-workers. As a result, counselors with a very narrow range of experience
with older adults are more likely to draw from stereotypic images and conceptions with clients (Newton & Jacobowitz, 1999, p. 25).

**Challenges for the Therapist**

Wilenksy and Weiner (1977) wrote, “The problem faced by the potential therapeutic dyad of older client and younger therapist is bridging the gap between two members representing very different cultural groups” (p. 376). Knight compared this effect to what happens when two people are fluent in speaking English, but they were raised in two different cultures. “Not only are the same words used in different ways, but the client’s experiences are rooted in a social context with which we are not familiar and may be influenced by values not similar to our own” (p. 31).

**Age-Centricity**

Lars Tornstam (2005) likened the effect of age-centricity to ethnocentricism; “one’s own ethnic group is perceived as natural and best, while other groups are defined as strange and inferior. They become “others” in an “othering” process sometimes ending in xenophobia.” Tornstam stated, “Many of us have a tendency to define the present time of life as the best one and as normative for how the rest of life should be” (p. 14-15). The clear warning, being that the counselor can easily project onto another person’s age a completely different concept than what the client is actually experiencing (Agronin, 2010).

**Denial of Aging**

The wider the age gap between counselor and client, the greater the possibilities
for “differing social, cultural, and technological experiences across generations” (Laidlaw & Pachana, 2009). Agronin (2010) warned that when faced with an older aged client, the naïve counselor may want to “normalize the encounter” by ignoring age differences completely. However, denial of the person’s age can produce blind spots in evaluation and treatment and lead to many problems later (Agronin, 2010, p. 44).

Denial of one’s own aging until later in life when one begins experiencing the effects of old age seems to be normal practice (Myers, 2007, p. 55). “Old age is a social category we join or anticipate joining with feelings of ambivalence . . . most of us aspire to reach old age; after all, the alternative is to die young (Kite & Wagner, 2002, p. 129).

**Human Condition**

Robert Butler (2008) wrote, “The status of older persons and our attitudes toward them are not only rooted in historic and economic circumstances. They also derive from deeply held human concerns and fears about the vulnerability inherent in the later years of life” (p. 211). Martens, Greenberg, Schimel, and Landau, (2004) wrote:

> Elder people have an uncanny way of exposing the existential dilemma we all can understand at some level and yet want very much to be free of. They are a living symbol of time running out, of faculties fading, of potentially frightening biological facts (p. 1534).

Counselor anxiety is apt to arise at times when working with older adults. “Clearly, our society teaches us to avoid thinking about these aspects of life, therapists tend to share this avoidance, and therapeutic work with [older people] confronts the therapist with these issues in a very personal manner” (Knight, 1996, p. 72). These feelings and
associations may start out unconsciously; the instinct to deny or minimize them is natural (Newton & Jacobowitz, 1999) but “the more they are kept out of conscious awareness, the greater risk for defensive postures, including inattention, anger, boredom, disgust, aversion, and even hatred” (Agronin, 2010, p. 53). Knight, (1996) cites some of these in addition to a “sense of fatigue or helplessness in the client’s presence; “reactions atypical for the therapist” and “a conviction not supported by accurate diagnosis that the client cannot benefit from therapy” (p. 70).

More important than the manner in which countertransference is experienced, is whether the counselor is able to manage and even utilize the information gathered from it (Newton & Jacobowitz, 1999). Unrecognized countertransference brings a host of implications for counseling including failure to observe the client’s uniqueness and individuality, failure to effectively manage clients’ transference reactions (p. 29), and a diminished capacity for empathy (p. 30).

Studies measuring attitudes of strangers towards older people have shown an overwhelming tendency to the negative when elder interactions were observed with shopkeepers, strangers in passing on the street, and prospective employers (Nussbaum, Pitts, Huber, Raup Krieger, & Ohs, 2005, p. 293). Martens, Greenberg, Schimel, and Landau (2004) assert that personal fears about aging and death “may motivate us to ignore and belittle and isolate the old” but we must remember that they are, of course, the ones experiencing the emotionally devastating effects of prejudice on top of having to contend with their own finitude in a more direct (p. 1534) and profound way than most can imagine.

Knight (1996) has observed clinical challenges regardless of the age of the therapist:
The young therapist may not yet have acknowledged the finitude of life and the middle-aged therapist may be actively struggling with or avoiding these issues in a personal way. Thus the therapist may be forced to confront [mortality] earlier in life than is normal . . . . Older therapists are open to the possibility of overidentification with the client (p. 73)

*Lack of Training*

Much of therapist anxiety in work with older adults is attributable to lack of training and practice, according to Bob Knight (1996), who spoke of the failure of most training programs to prepare therapists to work with older clients:

. . . the therapist has less theoretical understanding of the client [and in] perceiving the client’s problem and personality accurately . . . less self-knowledge in those areas in which older clients tend to elicit anxiety. Into this vacuum will rush the therapist’s stereotypes [negative or positive] of old age and projections of relationships with older significant others (p. 69).

