Age and Health Bias in Practicing Clinical Psychologists

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Although ageism is widely cited as a problem in mental health delivery, it is unknown whether practitioner biases are related to factors such as physical health. A randomly drawn national sample of experienced practicing doctoral-level psychologists (N = 371) responded to detailed vignettes of a client presenting with symptoms of depression, in which age (35 years or 70 years) and health (unremarkable or poor) were manipulated. Respondents completed ratings involving professional and interpersonal judgments about the hypothetical client. Results revealed some evidence for age bias, but much stronger effects indicating health biases regardless of client age. Because depressed older persons often present with concomitant health problems, health bias among clinicians is especially relevant for older patients. Implications for service delivery to older adults, and individuals with health problems, are discussed.

Among other factors, including relatively poor insurance coverage and reticence on the part of the elderly to seek mental health services, ageism on the part of service providers has been widely cited as an important factor in the relatively low proportion of elderly receiving treatment for mental health concerns (Lebowitz & Niederehe, 1992). Available estimates suggest that older adults constitute only 2.7% of the caseloads of psychologists (VandenBos, Stapp, & Kilburg, 1981) and are underserved in other outpatient mental health settings (Gatz & Smyer, 1992). Although recent regional surveys have indicated that there are increasing numbers of psychologists treating the elderly (Gatz, Karel, & Wolkenstein, 1991), it is generally thought that this population remains underserved. Mental health professionals have been described as “reluctant therapists” in treating the elderly (Kastenbaum, 1963), despite clear evidence that older clients respond positively to individual psychotherapy regardless of orientation (e.g., Arean et al., 1993; Scogin & McElreath, 1994; Thompson, Gallagher, & Breckenridge, 1987).

Empirical demonstration of ageism among mental health professionals is limited, however. Gatz and Pearson (1988) have suggested that the presence of bias among clinicians toward the aged has been greatly overstated and may be nonexistent. These reviewers note that research examining ageism among the general population suggests that such variables as personality traits and health status may exert a more powerful influence on attitudes toward potential clients than age.

Studies assessing age bias among practicing clinicians have suffered from a number of flaws, including use of small, regional samples, overly brief descriptions of potential clients, or use of within-subjects designs (Dye, 1978; Ford & Sbordone, 1980; Ray, McKinney, & Ford, 1987; Settin, 1982). Meta-analysis has shown that providing overly brief descriptions and using within-subjects designs tend to exaggerate potential biases in research on attitudes toward older adults (Kite & Johnson, 1988). In addition, all of these investigations of mental health professionals have focused only on treatment recommendations and diagnoses; none have attempted to measure professionals' perceptions of target personality characteristics, which may explain underlying factors behind any biases.

Available work examining the effects of both age and health on perceivers' attitudes toward the target has supported Wright's (1980) contention that the presence of a physical disability will spread to influence the judgments of characteristics having no necessary relationship with a person's disabling condition. Health factors have been found to exert more potent effects than age in activating negative biases within nonprofessional populations (Braithwaite, 1986; Gekoski & Knox, 1990; Milligan, Prescott, Powell, & Furchtgott, 1989). Gekoski and Knox (1990) have termed this bias healthism, referring to devaluative attitudes and stereotypes toward those in poor health. Within the general population, poor health appears to exert a more powerful effect than does age in activating negative biases.

Although physical health appears to activate negative biases among the general population, it is not known if it has the same effect on clinical psychologists or other mental health professionals. Knowledge of the existence of a negative bias toward a potential client on the basis of age, health status, or some combination of these factors by clinicians is important in that many clients may present with one or both of these conditions. More than 4 out of 5 people aged 65 years and older have at least one chronic health condition (U.S. Senate Special Committee on
Aging, 1991), and mental disorders in older patients commonly occur with comorbid physical illness (Lebowitz & Niederehe, 1992). Clarifying the existence (or nonexistence) of these age and health biases and the factors underlying them is essential in addressing any underservice or misservice these populations may be receiving from mental health professionals.

To address these concerns, we accessed a large, national sample of practicing doctoral-level psychologists, addressing the methodological concerns alluded to earlier. We used detailed descriptions of target persons while controlling for important details such as insurance coverage and the specific symptoms presented. Target age and health were manipulated in a between-subjects experimental design.

