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Correlates of Mental Health Clinician Self-Awareness and Insight of Attitudes Toward Older Adults

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Abstract

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by

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MS, Walden University, 2018

MS, Walden University, 2014

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

Older adults (ages 65 and older) are expected to increase in the United States by over 70 million by the year 2030. The older adult population requires specialized medical and mental health services to address the needs related to aging. Mental health clinicians trained to address these needs may help older adults to utilize mental health counseling. Self-awareness of attitudes, insight, and knowledge may be skills that affect the attitudes of mental health clinicians toward older adults. Previous research has found that mental health clinicians who engage in self-awareness during a counseling session may improve counseling competency; however, little research has focused on the role self-awareness of mental health clinician attitudes toward older adults may impact this. Additionally, current research does not identify specific factors which may influence self-awareness of attitudes toward this population. The stereotype embodiment theory described the influence that biases embedded in childhood may have on attitudes toward older adults. A multivariate correlational design was used to test for an association between 106 mental health clinicians' counseling older adult clients and self-reported self-awareness and insight. Mental health clinicians were recruited and surveyed using an online survey platform. The results suggested that years of licensed counseling experience may influence engagement in self-reflection, but that new tools must be developed to more accurately assess self-awareness in mental health counselors. Implications for potential positive social change include a better understanding of providing competent therapy by improving mental health clinician's attitudes toward older adults.

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Dedication

I would like to dedicate this work to my wonderful daughters, Julie and Dana, who were very understanding and supportive of me during this time. I would also like to send a special thank you to my husband, Abdallah, who took me to a variety of coffee shops more times than I can count to work on my writing. It seemed like he spent a lot of time waiting for me patiently without complaint. Without his support I could not have achieved this dream. My husband was a true inspiration and kept me focused on the prize. Finally, I would like to thank my mother. Although she passed away a few years ago, I will always remember her words of wisdom: “It is amazing what a girl can do.” Yes, mother, it is amazing what a girl can do.

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Chapter 1: Introduction to the Study

Introduction

Americans are living longer due to advances in medicine and health care, according to the National Center for Chronic Disease Prevention and Health Promotion (2011). Currently, older adults (ages 65 and over) comprise about 20% of the United States population as stated by Salaz et al. (2016). By the year 2030, Salaz et al. reported that there will be more than 70 million older adults, which will comprise the largest generational group of adults in the United States' history. If the older adult population increases as current population statistics predict it will, mental health concerns may increase as well.

The Institute of Medicine (IOM; 2012) warns that the growing older population will require specialized medical and mental health services to address the complexities of aging. The IOM also reports that one in five aging adults has more than one mental health and substance abuse issue. Also, the Center for Disease Control (CDC; 2012) reported that depression is common among older adults due to physical limitations and illnesses, but they often underutilize mental health counseling because they feel their needs are not adequately addressed. The need for mental health clinicians who understand the mental health concerns of this population and who can provide competent, informed counseling has not been adequately addressed in the current literature. Mental health clinicians may need to recognize lifespan development issues as a focus of their treatment planning when working with older adults (Laidlaw & McAlpine, 2008). Specifically, mental health

clinicians may need certain skill sets to recognize and adequately address the needs of various groups including the aging population.

Self-awareness is one such skill that may affect the attitudes of mental health clinicians toward older adults, and the quality of care they provide. The number of contact hours with older adults may be a factor that influences the self-awareness of attitudes toward this population. It is currently unclear in the literature what the relationship is, if any, between the number of hours of contact with older adults and a mental health clinician's self-awareness of his attitudes toward such patients. Filling this gap in the literature may help mental health clinicians identify factors that affect their professional services to older adult clients.

This research uniquely contributed to the literature on providing therapy to the aging population, by addressing mental health clinicians' self-awareness and knowledge of their attitudes toward working with this group. The study focused on how a mental health clinician's contact with such clients may predict mental health clinician self-awareness of attitudes toward older adults. This study was relevant to mental health clinicians because the current literature fails to address whether the degree of contact with certain client populations can influence mental health clinicians' self-awareness of attitudes.

Chapter 1 begins with a discussion of the background research addressing mental health clinician competence, work with older adults, and the general importance of self-awareness, including gaps in the literature as it pertains to my current study. Next, the relevance and immediacy of the lack of awareness of attitudes toward this group, as well

as how this study builds upon previous literature, is examined. Chapter 1 ends with a thorough description of the purpose, nature, and intent of the study, the variables measured, and the research questions and hypotheses.

Background of the Study

Literature dedicated to gerontology standards in counseling has determined that there is a growing demand for competency in mental health clinicians who provide therapy to older adults (Bourassa et al., 2015). Various aspects of the literature have examined a mental health clinicians' need for self-awareness of their attitudes related to this demographic and an examination of how personal biases and perceptions may impact counseling (Waltman et al., 2016). Providing mental health counseling to the aging population may also require a level of competency where a mental health clinician reflects on psychological approaches and experiences and how these may affect others (Chaney & Whitman, 2020).

Knapp et al. (2017) identified self-awareness as a vital skill in developing as an effective counselor and one which requires self-evaluation of competencies, personal biases, and views. Research by Waltman et al. (2006) related to mental health clinician competency supports the connection between a mental health clinician's self-awareness of skill level and client progress—particularly when working with clients who are challenging or of a special population. Some research has suggested that properly trained mental health clinicians, primary care physicians, and links to social services in the community which provide support to the aging population, are all vital to stemming the increase in suicide deaths of older adults (Maples & Abney, 2006). Therefore, mental

health clinicians who are self-aware of their attitudes and biases toward older adults may be better prepared to provide competent counseling.

Older adults are defined as 65 years of age and over according to the American Association for Geriatric Psychiatry (2002). In 1999, the number of older adults in the United States was 35 million, and by the year 2030, they are expected to comprise more than 40% of the population (American Association for Geriatric Psychiatry, 2002). Therefore, it is likely that older adults will need mental health counseling as would any other population. Mental health clinicians may need to recognize the unique presentations older adults have regarding mental health issues. Statistics show that older adults underutilize mental health services due to several factors, including ageism by mental health providers (Lagana & Shanks, 2002). Levy (2003, 2004, 2009) provided the stereotype embodiment theory from which the basis of this research stems. Lagana and Shanks (2002) maintained that ageism is perpetuated by embedded stereotypical thoughts related to older adults that may influence a mental health clinician's world view of this population.

If a mental health clinician is not self-aware of these viewpoints during therapy sessions, a stereotypical attitude may be transferred to the older adult affecting that mental health clinician's competence in working with this population. When mental health clinicians have an in-the-moment awareness of thoughts and viewpoints about a population they are working with, this may serve to uncover biases that stem from personal experiences (Salaz et al., 2016).

Three factors may predict the relationship between mental health clinicians' self-awareness of their attitudes toward older adults. The first factor may be the years of professional counseling experience. The second factor may be the number of older adult clients a mental health clinician sees professionally. The third factor may be the number of contact hours a mental health clinician has with such clients. Whaley and Davis (2007) discussed in their study on cultural competence in mental health services, that the more exposure mental health clinicians have to a special population the more likely they are to gain more confidence in working with this population. Boswell (2012) maintained that mental health clinicians who have contact with older adults at least once a month report a more favorable attitude than mental health clinicians who did not have this level of contact. This type of contact is distinct from overall general counseling experience in that it is not one dimensional or generic and allows for more exposure to age-specific issues related to the aging population (Boswell, 2012).

The literature failed to address whether years of professional counseling experience, the number of older adult clients seen by a mental health clinician, or the frequency of contact with older adults in a counseling session may predict aspects of mental health clinician self-awareness of attitudes toward older adults. Therefore, this study was needed to examine whether any of the factors may affect a mental health clinician's self-awareness of attitudes toward older adults, which could affect counseling competency.

Mental health clinicians will likely need to provide therapy to older adults during their careers. The need to be self-aware of attitudes related to the aging population may

be an important determinant of counseling competency. Social responsibility to competently serve the aging population in mental health is necessary (Tomko & Munley, 2012). Mental health clinicians must address age-specific stereotypes, which are often internalized and perpetuated by cognitive biases and negative attitudes toward older adults (Salaz et al., 2016). Therefore, mental health clinicians who are self-aware of their attitudes and biases toward older adults may be able to provide competent counseling.

Statement of the Problem

The challenges mental health clinicians face as they provide therapy to older adults may be indicative of limitations in a mental health clinician's knowledge related to the aging process and stereotypes perpetuated by the often-negative image of how society portrays people as they reach their senior years (Stuart Hamilton & Mahoney, 2003). Pompeo and Heller Levitt (2014) maintained that mental health clinicians lack a thorough understanding of how their attitudes toward older adults can affect their relationship with them. Waltman et al. (2016) also reported that mental health clinicians are often not the best in recognizing their shortcomings, and inaccurately report their attitudes and feelings related to counseling biases.

Knapp et al. (2017) addressed self-awareness as an important aspect of competent counseling. Mental health clinicians should question their awareness of how they react to their clients, whether they can evaluate their competency regarding the specific population they are working with, and whether they can monitor personal biases and values to avoid inappropriate recommendations (Knapp et al., 2017). Lack of mental health clinician self-awareness may contribute to a lack of overall competency in

providing therapy to older adults and can be a relational component to whether older adults return to therapy (Waltman et al., 2016). For example, in a study by Tomko and Munley (2013), clinical judgments by mental health clinicians providing care to older adults were likely to be negatively affected by a belief that mental illness is a normal part of aging. Research by Hayat et al. (2020) supported the role of self-efficacy and self-evaluation of competency and the direct affect it may have on successful performance and the learning process. This study found that the more medical students evaluated their performance the more likely they were to improve their academic performance.

The current literature on mental health clinician competence failed to completely address the issue of whether mental health clinicians are self-aware of their attitudes toward older adults. Further, it is unclear whether general counseling experience can elicit such awareness; or if contact with special populations such as older adults is necessary. Previous work identified that contact with older adults significantly predicted ageism in undergraduates training for careers as mental health clinicians, which could affect counseling competency (Tomko & Munley, 2013; Waltman et al., 2016). However, there is a lack of literature addressing the effect of older adult contact on other aspects of competencies of established mental health clinicians such as self-awareness. Understanding the relationship between the level of contact with the older adult population and the degree of self-awareness of attitudes toward this population may influence other mental health clinicians to examine their attitudes toward working with older adults. Ultimately, this may inform future research into methods of improving a

mental health clinician's self-awareness of biases and the measures of competency in working with special populations.

The results of this current study suggested that mental health clinicians may achieve heightened self-awareness of their own biases by initiating contact with special populations. Indeed, mental health clinicians are encouraged by the American Psychological Association (APA, 2014) guidelines to be aware of the possibility of biases toward working with special populations such as women and girls (Knapp et al., 2017). Additionally, the Association of State and Provincial Psychology Boards includes self-awareness of attitudes and biases as a guide for the scope of competent practice (Knapp et al., 2017). Further exploration of mental health clinician self-awareness of attitudes and biases toward older adults will help refine standard practices and improve the therapeutic experience of this population.

Purpose of the Study

The purpose of this quantitative, correlational survey design study was to explore whether total counseling experience or frequent counseling contact with older adults was a predictor of self-awareness of attitudes towards older adults. The variables that were measured were self-awareness of mental health clinician attitudes about older adults, the number of years of counseling experience, the number of older adult clients counseled regularly, and the number of weekly contact hours with such clients.

The relationship between contact with older adult populations and self-awareness of attitudes toward this group is not addressed in the current literature, although some addresses mental health clinician attitudes toward older adults. It is unclear if frequent

counseling contact with older adults affects the self-awareness of attitudes toward older adults (Polizzi, 2003). Self-awareness of attitudes toward special populations is an indicator of counseling competency and may predict a mental health clinician's competence in addressing the lifespan development needs of the aging population (Polizzi, 2003).

Research Questions and Hypotheses

Research Question (RQ1): Does the number of years of professional counseling experience, number of older adults seen weekly, and number of contact hours with older adults significantly account for a variance in mental health clinician engagement in self-reflection of attitudes toward older adults as measured by the Self-Reflection and Insight Scale (SRIS)? The null and research hypotheses that were tested are as follows:

H_o1: None of the three independent variables: the number of years of professional counseling experience, number of older adults seen weekly, and number of contact hours with older adults significantly accounts for a variance in mental health clinician engagement in self-reflection of attitudes toward older adults as measured by the Self-Reflection and Insight Scale.

H_a1: At least one of the three independent variables: the number of years of professional counseling experience, number of older adults seen weekly, and number of contact hours with older adults do significantly account for a variance in mental health clinician engagement in self-reflection of attitudes toward older adults as measured by the Self-Reflection and Insight Scale.

RQ2: Does the number of years of professional counseling experience, number of older adults seen weekly, and number of contact hours with older adults significantly account for a variance in mental health clinician need for self-reflection of attitudes toward older adults as measured by the Self-Reflection and Insight Scale? The null and research hypotheses that were be tested are as follows:

H_o2: None of the three independent variables: the number of years of professional counseling experience, number of older adults seen weekly, and number of contact hours with older adults significantly account for a variance in mental health clinician need for self-reflection of attitudes toward older adults as measured by the Self-Reflection and Insight Scale.

H_a2: At least one of the three independent variables: the number of years of professional counseling experience, number of older adults seen weekly, and number of contact hours with older adults do significantly account for a variance in mental health clinician need for self-reflection of attitudes toward older adults as measured by the Self-Reflection and Insight Scale.

RQ3: Does the number of years of professional counseling experience, number of older adults seen weekly, and number of contact hours with older adults significantly account for a variance in mental health clinician insight of attitudes toward older adults as measured by the Self-Reflection and Insight Scale? The null and research hypotheses that were tested are as follows:

H_o3: None of the independent variables: the number of years of professional counseling experience, number of older adults seen weekly, and number of

contact hours with older adults significantly account for a variance in mental health clinician insight of attitudes toward older adults as measured by the Self-Reflection and Insight Scale.

H_a3: At least one of the independent variables: the number of years of professional counseling experience, number of older adults seen weekly, and number of contact hours with older adults do significantly account for a variance in mental health clinician insight of attitudes toward older adults as measured by the Self-Reflection and Insight Scale.

Theoretical Framework

The theoretical basis for this study was the stereotype embodiment theory introduced by Levy (2009). This theory maintains that as children, people are exposed to negative viewpoints and descriptions of the aging process. From this, they form an idea of how older adults should act and be treated in society. Levy stated that as an individual grows, they tend to internalize these negative viewpoints of the aging process and then apply them as they see fit when encountering an older adult. Levy also pointed out that often people are not aware they are applying this stereotyped behavior to an older adult because the belief is so strong and the learned behavior is so comfortable. Stereotype embodiment theory encourages self-awareness of one's attitudes to avoid continued internalization of negative age-related notions.

Nature of the Study

The nature of this study was a quantitative non-experimental cross-sectional correlational survey design that allowed for a single round of data collection (Creswell,

2009). The data were collected from licensed mental health clinicians who self-identify as providing therapy to adult populations.

The independent variables for RQ1 were the total number of years of professional counseling experience, number of older adult clients seen weekly, and weekly contact hours with such clients. The dependent variable was the self-reflection of attitudes toward older adult clients. Data were analyzed to determine the predictive relationship between the independent variables and the dependent variable.

For RQ2, the independent variable was the total number of years of professional counseling experience counseling any demographic, number of older adult clients seen weekly, and weekly contact hours with older adults. The dependent variable was the insight of attitudes toward this group. An older adult client is defined as an adult 65 years or older (Lin et al., 2011). Data were analyzed to determine the predictive relationship between the independent variables and the dependent variable. A quantitative research focus provided the ability to use quick data collecting methods, such as surveys, to solicit responses from mental health clinicians who may work with the aging population.

Definitions

Contact hours: Direct contact hours would include ongoing individual, family, and/or group therapy. The term "ongoing" is further defined as a counseling relationship in which the mental health clinician meets with the client on more than one occasion and most likely once weekly (American Mental Health Counseling Association, 2010).

Counseling relationship: A therapeutic relationship based on trust, respect, and alliance. A mental health clinician is helping a client define, clarify issues, and resolve problems (American Mental Health Counseling Association, 2010).

Mental health clinician: Can be defined as a mental health professional who provides a professional clinical relationship that helps diverse individuals, families, and groups to achieve mental health, wellness, education, and career goals (American Psychological Association, 2017). This includes, but is not limited to, clinical psychologists, psychotherapists, social workers, mental health counselors, and counseling psychologists. They typically have a master's degree or higher in the field of mental health counseling, social work, counseling psychology, or clinical psychology and are practice-oriented professionals. They are licensed by state education and professional boards to practice counseling and psychotherapy. A mental health clinician's professional training consists of an understanding of the theory and research of behavioral sciences (Beck, 1999).

Older adults: Individuals who are aged 65 and over (Salaz et al., 2016).

