BAILEY, SARA W., Ph.D. The Game of *I am*: Enhancing Empathy and Improving Attitudes Toward Older Adults in First-Year Master's Students Training to Become Counselors and Student Support Professionals. (2018).
Directed by Dr. Laura M. Gonzalez and Dr. L. DiAnne Borders. 257 pp.

In the United States, adults 65 and older represent a significant and growing cultural minority (Cohn & Taylor, 2011). Ageist stereotypes, whether directed at older adults or internalized by elders themselves, can cause real harm to elders' mental and physical health (Nelson, 2016a). Mezirow's transformative learning theory (TLT; 1991) directly addresses the essential nature of challenging personal prejudices and cultivating empathy as critical to development within the adult learner, and transformative empathy-enhancing interventions have been used successfully to improve attitudes toward older adults in helping professionals and professionals-in-training (e.g., Friedman & Goldbaum, 2016; Henry & Ozier, 2011). Even though older adults receive mental health services at a lower rate than any other age demographic (Karel, Gatz, & Smyer, 2012), and greater numbers of older adults are entering postsecondary education (Chen, 2017; DiSilvestro, 2013; Kasworm, 2010), there has been limited focus in counseling and higher education research on meeting the needs of this expanding demographic. Intervening early in students' training to address age-related biases and to foster empathetic awareness (Andersson, King, & Lalande, 2010) aligns with the counseling profession's commitment to purposeful counselor preparation (Kaplan, Tarvydas, & Gladding, 2014) and professional competency standards for student support professionals (ACPA & NCPA, 2015).

Using Bartholomew's (1998) Intervention Mapping model (IM), I developed a three-part empathy-enhancing transformative learning intervention, "The Game of *I am*" (Bailey, 2016c). Using a pre-post quasi-experimental design, the purpose of the current feasibility study was to test the preliminary effectiveness of the intervention at enhancing self-reported empathy and improving self-reported attitudes toward older adults with first-year master's students training to be counselors ($N = 14$) and student support professionals ($N = 13$). Although preliminary qualitative themes emerged that supported its utility, quantitatively there were no statistically significant changes in mean empathy and attitude scores for the participants following participation in "The Game of *I am*" (Bailey, 2016c). Additional plans for the analysis of collected qualitative data are described and implications for integrating "The Game of *I am*" (Bailey, 2016c) into existing master's level coursework are discussed.

THE GAME OF *I AM*: ENHANCING EMPATHY AND IMPROVING ATTITUDES TOWARD OLDER ADULTS IN FIRST-YEAR MASTER'S STUDENTS TRAINING TO BECOME COUNSELORS AND STUDENT SUPPORT PROFESSIONALS

by

Sara W. Bailey

A Dissertation Submitted to
the Faculty of The Graduate School at
The University of North Carolina at Greensboro
in Partial Fulfillment
of the Requirements for the Degree
Doctor of Philosophy

Greensboro
2018

Approved by

Dr. Laura M. Gonzalez
Committee Co-Chair

Dr. L. DiAnne Borders
Committee Co-Chair

APPROVAL PAGE

This dissertation written by Sara W. Bailey has been approved by the following committee of the Faculty of the Graduate School at The University of North Carolina at Greensboro.

Committee Co-Chair _____
Dr. Laura M. Gonzalez

Committee Co-Chair _____
Dr. L. DiAnne Borders

Committee Members _____
Dr. A. Keith Mobley

_____
Dr. Rebecca G. Adams

_____
Date of Acceptance by Committee

_____
Date of Final Oral Examination

ACKNOWLEDGMENTS

So many people have walked alongside me as I've pursued this dream. Perhaps the most important thing I've learned along the way is the importance of a supportive community. I've had one, and I am eternally grateful.

Dr. Gonzalez, thank you for taking me on as your "first" and then being willing to stick with me when you stepped across Spring Garden into the School of Ed. I never would have predicted that your career shift would have made such a positive impact on my own journey in this PhD process. Dr. G., my "J" needed your "P." Dr. Borders, thank you for being my "second" and then stepping into the co-chair role. Your attention to detail, your love of the written word, and your APA acumen have made such an impact on me, and I'm a better writer because of you. Dr. Mobley, thank you for being "Dr. Tres." I have valued your insights and your depth and breadth of knowledge. Dr. Adams, thank heavens for the bathroom in Ferguson. Without it, our paths may never have crossed. I'm indebted to you for your support in my post-bacc process, and I promise, one day we're going to get that coffee.

