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A survey of Australian psychologists in aged care: The relationship between training, attitudes and professional practice with older clients.

Thesis submitted by

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in June 2008

for the degree of Doctor of Philosophy

in the Department of Psychology

James Cook University

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STATEMENT ON THE CONTRIBUTION OF OTHERS

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All research procedures reported in the thesis received the approval of the Human Ethics Committee of James Cook University (Appendix 1).

Professional editing and proof reading was carried out by Kate McAllan and Gillian Hamilton.

Professor Edward Helmes has contributed to all publications contained herein, advising on the following areas: conception of study, design, data interpretation, conclusions and editorial advice. Dr. Alistair Campbell advised on statistical analyses concerning Study 3 (Student Survey) and Study 6 (Comparison study). Dr. Kaarin Baikie advised on data analysis in Study 1 (Pilot Survey).

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ABSTRACT

The proportion of Australian adults aged over 65 years is due to increase over the next 20 years with corresponding increases in mental illness. A growing demand for clinical psychology services to older adults is expected yet overseas surveys indicate a low rate of specializing in working with the over-65 age group. The status of geropsychology in Australia is examined through exploratory analysis of survey data from a practising psychologist sample and from a post-graduate psychology trainee sample. Six published studies are reported that examine the relationship among training, personal contact and attitudes, and the relative contributions of these three factors to decisions on working with older adults among Australian psychologists. Pilot research highlights the importance of interest in working with older clients and additional training external to formal degree courses in discriminating between those psychologists who specialised in aged care compared to generalist practitioners. A national survey of psychologists identifies clinical exposure to older adults while training and negative expectations of subjective ageing as additional factors predicting specialist category membership. Low rates of professional involvement with older clients in general highlight the corresponding dearth of psychologists specialising in aged care service provision, a finding congruent with overseas research. The positive influence of clinical contact, as opposed to the absence of predictive ability for personal contact, is also emphasized in a survey of post-graduate psychology students. Professional attitudes, such as confidence and interest in working with older adults, are other predictors of interest in working with older clients among students. The use of the Reactions to Ageing Questionnaire in

several analyses also highlights the importance of affect in influencing behaviour, with professional attitudes predicting personal attitudes towards ageing, as opposed to personal contact or formal training. The final study underscores the role of contextual relevance, with training contributing to more variance in interest in working with older adults among trainees, as compared to practitioners whose professional interest was influenced more by attitudes. The contact hypothesis is not confirmed in this research in either the student or the practitioner samples. Strategies to promote the field of clinical geropsychology across a variety of settings, ranging from training to clinical service delivery are discussed.

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CHAPTER 1

LITERATURE REVIEW

A SURVEY OF AUSTRALIAN PSYCHOLOGISTS IN AGED CARE: THE RELATIONSHIP BETWEEN TRAINING, ATTITUDES AND PROFESSIONAL PRACTICE WITH OLDER CLIENTS

I. INTRODUCTION

There is a significant transformation occurring within Australia's demographic composition. Secondary to low fertility rates and reduced mortality, an increase in the proportion of Australian adults aged 65 and over is expected, with the current proportion of 12 percent increasing to 20% in 2021 and around 26% by 2051 (Australian Bureau of Statistics, 2000). The most rapidly growing sub-group of elderly adults is expected to be those aged 85 and older, rising from just under 300,000 in 2004 to around 2 million by 2051 or a proportion of nearly 8% of the Australian population (Australian Bureau of Statistics, 2004).

While the majority of these older people will grow older with no mental health problems, the projected figure for psychiatric disorders amongst the elderly has been estimated at 20% (Brodaty, 1991). In regard to specific disorders, despite epidemiologists' finding that depression is no more likely to occur in older people than in younger adults, rates of depression in hospitalised or institutionalized elderly are very high (30%-50%: Katz & Parmlee, 1997). Suicide rates are highest among elderly males (the 85 year old and over male demographic group is three times more likely to commit suicide compared to any other age group: McIntosh, 1995), as is the case with phobias

in elderly females (14.2%: Myers, Weissman, Tischler et al., 1984). The Australian Burden of Disease Study (Mathers, Vos, Stephenson & Begg, 2000) reports that depression is the leading cause of non-fatal disease burden in Australia with the highest proportion of years lost to disability. Projected burden of disease figures report that dementia will overtake ischaemic heart disease in becoming the largest contributor to rates of Disability Adjusted Life Years (DALYs) by 2016 (Mathers et al., 2000). Physical health symptoms associated with chronic illnesses also increase with age and at an even higher rate than psychiatric disorders (Belsky, 1999). Such figures pose a significant public health issue given the expected rise in the number of elderly people in the general population.

Given the magnitude of this public health issue, it is often not recognized that psychological treatment approaches have been found to exert a positive influence on the lives of elderly adults across a number of areas. For example, the prevalence of dementia increases with advancing age, rising from 6% of persons over 65 years of age to at least 24% of those aged over 85 (Henderson & Jorm, 1998). Disruptive behaviours associated with dementia have been shown to change in a positive direction following psychological intervention (Opie, Rosewarne & O'Connor, 1999). More recently, well controlled studies have emerged from the literature that augment earlier research designs limited to single case or very small sample sizes. Australian efforts in this area have highlighted the positive contribution of multi-disciplinary focused management in dementia care (Davison, Hudgson, McCabe, et al., 2007; Opie, Doyle & O'Connnor, 2002*)*, with a controlled trial of psychosocial interventions funded by the Commonwealth Department of Health and Ageing (Bird, Llewellyn-Jones, Smithers et

al., 2002) that demonstrated that such interventions are both clinically effective and cost-effective.

Cognitive-behaviour therapy has been supported in the literature for the treatment of depression (Laidlaw et al., 2003; Koder, Brodaty & Anstey, 1996) and anxiety (Nordhus & Pallesen, 2003). Psychological interventions have been found to be cost-effective within medical settings, with a meta-analytic study finding that subjects who participated in psychological therapy following surgery or cardiac events had shortened stays in hospital compared to control subjects (Mumford, Schlesinger & Glass, 1982). Such positive findings have been replicated with various conditions including arthritis (Puder, 1995), insomnia (Riedel, Lichstein & Dwyer, 1995) and for alleviating stress and depression in high risk groups such as carers (Brodaty, Green & Koschera, 2003).

Much of the research that demonstrates the efficacy of psychological interventions with older people has been conducted in the U.S. (Molinari, 2000; Lichtenberg, 1999) or the U.K. (Woods, 1995), but a notable amount has been conducted in Australia. An analysis of the Australian experience with geropsychology to date will be examined next.

II. THE HISTORY AND STATUS OF GEROPSYCHOLOGY IN AUSTRALIA

Geropsychology can be defined as psychological "research in normal ageing, mental disturbances/diseases and other conditions in ageing that influence well being, and the application of this knowledge in treatment and care of elderly individuals" (Johansson, 1992, p.20).

Clinical psychology is a comparatively young profession, with the sub-specialty of geropsychology being one of its most recent growth areas from a world-wide perspective. Research efforts in Australia began in the 1950s, developing largely in the period since World War II (O'Gorman, 2007) with the pioneering work of Alan Welford in the area of ageing and human performance and continuing with work across several areas pertinent to ageing such as retirement (Elsie Harwood and George Naylor in 1965). The formation of the Psychology and Ageing Interest Group in 1986, the first special issue on psychology and ageing published in the *Australian Psychologist* in 1993 and the 2000 International Year of Older Persons position paper on Psychology and Ageing (Gridley et al., 2000) all are initiatives indicating an increased profile of ageing within the Australian Psychological Society (Browning and Stacey, 1999). The volume of local research appears to be increasing with Australian publications in the field of geropsychology more than doubling over the past ten years (Wells, 2004).

However such enthusiasm within the research area does not appear to be paralleled within clinical psychology service delivery settings. In 1987, Ray Over conducted a survey of APS members and found that only 1% of the membership indicated a primary

interest in ageing (Over, 1991). Compared to Wells' analysis of interest group membership (Wells, 2004), this interest has doubled over the years but is still small in absolute terms. Within the area of neuropsychological assessment, interest is also low in a variety of recent surveys. A survey of APS College of Clinical Neuropsychologists membership reported only 6.4% of members listed some kind of interest in the aged (Casey, 1992). The 2004 membership directory of the NSW branch of the Australian Association of Cognitive Behaviour Therapy (AACBT) only has two of its 181 members listing aged care as their special interest and clinical activity. The South Australian Branch AACBT directory of 2006 also listed only two members specializing in aged care.

A survey of psychogeriatric services in Australia (Snowdon, Ames, Chiu & Wattis, 1995) found psychologists to have the lowest ratio (1 psychologist to 66,200 elderly), of any other health care discipline surveyed. This was half the number of psychologists allocated to services compared to psychogeriatric services in Britain. Browning and Stacey's (1999) conclusion that "in Australia, older people have the lowest rate of consulting a psychologist of any age group" (p.79) has been echoed by a more recent Victorian phone survey finding no psychologists within the Victorian rural aged care services and, within a whole metropolitan mental health sector, only two psychologists employed within aged care, as compared to 28 in <u>one</u> child and adolescent service alone (Gluyas, Wrigley & Bryant, 2004).

Correspondingly, Jorm (1994) found that only 86 per 100,000 of women 65 years and over had consulted a psychologist over a two week period with 38 per 100,000 of older

men. A more recent analysis of data from the National Survey of Mental Health and Wellbeing (Parslow & Jorm, 2000) confirms that people in older age groups are less likely to see psychologists and be seen instead by general practitioners than those in younger age groups. In a further survey analysis, older adults were also more likely receive medication compared to younger age groups for mental health problems (Parslow & Jorm, 2001). The composition of aged care service teams also indicates a paucity of psychology involvement, with psychologists representing 10% of total health professionals within teams compared to psychogeriatric nurses making up 44% of teams within NSW (Faculty of Psychiatry of Old Age, 2001). The concerns of David Stokes, Manager, Professional Issues within the APS, related to “was the role of psychology identified in the ACATs? Is there any clear understanding of the contribution that psychologists can make to the management of difficult behaviour, mood disorders and family issues? (2004, p.12)” indicate that the status of clinical geropsychology in Australia is currently extremely limited and requiring scrutiny and redress. This has already begun with results from an online member survey published by the National APS as part of its 2007 National Psychology Week activities regarding attitudes towards ageing. 1,507 respondents replied, indicating positive attitudes towards ageing in terms of psychosocial loss, physical change and psychological growth. Sixty percent of respondents also indicated that there were positive aspects to growing old (Mathews, Linder & Collins, 2007).

The recent inclusion of psychology items in the Australian Medicare reimbursement system is welcome but is still restricted to 12 sessions and requires a mental health treatment plan to be established by the client’s general practitioner. In the US, the Omnibus Budget Reconciliation Act of 1987 has permitted licensed psychologists and

clinical social workers to qualify for Medicare rebates as independent mental health providers. Amendments include the Nursing Home Reform Act (1987), which highlights psychological services in long term care facilities and the need to document attempts at psychosocial interventions prior to resorting to any type of physical or chemical restraint (Spira & Koven, 2005). The most recent improvement has been the introduction of six new “Health and Behaviour” US Medicare items in 2002 to promote the use of psychological interventions for health problems. Policy recommendations to improve access to psychological services to older Americans via Medicare have also been put forward (Karlin & Humphreys, 2007).

III. SURVEYS OF PSYCHOLOGICAL SERVICES TO OLDER ADULTS: INTERNATIONAL PERSPECTIVES

Is this local condition congruent with international levels of psychological involvement with older clients, despite other countries often having lowered financial barriers to older people seeking psychological care? The majority of published surveys have emerged from the US and indicate issues of concern in the area of clinical psychology with older populations.

In 1978, Dye reported a survey of over 1,000 responses from US clinical psychologists for the specific purpose of examining their involvement with older American clients. Breakdowns of practice patterns indicated that a third of clinical psychologists had experience with older clients, mainly in private practice settings. However a third of those sampled indicated a significant number of negative beliefs about the ability of older clients to benefit from therapy. About 20% of the sample indicated they would prefer not to work with older clients and a notable variable here was present exposure to older people within their case loads. The study concluded that although the sample of psychologists indicated knowledge and interest in working with older clients, the strength of negative stereotypical beliefs was of particular concern and required intervention via more specialist tertiary training and clinical experiences in the area. The poor response rate of 19% is also worthy of comment, and raises the possibility of an over-representation of psychologists working with older clients, as those with less interest and experience may not have responded.

Less positive findings emerged from a later study (Gatz, Karel & Wolkenstein, 1991) of Los Angeles County psychologists where only 4.4% of psychologists served older adults, again primarily in private practice settings. Examining the number of actual specialists in the area (defined as psychologists spending at least 50 to over 75% of their clinical time with older adult clients) through three separate surveys suggested that less than 1% of US National Register psychologists met this definition of a specialists in the area (Gatz, Karel & Wolkenstein, 1991).

The role of reimbursement in influencing psychologist involvement in aged care was examined by Barrick, Karuza and Dundon (1995) in their survey of New York State psychologists. Reporting higher figures than the previously cited surveys (older adults here made up 8% of psychology practice consumers), lack of social support networks and low levels of reimbursement were the two main barriers to psychologists providing services to older adults. Interestingly, beliefs regarding the older clients' suitability for therapy (specifically, resistive behaviour and lack of therapeutic compliance) were the next most commonly listed reason for psychologists not seeing older adults.

The most recent US national survey found that twice as many psychologists will be needed to meet service demands of future clients and stressed the need for specialist training (Qualls et al., 2002). Lee, Volans and Gregory report on a 1995 survey conducted by the Division of Clinical Psychology of the British Psychological Society which estimates that only 6% of new clinical psychology graduates go on to specializing in work with older people. An Israeli study found that 55% of clinical psychologists stated a specific desire not to work with older adults (Shmotkin, Eyal &

Lomranz, 1992). Limited training opportunities, little professional and personal contact with older people and corresponding lack of knowledge about the field were factors linked to such low recruitment levels (Scott, 1998). Such findings are not limited to psychologists and have been mirrored across a variety of health professionals including medical practitioners (Saarela & Viukari, 1995; Schigelone & Ingersoll-Dayton, 2004), physiotherapists (Mount, 1993), dieticians (Kaempfer, Wellman & Himburg, 2002), nurses (Wells et al., 2004) and social workers (Cummings & Adler, 2007; Cummings, Galambos & DeCoster, 2003).

Given the limited numbers of psychologists currently working with older adults, or interested in work with older adults, the next section will examine the factors associated with a positive interest in work with older adults.

IV. PREDICTORS OF INTEREST IN WORKING WITH OLDER ADULTS

An examination of positive influences on future employment with older clients reveals several factors correlating with working in this specialty.

(i)Age

The influence of age as a variable can be linked to Social Identity Theory (Tajfel & Turner, 1979). Here, people see themselves as a member of an in-group, contrasted with those others forming the out-group. In regard to ageing, people rate their own age group as more positive than other age groups in their efforts to maintain a positive self-identity. Therefore, younger people would have a comparatively negative view of older aged people, termed out-group bias. As we age, our schemas regarding older people become more enriched with our own experiences as well as becoming closer with what had been the out-group. With their positive self-identity under threat, middle-aged people may focus more strongly on the negative aspects of the out-group, in this case, elderly adults (Kite & Wagner, 2002).

A meta-analysis of 43 studies examining attitudes toward older people across various age groups (Kite & Johnson, 1988) confirmed that younger adults were viewed more positively in 30 of such studies. Providing specific information about the target older person mediated attitudes, as opposed to simple labels such as "old person". This was replicated in a more recent meta-analysis of 232 effect sizes examinining ageism along with older adults believing there were fewer differences between the young and old (Kite, Stockdale, Whitley et al., 2005). Higher ageism scores on multi-dimensional ageism scales also have been reported in younger subjects (Rupp, Vodanovich & Crede, 2005). Other studies have also examined age as a variable across a variety of

professional groups with a general trend for higher regard for older people when the professionals themselves were older. This finding appears to be particularly strong for general college student samples (Laditka et al., 2004).

An examination of health professional samples suggests that the influence of age is a more complex one with additional factors operating than age *per se*. Studies among nursing samples have had mixed results regarding whether older nurses hold more positive attitudes towards working with older people compared to younger nurses or trainees. Experience is a variable here among nursing samples, as prolonged exposure to dependent, frail and medically sick patients reaffirms stereotypes regarding older people in general in this "in group" of health care providers (Lookinland & Anson, 1995). An Australian study directed at older psychiatrists (Draper et al., 1999) found that positive attitudes towards personal ageing were associated with advanced age and good self-rated health, but that attitudes to one's own ageing had little effect on the types of cases accepted. However concern was expressed about younger psychiatrists holding negative stereotypes regarding psychiatric conditions assumed to be part of the ageing process, which therefore led to letting them go untreated. Addressing this issue in training was strongly recommended in this study. Cummings, Galambos and DeCoster (2003) have examined predictors of employment in gerontological social work and have found that training, elder contact frequency and quality and participation in practice with older clients during training were more significantly associated with working with older clients than age of the social worker.

(ii) Training

A common theme emerging from studies cited thus far is the importance of aging related course content within training. Courses related to aging aimed at directly challenging traditionally held stereotypes regarding older people (for example, that growing old is a negative experience characterized by poverty, ill health and resistance to change) have exerted a positive influence on college students (Shoemake & Rowland, 1993; Angiullo, Whitbourne & Powers, 1996), council employees (Stuart-Hamilton & Mahoney, 2003) and social workers (Cummings & Galambos, 2002).

Closer examination of training factors suggests that knowledge alone may be insufficient to improve motivation for future work with older clients. When including a variable controlling for contact with older clients, clinical experiences, as well as past contact with older adults, such as family or older friends, were found to account for more variance than ageing course content alone (Cummings, Galambos & DeCoster, 2003). *Symbolic interactionism* was put forward as the theoretical explanation for this finding, as attitudes, previously shaped by experience, can be adapted and challenged by additional knowledge and experiences. With increased exposure, older adults (previously the “other” group) now become incorporated into their given social in-group. In their survey of graduate social work students, Cummings et al. (2003) found that both contact and rewarding interactions with older clients, as compared to skills and classes, correlated with being employed in an aged-related clinical setting. Discussion of this finding recommended high quality field placement experiences as being a key factor in attracting graduates to the specialty. A more recent study highlighted the importance of training in improving student perceptions of their own

skill in working with older clients (Cummings & Adler, 2007). However practical considerations such as job availability and pay were also raised as variables influencing whether students worked with older groups (Cummings, Adler & De Coster, 2005).

Much has been written regarding the need for specialised training in the area of geropsychology. In a survey of clinical geropsychology postdoctoral graduates (Karel et al., 1999), longstanding interest in the field of ageing was noted prior to undertaking the course, raising the possibility that factors external to training may be influencing career choices: 31% of the sample stated that their interest in the field began before graduate school, with family experiences being a significant influence (49%). In regard to course content, internships within an aged care setting was the most recommended course component (89%) by graduates in these specialist programs (Karel et al., 1999). The benefits of training experiences were also highlighted in a study of the attitudes and knowledge of psychology graduate students following a geropsychology practicum where lower negative attitudes were noted compared to students who did not complete a specialist placement. Of note is that there were no differences between the two groups on ageing knowledge, again suggesting that contact and experience are the key factors in modifying attitudes and interest (Hinrichsen & McMeniman, 2002). This finding has been supported by a recent Australian survey of PhD students conducting research in an ageing related field that found that personal experiences with older people were more influential in triggering interest in ageing compared to having undertaken a course on ageing (Bartlett, Underwood & Peach, 2007).

Surveys of psychologists suggest that they would welcome further specialist training in geropsychology (Molinari et al., 2003). In the US, such opportunities are available, as over 60% of psychology programs that were accredited by the American Psychological Association (APA) had specific aged course content as reported in Helmes and Gee (2000). Clinical competencies have also been developed for psychologists specializing in the area within the APA that also serve to advise service delivery within the US Department of Veterans Affairs (Molinari et al., 2003). Three national conferences have been held in the US to discuss and plan for optimum training in professional geropsychology, commencing with the "Older Boulder" Conference on Training Psychologists for Work in Aging in 1981, Older Boulder II in 1992 and most recently the Pikes Peak Conference of 2007 (Knight, Karel, Hinrichsen, Qualls & Duffy, 2007). In Britain, a clinical placement within an aged care setting was a compulsory post-graduate requirement until 2006 and core competencies for working with older people as part of postgraduate course accreditation have been developed by the British Psychological Society's Working with Older People Special Interest Group (PSIGE, 2002).

Unfortunately such opportunities are limited in Australia. Only 3.5% of course teaching in approved Australian clinical psychology courses addresses old age practice issues, compared to 20% in the area of working with children (Kneebone, 1996). Since 1996, there has been a specialized training program in geropsychology, now based at James Cook University in Queensland, at post-graduate diploma, and clinical doctoral level, becoming accredited in 1998 (Helmes & Gee, 2000). Training in geropsychology is also available at the clinical doctoral level through the University of Queensland. In a recent Victorian survey of eight universities (Gluyas, Wrigley & Bryant, 2004), only two

courses contain age related content, with Melbourne University being the only institution to offer a unit specifically on psychogeriatrics. Course convenors appear to acknowledge the need for specialist training opportunities (Pachana, O'Donovan & Helmes, 2006) and an audit of psychology programs in terms of gerontology content is currently underway. One sign of some progress has been that specific ethical guidelines for clinical practice with older adults have been published (Pachana, Helmes & Koder, 2006).

(iii) Attitudes

What influence do attitudes exert on choosing to work with older adults? What is the evidence supporting the existence of stereotypes amongst health professionals, in particular psychologists?

Low motivation to engage in clinical practice with older clients has been found to be related to negative attitudes that give rise to discriminatory behaviour across a variety of disciplines (MacNeil, 1991). Health care workers stand accused of avoidance behaviour and of being influenced by ageism in several reports. Specializing with older adults has been viewed as being of lower status in nurses (Wells et al., 2004) and medical officers (Wilkinson & Ferraro, 2002), with the latter professional group accused of developing derogatory stereotype labels for older patients whilst in medical school, such as 'crock" and "gomer" ("get out of my emergency room", p.350).

The last 40 years has produced much literature on ageism in health professionals. Ageism among psychological therapy practitioners has been purported to stem from early psychoanalytic influences regarding the rigidity of the older person and their inability to change, as well as economic considerations about how worthwhile it is to put public funds into a population that generally has less time to benefit from any lifestyle changes as compared to say, children (Wolk & Wolk, 1971; Gatz & Pearson, 1988; Lookinland & Anson, 1995).

The first study raising concern regarding the influence of attitudes on psychological provision of care for older people was in 1978 when Dye found in her survey sample of 1,000 US psychologists that “older persons are perceived as being more rigid, unable to learn as readily and as having less energy available for therapeutic growth than younger persons ” (p.47). Results indicated that psychologists had basic knowledge regarding ageing and the ageing process, but that nevertheless they would prefer to work with younger populations. Concerns were raised regarding elderly clients being given lower service priority on account of attitudes with a small number of psychologists even providing no service delivery.

Gatz and Pearson (1988) further discussed the “reluctant therapist” (Kastenbaum, 1964) phenomenon. Their review of the literature concluded that whilst global ageism may not exist amongst service providers, specific negative biases affecting therapy delivery, particularly in the area of Alzheimer ’s disease, may be an influence. Closer analysis of psychotherapy biases in an Israeli sample of practising clinical psychologists indicated that positive views of psychotherapy with the elderly and past experience in

professional work specializing with this population were the strongest predictors of motivation to work with older adults. Ageism was blamed, with attributes such as rigidity, apathy and passivity of older clients precluding their ability to benefit from therapy, indicated in the responses of this sample (Shmotkin, Eyal & Lomranz, 1992). These findings were replicated in a British study with a survey of 371 trainee psychologists indicating fear of ageing together with general ageist responses influencing their motivation to work in the area. The view that psychiatric disorders were an inevitable part of the ageing process was particularly concerning: "older people's lives, filled with bereavement, failing faculties and limited opportunities are inherently depressing –so what can one do?" (Lee, Volans & Gregory, 2003 p.5).

In further discussions of attitudinal influences, Yarhouse and DeVries (1998) raise the issue of awareness of a clinician's own biases regarding ageing and the influence of past exposure to older adults, in particular in the areas of dependence, dying and death. The impact of such experiences and attitudes on the therapeutic relationship with an older client needs to be overtly recognized by clinicians to enhance ethical practice. In a subsequent survey of clinical psychologists, the authors found higher ethical behaviour with their elderly clients in those psychologists who had more training, were working with older adults and who decided to specialize in the area of geropsychology (Yarhouse & deVries, 2000).

Treatment biases have also been studied in an implicit manner by manipulating age in assessing clinical behaviour. James and Haley (1995) found a health, rather than age, bias in their sample of 371 psychologists given a clinical vignette where subjects were

asked to comment on diagnosis, suitability for psychological therapy, treatment recommendations and prognosis for a 35 or 70 year old client in either good or cardiac compromised health. The sample rated the older subject's condition as less suitable for psychotherapy, assigning a negative prognosis. The authors raise the possibility of an interaction with age and chronic physical illness in influencing clinical perceptions. Helmes and Gee (2003) replicated the age-related biases regarding suitability for therapy and prognosis when manipulating age in their clinical vignettes and also found less motivation amongst their psychology sample, although there was a high degree of accuracy in detecting depression regardless of client age.