Newton & Jacobowitz, (1999) contributed that therapists may experience “residual ageism,” which can emerge when faced with a particularly frustrating client, “even when the therapist has previously examined personal stereotypes and biases” (p. 25).

Researchers who have conducted studies on implicit age stereotyping have observed, “ageism can operate without conscious awareness, control, or intention to harm” (Levy & Banaji, 2002 p. 50). Since counseling involves responding from a personal knowledge base, counselors are not always conscious of how their own attitudes and aging constructs are affecting their competency (Myers, 2007; Crose, 1991).
Counselors need tools for self-evaluation, including but not limited to supervision and personal therapy (Knight, 1996). Recognizing less-than-conscious reactions is a necessary skill of the therapist that must be learned through self-observation (p. 69-70) and cultivating an ongoing process for self-reflection is critical (Agronin, 2010; Myers, 2007; Angus & Reeve; Okun & Kantrowitz, 2008; Karel et al., 2008).

**Age-related Negative Cognitions**

Ken Laidlaw and Nancy Pachana (2012) stated that in this decade, therapists are best equipped to be able to identify and challenge erroneous age related negative cognitions. Those who are inexperienced in work with older people may hear statements, “growing older is depressing” or “old age is a terrible time” or “I’m too old to change my ways now” and think that these may sound understandable or realistic (p. 603). In their clinical work, depressed older clients often use self-defeating messages or blame age for their problems. Michael Duffy (1999) said that in group work the group leader needs to be aware that members and leaders hold beliefs about aging and old age and to notice when stereotypical beliefs may limiting the group members in some way. For example, older people may use old age as an excuse to resist change, so being able to identify the difference between genuine loss and resistance may be necessary.

Dan Blazer reported, “By far, the most frequent psychological factor discussed in the literature as related to depression across the life cycle is cognitive distortions . . . which can predispose older adults who hold unrealistic expectations, over generalize adverse events, personalize events, or overreact to events” (p.15) “Cognitive distortions clearly increased the risk and persistence of depression in [older aged people]” (p. 17).
Knight and Poon (2009) advised that an assessment of the client’s beliefs about aging might serve in working with certain maladaptive thoughts. Laidlaw and Pachana (2009) reported that standard Cognitive-Behavior Therapy techniques are effective in challenging unhelpful thinking patterns.

**Age Self-Stereotyping**

Myers (2007) and Levy (2001) have stated that when people internalize the predominant social views of aging, they accept the negative attitudes and expectations associated with the stereotypic beliefs that they’ve been exposed to. Often, people hold these views for a lifetime before they reach old age. By the time they do, internalized stereotypes can manifest a range of outcomes, including personal devaluation, prejudice and discrimination towards same aged peers, decreased sense of self-efficacy, and withdrawal from normal activities (Myers, 2007, p. 63).

Initially what commonly arises is a questioning of one’s own abilities, regardless of actual health status (Rothman, 1992). The older person will be heard using old age to explain the occurrence of physical changes and behaviors, which are viewed as the declines that are expected with age. Often, family members echo these judgments, “What do you expect at your age?” (p. 89-90) or, “You can’t do that at your age!” (Myers, 2007, p. 60).

Knight and Poon (2009) reported that “older adults may accept the prejudice that their problems are irreversible and a natural consequence of aging” (p. 241). This assumption is often associated with the conclusion that seeking help is futile (Molinari, 1996, p. 196). “Those who hold negative expectations about old age are more likely to
think that being unhappy or depressed is a part of normal aging” (Knight & Poon, 2009, p. 241). The fallacy that depression is a normative part of aging has been recognized as a major contributing factor for worsened prognosis in older adults requiring treatment (Goncalves, 2009; Karel, Ogland-Hand, Gatz, & Unutzer, 2002).

Beliefs that the older person is “failing physically and mentally” or even thoughts of suicide may be reinforced by family members, neighbors, and professionals, who themselves have negative or hopeless views about old age (Knight, 1996, p. 98). Serious and unnecessary health complications can result when the older client’s physician employs internalized stereotypes in their diagnosis and treatment (Lachs, 2010; Karel, Ogland-Hand, Gatz, & Unutzer, 2002; Nussbaum, Pitts, Huber, Raup Krieger, & Ohs, 2005).