Next, my heartfelt thanks go to my on-the-fly administrative guru Jenn Cannon. Jenn, I hope you know how important you were in kickstarting my study. Scheduling as we recruited? What a concept! Just so we're clear, you're stuck with me, and that goes for you, too, Laura Land. Laura, you are a rock star recruiter, and I still feel bad about you missing that appointment. Thank you for jumping in! Mary-Katherine, Jenna, Molly, thank you for being part of my facilitation "Dream Team."

To those who played my game, participated in my pilot studies, gave me feedback, and let me word vomit as I was trying to figure out what I was doing, thank you. Special thanks go to Dr. Connie Jones, Dr. Laura Veach, and my "Little," Marcia McCall. Your support, your guidance, your mentorship, and your friendship are all precious to me, and I am so grateful to you for your shoulders and your hearts.

To Rick, even though this was not the original plan, you toughed it out right along with me. I'll never forget how conflicted I felt on the night you said, "Do it," as I was trying to figure out whether or not to apply to the doc program. Thank you for holding me when I wept, for laughing at my jokes, for telling me I could keep going even when I felt like quitting. I've loved you for a long time, and your love kept me sane (ish) during this process. Coming home to you at the end of every week was my bestest thing. To Oren, thank you for asking me questions about my research and being an all-around good egg. You inspire me with your creativity and your compassion, and I am so glad you're my kid. You continue to teach me the meaning of empathy, and I'll never be able to adequately thank you for those lessons.

To Mom, the fact that you didn't tell me that I was underachieving for all those years is a true testament to your ability to keep custody of the mouth. Thank you for believing in me, inspiring me, and for understanding when I was distracted. Your support has been vital and you're the coolest person I know. To Jack, I'm glad you have a place in your heart for me and the boys. You definitely have a place in ours.

To Bobbie and Jimmy, although you're not here to witness this, I'd like to think that wherever you are, you are proud of me.

And to those who think that they are too old to change paths, I'm here to tell you that if you really want it and are willing to sacrifice for a few years (and have a community of supporters to hold you up when you falter), you can do this. During seasons of this journey when I felt as if I was ready to throw in the towel, I remembered that I wasn't just doing this for me, I was also doing it for those who feel disempowered and "othered." For the kids (and adults) who were/are bullied or left out or picked last for the team, I did it for all of us. The intervention that this research is built on is designed to shake people up a bit, to remind them that when we "other" anyone, ultimately, we're "othering" ourselves. And that's not cool. So, don't do it. In the brilliant words of Bob Newhart, just "Stop it."

TABLE OF CONTENTS

LIST OF TABLES

Page

CHAPTER I

INTRODUCTION

In the years between 1946 and 1964, during what is now referred to as the "Baby Boom," 77 million babies were born in the United States (Moody & Sasser, 2015). Approximately 10,000 members of this cohort turn 65 years old every day (Cohn & Taylor, 2011) and, along with much of the world's population, will live longer than generations before them. In 1900, only 4% of the population was 65 years of age or older, and a baby born that year could expect to live to be 47 (Hooyman & Kiyak, 2011). In the United States in 2015, 14.9% of the population was 65 or older, and by 2050 it is predicted that 22.1% will be 65 or older (He, Goodkind, & Kowal, 2016). This "longevity revolution" (Butler, 1969; Fullen, 2016) is part of an ongoing cultural shift that is occurring as the United States becomes increasingly diverse in terms of race, ethnicity, and age (Colby & Ortman, 2015). These changes in demographic structure present both opportunities and challenges for counselors and other professionals to better serve an increasingly diverse population of older adults.