However some doubt has been cast on the strength of such reported ageist attitudes in affecting motivation to work with older clients (Knight, 1986; Robb, Chen & Haley, 2002). What also requires clarification is the nature of instruments used to measure attitudes, which in turn is influenced by how this construct is defined. The relationship between knowledge, stereotypes, attitudes and behaviour is a complex one, with little consensus regarding definition and measurement. The above discussion supports the need for knowledge in the area of ageing but also raises the hypothesis that positive experiences are critical in influencing attitudes and subsequent motivation to work with older adults. Further discussion on the constructs of "attitude" and "ageism" is relevant.

V. THE ROLE OF ATTITUDES AND THEIR EFFECT ON BEHAVIOUR

(i) Definition and historical perspectives

The study of attitudes has been a major focus within social psychology since the 1920s with the earliest definition emerging from Gordon Allport in 1935: "An attitude is a mental and neural state of readiness, organized through experience, exerting a directive or dynamic influence upon the individual's response to all objects and situations with which it is related" (p.810). The word is derived from the Latin *aptus* meaning "fit and ready for action" with current conceptualisation of the term referring to "a construct which, although not directly observable, precedes behaviour and guides our choices and decisions for action" (Vaughan & Hogg, 2005 p.97).

This two- component model of attitude, where an inferred mental process has an influence on judgemental responses, has been expanded to include behaviour with the tripartite model of attitudes comprising of affect, behaviour and cognition (Vaughan & Hogg, 2005). These components manifest respectively as prejudice (affect/emotion), discrimination (behaviour) and stereotyping (cognition or knowledge). Allport (1954) highlighted categorization as a natural consequence of judgement where objects are grouped based on perceived similarities and over generalizations. A group that is perceived as not possessing shared characteristics with an observer is deemed the "out-group" with the "in-group" promoting feelings of belonging due to perceptions of similarities. Social Identity Theory (SIT) developed from this original work to explain the development and maintenance of group stereotypes (Tajfel & Turner, 1979). Positive self-identities are maintained in an individual by perceiving a distinction between their in-group and the "other" or out-group. Negative stereotypes are a

consequence of motivation to elevate in-group over the other as they serve to exaggerate inter-group differences (Kite & Wagner, 2002).

(ii) The relationship between attitudes and behaviour

There is much controversy regarding the assumption that attitudes can reliably predict behaviour, with correlations as low as 0.15 being common (Wicker, 1969). Fishbein and Ajzen (1975) discuss variables that affect the strength of the relationship between attitudes and behaviours, such as the strength of beliefs and intention to act (or volition). Defining specific behaviours in specific situations was also a key factor rather than trying to predict specific behaviours from general attitudes. Therefore stronger beliefs lead to stronger intentions, increasing the likelihood of an observable action (behaviour) to maintain cognitive consistency - a more desirable state than cognitive dissonance. Their model states that a person will perform an action if both their attitude and their perception of the social norm is positive and if they perceive they have a high level of control over their behaviour. Other moderators of the attitude-behaviour consistency relationship are the amount of cognitive elaboration, ambivalence and stability of attitude, and increased accessibility and certainty (Petty, Wegener & Fabrigar, 1997).

(iii)The contact hypothesis

The contact hypothesis (Allport, 1954) grew out of studies regarding improving intergroup relations, specifically in the area of racial prejudice. The theory purports that in order to achieve positive attitudinal change towards an out-group, prolonged and co-operative interactions are necessary between the perceived in-group with the out-group.

Equal status between the two groups was also deemed to be a necessary condition. Contemporary views of the contact hypothesis have expanded Allport's initial proposed conditions to include the need for contact that serves to dispel stereotypes regarding the out-group. A particular out-group member also needs to be seen as representative of that group.

In their study of racial prejudice in high school students, Wittig and Grant-Thompson (1988) found that five contact conditions were all necessary in order to change attitudes towards outgroups:
"(a) voluntary contact supported by authority figures, (b) equal-status contact, (c) co-operative and inter-dependent contact, (d) contact providing the potential for forming friendships across groups, and (e) stereotype disconfirming contact." (Schwartz & Simmons, 2001, p.128). Contact quality has also been found to be more critical to favourable attitudes than contact frequency in regard to positively changing racial stereotypes (Allport, 1954; Wittig & Grant-Thompson, 1998). However limitations related to the ecological validity of these conditions in that they are unlikely to be met in the more common encounters between different groups have been discussed, together with inconsistencies in the definition and measurement of contact (Dixon, Durrheim & Tredoux, 2005).

These issues will now be discussed as they apply to attitudes toward older people.

VI. AGEISM: ATTITUDES TOWARDS THE ELDERLY

(i) Definition, historical perspectives and application of attitude models to older groups

Ageism is a term first coined by Robert Butler in 1969 to refer to negative stereotypes and discrimination against people on the basis of their age. It is unlike other stereotypes such as racism or discriminating on the basis of gender or ethnicity because all people have a chance (obvious factors such as health permitting) to become members of this out-group: that is, grow old. Applying the afore-mentioned SIT model, the in-group will in time become members of the out-group. Younger people are defined in the ageism and SIT context as the in-group with older adults being subjected to out-group biases as younger and middle aged people evaluate their own age group more positively in order to maintain a positive self-identity (Laditka et al., 2004). One must be wary of over-simplification when applying social identity theory to ageism, as all out-groups are not summarily disliked. In this case, members of the in-group ("young") seek out positive distinctions compared to older adults, which is relatively simple: they are not old. SIT theory predicts that the closer an individual gets to their definition of old age, the more complex their attitudes will be. Social mobility and social creativity often come into play, resulting in avoidance behaviour in seeking to maintain in-group identity. Variables such as the salience of particular time periods or situations (for example, one's 50th birthday or retirement circumstances) also influence an individual's perception of membership of either in- or out-group (Kite & Wagner, 2002).

In a review of studies on ageist stereotype process and content, Cuddy and Fiske (2002) conclude that older Americans are thought of as physically and mentally incompetent

but warm, with low status in society. This in turn leads to discriminatory behaviour in a variety of settings such as the workplace and denying appropriate medical treatment.

The meta-analytic study examining the influence of age on attitudes toward older adults cited earlier (Kite, Stockdale, Whitley et al, 2005) also found in its analysis of 232 studies that attitudes towards the elderly were significantly more negative than those towards younger people (Kite, Stockdale, Whitley et al., 2005). Physical attractiveness and to a lesser degree, competence, were the dimensions where most extreme differences depending on age were noted. The authors suggest that being presented with additional individuating information may prevent stereotypes being activated, leading to positive attitudes towards the older person. This is congruent with the tripartite model of attitudes where the knowledge, or cognitive function of attitudes, can be modified by providing material that contradicts categorization or generalizations that are the basis of prejudice (behaviour), as discussed earlier (Lookinland & Anson, 1995). Further support for the multi-dimensional nature of ageism comes from confirmatory factor analytic studies identifying affective constructs, as well as cognitive, in analyses of responses (Rupp, Vodanovich & Crede, 2005).

One example of prejudicial behaviour towards older adults would be avoidance of work with this population. This is also a result of applying Fishbein and Ajzen's (1975) model of intentions mediating attitudes. Here, negative attitudes result in lower intent or interest in working with older groups, which is in keeping with the literature with low health worker preferences in the area of old age (MacNeil, 1991). Conversely, positive experiences and knowledge regarding an undesirable group can lead to increased willingness to work with this out-group (Kane, 2003).

There has been considerable interest in applying the contact hypothesis to the study of attitudes toward the elderly. Caspi (1984) extended the model from improving inter-racial relations to include inter-age interactions in his study of the positive effects of exposure to elderly teaching aides on the attitudes of children. It has also been examined in the context of family relations, specifically in the area of amount and quality of contact with grandparents positively influencing attitudes towards older people (Harwood et al., 2005). An interaction between having positive attitudes towards the elderly, having personal experience with elderly people and subsequent interest in ageing, was found in graduate research students in ageing in a recent Australian study (Bartlett, et al., 2007). However other studies have found contradictory results with health provider groups such as physicians and nursing students where elderly patients were rated as more dependent and ineffective compared to middle aged patients in the health care groups that had increased contact compared to those who had little or no contact.

The influence of contact quality was first raised by Caspi (1984) and studied in depth more recently using social work samples (Cummings & Galambos, 2002; Cummings, Galambos & DeCoster, 2003; Cummings, Adler & DeCoster, 2005; Cummings & Adler, 2007). Initial study using multiple regression analysis of surveys completed by recent graduate social workers (Cummings & Galambos, 2002; Cummings, Galambos & DeCoster, 2003) revealed that both frequency and quality of contact with older clients and family members were the most significant predictors of age-related work when compared to training and knowledge in the area of aged care. Application of this finding to the definition of attitudes suggests that the most positive influence can be

attained at the affective level rather than the cognitive level: that is, favourable emotions, a result of higher quality contact, change attitudes as opposed to simply correcting erroneous beliefs (stereotypes) by increasing knowledge. Recent research involving contact with older grandparents and its influence on attitudes focused on the affective variable in intergroup contact acting as a mediator either in a positive (promoting empathy) or in a negative (causing anxiety) direction (Harwood et al., 2005).

Further work with social work samples plus recent criticisms of the contact hypothesis has introduced the variable of specificity or relevance: here, it is quality of contact with older clients plus age related skills that have been found to be the most powerful predictors of interest and future employment with older clients amongst social workers, rather than simply having general contact with an older person *per se* (Cummings & Adler, 2007).

(ii) <u>The measurement of ageist attitudes</u>

Despite the prominence of attitudes as a key concept in social psychology, there is little consensus as to the measurement of attitudes in the area of perceptions of elderly people.

Tuckman and Lorge (1953) developed the first published attitude questionnaire concerning older adults specifically. The Tuckman Lorge Questionnaire (TLQ) consists of a series of 137 negatively worded short statements about the elderly, originally developed from popular stereotypes. Thirteen content factors emerge from the statements, which require a yes/no response. Further analysis of the scale has

highlighted psychometric inadequacies with problems particularly in internal consistency (Cowan et al., 2004). The scale also fails to distinguish between the respondent's beliefs or factual knowledge and their attitude (Braithwaite, Lynd-Stevenson & Pigram, 1993).

In a response to the psychometric flaws of the TLQ, Kogan developed the Attitude Toward Old People Scale (1961), the KOP), consisting of 17 matched positive-negative pairs of Likert statements reflecting attitudes towards the elderly. Despite adequate split-half reliability (.66-.83), the scale has been criticized for being difficult to adapt for other age groups in comparative studies (Knox, Gekoski & Kelly, 1995). Other criticisms of the scale were the use of ambiguous terminology, confusing factual and attitudinal statements and little, if any attention to the relationship between attitude and behaviour (Cowan et al., 2004) and attitude and intention to work with older people (Knight, 1986), which is not congruent with current conceptual models of attitude.

Rosencranz and McNevin's (1969) Aging Semantic Differential (ASD), although still widely used, had difficulties even with its original design, restricting the study to perceptions of old men, which precludes the study of attitudes towards women. The ASD is comprised of 32 adjective pairs arranged in a seven- point Likert scale to be rated with three factors emerging: Instrumental-Ineffective, Autonomous-Dependent and Personal Acceptability-Unacceptability. Again, failure to distinguish between attitude and stereotype is a major criticism of the scale and concern has been raised as to the actual construct being measured, with the original factor structure being unable to be replicated (Knox, Gekoski & Kelly, 1995). A more contemporary revision of the ASD (Polizzi, 2003) avoided the use of generalized terms such as "old" or "elderly" as

those terms themselves can produce a response bias in assessing attitudes and added women aged 70-85 years of age as the target group. This new instrument resulted in four factors: attitude, intelligence/importance, health/confidence and physical appearance. Gender differences were found in loadings on all four factors in terms of attitudes towards men and women, an improvement on the original scale. Unfortunately the reliability of rating general adjectives is lowered considerably when specific situations and more information is provided about the target's behaviour (Braithwaite, Gibson & Holman, 1985-86).

The Facts on Ageing Quiz (FAQ) by Palmore (1977) was developed to directly measure knowledge of basic physical, psychological and social facets of ageing. The 25 item true/false instrument has been extensively used to evaluate the effects of training and educational programs in gerontology within professional groups such as nurses (Wells et al., 2004; Gething et al., 2002; Gething, 1994) and clergy and council workers (Stuart-Hamilton & Mahoney, 2003). Using this quiz for other evaluative purposes such as measuring attitudes, as opposed to factual knowledge, is invalid with low correlations with attitudinal measures that rely on judgements or perceptions (Gething, 1994; Stuart-Hamilton & Mahoney, 2003). High FAQ scores (indicating good knowledge of ageing) also did not correlate with extensive exposure to working with older adults and vice versa (Stuart-Hamilton & Mahoney, 2003). Ambiguous terminology in the instrument such as "most" also adversely affects its reliability and a more recent multiple-choice format has been found to lessen the chance of false positives, improving the instrument's sensitivity (Harris, Changas & Palmore, 1996). Despite its popularity, studies using the FAQ continue to demonstrate low correlations between FAQ scores and age-linked biases, as reported in the Cowan et al. (2004)

review of the instrument. It has been used in an Australian psychology sample with little discrimination between experienced and less experienced specialists in the field of gerontology. In this study, age itself was not a predictor of knowledge, raising issues regarding the validity of the quiz in measuring ageing knowledge (Rye & Pachana, 2003). The FAQ may well be measuring awareness of stereotypes as opposed to knowledge of the facts themselves.

The Fraboni Scale of Ageism (FSA) (Fraboni, Saltstone & Hughes, 1990) was developed to account for the different dimensions inherent in ageist attitudes. Having identified the lack of affective components in existing ageism questionnaires, the authors developed the 29- item scale to incorporate affective and behavioural elements not limited to cognitive components so as to be congruent with theoretical beliefs regarding the constructs underlying ageism. Three factors (antilocution, avoidance and discrimination) emerged from initial factor analysis. Further re-evaluation redefined the factors as stereotypes, separation and affective attitudes based on confirmatory factor analysis (Rupp, Vodanovich & Crede, 2005).

(iii)Implicit ageism

As discussed previously, ageism is unique compared to other areas of prejudice. One of the aspects that makes it so is the lack of overt recognition of its existence, partly due to no concrete organization representing members of the in-group who discriminate, in contrast to racism with hate groups who target particular visible religious or racial minorities. This has raised concerns regarding the implicit nature of ageism and the lack of public recognition as to its negative effects (Levy & Banaji, 2002). In fact, it can be viewed as the most widely accepted stereotype in the community, as demonstrated

through literature and the mass media. This has led to interest in the area of age stereotypes and attitudes that are beyond conscious control.

The existence of implicit ageism may account for the afore-mentioned difficulties in measuring explicit stereotypes and attitudes. The Implicit Association Test (Greenwald, McGhee& Schwartz, 1998) was developed to measure implicit cognitions by measuring response time latencies to two sets of pairings-one is the attitude object, in this case, young-old, the other a judgement or knowledge dimension pair (for example: home-career; strong-frail). Longer response times are thought to reflect weaker associations. A recent review revealed far stronger negative associations of old age-related pairings using the Implicit Association Test across all ages compared to explicit attitude studies (Levy & Banaji, 2002). The authors explain the maintenance of ageism into old age by postulating that older adults have had many years to accumulate stereotypes regarding older adults, which prove challenging to shift once internalized. Increased exposure to positive older role models is suggested as one way to combat automatic assumptions about older people. However, the Implicit Association Test has come under criticism for low predictive validity in weak relationships with behaviour when compared to a stronger association between explicit attitudes and consequent behaviour (Karpinski & Hilton, 2001).

(iv) Measures and attitudes towards one's own ageing

Butler's original model of ageism recognized that ultimately ageing would affect oneself, which accounts for fear of ageing as being central to the concept of ageism. This fear gives rise to social distancing that can be manifested as lack of interest in

working with older adults. Western culture in particular recognizes the threat of growing old as: “the threat to the young of their own fate: the prospects of diminishing beauty, health, sensation and ultimately death” (Greenberg, Schimel & Mertens, 2002, p.29).

Terror Management Theory has further developed this idea that ageism is a way humans manage their fear of their own inevitable death (Martens, Goldenberg & Greenberg, 2005). This theory focuses on death related anxiety that needs to be kept in control by avoidance of elderly people who remind us of our own mortality and inevitable decline. The role of fear and anxiety as central to ageism is highlighted here. Prejudice functions as a defence mechanism against the threat to self-esteem and mortality that the elderly provide consistently.

The Reactions to Ageing Questionnaire (Gething, 1994) was developed to measure attitudes to personal ageing as opposed to judgements of others, or the societal/social level of attitudes towards a particular group (Leonard & Crawford, 1989). It is a 27 item questionnaire where respondents rate their level of agreement or disagreement regarding emotions related to common aspects of ageing across a six point Likert-type scale. It has been validated in groups of nurses (Wells et al., 2004; Gething et al., 2002) and in a survey of Australian older psychiatrists (Draper et al., 1998). It has also been studied internationally to compare personal ageing attitudes amongst nurses in three countries (Gething, Fethney, McKee et al., 2004), amongst Pacific Islander health students (Gattuso & Shadbolt, 2002) and in comparing Australian rural and urban students (Gattuso & Saw, 1998). It has also examined the predictive validity of

reactions towards one's own ageing against a variety of highly relevant variables such as age, clinical training and experience in geriatrics and knowledge of ageing (Wells et al., 2004; Gething et al., 2002). Reliability across studies has been very high with a mean of 0.9. Reported factor structures including fear of "frailty" (Wells, Foreman, Gething et al., 2004), and with items in the RAQ predominantly loading on "anxiety about the future" (Gething, 1994) suggest that the instrument may be tapping into an anxiety construct such as that postulated by Terror Management Theory.

CONCLUSION

Including attitudes towards one's own ageing may introduce an aspect of the attitude construct that has been largely ignored: that of emotion or affect. Thus far, research has concentrated on beliefs and knowledge or discriminatory practices towards the elderly: the group has been viewed from an objective perspective, rather than a subjective one. Examination of one's own emotions related to growing old may illuminate the role of emotion in forming attitudes and influencing behaviour.

The contact hypothesis also deserves closer attention in light of previous findings that it is the quality of contact, rather than the quantity, that influences preferences to work with older adults professionally. This may also be mediated by an affective component with higher quality information circumventing previously held stereotypes. Quality contact itself assumes positive affect regarding exposure to the older person.

CHAPTER 2

OVERVIEW OF THE STUDY

I. RESEARCH QUESTIONS

Analysis of influences on attitudes and behaviour towards older clients is timely, given the expected increase in the proportion of older adults in the populations of developed countries. Identifying key predictors of positive attitudes and behaviour would direct future planning regarding geropsychology training and service provision in Australia, with consideration of current developments internationally.

The following series of studies aims to examine the affective component of the tripartite model of attitude formation (affect, behaviour, cognition) in the attitudes of psychologists towards working with older clients. The contact hypothesis is also of specific interest in order to replicate findings that highlighted the importance of the frequency and quality of contact with older adults in social work samples previously surveyed. Specific variables such as knowledge about older adults, attitudes towards ageing, training in assessment and interventions with older adults, clinical and personal contact, and confidence and interest in working with this population will be examined to assess their contribution as to whether or not a psychologist specializes in working with older adults. Necessary conditions for change in ageist behaviour will be discussed, with particular focus on emotions, as opposed to the existing interventions that operate at the cognitive level, as has been the case thus far.

The applied aspect of the present research aims to identify those factors that are predictive of a psychologist wanting to work with older adults, in order to prepare to meet the future demand for psychologists in the areas of both aged care and health care services more generally. Demographic variables are investigated, including gender and age, and aspects of training, which include the amount and satisfaction with coursework and clinical placements. These factors are surveyed in the present research which examines in some depth the current status of geropsychology in Australia. In order to gain possible insights into the directionality of interest among practising psychologists, variables in student interest in aged care are also explored.

The specific questions posed by this exploratory research are:

1. What is the current status of geropsychology in Australia? What proportion of psychologists specialize in health care service delivery to older adults and how does this compare to other countries?
2. What factors are related to whether a psychologist specializes in working with older clients? Are demographic, training, contact or attitudinal variables more important in contributing to a psychologist working with older people?
3. What are the characteristics of current training and work practices in geropsychology?
4. What is the level of interest among Australian trainee psychologists in working with older adults as clients? What factors are associated with levels of interest among trainees?
5. What factors predict positive attitudes towards personal ageing, as measured by the Reactions to Ageing Questionnaire (RAQ - Gething 1994), among Australian psychologists and how do these compare to other professions?

6. How do predictors of interest differ between psychology practitioners and future psychologists in order to identify possible strategies to increase the interest and number of psychologists actually working with older clients?

II. OUTLINE OF STUDY

The present research aims to answer the above questions through six projects. These involve six separate published research papers that have been developed from the results of three independent surveys of practitioners and students.

The first survey involves a pilot study of 201 Sydney-based practising psychologists (Study 1) in order to provide initial directions in terms of findings, questionnaire development, and survey implementation. The main project concerns a national survey of practising psychologists (Study 2) to address the main theoretical and service delivery questions posed above. Study 3 combines the pilot data and main survey data to gain a full national description of geropsychology training and service delivery patterns. In order to gain further insights into directionality and origins of interest and to assess the importance of training in the decision to specialize in clinical work with older adults, trainee psychologists are also surveyed nationally (Study 4). The predictors of attitudes towards growing old are examined through an analysis of RAQ score predictors (Study 5). Finally, predictive factors related to interest in working with older adults are compared between practitioners and trainees (Study 6).

CHAPTER 3: PILOT STUDY (Study 1)

Clinical Psychologists in Aged Care in Australia: A Question of Attitude or Training?

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Abstract

Despite increasing numbers of older people in the Australian population, few psychologists work with this segment of the population. The prevalence of psychological disorders in this age group is substantial and there is increasing evidence for the effectiveness of psychological treatments for these conditions in older adults. This study explored the reasons for the limited number of psychologists who work with this growing population. A survey of over 500 Australian psychologists based in Sydney, Australia, used the Reactions to Ageing Questionnaire (Gething, 1994) to assess attitudes, and other questions inquired about training, current practice, and interest in work with older adults. The response rate was 39%, with 17% of the respondents being specialists in work with older adults. Stereotyped attitudes did not differentiate specialists from generalists, but interest in therapy with older adults did, along with age, years of practice and working in an aged care setting. While the limited survey restricts the generalizability of the results, they do suggest that training in itself is not sufficient to overcome a reluctance to work with older adults. Supervised practice settings appear to be effective, but greater efforts are needed to increase both academic training and work settings for work with older adults in Australia.

Introduction

Projections regarding the number of Australians aged over 65 highlight substantial increases, especially within the next 10 years when the first members of the Australian baby boom generation reach 65. Currently, 12% of Australia's population is over 65 years of age with projection estimates in 2031 of 25% in this category (Australian Bureau of Statistics, 1998). Associated with such an increase are estimates of psychiatric disorders ranging from 6.1% (McLennan, 1998) to 20% in the over 65 age group by 2020 (Brodaty, 1991).

As a result of this demographic change, there will be an increasing need to provide psychological services to future older Australians, whether it be in the area of mental health service provision or within the physical health domain (for example, prevention programmes, behavioural health management for chronic diseases). Despite this need that is evident in several countries, concern has been raised regarding the paucity of psychologists servicing clients aged over 65, both in Australia (Koder & Ferguson, 1998; Phillips, 1989) and in the U.S. (Qualls, 1998; Haley, Salzberg & Barrett, 1993). The local service delivery pattern was found to be inadequate in a survey comparing Australian psychogeriatric services to those in Britain (Snowdon et al, 1995), with half the number of psychologists allocated to comparable services in Australia and psychologists having the lowest ratio compared to other disciplines in terms of service delivery to older adults (1 psychologist to 66,200 elderly clients). Ageism on the part of service providers and referral agents has been cited as one of the main explanations for such a lack of psychological service (Helmes & Gee, 2003; Koder & Ferguson, 1998).

There is increasing evidence that psychological treatments such as cognitive-behaviour therapy in the treatment of depression (Koder, Brodaty & Anstey,1996; Gallagher-Thompson & Thompson, 1995), anxiety (Stanley et al, 2003; Wetherell, Gatz & Craske, 2003), and behavioural management for challenging behaviours in dementia (Bird, Llewellyn-Jones, Smithers et al, 1998) are as effective for older populations as in younger age groups. Additionally, psychological approaches have also proven to be cost-effective in physical health settings, for example, in reducing the use of hypertensive medication, reducing visits to primary physicians in the case of somatoform disorders (Friedman et al, 1995), and reducing hospital stays following cardiac surgery (Mumford, Schlesinger & Glass, 1982). Cognitive-behaviour therapy has been found to significantly lower disability and psychological distress associated with chronic physical illnesses such as arthritis and pulmonary disease (Kunik et al, 2001; Kemp, Corgiat & Gill, 1991/2).

The Psychology and Ageing special interest group of the Australian Psychological Society has recognized the need to address issues concerning older Australian adults in its position paper contributing to the International Year of Older Persons (Gridley, Browning, Gething et al, 2000). Among recommendations emerging from that report are two that involve both psychological service delivery and the impact of ageism, namely that "health providers, including psychologists, take steps to address the issues of ageism in service delivery for older people" (Gething, Gridley, Browning et al, 2003, p.3) and that "the APS develop a policy concerning the role of psychologists in aged care" (Gething et al, 2003 p.8). Such a goal has been partially addressed through analysing trends in research and service delivery regarding older people (Wells, 2005;

Helmes, 2003) and recent publication of recommended ethical practice guidelines in working with older adults (Pachana, Helmes & Koder, 2006).