**Longevity Calls for a New Developmental Theory**

In 1990, Jane E. Myers wrote, “As the life span has increased, the need to update and revise existing developmental theories has become increasingly apparent” (p. 249). “Individuals may expect to spend three fourths or more of their lives as adults, [with] one-third or more as older persons” (Myer’s, 2007, p. 53). Someone who is federally legislated to retire in spite of being at the peak of their skill level “is expected not to work for the remaining 25% of their life span, like it or not” (p. 59). As the population ages, counseling older aged individuals, older aged couples, and multi-generational families will become an increasingly normative event (Piercy, 2010).

Bob Knight (1996) clarified that despite the discovery of lifespan developmental psychology in the 1970’s, there remained a divide between two separate camps of
practitioners. He stated that prior to 1980, most psychologists continued practicing according to a loss-deficit model of aging. Knight (1996) explained how this model failed in effectiveness on two accounts: First, it limited therapeutic work to “adjustment to the natural losses of late life” (p. 17). While many practitioners would limit therapy to grievance work, Knight took coping to the next level; beyond optimization of functioning he helped clients explore how life could be improved. The second weakness of the loss-deficit framework was the assumption that diseases and disabilities like heart disease or cancer are normal developmental processes for older people.

According to Molinari (1996), gerontological practitioners have become more grounded in the theory that human beings are capable of change across the life span. Researchers who study aging are moving away from the traditional medical model and focusing more on neural plasticity. Rather than concentrating on pathological aging, which limits conceptions of aging to losses and deficits, “recent research seeks to examine mechanisms that may compensate for cognitive decline” (Baltes & Baltes, 1990; Knight & Poon, 2008 p. 241; Willis & Schaie, 2006; Hertzog & Jopp, 2010; Fry & Keyes, 2010). The work of Knight & Poon (2008) challenges the belief that all older adults are frail. The authors refer to the “timely detection of age-related changes that are revisable through therapy” (p. 241), as well as certain aspects of late life development that bode well for counseling, such as increased ability to regulate emotions. Counselors who apply lifespan developmental theory to practice take the positive and negative aspects of cognitive maturation into consideration and believe that change is possible (Baltes & Baltes, 1990; Molinari, 2011; Knight & Poon, 2008; Willis & Schaie, 2006; Hertzog & Jopp, 2010; Fry & Keyes, 2010).
Evidence of a Cultural Lag

Joan T. Erber (2010) explained that until recently, the general model for human growth and development was overly simplistic, and life was basically depicted as occurring in two stages. Development was traditionally viewed as a process that occurred in early life; physical and psychological functions were believed to reach maturity and peak in young adulthood. Aging has been viewed as a separate process apart from development, typically illustrated as a subsequent, steady, downward sloping state of decline. This conception of maturation is a left over notion from psychoanalysis (Knight, 1996). Within the theoretical framework of determinism, childhood and adolescence are in focus (Molinari, 1996). Since no further development or change was expected to occur during later life there was no reason to explore or learn about the older population (Erber, 2010). Beliefs such as, “elders cannot change” (Knight, 1996; Palmore; 1999) and “personality traits become more rigid with age” (Brody & Semel, 1993, p. 107) shaped people’s thoughts about older adulthood (Erber, 2010).

A content analysis study on undergraduate psychology textbooks by Whitbourne and Hulicka (1990) cited examples of false and misleading information thematic of decline in reference to cognition, personality, and physical functioning. Contents included: excerpts that focused on biological decline; failure to differentiate between normal aging and disease; inevitability of deterioration; and the assumption that one’s chronological age determines biological functioning. Reinforcing statements about the “rigidity of older adulthood,” the erroneous use of the word “senility,” and the impression that “everything [body and mind] goes downhill” were also found. Derogatory statements resulting from poor wording were also identified. For example: "The old should not be
'laid on the shelf' while they still have something to contribute to the welfare of society" (p. 1132). The researchers’ main purpose for the study was due to concern about the lasting effects that aging misconceptions have on students:

The majority of students . . . tend to accept as truth what they believe the author of their textbook has stated. Even after the details are long forgotten, the overall impression gained from undergraduate psychology courses is likely to remain and to form a conceptual framework within which to think about, interpret, interact with, and convey information about [older] people (p. 1127).

Such beliefs color professional, social, and family interactions with older adults (Whitbourne & Hulicka).

Koenig and Spano (2006) described the aging literature as “problematic” in its depictions of aging as a series of “problems, pathologies, and deficits” (p. 30). While some developmental models describe growth and change in old age, many continue to “frame late adulthood as a time of accumulative losses, grief, and disengagement . . . . fraught with barriers to full participation in political, economic, and social life” (p. 30-31).