Although chronological age is not a reliable indicator of health or well-being, advanced age is frequently accompanied by reduced physiological function and resilience; changes to cognitive abilities, including a slowing of processing speed and increased likelihood of dementia; and major life transitions, including retirement and widowhood (Gatz, Smyer, & Digilio, 2016; Harma, 2012; Hebert, Weuve, Scherr, &

Evans, 2013; Ng, Allore, Monin, & Levy, 2016; Norcross & Fiske, 2015). In response to and in conjunction with these changes, older adults are also affected by mental health and substance use disorders. Approximately 20% of adults 65 and older meet the criteria for a mental disorder (Karel, Sakai, Molinari, Moye, & Carpenter, 2016; Solway, Estes, Goldberg, & Berry, 2010). Depression affects between 15% and 20% of adults 65 and older (Hansen, Flores, Coverdale, & Burnett, 2016). Rates of anxiety disorders in community dwelling elders are estimated to range between 1.2%-15%, with as many as 56% of adults 65 and older living with symptoms of anxiety that do not meet the Diagnostic and Statistical Manual of Mental Disorders criteria (DSM-V; American Psychiatric Association, 2013; Therrien & Hunsley, 2012). Depression and anxiety are frequently comorbid with other medical and mental health conditions, including chronic pain, dementia, substance use disorders, and cognitive decline (Hansen et al., 2016; Lenze et al., 2001; Therrien & Hunsley, 2012), rendering impacted elders "doubly vulnerable" (Gwyn & Colin, 2010, p. 39). The number of older adults living with a substance use disorder is predicted to more than double from an annual average (2002-2006) of 2.8 million to 5.7 million by 2020 (Han, Gfroerer, Colliver, & Penne, 2009). The rate of completed suicide is highest in older adults, with the rate for White men 85 and older double that of any other age demographic (Solway et al., 2010). The impact of mental health and substance use disorders on older adults is profound, leading to "poorer health outcomes and higher rates of hospitalization and emergency department visits, resulting in per-person costs that are 47% to more than 200% higher" (Bartels & Naslund, 2013, p. 493; Institute of Medicine, 2012).

Despite the prevalence and impact of mental health and substance use disorders in older adults, and even with ample evidence supporting psychotherapy as an effective intervention for treating such disorders in this population (Bartels & Naslund, 2013; Choi & DiNotto, 2013; Myers & Harper, 2004; Pinquart, Duberstein, & Lyness, 2007; Roseborough, Luptak, McLeod, & Bradshaw, 2013), adults 65 and older receive mental health services at a lower rate than any other age demographic (Karel et al., 2012). The reasons for this gap in care are complex and include both structural (e.g., limited Medicare coverage, transportation barriers) and psychosocial factors, such as the attitudes of older adults and the attitudes of the professionals tasked with serving them (Solway et al., 2010).

Although some researchers have posited that elders' negative beliefs about using mental health services represent a distinct barrier to care, the findings of researchers attempting to link chronological age with negative attitudes toward mental health care have been inconsistent (Kessler, Agines, & Bowen, 2015). According to some researchers, elders' attitudes toward utilizing mental health services may be related to their self-perceptions about aging, with those who hold a more positive view of later life being more likely to see mental illness as treatable and therefore choosing to engage in health supporting behaviors such as seeing a counselor (Levy, Zonderman, Slade, & Ferrucci, 2009; Wurm, Tesch-Römer, & Tomasik, 2007). Researchers who analyzed data from a Canadian survey of 35,236 adults 18 and older found that older adults who reported higher levels of social support were more likely to seek out mental health services than those who reported less support (Vasiliadis, Tempier, Lesage, & Kates,

2009). Some researchers have found that older adults tend to *prefer* psychotherapy to pharmacotherapy for symptoms of depression (Choi & Morrow-Howell, 2007). Perhaps, as these researchers have suggested, the attitudes of older adults do not represent a substantial obstacle to care. The more significant barrier to adequate mental health care services for this population may lie with the attitudes and beliefs of care providers themselves.