In addition, we studied two types of biases that may be exhibited by clinicians: professional bias and interpersonal bias. Professional bias may be thought of as relatively negative professional judgments, actions, or intentions (e.g., seeing a client as less appropriate for therapeutic intervention, differing treatment recommendations, or prognoses) on the basis of a client's age or physical health status, or both. Professional bias was typically the type explored in previous investigations. Interpersonal bias may be defined as the attribution of negative personal characteristics (e.g., rigid, intolerant, or ugly) to a person on the basis of his or her age or health status and has been explored only in investigations using nonprofessionals as participants. We also gathered data on a number of process variables, such as professionals' perceived competency in treating target patients.

We hypothesized that practicing clinical psychologists would exhibit professional and interpersonal healthist biases, consistent with the position of Gatz and Pearson (1988) and the findings of attitudinal literature using participants from the general public. Bias related to age, independent of health, was expected to be relatively small.

Method

Participants

Eight hundred (200 per cell) practicing doctoral-level psychologists were randomly identified through the 1991–1992 edition of the National Register of Health Service Providers in Psychology, an alphabetically arranged professional directory of approximately 16,000 practicing psychologists. This directory also provides information such as age ranges served and when most providers received their doctorate. Any psychologist who stated that his or her clinical practice was limited to a demographic group was excluded from the study. Any psychologist who stated that his or her practice was limited to a specific age range or gender was also excluded.

Procedure

Potential participants were sent a packet including a cover letter explaining the project, one of four possible vignettes, the survey instrument, and an addressed and stamped return envelope. Each cover letter had a handwritten note at the bottom that identified each participant by name, thanked him or her again for participating, and was signed by the investigator, a technique shown to increase response rates in mail studies using professionals (Maheux, Legault, & Lambert, 1989). For purposes of confidentiality, each potential participant was assigned a 4-digit code that was placed at the top of each survey instrument. If a potential participant had not returned his or her survey after 3 weeks, a second packet was sent out, identical to the first with the exception of the cover letter. Data regarding the number of years since each potential participant received his or her doctorate was collected from the National Register, to allow for preliminary analyses comparing professionals who returned the questionnaires versus nonrespondents.

Materials

Vignette. The following vignette was used:

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

A female client was used because women are significantly more likely to be depressed than men (Myers et al., 1984) and there are more older women than older men (U.S. Senate, 1991). A recent review of gender and therapeutic outcome indicates that there are no consistent differences between men and women in terms of responsiveness to psychotherapy (Garfield, 1986). Depressive symptomatology was thought to be an appropriate presentation as it is frequently seen by clinicians and has been shown to be amenable to psychotherapy in both younger and older adults (Scogin & McElreath, 1994).

The vignettes were varied according to age and health. The ages 35 and 70 were chosen because they were thought to be representative of two distinct generations. Health was varied as either unremarkable or with a detailed description of congenital heart disease that has necessitated several recent hospitalizations for the target person. This medical diagnosis was chosen for two reasons: (a) It appeared to be a valid diagnosis for both ages, and (b) it was thought that this presentation would effectively communicate that the patient was experiencing significant chronic health problems.

Survey instrument. Professional bias was assessed by asking participants the following questions:

1. "What do you think the most likely primary DSM–III–R [Diagnostic and Statistical Manual of Mental Disorders, 3rd edition, revised] diagnosis is for Ms. James’s presenting complaint?" Responses were coded according to the various diagnostic categories offered by respondents.

2. "How do you view Mrs. James's ability to develop an adequate therapeutic relationship with you?" Responses were coded on a 7-point Likert scale ranging from 1 (very good) to 7 (very poor).

3. "How appropriate a candidate for psychotherapy do you see Ms. James as being?" rated from 1 (very appropriate) to 7 (very inappropriate).
4. Treatment recommendations were assessed by asking "Please rank order your treatment recommendations for Ms. James." Respondents were provided with the opportunity to rank order the following: short-term psychotherapy, long-term psychotherapy, pharmacological intervention, or hospitalization.

5. "How likely do you feel the probability of Ms. James's presenting complaint being related to an organic mental disorder is?"; rated from 1 (very unlikely) to 7 (very likely).

6. "With regard to her presenting complaint, how would you rate Ms. James's prognosis?"; rated from 1 (very good) to 7 (very poor).