**The Scope of Gerontological Education for MFT’s**

The Council of Counseling and Related Educational Programs (CACREP), acknowledges that society is changing, evident by its incorporation of language like “pluralism,” “diversity,” and even “lifespan,” but marriage family therapy has been a field dedicated to working within a limited scope that focuses on children, adolescents, and young adults (Flori, 1989; Lambert-Shute & Fruhauf, 2011; Van Amburg, Barber & Zimmerman 1996; Yorgason, Miller, & White, 2009). A study on curriculum content
indicated that this is true for faculty as well as students (Barber & Lyness, 2001). Very few graduate programs offer aging-related coursework and training opportunities remain scarce (Karel, Gatz, & Smyer, 2012; Myers, 2007; Barber & Lyness, 2001; Foster, Krieder, & Waugh, 2009). Only two counseling programs in the United States have achieved accreditation for gerocounseling (Myers, 2007; Foster, Krieder, & Waugh, 2009). Foster, Krieder, and Waugh suggested that flexibility is perhaps what is lacking. Students and faculty are in need of some education and training. However, they may not want to have to adhere to the specific requirements of an accredited program.

At present, MFT students are faced with an all-or-none decision: commitment to a specialty or receive no gerontological training. CACREP’s decision to remove gerontology as a specialty is not a new situation, and in fact, follows in the wake of efforts that were initiated nearly 40 years ago. The ACA joined with the U.S. Administration on Aging, and through 5 grant projects, received funding in excess of $1.2 million for the purposes of developing curriculum and training designed to improve counseling competency with older persons. Various resources for graduate level training were created, and 3,200 practicing professional counselors received basic aging and gerontological training. In addition, two sets of competencies were established. The first set addressed the minimum competencies required of all counselors for individual and group work with older persons and their families. The second became the standards for a new National Certified Gerontological Counselor (NCGC) credential through the National Board for Certified Counselors (NBCC). By the 1990’s, gerontological counseling was the third fastest growing area of counselor preparation, following substance abuse and marriage family therapy. In 1997, a total of 200 people had achieved
certification as a NCGC. Based on this low level of interest, NBCC suspended the credential (Myers, 2007).

**Research Studies**

Very minimal research has been done to explore the relationships between attitude, level of training, and competency. One study, conducted by Yorgason, Miller, & White (2009), examined level of training and experience and counselor attitude about working with older aged clients.

**Sampling**- Clinical, associate, and student members of the American Association for Marriage and Family Therapy (AAMFT) were notified by postcard, from which a sample group (n= 191) between the ages of 23 and 77 (mean age= 46). Respondents reported working across a range of clinical settings, including private practice (37 percent), private nonprofit agencies (18 percent), university clinics (16 percent), public agencies (11 percent), medical facilities (6 percent), and other settings (9 percent). The sample group included 59 percent Caucasian, less than 1 percent Native American, 2 percent African American, and 8 percent not reporting race.

**Method**- Attitudes about age were studied by dividing the sample group in half. Group 1 and Group 2 were administered questionnaires designed to measure level of comfort respondents felt working with older vs. younger couple/caregivers. A multivariate analysis of covariance was used to compare the relationships between working with younger versus older and female versus male clients.

**Results**- Controlling for age and gender, results indicated that those that responded to the vignette with younger clients reported feeling higher levels of comfort in working
with the case than those that responded to the vignette with older clients. A significant finding was that regardless of age or sex of the respondents, these attitudes remained constant. Furthermore, when working with an older male versus older female client, comfort level remained constant. Client age, not the gender, elicited less comfort reported when working with older clients compared to younger ones.

Method- Counselor self-reported feelings of preparedness were measured by using a Likert scale method of rating whether training had prepared them to work with older adults and their families, how many courses taken and where, and how important their belief that training was important to effectiveness.

Results- Frequencies reflected that forty percent of respondents reported that they agreed or strongly agreed that their training had prepared them well, while 60 percent reported “neutral,” “disagree,” or “strongly disagree.” The majority believed training in aging issues was important with 34 percent in strong agreement, 51 percent in agreement, and 9 percent neutral. Only 3% did not agree, and yet in light of these results, only 3 percent had taken seven or more courses, 24 percent had taken none, and 60 percent had taken between one and three. An analysis of variance (ANOVA) was used to examine the relationship between courses taken and perceived effectiveness, competence, and interest in working with older adults. Results from this study indicated that training in aging issues seems to be linked with perceived competence and interest in working with older adults. Training was believed to be important for competency (Yorgason, Miller, & White (2009).

Limitations- Several aspects of the study place limitations on whether these findings
can be generalized. These include sample size, uncontrolled environment due to method of administration (Internet survey), and a likelihood that participation by clinicians included a higher proportion of individuals interested in aging compared to the general population of MFT’s. Among very few studies available, this was the only one representative of research conducted to measure competency with respect to amount of training received, in addition to evaluating counselor attitude in working with older adults.