There appears to be a general lack of student and professional interest in working with older adults in medicine, social work, and psychology (e.g., Bartels & Naslund, 2013; Eaton & Donaldson, 2016*;* Institute of Medicine, 2012). Over half of fellowships in geriatric medicine and psychiatry go unfilled each year (Bartels & Naslund, 2013). In its 2012 report, "In Whose Hands?" the Institute of Medicine predicted that training enough geriatric medicine specialists and geriatric psychiatrists to meet the growing need for such professionals *is not possible*. In their cross-sectional survey of over 1000 social work students, Chonody and Wang (2014) found that only 5.4% named aging as their primary professional interest. Only 4.2% of the 6334 psychologists surveyed in the 2008 APA Survey of Psychology Health Service Providers named older adults as their primary population of clinical focus (APA, 2014; Michalski, Mulvey, & Kohout, 2010).

Although research on counseling students' interest in gerontology-focused practice has been sparse (Stickle & Onedera, 2006), two studies indicated an encouraging level of interest in gerontological counseling (gerocounseling) by both master's- and doctoral-level counseling students (Foster et al., 2009; Nielsen, 2014). Despite student interest, however, gerontological counseling is no longer a specialty in CACREP-

accredited Programs (CACREP) and National Board for Certified Counselors (NBCC) standards (Bobby, 2013; Foster & Kreider, 2009), and, in some studies, counseling students have reported feeling ill-prepared to work with older adults (Foster & Kreider, 2009; Stickle & Onedera, 2006). This lack of focus on gerontological competencies in counselor education (Meredith & Watt, 1995; Nelson, 2017; Nielsen, 2014) may dissuade counseling students from choosing to work with older adults.

Departmental culture and the attitudes of counseling faculty toward gerontology may influence student attitudes toward and interest in working with older adults, and students who are encouraged by faculty to work with adults 65 and older may be more likely to do so (DeVries, 2005; Woodhead et al., 2013). For those counselor educators who are committed to enhancing students' interest in working with older adults despite the absence of professional gerontological counseling competency standards, there can be many potential challenges to integrating gerontology-focused content and curricula into counselor education. Some of those challenges may include budget constraints, a lack of departmental interest in gerontology, overworked and overscheduled counselor educators, and institutionalized ageism within departments (Meredith & Watt, 1995; Nelson, 2017; Zucchero, 1998; Zucchero, Iwasaki, Lewis, Lee, & Robbins, 2014). Additionally, researchers who have tested the utility of interventions designed to enhance student *content knowledge* about aging as a way to improve self-reported attitudes toward older adults have found inconsistent results (Allan & Johnson, 2009; Cottle & Glover, 2007; Gellis, Sherman, & Lawrance, 2003; Merz, Stark, Morrow-Howell, & Carpenter, 2016).

Counselor educators who are committed to training competent gerocounselors may find that, in addition to providing students with knowledge about the distinct cultural considerations of older adults, fostering students' awareness of their attitudes and biases toward older adults and encouraging development of an empathetic attitude are also essential to enhancing counselor identity development and training culturally competent counselors (Sivis & McCrae, 2010; Sue, Arredondo, & McDavis, 1992). Although dedicated counselor educators serve an essential role in the development of counseling students into competent helpers, a well-designed curriculum presented by the most enthusiastic educators who are committed to promoting gerocounseling may not be sufficient to produce quality gerocounselors if students themselves hold unexamined ageist biases toward older adults.

Ageism may be both ubiquitous and "socially condoned" (Norcross & Fiske, 2012, p. 982; Palmore, 2001), and ageist beliefs are common across age groups and throughout the lifespan (Allen, 2016; Bergman & Bodner, 2015; Bousfield & Hutchison, 2010). "Given the diverse societal facets of ageism, some argue that this form of prejudice is currently more prevalent than racism and sexism" (Norcross & Fiske, 2012, p. 984; Rupp, Vodanovich, & Credé, 2005). From having a "senior moment" to "dressing for your age," the process of getting older is often pathologized and presented as a battle to be fought or something to be feared (Applewhite, 2015; Cherry, Allen, Denver, & Holland, 2015; Nelson, 2016a). Fear of getting older and anxiety about one's own mortality may contribute to ageist beliefs (Bodner & Cohen-Fridel, 2014; Martens, Greenberg, Schimel, & Landau, 2004; Nelson, 2005). According to terror management

theory (TMT; Martens, Goldenberg, & Greenberg, 2005), avoidance of, repulsion by, and prejudice toward older adults has been hypothesized as a way to manage death anxiety. By stereotyping elders as being different, one can create the illusion of distance and guard against, at least temporarily, the threat of one's own mortality (Bodner, 2009). Developing awareness of such stereotyping is critical to both acknowledging one's biases and to exerting control over what can become an automatic response to people who are older (Bargh, Chen, & Burrows, 1996).