7. "How likely do you rate the probability of Ms. James attempting suicide in the near future?"; rated from 1 (very likely) to 7 (very unlikely).

Interpersonal bias was assessed with the Personal Acceptability-Unacceptability subscale of the Aging Semantic Differential Scale (Rosencranz & McNevin, 1969). Subjects rated the hypothetical client on 7-point Likert scales on 14 dimensions (e.g., generous-selfish, friendly-unfriendly), with higher ratings reflecting less favorable perceptions. This instrument measures a respondent's perception of the social acceptability of a target stimulus. This instrument is widely used and accepted within this avenue of research (e.g., Bell & Stanfield, 1973; Dooley & Frankel, 1990; Gekoski & Knox, 1990; Gekoski, Knox, Johnson, & Evans, 1984; Milligan et al., 1989; Rasch, Crystal, & Thomas, 1977).

The following questions were designed as a preliminary investigation into therapeutic process issues that might explain any age or health effects:

1. "How would you rate your subjective level of competence in treating Ms. James's presenting complaint?"; rated from 1 (very competent) to 7 (no competence).

2. "How comfortable would you feel in treating Ms. James's presenting complaint?"; rated from 1 (very comfortable) to 7 (very uncomfortable).

3. "How open to your treatment recommendations do you see Ms. James as being?"; rated from 1 (completely open) to 7 (completely closed).

4. "How much do you think Ms. James is to blame for her problems?"; rated from 1 (completely to blame) to 7 (completely blameless).

To ensure the effectiveness of the age and health manipulations, the following dimensions were embedded within the items from the Aging Semantic Differential Scale and served as manipulation checks: (a) Health was rated from 1 (healthy) to 7 (unhealthy), and (b) age was rated from 1 (young) to 7 (old).

Additional items were also included for descriptive purposes. These items included participant age, gender, theoretical orientation, years since doctorate, type of degree, type of practice setting, and percentage of clients seen in different age categories.

Results

Preliminary Analyses

Of 800 packets distributed, 371 completed forms were returned for a 46.38% response rate. Response rate did not differ significantly across the four experimental conditions. However, as a precautionary measure to compensate for the unequal cell sizes, Type III sums of squares within the SAS/STAT® GLM procedure (SAS Institute, 1989) were used in all analyses (Tabachnick & Fidell, 1989). When respondents and nonrespondents were compared by $t$ test on number of years since reception of doctorate, they did not differ significantly (mean number of years of respondents = 19.40, mean number of years of nonrespondents = 18.91).

Almost three quarters of the sample was male (74.39%), the average age was 50.86 ($SD = 9.65$), 71.62% reported themselves as being in private practice, and major theoretical orientations were represented (cognitive-behavioral = 32.97%, dynamic-humanistic-other = 41.08%, eclectic = 25.95%). Of particular interest was the relatively high percentage of clients over the age of 60 seen by responding clinicians ($M = 10.43\%$ of caseload). Chi-square and analyses of variance (ANOVA) showed the four groups did not differ significantly in any of these demographic and descriptive variables.

The manipulations of health and age were clearly effective. Subjects rated targets in the poor health condition to be in significantly poorer health, $F(1,366) = 650.18$, $p < .0001$, than the healthy targets. Older targets were also perceived to be significantly older, $F(1,366) = 499.33$, $p < .0001$, than younger targets. A main effect was also found for manipulated health, $F(1,366) = 18.09$, $p < .0001$, such that the targets in poor health were perceived as significantly older than targets with no apparent health problems.

Professional Bias Analyses

A $2 \times 2$ (Age X Health) multivariate analysis of variance (MANOVA) was conducted on the continuous items measuring professional bias. This analysis found significant main effects for age, Wilk's lambda ($5, 359$) = 6.82, $p < .0001$, and health, Wilk's lambda ($5, 359$) = 20.42, $p < .0001$. The interaction term was not significant. Follow-up ANOVAs were conducted on each of these items. A significant main effect was found for age on appropriateness for psychotherapy, $F(1,366) = 11.03$, $p < .001$, such that older targets were seen as being less appropriate candidates for therapeutic intervention. A significant main effect was also found for age on prognosis, $F(1,366) = 17.59$, $p < .0001$, such that older targets were viewed as having a poorer prognosis than were their younger counterparts. No age effects were found on the other items.