Self-awareness: This is a conscious self-monitoring where an individual can choose to control behavior by adjusting their viewpoint and world experiences (Pompeo & Levitt Heller, 2014). Self-awareness can also be thought of as self-knowledge, self-reflection, and insight. Individuals may seek to understand why they think the way they do and examine biases that may come from personal experiences, goals, and perceptions. This is identified and described by van Houten-Schat et al. (2018) as engagement in self-reflective learning needs where a person takes a moment to reflect on how much they

may or may not know about something. Self-awareness is considered a positive personal and professional attribute in the field of mental health counseling (Pompeo & Heller Levitt, 2014).

Assumptions

The assumptions that were considered in conducting this research were: (a) the participants for this study did not feel pressured to participate in the survey, (b) the participants had some degree of therapeutic contact with older adults, (c) the participants were competent in that they can read and understand the questions asked on the questionnaire, (d) the participants provided honest answers regarding the number of contact hours and frequency of sessions they have with older adults, and (e) all participants knew that they are volunteers and could withdraw from the study at any time without ramifications.

These assumptions were necessary for this study to make sure the relationship between mental health clinician self-awareness of attitudes with older adults and contact with older adults was tested.

Scope and Delimitations

This study was designed to include licensed mental health clinicians who practiced therapy with adults. Aspects of the research problem that were addressed were: (a) mental health clinicians' self-awareness of attitudes toward older adults and whether this influences counseling competency, and (b) whether the counseling experience or frequent counseling contact with older adults is a predictor of self-awareness of attitudes. The focus of this study was to predict what influences a mental health clinician's self-

awareness of attitudes toward older adults in a counseling session. Current research points to an increase in population in the United States over the age of 65 who may be seeking mental health treatment (Maples & Abney, 2006). Mental health clinicians who provide counseling to older adults were surveyed to determine if the number of contact hours or the frequency of sessions had an impact on the self-awareness of a clinician's attitudes toward this population. Participants in the study were recruited across the United States from a pool of mental health clinicians licensed to practice counseling.

Although participants were recruited across the United States from this pool of clinicians, it was not feasible to officially confirm professional licensing credentials. Nor was it possible to verify the extent of therapeutic contact with older adults without violating the Health Insurance Portability and Accountability Act of 1996.

Limitations

The methods of this study posed potential limitations regarding measurement and construct validity. Data that were collected may have potentially been influenced by social desirability bias such that it was likely that some of the participants over or under-reported on the survey to present a more desirable response. As a result, there may be some doubt that the participants' responses were genuine (Creswell, 2009). For example, Holden and Passey (2009) posited that respondents may answer the questions by responding in the way they think the researcher may want, to project a more favorable or desirable image of themselves. Specifically, social desirability bias has manifested in over-reporting good behaviors and under-reporting bad behaviors (Holden & Passey, 2009).

Regarding internal validity, Creswell (2009) maintained that uncontrolled extraneous variables such as the impact of time as a variable in the study may affect validity. Since this study did not take place over an extended time, it is unlikely that the participants changed in some way by growing weary or tired of their participation in the event. A threat to internal validity in this study was that measures were self-reported, and there could have been the risk that the answers given by the participants were not accurate.

A concern with external validity was that the recruitment of participants was from a convenience sampling from a select group of licensed mental health clinicians. Therefore, the results could not be generalized to all mental health providers.

Significance of the Study

This research uniquely contributed to the literature on providing therapy to the aging population by addressing mental health clinicians' self-awareness of their attitudes toward working with older adults. This study focused on how a mental health clinician's number of years of professional counseling experience, number of older adult clients, or number of contact hours with such clients may predict mental health clinician self-awareness of attitudes toward older adults.

This study was relevant to mental health clinicians because the current literature failed to address whether mental health clinicians may have a better therapeutic impact on working with older adults if they were self-aware of aging attitudes and personal biases. Salaz et al. (2016) supported the need for further research in this area by endorsing that mental health clinicians may benefit from an understanding of providing

therapy to older adults and how this may differ from working with other adult populations.

Current literature in the field of mental health care to older adults strongly supports adequate training and increased counseling skills in working with the aging population as they pass through their lifespan (Goldsmith & Kurpius, 2015). Tomko and Munley (2013) found in their study that older adults report being more likely to seek mental health services from mental health professionals who have a better understanding of clients from other cultures. Specifically, older adults expressed that it is important to them to be treated by mental health professionals who have multicultural competence, awareness, knowledge, and skill in working with a diverse population (Tomko & Munley, 2013). The results of this study are significant in that older adults seeking therapy may be willing to return if they feel a mental health clinician understands the issues of aging (Hsiao et al., 2017).

The implication for social change may be that mental health clinicians could use self-awareness and self-reflection to recognize how negative attitudes toward older adults may affect counseling competency. This may change the way older adults are perceived by mental health clinicians and provide a more positive therapeutic experience for them. More older adults may be willing to seek mental health counseling as a result, which could decrease barriers to help-seeking (Wuthrich & Frei, 2015).

Summary

For this chapter, research on the growing population of older adults and their need to receive competent mental health counseling was discussed. Mental health clinicians

can improve counseling competency when working with the aging population is through self-awareness of their biases, personal experiences, and values (Pieterse et al., 2013) This may be influenced by the number of years of professional counseling experience, the number of older adults a mental health clinician sees, or the number of weekly contact hours with older adult clients (Charles & Carstensen, 2010). It is currently unclear the extent to which any factor predicts mental health clinician attitudes towards older adults. Insufficient real data on this topic provided the opportunity for this research to fill a gap in the literature. The research questions developed emerged from the stereotype embodiment theory (Levy, 2009) and allowed for quantitative research. Additionally, this chapter outlined the background, problem statement, the purpose of the study, research questions, nature of the study, theoretical framework, scope and delimitations, limitations, and significance of the research.

In Chapter 2, the need for mental health clinicians to use self-awareness as a method for improving therapy when working with older adults is explored. How the independent variables in the research questions may impact this as well is also considered. Chapter 2 addresses a more detailed review of the literature and strategies that were used to obtain the selected resources are outlined. The theory used to support the study is described as well. This literature review helps generate future research which may lead to a better understanding of whether there is an impact of a mental health clinician's self-awareness of attitudes on aging and if this may influence therapy as a result.

Chapter 2: Literature Review

Introduction

Older adults in the United States may need mental health care services and should be provided those services by mental health clinicians who have competency related to the aging process. A lack of this competency may be due to a mental health clinician's attitude toward the aging process and stereotypes perpetuated by the often-negative societal portrayal of people as they reach their senior years. One way in which mental health clinicians may counter this negative and often biased attitude may be through self-awareness of personal biases, viewpoints, and self-knowledge of feelings related to counseling biases (Pompeo & Levitt Heller, 2014). Self-awareness may be influenced by several variables: the number of counseling contact hours a mental health clinician has with the aging population, the number of older adult clients seen weekly, and the number of years of counseling experience.

Chapter Overview

The problem driving this study was a lack of research into correlates of self-awareness in mental health clinicians serving the special population of older adults. The purpose of this quantitative study was to examine whether a mental health clinician's self-awareness of personal biases toward older adults may be related to either the number of years of professional counseling experience, the number of older adult clients seen, or the number of weekly contact hours with such clients. Summaries of research, annotations, and peer-reviewed journal articles that address the impact of mental health clinician competence related to the aging process and the effect of self-awareness on

improving the therapeutic process is addressed. This chapter will also compare the similarities and differences of research provided in the literature that may influence a mental health clinician's self-awareness of competency when working with older adults. Understanding the impact various practice related factors may have on a mental health clinician's self-awareness of competency when working with older adults will be explored as well. As further background, this chapter documents the theoretical foundations which provide a lens for the research. The literature review also includes articles related to self-awareness, mental health clinician attitudes, older adults, and aging. The chapter concludes with a summary of the literature review which highlights gaps in the literature and key variables for this study.

Literature Search Strategy

A search of the literature was conducted using many resources and a variety of databases: Psych-INFO, Google Scholar, and ProQuest Dissertation helped me locate peer-reviewed journal articles related to psychology, counseling, aging, and stereotypes. These research databases were used to find articles in counseling journals, geriatric psychology, educational gerontology, psychiatric nursing, and psychology books located in the Walden Library. Websites such as the Centers for Disease Control & Prevention and National Center for Chronic Disease Prevention & Health Promotion were explored as well.

Terms were searched that related to *aging in the United States, attitudes, biases, contact hours, frequency of therapy sessions, mental health clinician competency, gerontology, licensed mental health clinicians, mental health counselor, mental health*

providers, clinical psychologists, counseling psychologists, social workers, older adults, society view of aging, stereotypes, aging self-stereotypes, world view, stereotype embodiment theory, and *Levy.*

Synopsis of the Current Literature

Statistics from the CDC predict that because Americans are living longer due to better physical health, older adults—who are described by the CDC as 65 and older—will reach 71 million by the year 2030 (CDC, 2007). Also, the IOM reported that it is expected that these older adults will have an increased need for mental health services that are not being properly addressed by the present health care system (IOM, 2012). Goldsmith and Kurpius (2015) posited that the need to train mental health clinicians in the mental health needs of older adults has never been greater. The APA provides guidelines for working with older adults and encourages training and continued self-reflection of knowledge of aging stereotypes (APA, 2004).

Tomko and Munley (2012) reported in their research that less than 3% of older adults seek mental health services, due to their concerns related to ageism. The current research supported this by stating that adults in most of the world who are age 70 or older have a higher rate of suicide than any other age group (Van Orden & Conwell, 2016). Mental health clinicians who have negative perceptions of older adults may overlook important clinical symptomology that they would judge with more severity in younger adults (Tomko & Munley, 2012).

The literature supports that mental health clinician biases related to special populations such as older adults may have an impact on therapy. The literature also

addresses such factors as a mental health clinician's age, gender, and professional training and experience as potential influences on attitudes toward older adults. What is missing in the literature, however, is whether mental health clinicians are reflecting on these biases during a therapy session and are self-aware of their attitudes toward older adults. Mental health clinicians who are multiculturally competent tend to have a better viewpoint of special populations (Tomoko & Munley, 2012). Flores and Sheely-Moore (2020) supported this by urging counseling professionals to implement more culturally responsive strategies in their mental health practice. They are more likely to be professionally developed in areas such as awareness and knowledge related to treating older adults which may help encourage older adults to seek mental health services (Tomoko & Munley, 2012).

Karel et al. (2012) reported in their study that clinical psychologists do not have an enthusiastic viewpoint about working with older adults and often choose not to specialize in this field. Koder and Helmes (2008b) suggested that factors such as contact with older adults, specialized training in this area, and knowledge about the aging process may impact whether a psychologist specializes in older adult mental health care. An Australian survey study conducted by Koder and Helmes (2008a) reported that only 6% of psychologists surveyed listed aged care as their specialty and 40% of the sample reported that they did not have any contact with older adult patients. Koder and Helmes posited that negative attitudes toward older adults fueled by professional ageism may contribute to the lack of interest in working with older adults.

Attitudes and Older Adults

Positive and negative age stereotypes tend to impact the cognitive and physical functioning of older adults, both of which depend on the content of the stereotype (Levy & Leifheit-Limson, 2009). For example, if someone is conditioned throughout his or her lifespan to think of aging as a negative impact on health, then a negative self-perception of aging is reinforced (Chasteen, 2000). This internalization of aging stereotypes can lead to cognitive self-stereotypes. Thus, cognitively, an older adult may expect to begin experiencing negative traits of aging such as mental incompetence, forgetfulness, and slow information processing reinforcing an internalized negative self-perception (Levy 2009). Moreover, internalized negative age stereotypes can affect physical functioning by reinforcing how older adults measure their view of overall physical health (Chasteen, 2000). In a study conducted by Levy (2009), older adults who had a negative self-perception of aging had greater cardiovascular stress than those who had a more positive view of aging. The authors found that older adults exposed to positive attitudes toward aging were more likely to have positive feelings about themselves, maintain better physical and cognitive functions, and view aging as a normal part of lifespan development (Levy & Leifheit-Limson, 2009).

Boswell (2012) described how people feel strongly that their viewpoints and world view about aging are correct because the internal stereotypes are solidly accepted by them. Because of these strong feelings and attitudes, Levy (2004) asserted that someone may not be aware that he or she is applying this stereotyped behavior to an older adult because the learned behavior becomes comfortable. Learned behavior is considered

by Polizzi (2003) to be the reason negative attitudes toward older adults continue and may be difficult to change. What Boswell (2012) failed to address in the literature is how mental health professionals may be transferring this negative viewpoint to a client because they are not reflecting on their internalized and embedded stereotypes related to specialized populations such as older adults.

Salaz et al. (2016) posited that mental health professionals limit their ability to work with older adults due to a lack of knowledge about the age-specific features of older adult anxiety. Because of this, mental health professionals often assume they can treat older adult anxiety as they would those of other age populations (Salaz et al., 2016). In this research, Salaz et al. maintained that ageism attitudes become the basis of mental health treatment fundamentals when working with older adults.

Biering (2019) found that older adults reported a strong connection to mental health professionals who were competent in the aging needs of this population. Older adults expected treatment from mental health professionals who examined their competence in working with lifespan development issues and self-awareness of aging attitudes. Older adults expressed concern when they recognized that a mental health professional may not be knowledgeable or experienced in working with specialized populations and were less likely to use mental health care as a result (Mackenzie et al., 2008). Mackenzie et al. (2008) maintained that a mental health professional's attitude about older adults and treating aging-related needs was the most important reason an older adult continues or discontinues to seek mental health services.

Self-Awareness of Attitudes

The literature does not settle on a singular definition of mental health clinician self-awareness. Brown and Ryan (2003) defined self-awareness as a conscious awareness of one's internal state and the effect this has on the interactions or relationships with others. Brown and Ryan also described self-awareness as a cognitive state of being that is difficult to measure because it is a personal and intimate form of self-reflection and insight. Pieterse et al. (2013) similarly defined self-awareness as "a state of being conscious of one's thoughts, feelings, beliefs, behaviours, and attitudes" (p.192). Pieterse et al. noted that the above factors of self-awareness are formed by a person's developmental and social influences and are more easily measured through self-reflection and insight. Knapp et al. (2017) identified self-awareness as an important aspect of effective psychotherapy. Barry et al. (2021) maintained that self-awareness makes effective leaders because it allows one to see themselves in an internally focused light and recognize the impact their viewpoint may have on others. The General Principles of the APA Ethical Principles of Psychologists and the Code of Conduct (American Psychological Association, 2017) advise mental health practitioners about the importance of self-awareness. Under Principal A (Beneficence and Nonmaleficence), psychologists are asked to "strive to be aware of the possible effects of their own physical and mental health on their ability to help those with whom they work." Additionally, the Association of State and Provincial Psychology Boards includes self-awareness of attitudes, self-reflection, insight, and biases as a measure of competent practice (Knapp et al., 2017).

Types of Self-Awareness

Situational Self-Awareness

Situational self-awareness tends to be an automatic process where a mental health clinician would compare his or her current actions to internalized standards (Silvia & Duval, 2001). This type of self-awareness would allow mental health clinicians to stop, reflect, and make changes in thought during a counseling session (Silvia & Duval, 2001). However, Silvia and Duval point out that this may not always be happening during a therapy session because the mental health clinician may be too intent on using listening skills to problem solve situational issues addressed by the client. Silvia and Duval (2001) maintained that self-awareness should be an automatic process that is ongoing throughout a counseling session.

Pieterse et al. (2013) posited that training for mental health clinicians tends to view self-awareness as an incidental part of a therapist's training. Pieterse et al. distinguished between a global self-awareness which lays the foundation for the therapeutic approach, and self-awareness that punctuates a mental health clinician's consciousness during a therapeutic session. Likely, both types of self-awareness are employed when counseling older adults (Silvia & Duval, 2001).

Dispositional Self-Awareness

Dispositional self-awareness is a type of self-consciousness where mental health clinicians may reflect on their attitude and the effect this has on their relationship with others (Silvia & Duval, 2001). Dispositional self-awareness may also be thought of as self-attentiveness and a characteristic of a personality which questions how one's

viewpoint may contribute to the desired outcome (Fenigstein et al., 1975).Throughout the literature review regarding self-awareness, it was noted that the measurement of self-awareness may be difficult because it is internal and private to an individual (Grant, 2002).

Contact Hours and Consistent Counseling

The New York State Education Department Office of the Professions (NYSED OP: 2017) defines contact hours for mental health clinicians as one hour of face-to-face client contact. This may consist of in-person, group, or telephone contact. Pope-Davis et al. (1995), in a quantitative study examining counseling competencies of psychology graduate students, determined that consistent counseling contact with diverse clients was a predictor of multicultural counseling competency, but it is unclear if this extends to the special population of older adults.

Another study looked at contact hours with older adults in graduate clinical and counseling psychology students. The results of the study indicated that more positive personal experiences with older adults led to more interest in working with this population as well as lower rates of negative attitudes and increased knowledge about older adult mental health issues (Woodhead et al., 2013).