Since the 1980s, the counseling profession has recognized the need for culturally competent practice and has emphasized "training multiculturally skilled counselors who are able to provide ethical and effective counseling interventions to culturally diverse clients" (Tomlinson-Clarke, 2013, p. 1). Sue et al. (1982) introduced a Tripartite Model of Cross-Cultural Competence, in which three distinct attributes of cultural competence were identified: knowledge; culturally-appropriate skills; and awareness of personal beliefs, biases, attitudes, and values (Tomlinson-Clarke, 2013). Awareness of one's attitudes, values, assumptions, and biases (Sue et al., 1992), and exploration of one's own privilege and culture (Black & Stone, 2005; Ratts, Singh, Nassar-McMillan, Butler, & McCullough, 2015), have been named as essential to multicultural competence and counselor identity development. Providing students ample opportunities to become aware of and evaluate their attitudes toward older adults early in their counselor training can play a valuable role in developing gerontological counseling competence.

There may be reluctance on the part of counseling students to admit any prejudicial feelings or ageist biases (Cherry et al., 2016), fearing the judgments of others,

especially faculty. However, the impact of counselor ageism on older adults can be devastating for health and overall well-being (e.g., Levy et al., 2009; Tomko & Munley, 2012), such as when a counselor who believes that confusion is a normal part of aging might fail to recognize symptoms of depression or a substance use disorder in an older client (American Psychiatric Association, 2013; McBride & Hays, 2012). Counselor educators committed to social justice and gerontological counseling competencies are called to move the profession one step closer to "dismantling the mechanisms of discrimination" (Boysen, 2010, p. 211), including addressing students' beliefs, values, and attitudes regarding older adults.

CACREP requires its accredited programs to include "strategies for identifying and eliminating barriers, prejudices, and processes of intentional and unintentional oppression and discrimination" (CACREP, 2015, p. 9). Transformative learning theory (TLT; Mezirow, 1991) provides a framework for sparking such awareness in students. "The TLT process pushes…learners further into critical thinking, beyond the basic acquisition of factual knowledge, where the learner considers multiple view points and begins to question prior beliefs and values as well as prior assumptions" (Cohen, Brown, & Morales, 2015, p. 187). According to this theory, the catalyst for transformative learning is a triggering event, known in TLT as a *disorienting dilemma*, presented within a context that encourages reflection and group discourse. In counselor education, intense classroom experiences in which students are presented with viewpoints that differ from their own can serve as disorienting dilemmas. By engaging in critical self-reflection and group discourse in the face of a challenge to existing perspectives, learners can see

through their existing beliefs and rationally reassess the validity of existing and previously unchallenged perspectives (Mezirow, 1991).

Empathy, "a sophisticated human relating skill" (McAllister et al., 2011, p. 22), is essential for transformative learning to occur, and is evident in critical reflection and discourse in which learners consider the perspectives of others in order to better understand them. Carl Rogers defined empathy as one of the core conditions for therapeutic change (Rogers, 1957) and, although the definition of empathy continues to be debated (Teding van Berkhout & Malouff, 2016), provider empathy has been linked to improved client outcomes in medical, social work, psychology, nursing, and counseling research (e.g., Beck, Daughtridge, & Sloane, 2002; Constantine, 2001; McAllister et al., 2011; Moyers, Houck, Rice, Longabaugh, & Miller, 2016; Watson, Steckley, & McMullen, 2014). Decety and Moriguchi (2007) have named perspective taking as an essential component of empathy, and research into the utility of active perspective taking as an effective way to enhance self-reported empathy is plentiful (e.g., Batson et al., 1997; Bearman, Palermo, & Williams, 2015; Galinsky & Moskowitz, 2000; Rapisarda, Jencius, & McGlothlin, 2011). The emancipatory process of transformative learning best occurs within the context of a learning environment that provides both a balance of challenge and support and opportunities for perspective taking, critical reflection, and engagement with other learners (Kitchenham, 2008). One platform with rich potential for such learning is found in active learning interventions such as transformative role-playing games.