Therefore the field of clinical geropsychology appears to be very much in its infancy in Australia compared to the United States, where training in this specialty has been recognized as needed, with well recognized standards for practice (American Psychological Association, 2003; Knight, Teri, Wohlford et al, 1995) and in the comparable specialty of aged care psychiatry - amongst world leaders in the field (Camus, Katona, Lima, et al, 2003).

Gatz, Karel and Wolkenstein (1991) found that only 4.4% of U. S. psychologists specialize in servicing older adults. Such work has led the way for more scientific discussion on possible solutions, but such studies have been heavily skewed towards the examination of trainees and training issues (for example: Lee, Volans & Gregory, 2003; Qualls, 1998). While there is an association between exposure to older clients in training, geropsychology course content and the likelihood that a trainee will choose to specialize in working with older populations (Hinrichsen & McMeniman, 2002; Karel et al, 1999), ageism has been put forward as one of the most powerful biases across various professional practitioner groups. Negative stereotypes among practitioners may have been influenced by early psychoanalytic theory that emphasized the rigidity of the older person leading to their inability to change. Furthermore, economic considerations about how worthwhile it is to put public funds into a population that generally is presumed to have less time to benefit from any lifestyle changes compared to, say, children, have also been cited as adversely influencing attitudes and employment patterns (Lookinland & Anson, 1995; Gatz & Pearson, 1988; Wolk & Wolk, 1971). The

dearth of knowledge regarding the ageing process in Australian students (48.4% correct responses on the Facts on Ageing Quiz, Rye & Pachana, 2003) is more recent evidence for ignorance among psychology trainees in the field of ageing.

The only systematic study examining correlations between knowledge of ageing, negative attitudes and their influence on the role of clinical psychologists was carried out in 1978. Dye conducted a survey on over 1,000 U.S. clinical psychologists for the specific purpose of examining their involvement with older American clients. Breakdowns of practice patterns indicated that a third of clinical psychologists had experience with older clients, mainly in private practice settings. A third of those sampled indicated a significant number of negative beliefs about the ability of older clients to benefit from therapy.

A frequent criticism of such studies is the lack of a reliable and valid questionnaire specifically targeting ageist attitudes as the outcome measure. A questionnaire (The Reactions to Ageing Questionnaire; RAQ) has been recently developed for this purpose with a recent validation study (Gething, 1994; Gething, Fethney, McKee et al, 2002), suggesting misconceptions and ageism existing among British and Australian nurses. It has also been utilized in the RANZCP Senior Psychiatrist Survey (Draper, Gething, Fethney & Winfield, 1999) with positive attitudes towards personal ageing being linked to age, gender and self-rated good health. A large-scale survey examining predictors of negative attitudes towards older adults using the RAQ carried out by the Lincoln Gerontology Centre at La Trobe University in Victoria found a lack of education in gerontology as a significant factor (Wells, Foreman, Gething, & Petralia, 2004). The

measure is notable in measuring attitudes towards ageing in a less direct way by measuring one's own attitude to ageing. While not directly targeting implicit cognitions in the vein of the Implicit Association Test (Greenwald, McGhee & Schwartz, 1998), nevertheless it is less prone to response biases and has better validity compared to the Ageing Semantic Differential (Rosencranz & McNevin, 1969) while having a significant correlation with the latter.

The Present Study

Despite the aforementioned concerns regarding Australian psychologists, their limited numbers in aged care settings, lack of training and exposure, and the role of provider stereotypes, no empirical study has been carried out to evaluate the extent of these factors in practising psychologists.

Specific characteristics including working exclusively with older clients, post-graduate training in geropsychology, and membership of the Psychology and Ageing special interest group were examined in terms of their relationship with scores on the ageism questionnaire. Outcomes of interest were the factors influencing a psychologist specializing in the field of geropsychology to direct future training and development of this much-needed specialty.

Method

A survey questionnaire was sent to persons listed under the heading of "psychologist" in the Sydney Yellow Pages telephone directory. Surveys were also distributed to psychologist attendees at the Anxiety Research Network Conference held at Macquarie University, Sydney in November 2004. Psychologists who were members of the Australian Psychological Society's "Psychology and Ageing" Interest Group within the Sydney Metropolitan Region were also invited to participate in the survey.

In addition to the Reactions to Ageing Questionnaire, this survey included demographic variables such as age, gender, years in practice, primary work setting, theoretical orientation, degree, years since graduation, amount of coursework/training in ageing issues, and practice and exposure to older adults in clinical placements. Variables related to the actual potential of encountering older clients within a particular clinical setting were also recorded. Qualitative issues around satisfaction in certain areas such as amount of training involving elderly clients, exposure during clinical *practica*, and interest and confidence when working with older clients were measured. The survey also contained specific items examining attitudes towards conducting therapy with older clients.

Follow-up surveys were sent to the whole sample four weeks after the first mail-out.

Results

Participants

In total, 516 surveys were sent out with an initial response rate of 26.3%, rising to a final response rate of 39% (n = 201) following the second mail-out. A higher response rate was achieved by the specialist group (66% vs 36.1% of psychologists who did not practise predominantly with older clients).

Nine cases were missing one or more response on the continuous variables, representing 4.5% of the sample. These cases were excluded only if they were missing data required for the specific analysis being performed or were calculated as an outlier case ($z > 3.29$, $n = 1$ within RAQ data), as recommended in Tabachnick and Fidell (2001).

Of the total sample, 83.1% of respondents met criteria as “generalist” psychologists with 16.9% being defined as specialists, meaning that over 50% of their total clinical caseload involved working with clients aged over 65.

Ages ranged from 27 to 80 [M= 48.71, SD = 11.39), with 25.9% males and 72.6% female (3 missing). Experience (as measured by how many years spent working in psychological practice) ranged from 1 year to 52, with a mean of 15.58 (SD = 10.56).

Comparison between generalist psychologists and psychologists specializing in aged care.

Tables 1-3 report comparisons between generalists and specialists on demographic, training and attitudinal variables respectively. Significant differences were obtained between the groups on age, with specialists being younger. Similarly specialists had less experience and were more likely to be working within the government sector as opposed to private practice. The specialists also had correspondingly more confidence and interest in working with older adults. The groups did not differ on their RAQ scores or on specific items relating to attitudes regarding conducting therapy with older clients. There were no gender differences between specialists and generalists.

In terms of categorical variables measuring training, education, clinical activities and therapy model, significant differences were obtained in the area of having participated in specific geropsychology training and having experienced a specialist geriatric area placement as part of their degree. Specialists were also found to be more likely to hold Masters level qualifications, work within the government sector and have working with challenging behaviours and carers as major components of their clinical work. APS College membership or having an aged care course component as part of their degree were not found to be significantly different when comparing psychologists who specialized in the area of aged care with those who worked within the general population. Interestingly, 65.7% of the generalists reported they had access to older clients.

A very large effect size (Cohen 1988) was obtained for the interest variable, where 28% of the variance in interest was explained by the group (specialist vs generalist) variable (E^2= 0.287).

A discriminant function analysis was performed with group (specialist vs generalist psychologist) as the dependent variable and age, aged care courses in degree, specific geriatrics training, years spent working, confidence, interest in working with older adults, total score on attitudes towards conducting therapy with older adults and RAQ score as predictor variables. Results on 192 cases with complete data based on a single discriminant function were significant in differentiating between specialist and generalist psychologists (chi-square = 88.041, *df* = 8, $p \leq .0001$). The function successfully classified 80.2% of original grouped cases with accurate classification of 80.5% of generalist and 78.8% of specialist psychologists. Having participated in specific training courses in the area of geriatrics external to formal studies, years spent working (negatively correlated) and in particular, interest in working with older clients were the best predictors of whether a psychologist was likely to specialize in working with older adults based on correlations between predictor variables and the discriminant function.

RAQ analysis

Although not reaching statistical significance, RAQ score means were lower for generalist psychologists than for specialists, with higher scores corresponding to more positive attitudes to personal aging (see Table 3). This is within the range of means obtained in the Senior Psychiatrist Survey of Draper et al (1999). Cronbach's alpha for

the RAQ was .87. A principal components analysis suggested that a three factor solution was most appropriate, with the first six eigenvalues of 6.57, 2.37, 2.09, 1.44, 1.25, and 1.16. Following varimax rotation, factors corresponding to "worry about growing old" (14.9%of variance), "positive expectations of old age" (14.1% of variance) and "negative personality changes" (11.84% of variance) were interpreted. Items generally loaded highly on only one component. The two exceptions were item 15 (accept death of friends), which had equal loadings on the second and third components, and item 7 (worry about dying), which had equal loadings on the first and third components.

Discussion

In the present study, exposure to clinical experiences involving older clients was related to working with older adults, rather than attitudes towards growing old. Training within the sub-specialty of geropsychology failed to predict whether a psychologist would work with older adults, with the latter being more influenced by interest in working with older people.

Age and years of clinical experience were related to working with older adults with younger psychologists with less experience being more likely to specialize. Of note is the higher number of specialists in this survey being employed within government departments, raising the possibility of work within aged care being more readily available to new graduates and, by association, this being less desirable an area to work

in. The other possibility is that aged care is a relatively new inclusion in post-graduate psychology courses with the profile for the need for specialist psychogeriatric services in Sydney being relatively recently highlighted (Brodaty, 1991). This suggestion has been reflected in the growth in Australian research in the area of aged care psychology over the past 10 years (Wells, 2005). However, in comparison, the American Psychological Association has been more proactive in raising awareness of the specialized needs of older adults with an Interdivisional Task Force on Qualifications for Practice in Clinical and Applied Geropsychology being established to address training and practice issues (Qualls et al., 2002). There is no Australian equivalent to such a group.

Generalist psychologists had a moderate level of access to older clients (65.7%), so the comparatively low percentage of specialists (or psychologists having more than 50% of clients over 65 years of age) deserves attention. A factor for consideration is the comparative difficulty among older clients in affording the costs of private practitioner fees. Medicare rebates are a new inclusion for Australian Allied Health providers and are limited in terms of the number of sessions the government will pay for. This is in contrast to the U.S., where government (Medicare) reimbursements have been available for mental health services, although at a lower rate compared to fees for medical treatment (Qualls, 1998). Other factors adversely affecting access to psychologists in private practice for potential clients include transport, having to care for dependent spouses and clinical practice facilities that do not cater for physical disabilities (for example, no access to lifts, car parking).

Biases among the older clientele themselves need to be examined. There has been much discussion regarding the tendency for older people to focus more on physical explanations for discomfort. Older age groups have been cited as being resistant in accepting emotional rationales for perceived problems and so are less likely to seek help from a psychologist (VandenBos, 1993). However, with the increase in the number of adults over the age of 65 within the next 20 years, this position regarding age cohort effects will need reviewing.

There has been increasing exposure via the mass media regarding the importance of psychological factors. This has led to greater knowledge of alternative psychological treatments for medical conditions that may have been previously managed without psychological input. An increasing role for psychologists across several areas such as management of pain and coping with chronic illness is likely. Future psychological practice also needs to encompass healthy ageing issues such as pre-retirement counselling (Ferguson & Koder, 1998).

A limitation of the present study is the definition of elderly as “over 65” rather than more specific examination of age ranges, especially with more people living past the age of 80. Future research may wish to examine the role of psychologists in this older cohort as their numbers increase. This study also is limited to an analysis of Sydney-based psychologists: hence, a national sample may prove to be more representative. Access to older clients also involves employment opportunities in the area of aged care and the present study is skewed towards the private sector. Analysis of psychologist employment figures among Australian government facilities servicing older clients (for

example, aged care assessment teams) may give more insights into access and training trends.

The study supports a recommendation for future courses on aged care to include a placement in an aged care setting under supervision of a psychologist. Research has highlighted the importance of having quality contact with older clients as being integral to training in working with older groups (Cummings & Galambos, 2002). The Contact Hypothesis gives theoretical support to this recommendation: it purports that preconceived prejudices are invalidated by positive experiences, thus lowering ageism (Schwartz & Simmons, 2001; Allport, 1954). The present survey indicated high levels of satisfaction with specialist placements (mean of 7.6 from 10), suggesting high quality contact with older clients.

In contrast, psychologists in the survey rated the level of their education in psychology in equipping them to work with older clients poorly (4.1 from 10), suggesting the need for specific courses in geropsychology within their undergraduate and post-graduate degrees, despite this not being predictive of specializing in aged care. Providing a balance of both knowledge and experiences with older clients in their training may stimulate future interest in working in the area of aged care. In this way psychologists will be better prepared to meet the needs of this growing proportion of older Australians.

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Table 1

Comparison between generalists and specialists on demographic variables shown as mean (SD) or number (%) as appropriate

Demographics	Generalists (n =164)	Specialists (n= 34)	Statistic
Age	50 (10.9)	45 (13.5)	$t = 2.238$ *
Gender: Females	117 (71.3%)	29 (85.3%)	$\chi_1^2 = 2.831$
Years spent working	16.91	10.38	$t = 3.373$***
Access to older clients:Yes	88 (65.7%)	34 (100%)	$\chi_1^2 = 15.196$***
Working within a government department:Yes	43 (25.6%)	26 (81.3%)	$\chi^2_1 = 36.845$***

*** $p \leq 0.05$ ** $p \leq 0.01$ *** $p \leq 0.001$**

Table 2

Comparison between generalist and specialist psychologists on training

		Generalists (n = 167)	Specialists (n = 34)	
Academic	4th year or under	29 (17.4%)	2 (5.9%)	
Qualifications:				
	PG diploma/MA	61 (36.5%)	7 (20.6%)	
	Masters	47 (28.1%)	24 (70.6%)	χ^2_4= 23.1 ***
	DPsych	4 (2.4%)	0 (0%)	
	PhD	26 (15.6%)	1 (2.9%)	
Aged Care Course in degree: Yes		95 (56.9%)	25 (73.5%)	χ^2_2 = 3.252
Specific geriatrics training: Yes		13 (7.8%)	12 (35.3%)	χ^2_1 = 19.63***
Placement in aged care setting: Yes		25 (28.7%)	15 (65.2%)	χ_1^2= 10.462***

*** p≤ 0.05 ** p≤ 0.01 *** p≤ 0.001**

Table 3

Comparison between generalist and specialist psychologists on attitudinal variables shown as mean (SD)

	Generalists (n= 164)	Specialists (n= 33)	
Confidence in working with older adults (range 0-10)	6.93 (1.935)	7.79 (1.556)	t= -2.386**
Interest in working with older adults (range 0-10)	5.7 (1.731)	8.55 (1.416)	t=-8.856 ***
Attitudes towards therapy item total (max=30)	24.99 (2.27)	25.15 (1.68)	t= -.392
RAQ scale	106.29 (16.58)	107.39 (19.02)	t= -.338

* p≤ 0.05   ** p≤ 0.01   *** p≤ 0.001

CHAPTER 4: NATIONAL PSYCHOLOGIST SURVEY (Study 2)

Predictors of Working with Older Adults in an Australian Psychologist Sample:

Revisiting the Influence of Contact

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Abstract

Despite increasing numbers of older people in most global populations and increasing evidence of the efficacy of psychological therapy in older clinical populations, few psychologists work with older clients as compared to other clinical groups. In the present research, the authors examine potential influences on psychologists choosing to specialize in working in the field of aging. The authors surveyed 1,498 psychologists Australia-wide to examine which factors exerted the most influence on choosing to specialize in clinical work with older clients. Clinical exposure to older clients and age-related course content within training programs, together with further education external to formal training were significantly correlated with specializing in aged care. Holding a more negative attitude towards one's own ageing was another predictor of specialist category membership, with interest in working with older clients also being a significant factor based on direct logistic regression analysis. In contrast to previous work, amount or quality of contact with older persons did not appear to relate to working with older adults. These findings highlight the importance of quality training experiences in influencing attitudes toward working with older adults.

Keywords: Clinical training, older adults, contact hypothesis, ageism, geropsychology

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Predictors of Working with Older Adults in an Australian Psychologist Sample: Revisiting the Influence of Contact

People aged 65 years and over represent the fastest-growing demographic in most developed countries (World Health Organization, 2002), including Australia (Australian Bureau of Statistics, 2004). The Australian Bureau of Statistics predicted that by 2051, 27% of the population will be over 65 years of age, with almost half of the population being over 50 years of age, compared with the current level of one third in the latter age group. By 2051, 6 to 8% of the Australian population will comprise people over the age of 85. These estimates are similar to projections cited for other countries, including the United States (American Association for Geriatric Psychiatry, 2004). This increase will also result in corresponding increased rates of dementia and mental illness, with predictions of a doubling of mental illness in older adults by 2030 (Friedman, 2004).

Consequently, geropsychology would appear to be a potential growth area for future practice by current psychologists and those planning a career in psychology, given the expected demand for service to this growing age group. However, evidence from survey studies in both Australia (Browning & Stacey, 1999; Over, 1991) and other countries (Scott, 1998; Shmotkin, Eyal, & Lomranz, 1992) highlights a dearth of psychologists specializing in working clinically with older clients.

Gatz, Karel, and Wolkenstein's (1991) finding that only 4.4% of psychologists specialize in providing services for older adults has led the way for more scientific

discussion on possible solutions and predictors of choosing to specialize in working professionally with older adults. Influences on future employment with older clients have been linked to social identity theory (Tajfel & Turner, 1979), with studies on professional health care groups (Draper, Gething, Fethney, & Winfield, 1999; Lookinland & Anson, 1995) finding that groups with older members held more positive attitudes towards older patients compared with younger patients because the group members were closer in age to the outgroup.

The role of training has been extensively studied in regard to its ability to directly challenge existing stereotypes, with the conclusion that information alone is insufficient to achieve this result (Cummings, Galambos, & DeCoster, 2003; Hinrichsen & McMeniman, 2002). This deduction has been linked to the tripartite component model of attitude formation (Vaughan & Hogg, 2005) in which increased knowledge about a group experiencing discrimination only addresses the cognitive component of attitude, thereby addressing stereotypes rather than prejudice (the affective component) or discrimination (behaviour toward an outgroup member).

A common theme emerging from both the theoretical and applied literature is the importance of high-quality (rather than high-quantity) contact with older people as opposed to increased knowledge. Researchers conducting implicit ageism studies have argued that the maintenance of ageist attitudes is a result of accumulated internalised stereotypes regarding older adults which can be shifted primarily by increased exposure to positive experiences with older adults (Levy & Banaji, 2002). The contact hypothesis of Allport (1954) has been studied in relation to changing attitudes towards older adults

(Caspi, 1984), with recent studies of social work graduates finding that both frequency of contact with older adults and rewarding interactions with older clients were the most significant predictors of working with older clients compared with participation in specific gerontology training, internships and skills in the area of aged care (Cummings et al, 2003; Cummings & Galambos, 2002). Such support for the influence of contact has also been found to increase medical students' interest in working in geriatrics (Schigelone & Ingersoll-Dayton, 2004). Application of this finding to the definition of attitudes suggests that the most positive influence can be attained at the affective level rather than the cognitive level: that is, favourable emotions resulting from high- quality contact change attitudes as opposed to simply correcting erroneous beliefs (stereotypes) by increasing knowledge.

The growing need for psychological service delivery to the older population necessitates further study of factors influencing psychologists' decisions to work with older adults. Future planning in the areas of training and service delivery would benefit from knowledge of the factors that would increase interest in working in this area.

In the present study, we aim to examine the influence of contact with older clients on psychologists' behaviour in the form of service delivery patterns to older clients. The role of emotional attitudes (psychologists' attitudes towards their own ageing, confidence and interest in working with older clients) is also hypothesized to be an influence in choosing to work in this specialty area. The study tests the contact hypothesis among practising psychologists in examining predictors of working with older adults. Specific variables such as attitudes towards ageing, training, clinical and

personal contact, confidence, and interest in working with this population are examined to assess their contribution to whether a psychologist specializes in working with older adults.

Method

Procedure and Materials

After a pilot study involving 201 Sydney psychologists (Koder & Helmes, 2006), a survey questionnaire was sent to persons listed under the heading *psychologist* in Yellow Pages directories from each Australian state and territory, with the exception of Western Australia. This state has public-access published addresses of all registered psychologists, so surveys received could be used to test for sampling bias resulting from the use of the telephone directory. Members of the Australian Psychological Society's (APS's) Psychology and Ageing Interest Group were also invited separately to participate in the survey by personalized email invitation from the national and state convenors of the group.

The main survey was preceded by a brief pre-contact letter advising recipients of the request to complete a survey that would arrive within the next few days. Follow-up surveys were sent to those who had not returned a survey within approximately a month, including the APS special interest group members, who were sent an email reminder. Such tailored design methodology has been validated in several studies

highlighting the need for multiple, personalized contacts to maximize response rates (Dillman, 2000).

The survey addressed the following areas:

Contact frequency and quality

In accordance with the methodology used in the initial social work graduate study (Cummings & Galambos, 2002), participants were asked to rate the frequency of contact with their older family members and, in a separate item, friends over the age of 65 on a scale of 1 (*rarely-almost never*) to 5 (*very frequently-more than once a week*). Quality of contact with older family members and, again, separately with friends over 65 years of age was rated on a similar 5-point scale, with 1 representing that the participant did not find interactions with their family members and friends over 65 years of age at all rewarding and 5 indicating an extremely rewarding interaction. The present methodology uses anchors for rating frequency as opposed to leaving the questions open-ended. An additional item rating the frequency of contact with older friends while training as an undergraduate was included to account for mature-aged psychology graduates as well as to see whether there was an influence of having contact while in training.

Training

Items in the survey inquired about the amount of training in ageing-related subjects, both within degrees and external to programs, as well as whether the participant had exposure to clinical placements in aged care.

Employment in aged care

The survey asked the length of time the psychologist had been practising, as well as how much time was spent in private practice. Items relating to work practices were included (regarding clinical therapy, neuropsychology, assessment, and research) as well as the proportion of clients aged over 65 years of age. The survey contained an item related to access to older clients as well as asking the participant about potential factors limiting the number of older clients coming to their workplace (e.g., are they rarely referred older clients, does another part of their work setting cater to this population, are they specialists in the education or child psychology field?).

Attitudes

Participants were asked to rate their levels of confidence and interest in working with older clients on a 10-point Likert-type scale. An item related to perceived difficulty in conducting therapy with older clients compared with younger age groups was included. This emerged as the major predictive construct in an analysis of an earlier survey using several items relating to attitudes about conducting therapy with older client groups (Koder & Helmes, 2006).

The main measure of ageist attitudes was the Reactions to Ageing Questionnaire (RAQ; Gething, 1994). It has been validated in many countries and was recently used in a similar study using British and Australian nurses (Gething et al., 2002). It has been validated against the most commonly used measures of ageing such as the Ageing Semantic Differential (Rosencrantz & McNevin, 1969) and the Facts on Ageing Quiz

(Palmore, 1977). It measures the attitude towards one's own ageing, with subjects anticipating their future characteristics when they are old. It consists of 27 items in a Likert-type format along a six point agree-disagree continuum. In a survey of 201 Sydney-based psychologists, three factors emerged from the scale: worry about growing old, positive expectations of old age and negative personality changes (Koder & Helmes, 2006). Higher scores on the RAQ can be interpreted as holding a more positive attitude towards one's own ageing.

Results

Participants

Of 2,762 questionnaires sent out, 312 were returned because of incorrect addresses and 1,498 completed questionnaires were returned. This final overall response rate of 61.1% incorporates returns from the initial and follow-up mailings and responses to the email request to the APS Psychology and Ageing Interest Group membership through the national and state convenors. The response rate is an improvement to an earlier survey of Sydney psychologists (39% response rate) that did not utilize personalized letters or a pre-contact letter (Koder & Helmes, 2006).

Twenty-two cases were missing one or more responses on the continuous variables, resulting in at least 99% of cases being represented in the sample. Cases were excluded only if they were related to the specific analysis in question. Three outliers were found

with scores transformed to reflect a standard score of z = 3 (Tabachnick & Fidell, 2001).

Specialists were defined as psychologists for whom at least 50 percent of their clinical caseload was composed of clients aged 65 or over. These made up 4.8% of the current sample, with the vast majority of participants (95.2%) being *generalist* psychologists.

Recruitment and sampling bias was assessed through comparisons with the Western Australian sample (41% of total sample), where all registered psychologists were sent surveys, including members of the local APS Psychology and Ageing Interest Group. Therefore, members of the latter group were not recruited by e-mail invitation. Of the Western Australian sample, 3.1% were specialists, compared with 6% of the non-Western Australian sample. Furthermore, only 0.06% of the total sample were members of the APS interest group. APS interest group members comprised 46% of specialists. These figures suggest that the recruitment method differences did not heavily influence results in that the interest group membership was too small to influence the overall outcome and there were roughly equivalent numbers of specialists in both the Western Australian and non-Western Australian samples.

Ages of participants ranged from 23 to 87 years (M = 49.72 years, SD = 10.8), with 72.3% of the sample being women and 27.2% men (eight did not report gender). There was a correspondingly large range in terms of clinical experience in psychology (measured as years of practice), being from one year's experience to 60 (M = 16.42 years, SD = 9.7).

In regard to training variables for the total sample, approximately 60% of the sample achieved post-graduate qualifications. However, psychology training was rated poorly (M = 3.91, SD = 2.2) in terms of preparing students to work with older clients. Nearly half the total sample (47.7%) had exposure to at least one aged care course within their formal psychology training.