The present study expanded this finding to determine if a similar relationship holds for licensed, practicing clinicians. Woodhead et al. (2013) also found that perceived competence in working with older adults was associated with the number of older adult practicum sites as well as total adult contact hours. Although this was found in graduate

students who were training to be psychologists, it is unclear if this extends to other licensed mental health clinicians who are currently practicing.

Salaz et al. (2016) described a study that looked at the knowledge mental health clinicians had about depression and dementia and determined that similar aspects of knowledge existed related to depression and dementia in older adults across clinicians. The results of this study were used to measure mental health clinicians' knowledge levels as they relate to the level of contact a clinician has with a population. This study did not, however, address consistency in counseling older adults.

The American Psychological Association (APA) professional standards for mental health practitioners support consistent therapy but do not discuss a specific number of therapy sessions per week (American Psychological Association, 2017). Tomko and Munley (2013) reported in their study, a need for health care professionals to have more contact with older adults to help reduce the negative perceptions often associated with aging. More clinical exposure in providing mental health care to older adults leads to increased geriatric knowledge and skill (Tomko & Munley). Additionally, these researchers found that improved attitudes toward older adults were associated with more contact (Tomko & Munley, 2013). Taken together, the literature seems to support that increased contact with a population of interest is associated with enhanced competency, but it has not been examined if contact with older adults is associated with increased self-awareness specifically.

Years of Professional Counseling Experience and Competency

The American Psychological Association (APA) Guidelines for Psychological Practice with Older Adults notes that mental health professionals have established counseling competencies that require formal education, supervision, and consultation experience under the guidance of experienced professionals (American Psychological Association, 2004). The supervision is mandated by state regulations and should be provided by a licensed or certified professional. In addition to competencies in working with older adult clients, competencies about other special populations have also been defined. The American Counseling Association (ACA; 2009) endorsed competencies for counseling with transgender individuals, along with their families and communities. Among the competencies was the requirement that mental health professionals conduct counseling-related practices with an emphasis on human growth and development and career and lifestyle development (ACA). According to Dispenza and O'Hara (2016), having high levels of ethical values and expectations as a mental health professional does not guarantee a high standard of counseling competency, regardless of years of experience.

Subsequently, Dispenza, and O'Hara (2016) found that counseling competency was most reliant on culturally responsive identification of specific developmental needs in individuals across their lifespan. They determined this may come with more counseling experience and exposure to a variety of populations. Dispenza and O'Hara recommended that mental health professionals working with clients of marginalized backgrounds should be self-aware of their skills, own biases, and knowledge deficits so

that this does not negatively affect competency. Tomko and Munley's (2012) study examined years of experience as potentially affecting counseling competence toward older adults. They found that increased training and experience working with older adults by mental health clinicians decreased negative attitudes toward this population. They also suggested that there is a need for additional research with mental health counselors in training and experience in working with older adult clients. It is necessary to replicate and validate the findings of this study in a population of licensed mental health clinicians.

Theoretical Foundation

Stereotype Embodiment Theory

The stereotype embodiment theory introduced by Levy (2003, 2004, 2009) described how ageism is a product of internalized stereotypes that can be perpetuated by a reflection of those attitudes toward older adults. As we grow through the lifespan, we may internalize these negative attitudes of the aging process and then possibly apply them as we see fit when encountering an older adult. We may not be aware that we are applying this stereotyped behavior to an older adult because the belief is so strong, and the learned behavior is so comfortable (Levy, 2009). Mental health clinicians also may not be aware that they are applying stereotyped behavior to older adults in a counseling session.

The current study built upon the theory because it examined correlates of self-awareness of potential stereotypes toward the aging process in mental health professionals, where Levy simply introduced the theory at a general population level (Levy, 2009). Mental health clinicians, despite advanced training and education in mental

health and counseling, could be affected by internalized stereotypes (Waltman et al., 2016). They may project these negative attitudes onto their clients which may affect the quality of the therapy and thus mental health clinician competence (Waltman et al.). Increased self-awareness of internalized stereotypes by mental health clinicians may mitigate the effects of those stereotypes, and this effect may be dependent on variables such as a mental health clinician's professional experience or contact with older adult clients. The results of this study suggested whether certain mental health clinician practices might increase self-awareness of attitudes toward aging. This work might inform the future development of strategies to mitigate the effects of the stereotype embodiment theory on professional counseling competency.

Four Components of Stereotype Embodiment Theory

Levy's theory of stereotype embodiment has four components. Levy posited that stereotypes are: (a) internalized across the life span, (b) can operate unconsciously, (c) gain importance from self-relevance, and (d) utilize multiple pathways (2009). Each component is responsible for building expectations of future physical and cognitive functioning as we age. Additionally, Levy maintained that society applies these embedded stereotypes as a viewpoint for aging.

The first component of the stereotype embodiment theory recognizes that stereotypes can be internalized across the life span. Levy (2009) mentioned that aging stereotypes develop during childhood when children accept attitudes and stereotypes from family, friends, or their environment and believe that this is how an older person must behave. As people enter adulthood, they may foster the stereotypes they have

learned and begin to internalize them, creating expectations about their aging processes (Levy, 2009). Levy described a study conducted by Seedfeldt, et al. (1977, p. 509) where children were asked how they would feel when they become old, and 60% of these children responded that they would feel "awful", indicating they thought negatively of aging. Levy posited that these stereotypes can become self-stereotypes which create conscious and unconscious images of how people should act as they age. Consequently, adults carry this negative self-perception of aging throughout their lifespan by internalizing it and applying it to themselves. This continues to perpetuate the attitudes and stereotypes of aging that may have originated from a person's family, culture, or environment (Levy, 2009).

The second component of the stereotype embodiment theory is that stereotypes can operate as a sort of independent agent and influence the way we think and view our world without conscious recognition. For example, as children, we are exposed to negative viewpoints and descriptions of the aging process that become internalized upon entering adulthood (Levy, 2009). Masoro (2006) maintained that the aging process is usually considered by many as a period of progressive overall decline and most noticeable in the later stages of life. Levy furthered this thought by positing that people are "cognitive misers" and tend to accept what is told to them rather than challenge the reality of it. Therefore, as people age the stereotypes are reinforced because they are responding to the negative aspects of what they are told aging consists of rather than challenging and rejecting this as a negative stereotype.

The third component of the stereotype embodiment theory maintains that a person can gain importance from self-relevance. Levy (2009) discussed that adopting a negative self-image of how to act and function physically, emotionally, and cognitively results from determining that this stereotype must be true and does not warrant a challenge. Therefore, as individuals age, repeated exposure to negative aging stereotypes may become a self-fulling prophecy, impeding the achievement of realistic and attainable physical, emotional, and cognitive goals (Levy, 2009).

The fourth component of the stereotype embodiment theory addresses how aging perceptions may impact multiple cognitive and physical pathways. Levy (2009) defined the multiple pathways as ways in which older adults can be affected by this negative stereotype. They consist of psychological, behavioral, and physiological outcomes. Levy further stated that the components tend to be top-down and are transferred from societal views on aging to the older adult. The psychological pathway determines expectations of the process of aging which can translate into a self-fulfilling characterization and is thought of as matching behavior to the stereotype (Levy & Leifheit-Limson, 2009).

Finally, mental health clinicians may need to recognize that aging stereotypes can be internalized by older adults and applied to their aging expectations and experiences, becoming aging self-stereotypes (Levy, 2009) These aging self-stereotypes may contribute to the reason older adults view themselves in negative ways. Thus, mental health clinicians who are self-aware of possible biases may recognize their attitude toward older adults as negative and self-imposed (Pieterse, et al., 2013). It may be likely

that a mental health clinician's self-awareness of attitudes toward older adults may be enhanced by total counseling experience or frequent counseling contact with older adults.

Significance

The current research contributed to clinical psychology in that it highlighted how self-awareness of attitudes toward older adults may influence counseling competency. This study highlights the need for mental health clinicians to be better aware of embedded stereotypes that influence viewpoints and clinical practices related to working with older adults. It also illuminated how the number of contact hours spent working with older adults and the frequency of counseling contact influences how mental health clinicians respond to treatment practices that may be influenced by biases and negative attitudes toward older adults seeking mental health treatment. This knowledge may change the way older adults are regarded in counseling sessions, decrease negative perceptions of the aging population, and encourage more older adults to utilize mental health services (Tomko & Munley, 2012).

Summary

Mental health clinicians who serve special populations such as older adults face challenges that may not be addressed in their education. The literature has identified mental health clinician's self-awareness of attitudes toward older adults as an aspect of counseling competence. The full scope of factors that may influence self-awareness has not been defined. These factors are an important aspect of enhancing mental health clinician competency by mitigating vulnerability to internalized stereotypes about the aging process. Some studies have identified factors such as years of professional

counseling experience as influencing measures of competency in treating special populations such as LGBTQ+ individuals (Dispenza & O'Hara, 2016). So far, it has remained unclear which variables have a similar predictive capability for mental health clinicians working with older adult clients. Indeed, the full scope of variables that influence mental health clinician self-awareness has not been discerned. Taken together, the literature indicated a need to identify contact-related correlates of self-awareness more fully in mental health clinicians working with specialized populations such as older adults.

This study illuminated potential associations between contacts with older adult clients, years of professional counseling experience, and self-reported self-awareness. This can inform future curriculum development, continuing education initiatives, and guidelines for counseling best practices. In Chapter 3, research design and methodology, along with details of the data collection methodology, are discussed. This design identified the factors which may influence mental health clinician self-awareness of attitudes toward older adults.

Chapter 3: Research Method

Introduction

The purpose of this quantitative study was to determine to what degree various practice-related factors influence aspects of a mental health clinician's self-awareness of attitudes toward older adults. The variables in this research study were measured using a correlational design. The major sections in this chapter are the research design and the rationale for selecting this design, the independent variables (predictors) and dependent (response) variables, the targeted population and size, a description of sampling procedures, and a power analysis tool used to calculate the sample size. This chapter will focus on how participants were recruited, the consent form description, data collection, the follow-up process, and threats to internal and external validity.

Research Design and Rationale

Three research questions were addressed in this study:

RQ1: Does the number of years of professional counseling experience, number of older adults seen weekly, and number of contact hours with older adults significantly account for a variance in mental health clinician engagement in self-reflection of attitudes toward older adults as measured by the Self-Reflection and Insight Scale?

> H_o1: None of the three independent variables: the number of years of professional counseling experience, number of older adults seen weekly, and number of contact hours with older adults significantly account for a variance in mental health clinician engagement in self-reflection of attitudes toward older adults as measured by the Self-Reflection and Insight Scale.

H_a1: At least one of the three independent variables: the number of years of professional counseling experience, number of older adults seen weekly, and number of contact hours with older adults do significantly account for a variance in mental health clinician engagement in self-reflection of attitudes toward older adults as measured by the Self-Reflection and Insight Scale.

RQ2: Does the number of years of professional counseling experience, number of older adults seen weekly, and number of contact hours with older adults significantly account for a variance in mental health clinician need for self-reflection of attitudes toward older adults as measured by the Self-Reflection and Insight Scale?

H_o2: None of the three independent variables: the number of years of professional counseling experience, number of older adults seen weekly, and number of contact hours with older adults significantly account for a variance in mental health clinician need for self-reflection of attitudes toward older adults as measured by the Self-Reflection and Insight Scale.

H_a2: At least one of the three independent variables: the number of years of professional counseling experience, number of older adults seen weekly, and number of contact hours with older adults do significantly account for a variance in mental health clinician need for self-reflection of attitudes toward older adults as measured by the Self-Reflection and Insight Scale.

RQ3: Does the number of years of professional counseling experience, number of older adults seen weekly, and number of contact hours with older adults significantly

account for a variance in mental health clinician insight of attitudes toward older adults as measured by the Self-Reflection and Insight Scale?

H_o3: None of the independent variables: the number of years of professional counseling experience, number of older adults seen weekly, and number of contact hours with older adults significantly account for a variance in mental health clinician insight of attitudes toward older adults as measured by the Self-Reflection and Insight Scale.

H_a3: At least one of the independent variables: the number of years of professional counseling experience, number of older adults seen weekly, and number of contact hours with older adults do significantly account for a variance in mental health clinician insight of attitudes toward older adults as measured by the Self-Reflection and Insight Scale.

For the first research question, the independent (predictor) variables were the number of years of professional counseling experience, the number of older adult clients seen weekly, and weekly contact hours with older adults. The dependent (criterion) variable in this study was engagement in self-reflection of attitudes toward older adults as measured by the Self-Reflection and Insight Scale.

The second research question's predictor variables were years of professional counseling experience, the number of older adult clients seen weekly, and weekly contact hours with older adult clients. For the second research question, the dependent variable was a mental health clinician's need for self-reflection of attitudes toward older adults as measured by the Self-Reflection and Insight Scale.

The third research question's predictor variables were years of professional counseling experience, the number of older adult clients seen weekly, and weekly contact hours with older adult clients. For the third research question, the dependent variable was a mental health clinician's insight of attitudes toward older adults as measured by the Self-Reflection and Insight Scale.

This research was conducted using a multiple linear regression analysis design which consisted of a cross-sectional online survey. The regression analysis was used because it allowed for a description of a relationship between a predictor and a response variable. The survey was a convenient way to gather information about mental health clinicians' years of professional counseling experience, the number of older adults seen weekly, the number of contact hours spent with an older adult, and insight of attitudes toward older adults from a large, convenience sample. Time and resource constraints were closely examined. The amount of time needed for the survey to be completed by the participants was about10 minutes. This included the delivery of the purpose and the research instructions.

The survey design aligned consistently with research designs that are needed to advance knowledge in this discipline by capturing a larger participant pool and increased objectivity (Nachmias, 2008). The cost of the survey was nominal as it was distributed through an online survey generator rather than traditional postal service mail. Since an online survey delivery generator such as Qualtrics was used, this was more convenient for participants to access (Evans & Mathur, 2018). It also allowed for a more accurate

way to collect the data. More statistical power was retained as a result of this type of delivery design (Frankfort-Nachmias & Nachmias, 2008).

Methodology

Population

The target population was mental health clinicians, 18 years of age or older, who were licensed to provide counseling and psychotherapy throughout the United States as determined by their state licensing and education board (American Psychological Association, 2017). The size of the target population was not known but may be above the required sample size.

Sampling and Sampling Procedures

A convenience sampling strategy was used. This type of sampling was chosen because creating a probability sample would not have been economical to develop and distribute. Additionally, convenience sampling allowed for a more efficient way to obtain a sample size sufficient to detect an effect of the predicted effect size (Frankfort-Nachmias, & Nachmias, 2008).

This sampling was from mental health clinicians who identified themselves as licensed to practice counseling and psychotherapy. They responded to an invitation posted on an electronic survey platform such as Qualtrics (Appendix A).

The sample was drawn from volunteers who responded to an invitation sent out, via a LISTSERV of practicing mental health clinicians, through such referral services as the American Counseling Association or the APA (Appendix A). Potential participants could contact me through email so that I could explain the study and provide informed

consent information. They could go directly to Qualtrics by clicking on the link. They accessed the survey which asked for details related to research questions and other pertinent information.

The sample size was determined by conducting a power analysis using G*Power version 3.1 as follows: test family was set as F-tests, a statistical test was set as linear multiple regression: fixed model, R^2 increase. The type of power analysis was set as a priori: compute sample size given power, and effect size. The input parameters were set at a 0.15 medium effect size, an alpha level of 0.05, and a power level of 0.8. The total number of predictors was set at 3, while the number of predictors tested was set at 1. This yielded a required sample size of 55 participants. A minimum of 100 participants were recruited to maintain statistical power after accounting for expected participant attrition due to failure to complete the online survey. The chosen alpha level, effect size, and power level followed guidelines as described in Faul et al. (2009).

Procedures for Recruitment, Participation, and Data Collection

Briefing Procedures

Participants in this study were voluntarily recruited using Qualtrics. There was a small description of the study and a link to an online survey which was created with Qualtrics web-based software (see Appendix A). Participants were briefed in writing on informed consent (see Appendix B). The participants were advised via the email link of any potential psychological risks that may be associated with their completion of the survey and the Self-Reflection and Insight Scale. Participants were informed of the procedures being followed to ensure confidentiality. Participants were informed that they

would receive <$2 compensation for completing the survey and the Self-Reflection and Insight Scale. Participants were advised that they could receive the results of the study when it was completed if they so desired. A summary of the results of the study was retained for any participants who were interested in contacting me for the results. There were no follow-up interviews.

Data Collection

Participants who agreed to participate in the study were given a link to log into Qualtrics. There was a brief introduction that explained the participant's right to agree to participate and to withdraw from the study at any time. There was a consent form for participants to continue with the survey. There were inclusion-exclusion questions asking participants if they were practicing, licensed mental health clinicians (see Appendix B). If they answered negatively to this question, they were provided a thank you for their consideration and the process ended. For participants who answered "yes," they could click on the demographic portion of the survey which was Phase 1 of the data collection (see Appendix C). Demographics that were collected were the years of professional counseling experience, the number of older adult clients seen weekly, and weekly contact hours with older adult clients (see Appendix C). This process ended with a thank you and a display of the consent form to continue. Phase 1 of the data collection took about 1 minute to complete.