Blending collaborative play with facilitated debriefing, transformative role-playing games emphasize "the authenticity and the conditions of the play experience rather than…predefined educational goals. In other words, (they are) more focused on the journey than on the results" (Daniau, 2016, p. 428). Daniau (2016), suggesting a link between transformative role-playing games and empathy development, highlighted the importance of group debriefing following game play, in keeping with TLT's emphasis on discourse, as a tool for participants to synthesize their experiences with their existing learning and awareness. In one study, an active learning role-play intervention that included critical reflection, group dialogue, and perspective taking improved perceived gerontological competence, clinical awareness, and self-reported empathy toward older adults in social work graduate students (Friedman & Goldbaum, 2016). A board game transformational learning activity, called "The Game of Late Life," improved self-reported attitudes toward older adults and reduced aging anxiety in first-year psychology students (Brinker, Roberts, & Radnidge, 2014). Simulation aging activities, such as "The Aging Game" (McVey, Davis, & Cohen, 1989), have enhanced self-reported empathy and positively affected attitudes toward older adults in studies with college students, nursing and nutrition students, radiographers, and medical students (Booth & Kada, 2015; Green & Dorr, 2016; Henry & Ozier, 2011; Pacala, Boult, & Hepburn, 2006). Active learning interventions such as role plays, games, and film screenings, have been used successfully with counseling students and school counselors to transform attitudes and enhance self-reported empathy and multicultural awareness toward racial, ethnic, and linguistic minorities (Kim & Lyons, 2003; Paredes, 2010; Rapisarda et al., 2011; Villalba

& Redmond, 2008). To date, such interventions have not been used to address master's-level counselor trainees' self-reported empathy or attitudes toward older adults.

As the "largest generational cohort in U.S. history" (Foster et al., 2009, p. 227) ages, the need for qualified medical and mental health professionals, including gerocounselors, will continue to grow. Without adequately trained and enthusiastic counselors ready and willing to serve the needs of this expanding demographic, there is likely to be a widening gap between adults who are older and adequate counseling services. Assessing for and impacting empathy and attitudes toward older adults in counselor trainees aligns with our profession's commitment to social justice and culturally competent practice. In this feasibility study, I tested the preliminary effectiveness of a three-part transformative learning intervention, "The Game of *I am*" (Bailey, 2016c), on enhancing self-reported empathy and improving self-reported attitudes toward older adults in first-year master's counseling students.

Purpose of the Study

The purpose of this feasibility study was to test the preliminary effectiveness of a transformative learning intervention, "The Game of *I am*" (Bailey, 2016c), with first-year master's counseling students enrolled in first-semester coursework in a full-time CACREP-accredited counseling program. The intervention was conducted in three parts. First, students submitted an online "pre-reflective" journaling post in which they wrote about their attitudes toward their own aging by responding to the prompt, "Today is your 75th birthday. Describe your life, your personality, your habits, and your health." Approximately a week later, students played "The Game of *I am*" (Bailey, 2016c), a role-

playing game in which students engaged in perspective-taking as they took turns reading short vignettes describing scenarios in which older adults were faced with negative ageist stereotypes, verbally processed their emotional responses to the prompts, engaged in a brief facilitated group dialogue, and then progressed around a game-style board. Immediately following game play, students participated in a facilitated group debriefing, discussing the experience of the game and how it affected them. Approximately a week after participation in "The Game of *I am*" (Bailey, 2016c), students submitted an online "post-reflective" journaling post in which they responded to the prompt, "How would you feel about working with a 90-year-old client who presents with symptoms of depression?"