Comparison Between Generalist Psychologists and Psychologists Specializing in Aged Care

Table 1 shows statistically significant differences between specialist and generalist psychologists on age. Specialist psychologists tended to be younger ($E^2 = 0.01$) and less clinically experienced in terms of years spent working ($E^2 = 0.01$) but effect sizes are small. Specialist psychologists (N= 72) had achieved a higher degree of academic qualification. ($X_4^2 = 36.15$, $p \leq 0.001$): 73% had masters degrees or doctoral qualifications compared with 59% of generalists (N=1424). There were no differences between the two groups in terms of gender.

Of note is that bachelor's degree psychology graduates are able to be registered in Australia and thus able to practise but these data suggest that comparisons with the United States can be made with some validity given that the majority of specialists were postgraduates. There is some variability between postgraduate clinical masters programs in Australia: however, their coursework and clinical practice (1,000 hours of supervised practice) components render them somewhat comparable to U.S. clinical PsyD programs in the amount and proportion of required supervised practice and coursework. Significant differences were also noted in evaluations of training, with

specialists giving more positive ratings (5.3 out of 10 signifying adequate training, compared with 3.8 for generalists), although again, the magnitude of this difference is small ($E^2 = 0.02$). Specialists were also more likely to have an assessment role, such as neuropsychological assessment, compared with generalists, X^2 (3) = 35.36, p≤ .001, who were more likely to be in the therapy field (74.6%). The latter spent a higher proportion of their working week in private practice, with 43% of generalists stating that their total practice comprised private practice, compared with 9.7% of specialists, X^2 (4) =53.42, p≤ .001).

In terms of training variables, specialists were more likely to have undertaken specialised training outside of their formal qualifications (see the specific geriatrics training variable on Table 1) and to have had at least one aged care content course within the latter. Similarly, specialists also appeared to have been exposed to clinical work with older clients within their formal training in the form of a placement (see the placement in aged care setting variable on Table 1).

Not surprisingly, specialists had greater access to older clients (X^2 (1) = 39.44, p≤.001). However, 61% of generalist practitioners claimed to have at least 5% of their caseload comprising clients aged 65 and over. Reasons linked to limitations on access indicated that not being referred older clients was the most common barrier (29.7%), with 35.5% feeling that they did not have any limits and an additional 17.4% of the sample identifying themselves as specialists in child psychology.

Results from the independent-samples *t*-test as shown in Table 2 indicate a lack of influence of contact, either with older friends or family or during training. Quality of

contact scores failed to reach significance when comparing specialist with generalist psychologists. Scores across all participants indicated moderately to very rewarding contacts with both older family and/or older friends, with contact frequency averaging about once a month.

Significant differences existed between the groups on the attitude variables of confidence and interest in working with older clients (see Table 3). The magnitudes of the differences in the means were large to very large (E^2= 0.15 and 0.29 for confidence and interest, respectively), with the specialist-generalist grouping variable accounting for 29% of the variance in interest. Perceptions of how difficult it is to conduct therapy with older people and attitudes towards one's own ageing (as measured by the RAQ) failed to reach significance. Cronbach's alpha for the RAQ was .904 in this sample. A principal-components analysis followed by parallel analysis and oblimin rotation supported a three-factor solution. Worry about growing old, positive anticipation of old age and predicted negative personality changes formed the three factors. The worry factor accounted for 29.69% of the variance, with 8.72% and 6.36% of variance contained in the positive anticipation of old age and predicted negative personality change factors, respectively.

Direct logistic regression analysis was performed on group (generalist, specialist) as the outcome variable, with contact frequency and quality, speciality training either within or external to the degree, clinical placement and all attitudinal variables (confidence, interest, difficulty and RAQ scores) as predictors. 1,292 cases were included in the analysis. A test of the model indicated that the predictors were statistically reliable in distinguishing between generalist and specialist psychologists (X^2 (10) =284.31, p<

.0001). Between 19.8% and 61.2% of the variability in scores was explained by this set of predictor variables. Of the generalists, 98.9% were correctly classified by the model, compared with 58.7% of specialists. The overall percentage correct was 97%. The major factors influencing whether a psychologist was in the specialist group, based on the Wald criterion, were whether a psychologist had undergone special training in aged care outside of the degree, interest, perceived difficulty and RAQ score. Specialist psychologists were between 2.5 and 11.72 times more likely to have undergone speciality training (ExpB=5.37), and between 3.0 and 7.5 times likely to have higher degrees of interest in working with older adults (ExpB=4.48) compared with generalists, on the basis of odds ratio 95% confidence intervals. Directionality based on negative *B* values indicated that specialists found working with older clients to be more difficult than did generalists (*B*=-0.309) and that specialists held more negative views about their own ageing than did generalists (*B*=-0.024).

Discussion

Results from the present study failed to support the hypothesis that psychologists who have had more contact and/or rewarding contact with older people (either family or friends) are more likely to choose to work with older adults. This finding is contrary to previous research where contact frequency and quality were predictors of interest in working in aged care among health care groups such as medical students (Schigelone &

Ingersoll-Dayton, 2004) and contact frequency was related to specialized employment with older adults among graduate social work students (Cummings & Galambos, 2002). Scores from the present research showed positive attitudes towards older people (as measured by how rewarding contact was rated), regardless of relatedness and independent of whether psychologists specialized in working with older adults professionally. The present study supported previous findings that family contact does not have an impact on employment involving work with older client groups (Cummings & Galambos, 2002).

Methodological issues require close examination when comparing studies on the use of contact as a key variable. Close analysis is required in defining *older adults*, as the specific relationship appears to influence results with negative findings in relation to older family members (Cummings & Galambos, 2002) yet positive influences of contact quality when related to experiences with clients (Cummings et al., 2003) and when the term *older adults* is used loosely, without clear definition of subgroups. In the present study we restricted the subgroups to personal as opposed to professional contact. As well as defining relationships, we also attempted to specify the frequency of contact (weekly, monthly etc.) as opposed to open-ended questions such as “How often do you have contact?” that are answered without anchors regarding time. The latter are subject to individual interpretation, and a proliferation of nonquantitative analyses of contact effects has been a major criticism of past research involving the contact hypothesis (Pettigrew & Tropp, 2006). Problems such as generalization of specific positive contact effects, direction of causality (Is it positive contact per se that leads to greater exposure to an outgroup, or do individuals who are prejudiced avoid the outgroup?), and limits on ecological validity (i.e., high-quality and -quantity contact is

often rare in real-life situations) have been discussed in recent evaluations of the contact hypothesis (Pettigrew& Tropp, 2006; Dixon, Durrheim, & Tredoux, 2005).

Perhaps social psychologists have been too enthusiastic in regard to Allport's initial discussion of prerequisites for positive contact effects while not heeding his warning that "theoretically, every superficial contact we make with an out-group member could by the "law of frequency" strengthen the adverse associations that we have" (Allport as cited in Dixon et al., 2005, p.698). In the present study, the directionality of the RAQ *B* value within the regression analysis indicated a negative influence of contact; that is, the more negative one's attitude towards one's own ageing, the more likely one is to specialize in aged care. This suggests that spending the majority of clinical time exposed to older age groups may, in fact, raise one's own anxiety about growing old. Negative stereotypes may well be strengthened when primarily dealing with the vulnerable, dependent subset of what is a very heterogeneous population.

Further evidence for the influence of attitudes on behaviour-in this case, working with older adults- can be seen when examining the variables of confidence and interest in this study. Specialist practitioners had significantly higher ratings than generalist psychologists in the areas of confidence and interest in working with older adults. Although this finding may seem obvious, an interrelationship with training may be operating. Specialists had at least one aged care course in their degree, had undergone specialist training in aged care, and were more likely than generalists to have had clinical exposure to older adults within their training. This is congruent with previous research highlighting the importance of high-quality clinical contact via internships in influencing graduate students' choice of specialty (Cummings & Galambos, 2002) as

well as knowledge regarding the role of clinical psychology work with older clients and high-quality supervision (Scott, 1998; Haley & Gatz, 1995). Whether the positive attitudes preceded planning to study in aged care and a desire to specialize or whether the attitudes were shaped by the positive training experiences themselves is difficult to ascertain from the present data. Interest and confidence may have been positively affected by the specialists' increased knowledge in the area of aged care psychology. Further research with trainees may determine the directionality of these findings.

Unfortunately, this study also highlighted that little appears to have changed since earlier surveys showed that between 1 and 4% of psychologists were either interested in or specializing in working with the elderly, first reported in 1991 (Over, 1991; Gatz et al., 1991; Wells, 2004). Several possibilities to account for this persistently low rate emerge from close analysis of results.

Analysis of work description data suggests that neuropsychological assessment may be a more common referral issue compared with clinical therapy, with three times as many specialists working predominately as neuropsychologists compared with generalists. The difference in the number of child psychologists (17.4% of the sample) compared with the aged care specialists (4.8%) is further evidence of the dearth of psychologists in what may still be a relatively new speciality.

Although 61% of practitioners claimed to have some clinical contact with older clients, the main limitation to access was attributed to low referral rates. Results from the 1997 National Survey of Mental Health and Wellbeing indicated that older recipients of mental health services were likely to receive medication as their primary treatment and

had a lower likelihood of seeing psychologists than of seeing general practitioners (Parslow & Jorm, 2000; 2001). Ignorance as to the potential role for clinical psychology services may be operating here, with both referrers and practitioners possibly holding narrow views of what a psychologist can offer to an older person (e.g., only neuropsychological assessment services). Clearly more efforts are required in the area of promoting psychological work with older populations, particularly with primary care physicians. The role of biases within the client group themselves or possible cohort effects regarding the stigma of seeking help from a mental health professional need to be considered. Surveying beliefs in this area among referrer groups (e.g., physicians) would illuminate such viewpoints and give direction to future training and education efforts.

Cost is another potential barrier to access. The present study was carried out prior to the introduction of Medicare rebates for psychology services in Australia (which commenced in November 2006) with its policy of increased reimbursement for services performed by qualified clinical psychologists. Australian Department of Veterans Affairs (DVA) psychologists are all equally reimbursed at a lower level compared with other psychologists providing clinical psychology Medicare services.

Neuropsychological services are not reimbursed by Medicare in Australia, to date. The United States, in contrast, has had Medicare rebates for licensed psychologists since the Omnibus Budget Reconciliation Act of 1987. Of interest are similar rates of specialist psychologists in aged care despite these public policy differences between the two countries. The full effect of making psychological services affordable for older clients needs further examination, using cost as a specific survey item.

The present study is primarily exploratory in nature, and our aim is to identify key factors influencing psychologists' choice to work with older adults. However, causality cannot be determined from the present data. Findings may also be limited by extraneous variables such as sampling bias, where specialists were largely from a government-employed sample (e.g., working as part of community aged care assessment teams or in public hospitals), compared with generalist psychologists who were more likely to be working in private practise fee-for-service settings. However, over half the generalist sample has some government employment. Researchers conducting future replications of this study may wish to examine potential influences on key variables identified in the present study, such as age.

Demographic variables influencing attitudes towards ageing, such as the health, retirement status, race and ethnicity of respondents, warrant further investigation to broaden discussion. Whether respondents had any experience of personal caregiving with an older relative would also be a worthwhile variable to examine.

The findings of this study suggests two main areas of intervention that could help to increase the number of psychologists interested in working with older clients and thereby meet the mental health needs of future older persons. Education of trainee psychologists needs careful attention, given that the current study's most powerful predictor variable was specialist training in aged care. Future training programs for psychologists need to increase aged care content and such content can be positively received by trainees. Knowledge and clinical skills training can serve to heighten interest and confidence in working with older clients. This training has received formal

financial support in the United States, with an example being the 2003 Graduate Psychology Education program being funded to specially address shortages in the provision of psychological services to older Americans (APA, 2003).

Formal training should contain compulsory aging components at undergraduate and post-graduate levels. The United Kingdom model mandates clinical placements in aged care settings, and among several U.S. Veterans Affairs initiatives are the establishment of centres of excellence that incorporate research as well as clinical care and education (Cooley, 1995). Furthermore, in the United States, agencies such as the U.S. Department of Veterans Affairs, one of the largest employers of psychologists, consults with geropsychologists to specify clinical competencies needed for working with older adults by means of its Veterans Affairs Technical Advisory Group (Molinari et al., 2003). Such a mechanism is not operating in Australian aged care settings to date. The 1981 and 1992 Older Boulder national conferences on training psychologists to work with elderly patients addressed the training of future psychologists to meet the needs of older adults in a U.S. setting (Knight, Santos, Teri, Wohlford, & Lawton, 1995). Such a meeting is needed within Australia, given that its population projections are similar to those of the United States. Recommendations regarding the provision of psychological services for older adults in Australia have recently been published as a response to concerns regarding the status of geropsychology; recommendations for training are also discussed (Pachana, Helmes, & Koder, 2006). Increased students' clinical exposure to older adults by having compulsory placements in aged care settings within postgraduate clinical programs would have a great impact on increasing interest in aged care employment among psychologists. Following American examples, such as having government reimbursement for psychologists to provide clinical services to nursing

homes, would also increase placement opportunities in Australia (Qualls, Duffy, & Crose, 1995). More relevant to the United States is ensuring that recommendations regarding future training (e.g. Haley & Gatz, 1995) are, in fact, being carried out where practicable, although it is recognized that recommendations are not mandatory standards. Furthermore, the effects of these programs in terms of increasing interest in geropsychology need evaluation through future survey studies.

The other potential area of intervention involves referrer groups such as primary care physicians. Results from the present study have raised issues pertaining not only to limits on access to older clients but also to possible ignorance as to the scope of the psychologist's role. Intervention studies aimed at examining the effects of medical practitioner education on psychosocial interventions and surveying awareness of what a psychologist can offer to older patients with mental or physical illness would improve access to care as well as the quality of life of patients. Liaison between academic schools within tertiary institutions, such as having psychology lecturers involved in medical training programs in the field of behavioural science during a geriatrics term, is another potential avenue of educating future referrers to psychologists.

The expected significant growth in the over-65 population necessitates prompt action to decrease barriers to working psychologically with older adults. It is ironic that there even needs to be discussion on positive promotion of the one group that faces discrimination because of a condition that is likely to be encountered by most of humanity: ageing.

Table 1

Comparison between generalists and specialists on demographic and training variables shown as mean (SD) or number (%) as appropriate

Demographic Variables	Generalists (n =1426)	Specialist (n= 72)	Statistic
Age	50 (10.7)	44.36 (11.6)	t(1483) =4.34***
95% CI	49.44-50.56	41.63-47.09	
Gender: Females (N=1490)	1024 (94.6%)	58 (80.6%)	χ_1^2= 2.398
Years spent working	16.67(9.6)	11.61(10)	t(1480)= 4.42***
95% CI	16.17-17.18	9.26-13.96	
Access to older clients: Yes (N=1496)	912 (64%)	72 (100%)	χ_1^2= 39.35***
Aged Care Course in degree: Yes (N=1493)	668 (47%)	48 (66.7%)	χ^2_1 = 10.61**
Specific geriatrics training: Yes (N=1497)	188 (13.2%)	51(70.8%)	χ^2_1 169.72***
Placement in aged care setting: Yes (N=1498)	178 (12.5%)	33 (45.8%)	χ_1^2= 62.997***

*** p≤ 0.05 ** p≤ 0.01 *** p≤ 0.001**

Table 2

Comparison between generalist and specialist psychologists on contact variables

	Generalists (n = 1426)	Specialists (n = 72)	
Total Frequency of contact*	6.47(1.98)	6.5(2.11)	t(1378)= -0.10
Total Quality of contact*	7.5 (1.56)	7.71(1.58)	t(1373)= -1.08
Total Contact**	16.38 (3.62)	16.83(4.1)	t(1353)= -0.98

* range=0-10 (combined score of contact with family and friends)

** range =0-20 (all contact variables)

Table 3

Comparison between generalist and specialist psychologists on attitudinal variables shown as mean (SD)

	Generalists (n= 1416)	Specialists (n= 72)	
Confidence in working with older adults (range 0-10)	6.71 (2.23)	8.96 (1.04)	t(108)=16.47***
95% CI	6.6-6.83	8.71-9.2	
Interest in working with older adults (range 0-10)	5.94(1.84)	9.29(0.99)	t(98)=-26.23 ***
95% CI	5.85-6.04	9.06-9.53	
Perceived difficulty in working with older adults (range 0-10)	6.61 (2.08)	6.66 (2.31)	t(75)= -0.15
RAQ scale	110.41(19.42)	109.38 (19.60	t(1486)= -0.43

* p≤ 0.05   ** p≤ 0.01   *** p≤ 0.001

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CHAPTER 5-DESCRIPTIVES OF THE COMBINED NATIONAL SAMPLE

(Study 3)

The Current Status of Clinical Geropsychology in Australia: A Survey of Practising Psychologists.

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Abstract

Little recent objective evidence exists to qualify past concerns regarding the low numbers of psychologists working with older adults in Australia. The present study reports on figures from two surveys of Australian psychologists, finding that of the 1,699 psychologists surveyed, only 6% specialize in treating older adults. This figure is comparable to those from studies conducted overseas, where more training and employment opportunities are available. Reasons for such low figures are explored together with recommendations to meet the future demand for psychological services as the proportion of elderly adults within the Australian population increases.

The current status of clinical geropsychology in Australia: a survey of practising psychologists

Introduction

The rapid increase in the over-65 demographic in most developed countries will result in a corresponding greater need for physical and mental health aged care services. Proportions of the world's population aged over 65 in 2001 ranged from 9% in Israel to 18% in Japan and Italy (Weiss, 2005); and 20% of the US population is estimated to be over the age of 65 by 2030 (American Association for Geriatric Psychiatry, 2004). This is comparable to Australian projections that predict that by 2051, around 7% of the population will be over 85 years of age (Australian Bureau of Statistics [ABS], 2004).

While aged care psychiatry services in Australia have acknowledged the need for speciality training and clinical services for older Australians (Brodaty, 1991), much has been written regarding the dearth of psychological services delivered to those aged over 65 (e.g., Koder & Ferguson, 1998). More than 15 years has passed since Over's survey of Australian Psychological Society (APS) membership reported that only 1% of members indicated a primary interest in ageing (Over, 1991). Since then there has been much speculation as to reasons for low service provision with poor training cited as a major factor (e.g., Kneebone, 1996). But attempts to quantify psychological involvement and associated issues are scarce.

Despite increases in the amount of research in ageing and interest within the APS (Wells, 2005), Australian surveys specifically examining clinical practice with older

clients and service delivery yield far less positive results. The early surveys utilized older client groups as subjects in order to formally examine psychology usage, with only 86 per 100,000 women 65 years and over having consulted a psychologist within a two-week period The figure for psychology consultations with older male clients is even lower (38 per 100,000) (Jorm, 1994). The more recent National Survey of Mental Health and Wellbeing (Parslow & Jorm, 2001) found that older patients were more likely to be seen by a general practitioner for mental health problems, and to prefer medication as treatment, compared to younger patients. A recent telephone survey of Victorian psychologists found that within one metropolitan mental health sector, only two psychologists were employed specifically to provide aged care services compared to 28 psychologists in the child and adolescent area (Gluyas, Wrigley & Bryant, 2004).

International survey studies of psychological services to older adults yield a range of figures, with an early US survey finding that one third of the sample had clinical experience with older clients and one third also held negative beliefs regarding the ability of older clients to benefit from therapy (Dye, 1978). A more recent survey of Los Angeles-based psychologists yielded only 4.4% of practitioners specializing in providing services to older clients. Furthermore, only 27% of this subsample indicated that they had received specialized geropsychology training (Gatz, Karel & Wolkenstein, 1991), raising the possibility that the majority of these specialists may not have originally intended to practise in the area or have received inadequate training. A subsequent U.S. survey reports a figure of 3% of psychologists who considered themselves as specializing in aged care clinical practice in a national sample of 1, 227 American Psychological Association members (Qualls, Segal, Norman, Niederehe, & Gallagher-Thompson, 2002) Only 16% of these specialists had participated in a clinical

placement in an aged care setting during their training and the majority indicated that their main source of preparation for working with older adults was "informal clinical experience and on-the-job training" (p.437).

Low rates of financial reimbursement and limited social networks were the main reasons given by respondents to the question of barriers to providing clinical psychology services to older adults in their sample of practising psychologists within a metropolitan part of New York State. This survey yielded a figure of 8% of respondents indicating that they served clients aged over 65 (Barrick, Karuza & Dundon, 1995). Survey figures from the United Kingdom also highlight low interest in working with older adults with a 1995 British Psychological Society survey finding that from the 220 clinical psychologists graduating annually, only 6% will specialize in aged care (Lee, Volans & Gregory, 2003).

Limited information on the amount of actual speciality training and how much this influenced the decision to work with older clients suggests that adequate training in aged care cannot automatically be assumed among psychologists considering themselves to be specialists.

The present study is a national survey of current practice and interest in working with older adults in an effort to objectively examine levels of clinical involvement. Obtained data were from two original surveys aimed at examining predictors of interest in working with older adults (Koder & Helmes, in press; 2006). Current results aim to

revisit past assertions that the status of geropsychology in Australia is poorly established, especially compared to overseas (Koder & Ferguson, 1998). There is yet to be any quantification of such concerns, as indicated by the percentage of practising clinicians delivering psychology services to older Australians. The survey also aims to examine training experiences and existing clinical practice with older adults in order to best plan for future psychology training and service delivery in the light of demographic projections.

Method

Participants were drawn from three sources: the Yellow Pages telephone directory of each capital city in each state and each country area; a list of Western Australian registered psychologists obtained via government gazette public access information; and the APS Psychology and Ageing Special Interest Group, in which national and state convenors invited participation in the survey via email. The final sample for the present investigation was obtained via combining common items from two separate surveys, one with a Sydney sample (Koder & Helmes, 2006) and the subsequent survey as a national sample excluding Sydney (Koder & Helmes, in press). Sampling methodology is described in detail in the aforementioned publications.

Differences in response rates were noted between sources, with the highest rate obtained when the tailored design method (Dillman, 2000) was used. The Sydney sample (201 responses) who did not receive a pre-contact letter advising of the arrival of a survey within a few days, had a lower response rate (39%) compared to the rest of

the national sample surveys (61%). Response rates from the Psychology and Ageing interest group were also generally lower, with recruitment methods (via email request) similar in both Sydney (32% response rate) and the national sample study (40.5% response rate) for the interest group members.

After combining results from the two studies (Sydney sample and national sample), the response rate was 52.8% with a total of 1,699 psychologists responding from 3,213 surveys initially sent following the elimination of incorrect addresses. This response rate is significantly higher than those reported in previous US national surveys, which are reported as 19% (Dye, 1978) and 24.7% (Qualls, Segal, Norman et al, 2002).

The definition of "specialist" in the present study was having at least 50% of clients being over the age of 65. This proportion is comparable to previous survey definitions where quantifiable information (as opposed to a dichotomous definition response such as "I do/do not serve older adults" or by checking a list of client populations) has been provided (Gatz, Karel & Wolkenstein, 1991). The survey sought information regarding the amount and evaluation of training in the area of aged care, amount of private practice, how many years a psychologist had been working, work practices, whether the clinician had access to older clients (meaning that the clinician had the potential to see older clients within their particular workplace) and attitudinal variables such as confidence and interest in working with older clients.

Statistical comparisons between specialist and generalist psychologists have been reported elsewhere (Koder & Helmes, in press; 2006).

Results

Number of specialists

In terms of demographic variables, female practitioners (72.7%) outnumbered males (27.3%). Ages ranged from 23 to 87 with the mean age being 49.6(SD = 10.9).

Results from the present survey show that only 6.1% of Australian psychologists provide the majority of their clinical services to older clients with 1,595 psychologists making up the generalist group compared to 104 specialists. A total of 60.2% of psychologists indicated that they did see some elderly clients, with 39.8% indicating no exposure to older clients. A total of 66.4% of the sample stated that they had access to older clients.

Training

Of the sample, 59.4% had obtained Masters qualification or above, with 10.5% having obtained their PhD. Nearly half the sample (49.1%) had exposure to at least one ageing-related content subject within their training, with 15.5% having engaged in specific training in aged care external to their formal psychology degree training (e.g., a workshop in cognitive-behaviour therapy or psychotherapy with older clients). Evaluations of how well formal education in psychology had prepared psychologists for

clinical work with elderly clients was rated poorly (*M*=3.9 out of 10. *SD* = 2.21). A total of 14.7% of the sample had done a placement within an aged care setting such as a psychogeriatric ward or community aged care service.

Professional practice

The proportion of the sample in full-time private practice was 41.4%, with 26.8% being in full-time government employment. Clinical work description items indicated that the majority of psychologists delivered clinical therapy services (75.6%), with 9.1% providing neuropsychological or other assessment services. The average number of years spent in practice was 16.4 (*SD* = 9.83) with a range of 1 to 60 years.

Attitudes towards practice with elderly clients

The average rating of confidence in working with older clients was moderate (*M* = 6.9 out of 10, *SD* = 2.21) with the sample indicating no particular age preference in terms of interest in working with the elderly (*M*= 6.1 out of 10, *SD* = 1.96).