Phase 2 of the data collection was a link through Qualtrics that took the participant to the Self-Reflection and Insight Scale (see Appendix D). Phase 2 also had informed consent to continue with this part of the data collection. A thank you was

generated if the participant chose to continue. The completion of Phase 2 took approximately 5 minutes.

Instrumentation and Operationalization of Constructs

The Self-Reflection and Insight Scale (SRIS)

Grant et al. (2002) developed and validated a way to measure private self-consciousness. This resulted in the Self-Reflection and Insight Scale (SRIS), which was an advance of the Private Self-Consciousness Scale (Fenignstein et al., 1975). This is a 12-item scale addressing private self-consciousness and an eight-item scale that focuses on affect and perception. The Self-Reflection and Insight Scale is designed to determine whether a counselor experiences self-awareness of personal attitudes during a therapy session by assessing how someone knows what they know. Grant et al. defined self-reflection as the way someone evaluates their thoughts and feelings and applies this to behavior. This is a purposeful and automatic response to self-directed learning and cognitive growth (Pieterse et al., 2013).

In developing the scale, Grant et al. (2002) examined two separate factor analyses concerning the new scale. The first was Self-Reflection (SRIS-SR), which was designed to evaluate cognition and behavior and to analyze and evaluate the way one thinks and feels. The second was Insight (SRIS-IN), which was designed to measure how clearly someone understands these thoughts, feelings, and behaviors (Grant et al., 2002). Grant et al. posited that the way someone understands their thoughts, feelings, and behaviors related to a sense of purpose and self-directed behavioral changes.

The relationship among self-reflection, insight, self-regulation, and goal attainment is complex (Roberts & Stark, 2008). Obtaining a personal or professional goal requires cognitive flexibility according to Grant et al. (2002). Grant et al. described this as the ability to engage in awareness that options or alternatives are available in any situation and to be willing to adapt and be flexible to this situation. It may be difficult to observe if this is taking place in an individual because the process is generally personal and private contemplation. Nevertheless, a valid and reliable scale to measure these characteristics is useful and needed.

In the initial development of the scale, the developers intended it as an advance on the previously used private self-consciousness scale, which had been criticized for not accurately capturing the essence of self-reflection (Roberts & Stark, 2008). Grant et al. (2002) developed the Self-Reflection and Insight Scale through initial factor analysis of factors for two scales: one intended to measure "insight" and the other intended to measure "self-reflection." After principal component analysis and successive elimination of factors which showed minimal loading or loading onto more than one scale, a final two-factor scale consisting of 20 items resulted. The Cronbach's alpha coefficient for the self-reflection scale was 0.91 and 0.87 for the insight scale. There was no significant correlation between the two factor scales and no significant differences in average scores for men and women. In his original presentation of the scale, Grant (2002) found that the Self-Reflection and Insight Scale had a Cronbach's alpha of 0.87 for the whole scale. Another more recent study used the Self-Reflection and Insight Scale and found the

Cronbach's alpha to be 0.71 for Need for Self-Reflection, 0.78 for Engagement in Self-Reflection, and 0.83 for Insight (Naeimi et al., 2019).

The test-retest reliability was assessed, and the correlation was 0.77 for the self-reflection scale and 0.78 for the insight scale after seven weeks. Lastly, congruent validity was tested by correlation to established and related scales. For example, scores on the self-reflection scale correlated negatively with measures of depression, anxiety, and stress. Scores on the self-reflection scale were lower for individuals who did not keep diaries or journals for reflection. This shows the construct validity of the scale because those who keep diaries would be expected to show greater self-reflection than those who do not engage in this practice.

The Self-Reflection and Insight Scale has not yet been used to measure mental health clinician self-awareness of biases and internalized stereotypes applied to older adults, but it has been used to evaluate how self-awareness can increase goal attainment and performance. Thus, this study served as a novel use of this scale and informed its validity and applicability to questions in the clinical psychology field.

Although the Self-Awareness and Insight scale has been used in previous studies, there may be some error associated with using a constructed scale to quantify an abstract variable such as self-awareness. Grant et al. (2002) pointed out that evaluating metacognitive factors such as thoughts, feelings, insight, and self-reflection are based on a person's innate ability to monitor and regulate behavior. Since this requires a person to use conscious and purposeful self-reflection and self-monitoring, there may be a difference in the applied effort as a result (Rosin, 2015).

Data Analysis Plan

The Statistical Package for Social Sciences (SPSS) Version 26 software (Field, 2014) was used to analyze the data that was collected. The data was examined for distributional properties and any assumptions that may be met for each statistic (Frankfort-Nachmias & Nachmias 2008). The assumptions were as follows: linearity, homoscedasticity, independence, no multicollinearity, and normal distribution. Linearity assumed a linear relationship between the independent and dependent variables. Homoscedasticity assumed that the variance in the residuals was constant across observations. Independence assumed that individual observations were not correlated with each other. The assumption of no multicollinearity required that two or more independent variables were not correlated with one another. Lastly, the residuals were assumed to be normally distributed. Extreme outliers were removed as they could skew the data.

Multiple linear regression analyses were conducted for each of RQ#1, RQ#2, and RQ#3. All measured variables, including years of counseling experience, weekly contact hours with older adults, number of older adult clients seen weekly, self-reflection score, and insight score, were analyzed as discrete numerical variables. A line of best fit and a corresponding multiple regression equation was generated to describe the predictive relationship between the independent variables and the dependent variables. Confidence intervals and p-values were used to estimate statistical significance.

Threats to Validity

External threats to validity were considered when soliciting participation for research. Recognizing internal and external validity in a study can reduce errors in collecting and analyzing data, increasing the validity of this study's conclusions. Mental health clinicians might be reluctant to respond accurately if their responses would undermine their perceived competence as a professional clinician. Thus, the response rate may have been low or biased, and some participants might have answered more subjectively than others. Furthermore, a convenience sample might not have captured the full scope of the licensed mental health clinician profession as the sample size was drawn from a random representation of this population. Any generalization to other populations was limited as a result. Since there was no way to verify who completed the survey, participation accountability may have been lost. There was also no way to determine whether a participant actually completed the survey themselves, as they could have asked someone else to complete the survey for them.

An internal threat to validity may have been the use of the internet to launch the survey and collect data. It is unlikely that control over access to the secured link to the research project could have been maintained. Participants may have been able to share information from the survey and may have thus allowed others to complete the survey.

Some mistakes may have been made when entering and analyzing data results from the research project. Quality control was needed throughout the data collection process to avoid threats to internal validity and maintain accuracy (Frankfort-Nachmias & Nachmias, 2008). Another threat to internal validity was that participants may have

become familiar with the survey and Self-Reflection and Insight Scale (SRIS) which could have been a threat to the experimental layout. This could have overstated or understated the research objective.

Ethical Procedures

Standards regarding ethical research, guidelines, and regulations as maintained by the American Psychological Association (APA) and Walden University were followed. Data was not collected until the Institutional Review Board (IRB) at Walden University approved this. Each participant was advised of privacy, ethical procedures, and standards in writing and asked to sign an informed consent regarding this. The informed consent explained that participation was voluntary and that participants could withdraw from the research project at any time in the process. Any risks to the participant while completing the research project was outlined in the consent. Any potential benefit to participating in the research was outlined in the informed consent. The informed consent also stated there was no incentive offered for participating in the research. When the amendment for data collection was approved, the informed consent was also changed to reflect the nominal monetary compensation offered for completing the study. Contact information for the researcher with email and phone number was provided to participants in case there were any questions or concerns. Participants were able to request a summary of the research through the researcher's email and phone number provided.

After approval was obtained from the IRB, participants, who were practicing mental health clinicians 18 years or older, were recruited through Qualtrics, which is an online survey platform (Appendix A). Once adult participants were identified, they were

redirected to a Qualtrics survey which gathered information from them anonymously. The informed consent form advised participants that all the data collected from this study and any participant information remained confidential; and included a statement that advised the participants that the information obtained was used only for research purposes and not for any clinical or diagnostic reasons. Walden University required that data be maintained for five years or more after the completion of this doctoral study (Walden University, 2011). Qualtrics was used to collect the raw data for this study, and any analysis generated from SPSS was saved on a password-protected personal laptop in a password-protected file.

Summary

Chapter 3 included information related to the methodology that was used to conduct this research. Aspects of this chapter included details about the data collection procedures, process related to the independent and dependent variables, research design, and methods that were used to evaluate collected data. A quantitative research design was chosen to help predict the impact of various mental health clinician practice-related variables on aspects of self-awareness of attitudes toward older adults. Recruitment of participants and sampling size were discussed. Threats to internal and external validity and ethical considerations were evaluated. Chapter 4 focuses on the collected data which was organized in tables to demonstrate the results of the study.

Chapter 4: Results

Introduction

Research on providing mental health counseling to older adults (ages 65 and over) concentrates on the anticipated need that older adults may require, but it is possible that few will seek these services due to concerns related to ageism of mental health providers. The purpose of this quantitative study was to explore to what degree various practice-related factors correlate with aspects of a mental health clinician's self-awareness of attitudes toward older adults. In this chapter, data collection information, results, and assumptions are reviewed; and it concludes with a summary. The processes used to collect and analyze data to address the RQs and test the hypotheses are described. The following research questions were addressed in this study:

RQ1: Does the number of years of professional counseling experience, number of older adults seen weekly, and number of contact hours with older adults significantly account for a variance in mental health clinician engagement in self-reflection of attitudes toward older adults as measured by the Self-Reflection and Insight Scale?

H_o1: None of the three independent variables: the number of years of professional counseling experience, number of older adults seen weekly, and number of contact hours with older adults significantly accounts for a variance in mental health clinician engagement in self-reflection of attitudes toward older adults as measured by the Self-Reflection and Insight Scale.

H_a1: At least one of the three independent variables: the number of years of professional counseling experience, number of older adults seen weekly, and

number of contact hours with older adults do significantly account for a variance in mental health clinician engagement in self-reflection of attitudes toward older adults as measured by the Self-Reflection and Insight Scale.

RQ2: Does the number of years of professional counseling experience, number of older adults seen weekly, and number of contact hours with older adults significantly account for a variance in mental health clinician need for self-reflection of attitudes toward older adults as measured by the Self-Reflection and Insight Scale?

H_o2: None of the three independent variables: the number of years of professional counseling experience, number of older adults seen weekly, and number of contact hours with older adults significantly account for a variance in mental health clinician need for self-reflection of attitudes toward older adults as measured by the Self-Reflection and Insight Scale.

H_a2: At least one of the three independent variables: the number of years of professional counseling experience, number of older adults seen weekly, and number of contact hours with older adults do significantly account for a variance in mental health clinician need for self-reflection of attitudes toward older adults as measured by the Self-Reflection and Insight Scale.

RQ3: Does the number of years of professional counseling experience, number of older adults seen weekly, and number of contact hours with older adults significantly account for a variance in mental health clinician insight of attitudes toward older adults as measured by the Self-Reflection and Insight Scale?

H_o3: None of the independent variables: the number of years of professional counseling experience, number of older adults seen weekly, and number of contact hours with older adults significantly account for a variance in mental health clinician insight of attitudes toward older adults as measured by the Self-Reflection and Insight Scale.

H_a3: At least one of the independent variables: the number of years of professional counseling experience, number of older adults seen weekly, and number of contact hours with older adults do significantly account for a variance in mental health clinician insight of attitudes toward older adults as measured by the Self-Reflection and Insight Scale.

Data Collection

Once IRB approval was granted, participant recruitment began September 10, 2021, and ended December 27, 2021. This was the first attempt at participant recruitment. Due to low response, a second attempt was begun January 12, 2022, and ended January 20, 2022. Participants were recruited using social media sites such as Facebook, Instagram, and LinkedIn. A recruitment flyer was posted on each platform (see Appendix A). This flyer listed qualifying criteria to continue with the study. The flyer then directed potential participants to a Qualtrics link where the actual survey was located, along with the informed consent. To improve participation, friends, colleagues, and associates in the field of mental health were asked to share the post with others.

The initial postings on social network sites yielded only 32 participants, of which only 10 completed the Qualtrics survey in its entirety. Of the 10 completed, seven were

removed from the data collection due to not meeting the inclusion criteria of being a licensed mental health clinician. Because of low recruitment numbers, it was decided to seek participant recruitment from a paid recruitment site called Prolific. This site was appealing because it is a large crowdsourcing community that is user-friendly and provides participants with compensation for completing the survey. Participants were provided $1.75 for completing the survey. Participants who wished to take part in this study were linked to the Qualtrics survey where data were collected. Since there was a change in the way it had been approved to recruit participants by the Walden University IRB, a request for change in recruitment was submitted for approval. The request was approved on January 12, 2022. Prolific posting was initiated at that time. Data collection officially ended on January 24, 2022. A total of 103 participants were received through Prolific and three from the social media recruitment sites, which yielded a total of 106 usable responses.

Data Analysis Procedures

Raw data were transferred from the Qualtrics survey to version 26 of SPSS once all data collection was completed. Statistical assumptions were tested, and a multiple linear regression analysis was completed. This was used to explore the relationship between the number of years of professional counseling experience, number of older adults seen weekly, and number of contact hours with older adults in therapy.

Variable Summary Statistics

Summary statistics were computed for independent and dependent variables. For the weekly number of older adult clients counseled, the mean was 5.05, standard

deviation, 4.210, range 0-20. For weekly number of contact hours with older adult clients, the mean was 10.1, standard deviation 11.7, range 0-48. For number of years of licensed counseling experience, the mean was 3.8, standard deviation 3.1, range 0-15. A value of "0" here indicated that the respondent was in the process of completing their first year of practice post-licensure.

For the score of the Engagement in Self-Reflection subscale score, the mean was 23.4, standard deviation 2.8, range 18-31. For the Need for Self-Reflection subscale score, the mean was 25.6, standard deviation 3.5, range 18-31. For the Insight subscale score, the mean was 31.2, standard deviation 4.4, range 22-42. Table 1 shows the values for mean, standard deviation, and range for each variable.

Table 1

Summary Statistics

Variable	Mean (std. deviation)	Range [min-max]
Weekly number of older adult clients counseled	5.05 (4.210)	[0-20]
Weekly contact hours with older adult clients	10.1 (11.7)	[0-48]
Number of years of licensed counseling experience	3.8 (3.1)	[0-15]
Engagement in self-reflection	23.4 (2.8)	[18-31]
Need for self-reflection	25.6 (3.5)	[18-31]
Insight	31.2 (4.4)	[22-42]

Statistical Assumptions

SPSS was used to test assumptions for multiple regression. The five assumptions tested were:

(1) There is a linear relationship between the independent and dependent variables.

(2) The residuals of the regression models are homoscedastic.

(3) There is no multicollinearity between two or more independent variables.

(4) The regression residuals are independent.

(5) The regression residuals are normally distributed.