"The Game of *I am*" (Bailey, 2016c) could be integrated into existing counseling coursework as a way to highlight some of the distinct cultural considerations of aging and encourage student empathy development and improve student attitudes toward older adults. This intervention is aligned with the counseling profession's core values: "enhancing human development throughout the lifespan,…honoring diversity,… promoting social justice,…(and) practicing in a competent and ethical manner" (American Counseling Association, 2014, p. 3).

Research Questions

To assess the preliminary effectiveness of a transformative learning intervention, "The Game of *I am*" (Bailey, 2016c), at enhancing master's counseling students' self-reported empathy and improving their self-reported attitudes toward older adults, this feasibility study utilized a one-group pretest-posttest design. Participants were recruited

from a convenience sample of first-year master's counseling students enrolled in full-time CACREP-accredited counseling programs at two universities. The research questions were as follows:

Research Question 1: Will participation in "The Game of *I am*" result in significant pre-post intervention mean differences in self-reported empathy as measured by the Toronto Empathy Questionnaire (TEQ; Spreng, McKinnon, Mar, & Levine, 2009) in first-year master's counseling students?

Research Question 2: Will participation in "The Game of *I am*" result in significant pre-post intervention mean differences in self-reported attitudes toward older adults as measured by the Fraboni Scale of Ageism (FSA; Fraboni, Saltstone, & Hughes, 1990) in first-year master's counseling students?

Need for the Study

Older adults represent a significant and growing cultural minority, but counseling students may feel inadequately prepared to work with them (Foster & Kreider, 2009; Stickle & Onedera, 2006), and few counselors have reported receiving specific training in gerocounseling (Foster & Kreider, 2009; Fullen, 2016; Institute of Medicine, 2012). Gerontological counseling is no longer a specialty in CACREP and NBCC standards (Bobby, 2013; Brueske, 1999; Foster & Kreider, 2009), and although the few available studies on this topic suggest that there may be student interest in gerocounseling, few students feel well-prepared to serve this population (Foster & Kreider, 2009; Stickle & Onedera, 2006), and few practicing counselors report having had specific training in gerocounseling (Fullen, 2016). The gap between the need for qualified gerocounselors

and available and well-trained gerocounselors may be linked to deficient empathy and ageist biases toward older adults (Chonody, Webb, Ranzijn, & Bryan, 2014).

Greater awareness of the centrality of multicultural counseling competence to ethical practice has resulted in an expanding research base focused on counseling diverse populations, including research into the origins of bias, ways to assess multicultural competence, and interventions designed to develop multicultural counseling competence. Although gerontological counseling competencies are no longer a part of CACREP and NBCC standards (Bobby, 2013; Foster & Kreider, 2009), multicultural counseling competencies have been highlighted as *essential* to professional counseling identity in the 2016 CACREP standards (CACREP, 2015; Ratts et al., 2015). To date, however, there continues to be a lack of research on interventions designed to enhance gerontological counseling competencies in master's level counselors.

With an anticipated shortage of mental health professionals interested in working with older adults (Chonody & Wang, 2014; Foster et al., 2009; Nelson, 2016; Institute of Medicine, 2012), intervening early in a counseling student's training to address age-related biases and to foster increased empathetic awareness (Andersson et al., 2010) aligns with our profession's commitment to wellness (Yep, 2008) and purposeful counselor preparation (Kaplan et al., 2014).

Definition of Terms

O*lder adults* or *adults who are older* or *elders* or *older people* refers to adults 65 years old and older.

Baby Boomers refers to adults born between 1946 and 1964.

Ageism is broadly defined as prejudice toward older adults, and is drawn from Butler's (1969) original definition, "prejudice by one age group toward other age groups" (p. 243). Iversen, Larsen, and Solem (2009) redefined ageism within four dimensions: cognitive; affective; behavioral; and social network, institutional, and cultural discrimination. This broadening of the concept is in keeping with ACA's 2014 Code of Ethics and its focus on context and social justice.

Gerocounseling or *gerontological counseling* or *gero-focused counseling* is defined as providing counseling services to older adults.

Empathy was named as one of the core conditions for therapeutic change by Carl Rogers (1969) and, although its definition has continued to be debated (Teding van Berkhout & Malouff, 2016), in this study, following definitions by both Mezirow (2003) and Trent, Park, Bercovitz, and Chapman (2016), empathy is defined as imagining, co-experiencing, and sensing the undeclared feelings and thoughts of another.