Discussion

It appears there has been, at best, modest change since earlier assertions regarding the paucity of psychological therapy services to older clients (Koder & Ferguson, 1998; Phillips 1989), with these concerns being objectively confirmed. Only 6% of psychologists specialized in geropsychology, based on the present sample, with nearly

40% of psychologists indicating they had no clinical contact with older clients. This contrasts sharply with the continuing higher levels of psychologists interested in, and funded for, work with children, who comprise a declining proportion of the population (ABS, 2001).

This figure is congruent with overseas rates in countries where the status of geropsychology is more prominent and there is more support. For example, in the United States, psychology services have been reimbursed by Medicare since 1987 and there are more educational and training opportunities to specialize in aged care (Knight, Teri, Wohlford & Santos, 1995). Hence lack of reimbursement and poor training cannot be solely responsible for persistently low levels of service provision to older clients.

Sixty per cent of the current sample indicated they had some degree of clinical contact with older clients (at least 5% of their clients were aged over 65) with two thirds of the sample stating they had access to this population. Furthermore, at least twice as many psychologists (15%) had done formal training with aged care content in the form of clinical placements or specific courses external to their degrees as compared to the rate of specialist psychologists. Therefore, despite having undertaken specialist training and placements, specialist rates of practice with older adults are still lower. Attitudes towards working with older clients such as confidence and interest, appeared unremarkable based on the present sample. This raises the issue of potential biases within the client group themselves or referrers to psychology services. The latter includes government departments that do not make provision for the potential role for

psychologists on multi-disciplinary teams such as Aged Care Assessment Teams or within public hospital geriatric wards.

There may also be a cohort effect that needs to be considered. Until recently, the predominant category of older client for many psychologists may well have been the "young-old", who comprised a small amount of a general therapy caseload and whose needs may not have been significantly different from those of their general adult clients (Qualls et al., 2002). Therefore the issue of specializing in aged care may have appeared redundant in the light of past population demographics. Coupled with this are documented low rates of consultations to a psychologist by older adults (Parslow & Jorm 2000; Jorm, 1994), with continuing stigma attached to mental illness and a tendency to attribute problems to physical illness cited as barriers to seeking out psychological help among older adults (Koder & Ferguson, 1998). A trend to favour medication as the primary treatment for older adults (Parslow & Jorm, 2001) and ignorance on the part of potential referrers regarding the range of services psychologists can offer (Koder & Helmes, in press) further relegates psychological therapy to one of the least-considered options in treating geriatric mental illness, despite its well-documented therapeutic efficacy: for example, the work by Bird, Llewellyn-Jones, Smithers and Korten (2002) in challenging behaviours in dementia; and the use by Laidlaw, Thompson, Dick-Siskin & Gallagher-Thompson (2003) of cognitive-behaviour therapy in depression and anxiety.

With the rapid ageing of the 85-and-over age group (ABS, 2004), the need for specialised training and service delivery will become more salient. The present survey

rated current training in preparing psychologists to work with older clients poorly and this figure will need challenging if the future demand for psychological services to the growing number of older Australians is to be met. Improvements in attitudes toward psychological therapy, with more acceptance of non-physical factors contributing to a patient's presentation as the "baby boomer" cohort enters old age, are further likely to increase the viability and need for psychological services. Furthermore, this age group is likely to be more enlightened regarding the benefits of psychological therapy, with less stigma attached to mental illness, resulting in an increased demand from the client group themselves for non-pharmacological treatments. Past barriers to access such as cost are already changing with the advent of Medicare reimbursements for psychological therapy since November, 2006.

Recommendations

Preparation to meet the increase in demand for psychological service to older adults appears to be a priority, with intervention needed in two directions. The client group themselves need to be made aware of the existence and benefits of psychological therapy. Here, specialist practitioners via the APS Psychology and Ageing Interest Group can make a contribution via liaison with relevant referrers (e.g., local general practitioner groups) and community or government groups who provide services for older Australians (e.g., Council on the Ageing). Educational institutions have a role in promoting the benefits of psychological therapy in older populations through their support of applied research that has implications to clinical practice, and this appears to be increasing (Wells, 2005).

The most obvious and often-discussed method of directly increasing the number of psychologists working with older clients involves increasing the amount of training in aged care, especially quality clinical exposure (Kneebone, 1996; Koder & Helmes, 2006; Qualls et al., 2002). The proportion of psychologists who had exposure to aged care content or older clients within their training in the present study was still low. Innovative ways of promoting clinical internships in aged care could include reimbursement or government sponsorship of placements in aged care facilities, having compulsory exposure to a certain number of clients over the age of 65 within a general adult placement or attachments to a local general practitioner catchment area (given the latter group see a high number of older clients) at either a trainee or provisional registration level.

The need for quality supervision needs to be addressed in conjunction with such recommendations. Ensuring that trainees receive a high standard of supervision and a positive clinical experience is essential. Ideally, supervisors themselves need sufficient clinical experience within the field of aged care, being members of the APS Special Interest Group and being able to meet criteria for continued professional development, specific to aged care populations. This is obviously dependent on the availability of such experienced supervisors, and an investigation into the number of psychologists who meet these criteria seems timely. Placements themselves need to expose students to a variety of clinical conditions including more common serious conditions such as depression and challenging behaviours in dementia, which should be mandatory cases to see. Log books with written therapy plans and treatment sessions with heavy emphasis on treatments with well-established research efficacy are strongly recommended. To this end, students should also be able to demonstrate sound

knowledge of the scientific literature in the field of geropsychology. Guidelines for the provision of psychological service for older adults have been published (Pachana, Helmes & Koder, 2006).

It behoves the APS and its specialist Colleges to work in conjunction with State Psychology Registration Boards to mandate compulsory direct and indirect exposure to older clients and courses related to aged care. Further study on normal aging is also essential to challenge stereotypes that old age is a largely negative experience.

Conclusion

Current rates of psychology involvement in aged care remain low. Any prior complacency on behalf of psychology as a profession requires challenging due to the ongoing increase in the number of older Australians, particularly the "old-old" group over the age of 85. Past barriers such as cost, lack of access and research or formal training are gradually being addressed.

The challenge for clinical psychology is to provide quality opportunities (within training and employment) for clinical exposure to older adults as well as to promote their services within both referring agents and the client group themselves.

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CHAPTER 6 - NATIONAL SURVEY OF POST-GRADUATE PSYCHOLOGY TRAINEES (Study 4)

Predictors of interest in working with older adults: A survey of post-graduate trainee psychologists

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Abstract

Despite the growing number of older adults that implies an increasing need for psychological services, few psychologists choose to specialize in working with older clients. The present cross-sectional research examined predictors of student interest in working with older clients in an effort to understand factors that may influence future psychologists to work in this area. The targeted sample consisted of Australian post-graduate psychology students whose course co-ordinators responded to a request to participate in this national survey. Four hundred and thirty-one post-graduate trainee psychology students completed the survey which examined training, contact and attitudinal variables. This represents a 45.3% response rate from surveys being distributed by course co-ordinators. Having undergone or intending to do a placement within an aged care setting was the most powerful predictor of interest, with confidence in working with the elderly and positively anticipating old age being attitudinal factors related to increased interest. Amount or quality of contact with older adults and formal education through aging-related coursework failed to predict interest, based on hierarchical regression analysis. Implications for future training of psychologists highlight the importance of quality clinical experiences with older clients during training as opposed to pure course work.

KEY WORDS: **Post-graduate training, interest in aging, contact hypothesis, ageism, geropsychology, aged care, psychology training**

The population over 65 is the fastest growing age group in the developed world with population projections of 27% in this category by 2051 (Australian Bureau of Statistics, 2004; World Health Organization, 2002). Corresponding increases in mental illness among older adults creates a growing demand for psychologists trained in clinical service provision for older clients, especially in the area of dementia. There is a growing research base supporting the use of psychological interventions suitable to older adults such as cognitive-behaviour therapy for depression (Laidlaw, Thompson, Dick-Siskin & Gallagher-Thompson, 2003) and the psychosocial management of challenging behaviours in dementia (Bird, Llewellyn-Jones, Smithers & Korten, 2002). Yet despite such potential, few psychologists work with the elderly as compared to other age groups, such as children, with the proportion of psychologists specializing in aged care being around 3-4% (Gatz, Karel & Wolkenstein, 1991; Koder & Helmes, in press; Qualls, Segal, Norman et al, 2002).

The literature has identified several factors related to this lack of interest among practising psychologists, including poor training (Qualls, 1998; Gatz, Karel & Wolkenstein, 1991); ageist attitudes (Lee, Volans & Gregory, 2003; Shmotkin, Eyal & Lomranz, 1992), limited clinical exposure during training (Koder & Helmes, 2006; Hinrichsen & McMeniman, 2002) and low reimbursement (Barrick, Karuza & Dundon, 1995). Given the potential for quality training to positively influence attitudes towards older adults, it is worth examining these factors within trainee samples. Interest emerged as the major influence on whether a psychologist specialized in aged care in a recent study of Australian clinicians (Koder & Helmes, in press). By identifying factors linked to interest in working with older adults while training in clinical psychology,

these can then be addressed by educational institutions in order to increase the number of psychologists choosing to specialize in geropsychology.

Similar concerns regarding the need to provide clinical services for the increasing number of older adults have been raised among other health professional groups. Desire to work with older adults has been rated at around 10% compared to other age groups within the social work profession (Anderson & Wiscott, 2003; Gellis, Sherman & Lawrence, 2003). Dietetics students ranked clients aged over 65 as the lowest preferred age group to work with (Kaempfer, Wellman & Himburg, 2002) and among medical trainees, only 4% expressed a strong interest in specialising in geriatric medicine (Fitzgerald, Wray, Halter, Williams & Supiano, 2003).

Influences on interest in working with older clients among trainee health care groups have included training, contact and attitudes. Mixed results have been reported as to the positive influence of courses devoted to aging on preferences to work with older clients with one study even finding a negative influence of their course on aging at postcourse test in their 87 undergraduate students (Davis-Berman & Robinson, 1989). Formal training has been found to improve attitudes towards the elderly (Dorfman, Murty, Ingram & Li, 2007; Hinrichsen & McMeniman, 2002), but not necessarily intention to work with this client group (Carmel, Cwikel & Galinsky, 1992). There may be an interaction with the number of aging courses having been taken (Anderson & Wiscott, 2003).

Contact with older people is another factor that has received attention in terms of its relationship with choosing to work with older populations. In their 2005 survey of 382 graduate social work students, Cummings, Adler and DeCoster found that both frequency of contact with older adults and rewarding clinical contact with clients while in training emerged as significant predictors of student interest in working with older clients. Self-ratings of skills for working with older clients (as opposed to knowledge) and positive views on career prospects within aged care settings were the other two predictive factors positively linked to interest in this study. Interest in undertaking further post-graduate study in geropsychology was found to stem from both professional work experiences and family contact with older people in a survey of post-doctoral psychology students (Karel, Molinari, Gallagher-Thompson & Hillman, 1999). Increased exposure to older people was found to improve attitudes and work preferences towards the elderly in medical students (Fitzgerald et al, 2003) and in the early stages of physical therapy education (Mount, 1993). However some studies have again found that while increasing exposure to older people improves attitudes towards older clients, this does not necessarily translate to intent and behaviour in terms of wanting to specialize in aged care (Carmel, Cwikel & Galinsky, 1992) with the type of contact during training being identified as a crucial variable (Schigelone, 2003), together with attitudes towards personal aging (Anderson & Wiscott, 2003).

A comparative study of 90 psychology trainees who participated in a geropsychology placement compared to those who did not, supported the need for specialised placements in positively impacting on interest in aging (Hinrichsen & McMeniman, 2002). Further work examining training issues with psychology students, including direct clinical exposure, have also reported positive results. However their

generalizability is limited by the use of more qualitative methodology such as content analysis of responses (Lee, Volans & Gregory, 2003) and small sample sizes (Brodie, 2004). A large-scale Australian national survey of post-graduate psychology students using statistical multiple regression analysis to identify predictors of interest has yet to be published to date.

The present study aims to identify influences on interest among Australian post-graduate psychology students. Training, clinical and personal contact with older adults and attitudinal variables such as attitudes towards one's own aging, confidence and perceived difficulty in working with older adults are studied to examine their relative contributions in influencing interest in working with older clients.

Method

Participants and procedure

Recruitment was via an email request to the Heads of the School of Psychology of every University with a Psychology Department in Australia. Thirty-five psychology departments were sent emails with a repeat request being sent out to initial non-responders after one month. Five universities failed to respond to either request and four universities were ineligible due to the absence of a post-graduate clinical psychology program. This resulted in a total response rate of 83.8%. Those Heads of School agreeing to have their post-graduate psychology students participate in the study forwarded on the email request to the post-graduate clinical psychology program co-ordinators. Surveys were sent via regular mail to the course co-ordinators who

distributed them to students at the beginning of Semester 1, 2007 during a coursework lecture. A cover letter outlined the voluntary and confidential nature of the research and provided instructions to return the survey in a pre-paid envelope if the student decided to participate. All students across all years of study were targeted. It should be noted that Australian post-graduate coursework and clinical practice requirements (1000 hours of supervised practice) are comparable to United States clinical Psy.D. programs in terms of these supervised practice and coursework components.

Nine hundred and fifty surveys were sent out Australia-wide, covering 26 universities offering post-graduate training programs in clinical psychology with 431 returns resulting in a final survey response rate of 45.3%. This figure may well represent an under-estimate as there is no guarantee that every survey sent was actually received given the indirect nature of distribution resulting in factors beyond the researcher's direct control, such as the number of students in attendance on the particular day surveys were distributed.

Instrument

The survey contained items relating to demographic variables such as gender and age, year of program and whether the student was studying on a full-time or part-time basis. Training variables included the evaluation by the student of how well they felt their present education would equip them in future clinical work with older clients. The survey also asked whether the student had planned or had actually done a clinical

placement in an aged care setting and how many subjects within their formal training had specific aging content.

In order to assess the relative contribution of contact with older people independent of training, students were asked to separately rate the frequency and quality of contact on a 5 point scale ranging from 1 (rare contact; not at all rewarding) to 5 (seen very frequently, such as more than once a week; extremely rewarding interactions) with older family members and then on separate items evaluating these variables with older friends and acquaintances, resulting in four items relating to contact. Such methodology has been utilized in similar studies with social work students (Cummings, Adler & DeCoster, 2005).

Finally the survey contained 10 point Likert-type scale items rating the level of confidence and interest in working with older clients, together with a measure of the level of difficulty students perceived in terms of conducting therapy with the older client group. The Reactions to Ageing Questionnaire (RAQ) completed the attitudinal variable list: this 27-item, 6-point Likert-type scale questionnaire has been well validated as a good measure of ageism through assessing attitudes towards one's own aging in terms of level of agreement (Gething, 1994). It has been used to measure attitudes towards aging in international, as well as Australian, samples of nurses (Gething, et al, 2004; Gething, et al, 2002) and psychiatrists (Draper, Gething, Fethney & Winfield, 1999). Recent findings suggest a relationship between a lack of education in gerontology and negative attitudes towards aging (Wells, Foreman, Gething &

Petralia, 2004). Higher scores on the RAQ represent a more positive attitude towards aging.

In the present sample, the mean Reactions to Aging Questionnaire score was 103.04 (SD=16.98), comparable to previously reported figures (Koder & Helmes, 2006; Draper et al, 1999). Cronbach's alpha was 0.899 indicating good reliability. Principal component analysis and oblimin rotation resulted in the emergence of four factors from the present data: worry, positive anticipation of old age, negative personality characteristics and loss of loved ones.

Results

Descriptive Statistics

The typical graduate psychology student in this survey was female (86%) and 29 years old (SD=7.3). Age ranges were from 21 to 64. Half of the students were in the first year of their post-graduate training program (49.2%) with the majority studying on a full time basis (79.8%).

In terms of specific training variables pertinent to aged care, the quality of training in aged care was rated as just adequate (Mean=5.04 out of 10; SD=1.98). Nearly a quarter (23.1%) of students had done or were planning to do a placement within an aged care setting and 25% of the sample indicated having exposure to one (13.7% of the sample) or more subjects devoted to aging within their undergraduate or post-graduate training

at the time of completing the survey. 1.2% had completed a whole course within their degree related to issues of older persons or the psychology of aging with only two students undertaking a speciality training program in geropsychology (Doctor of Geropsychology or Masters in Clinical Geropsychology). The most common form of training in aging was having some aging-related content within a subject (58%).

In terms of attitudinal variables, students rated themselves as moderately confident in working with older clients (Mean=5.38; SD=1.98). They rated conducting therapy with older clients as somewhat challenging (Mean=5.72; SD=1.84). Interest in working with older adults was rated most commonly as being of "no particular preference" in terms of choosing to work with older adults with the mean of 5.31 out of 10 with 4.8% planning to specialize in the area of aged care.

Bivariate Statistics

Assumptions of correlation and multiple regression were checked with four outliers being identified and removed due to their extreme nature based on Mahalanobis Distance calculations (critical value = 32.909). Tolerance and VIF scores indicated low intercorrelations between variables therefore non-violation of multicollinearity assumptions. Inspection of standardised residuals did not indicate a curvilinear relationship with residuals plots representing no major deviations from a normal distribution.

Correlation

Examination of Pearson correlations (Table 1) suggested medium relationships between interest and placement (r=.469) and interest and confidence (r=.427). These variables

were significant at the $p<.01$ level. Other variables reached significance (Table 1), however their correlations were below 0.3 with coefficients of determination below 10 percent. Hence the significance of the Pearson correlation was probably due to the larger sample size in this study. Intercorrelations between variables (Table 1) suggested relationships between frequency and quality of family contact ($r=.373$) and quality of family contact and quality of friend contact ($r=.496$). The correlation between confidence and placement was .243. Intercorrelations between the variables that had a relationship with interest were small with only 6% of shared variance between placement and confidence. Nearly a quarter of the variance in interest (22%) was explained by the placement variable with 18% of interest variance shared with confidence.

Multiple Regression Findings

Hierarchical multiple regression analysis was performed in order to assess the relative contributions of contact, training and attitudinal variables in influencing interest in working with older adults. The RAQ was divided into its four factors with each entered into the attitude block along with the variables of perceived difficulty and confidence in working with older adults. Training factors were entered in the first block followed by contact and then by attitude factors to assess their individual contribution to interest, which served as the dependent variable.

R^2 values in the first Model (Table 2) indicated that training variables (aged care courses, placement) explained 23.3% of the variance. Contact variables added an additional significant increase in variance of 5.8, while attitudinal variables contributed

a further significant 10.4% of variance. The model incorporating all three stages as a whole is significant [$F(12,373)=20.334$, $p<.0001$)], explaining 39.5% of the variance in interest.

Evaluation of the independent variables (Table 3) suggested that placement (beta=.370), confidence (beta=.247) and positive anticipation of old age (beta= .202) were the only variables making a statistically significant contribution ($p<.001$) with neither contact nor the number of courses in formal training making a unique contribution to interest.

Discussion

The most significant predictor of psychology graduate students' interest in working with older clients based on the present results is having done or intending to do a placement in an aged care setting. Formal study of subjects relating to aged care psychology does not seem to influence interest in future clinical work. Confidence was also related to interest, yet appeared to be acting independently to having done a clinical placement. Therefore it cannot be assumed that having had clinical exposure to older clients via placements directly causes improvements in confidence in working with the elderly. The other attitudinal variable influencing interest based on regression analysis was holding positive attitudes to growing old. The frequency and quality of contact with either older family or older friends failed to predict interest in working with older adults. This finding is in contrast to previous studies with social work students where frequency of personal contact with elders was related to interest, as was frequency of

contact in clinical internships (Cummings, Adler & DeCoster, 2005; Cummings & Galambos, 2002).

Hence it appears that the context of contact is an important variable. In the present study, clinical client contact while in training was significantly related to interest in working with older clients compared to general contact external to training. Revisions of Allport's original contact hypothesis (Allport, 1954) have emphasized the importance of specific conditions for contact with an out-group to result in a positive effect, highlighting the importance of high quality contact experiences that are voluntary and that disconfirm stereotypes (Schwartz & Simmons, 2001; Wittig & Grant-Thompson, 1998). The present findings can add the condition of relationship specificity and cautions against the use of general terms such as "older adults" when examining contact effects with this sub-group which is one of the most heterogeneous groups to examine within the social psychology literature on prejudice. The environment in which the context took place needs to be clearly identified in future research.

Attitudes towards older people and growing old also related to a desire to work with older clients. Looking forward to growing old and feeling confident when professionally interacting with older adults can positively impact future employment with older clients. Therefore it appears that the affective component of attitude formation would be the most salient level of focus in terms of changing attitudes towards the elderly. Intervening at the cognitive or knowledge base component does not appear to influence intent, based on the present results given that courses in aged care

were not related to interest in future work with older clients. This finding confirms previous research regarding the need for positive experiences, (rather than knowledge alone), that challenge pre-existing stereotypes in order for the out-group to change status and become acceptable (Cummings, Galambos & DeCoster, 2003; Rogan & Wylie, 2003; Hinrichsen & McMeniman, 2002).

Recommendations

The findings of this study indicate that it is the planners of future psychology program content who have the most potential to positively influence service delivery to older adults and reverse the trend for psychologists to neglect this rapidly growing demographic. Increasing the amount of clinical exposure to older clients while in training is the most obvious intervention strategy. Rogan and Wylie (2003), in their work with undergraduate nursing students, emphasize the need for training programs in aged care to integrate formal learning content with clinical practice, to prepare students prior to commencing placements (for example, discussing myths and facts on aging) and to have close supportive contact with supervisors that includes debriefing. In a survey of British trainee clinical psychologists, 45% of students indicated quality placements as being the best way to increase the number of psychologists specializing in aged care with having a designated course staff member devoted to clinical geropsychology supervision. There is also evidence that clinical placements in older adult settings are positively received by students (Brodie, 2004). Respondents also suggested that such placements should not be left till later on in their training so as to have the maximal influence on career choice (Lee, Volans & Gregory, 2003).

Innovative training suggestions for improving interest in working with older adults (Haley & Gatz, 1995), have included providing more indirect exposure to older adults through related areas of interest such as neuropsychology (expand existing program to include pathology common in older persons and then discuss normal cognitive aging), family therapy (expand to include three generations, not just limiting to parent-child dyad) or health psychology (include discussion/exposure to older adults' health issues). Encouraging brief research projects that include practical components using older subjects may also stimulate future interest in working with older clients (Haley & Gatz, 1995). US initiatives for trainees such as post-doctoral fellowships in aging and Veterans Affairs-sponsored APA-accredited internships, are other practical suggestions for increasing clinical exposure to older clients (Cooley, 1995).

Limitations

The present study cannot examine the directionality of results due to its cross-sectional design. Rather, it focuses on relationships between attitudes, intent and possible influences such as contact. Causal relationship patterns such as whether confidence pre-dates any psychology training experience would be valuable in order to correctly target key variables. Other potential influences such as the health status of respondents and experiences caring for older people external to training (for example, grand-parents, voluntary work) may also have implications for results regarding positive attitudes and confidence with the elderly.

Future research in the area needs to directly evaluate teaching methods in aged care such as the value of having close support, preparation and debriefing following

placements with older clients. Formally evaluating the quality of placements as well as documenting the content of such experiences would be helpful in terms of identifying potential challenges and specific positive elements of placements. The role of residential facilities as potential sites for clinical placements also needs exploration via surveying managers in those areas and broadening discussion on training barriers to include the providers of clinical employment in aged care settings.

Conclusion

It behoves educators of future psychologists to re-examine post-graduate training programs and direct training methods in geropsychology to maximize the ecological validity of course content. The present study supports the role of quality exposure to older clients while in training with well-supported, compulsory placements, in co-ordination with relevant course-work, being the ideal.

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Table 1

Pearson correlation coefficients for interest in working with older clients and independent variables

	Interest	Age	FFamily Contact	QFamily Contact	FFriend Contact	QFriend Contact	Aged care courses	Placement	Confidence	Difficulty	Positive Ant.
Interest	1										
Age	.194**	1									
Frequency of family contac	.092	.146**	1								
Quality of family contact	.185**	.028	.373**	1							
Frequency of friend contact	.251**	.233**	.279**	.254**	1						
Quality of friend contact	.288**	.198**	.128	.496**	.498**	1					
Aged care Courses	.162**	-.004	.079	.047	.046	.018	1				
Placement	.469**	-.010	-.004	.067	.147**	.149**	.099	1			
Confidence	.427**	.271**	.105	.120	.228**	.247**	.222**	.243**	1		
Difficulty	.219**	.128**	.151**	.161**	.138**	.119	.147**	.013	.372**	1	
Positive anticipation of growing old	.292**	.220**	.031	.173**	.200**	.263**	.033	.070	.149**	.230**	1

**correlation is significant at the 0.01 level (2-tailed)

Table 2

Hierarchical regression model summary

Model	R square Change	F Change	*P*
1(Training variables)	.23	58.315	.001
2 (add Contact variables)	.058	7.772	.001
3 (add Attitudinal variables)	.104	10.687	.001

Table 3

Summary of hierarchical regression: Training, contact and attitudinal variable coefficients

	B	SE B	Beta
Placement	1.602	.183	.370**
Aged care courses	.104	.086	.051
Frequency of family contact	.020	.065	.014
Quality of family contact	.055	.092	.030
Frequency of friend contact	.091	.082	.055
Quality of friend contact	.127	.094	.074
Confidence	.230	.044	.247**
Difficulty	.051	.046	.050
Worry (RAQ)	-.024	.020	-.056
Positive anticipation of old age (RAQ)	.089	.020	.202**
Negative personality changes (RAQ)	.001	.027	.001
Loss (RAQ)	-.018	.029	-.027

**$p < .001$

CHAPTER 7: THE RAQ ANALYSIS: PREDICTORS OF ATTITUDES TOWARDS PERSONAL AGEING (Study 5)

Reactions to Ageing Among Australian Psychologists

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ABSTRACT

Objective: To assess attitudes towards personal ageing among Australian psychologists.