Significant main effects were found for health on each item analyzed. The targets in poor health were rated as less able to develop an adequate therapeutic relationship, $F(1,366) = 14.43$, $p < .001$, as being less appropriate for therapeutic intervention $F(1,366) = 13.42$, $p < .001$, as more likely to have their presenting complaint related to an organic mental disorder $F(1, 366) = 13.42$, $p < .001$, as being less likely to commit suicide, $F(1, 366) = 18.52$, $p < .0001$, than were the targets in no apparent physical distress. None of the interaction terms were found to be significant. Means and standard deviations of the professional bias items are presented in Table 1.

We conducted additional analyses to examine for potential differences as a function of target age and health on the two categorical items used to measure professional bias: diagnosis and treatment recommendations. With regard to diagnosis, 48.27% of respondents diagnosed the target (regardless of condition) as having Major Depression. The other diagnoses included Adjustment Disorder (18.68%), Uncomplicated Be-
reavement (10.63%), Dysthymia (9.20%), and Brief Reactive Depression (1.44%). Respondents who did not complete this item (11.78%) were not included in this analysis. When responses were categorized as either major depression or other and compared by chi-square analysis across groups, no significant differences were found.

Rather than following instructions to rank order all possible treatment recommendations, the vast majority of respondents ranked only 1 or 2 recommendations. Because of this, it was determined that the most appropriate analysis on this variable would be to examine for potential differences that the different treatment recommendations were ranked as the first choice across groups. The treatment options were categorized as short-term psychotherapy (64.37%), pharmacological intervention (20.40%), or other (includes long-term psychotherapy, hospitalization, and other; 15.23%). Chi-square analysis revealed no significant differences across groups for any of these recommendations.

Interpersonal Bias Analyses

A 2 x 2 (Age x Health) MANOVA was conducted by using the scores on each item from the Personal Acceptability–Unacceptability subscale of the Aging Semantic Differential Scale. A significant main effect was found for health, Wilks’s lambda (14, 350) = 4.68, p < .001, but no significant age or interaction effects.

Followup ANOVAs revealed significant main effects for health on the dimensions of handsome–ugly, \( F(1, 363) = 20.73, p < .0001 \); cooperative–uncooperative, \( F(1, 363) = 11.43, p < .001 \); optimistic–pessimistic, \( F(1, 363) = 13.46, p < .001 \); flexible–inflexible, \( F(1, 363) = 6.11, p < .05 \); hopeful–dejected, \( F(1, 363) = 7.68, p < .01 \); happy–sad, \( F(1, 363) = 6.88, p < .01 \); truthful–suspicious, \( F(1, 363) = 5.86, p < .05 \); tolerant–intolerant, \( F(1, 363) = 13.41, p < .001 \); pleasant–unpleasant, \( F(1, 363) = 20.02, p < .0001 \); and exciting–dull, \( F(1, 363) = 3.80, p < .01 \). In all these cases, the effect was such that the targets in poorer health were rated more negatively than those with no apparent health problems. Significant Age x Health interactions were found for the dimensions of tolerant–intolerant, \( F(1, 363) = 7.09, p < .01 \); ordinary–eccentric, \( F(1, 363) = 4.34, p < .05 \); and exciting–dull, \( F(1, 363) = 5.57, p < .05 \); such that the younger targets in poor health were viewed most negatively. These interactions should be interpreted with caution, however, because the MANOVA for the interaction was not significant. The means and standard deviations of the interpersonal bias items are presented in Table 2.

Process Issues Analyses

Because these variables represented diverse dimensions, individual 2 x 2 ANOVAs were conducted on each item. Significant main effects were found for health on psychologist’s subjective competence, \( F(1, 366) = 33.48, p < .0001 \); psychologist’s comfort in treating, \( F(1, 367) = 29.11, p < .0001 \); and target’s openness to treatment recommendations, \( F(1, 367) = 48.81, p < .0001 \). Psychologists rated themselves as less competent and comfortable in treating the target in poor health and viewed the target in poor health as less open to recommendations. No significant effects were found in these analyses for age or the interaction term. The means and standard deviations of the variables used in these analyses are presented in Table 3.

Discussion

The main purpose of this study was to determine the effect of age on mental health professionals’ perceptions of a presenting client when other salient factors, such as health, were carefully controlled. The finding that professionals continue to rate older clients as less appropriate for their services and see their prognosis as less positive than for younger clients is consistent with previous work in this area and is unsettling in light of numerous published studies reporting successful treatment of depression with this population.