**Additional Research**- Foster, Krieder, & Waugh (2009) conducted a survey study exploring level of interest in select gerocounseling topics among graduate students (n=385). Research conclusions coincided with Yorgason, Miller, & White’s (2009). Students reported feeling ill-prepared to work with older adults without training. In addition, study participants expressed a substantial interest and willingness to learn more about some common gerocounseling specialty areas (Foster, Krieder, & Waugh, 2009).

**Synthesis of the Literature Review**

Stereotyping is one way in which the brain tends to organize and create categories and is not necessarily a social problem. Rather, it is the affective components such as prejudice and stigmatization that suggest the need for education and thoughtful consideration when working with certain populations. This is the main premise of cultural competency (Office of Minority Health, 2006). However, age is not consistently acknowledged as a cultural factor in the curriculum (Barber & Lyness, 2001; Yorgason, Miller, & White, 2009). While researchers and academia have dedicated substantial research towards understanding racial and gender discrimination, ageism has essentially
been ignored (Nelson, 2005).

Evidence-based practitioners in geropsychology report that regardless of the age of the therapist, there are unique experiences likely to be sustained in the therapeutic relationship when the client is older (Knight, 1996; Agronin, 2010) and those who lack adequate education and experience are more prone to call upon stereotypes and aging misconceptions, whether they do it consciously or not (Erber, 2010; Knight, 1996; Newton & Jacobowitz, 1999).

MFT’s will likely observe a growing number of older adults in their practice. It will be important for professionals to be able to recognize cultural attitudes and prejudicial beliefs directed at them by others as well as themselves. Counselor ability to identify the effects of personal attitudes and expectations about aging and mortality will also become increasingly important.
CHAPTER III

Project

Introduction

This is a graduate project designed to offer information that, at the time of its assemblage, has not been made readily available in a comprehensible format applicable to MFT students, practicing interns, or licensed professionals. This work is being presented for the purposes of assisting the self-study post-graduate by introducing some main areas of topic that are worthy of further consideration and research. Demographic changes will present challenges to practice according to boundaries of competence as per codes C.2.a. and C.2b. (American Counseling Association, 2005, pp. 4-10) as well as others found under Section A: The Counseling Relationship and Section C: Professional Responsibility (see APPENDIX A).

Development of the Project

In recent years, geropsychologists have come to regard attitude as an essential and primary domain area for competency (Knight, Karel, Hinrichsen, Qualls, & Duffy, 2009). “Respect for older adults and awareness of one’s own ageist biases” is a core foundational competency for professional geropsychology (p. 208).

Researchers have made the observation that a unique characteristic of ageism is a perpetual short-sightedness on the part of people in the early stage of their life. The “non-elders” of today will one day themselves become members of the out-group whom they perceive to be separate from. Thus, “the perpetrators” of ageism are intimately connected with their target, which will eventually be replaced by themselves (Martens, Greenberg,
Schimel, & Landau, 2004). Education would be more complete, if only the relatedness between the young and the old were included, rather than omitted. Falk & Falk (1997) wrote:

> The study of gerontology is always about the self. The student learns about his[/her] own anticipated condition . . . . Education concerning aging and old age therefore serves to decrease bigotry and prejudice against the old and to make one’s own aging more understandable and livable (p. 155).

**Intended Audience**

Three independent studies analyzed the contents of the leading professional journals in marriage family therapy covering the years from 1976-1985 (Flori, 1989), 1986-1993 (Van Amburg, Barber, & Zimmerman 1996), and 1997-2006 (Lambert-Shute & Fruhauf, 2011). Data collected and analyzed by all three studies revealed:

Family therapy is a field that historically has had a focus on problems of parents, couples, and young families. Even though awareness has marginally increased (i.e., the discussion in Family Therapy Magazine (2002) was devoted to issues on aging), little work has addressed the lives of older adults and their families (Lambert-Shute & Fruhauf, 2011, p. 34; Flori, 1989; Van Amburg, Barber, & Zimmerman, 1996).

Based on the research, it seems that MFT students, trainees, supervisors, interns, licensed MFT’s, faculty members, and school administrators would benefit from exposure to information that draws upon relevant age statistics and best practices among geropsychologists and counselors of the past several decades. An awareness of such information would be personally and professionally beneficial to the MFT.
Project Outline

A. Demography is an important component of the study of aging and older adulthood.

    a. “Demographic information is essential for understanding past and present population characteristics . . . it can also be used to project future trends in the size and growth of a particular segment of the population” (Erber, 2010, p. 15). Therapists may utilize this information to learn about and prepare for the needs of their clients. For example:

        i. “If people can expect to live 20 or 30 years after retirement, then it is entirely possible that many older people will seek out psychotherapy as a means of maintaining person growth or for grappling with the challenges of aging” (Laidlaw & Pachana, 2009).