Method: 604 practising psychologists were surveyed using the Reactions to Ageing Questionnaire (RAQ). Potential predictors of attitudes to ageing, such as age, gender and number of years in clinical practice were examined, together with the amount and quality of contact with older family members and older friends. Measures related to the training of psychologists were also of interest.

Results: The strongest significant predictors of attitudes to ageing were respondents' age and positive attitudes towards conducting therapy with older clients. Contact and training variables were not associated with scores on the RAQ.

Conclusion: These results highlight age as a contributing factor in attitude formation.

KEY POINTS:

- Attitudes towards one's own ageing become more positive as we grow older.
- Training does not influence attitudes to ageing in a middle-aged sample.
- Amount and quality of contact with older adults, including older clients, do not influence attitudes towards personal ageing.
- Positive attitudes towards personal ageing are associated with high levels of confidence in, and positive attitudes towards, the use of therapy with older adults.

KEY WORDS:

Ageism, attitudes, contact hypothesis, psychologists, personal ageing

Introduction

Increasing attention has been paid to identifying influences on attitudes towards older people held by health professionals, arising from an anticipated increase in the need to supply clinical services to the growing number of elderly Australians. While interest in working with older adults is associated with amount and quality of contact [1, 2], training [3], age [4, 5] and years of clinical experience [6], many health professionals have been found to hold negative attitudes towards older adults [6].

Little work has been carried out on this topic with Australian psychologists despite strong support for the efficacy of psychological interventions in aged care settings [7, 8]. Few psychologists identify themselves as specializing in work with older adults in Australia compared to other disciplines such as old age psychiatry and other client groups, such as children and adolescents [9]. Research has identified biases among practising psychologists regarding the suitability of older clients for psychological treatment. Ageist attitudes and a lack of training are associated with the tendency to deny psychological treatment to older clients [10, 11].

Ageism is frequently measured through knowledge of ageing [12] or attitudes towards older people, using statements in which aspects of "being old", such as personality characteristics or lifestyle, are judged [13]. Attitude towards one's own ageing using the Reactions to Ageing Questionnaire (RAQ) is an alternative measure of ageism that addresses the personal, rather than societal level, of measurement [14, 15] and correlates with how the respondent rates older people [15]. One study of Australian psychologists [16] found that subjective ageing was unrelated to whether or not a psychologist specialized in aged care, but age, years

spent working and interest in working with older adults emerged as predictors in classifying psychologists as specialists in aged care work. Age has been shown to strongly correlate with the age of the clinician across a number of professionals such as psychiatrists [4] and nurses [15]. Other factors of importance include gender and health (psychiatrists). Specific education in aged care and factual knowledge about ageing has also been associated with more positive attitudes to ageing in samples of nurses [17, 18]. Amount of contact with older family members or older friends appears to be unrelated to RAQ scores in samples of nurses [14] or students [19].

By identifying predictors of positive attitudes towards ageing among Australian psychologists, the present study aims to identify possible strategies for increasing interest in working with the growing population of older people.

Method

Participants and procedure

A survey questionnaire was mailed to psychologists listed in the Western Australian Registration Board published directory of registered psychologists. Use of this sampling frame maximised the representativeness of the sample, in comparison with other sampling methods biased towards psychologists in private practice.

Six hundred and four psychologists completed surveys, representing a 51.3% response rate. The average age of respondents was 47.8 years (SD=11.0, range 25 to 77 years, median 50

years). The majority of respondents were female (75.5%). These sample characteristics are comparable to those of another recent survey of Australian psychologists [16], suggesting adequate generalizability of the sample.

Materials

The survey included demographic items such as age, gender and years spent working as a psychologist. Training variables included highest qualification, the number of courses with content on ageing, whether a participant had done a clinical placement within an aged care setting, and evaluations of how well training had prepared respondents to work with older clients. Interest, confidence and perceived difficulty in working with older clients were assessed through Likert-type scales with scores ranging from 1 to 10. The percentage of current clients aged over 65 and the amount and quality of contact with older family members and friends were also assessed.

The RAQ, the measure of ageist attitudes utilized in the survey, has been validated in international samples and against several other measures of ageism [14, 17, 19]. It comprises 27 items, each a statement of expectations regarding older age. Responses indicate level of agreement along a 6 point Likert-type scale. The RAQ demonstrated good internal consistency in the present study (Cronbach's alpha = 0.9). Higher scores on the RAQ indicate more positive attitudes towards one's own ageing.

Results

Masters level (or higher) qualifications had been attained by 63.0% of participants: 53.0% had been exposed to ageing-related topics as part of their formal psychology training, and 10.6% had completed a training placement within an aged care setting. The average career duration was 16.7 years (SD=9.63). Although this level of clinical experience is comparable to that reported in previous surveys [16], the present sample yielded a very low rate of psychologists specializing in aged care psychology (2.2%), and 52% did not currently see any older clients. The mean RAQ score was 109.0 (SD=19.4), range 55-157, comparable with other studies [4, 18].

A relatively high correlation was noted between age and years spent working (.64), influencing their relationship with RAQ scores in the subsequent regression equation (Table 1). Confidence in working with older clients correlated with interest (.59), positive evaluations of training (.46), and perceived difficulty in working with older adults (.46), suggesting the last of these need not necessarily be interpreted negatively. Similarly, interest and difficulty had 10% shared variance. The number of clients over the age of 65 was not associated with other independent variables or RAQ scores.

The set of variables entered simultaneously into the standard multiple regression equation (following affirmative tests of assumptions) accounted for only 13.3% of the variance in RAQ scores, although the model as a whole was significant [$F(13, 507) = 5.96$, $p < .0001$]. Variables independently associated with RAQ scores were age, difficulty and confidence in working with older clients, and number of years working in psychology. Gender, contact and

training variables made no significant independent contributions to the variance in RAQ scores (Table 1).

Discussion

The present study confirms previous findings regarding the effect of personal age on ageist attitudes [4]: positive expectations of ageing increase as we grow older. Hence, pre-conceived negative associations with old age may be dispelled by direct positive experiences of ageing. The participants in this sample were middle aged-, older than those in previous studies that surveyed nurses [14, 17].

Attitudes towards personal ageing were also linked to attitudes regarding working with older clients, in terms of both confidence and perceived difficulty. It appears that "difficulty" was regarded as a positive aspect of working with this client group: it was seen as a stimulating challenge and was correlated with increased therapist confidence. Similar to a previous study examining psychologists' motivation to work with older clients [11], professional attitudes, rather than contact with older family and friends, were related to ageist attitudes. Subjective attitudes to ageing were not associated with either specialising in working with older clients or with training factors, such as formal knowledge or professional contact through clinical aged care placements. It is possible that training did not predict attitudes to ageing because the present sample was older than those of previous studies and had more work experience. This result raises the possibility that factors other than training or contact might influence RAQ scores. A limitation of this study was a lack of information regarding the respondents'

own health and personal experiences of caring for older people. Including other variables that may impact on a respondent's experiences of ageing (such as socio-economic status, marital status and retirement plans) would perhaps have accounted for more variance in RAQ scores than was achieved in the present study. The relationship between attitudes towards one's own ageing and actual behaviour towards older people also needs further examination. The present study suggests that attitudes in one area (here, professional attitudes) can relate to attitudes in another context.

The present study failed to find a relationship between training and attitudes towards ageing: however, nearly half of the sample had not been exposed to any ageing-related content during their training, which can represent up to eight years of full-time study. Criticism has been levelled at the lack of age-related training within the clinical psychology profession [20]: only two universities currently offer specialist programs in geropsychology [21]. In a recent Australian survey, clinical psychology program directors indicated a need to increase course content on ageing [21]. Based on the present findings, recruiting mature-age trainees into psychology programs may also have a positive impact on psychology students' attitudes.

This study highlighted the importance of targeting attitudes in combating negative preconceptions regarding ageing. In preparing health professionals for the increasing number of older consumers, educators need to be mindful of the complexities in attitude formation. Courses should identify and address ageist attitudes, to complement theory and factual knowledge on ageing processes, and should continue to target attitudes through post-graduate professional development. Exposure to positive ageing experiences may also serve to influence attitudes and help provide much-needed balance in service delivery to older Australians.

Table 1

Summary of standard multiple regression: Variable coefficients with Total RAQ score as DV

	B	SE B	Beta
Age	.270	.101	.153*
Gender	-2.89	1.952	-.064
Aged Course in degree	.814	1.111	.035
Placement with older clients	-.381	2.747	-.006
Years spent working	-.257	.113	-.128*
% of clients aged over 65	-.335	.680	-.022
Confidence	1.035	.488	.128*
Interest	-.080	.548	-.008
Frequency of contact	-.226	.465	-.023
Quality of contact	.859	.610	.068
Highest qualification	.842	.822	.044
Difficulty	1.761	.435	.190*

*=P<.05

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CHAPTER 8: COMPARISONS BETWEEN PRACTITIONERS AND TRAINEE PSYCHOLOGISTS (Study 6)

Interest in ageing: Comparisons between present and future psychologists

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Abstract

We explore the influences on interest in working with older adults among Australian psychologists and post-graduate trainee psychologists. Training, contact and attitudes have all been identified as having a significant impact on such interest. Predictors of interest in 1,498 practising psychologists, including specialists in aged care, were compared to those of 431 graduate psychology trainees. Attitudinal variables, particularly confidence in working with the elderly, were the strongest predictors of interest in practising psychologists whereas training variables exerted the most influence in the trainee sample. Clinical exposure to older clients while training influenced interest in both practising and trainee psychologists. Demographic variables and the amount of personal contact did not relate to interest in either sample. Implications for training are discussed.

KEY WORDS:

Psychologists, training, ageism, contact hypothesis, attitudes

Introduction

Given the expected rise in the over-65 age group in the future, increasing the interest in working with older clients has recently been the focus of attention among health professionals. Concern has been raised about the lack of enthusiasm for providing health care services for older adults, compared to other client groups such as children, with under-representation of the older age range in surveys of client group desirability (Cummings & Adler, 2007; Kaempfer, Wellman & Himburg, 2002; Berenbaum, 2000). Among psychologists, survey studies suggest that between four and six percent of practitioners specialize in clinical service delivery to older adults (Koder & Helmes, 2008; Gatz, Karel & Wolkenstein, 1991) and interest among trainee populations also appears low (Brodie, 2004).

Examination of influences on interest have concentrated on contact with older adults (Cummings, Adler & DeCoster, 2005), amount of training devoted to aged care courses (Anderson & Wiscott, 2003; Hinrichsen & McMeniman, 2002, Carmel, Cwikel & Galinsky, 1992) and attitudes towards working with the elderly (Fitzgerald et al, 2003; Shmotkin, Eyal & Lomrantz, 1992). However, few studies have compared trainee and practitioner samples in an effort to illuminate the inter-relationship between training, attitudes and intent. Age may well be a mediating variable here but inconsistent findings emerge concerning the influence of age on attitudes towards the elderly and specializing in aged care. Lookinland and Anson's (1995) comparative study of students and registered

nurses reported that age was unrelated to attitudes in that population, yet older psychiatrists demonstrated a more positive attitude to personal ageing in an Australian survey (Draper et al, 1999). Support has emerged in the literature for increased experience with older clients being linked with interest as opposed to age *per se (*Koder & Helmes, in press a; Hinrichsen & McMeniman, 2002; Shmotkin, Eyal & Lomranz, 1992). Clinical placements have been identified as a potential source of motivation while training (Brodie, 2004; Lee, Volans & Gregory, 2003).

Causal links between these factors need to be extricated for educators to target appropriate interventions in order to increase interest in working with older adults. Whether pre-existing positive attitudes towards older adults (perhaps influenced by contact) leads to increased interest in servicing this population, as was the case in a recent Australian study of ageing researchers (Bartlett, Underwood & Peach, 2007), or whether high quality training experiences in aged care directly causes more interest, is worthy of investigation. Identification of the specific nature of contact and training also needs further analysis.

The present exploratory study aims to compare predictors of interest in both a trainee and practitioner psychologist sample in order to identify influences on interest and illuminate possible causal directions. The relative contributions of contact, training and attitudinal variables towards interest in working with older clients are of interest in both trainee and clinical practitioner populations.

Method

The present data were part of two survey studies described in detail by Koder & Helmes (in press a, b). The practitioner sample was obtained from three sources: the Australian Yellow Pages telephone directory listing of psychologists, the Western Australian list of registered psychologists, and the Australian Psychological Society Psychology and Ageing interest group members. Interest group members were invited to participate by email invitation from the national and state convenors. Other psychologists received surveys via regular mail. This resulted in a total response rate of 61.1%.

The post-graduate trainee sample (Koder & Helmes, in press b) was recruited via course convenors who distributed surveys at the commencement of the 2007 academic year, having positively replied to an email request sent to all Australian post-graduate psychology programs (response rate = 83.8%). Four hundred and thirty one surveys were returned via reply-paid envelopes, representing a trainee survey response rate of 45.3%.

The sub-set of items from the original surveys that were of interest to the present comparative study focused on training variables (how many aged care courses participants had been involved in during their training, whether they had participated in a clinical placement while training), contact (both frequency and quality were analysed via a 5-point

Likert-type scale) and attitudes (confidence in working with the elderly, whether elderly clients are seen as more difficult to work with compared to other age groups). A final attitudinal aspect of the survey included the factors from the Reactions to Ageing Questionnaire-RAQ (Gething, 1994) emerging from principle components analysis of each study (Koder & Helmes, in press a, b). Both student and practitioner samples shared common factors of worry, positive anticipation of old age and negative personality changes with the student sample having an additional factor of losses. The RAQ aims to measure subjective attitudes towards personal ageing and has been validated in international samples (Gething et al, 2004) and against other measures of attitudes toward ageing (Gething, 1994).

Both data sets (practitioner and trainee) were independently subjected to descriptive statistical analysis (trainee statistics reported in Koder & Helmes, in press b), followed by hierarchical regression analysis, in order to compare critical influences on interest in working with the elderly. Training variables were entered at step 1, followed by contact variables with attitudinal variables forming the third level of variables in the hierarchical regression analysis.

Results

Comparison of descriptive statistics

Both practitioner and trainee groups had a large proportion of females (Table 1), with practitioners (*M* = 49.72, *SD* = 10.81) being older than trainees (*M* = 29.22, *SD* =7.3). This significant difference between the ages of trainees and practitioners yielded a large effect size (eta^2=0.52). In terms of training variables, a greater proportion (23.1%) of students had clinical exposure to older clients in the form of a placement while training, compared to practitioners (14%). 75% of students indicated they had had no aged care content during their training beyond some within subject content, compared to 52% of practitioners, with the student group expressing more satisfaction with the quality of aged care content during training compared to practitioners (Table 1).

In terms of attitudinal variables, practitioners had significantly higher scores in the areas of interest and confidence in working with the elderly and rated older clients as no more difficult or challenging to work with compared to other age groups. Practitioners also had higher scores on the RAQ compared to students (Table 1). Both groups rated the frequency of contact with family as averaging about once a month with quality of contact rated as moderately to very rewarding.

Hierarchical regression analysis

From Table 2 it can be seen that attitudinal variables were the predominant influence on interest in working with the elderly in the practitioner group, accounting for 27.3% of the variance in interest. The variable of confidence accounts for nearly half of the total variance, based on semipartial correlation correlations (part r = .439). Conversely, in the trainee sample, it is training variables that account for the most variance in interest (R^2 change=.23). Both practitioner and trainee regression models were significant (Table 2), explaining approximately 40% of the variance in interest (p <.001). Overall contact failed to make a substantial contribution in both trainee (R^2 change = .058) and practitioner (R^2 change =.063) samples.

Examination of individual independent variables indicated that having done a placement influenced both practitioners and trainees (Table 3) with confidence in working with the elderly and positive anticipation of old age being the only other shared influences on interest. No other unique variables contributed to interest in the trainee sample. Quality of friend contact, number of aged care courses and the RAQ factors all made statistically significant contributions (p<.001) to interest in the practitioner sample.

Discussion

It is the nature of the contact that appears to relate to interest in working with older people, rather than contact *per se*. Both practitioners and trainees indicated that placements were important in promoting interest. Placements may serve to dispel any myths regarding the older client's ability to benefit from psychological therapy. Further support for this is indicated by a relationship between confidence in working with older people and interest in practitioners and trainees. The fact that practitioners also appear to hold fewer biases relating to the suitability of older clients for psychological therapy (having rated them as no different to other age groups to work with) underscores the importance of relevant contact: here, in a clinical setting, rather than personal contact.

The contribution of age cannot be ignored when interpreting these results. The average age of practitioner participants was clearly middle-aged compared to their significantly younger student counterparts. Attitudes may be more relevant in an older sample as they are closer in age to the target group, thus not only having had more time for positive experiences to dispel any pre-existing stereotypes or prejudices regarding older people, but also having a higher proportion being members of the target group themselves. This age interaction finding is similar to the survey of Australian ageing researchers (Bartlett, Underwood & Peach, 2007) where researchers' own ageing was more important in influencing interest for participants aged over 40.

The relevance factor is further supported by the differences in the category of predictors. For students, training is far more relevant compared to psychologists who are already practising. In older, practising psychologists, there are additional and broader factors that influence interest as an attitude in itself, such as quality of contact with older friends and not holding negative expectations regarding changes in old age or worrying about the future. Hence, it does not appear that students enter into their tertiary training directly pre-disposed to working with older clients due to factors such as positive contact with family and friends. Based on the present results, it is more likely students are influenced by positive relevant clinical experiences while training. In practitioners, there are other variables that come into play such as their own age, confidence and attitudes towards personal ageing.

Significant changes to Australian post-graduate psychology training programs have also occurred within the last 20 years, with the present study suggesting there is, in fact, less course content relating to old age but that more students at present are experiencing a placement in an aged care setting and rating their level of preparedness to work with older clients more highly. This supports previous research regarding the lack of contribution of formal courses in aged care towards interest and attitudes (Carmel, Cwikel & Galinsky, 1992).

However other influences may also account for differences in interest concerning providing services to older clients and herein lies the main limitation to the present study. A cohort

effect may be operating between these two groups, given their age disparity with "baby boomers" being the predominant cohort of practitioner sample who may feel more secure regarding the future (so resulting in less ageism), compared to younger students who are faced with possible financial and housing challenges. Personality characteristics and health status of respondents were not measured. This study is also exploratory in nature and cross-sectional rather than longitudinal in design. A longitudinal study of students, examining whether those who intended to work with older clients were actually successful in doing so, would clarify extraneous variables relating to employment such as job availability.

It is clear that clinical exposure to older clients while in training is a common factor in increasing interest in providing health services for this neglected client population. Confidence in clinical practice is also critical, as suggested by other studies in the area that highlight the importance of a practitioner feeling they have the necessary skills to carry out their work (Cummings & Adler, 2007). This suggests that the most salient setting to influence these variables is the tertiary education level where beginning psychologists can have positive, direct clinical experiences with older clients in a supportive environment. Suggestions for providing quality placements have been made in previous research addressing student interest (Koder & Helmes, in press b). Rather than focusing on increasing formal course content, facilitating high quality specialty placements in aged care settings needs to be an urgent priority for educators in psychology.

TABLE 1

Comparison between practitioner and trainee psychologists on independent variables shown as mean (SD) or number (%) as appropriate

Variables	Practitioners (n =1492)	Trainees (n= 431)	Statistic
Age	49.72 (10.81)	29.22 (7.3)	t = 44.94*
Gender: Females	72.6%	86.5%	χ_1^2= 33.33*
Aged Care Course in degree: Yes	47.9%	25.2%	χ_4^2 = 76.52*
Placement in aged care setting: Yes	14%	23.1%	χ_1^2= 19.12*
Evaluation of training #	3.91 (2.21)	5.04 (1.98)	t= -10.05*
Confidence in working with older adults #	6.82 (2.24)	5.38 (1.98)	t= 12.69*
Interest in working with older adults #	6.11(1.95)	5.31(1.84)	t=7.72*
Perceived difficulty in working with older adults #	6.62 (2.09)	5.72 (1.84)	t= 8.46*
RAQ scale	110.38 (19.43)	103.04 (16.98)	t= 7.40*

* p≤ 0.001 # range: 0-10

TABLE 2

Hierarchical regression model summary: comparison of practitioners and trainees

	Practitioners		Trainees	
Model	R^2 change	F change	R^2 change	F change
1 Training variables	.066	47.533*	.23	58.315*
2 add Contact variables	.063	24.239*	.058	7.772*
3 add Attitudinal variables	.273	121.71*	.104	10.687*
Total R^2	.402		.395	
Overall model	F(11,1332)=81.529*		F(12,373)=20.334*	

*p<0.001

TABLE 3

Hierarchical regression: Comparison of independent variables between practitioners and trainee psychologists

	Practitioners			Trainees		
Variable	B	SE B	Beta	B	SE B	Beta
Placement	.616	.126	.109 **	1.602	.183	.370**
Aged care courses	.122	.052	.051*	.104	.086	.051
Quality of friend contact	.200	.057	.095**	.127	.094	.074
Confidence	.463	.022	.532**	.230	.044	.247**
RAQ worry	-.017	.008	-.058*	-.024	.020	-.056
RAQ positive anticipation	.049	.013	.097**	.089	.020	.202**
RAQ negative personality	-.038	.014	-.065*	.001	.027	.001

*p<.05 **p<.001

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CHAPTER 9

DISCUSSION

INTRODUCTORY SUMMARY

The present research described three separate surveys with the common aim of identifying predictors of working with older clients. The pilot study of Sydney practising psychologists and the national Australian survey of practising psychologists used as the criterion variable whether or not a psychologist specialised in working in aged care. Post-graduate trainee psychologists were surveyed about variables related to interest in working with older adults. The Reactions to Ageing Questionnaire was the formal measure of attitudes towards ageing, with demographic factors, training and other attitudinal items related to clinical practice with older adults included in the survey content.

The finding common to the three studies was the role of clinical placements in influencing interest (among trainee psychologists) and actual practice in working with older clients. Participation in a placement in an aged care setting accounted for a significant amount of variance in either belonging to specialist practitioner groups or being interested in working with older adults in the future. The other shared variable was having confidence in working with older people. Contact - either with family or acquaintances- failed to influence intent or practice in terms of working with older people-a finding that is contrary to previous studies on countering negative stereotypes.

However, the present research also introduced the effect of the context in which contact occurred. It appears that clinical contact is more relevant, compared to contact outside of the clinical setting, such as with older family members. When examining predictors of clinical practice, attitudes and contact variables need to relate specifically to that context in order to exert influence, such as contact with clients in the form of a placement.

I. SUMMARY OF RESEARCH QUESTIONS AND MAIN FINDINGS

(i) The status of geropsychology in Australia: A cause for concern

A primary practical question put forward by this research and specifically addressed in Study 3 related to the status of geropsychology in Australia. Previous discussion of this issue has raised concerns regarding the dearth of clinical psychologists in aged care in Australia but exact figures were lacking (Koder & Ferguson, 1998). The present national survey resulted in a figure of 6.1% of specialists (the definition of specialist was a clinician whose caseload comprised at least 50% of clients over the age of 65). This figure is comparable to previous overseas studies (e.g., Lee, Volans & Gregory, 2003; Qualls, Segal, Norman, Niederehe & Gallagher-Thompson, 2002). The student survey indicated that 5% of trainees plan to specialize in aged care and only two students from a sample of 431 were engaged in study in aged care in the form of a specialist geropsychology program. Such findings do not bode well in terms of preparing to meet the future demand resulting from increasing numbers of elderly Australians requiring psychological services.

(ii) Training in geropsychology

Other demographic and professional practice results from the national survey suggested that practitioners were typically aged in their late 40s and were female with 16 years of professional experience in psychology. Psychology training appeared to be lacking in terms of preparing psychologists to work with older adults despite half of the respondents having had exposure to at least one course with ageing related content. This situation appears to have improved marginally with current trainees rating their level of preparedness in working with older adults more highly than practitioners, yet the trainee survey found that there has been a decrease in ageing related course content over the past 20 years (Study 6). Concerns regarding training in geropsychology have been raised in a recent survey of clinical psychology program directors (Pachana, O'Donovan & Helmes, 2006) with course directors indicating a common desire for increased course content on working with older adults.

Improved ratings in terms of adequacy of ageing related training may well be a result of an increase in clinical exposure in the form of more students undertaking a placement compared to practitioners. As stated previously, having done a clinical placement in an aged care setting predicted whether a psychologist worked primarily with older clients. Both the pilot survey (Study 1) and the national survey (Study 2) agreed that specialists in aged care were more likely to be younger, less professionally experienced, more likely to be working within a government setting in an assessment role and had completed training

in gerontology external to their formal degrees. Contact, gender and the amount of aged care content in formal training failed to predict whether a psychologist actually worked with older clients. The influence of aged care courses has been the subject of interest within the educational gerontology literature with mixed results (for example the negative result following training courses in aged care highlighted in Carmel, Cwikel & Galinsky, 1992). The consistent finding is that knowledge alone is insufficient in addressing negative attitudes and behaviour towards older clients (Schigelone, 2003; Hinrichsen & McMeniman, 2002).