The first assumption is that there is a linear relationship between the independent and dependent variables. This assumption was met for all conditions except for Need for Self-Reflection and the number of older adult clients over 65. This can be observed through partial regression plots between the independent variable and dependent variable for each model and through statistical tests for partial linear regression (see Figures 1-3)

Figure 1A

Partial Regression Plot for Engagement in Self-Reflection: Years of Licensed Experience

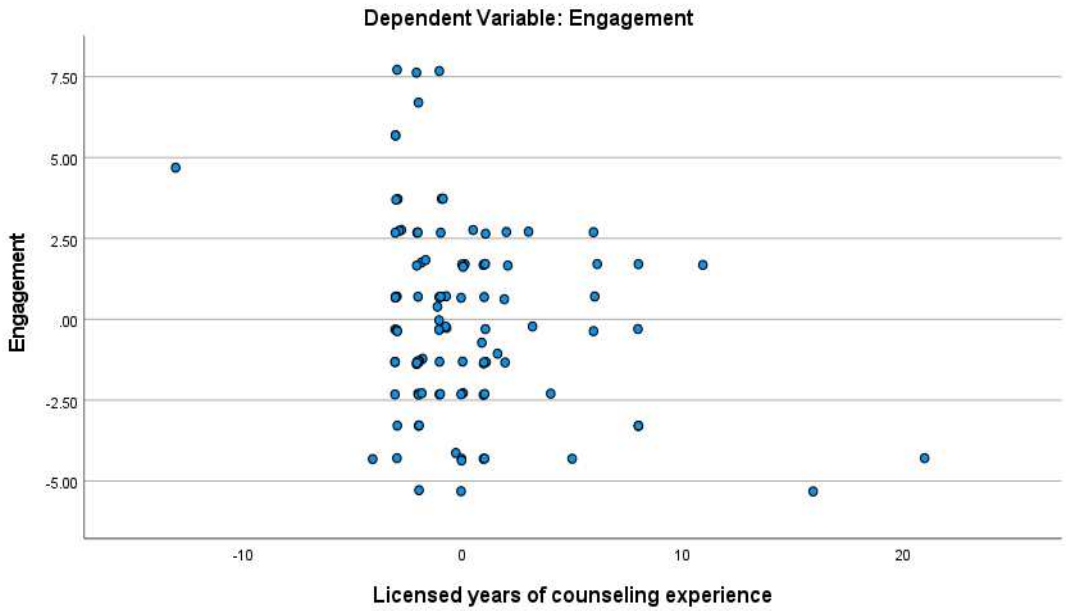


Figure 1B

Partial Regression Plot for Engagement in Self-Reflection: *Weekly Older Adult Clients*

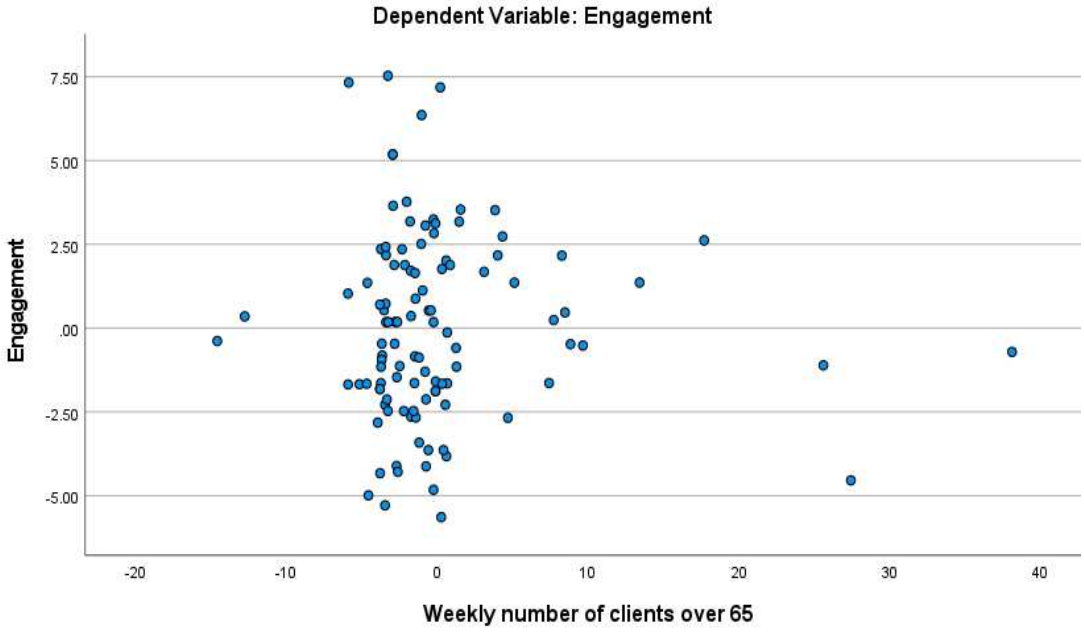


Figure 1C

Partial Regression Plot for Engagement in Self-Reflection: Weekly Contact Hours

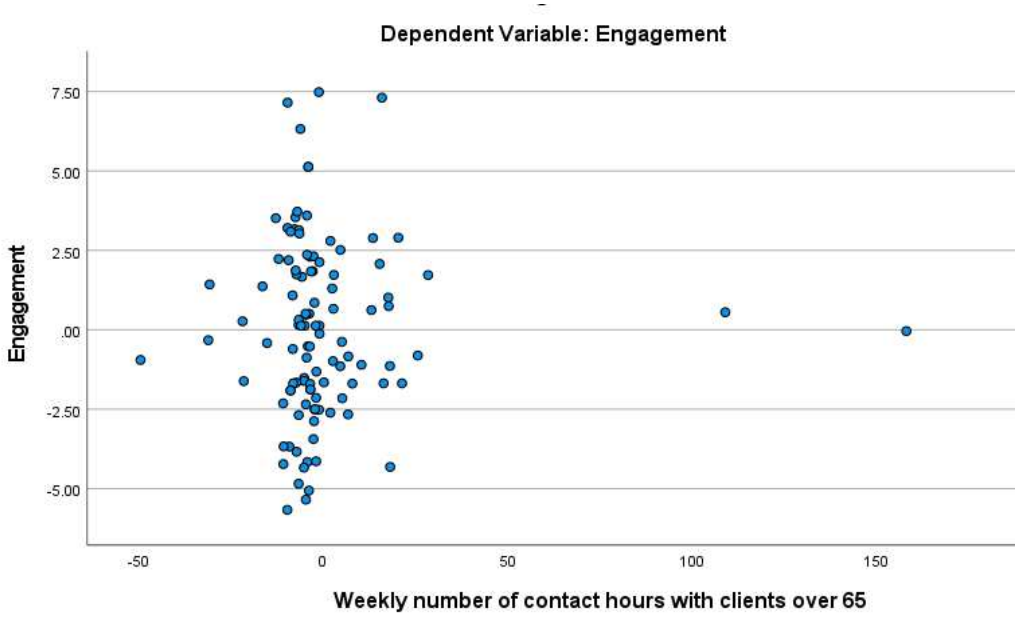


Figure 2A

Partial Regression Plot for Need for Self-Reflection: Years of Licensed Experience

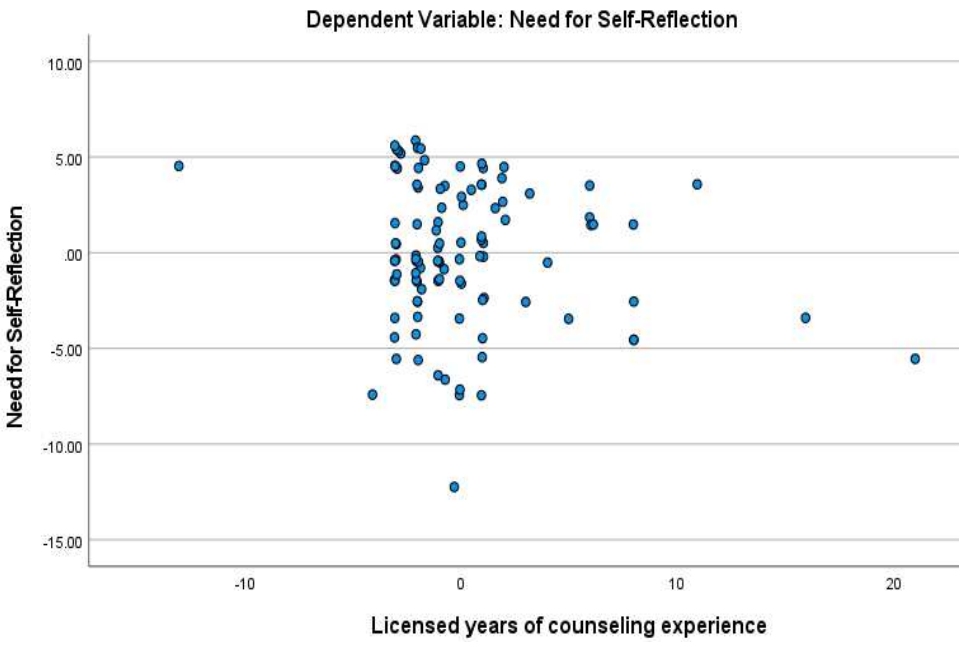


Figure 2B

Partial Regression Plot for Need for Self-Reflection: Weekly Number of Older Clients

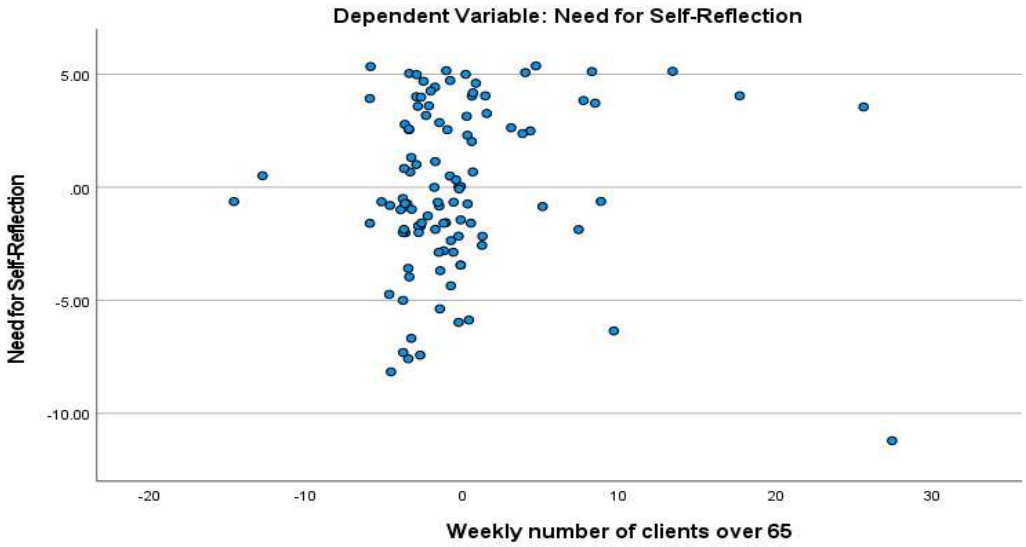


Figure 2C

Partial Regression Plot for Need for Self-Reflection: Weekly Number of Contact Hours

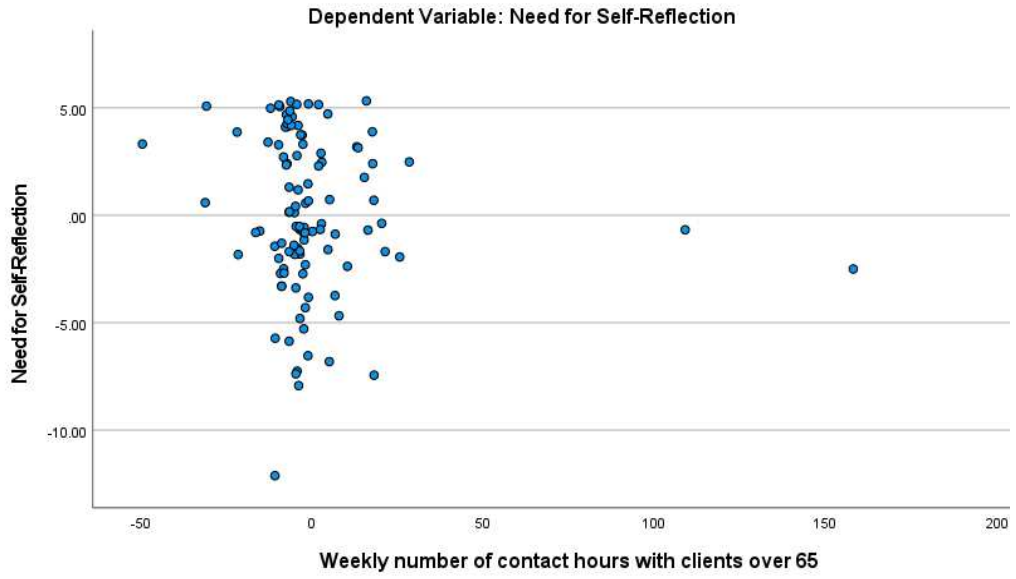


Figure 3A

Partial Regression Plot for Insight: Years of Licensed Experience

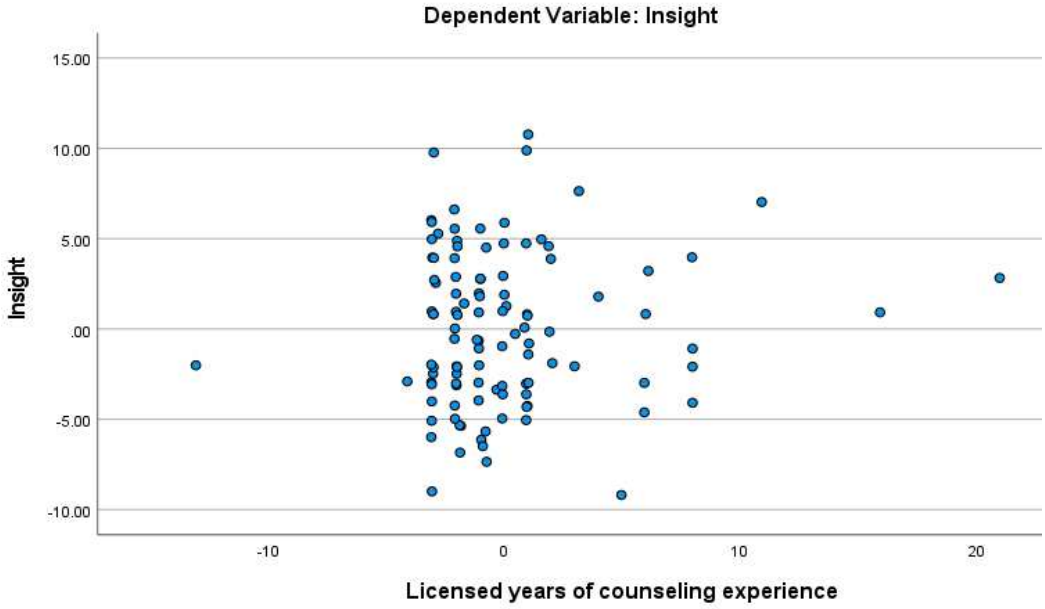


Figure 3B

Partial Regression Plot for Insight: Weekly Number of Older Clients

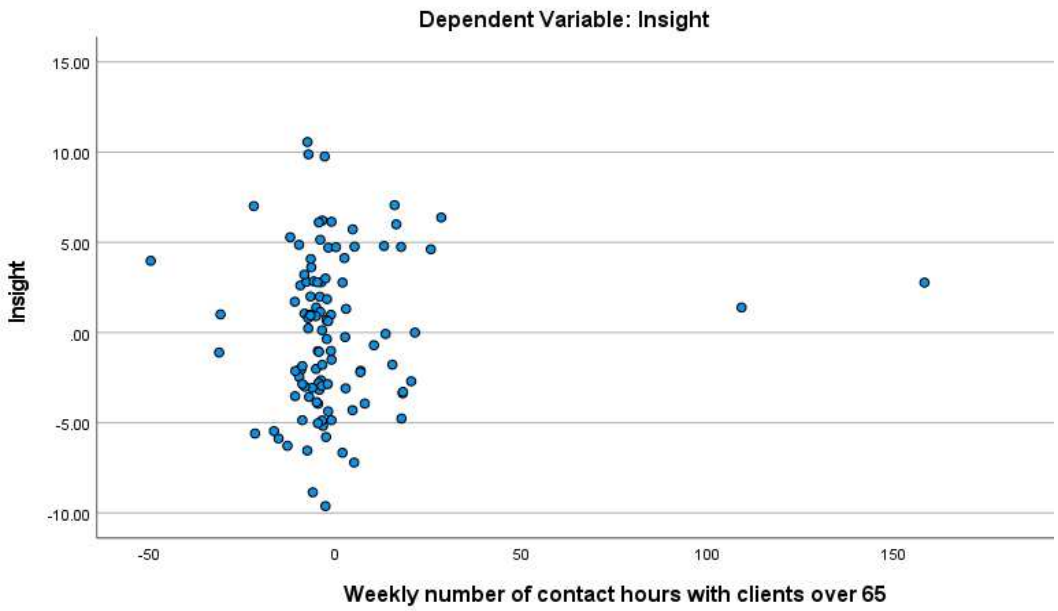


Figure 3C

Partial Regression Plot for Insight: Weekly Number of Contact Hours

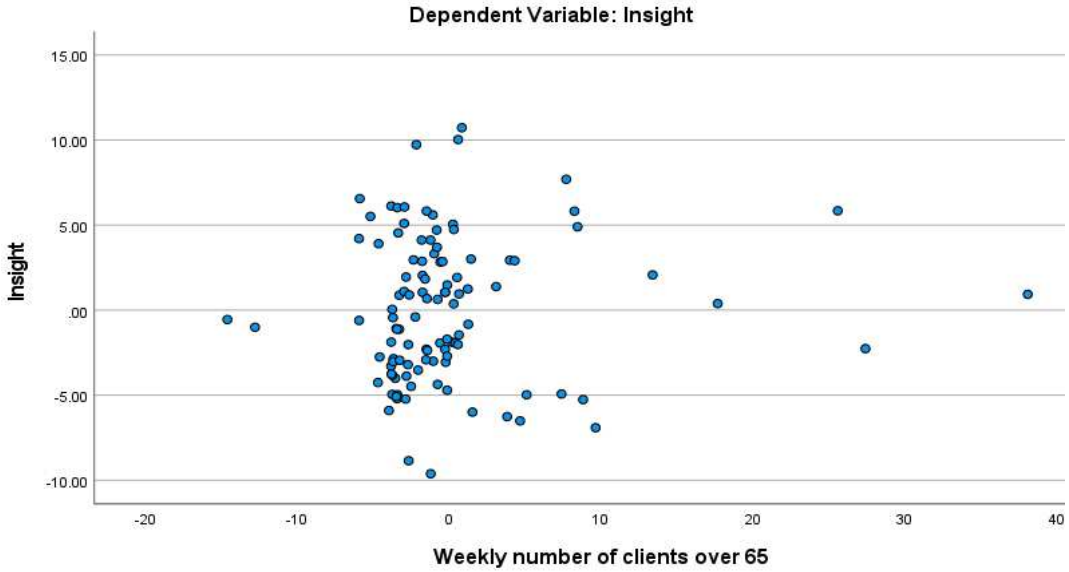


Table 2 shows statistics for the partial regression plots for each model. The non-linear relationship between Need for Self-Reflection and number of older adult clients over 65 is an indication that the first assumption is violated for this interaction, and the independent variable is a poor predictor of the dependent variable. Indeed, the analysis found no evidence of a significant predictive effect for these two variables.