A positive finding with regard to age was that those individuals 60 years and older constituted approximately 10% of the average responding clinician’s caseload. This is substantially higher than national figures reported elsewhere (Gatz & Smyer, 1992) and is consistent with recent reports based on regional samples indicating a trend for increasing numbers of elderly being treated by psychologists than previously reported (Gatz, Karel, & Wolkenstein, 1991).

Healthism on the part of service providers appears even more pervasive than ageism, leading not only to professional bias but also to interpersonal biases for both older and younger targets. The fact that clinicians offered consistently less positive interpersonal ratings for persons in poor health relative to those with

### Table 1

<table>
<thead>
<tr>
<th>Item</th>
<th>Healthy (N = 82)</th>
<th>Unhealthy (N = 100)</th>
<th>Healthy (N = 99)</th>
<th>Unhealthy (N = 90)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Therapeutic relationship</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M</td>
<td>2.21</td>
<td>2.21</td>
<td>2.21</td>
<td>2.21</td>
</tr>
<tr>
<td>SD</td>
<td>1.16</td>
<td>1.16</td>
<td>1.16</td>
<td>1.16</td>
</tr>
<tr>
<td><strong>Candidate for psychotherapy</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M</td>
<td>2.21</td>
<td>2.21</td>
<td>2.21</td>
<td>2.21</td>
</tr>
<tr>
<td>SD</td>
<td>1.16</td>
<td>1.16</td>
<td>1.16</td>
<td>1.16</td>
</tr>
<tr>
<td><strong>Organic mental disorder</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M</td>
<td>2.39</td>
<td>3.53</td>
<td>2.22</td>
<td>3.13</td>
</tr>
<tr>
<td>SD</td>
<td>1.27</td>
<td>1.66</td>
<td>1.80</td>
<td>1.63</td>
</tr>
<tr>
<td><strong>Prognosis</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M</td>
<td>2.30</td>
<td>3.17</td>
<td>1.89</td>
<td>2.79</td>
</tr>
<tr>
<td>SD</td>
<td>0.85</td>
<td>1.13</td>
<td>0.94</td>
<td>1.02</td>
</tr>
<tr>
<td><strong>Likelihood of suicide</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M</td>
<td>4.70</td>
<td>4.23</td>
<td>4.88</td>
<td>4.21</td>
</tr>
<tr>
<td>SD</td>
<td>1.24</td>
<td>1.28</td>
<td>1.18</td>
<td>1.35</td>
</tr>
</tbody>
</table>

Note. Higher scores denote ratings of target as having poorer ability to develop a therapeutic relationship, being less appropriate for psychotherapy, being more likely that symptoms are related to an organic mental disorder, having poorer prognosis, and being less likely to attempt suicide.
Ordinary-eccentric  
Neat-untidy  
Friendly-unfriendly  
Pleasant-unpleasant  
Tolerant-intolerant  
Trustful-suspicious  
Tolerant-intolerant  
Trustful-suspicious  
Tolerant-intolerant  
Trustful-suspicious  
Tolerant-intolerant  
Trustful-suspicious  
Tolerant-intolerant  

The tive reason is apparent why persons in poor health would be rated more negatively on dimensions such as tolerant-intolerant or flexible-inflexible. This is of particular concern for older adults. Older adults frequently present with symptoms of depression in the context of a chronic physical illness. Thus, if older persons are not viewed less positively because of age factors by psychologists, they are very likely to be viewed less positively on the basis of health factors. On two measures (appropriateness for psychotherapy and prognosis), we found no apparent health problems is especially distressing. No objective reason is apparent why persons in poor health would be rated more negatively on dimensions such as tolerant-intolerant or flexible-inflexible. This is of particular concern for older adults. Older adults frequently present with symptoms of depression in the context of a chronic physical illness. Thus, if older persons are not viewed less positively because of age factors by psychologists, they are very likely to be viewed less positively on the basis of health factors. On two measures (appropriateness for psychotherapy and prognosis), we found

effects for both age and health. Older persons in poor health may thus be at risk to experience a form of double jeopardy in their encounter with a mental health professional.