(iii)The role of attitudes

Attitudes toward working with older clients were also of interest in the present research. The practitioner survey highlighted the relationship between actual behaviour and interest, with interest emerging as a main factor influencing specialist and generalist group membership. Specialists rated older clients as more difficult to work with and had higher scores on personal ageing anxiety as measured by the Reactions to Ageing Questionnaire (RAQ) in the national survey (Study 2). However closer examination of the RAQ (Study 5), suggests that higher perceived difficulty scores need not necessarily be interpreted as a negative finding, with work with older people perhaps being seen as more challenging and interesting. Predictors of RAQ scores again highlighted the importance of context specificity with attitudes such as perceived difficulty and confidence in working with older clients being predictors of positive attitudes to personal ageing, as opposed to training and contact variables. Age was also related to attitudes to subjective ageing, thus affirming the

theory that our expectations of old age become more positive as we ourselves age, due to increased experience with ageing and the out-group itself (Tajfel & Turner, 1979). Age also was positively associated with work experience, although the number of years spent working as a psychologist does not appear to influence subjective attitudes (Study 5). It appears professional contact with clients is less important than having the potential for shared experiences and empathy due to increased age and life experience in general.

The survey of trainee psychologists (Study 4) aimed to illuminate possible directionality of findings. Having raised the possibility that specialists being younger and less experienced may be due to extraneous practical factors such as job availability (as opposed to intentional factors such as actively seeking out employment within aged care), trainees in fact identified placements and having confidence in working with older clients as being responsible for increased interest. Again, contact failed to exert any influence, as was the case with formal ageing related courses. Therefore, comparisons between the types of predictors in practitioners and trainees (Study 6) suggest that psychologists do not enter their training with a predisposition to working with older clients. Rather, their professional contact with older clients influences their decision to work with older clients and actual behaviour, that is: specialising in aged care.

II. THEORETICAL IMPLICATIONS OF FINDINGS

(i) The role of emotion in attitude formation and its relationship with behaviour

The tripartite model of attitude formation which includes emotion or affect in the formation of attitudes (Vaughn & Hogg, 2005) appears to be confirmed with RAQ scores being related to actual behaviour: here, working with older people. The lack of influence of formal ageing-related coursework suggests that addressing stereotypes (or intervening at the cognitive level) fails to impact on behaviour as opposed to direct experiences that could dispel any existing prejudice. Increasing formal knowledge regarding older people did not predict whether a practitioner or student was respectively working with or interested in working with older people. Significant results from the measure that directed responses at a personal, rather than societal, level (RAQ) further supported the need to measure attitudes at an emotional level. The factor structure of the RAQ strongly indicated the presence of an emotional construct in the scale due to the worry factor accounting for nearly a third of the variance in RAQ scores following principal component analysis (Study 2).

Social identity theory (Tajfel & Turner, 1979) was supported by the present study with age being related to RAQ scores (Study 5). Therefore the theory can also be extended to apply to professional health service providers and their attitudes towards clients. It appears that

attitudes transcend professional barriers, as similar age groups are perceived as members of an in-group and void of negative stereotypes.

Fishbein and Ajzen (1975) discuss the need for specificity in trying to predict behaviour from attitudes- a comment that has significance in the present research. In comparing trainee and practitioner predictors of interest in working with older clients (Study 6), attitudes were stronger predictors for the (older) practitioners compared to the training variables having more salience in the student group. Correlations between attitudes and behaviour may rise if they are defined carefully and made relevant to the specific situation. In the present research, a consistent finding was the significant relationship between confidence and both attitudes and behaviour. Yet this was carefully defined as confidence in working with older people - relevant to clinical psychology practitioners. Previous research examining intent, attitudes and actual behaviour have often aimed to predict intent from general attitudes, as opposed to attitudes and actual behaviours relative to the specific situation (McKinlay & Cowan, 2006).

The present research suggests that any intervention into attitude change needs to incorporate engagement at the emotional level, more so than at the cognitive level, to fully impact on intent and actual behaviour.

(ii) The contact hypothesis re-evaluated

The contact hypothesis failed to predict either attitudes towards personal ageing or behaviour in the present research. Examination of favourable conditions needed to maximize the positive influence of contact (Schwartz & Simmons, 2001) suggests that these conditions need closer definition. The contact provided by placements may have had a positive effect on ageist attitudes. The main clinical therapy model taught across Australian universities tends to be cognitive-behavioural (Pachana, O'Donovan & Helmes, 2006). This model focuses on working collaboratively with clients in aiming to alleviate distressing symptoms such as depression or anxiety, through self-control techniques such as relaxation training, or by challenging irrational cognitions regarding themselves, their experiences and their future. Cognitive-behaviour therapy therefore would be promoted and practised within therapy placements, this being the most familiar model for psychology students. Placements in aged care settings were rated favourably by both practitioner and student psychology groups so it is not unreasonable to assume that a certain degree of success in clinical experiences with clients was reached in these placements, thus dispelling any pre-existing stereotypes of elderly people being unable to learn, being weak and not worth working with, as has been suggested by other studies with clinical psychologists (Shmotkin, Eyal & Lomranz, 1992). Therefore criteria for favourable contact (Wittig & Grant-Thompson, 1998) such as its voluntary nature (placements in aged care settings are not compulsory in Australia), equal status (presumed by the collaborative tenet of CBT), mutually positive in regard (assumed in any client-therapist relationship) and stereotype-disconfirming (as discussed above) were met by placements, but are not necessarily so relevant external to the clinical setting. Contact with family and friends may well contain

many more extraneous variables that may not meet the criteria for contact to exert a positive influence on attitudes and behaviour.

Another condition that needs to be satisfied and adequately measured related to contact appears to be the level of affect as a consequence of contact. Previous studies have examined this in terms of including assessment of how rewarding contact is, but perhaps the appropriateness of this term requires closer examination. Schigelone (2003) has discussed the interaction of client or patient contact with attitudes of care deliverer and highlighted the expression of self-efficacy in attitudes. The present research appears to support this theory that more positive attitudes towards older people result from contact in which a care deliverer feels more confident and competent in their professional work as seen in the relationship between confidence and interest, action and RAQ scores. Defining success in terms of work-related results and client-therapist interactions would appear to be a logical point of entry in intervening in the area of attitude change amongst professionals.

The present research also differed from past methodology using contact as a variable in defining frequency and quality with anchors (for example, “once a month”) rather than general terms open to interpretation. This would narrow variance in respondents’ ratings, in particular the younger trainee ratings that may have had fewer opportunities for contact with older family and acquaintances (Study 4, Table 1). The contact hypothesis has been criticized for adopting non-quantitative methodology (Pettigrew & Tropp, 2006) with previous studies failing to define the target group, using terms such as “older adults” as

opposed to the present research that specified family or friends and defined specialist psychologists.

In conclusion, the present research has added to the literature by highlighting the importance of both careful definitions of terms and situational specificity when examining the issue of contact.

(iii) The Reactions to Ageing Questionnaire: More support for the importance of emotion

The Reactions to Ageing Questionnaire (Gething, 1994) was chosen as the present research's primary measure of ageism due to its high reliability and validity with other measures of ageism and use in health groups such as nurses (Wells, Foreman, Gething & Petralia, 2004) and psychiatrists (Draper, Gething, Fethney & Winfield, 1999). In addressing one's subjective ageing, it also tapped into affect as opposed to knowledge.

The factor structure of the RAQ in the present research differed from two previous analyses. Three factors emerged from principal component analysis of practising psychologists (Study 1, 2): worry about growing old, positive anticipation of old age and negative personality changes. The trainee study with its younger subjects had an additional fourth factor loading on loss-related items. Such results are at odds with previous earlier work with health professional samples which identified physical wellbeing, denial of ageing and isolation as additional factors (Gething, 1994), and in another study using nurse

samples (Wells et al, 2004): frailty, tedium and loss. However, the most recent research on the RAQ resulted in a similar three-factor structure to the present result, defining the factors as negativity about growing older, perceived personal attributes and positive aspects of ageing (Gething, Fethney, McKee, Persson et al, 2004).

Similar to other studies (Gething, 1994), age was identified as a significant predictor of RAQ scores, together with other attitudes towards conducting therapy with older clients, such as confidence and perceived difficulty (Study 5). These attitudinal inter-relationships, together with the large contribution of a worry factor on RAQ variance, support the RAQ being a measure of the affective component of ageism. Training and contact failed to relate to RAQ scores in the present research (Study 5). The present research had a much larger sample, averaging 600 participants, compared to previous studies. High internal consistency was obtained in all three samples (Study 1, 2, and 4). Predictive validity of the RAQ was demonstrated with RAQ scores being significant in correctly classifying psychologists who specialised in aged care (Study 2). This is a successful start to meeting the recommendation put forward by Gething et al (2004): “The nexus between attitudes, behaviour and practice has yet to be demonstrated empirically” (p.53).

(iv) Survey methodology and comparisons of response rates

Adequate sample representation is crucial to increase the precision in estimating the characteristics of the population being examined. Larger sample sizes help reduce sampling error. The present research aimed to maximize response rates using the tailored design method (Dillman, 2000). The pilot study (Study 1) did not use this method and mailed surveys without personally addressing cover letters, resulting in a comparatively poor response rate (39%), as warned by Dillman: "the mail survey method was considered undesirable - a procedure to be avoided if at all possible because of poor response rates and a host of other deficiencies" (p.4). The tailored design method, with its emphasis on both repeated contacts and personalized communication, resulted in a higher response rate (Study 2) of 61%. This latter response rate compares favourably to other mail surveys using practitioner groups with similar survey items. For example a 48% response rate was obtained in a survey of psychiatrists using the RAQ in Draper et al's 1999 study and 45.7% in a survey of recent social work graduates (Cummings & Adler, 2007). A very high response rate with clinical psychologists was obtained in a study where participants were administered the survey questionnaire in person at their worksite, with only two participants declining to participate from 190 (Shmotkin, Eyal & Lomranz, 1992). Other mailed survey studies in general using psychologist samples result in similar response rates to the professional groups cited above (for example, James & Haley, 1995). Dye's 1978 national US survey of psychologists resulted in a response rate of only 19%.

The student study (Study 4) utilized a different method. Surveys were sent via course co-ordinators. A very high interest in having their students participate in the study was implied by the high response rate (84%) of Heads of Psychology Departments to the original email

request. The final survey response rate (45%) was congruent with other student surveys that were also to be returned by mail (Weiss, 2005; Gellis, Sherman & Lawrance, 2003). The impact of personalized contact as opposed to having surveys distributed by a person not directly involved in the research project is underscored in the light of an 83% response rate in a study of social work students where surveys were distributed and explanations given in person regrading confidentiality and the nature of the study (Cummings, Adler & DeCoster, 2005). Relatively high numbers in the present study were obtained due to its national distribution, as opposed to focus on a local university or State as is more often seen in the literature with reported sample sizes as low as 96 (Gellis, Sherman & Lawrance, 2003).

Therefore the present research has highlighted an important methodological variable that has the potential to positively impact on reducing sampling error: that of personalized, repeated contact in survey implementation.

III. PRACTICAL IMPLICATIONS OF FINDINGS

(i) Training

As previously discussed, formal training in clinical psychology with older adults does not appear to adequately prepare psychologists for work with this population. Arguments have been raised that this group is one of the most heterogeneous age groups (Peterson, 2004),

thereby negating the need for specialised attention. However older clients can present with unique issues related to increased physical illness and medical conditions, in particular dementia. Dementia is predicted to reach epidemic proportions in the next 20 years, proving costly and disabling (Access Economics, 2003). Research on the impact of psychological intervention on challenging behaviours in dementia has shown it to be clinically effective and cost effective in reducing distress in carers and preventing placement in residential care (Bird, Llewellyn-Jones, Smithers & Korten, 2002). Cognitive-behaviour therapy has also been the subject of recent attention, with applications to conditions that tend to occur more commonly in older adults such as working with physically frail elderly, treating co-morbid depression in chronic conditions, such as Parkinson's Disease and following stroke (Koder, 2007). Therefore efforts need to be directed to training future psychologists in working with this growing population, given the expected rise in numbers of older adults and associated conditions.

Increasing course content devoted to ageing *per se* is unlikely to have much impact on intent, behaviour and attitudes towards working with older Australians, based on the present and past research on the effects of training. Direct exposure to clinical settings that can provide a positive experience for trainee psychologists appears to be the most efficacious method of impacting on behaviour: that is, actual work with older clients. Should future efforts at increasing course content in ageing be coupled with quality clinical exposure, it is more likely that attitude change is going to occur as both cognitive (knowledge) and affect as well as behaviour (actual clinical work with older clients) will be addressed, these forming the components of attitudes. Whether placements alone are

sufficient in promoting positive attitudes and influencing behaviour is not known, with a British survey of trainee psychologists recommending both "good quality placements and teaching" (Lee, Volans & Gregory, 2003, p.7). Lack of experienced lecturers in teaching ageing related courses may be an impediment to increasing course content, but solutions have been raised including using the expertise of field supervisors (Kneebone, 1996).

The present research suggested that training is highly relevant for students compared to attitudes in terms of influencing their interest in working with older clients (Study 6). In particular, having completed a relevant placement was the most predictive variable in making a unique contribution to interest in working with older people, followed by confidence in working with the elderly. Research has supported the positive effect of placements in changing attitudes towards working with older clients (Brodie, 2004) and that these can be positively received in themselves, with practitioners in the present research rating placements in old age settings highly (Study 2). Overseas studies have also highlighted positive feedback regarding direct training in the old age specialty amongst psychologists (Packard, 2007; Karel, Molinari, Gallagher-Thompson & Hillman, 1999). Therefore placements in aged care settings appear to be valued and should be given higher priority amongst planners of education programs in psychology. Furthermore, increasing specialists in aged care would have a positive effect on future training and placements as the pool of supervisors and lecturers in this field will subsequently grow.

(ii) Service delivery

Specialists in aged care appeared to be more likely to provide assessment services compared to therapeutic interventions (Study 2). This may interact with the finding that specialists also were more likely to hold post-graduate qualifications as neuropsychology is taught at a more intensive level in post-graduate clinical programs. Specialist neuropsychology training has become more increasingly popular and this is only available at a post-graduate level with seven universities offering specific clinical neuropsychology programs in a recent survey (Pachana, O'Donovan & Helmes, 2006). Whether clinical experience in aged care should then be a part of under-graduate psychology programs is worthy of consideration in order to impact on the numbers of specialists in aged care. Concern regarding the lack of practical experience in under-graduate/4th year training has been raised with recommendations to incorporate professional experience with clients earlier in training in order to improve clinical standards (Jones, 2008). This has been found to impact positively on nurse samples' attitudes (Rogan & Wyllie, 2003). Having positive professional contact with older clients early on in a psychologists' career may also have a positive effect on attitudes and interest in working with the elderly (Lee, Volans & Gregory, 2003).

The comparative dearth of practice in clinical therapy compared to assessment by specialists in aged care is a concern given the expected rise in mental illness in older Australians (Kneebone, 1996; Brodaty, 1991). Unfortunately, it may well reflect a narrow focus in post-graduate training with few opportunities to learn about a breadth of topics

relevant to aged care practice (Kneebone, 1996). Issues such as grief, retirement and behaviour management in nursing homes can be covered in training so as to prepare psychologists for work with this population (Ferguson & Koder, 1998). Perhaps the lack of effect for formal training may also reflect lack of coursework in clinically relevant therapy areas with 3.5% of course content specific to work with older people compared to devoting over 20% of course content to children in an examination of Australian psychology training (Kneebone, 1996). The present practitioner survey (Study 2) mirrored that earlier study with 17.4% of the sample defining themselves as child psychologists as opposed to 4.8% specializing in work with older adults.

Practitioners appeared to have access to older clients within their workplace and identified lack of referrals as the main barrier to seeing older clients. As discussed in Study 2, several factors may be responsible. A cohort effect could be operating with the current group of people aged over 65 being less aware of the positive benefits of psychological interventions and possibly holding negative biases regarding seeing a psychologist. Older people tend to present to medical general practitioners with psychological complaints (Parslow & Jorm, 2001) and a variety of myths regarding the older person's ability to benefit and change as a result of psychological therapy abound (Laidlaw, Thompson, Dick-Siskin & Gallagher-Thompson, 2003). Referral agents may hold a bias regarding the role of a psychologist, narrowing this down to assessment of cognitive dysfunction. It behoves various relevant APS Colleges and Interest Groups to be active in educating potential referrers and clients in the range of activities that psychologists carry out in the area of aged care, extending to promoting positive ageing (Gething, Gridley, Browning, Helmes et al, 2003). Balancing

knowledge of mental illness with the normal experience of ageing is needed in practice and training. For example, psychologists may have a role in helping people adjust to retirement.

In relative terms, geropsychology is a new specialty and this may influence job availability. As discussed via Study 2, new graduates may have found work within government aged care settings more readily available due to its undesirability compared to say, general clinical work or work with children, resulting in younger, less experienced psychologists making up the workforce in aged care settings. Hopefully as such workers increase and employers see the value of psychology input, it will be seen as equally attractive. Being a pioneer in a clinical area can be an attraction for a clinician in itself with clinical therapy with older clients only receiving special attention in the literature from the mid to late 1980s, despite developmental theories appearing some 30 years earlier with the work of Erik Erikson (Knight, Santos, Teri & Lawton, 1995).

Practical service delivery issues unique to aged care include physical access, transport, the need to often incorporate carers into therapy programs and the number of older people in residential facilities. The last setting raises many issues from education of staff to ethically defining responsibilities and confidentiality: such process oriented but practical concerns need to be considered by practising clinicians and addressed in the training of psychologists. The older person needs to be recognized as being part of their community in any effective health care model where practitioners are brought into the community as

opposed to an individual client-therapist setting in an office. This may also help make mental health service delivery more accessible, demystifying the role of psychologists.

(iii) Addressing ageism

Age of respondent correlated significantly with scores on an ageism scale (Study 5). This raises speculation as to whether training efforts are best directed at older trainees who may be more interested in working with older clients due to shared social identity. However age did not predict actual practice: rather, younger psychologists were more likely to specialize in aged care.

The present research has uncovered an association between actual behaviour, positive clinical experiences and positive attitudes towards ageing, with the latter two variables predicting both student and practitioner interest and behaviour. Professional attitudes also appear to be related to general attitudes towards personal ageing, underscoring the need to address any ageing biases by practical exposure during training. Again, exposure to successful ageing to avoid negative stereotypes of the elderly as infirm is essential. Situational specificity is important given the lack of effect for personal contact outside of

training, despite contact with family and friends being rated as positive and relatively frequent across the studies of this research.

Professional ageism has been discussed in the literature with concerns raised about older clients being denied access to efficacious treatment of conditions common to older people such as depression (Helmes & Gee, 2003). Reducing this form of ageism through exposure to successful therapy outcome is necessary to avoid generalizations regarding the prognosis of psychological conditions in older clients. Increasing opportunities to challenge negative beliefs regarding the older person's ability to benefit from psychological input needs to be given heightened importance in program development. Broader cultural values may also need to be addressed given the skewed emphasis on youthfulness in present day Western media and culture.

IV. RECOMMENDATIONS

(i) Training

The present research has consistently highlighted the importance of relevant clinical exposure during the training phase of a clinical psychologist's career. Therefore clinical placements in aged care settings should ideally be made a mandatory component of a psychologist's training. Lack of clinical supervisors is an impediment to this goal both in Australia and overseas, yet flexible alternatives have been discussed (Study 4). For

example, psychology trainees can have exposure to older clients via placements in a rehabilitation or pain management service. Stipulating the amount of exposure to clients aged over 65 should be included in APS mandatory training recommendations for clinical psychologists.

Training should attempt to integrate theory with practice by preparing students for their work in older age settings and having courses in age-related topics in close temporal proximity to actual placements. Process oriented attention by means of student discussion of expectations, concerns and debriefing is also highly recommended. Small group tutorials would be an ideal setting for this to take place as potential age-related biases and stereotypes can be addressed within the confines of a potentially less threatening environment.

Much has been written of late regarding core competencies for psychological work with older clients (Pachana, Helmes & Koder, 2006). Three major US meetings on this topic have been held since 1981 regarding training, with the Pikes Peak Model for Training in Professional Geropsychology (Knight, Karel, Hinrichsen, Qualls & Duffy, 2007) recommending that geropsychologists should be competent in service delivery in a variety of settings, including inpatient and community medical and psychiatric settings, as well as long term care settings. This document also discusses the variety of entry points in training specifically in geropsychology, including post-masters or doctoral training. Post-doctoral

fellowships are a relatively recent progression of academic training in Australia but could be a method to support further study in aged care for psychologists.

Training external to universities, such as workshops sponsored by psychological organizations such as the APS and Australian Association for Cognitive Behaviour Therapy, can provide added support for those either wishing to expand on their knowledge or for promoting awareness of aged care issues within general clinical psychology work. Workshops and lecture series have recently been promoted to good effect among US psychologists wishing to broaden their knowledge base to include work with older clients. Supervision for practising psychologists also needs attention and mentoring programs have been discussed as a means of promoting geropsychology within generalist psychology practitioners (Packard, 2007). Members of the APS Psychology and Ageing interest group should be encouraged to join other, more general psychology organizations and represent geropsychology as a sub-specialty.

(ii) Improving access to geropsychology services

The main survey of practising psychologists (Study 2) indicated that although psychologists had the potential to see older clients within their practice, referrals were not forthcoming. This raises several issues regarding access that need addressing in order to improve service delivery.

Potential referring agents such as general practitioners need to be educated regarding the benefits of psychological intervention for their patients. One salient example is in the area of anxiety management where commonly prescribed benzodiazepines can lead to iatrogenic problems such as ataxia and confusion, causing additional disability. The best starting point for this is within the education of medical students. Although medical training does acknowledge the role of behaviour on illness development and maintenance, specific training in aged care psychology is minimal. Geriatric rotation could include exposure to allied health professionals such as psychologists in order to increase awareness of non-pharmacological management of common medical and psychiatric conditions in older patients. Inter-departmental liaison between psychology and medicine within tertiary institutions is recommended to broaden education of future health practitioners in aged care. This may also decrease any negative stereotypes held by medical students by seeing positive results of age-related interventions.

Psychologists could also liaise with general practitioners in discussing how best to address common presentations of older patients such as pain, anxiety and depression. Area Health Services in Australia comprise Divisions of General Practice where specialists in geropsychology could give presentations to GPs in order to heighten awareness of the interface between behaviour and a variety of medical presentations and the role of clinical psychology. Similar co-operation has already begun between the APS Psychology and Ageing interest group and the Royal Australian and New Zealand College of Psychiatrists Faculty of Old Age Psychiatry.

Other allied health professional groups, ranging from nurses to social workers, need to become aware of the role of clinical psychology. For example, the active lobbying for psychology positions on aged care assessment teams is strongly recommended, especially in light of the increase in the prevalence of dementia with an ageing population, which in turn requires accurate diagnosis supported by assessments by psychologists.

Psychologists themselves are encouraged to be proactive in publishing treatment outcome results of interventions in promoting interventions with a sound research base. To this end, psychologists need to be aware of grants and other funding opportunities to pursue their research work. Although this should already begin during post-graduate training, it can be promoted via the various professional psychology bodies. The APS and university psychology departments should be active in lobbying for research funding from a variety of local, state, federal and community sources. In this way, interventions can be readily accessed by older consumers whilst simultaneously increasing the scientific knowledge and exposure of issues related to geropsychology. Furthermore, liaison between psychology departments and employers in aged care settings (for example, in residential facilities) can result in increased opportunities for students to conduct research.

(iii) Increasing consumer awareness

Older adults may not be aware of the role of psychological factors in their behaviour and illnesses. As stated previously, the current cohort of the old-old (over 80s) tend to attribute somatic causes to emotional problems. However this is likely to change once the baby

boomers reach over 70 years of age. Preparing for the likelihood of increased numbers of consumers desiring non-medical interventions is prudent. Avenues for marketing psychology could include presentations during "Seniors" week and regular liaison with local community groups such as the RSL, Probus or other clubs on a range of topics such as relaxation, pain management or managing retirement. This introduces a preventative component to the role of clinical psychology in the care of older adults.

Cost is often cited as a reason for not consulting a psychologist. Medicare rebates have been introduced since November, 2006, making psychological intervention more affordable. However, dementia is excluded from rebatable conditions, and this shortcoming needs to be addressed, as was successfully done in the case of autism by advocacy groups (Autism Victoria, 2007). The need for continued advocacy to government authorities on behalf of older Australians is underscored in the light of US findings that older adults have a low rate of usage of mental health services on account of limits on rebates, despite the wide spread availability of Medicare there (Karlin & Humphreys, 2007). Government bodies need to be made aware that problems of old age are not just medical problems but can become social ones (for example, untreated mental illness developing into homelessness).

Other government organizations such as the Department of Veterans Affairs have contractual arrangements with practising psychologists but consumers are often not aware of this service. Community organizations such as the Parkinsons Association and Victims Compensation Unit are other sources of access to psychology services at no cost to the

consumer. A potential project for psychology organizations would be to provide a list of such services to general practitioners. These services providing access to psychologists need to liaise closely with universities, hospitals and community health services to promote awareness of their potential use.