        ii. Members of the current older adult cohort witnessed their own parents die at a young age when the average life expectancy was much lower. Many experience anxiety due to the false assumption that they are likely to follow suit since it is common belief that aging is simply a matter of biological inheritance (Laidlaw & Pachana, 2009).

    b. Counselors differ in their beliefs about aging and older people. Some believe in the potential for growth and change over the lifespan, while others view aging as apart from the rest of the life span (Myers, 1990).
i. Counselors will approach older clients differently depending on which developmental theory they use as the basis for assessment, diagnosis, and treatment (Knight, 1996; Myers, 1990).

ii. Advocacy is a function of professional counseling.

iii. Advocacy hinges upon accuracy of information. Therefore, accuracy of knowledge about aging is a vital aspect of professional counseling.

iv. Facts about aging can serve to clarify general uncertainty surrounding normal aging. For example:

1. Aging inevitably impacts everyone. “Each day, human beings incur a non-functional decline at a rate of 0.8% every year, past the age of 25” (Duffy, 1999, p. 340).

2. The effects of aging manifest in people differently, and, to varying degrees depending on multiple variables that are biopsychosocial.

3. Social and lifestyle factors, not just biology and genetics determine how an individual ages (Laidlaw & Pachana, 2009).

4. Recent discoveries in neuroscience support the theory that change and development are not limited to the early years in life and the potential for development and change are not determined by chronological age.

5. The actual starting point for old age is not clearly demarcated (Kite & Wagner, 2002). Age 65 remains “an arbitrary marker for older adulthood” (Erber, 2010, p. 12) that was originally borrowed from the German retirement system when the Social Security System
was established in the U. S. in 1935.

B. Age is a complex construct that is used as a referential means of categorizing people in organized societies and is associated with social status and identity.

   a. Stereotypic assumptions about chronological age and age categorization are commonly mistaken for normative characteristics of aging in America.

   b. The aging process in America is generally viewed with negative social perceptions attached to it.

       1. “Age has always differentiated people, and there is no denying that real aging occurs or that changes can be problematic, but all too frequently these changes are perceived as either pathological or depreciatory” (Hendricks, 2005, p. 5.)

   c. Research studies on implicit age stereotyping indicate that “ageism can operate without conscious awareness, control, or intention to harm” (Levy & Banaji, 2002, p. 50).

C. Counseling involves responding from a personal knowledge base and counselors are not always conscious of how their own attitudes and participation in social labeling are affecting their competency (Myers, 2007; Crose, 1991).

   a. “Recognition of one’s own attitudes about aging and understanding how these attitudes influence behavior are critical for developing a working relationship with older people to age well” (Angus & Reeve, 2012).

   b. Researchers indicate that professional training is critical for reducing possible obstacles to the therapeutic relationship.

       i. A special awareness of attitudes entails methods for ongoing self-
evaluation and having a process of self-reflection (Agronin, 2010; Karel et al, 2008; Knight, 1996; Martens, Greenberg, Schimel, & Landau, 2004; Myers, 2007) since “many psychotherapists working with older people are confronted with their own unacknowledged fears about aging and mortality” (Laidlaw & Pachana, 2009, p. 608)

1. Knight (1996) observed that the young therapist may not yet have acknowledged the finitude of life, and the middle-aged therapist may be actively struggling with or avoiding these issues in a personal way . . . . Older therapists are open to the possibility of overidentification with the client” (p. 73).

ii. The Introduction to Section C: Professional Responsibility of the 2005 edition of the *ACA Code of Ethics* states that “Counselors engage in self-care activities to maintain and promote their emotional, physical, mental, and spiritual well-being to best meet their professional responsibilities (p. 9).

iii. Possible consequences of failure to manage personal attitudes and anxieties associated with aging-related cognitions and prejudices include but are not limited to:

1. Unintended communication of prejudicial beliefs and attitudes about age.
2. Violation of ethics codes concerning primary responsibility of the counselor, personal values, advocacy, professional competence, and discrimination.
3. Inaccurate knowledge about aging and older adulthood constitutes a barrier preventive of older adults from participating in life to their full potential.

4. Unacknowledged countertransference has been observed as the cause for counselor ineffectiveness. Examples include: inhibition, derailment of, or unnecessary termination of the therapeutic process (Newton & Jacobowitz, 1999; Brody & Semel, 1993; Molinari, 1996; Agronin, 2010).