Several explanations should be considered in accounting for healthist biases. Because the majority of respondents to this project are in private practice, the health biases exhibited by respondents may be reflective of a lack of experience with medically ill patients. Respondents rated their level of subjective competence and comfort in treating targets in poor health significantly lower than for targets with no health problems.

The health effects found in this study appear supportive of Wright's (1980) hypothesis that the presence of a physical disability may spread to influence judgments of characteristics having no necessary relationship with a person's disabling condition. It is likely that a heuristic (e.g., Chia, 1980; Hill, Lewicki, Czyzewska, & Boss, 1989) regarding the desirability and treatability of both physically impaired and older patients affected the ratings and may operate in everyday clinical practice. Regardless of the underlying mechanism, mental health professionals should be aware of the potential for such biases and make efforts to avoid them.

This phenomenon does not appear to occur exclusively among mental health professionals. Within the medical profession, Hall, Epstein, Decantins, and McNeil (1993) have shown that physicians' liking of their patients is significantly influenced by the physical and mental health of their patients, such that patients with chronic health problems are liked less by their physicians than those with occasional problems.

In our study, age and health did not affect measures of diagnosis or treatment recommendations. It is possible that psychologists may harbor internal doubts and biases regarding these patients, but their professional behavior remains unchanged. However, it is likely that clinicians communicate their apprehension in treating these patients in a subtle fashion. Seminal to all schools of treatment is the therapist's ability to form a strong therapeutic alliance with the patient (Horvath & Luborsky, 1993). It would appear difficult, however, to provide a physically impaired patient with as warm and trusting an environment as provided to an apparently healthy patient if one feels the former to be less handsome, cooperative, optimistic, flexible, hopeful, happy, trustworthy, tolerant, pleasant, and exciting than the latter. Thus, the biases noted in this study may result in the creation of a self-fulfilling prophecy, in which treatment outcome is adversely affected by the clinician's preconceived beliefs.

This study had a number of significant strengths. It appears to be the first investigation of its kind to use a large, national sample of practicing doctoral-level psychologists who specifically stated that they offered their services to those 65 years of age and older. We attempted to control for a number of variables that have previously been shown to increase the likelihood of falsely inducing negative biases, including overly brief descriptions of the target and a within-subjects design. Other important variables, including the patient's specific symptoms and availability of insurance reimbursement, were controlled.

Future work should assess the effect of medical conditions other than congenital heart problems on clinical perceptions. It is important to better understand how severity of illness is re-

### Table 2

**Means and Standard Deviations of Interpersonal Bias Items**

<table>
<thead>
<tr>
<th>Item</th>
<th>Healthy 70-year-old (N = 82)</th>
<th>Unhealthy 70-year-old (N = 100)</th>
<th>Healthy 35-year-old (N = 99)</th>
<th>Unhealthy 35-year-old (N = 90)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
<td>M</td>
<td>SD</td>
</tr>
<tr>
<td>Generous-selfish</td>
<td>3.39</td>
<td>0.80</td>
<td>3.41</td>
<td>0.90</td>
</tr>
<tr>
<td>Handsome-ugly</td>
<td>3.67</td>
<td>1.14</td>
<td>3.66</td>
<td>1.16</td>
</tr>
<tr>
<td>Cooperative-</td>
<td>2.49</td>
<td>0.76</td>
<td>2.56</td>
<td>1.03</td>
</tr>
<tr>
<td>uncooperative</td>
<td>M</td>
<td>SD</td>
<td>M</td>
<td>SD</td>
</tr>
<tr>
<td>Optimistic-</td>
<td>4.80</td>
<td>1.03</td>
<td>4.80</td>
<td>1.11</td>
</tr>
<tr>
<td>pessimistic</td>
<td>M</td>
<td>SD</td>
<td>M</td>
<td>SD</td>
</tr>
<tr>
<td>Flexible-inflexible</td>
<td>3.91</td>
<td>0.93</td>
<td>3.93</td>
<td>1.01</td>
</tr>
<tr>
<td>Hopeful-dejected</td>
<td>4.95</td>
<td>1.35</td>
<td>5.16</td>
<td>1.19</td>
</tr>
<tr>
<td>Happy-sad</td>
<td>5.89</td>
<td>0.97</td>
<td>5.86</td>
<td>0.84</td>
</tr>
<tr>
<td>Friendly-unfriendly</td>
<td>3.34</td>
<td>0.90</td>
<td>3.42</td>
<td>0.87</td>
</tr>
<tr>
<td>Neat-untidy</td>
<td>3.30</td>
<td>0.85</td>
<td>3.41</td>
<td>0.96</td>
</tr>
<tr>
<td>Trustful-suspicious</td>
<td>3.12</td>
<td>0.83</td>
<td>3.00</td>
<td>0.89</td>
</tr>
<tr>
<td>Tolerant-intolerant</td>
<td>3.46</td>
<td>0.72</td>
<td>3.40</td>
<td>0.79</td>
</tr>
<tr>
<td>Pleasant-unpleasant</td>
<td>3.07</td>
<td>0.85</td>
<td>3.04</td>
<td>0.89</td>
</tr>
<tr>
<td>Ordinary-eccentric</td>
<td>3.30</td>
<td>0.88</td>
<td>3.20</td>
<td>0.93</td>
</tr>
<tr>
<td>Exciting-dull</td>
<td>4.11</td>
<td>0.68</td>
<td>3.99</td>
<td>0.73</td>
</tr>
</tbody>
</table>