Table 2

Significance (p) Values for Partial Linear Regression

	Dependent variable		
Independent variable	Engagement in self-reflection	Need for self-reflection	Insight
Weekly contact hours with older adult clients	0.369	0.118	0.155
Number of clients over 65	0.433	0.032	0.376
Number of years of licensed practice	0.259	0.179	0.658

The second assumption of homoscedasticity was evaluated using scatterplots of the standardized versus predicted residuals for each model. Data are homoscedastic if variances among the standard errors are equivalent, which is manifested as no funneling in the scatterplot. There appeared to be mild funneling in the scatterplots for these data, suggesting that slight heteroscedasticity may be present and this assumption may have been violated and thus the results of the regression analyses may be invalid.

Figure 4A

Scatter Plot of Standardized Versus Predicted Residuals for Regression Model

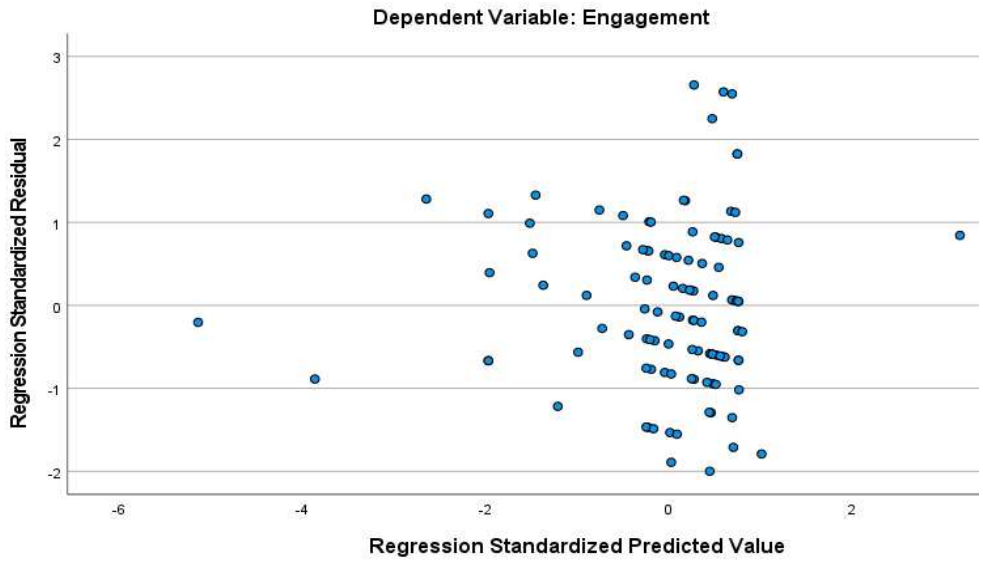


Figure 4B

Scatter Plot of Standardized Versus Predicted Residuals for Regression Model

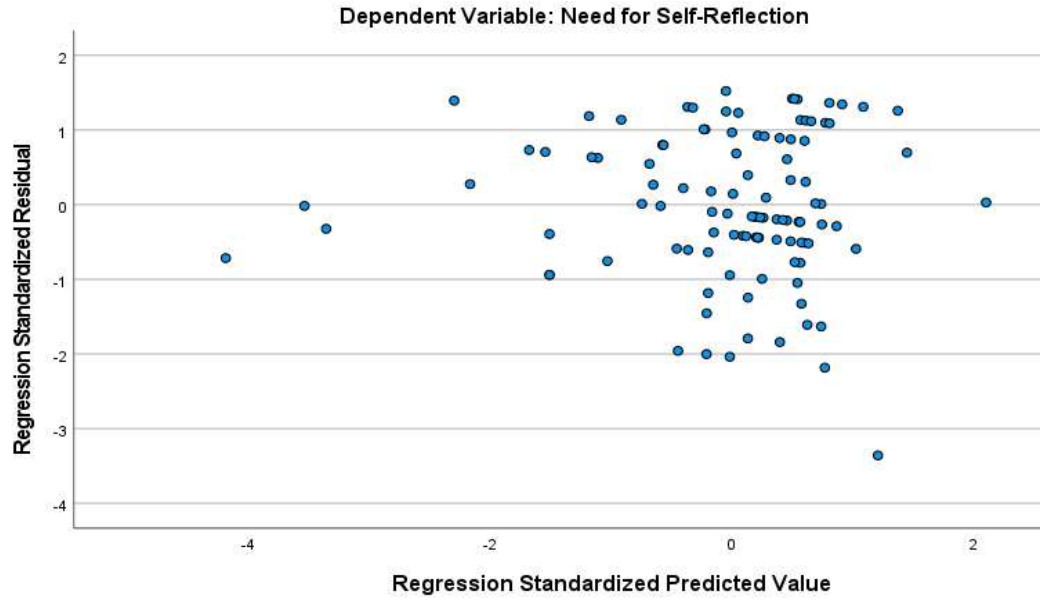
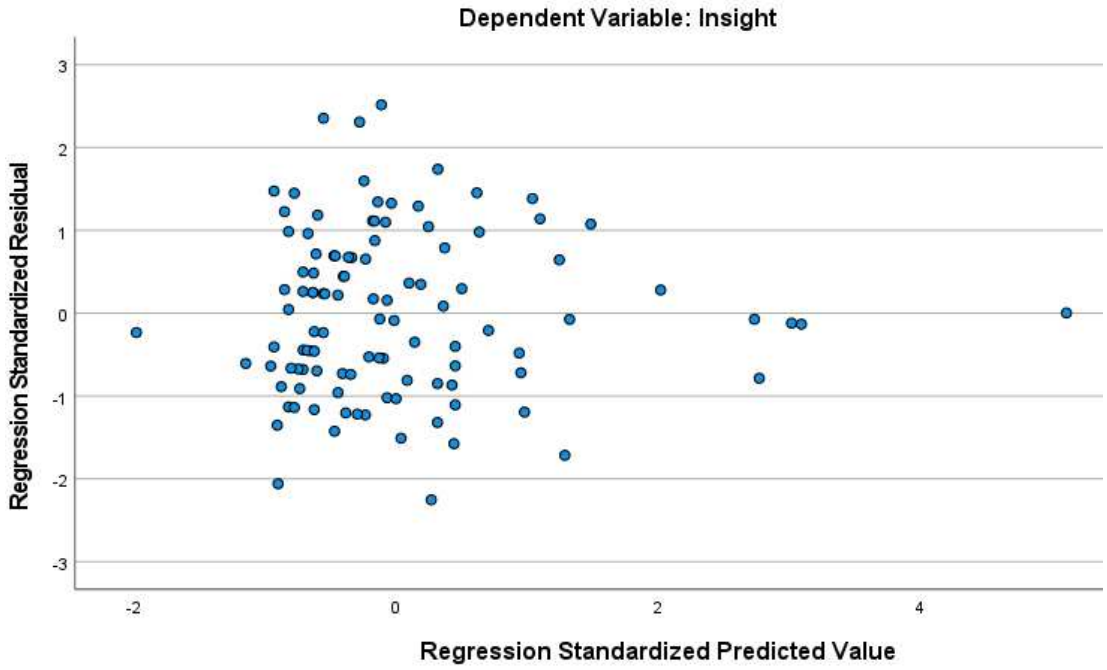


Figure 4C

Scatter Plot of Standardized Versus Predicted Residuals for Regression Models: Insight



The third assumption tested was for multicollinearity. Multicollinearity shows where independent variables in a model may be correlated. In a regression model, two or more variables are considered highly collinear and problematic if their correlation coefficient is determined to be plus or minus 0.8 or greater. Regression analyses were run for this study, and none of the independent variables were correlated above 0.51. Additionally, the independent variables noted in Table 3 show tolerance scores above 0.2 and VIF scores below 10 which gave a separate indication that the multicollinearity assumption was met.

Table 3

Collinearity Statistics

Independent Variables	Tolerance	VIF
Licensed Years of counseling experience	0.999	1.001
Weekly number of clients over 65	0.769	1.301
Weekly number of contact hours with clients over 65	0.770	1.299

For the fourth assumption, Durbin-Watson statistics were used to test for autocorrelation in the values of the residuals and if they were independent as assumed for the regression analysis. The Durbin-Watson statistic has a value between 0 and 4. The value should be near 2 to meet this assumption. The Durbin-Watson statistics for the three models were 1.876 for Engagement in Self-Reflection, 2.285 for Need for Self-Reflection, and 2.310 for Insight (Table 4). The last assumption was tested using Cook's distance to ensure there were no outliers influencing the model. The values should be below 1 for every data point for this assumption to be met. All 106 data points had Cook's distance values below 1.

Table 4

Durbin-Watson Test for Autocorrection

Model	Durbin-Watson Statistic
Engagement in Self-reflection	1.876
Need for Self-reflection	2.285
Insight	2.310

The fifth and final assumption of normally distributed regression model residuals was also evaluated using the Shapiro-Wilk test. The residuals of the models of

Engagement in Self-Reflection ($p = 0.109$) and Insight ($p = 0.204$) were normally distributed. The residuals of the model for the dependent variable Need for Self-Reflection were not normally distributed, but notably the result is marginally significant ($p = 0.03$). The P-P plot and a histogram for each model is shown in figures 5-7. When dots can be observed clustered close to the line this indicates that the residuals are approximately normally distributed. The P-P plots for Engagement in Self-Reflection and Insight models show tightly clustered dots with little deviation. For the Need for Self-Reflection model, the visually apparent, albeit relatively modest, deviation from the line coupled with the significant Shapiro-Wilk test indicated that the assumption of normality of residuals does not hold for this model.

Regarding the Need for Self-Reflection, the vitality of the assumption of normally distributed residuals has been debated. With larger sample sizes, such as this study with over 100 observations, the central limit theorem indicates that the distribution of the residuals would approximate normality (Nachmias & Guerrero, 2018). Even in cases where normally distributed residuals are present, the Shapiro-Wilk test would still yield a significant p-value in alpha (usually 5%) of cases. Some have suggested that graphical methods are the best way to assess normality, and that linear regressions are tolerant to small deviations from normality (Nachmias & Guerrero, 2018). Based on this information, a linear regression analysis was likely appropriate, but the validity of hypothesis testing may be compromised and should be interpreted with caution.

Skewness and kurtosis testing was run for the dependent variables. Since no demographic data were collected, descriptive statistics for only the dependent variables

are presented here. A normal distribution will have variables displayed in a bell-shaped curve. When this is the case, most of the occurrences of a trait will cluster together at the center of the distribution and fewer occurrences will be displayed further away from the center. A normal distribution will be a continuous one that is symmetrical on both sides of the mean. The further away from the center the occurrence is from the mean or average, the larger the standard deviation. Occurrences in data points that fall above and below the mean are described as having skewness because of lack of symmetry. When the distribution of data points is clustered at the left side of the bell-shaped curve or lower end, they are considered negatively skewed. When these data points are clustered at the right end of the curve or higher end, they are considered positively skewed.

Table 5 shows the skewness and kurtosis of the variables in this study. The skewness of Engagement subscale was 0.444. Measures of skewness that fall between -1 and -0.5 or 0.5 and 1 are moderately skewed (Trafimow, et al., 2019). The histogram showed a positive skewness which is moderate, as most of the values were depicted on the lower end of the bell curve. The kurtosis was 0.250, thus it was leptokurtic or heavy-tailed.

The skewness of Need for Self-reflection subscale was -0.431. Values were clustered on the left side of the bell curve which indicated a slightly negatively skewed distribution. Kurtosis was -0.164, which is less than zero and slightly platykurtic.

The skewness of the Insight subscale was 0.182. Figure 7 shows values clustered to the right of the distribution which showed slightly positively skewed distribution.

Kurtosis was measured at -0.519 which was below zero with a broader peak and flatter tail. This distribution is considered platykurtic.

The skewness and kurtosis of the cases of the dependent variables were not anticipated to significantly impact the data interpretation. A normal distribution of the observations of the dependent variable is not an assumption of the multiple linear regression test (Nachmias & Guerrero, 2018). Rather, the residuals of the model should be normally distributed, and this assumption has been addressed previously. Figure 8 shows the histograms for each of the three dependent variables.

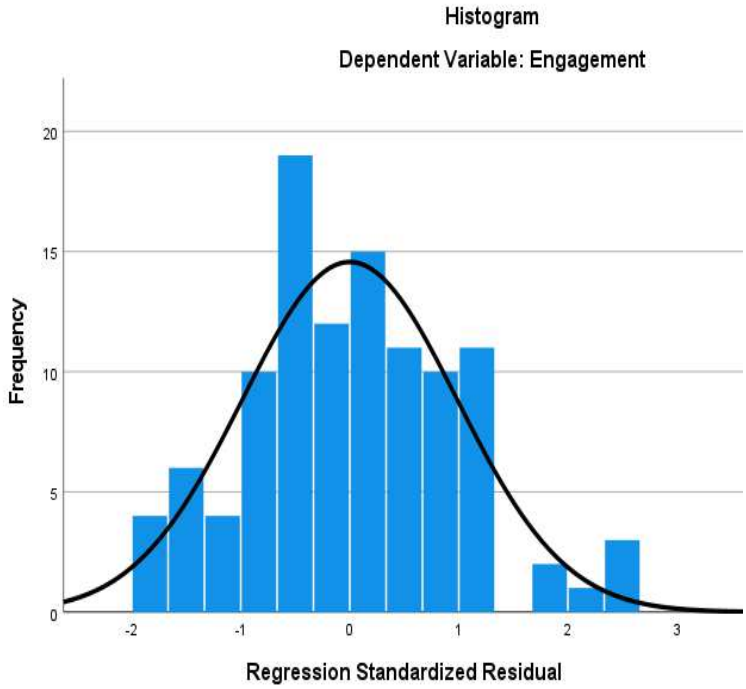
Table 5

Skewness and Kurtosis

	Skewness		Kurtosis	
	Statistic	Std. Error	Statistic	Std. Error
Engagement in self-reflection	0.444	0.233	0.250	0.461
Need for self-reflection	-0.431	0.233	-0.519	0.461
Insight	0.182	0.233	-0.519	0.461

Figure 5

Histogram and Normal PP Plot for Engagement in Self-Reflection



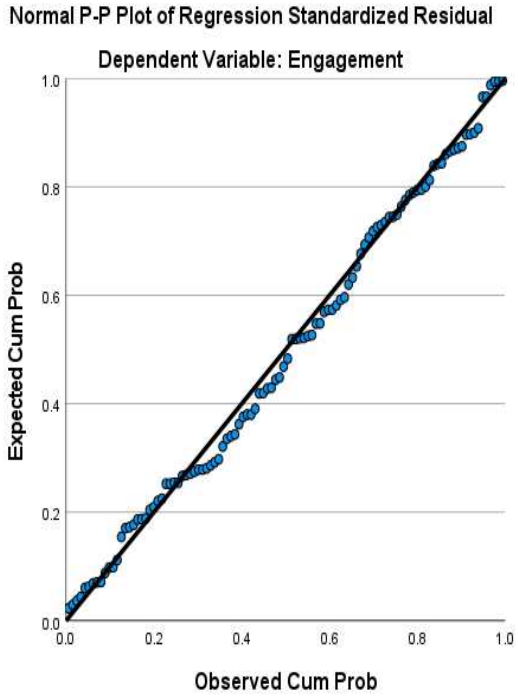
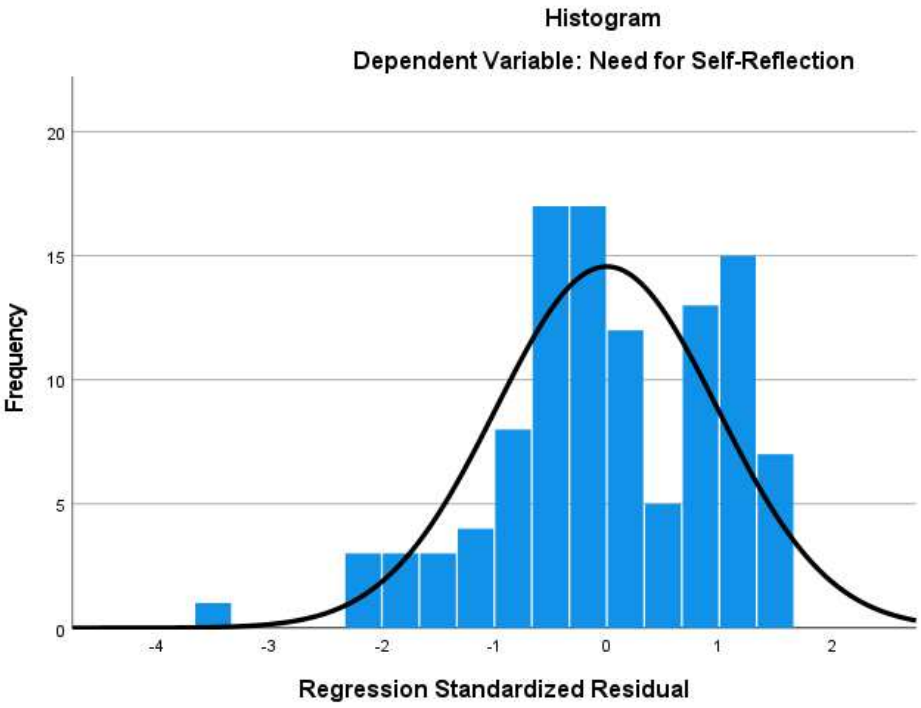