5. Failure to be empathic with client (Newton & Jacobowitz, 1999).

D. Research studies indicate a need for more current academic and professional literature about aging and older adulthood developmental processes.

a. Facts of normal aging are critical for accurate assessment, diagnosis, and treatment (Knight, 1996; Laidlaw & Pachana, 2009; Molinari, 2011).

b. Cognitive research of the past two decades has provided evidence for lifespan developmental theory (Schaie & Willis, 2011), indicative of developmental gains and losses (Hertzog & Jopp, 2010) occurring across the lifespan as opposed to the traditional view that development occurs only in early years of life, followed by a state of decline (Baltes & Baltes, 1990).

c. Until educational and training resources for MFT’s become available, the counselor is responsible for seeking ways to enhance their own preparedness for working with older adult clients.
CHAPTER IV

Conclusion

“We have limited ourselves, our patients, and families with lowered expectation for improvement and function, because of ageist attitudes . . . . Our ability to detect and treat disease, mental or physical, rests on our ability to “look” beyond attitudinal limits and barriers, to the real diagnosis . . . much of what we see mentally and physically can be improved and sometimes cured. Quality of life can surely be improved with attitude” (Michael Duffy, 1999, p. 340).

Summary

Bob Knight, Kenneth Laidlaw, Jane E. Myers, Michele Karel, and Michael Duffy are some among a group of seasoned colleagues whose work reflects decades of best practice methods, interventions, and ways of thinking about older aged clients. Counseling methods and interventions by geropsychologists demonstrate a movement towards practice based in scientific knowledge that integrates age as a cultural component while utilizing a strengths-based approach. Consistent implementation of the lifespan developmental perspective will however, involve a letting go of outdated beliefs that scientists now believe were incomplete conceptions about the neuroscience of normal aging (Baltes & Baltes, 1990; Hertzog & Jopp, 2010; Schaie & Willis, 2011).

Discussion

Americans can expect to live more years and to live healthier for significantly longer than previous cohorts. Longevity raises the concerns: “How can the quality of life be maintained with advancing age and how can healthcare be made cost-effective?”
Coinciding is the question, “What are implications that longevity has for counseling?” The asking of which is timely, and necessitates a more thorough investigation by more counselors, scholars, faculty members, professional associations, and practitioners. Specifically, how proximal interactions are influenced by a reciprocal relationship between culture and the individual and what are the macro, mid-level, and micro-level societal components that influence and reinforce the values of the dominant culture and therefore ways in which age bias affects the therapeutic relationship.

**Future Considerations and Research**

“[Counselors] practice in a non-discriminatory manner within the boundaries of professional and personal competence and have a responsibility to abide by the ACA Code of Ethics . . . . Counselors have a responsibility to the public to engage in counseling practices that are based on rigorous research methodologies” (American Counseling Association, Section C Professional Responsibility, 2005, p. 9).

Schaie & Willis (2011) state that “In order to realize the enormous potential of longer life, scientists must come to a more comprehensive understanding of human aging and the social, psychological and biological factors that contribute to optimal outcomes” (p. ix).

If misconceptions about aging and old age could be put aside, the counseling profession could clarify ways in which it is naturally suited to integrate the concept of aging well with counseling family members. Over the past two decades, increasing numbers of practitioners in biology, medicine, nursing psychology, social work, and nursing have received degrees in gerontology. In more recent years, planners in the aging
network, nursing home administrators, and specialists in rehabilitation and recreation have joined the team approach for healthcare (Knight, 1996; Molinari, 2011). Whether marriage family therapy is to become one such profession that obtains gerontological specialty status is irrelevant to the fact that all professionals work together within a larger system.

About one fourth of the general population consists of the 75 million middle-aged individuals who were born between the years 1946-1964. This cohort represents a significant proportion of a potential client base for the MFT at present, and into the coming decades. While physicians, psychiatrists, psychologists, and all healthcare workers continue services as per their specific functions with the current older adult population, the role of MFT occupies a position at the frontline level of defense where identification of treatable mental health issues could prove to influence future health in the long run. MFT’s may play a vital role for the new generation of middle-aged people who are making the transition into “older adulthood.” Demographic changes in motion, it is in the best interest for all that the profession update its knowledge base so that MFT’s may stand ready with skills and awareness appropriate for working within the context of an aging society.

Therapists engage in a professional relationship with the public that is uniquely positioned at mid-societal level. MFT’s facilitate interventions that teach the client to develop skills for healthy coping and adaptation; the same kind of cognitive changes that newer research is seeing in studies on learning and resiliency in later life.

In order to meet the newer challenges of aging in the twenty-first century, the present generation of older adults, more than previous generations, is striving to
maximize internal and external resources and to explore new sources of life-strengths. What older adults are increasingly experiencing is the need to evaluate and take stock of their reservoir of social, emotional, and cognitive strengths that may assist them in facing present and future challenges, crises, and struggles (Fry & Debats, 2010, p. 16).

Jane E. Myers (2007) spoke of advocacy as a function of the role of counselor:

Empowerment refers to actions intended to help people help themselves or create personal power, whereas advocacy refers to actions taken on behalf of others to ensure that empowerment does, in fact, occur . . . the intended outcome: to create environments in which individuals are able to live their lives effectively and with a sense of well-being, in which they can choose to change themselves or their life circumstances to achieve their goals and live life more fully (p. 64).