Note: Lower values are associated with the more desirable characteristic listed in each pair.
larger issues, such as health care reform (Gatz & Smyer, 1992), for older adults will increasingly be addressed in the context of (Knight, Teri, Santos, & Wohlford, in press). Mental health care rather, results underscore recommendations that psychologists diverse somatic conditions (Blanchard, 1994). Geriatricians are that clinicians are able to effectively treat depression in the elderly presenting problem. There is also clear evidence demonstrating that psychologists were appropriately attentive to the target's subjective competence and less comfort in treating the target, and the target standing how health biases affect perceptions relevant to older varying levels of physical disability. Study of health conditions apparent toward individuals with more severe health problems. Higher scores denote ratings of psychologists as having less subjective orientation that was used leaves unanswered where the threshold for blame for their problems.

The results of this project should not be interpreted as an indication that psychologists and other mental health providers are unwilling or unable to provide effective services for the elderly or the physically ill. Even when age or health were found to affect ratings of the target, mean scores on such items as appropriateness for psychotherapy and subjective confidence of the psychologist in treating the target were near the positive ends of the rating scales. Over 60% of the psychologists recommended short-term psychotherapy for the target, regardless of age or health, suggesting that psychologists were appropriately attentive to the target's presenting problem. There is also clear evidence demonstrating that clinicians are able to effectively treat depression in the elderly (Scogin & McElreath, 1994) and that psychological intervention can be an effective component in the treatment of numerous and diverse somatic conditions (Blanchard, 1994). Geriatricians are also quite receptive to psychological assessment and intervention for their elderly patients (Haley, Salzberg, & Barrett, 1993). Rather, results underscore recommendations that psychologists gain experience in mental health services to nontraditional populations, such as the elderly or those in poor physical health (Knight, Teri, Santos, & Wohlford, in press). Mental health care for older adults will increasingly be addressed in the context of larger issues, such as health care reform (Gatz & Smyer, 1992), and psychologists and other mental health professionals must be better prepared to treat patients of all ages with comorbid health problems.

Table 3

<table>
<thead>
<tr>
<th>Item</th>
<th>70-year-old</th>
<th>35-year-old</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Healthy (N = 82)</td>
<td>Unhealthy (N = 100)</td>
</tr>
<tr>
<td>Confidence in treating target</td>
<td>1.68</td>
<td>2.15</td>
</tr>
<tr>
<td></td>
<td>0.66</td>
<td>1.06</td>
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<tr>
<td>Comfort in treating target</td>
<td>1.63</td>
<td>2.09</td>
</tr>
<tr>
<td></td>
<td>0.63</td>
<td>1.11</td>
</tr>
<tr>
<td>Openness to recommendations</td>
<td>2.55</td>
<td>2.91</td>
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<tr>
<td></td>
<td>0.74</td>
<td>1.02</td>
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<tr>
<td>Blame for problems</td>
<td>5.57</td>
<td>5.89</td>
</tr>
<tr>
<td></td>
<td>1.16</td>
<td>1.04</td>
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</table>

Note. Higher scores denote ratings of psychologists as having less subjective competence and less comfort in treating the target, and being less open to treatment recommendations and being less to blame for their problems.

References


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