Figure 6

Histogram and Normal PP Plot for Need for Self-Reflection



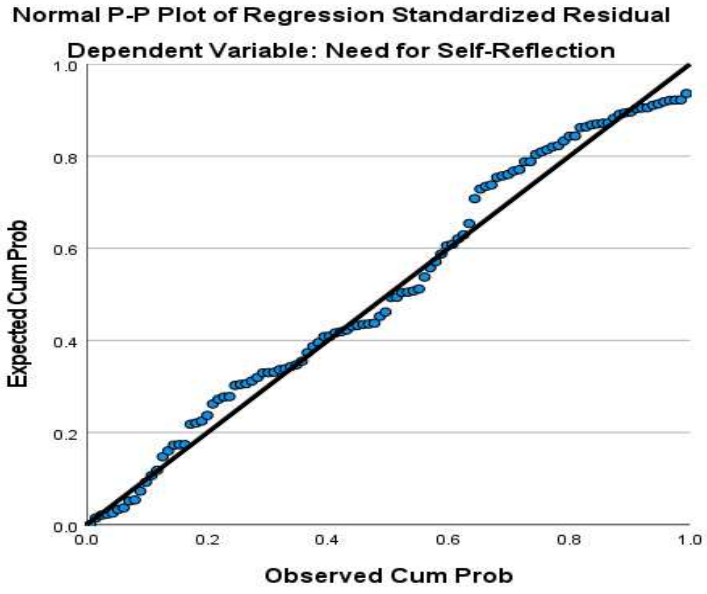
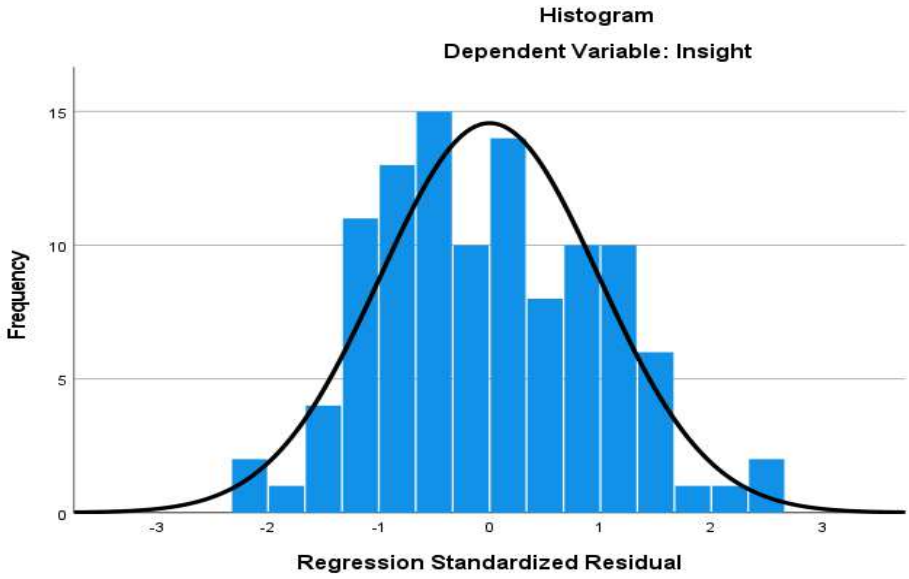


Figure 7

Histogram and Normal PP Plot for Insight



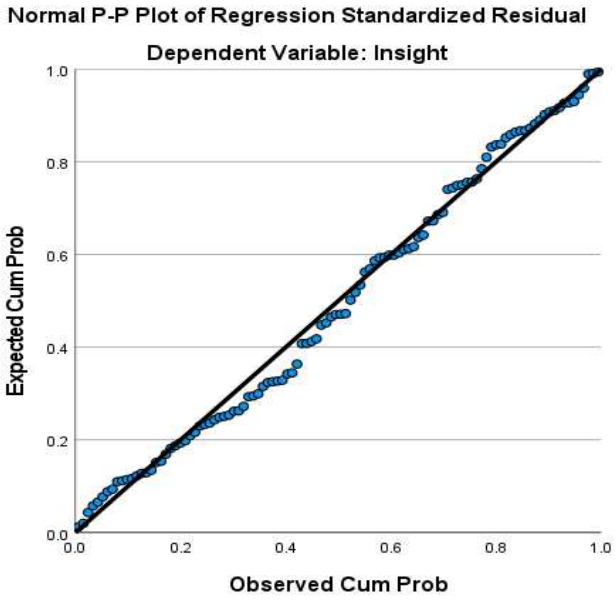
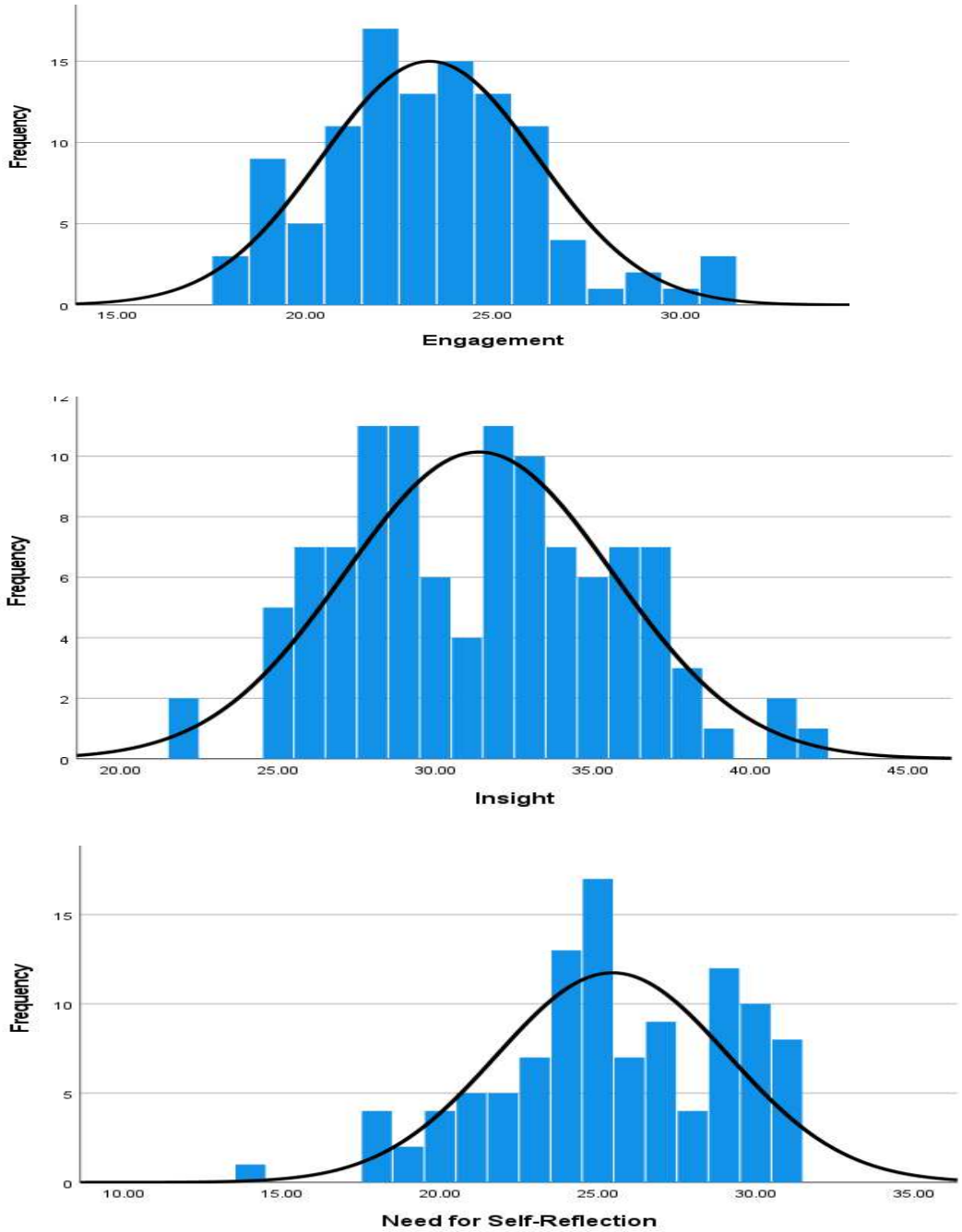


Figure 8

Frequency Distribution of Engagement, Insight, Need for Self-Reflection Subscales



Instrument Measurement Analysis

The Self-Reflection and Insight Scale (SRIS) was chosen for this study because of its reliability to measure levels of engagement in private self-reflection and insight in clinical practice (Grant, 2002). For this study, Cronbach's alpha scores were -.198 for Insight, .514 for Need for Self-Reflection, and .405 for Engagement in Self-Reflection. The overall Cronbach's alpha for the Self-Reflection and Insight Scale for this study was .592. The scale showed unacceptable internal consistency in this study, indicating that the scale is not consistently measuring the same characteristic. Due to this low reliability, interpretation of results of the study is severely compromised and should not be interpreted definitively.

Table 6

Reliability Measurement

Instrument Reliability	N/items	a
Self-reflection & Insight Scale-Total	20	.592
Insight	6	-.198
Need for Self-reflection	6	.514
Engagement in Self-reflection	8	.405

Results

At a significance level of 0.05, none of the overall models were significant. Thus, the statistical results support a failure to reject the null hypothesis for each of the three research questions. For Engagement in Self-Reflection, the results approached statistical significance: $F(3,101) = 2.374$, $p = 0.074$, $r^2 = 0.064$. Here, only the licensed years of counseling experience statistically significantly predicted scores in the Engagement in

Self-Reflection subscale, b = - 0.177, t (104) = - 2.656, p = 0.0090. For Need for Self-Reflection, the model was not significant, F (3,101) = 1.232, p = 0.302, r^2 = 0.034. For Insight, the model was also not significant F (3,101) = 0.978, p = 0.406, r^2 = 0.027. This means that none of the independent variables significantly predicted Need for Self-Reflection or Insight. Since the model with the dependent variable Engagement in Self-Reflection was approaching statistical significance, and independent variable licensed years of counseling experience was individually a significant predictor, a separate linear regression analysis was run with licensed years of counseling experience as the sole predictor. The results of this model were significant: F (1, 103) = 7.130, p = 0.009, r^2 = 0.063. The final regression equation for this model is: Engagement in Self-Reflection = 24.009 – (0.176) (Number of years of licensed counseling experience). While it is tempting to infer meaning from the statistical test, given the very low Cronbach's alpha for this model (0.405), the results of this model should be interpreted with extreme caution at best. A more conservative conclusion is that the results of the hypothesis testing cannot be seriously interpreted given the low internal consistency. Summaries of the statistical test results individual regression coefficients for the models are presented in Tables 7-10.

Table 7

Engagement in Self-Reflection (one predictor only)

Variable	B	Std. Error B	Beta	T	Sig. (p)
Licensed years of counseling experience	-0.176	0.066	-0.251	-2.67	0.009

Table 8

Engagement in Self-Reflection

Variable	B	Std. Error B	Beta	T	Sig. (p)
Licensed years of counseling experience	-0.177	0.067	-0.252	-0.2656	0.009
Weekly number of clients over 65	-0.013	0.040	-0.034	-0.317	0.752
Weekly number of contact hours with clients over 65	0.003	0.013	0.029	0.268	0.789

Table 9

Need for Self-Reflection

Variable	B	Std. Error B	Beta	T	Sig. (p)
Licensed years of counseling experience	-0.140	0.086	-0.156	-1.613	0.110
Weekly number of clients over 65	0.039	0.052	0.082	0.748	0.546
Weekly number of contact hours with clients over 65	-0.015	0.016	-0.104	-0.949	0.345

Table 10

Insight

Variable	B	Std. Error B	Beta	T	Sig. (p)
Licensed years of counseling experience	0.078	0.100	0.075	0.774	0.441
Weekly number of clients over 65	0.039	0.061	0.071	0.644	0.521
Weekly number of contact hours with clients over 65	0.017	0.019	0.102	0.923	0.358

Summary

In this chapter, data collection strategies were summarized, detailed assumption testing was described, and results of the data analysis were presented. None of the overall models were significant, and the null hypothesis was not rejected for any of the three independent predictor variables.

In the next chapter, the interpretation and implications of these results are discussed as they pertain to the research questions. The results are discussed in the context of the body of literature from which the research questions were developed. Strengths and limitations of the current work are discussed as well. The chapter finishes with conclusions and recommendations as to how future studies may build off this research.

Chapter 5: Discussion, Limitations, and Recommendations

Introduction

The purpose of this quantitative correlational study was to determine to what degree various practice-related factors influence aspects of a mental health clinician's engagement in self-awareness, need for self-reflection, and insight toward older adults. The independent variables measured were number of older adult clients counseled per week, number of years of professional counseling experience, and number of weekly contact hours with older adult clients. This correlational study was an extension of literature that addressed the need for mental health clinicians to engage in self-awareness of their competency to provide mental health counseling to older adults (ages 65 and older). A multiple linear regression analysis was used to determine whether the number of older adults counseled, years of professional counseling experience, or number of weekly contact hours were predictive of any of the three variables: engagement in self-awareness, need for self-awareness, or insight.

The statistical results of this study led to a conclusion to fail to reject the null hypothesis as none of the overall models were significant. An extremely cautious interpretation of the data, however, suggests that number of years of licensed experience may have some predictive value on degree of counselor engagement in self-reflection. In this chapter, the results are interpreted, and the interpretation is supported by the prior literature and theoretical framework that were explored in Chapter 2. Any limitations of the study are discussed and recommendations for further research and positive social change are made.

Interpretation of the Findings

The research findings extended knowledge in the field of mental health counseling by exploring the relationship between years of counseling experience, number of older adult clients seen per week, and number of weekly counseling contact hours with older adults as measures of counseling competency. This study attempted to identify factors which may be indicative of a mental health clinician better equipped to deliver competent therapy to special populations. Flynn et al. (2020) suggested that professional counselors may benefit from more frequent exposure to multiple marginalized communities such as LGTQ+ older adults and older adults of color as this can strengthen professional growth and therapeutic connections. Grant (2003) posited that professional coaching may have an influence on self-reflection and insight which could positively impact readiness for applied professional practice. The current work was the first study that tried to validate a research tool used to measure self-reflection and insight in a professional mental health clinician survey population. Grant's Self-Reflection and Insight Scale was administered to undergraduate students within one university using a paper questionnaire (Grant et al., 2002).

Salaz et al. (2016) posited that mental health clinicians may limit the amount of counseling experience with older adults due to a lack of knowledge and levels of counseling competency about this population. Levy's (2009) stereotype embodiment theory supported this as well by noting that internalized stereotypes and biases about older adults prevail and may impact attitudes toward older adults. Further research may benefit the field of mental health clinicians working with older adults by exploring

predictors of stereotypes and biases. For example, such stereotypes as social isolation, caregiving, and cognitive functioning; and how these may impact counselor attitudes toward this population. The Fraboni Scale of Ageism (Fraboni et al., 1990) may be used to evaluate these biases when considering further research.

Prior researchers have postulated that mental health clinicians who engage in self-awareness and self-reflection during therapy sessions may be more aware of personal biases and views (Knapp et al., 2017). A self-awareness of attitudes regarding special populations may increase counseling competency (Biering, 2019). Since self-awareness of attitudes regarding special populations may increase counseling competency, it is still necessary to continue investigating what predictors affect self-awareness.

The literature considered a variety of special populations, but it did not apply these findings to older adults. I selected this population because it has not been studied whether mental health clinicians engage in self-awareness and self-reflection of their biases toward older adults during a counseling session. I used three subscales from the Self-Reflection and Insight Scale by Grant et al. (2002) and applied them to mental health clinicians who counsel older adults. The subscales were Insight, Need for Self-Reflection, and Engagement in Self-Reflection.