Introduction to Section C: Professional Responsibility and Ethical Code A.6.a of the ACA Code of Ethics (2005) state:

Counselors advocate to promote change at the individual, group, institutional, and societal levels that improve the quality of life for individuals and groups and examine potential barriers that inhibit access and/or the growth and development of clients (American Counseling Association, 2005, p. 5).

Advocacy hinges upon accuracy of information (Myers, 2007). Accuracy of knowledge about aging will become increasingly important for all health care practitioners who may anticipate increased contact with older adults (Erber, 2010).
In conclusion, it seems that MFT’s who have aging-related knowledge will have greater competency in achieving the ultimate goal on a micro and macro level simultaneously; helping persons of all ages to optimize their well being for life. Attitude has an impact on expectations and therefore, therapeutic outcomes. Michael Duffy (1999) submitted that some preventive efforts at much younger ages may actually have their strongest effects in old age (p. 315). The aging-related attitudes counselors maintain with respect to themselves and their clients have a significant bearing on the long-range effectiveness of counseling, and not just in the immediate moment of need.

Martens, Greenberg, Schimel, and Landau (2004) suggest, “perhaps the more we understand how our fears related to the aging process and death interact with our connections to [older] people, the more we will temper the tendency to differentiate ourselves from them . . . there might even emerge the possibility of learning from those who are closest to dealing with [what we must all face one day:] the end of life” (p. 1534).

Willingness to recognize and sit with one’s own fears and anxieties about aging and death . . . is crucial to effective psychotherapy with [older clients]. Differences between young and old in needs, feelings, and perceptions are not as great as the young would like to believe (Newton & Jacobowitz, 1999, p. 30).

Michael Duffy (1992) wrote:

The therapist needs to focus on the “inner age” of the client versus chronological age . . . the therapist recognizes the essential sameness of human experience and pain, despite age, cohort, or cultural differences (p. 435).
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APPENDIX A

ACA Code of Ethics (2005), Sections A and C

Section A: The Counseling Relationship

Counselors encourage client growth and development in ways that foster the interest and welfare of clients and promote formation of healthy relationships. Counselors actively attempt to understand the diverse cultural backgrounds of the clients they serve. Counselors also explore their own cultural identities and how these affect their values and beliefs about the counseling process. Counselors are encouraged to contribute to society by devoting a portion of their professional activity to services for which there is little or no financial return (pro bono publico).

A.1. Welfare of Those Served by Counselors

A.1.a. Primary Responsibility- The primary responsibility of counselors is to respect the dignity and to promote the welfare of clients.

A.4.b. Personal Values- Counselors are aware of their own values, attitudes, beliefs, and behaviors and avoid imposing values that are inconsistent with counseling goals. Counselors respect the diversity of clients, trainees, and research participants.

A.6. Roles and Relationships at Individual, Group, Institutional, and Societal Levels

A.6.a. Advocacy- When appropriate, counselors advocate at individual, group, institutional, and societal levels to examine potential barriers and obstacles that inhibit access and/or the growth and development of clients.
Section C: Professional Responsibility

Counselors aspire to open, honest, and accurate communication in dealing with the public and other professionals. They practice in a non-discriminatory manner within the boundaries of professional and personal competence and have a responsibility to abide by the ACA Code of Ethics. Counselors actively participate in local, state, and national associations that foster the development and improvement of counseling. Counselors advocate to promote change at the individual, group, institutional, and societal levels that improve the quality of life for individuals and groups and remove potential barriers to the provision or access of appropriate services being offered. Counselors have a responsibility to the public to engage in counseling practices that are based on rigorous research methodologies. In addition, counselors engage in self-care activities to maintain and promote their emotional, physical, mental, and spiritual well-being to best meet their professional responsibilities.

C.2. Professional Competence

C.2.a. Boundaries of Competence- Counselors practice only within the boundaries of their competence, based on their education, training, supervised experience, state and national professional credentials, and appropriate professional experience. Counselors gain knowledge, personal awareness, sensitivity, and skills pertinent to working with a diverse client population.

C.2.b. New Specialty Areas of Practice- Counselors practice in specialty areas new to them only after appropriate education, training, and supervised experience. While developing skills in new specialty areas, counselors take steps to ensure the competence of their work and to protect others from possible harm.
C.5. Nondiscrimination

Counselors do not condone or engage in discrimination based on age, culture, disability, ethnicity, race, religion/spirituality, gender, gender identity, sexual orientation, marital status/partnership, language preference, socio-economic status, or any basis proscribed by law. Counselors do not discriminate against clients, students, employees, supervisees, or research participants in a manner that has a negative impact on these persons.