V. LIMITATIONS OF THE PRESENT STUDY AND FUTURE RESEARCH

The present research is cross-sectional in nature and precise causal relationships between variables remain unknown. Continued examination of the interest, attitudes and behaviour of post-graduate psychology students as they progress through their training and enter the workforce may provide more accurate analysis of the inter-relationships between these variables and working with older clients. Of particular interest is whether pre-existing attitudes change as a result of both direct and indirect exposure to older clients.

Comparison of attitudes of students undertaking speciality training in geropsychology and those doing more general training would be of interest. Such results can be directly compared to the present practitioner survey in examining predictors of choosing to work and train specifically in aged care. Continued follow-up of students who undertake and complete specialty training in geropsychology would more accurately specify the relative influences of training and experience. A survey of students who have completed geropsychology training in terms of subsequent employment availability and clinical practice may illuminate both the relationship between intent and actual behaviour (whether they actually worked in aged care) and employment opportunities.

Evaluating placements more closely may add to definitions regarding the components of a high quality placement in an aged care setting. One such project would be to carefully analyse post-placement written evaluations by students and pool results for those involving older clients in order to identify predictors of successful placements.

The survey questionnaire did not address other variables that may impact on attitudes towards one's own ageing, such as health, religious beliefs and retirement plans. These have been examined in other work using the RAQ that suggested they indeed do exert influence on attitudes (Draper, Gething, Fethney & Whitfield, 1999). Exposure to caring for older relatives or living with a grandparent may also affect results and such influences require further analysis. Potential personality traits of people specializing in aged care would be a worthwhile extension of the present research. There is a gap in the literature on

predictors of ageism in terms of stable trait factors compared to state personality traits that are more open to change.

The subjects of this research were recruited via the telephone directory and despite efforts to reduce coverage error, address potential sampling bias (potentially towards private practitioners) by adding the Western Australian group (comprising all registered psychologists for that state) and by good return rates, improvements in sampling can be considered. Here, access to more government department employed psychologists would improve the representativeness of the sample. Support from the APS in sponsoring a national survey would be one method of achieving this goal, although it is likely that a lower proportion of government employees belong to the APS than of private practitioners. Higher response rates in the student survey may have been obtained if direct distribution was possible but this was offset by sending the surveys to a wider national sample both to increase numbers and to limit potential bias from individual campuses or States.

The present research has raised a variety of issues pertaining to the construct of ageism. This work has been exploratory in nature as opposed to testing specific hypotheses regarding the influences on attitudes and behaviour. The results highlight the importance of direct relevant exposure to older clients and these results require replication with other disciplines and psychology sub-specialties, such as those who work in residential aged care. Confirmatory factor analysis in the form of structural equation modelling to assess the validity of the tripartite model of attitude formation would be valuable. The RAQ does not

appear to have been the subject of confirmatory factor analysis of its constructs. Given the variance in identified factors thus far in the literature on the RAQ, this seems timely.

VI. CONCLUSION

The present research presented six separate studies related to the examination of psychologists' attitudes, training and behaviour in the provision of services to older Australians. Three survey studies were reported together with results pertaining to the main independent measure-subjective attitudes to ageing.

Practical, relevant clinical exposure to older adults appears to be the main factor influencing psychologist behaviour and subsequent service delivery. Suggestions for increasing the number of placements in aged care settings have been made, but support for this on a range of levels (university, potential placement sites, clients themselves) is necessary and has been a subject of increased discussion within the profession. A proposal to seek government support for students on placements in residential aged care facilities is currently being drafted through the Australian Psychological Society at the time this thesis is being written.

Geropsychology is a relatively young specialty and it behoves current academic and clinical leaders in the field to lobby for increased exposure in terms of employment

availability and meaningful course content. Re-examining these issues in several years time, once the potential pool of clients and practitioners has risen, will hopefully see that clinical geropsychology has “come of age”.

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LIST OF APPENDICES

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APPENDIX A - ETHICS APPROVAL

JAMES COOK UNIVERSITY Townsville Qld 4811 Australia Tina Langford, Ethics Administrator, Research Office. Ph: 07 4781 4342; Fax: 07 4781 5521

ETHICS REVIEW COMMITTEE **Human Ethics Committee** *APPROVAL FOR RESEARCH OR TEACHING INVOLVING HUMAN SUBJECTS*					
PRINCIPAL INVESTIGATOR	**Deborah-Anne Koder**				
SUPERVISORS	A/Prof Edward Helmes & Mr Alistair Campbell (Psychology)				
SCHOOL	Psychology				
PROJECT TITLE	**A survey of Australian psychologists in aged care: the relationship between training, attitudes and professional practice with older clients**				
APPROVAL DATE	12 Aug 2005	**EXPIRY DATE**	31 Aug 2007	**CATEGORY**	1
This project has been allocated Ethics Approval Number with the **following conditions**:				**H**	**2141**

1. All subsequent records and correspondence relating to this project must refer to this number.
2. That there is **NO** departure from the approved protocols unless prior approval has been sought from the Human Ethics Committee.
3. The Principal Investigator **must advise** the responsible Ethics Monitor appointed by the Ethics Review Committee:
   - periodically of the progress of the project;
   - when the project is completed, suspended or prematurely terminated for any reason;
   - if serious or adverse effects on participants occur; and if any
   - unforeseen events occur that might affect continued ethical acceptability of the project.
4. In compliance with the National Health and Medical Research Council (NHMRC) *"National Statement on Ethical Conduct in Research Involving Humans"* (1999), it is **MANDATORY** that you provide an annual report on the progress and conduct of your project. This report must detail compliance with approvals granted and any unexpected events or serious adverse effects that may have occurred during the study.

NAME OF RESPONSIBLE MONITOR	Gordon, Frances
EMAIL ADDRESS:	frances.gordon@jcu.edu.au
ASSESSED AT MEETING **22 Sep 06: Amendment approved: Additional subjects from Masters Programs (interstate).**	***Date:*** 27 Jul 2005
APPROVED **Associate Professor Peter Leggat** **Chair, Human Ethics Committee**	***Date:*** 12 Aug 2005
Tina Langford Ethics Officer **Research Office** Tina.Langford@jcu.edu.au	Date: 27 September 2006

APPENDIX B: PILOT SURVEY

JAMES COOK UNIVERSITY

SCHOOL OF PSYCHOLOGY

A SURVEY OF PSYCHOLOGISTS AND THEIR EXPERIENCES WITH ELDERLY CLIENTS

Demographic information:

1. Age: _____

2. Gender: Male/Female (please circle)

Education and training:

3. Please state your highest academic qualification:

---

4. Please list to the best of your recollection any components in the courses listed above that specifically relate to aged care or other issues of elderly persons *(eg. neuropsychology of dementia in neuropsych. component of Masters; normal age related changes in the brain in undergraduate Year 3):*

5. Have you done any training specifically in working with older adults? Please state through which institution. *(eg. Institute of Psychiatry 'Psychiatry of Old Age' Course, Diploma in Gerontology, University of Sydney):*

6. How well do you think your education in psychology equipped you for clinical work with elderly clients*?:*

1	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*
very poorly				*just adequately*					*very well*

7. Did any of your courses have a clinical placement/practicum as a formal requirement*?*

Yes/No *(Please circle)* *(*If no, go to Question. 10)

8. If so, please describe any specific aged care setting experience (*eg. psychogeriatric community team placement, Memory Disorders Clinic):*

9. How would you rate your satisfaction with the above placement/s?

1	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*
very dissatisfied				*adequate*					*very satisfied*

Professional membership:

10. Please state your APS College affiliation (if any):

Counselling _____
Clinical _____
Neuropsychology _____
Other (Specify) ____________________
Nil _____
Not an APS member _____

11. Are you a member of the APS ‘Psychology and Ageing’ Special Interest Group?:

Yes/No *(Please circle)*

If you answered “ no” please go to question 13.

12. Please rate your overall level of satisfaction with the Psychology and Ageing Group in terms of addressing your professional needs.

1	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*
very dissatisfied				*adequate*					*very satisfied*

Comments: ____

____

Employment:

13. What is your current level of employment? *Full-time/Part-time*

14. Do you also work for a government agency? *Yes/No*

15. If so, what is your current professional position/title? (*eg. Senior Clinical Psychologist, Mental Health worker, Private Practitioner, Consultant):*

____

16. What proportion of your working week is spent in private practice?

<10% ____
10-25% ____
25-50% ____
50-75% ____
75-100% ____

17. How many years have you been practising as a psychologist? ____________

18. Have you ever been employed in an aged care setting? If so, please describe the setting:

____
____
____
____

19. Please tick the category most closely describing your current work setting involving the bulk of your working week:

a) General hospital ___
b) In-patient mental health unit ___
c) Out-patient/community mental health team ___
d) Non-government organisation ___
e) Child/adolescent team/unit ___
f) Neuropsychology practise ___
g) Administration ___
h) Research team ___
i) University department ___
j) Independent practise ___
*k) Other (*please specify) ___

20. Please tick the category that best describes the age range of your clients:

a) Under 13 years of age ___
b Between 13 and 25 years of age ___
c) General adult (18-65 years) ___
d Over 65 years ___

IF YOU ANSWERED A OR B PLEASE GO ONTO QUESTION 25

THE NEXT SET OF QUESTIONS SPECIFICALLY RELATE TO CLINICAL PRACTICE WITH OLDER CLIENTS

21. What proportion of your clients would be over 65 years of age? *(tick the appropriate percentage):*

a) Under 5% ____
b) Between 5 and 25% ____
c Between 25 and 50% ____
d) Between 50 and 75% ____
e) Over 75% ____
f) Total practice ____

22. Do you have potential access to older clients (over 65) in your workplace?:

Yes/No (Please circle)

IF YOU ANSWERED NO PLEASE GO ONTO QUESTION 25

23. Please number the types of activities you perform **involving older adults** in order of level of frequency *(eg. if primarily neuropsychological assessment, write 1 and then rate the remaining activities in terms of how much time is spent on them down to 9):*

a) Neuropsychological assessment ____

b) *Individual therapy* ____
c) *Group therapy* ____
d) *Consultation with organisations/professionals* ____
e) *Research* ____
f) *Teaching* ____
g) *Working with carers* ____
h) *Supervision* ____
i) *Administration* ____

24. Please tick the models of intervention that best describe your clinical work with elderly clients*. (*Do not tick more than 3):

a) *N/A (*not primarily conducting therapy) ____
b) *Cognitive-behaviour therapy* ____
c *Management of challenging behaviours* ____
d) *Family therapy* ____
e) *Narrative therapy* ____
f) *Solution-focused therapy* ____
g *Carer counselling* ____
h) *Dynamic psychotherapy* ____
i) *Supportive counselling* ____

25. Please rate your level of confidence in working with older clients.

1	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*
not at all confident				*moderately confident*					*very confident*

26. Please rate your level of interest in working with older clients.

1	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*
would not see if I had a choice				*no particular preference*					*specialise in the area*

27 The following statements have been attributed to health workers' beliefs about elderly clients. Please rate how strongly you believe these statements:

		Agree	No opinion	Disagree
a)	*Older people can be too rigid to change*	*1*	*2*	*3*
b)	*I can learn from older people*	*1*	*2*	*3*
c)	*Older people are capable of benefiting from therapy*	*1*	*2*	*3*
d)	*I enjoy working with older people*	*1*	*2*	*3*
e)	*Working with the elderly is challenging*	*1*	*2*	*3*
f)	*I wonder if it's worth putting effort into older people*	*1*	*2*	*3*
g)	*I enjoy hearing about the lives of my older clients*	*1*	*2*	*3*
h)	*The "usual" therapies are harder to use with older clients*	*1*	*2*	*3*
i)	*Older people will soon die, so what's the point?*	*1*	*2*	*3*
K	*There's no difference in doing therapy with older clients*	*1*	*2*	*3*

28. Reactions to Ageing Questionnaire

(Gething, L. 1994 Australian Journal on Ageing, 13, 77-81.)

REACTIONS TO AGEING QUESTIONNAIRE

Here is a list of questions describing how people feel about themselves as they age. Statements refer to thoughts about growing older and about events associated with ageing. Please **tick a box** to indicate how much you agree/disagree with each statement as it refers to your own reactions to being over 65 years of age.

Please answer each question on its own merits and do not refer back to earlier answers.

		I disagree very much	I disagree somewhat	I disagree a little	I agree a little	I agree somewhat	I agree very much
1	Old age will be an enjoyable time of life.						
2	I worry that I might become senile and lose my mind.						
3	I hope that I might look back on my life with a sense of pride.						
4	I will be more lonely than I am now.						
5	Old age brings satisfactions which are not available to the young.						
6	Becoming frail is rarely an issue which concerns me.						
7	I worry about dying and leaving behind those I love.						
8	It worries me that I won't enjoy life as much as I do now.						
9	I find the thought of growing old depressing.						
10	Life can get better once you pass middle age.						
11	I will regret the loss of strength and attractiveness.						
12	I don't feel there is much to be scared about becoming an older person.						
13	I worry about loss of independence.						
14	I expect to be a loving caring person.						
15	I will be able to accept the death of friends and loved ones as a natural part of life.						
16	I look forward to growing old with someone I love.						
17	I worry about becoming frail.						
18	I will become more irritable and grouchy than I am now.						
19	Others may find me difficult to get along with.						
20	I will be more set in my ways and reluctant to change.						
21	I won't like growing old.						
22	I do not worry about the thought of becoming senile and losing my mind.						
23	I will worry about the loss of loved ones around me.						
24	In my old age I will be as enthusiastic about life as I am now.						
25	There is a lot to look forward to in regard to being old.						

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Research Centre for Adaptation in Health and Illness

Please check the survey that you have answered all the relevant questions, place the booklet in the reply paid envelope enclosed and return as soon as possible.

Thank you very much for your time in completing this questionnaire.

APPENDIX C - PRE-CONTACT LETTER - Main survey

Type in name and address as to appear on window envelope

Dear Colleague,

A few days from now you will receive in the mail a request to complete a brief survey being conducted through James Cook University.

It concerns psychologists' experiences with older adults both personally and professionally. Data from this National survey will significantly aid future planning in the education and clinical service provision for older Australians, a relatively neglected area.

The study forms the principal researcher's PhD and has been approved by the Human Ethics Committee at James Cook University.

Thank you for your time and consideration in supporting this project.

Yours sincerely,

DEBORAH KODER

PhD Candidate
School of Psychology
James Cook University
Townsville QLD 4811
Tel: (07) 4781 4182

APPENDIX D - COVER LETTER- Main Survey

(Type in name and address)

Dear Colleague,

Re: *A Survey of Australian Psychologists in Aged Care: The Relationship Between Training, Attitudes and Professional Practice with Older Clients.*

I am writing to ask for your assistance in completing a survey as part of a study into psychological services for older Australians.

Your training, current practice information and attitudes will help in understanding service delivery patterns to older clients. Results from the survey will be very helpful in planning psychological training and clinical services for this increasing sector of the Australian population.

The survey takes approximately 10 minutes to complete and your participation is voluntary. All information is completely confidential and your responses will only be released as pooled results from which any one score cannot be identified. You will see a number on the back of the return envelope that is only used to track responses. Upon receipt of your completed questionnaire, your name will be deleted from the mailing list. Confidentiality is very important so the list of names will be destroyed with no identifying feature on the actual survey. If you would prefer not to respond, please return the blank survey in the enclosed stamped envelope.

The project has been approved by the Human Ethics Committee of James Cook University. Data from the survey will be used toward the principal researcher's Doctor of Philosophy thesis. Should you have any concerns, please contact me via email: deborahpsych@aol.com or you can contact the University Research Office via Tina Langford, Ethics Administrator, James Cook University, Townsville, QLD 4811.Phone: (07) 4781 4342, email: Tina.Langford@jcu.edu.au

Thank you very much for your help in this important National survey.

DEBORAH KODER

Doctoral Candidate
School of Psychology
James Cook University

Primary Supervisor:

Prof. E. Helmes
School of Psychology
James Cook University

(07) 4781 5159

Secondary Supervisor:

Dr. A. Campbell
School of Psychology
James Cook University

(07) 4781 4182

APPENDIX E - MAIN SURVEY

JAMES COOK UNIVERSITY

SCHOOL OF PSYCHOLOGY

A SURVEY OF PSYCHOLOGISTS AND THEIR EXPERIENCES WITH OLDER ADULTS

Demographic information:

1. Age: _____

2. Gender: Male/Female (please circle)

Contact with older adults outside work context:

3. At present, how often do you have contact with **your family members** over 65 years of age?

1	2	3	4	5
rarely	infrequently	sometimes	frequently	very frequently
(almost never)		(about once a month)		(more than) once a week)

4. In general, how rewarding have you found your interactions with **your family members** over 65 years of age to be?

1	2	3	4	5
not at all	a little	moderately	very	extremely

5. How often do you currently have contact with **your friends or acquaintances** over 65 years of age?

1	2	3	4	5
rarely	infrequently	sometimes	frequently	very frequently
(almost never)		(about once a month)		(more than) once a week)

6. In general, how rewarding have you found your interactions with **your friends or acquaintances** over 65 years of age to be?

1	2	3	4	5
not at all	a little	moderately	very	extremely

7. During your formal undergraduate psychology training, how often did you have contact with **your friends or acquaintances** over 65 years of age?

1	2	3	4	5
rarely	infrequently	sometimes	frequently	very frequently
(almost never)		(about once a month)		(more than) once a week)

Education and training:

8. Please indicate your highest academic qualification in psychology:

Bachelors ____

Honours, PG Diploma ____

Masters ____

D.Psych ____

PhD ____

9. How many subjects in your formal psychology training specifically related to issues of older persons or the psychology of ageing? (*tick the appropriate content)*

Nil content ____

One subject ____

Two subjects ____

Whole course ____

within degree ____

Designated specialty degree ____

(eg D. Geropsych)

10. Have you done any training specifically in aged care outside of your formal psychology training? *(eg. Institute of Psychiatry 'Psychiatry of Old Age' Course, day workshops):*

Yes/No (Please circle)

11. How well do you think your education in psychology equipped you for clinical work with elderly clients?:

1	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*
very poorly				*just adequately*					*very well*

12. Have you done a clinical placement/practicum in an aged care or psychogeriatric setting?

Yes/No *(Please circle)*

Employment:

13. How many years have you been practising as a psychologist? __________

14. What percentage of your time is spent in private practice?

(tick the appropriate percentage)

nil ____

5-25% ____

25-50% ____

50-75% ____

total practice ____

15. Please tick the one category <u>most closely</u> describing your current work practice involving <u>the largest amount</u> of your working week:

a) Clinical therapy ___
b) Neuropsychology practice/assessment ___
c) Research ___
*d) Other (*please specify) ___

16. What proportion of your clients would be over 65 years of age*? (tick the most appropriate percentage):*

a) Nil ____

b Between 5 and 25 ____

c) Between 25 and 50% ____

d) Over 50% ____

e) Total practice ____

f) Not applicable (not a clinician) ____

17. Do you have access to older clients (over 65 years of age) in your workplace?:

Yes/No *(Please circle)*

18. Please tick the main factor limiting the number of older clients coming to your workplace:

(a) Nil-there are no such limits ____

(b) do not work within a clinical setting ____

(eg organizational, sports psychology, teaching)

(c) *specialize in the area of child/adolescent psychology* ____

(d) *I am rarely, if ever, referred older clients* ____

(e) *I have poor physical access in my setting (eg stairs)* ____

(f) *Another part of my work setting caters to this population (eg if located in general hospital)* ____

(g) *Older people are unaware of my practice* ____

19. Please rate your level of confidence in working with older clients.

1	2	3	4	5	6	7	8	9	10
not at all confident				*moderately confident*					*very confident*

20. Please rate your level of interest in working with older clients.

1	2	3	4	5	6	7	8	9	10
would not see if I had a choice				*no particular preference*					*specialise in the area*

21. Please rate how difficult you feel conducting therapy is with older clients compared to other clients.

1	2	3	4	5	6	7	8	9	10
highly difficult				*somewhat challenging*					*no different to younger clients*

22. ***Reactions to Ageing Questionnaire***

(Gething, L. 1994 Australian Journal on Ageing, 13, 77-81.)

(See Appendix B)

APPENDIX F - TRAINEE SURVEY-Cover Letter

February, 2007

Dear Colleague,

Re: *A Survey of Trainee Psychologists and their Experiences With Older Adults.*

I am writing to ask for your assistance in completing a survey as part of a wider study into psychological services for older Australians.

Information concerning your training and contact with older adults, and attitudes will help in understanding service delivery patterns to older clients. Results from the survey will be very helpful in planning psychological training and clinical services for this growing sector of the Australian population.

The Head of the School of Psychology from your particular program has given approval for recruitment for this study to occur. A relevant member of the academic staff is handing out the survey in the first weeks of the semester or I will be attending to distribute it myself. The survey takes approximately 10 minutes to complete and your participation is voluntary. All information is anonymous and your responses will only be released as pooled results from which any one score cannot be identified. A reply paid envelope is attached for returning the survey.

The project has been approved by the Human Ethics Committee of James Cook University. Data from the survey will be used toward the principal researcher's Doctor of Philosophy thesis. Should you have any concerns, please contact me via email: deborahpsych@aol.com, one of the my supervisors listed below or you can contact the University Research Office via Tina Langford, Ethics Administrator, James Cook University, Townsville, QLD 4811.Phone: (07) 4781 4342, email: Tina.Langford@jcu.edu.au.

Thank you very much for your help in this important National survey.

DEBORAH KODER	Primary Supervisor:	Secondary Supervisor:
Doctoral Candidate School of Psychology James Cook University	Prof. E. Helmes School of Psychology James Cook University	Dr. A. Campbell School of Psychology James Cook University
	(07) 4781 5159	(07) 4781 4182

APPENDIX G -TRAINEE SURVEY

JAMES COOK UNIVERSITY

SCHOOL OF PSYCHOLOGY

A SURVEY OF TRAINEE PSYCHOLOGISTS AND THEIR EXPERIENCES WITH OLDER ADULTS

Demographic information:

1. Age: _____

2. Gender: Male/Female (*please circle*)

Contact with older adults:

3. At present, how often do you have contact with **your family members** over 65 years of age?

1	2	3	4	5
rarely	infrequently	sometimes	frequently	very frequently
(almost never)		(about once a month)		(more than) once a week)

4. In general, how rewarding have you found your interactions with **your family members** over 65 years of age to be?

1	2	3	4	5
not at all	a little	moderately	very	extremely

5. How often do you currently have contact with **your friends or acquaintances** over 65 years of age?

1	2	3	4	5
rarely	infrequently	sometimes	frequently	very frequently
(almost never)		(about once a month)		(more than) once a week)

6. In general, how rewarding have you found your interactions with **your friends or acquaintances** over 65 years of age to be?

1	2	3	4	5
not at all	a little	moderately	very	extremely

Education and training:

7. How many subjects in your formal psychology training so far have specifically related to issues of older persons or the psychology of ageing? (*tick the appropriate content)*

Nil content ____

Some content within a subject ____

One subject ____

Two subjects ____

Whole course within degree ____

Designated specialty degree ____

(eg D.Geropsych/M.Geropsych./PG.Dip.Geropsych)

8. Which year of your Masters program are you currently enrolled in? *(tick the corresponding year)*

1st year ____

2nd year ____

3rd year ____

9. Are you studying on a full-time or part-time basis? (*Please circle*)

Full-time/Part-time

10. How well do you think your present education in psychology will equip you for clinical work with elderly clients?:

1	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*
very poorly				*just adequately*					*very well*

11. Have you done or do you plan to do a clinical placement/practicum in an aged care or psychogeriatric setting?

Yes/No (Please circle)

12. Please rate your level of confidence in working with older clients.

1	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*
not at all confident				*moderately confident*					*very confident*

13. Please rate your level of interest in working with older clients.

1	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*
would not see if I had a choice				*no particular preference*					*specialise in the area*

14. Please rate how difficult you feel conducting therapy is with older clients compared to other clients.

1	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*
highly difficult				*somewhat challenging*					*no different to younger clients*

PLEASE TURN THE PAGE

22***. Reactions to Ageing Questionnaire***

(Gething, L. 1994 Australian Journal on Ageing, 13, 77-81.)

(See Appendix B)

APPENDIX H –STATISTICAL RESULTS

(a) Discriminant Function Analysis (Study 1)

Structure Matrix	Function
Variable	1
Interest	.831
Specific geriatrics training	.385
Years spent working	-.351
Age	-.252
Confidence	.228
Aged care course	.160
Total attitude score	.044
RAQ	.028

Classification Results-80.2% of original grouped cases correctly classified

		Predicted Group Membership	
		Generalist	Specialist
Count (N)	Generalist	128	31
	Specialist	7	26
%	Generalist	80.5	19.5
	Specialist	21.2	78.8

(b) Logistic Regression (Study 2)

Variables in the equation

Variable	B	SE B	Wald	Exp(B)
Frequency of contact during training	-.106	.155	.466	.899
Speciality training in aged care	1.681	.398	17.83**	5.372
Placement	-.154	.432	.127	.857
Confidence	.355	.184	3.73	1.426
Interest	1.501	.209	51.314**	4.485
Difficulty	-.309	.098	9.992*	.734
Total RAQ	-.024	.010	5.61*	.977
Total frequency contact	-.033	.104	.099	.968
Total quality contact	-.194	.139	1.945	.824
Number of aged care courses	.683	.407	2.815	1.981

*p<.05 **p<.001

Classification Table

Observed		Predicted Group Membership		
		Generalist	Specialist	% correct
Group: generalist vs specialist	Generalist	1216	13	98.9
	Specialist	26	37	58.7
Overall percentage				97%