This study found no association between the number of years of licensed counseling experience predicted any measures of counseling competency as measured by the Self-Reflection and Insight Scale. The overall model was not significant; however, the model that used only years of counseling experience predicted, with statistical

significance, Engagement in Self-Reflection. The results regarding the Insight subscale are not interpretable because of the lack of reliability of the scale in this study.

Broadly speaking, there may be a range of factors that influence self-reflection in clinicians such as the population they counsel, years in practice, and personality (Silva & Phillips, 2010). It may be that those in practice for longer are older themselves and see similarities between themselves and their clients which may trigger self-reflection (Wagner et al., 2018). This does not explain the lack of significance when considering Need for Self-Reflection subscale. Perhaps this has to do with the conscious aspects of the process.

Grant et al. (2002) discussed that engagement in self-reflection is conscious, but the need is a very automatic process. This need may be determined by the individual's desire to control his actions by avoiding inappropriate behaviors and changing them to appropriate solutions (Grant et al., 2002). As a result, it may be that more years of experience makes counselors more aware of their biases across various domains not specific to older adults, and they then engage in self-reflection broadly as a therapeutic principle. Huppert et al. (2001) supported this by suggesting that the psychotherapy experience was positively associated with outcomes when using cognitive behavioral therapy as a modality with panic attacks.

This study found no association between the number of older adult clients counseled weekly, and counseling competency as measured by the Self-Reflection and Insight Scale. The model was not significant, which was surprising because Wagner et al. (2018) posited that counselors who are more exposed to older adults through counseling

sessions may recognize how this impacts their interest, attitudes, and understanding of this population. Perhaps such contact in general is not enough to spur self-reflective behaviors; rather there must be an accompanying stimulus that challenges an embodied stereotype held by the counselor. The rationale behind the research question was that being exposed to multiple older adults may serve to counteract stereotypes about the aging process by engaging in self-awareness of competency (Wagner et al., 2018).

Having extensive therapeutic interactions with older adult clients who do not conform to stereotypical caricatures may trigger additional reflection (Wagner et al., 2018). In the case of this study, it is possible that on average the counselors surveyed either did not work with enough older adult clients to see a diversity of individuals, or they tended to attract or accept clients that fit already internalized stereotypes, thus leaving little room for self-reflection. Self-reflection in professionals may be fueled by insight and analyzing their behavior with the desire to make changes that impact competency (Grant et al., 2002).

Lastly, this study found no association between the number of weekly counseling contact hours with older adult clients, and engagement in self-reflection, need for self-reflection, or insight. Perhaps this research question was not distinct enough from the number of older adult clients. It is likely that just spending more time with older adults would not present opportunities to challenge internalized stereotypes about the aging process. Maybe after a certain point there is therapeutic fatigue with the same client and the counselor becomes complacent and views the session as routine. Wagner et al. (2018)

suggested that self-awareness of attitudes may involve self-criticism which can cause reluctance to remain critical of levels of professional competency.

The low Cronbach's alpha for all three subscales means that the possibility could not be excluded that there is not a predictive relationship between any of the three independent and three dependent variables. This study was not able to detect such a relationship if it in fact exists. This aspect will be discussed further in the next section.

Limitations of the Study

This study had several limitations. No demographic information was collected, with the intention to maintain anonymity, though in fact there would have been no breach of anonymity had demographics been collected. This meant that data could not be analyzed with potentially contributing factors such as gender, age, and license type (i.e., LMHC, LCSW, PhD, etc.) as covariates. It is possible that different training programs teach principles of self-awareness and counseling competency differently and thus certain types of counselors are more or less likely to engage in self-awareness behaviors. While the number of years of counseling experience likely correlates with age of the counselor, knowing the precise age of each of the respondents would have been helpful to determine if age was a contributing factor to the models. Future studies should collect detailed demographic data from participants. Also, there was no way to truly know if the respondents were licensed clinicians which the qualifications specified. Since credentials could not be verified, it was assumed that those who answered the survey did so truthfully.

Another limitation was the recruiting method. The initial method used to collect data was convenience sampling through social network sites. This method provided a very limited response so a paid recruiting pool was used to increase interest. Although participation in the survey increased using this method, participants may not have taken the survey seriously and recorded answers to the survey quickly to receive compensation. Using a volunteer sample may have compromised the validity of the survey because volunteers may not have the same attributes as a general population sample (Hammer, 2017). This may explain the low Cronbach's alpha for all the subscales and especially the Insight subscale. Thus, the study's findings may not be generalized across populations.

Finally, this study was the first one to attempt to validate the Self-Reflection and Insight Scale in a mental health clinician population using an online format. The extremely low Cronbach's alpha indicated that the scale was not reliable when used in this setting and with this population. This indicates that the Self-Reflection and Insight Scale had low to unacceptable (depending on the subscale) internal consistency when used in this context and population. The scale as published by Grant et al. (2002) had an overall Cronbach's alpha for the four-factor model of 0.87 and was validated using a group of college-aged adult psychology students enrolled at a regional public university in the United States and administered in person via a paper format. The online platform and/or the administration of this scale to a different population may have affected the validity (Eysenbach & Wyatt, 2002). Future work can modify or redevelop a scale with proper validity to achieve a Cronbach's alpha of at least 0.8 before continuing further.

Recommendations

Future research that would be beneficial may include a modification to the Self-Reflection and Insight Scale to try to ameliorate internal validity issues. If such a modification was not effective, perhaps an entirely new scale should be created. This development may involve running an exploratory factor analysis or a confirmatory factor analysis to modify the scale so that it is most accurately and reliably capturing the goal information. Collecting demographic information on mental health clinicians such as age, sex, racial and ethnic identity, cultural group, education level, and specific mental health clinical licensure (i.e., LCSW versus LMHC) may improve generalization across populations and comparisons to other studies. Additionally, gaps may be easier to find in existing research specifically geared to variations in certain populations (Beins, 2009). Demographics can provide necessary information that would be used to synthesize existing research studies and analyze the results (Hammer, 2011).

It is recommended to validate alternative online survey administration since this is the most convenient, cost-effective method to collect data with the potential for a greater participant response (Beins, 2009). Additionally, counselor factors which influence aspects of counselor competency when providing therapy to older adults is still an open question, and would need to be considered for further studies. These factors may include a desire to work with this age group, counselor core educational courses that directly address the aging process, and mental health concerns related to older adults (Wagner et al., 2018).

Future research should establish a link between counselor self-awareness behavior and attitudes about the aging process in order to more directly investigate how self-awareness may affect counselor competency. A future study could develop and validate a questionnaire measuring counselor degree of agreement or disagreement with statements portraying stereotypes around the aging process. This procedure would establish a link between these two aspects that make up the foundation to further explore aspects of therapy practice (i.e., client population, counseling contact hours, years of experience), which may moderate the relationship between self-awareness of attitudes and counselor competency.

Implications

The demand for mental healthcare is increasing across the United States, according to Lake (2017). Lake also described mental illness as the next pandemic of the 21st century and urged health care agencies and educational institutes to increase training in geriatric care. The aging population is growing as well with over 70 million Americans expected to reach age 65 and older by the year 2030 (Salaz et al., 2016). Demand for mental healthcare is expected to increase in the aging population as well (IOM, 2012). Harmful stereotypes about the aging population persist and may impact the attitudes of clinical mental health counselors (Mallers & Ruby, 2017).

The significance of this study is that the findings may offer some understanding of how biases and attitudes may impact counseling competency and shed light on the need for counselors to engage in self-awareness of their attitudes toward older adults. Regarding positive social change, older adults may feel more comfortable using mental

health counseling if they perceive their counselor is competent to work with older adult clients. Mental health clinicians who check their understanding, attitude, and desire to work with older adults may have better insight into counseling competency regarding this population (Mallers & Ruby, 2017).

Singh (2020) posited that there is a great need for mental health clinicians to recognize ageism and the lack of attention given to gerontology practices regarding health disparities. Singh mentioned that mental health counselors who are not aware of these disparities through self-evaluation of their own competencies may not provide quality mental health care to older adults. Singh mentionedthat older adults may recognize this deficit in competency and choose not to seek mental health services. To contribute to positive social change, this research may illuminate the importance of better teaching practices and education regarding mental health care for older adults. As a social justice point, a positive outcome would be to reduce the underutilization of mental health services by older adults and ultimately improve the care they receive.

While research has explored aspects of providing competent counseling to other special populations such as gender and sexual minorities, ethnic minorities, etc., more research studies that address the aging population are needed (Chaney & Whitman, 2020). Contribution to positive social change was attained by investigating how aspects of counselor experience and contact with the aging population affect counselor self-awareness behavior and how this may impact counseling competency. Positive social change can happen when factors are identified which promote or inhibit self-awareness behaviors in clinical mental health counselors. This study may help advance the

understanding of what is necessary to provide competent counseling to the aging population and improve health care disparities within the older adult population.

An important methodological implication was that this study showed that the Self-Reflection and Insight Scale was not necessarily reliable when administered to a survey population consisting of mental health clinicians. Grant, et al. (2002) posited that some individuals may not engage in conscious or purposeful self-reflection measured by the Self-Reflection and Insight Scale. Grant, et al. further suggested that for these individuals, a self-reflection process and insight may be automatic instead of deliberate. As the Self-Reflection and Insight Scale is the only scale known that measures self-awareness behaviors, this study has revealed an important challenge which must be worked through before meaningful research can continue.

Conclusion

Overall, this study drew attention to the special population of older adults and mental health clinicians who provide therapy to them. Since it is likely that older adults will seek mental health services, they may benefit from mental health clinicians who are more self-aware of biases and negative attitudes toward them. Mallers & Ruby (2017) posited that competent counseling involves knowledge and experience in working with older adults. Although more research is needed, this study suggested that counselors with more years of experience may be better equipped to deliver therapy to older adults. Levy (2004) described competency as the evaluation of attitudes and perception of biases as the single most important factor in understanding special populations.

The impact on positive social change may be that mental health clinicians who engage in self-reflection and insight of competency to provide therapy to older adults may provide a more positive outcome in counseling. This may encourage older adults to increasingly utilize mental health counseling services, because they may find the care received is reflective of their life-span development issues. This study also underscored the need for the development of research tools to measure aspects of counselor competency when working with older adults. Additionally, education programs addressing counselor competency when working with older adults may need to be part of a counselor's training (Chaney & Whitman, 2020). To impact positive social change, such programs could increase coursework in geriatric counseling, the aging process, and lifespan development issues associated with older adults as it would be beneficial for counselors working with this special population.

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Appendix A

Recruitment Flyer

Are you a licensed mental health clinician?
Do you provide therapy to older adults ages 65 and over?
Are you 18 years of age or older?

Please consider participating in a research study which is conducted by Susan McInvale who is a doctoral candidate at Walden University. This study will explore whether mental health clinicians engage in self-awareness and insight during counseling sessions. The information obtained from this study may help counselors improve clinical practices and clinician competency in providing therapy to older adults.

About the study:

- One 1-minute inclusion/exclusion questionnaire
- One 1-minute demographic questionnaire
- One 5-minute online survey
- For privacy protection, no names will be collected

You may be eligible to participate in the study if you:

- Are 18 years and older
- Are a licensed mental health clinician currently practicing
- Are providing therapy to older adults (65 and older)

Appendix B

Inclusion-Exclusion Questionnaire

Please answer the following questions related to professional background. Please answer the questions by checking either yes or no. If you answer yes to all these questions, and you have agreed to participate in this study, please consent by completing the online survey. Thank you.

1. Are you a licensed mental health clinician?

   Yes _____ No _____

2. Are you currently practicing mental health therapy, counseling, or psychotherapy?

   Yes _____ No _____

3. Do you provide therapy to the aging population (65 years of age or over)?

   Yes _____ No _____

Appendix C

Demographic Survey for All Participants

Questionnaire

1. Are you 18 years of age or older?

Yes ____ No _____

2. Are you currently a licensed mental health clinician licensed to practice mental health therapy?

Yes _____ No _____

3. Do you provide therapy to older adults (ages 65 and older)?

Yes _____ No _____

4. Years of professional counseling experience.

0 to 5

5. What is the number of counseling contact hours per week you have with older adults? _____

Appendix D

Self-Reflection and Insight Scale

The Self-Reflection and Insight Scale appears on the following two pages, with 9/20 questions on the first page, and questions 10 – 20 on the second page. The scoring instructions are given on the third page of this appendix.

Self-reflection and Insight Scale

(Factors, reverse scoring and scoring instructions shown)

Please read the following questions and circle the response that indicates the degree to which you agree or disagree with each of the statements. Try to be accurate, but work quite quickly. Do not spend too much time on any question

THERE ARE NO "WRONG" OR "RIGHT" ANSWERS – ONLY YOUR OWN PERSONAL PERSPECTIVE

BE SURE TO ANSWER EVERY QUESTION ONLY CIRCLE ONE ANSWER FOR EACH QUESTION

			Disagree Strongly	Disagree	Disagree Slightly	Agree Slightly	Agree	Agree Strongly
			1	2	3	4	5	6
1.	I don't often think about my thoughts	(E)						
2.	I am not really interested in analyzing my behaviour	(N)						
3.	I am usually aware of my thoughts	(I)						
4.	I'm often confused about the way that I really feel about things (R)	(I)						
5.	It is important for me to evaluate the things that I do	(N)						
6.	I usually have a very clear idea about why I've behaved in a certain way	(I)						
7.	I am very interested in examining what I think about	(N)						
8.	I rarely spend time in self-reflection (R)	(E)						
9.	I'm often aware that I'm having a feeling, but I often don't quite know what it is (R)	(I)						

Note E=Engagement in self-reflection; N=Need for self-reflection; I=Insight into self-reflection.

The remaining questions appear overleaf, along with permissions and copyright.

10. I frequently examine my feelings	(E)	Disagree Strongly 1	Disagree 2	Disagree Slightly 3	Agree Slightly 4	Agree 5	Agree Strongly 6
11. My behaviour often puzzles me (R)	(I)	Disagree Strongly 1	Disagree 2	Disagree Slightly 3	Agree Slightly 4	Agree 5	Agree Strongly 6
12. It is important to me to try to understand what my feelings mean	(N)	Disagree Strongly 1	Disagree 2	Disagree Slightly 3	Agree Slightly 4	Agree 5	Agree Strongly 6
13. I don't really think about why I behave in the way that I do (R)	(E)	Disagree Strongly 1	Disagree 2	Disagree Slightly 3	Agree Slightly 4	Agree 5	Agree Strongly 6
14. Thinking about my thoughts makes me more confused (R)	(I)	Disagree Strongly 1	Disagree 2	Disagree Slightly 3	Agree Slightly 4	Agree 5	Agree Strongly 6
15. I have a definite need to understand the way that my mind works	(N)	Disagree Strongly 1	Disagree 2	Disagree Slightly 3	Agree Slightly 4	Agree 5	Agree Strongly 6
16. I frequently take time to reflect on my thoughts	(E)	Disagree Strongly 1	Disagree 2	Disagree Slightly 3	Agree Slightly 4	Agree 5	Agree Strongly 6
17. Often I find it difficult to make sense of the way I feel about things (R)	(I)	Disagree Strongly 1	Disagree 2	Disagree Slightly 3	Agree Slightly 4	Agree 5	Agree Strongly 6
18. It is important to me to be able to understand how my thoughts arise	(N)	Disagree Strongly 1	Disagree 2	Disagree Slightly 3	Agree Slightly 4	Agree 5	Agree Strongly 6
19. I often think about the way I feel about things	(E)	Disagree Strongly 1	Disagree 2	Disagree Slightly 3	Agree Slightly 4	Agree 5	Agree Strongly 6
20. I usually know why I feel the way I do	(I)	Disagree Strongly 1	Disagree 2	Disagree Slightly 3	Agree Slightly 4	Agree 5	Agree Strongly 6

E = Engagement in self-reflection: N = Need for self-reflection: I = Insight: R = Reverse scored

Grant, A. M., Franklin, J., & Langford, P. (2002). The Self-reflection and Insight Scale: A new measure of private self-consciousness. Social Behavior and Personality, 30, 821-836. – *Permission is freely granted to use this scale for research and therapeutic/coaching purpose. Commercial use of this scale requires written permission from A. M .Grant. Email:* anthonyg@psych.usyd.edu.au

Scoring Instructions

The scoring process is very simple. Summed scores are used. There is no scaling or scale transformation required other than basic reverse scoring for four items.

Step 1.
Reverse score those items marked (R).
An original score of "1" would become"6"; "2" would become "5"; "3" becomes "4" and visa versa.

Step 2.
Sum the scores for each subscale

Engagement in Self-reflection Sub-scale – Items: 1, 8, 10, 13 (R), 16, 19

N = Need for Self-reflection Sub-scale – Items: 2, 5, 7, 12, 15, 18

I = Insight Sub-scale – Items: 3, 4, 6, 9 (R), 11 (R), 14 (R), 17 (R), 20