Brief Overview

The study is presented in five chapters. Chapter 1 introduced the impact of demographic shifts on the need for qualified gerocounselors, possible barriers to meeting this growing need, the purpose of the study, statement of the problem, the research questions, definition of terms, and the content of the five chapters.

Chapter 2 is a literature review of relevant research, including changes that typically occur in later life; the prevalence and impact of mental health and substance use disorders in older adults; challenges to elders' access to care; attitudes about aging;

ageism; empathy and empathy-enhancing interventions; age as a cultural consideration in counselor education; transformative learning theory; and the need for the study.

Chapter 3 describes the methodological plans for the current feasibility study, including recruitment strategy and participants; intervention development; results from an initial implementation study, variables and instruments; procedures; statistical analyses; and results from two pilot studies. Research questions and hypotheses are also included.

The results of the data analysis are explained in Chapter 4. Chapter 5 provides a discussion of the results from this feasibility study, including study limitations, implications for professional practice, and future areas for research on the impact and utility of "The Game of *I am*" (Bailey, 2016c) on enhancing master's counseling students' self-reported empathy and self-reported attitudes toward older adults, as well as potential use of the intervention beyond counselor education.

CHAPTER II

REVIEW OF THE LITERATURE

Introduction

> *We all have only the two choices, growing old or dying young.*
> (Nelson, 2017, p. 325)

In their 1982 position paper, responding to the increasing cultural diversity in the United States, Sue et al. introduced a Tripartite Model of Cross-Cultural Competence, in which cross-cultural counseling was defined as "any counseling relationship in which two or more of the participants differ with respect to cultural background, values, and lifestyle" (p. 47). This paper heralded an increasingly inspired focus on the importance of addressing culture as a key consideration in counseling relationships. The primary emphasis in this 1982 paper as well as in a 1992 "call for action regarding the implementation of multicultural standards" (Sue et al., 1992, p. 447), was on racial and ethnic concerns. Even so, Sue et al. (1992) acknowledged that "all forms of counseling are cross-cultural" (p. 448).

There is one cultural consideration that is truly universal and affects every member of every family, tribe, nation, race, ethnicity, religion, class, and creed to various degrees throughout the lifespan: age. Despite the universality of getting older, age as a cultural consideration has not been a primary area of focus in multicultural counseling competency research, and attention to the cultural considerations of age in counseling has

been limited. Counselor educators who are committed to enhancing cross-cultural counseling competencies in their students are presented with an opportunity to address the need for qualified gerontological-focused counselors to serve a rapidly growing population of older adults. Addressing this need will require counselor educators to assess students' empathetic awareness and their attitudes toward older adults, intervening early in a student's education to train counselors who are well-equipped and ready to serve this population. In recognition of the opportunity and challenges to the counseling profession these demographic shifts present, this study was designed to explore the process of assessing and addressing empathy development and attitudes toward older adults in first-year counseling master's students.

In this chapter, I will review relevant literature on ongoing population shifts; changes that frequently occur in later life; the prevalence and impact of mental health and substance use disorders in older adults, including challenges to elders' access to care; attitudes about aging; the impact of ageism; and empathy and empathy-enhancing interventions. Next, I will explore age as a cultural consideration in counselor education. I will then describe Mezirow's (1991) transformative learning theory (TLT) and review relevant research on transformative learning interventions, in support of using TLT as the theoretical framework of my study. After clarifying the need for the study, I will briefly describe my intervention, "The Game of *I am*" (Bailey, 2016c), and outline study procedures.

An Older World

In 2015, approximately one in every seven Americans was 65 or older (Administration on Aging, 2016), and for the first time in recorded history, by the year 2020, across the globe, adults 65 and older will outnumber children less than five years of age (He et al., 2016). This global "longevity revolution" (Butler, 1969; Fullen, 2016) is occurring as the United States is becoming increasingly diverse in terms of race, ethnicity, and age (Colby & Ortman, 2015), and is the result of a combination of several distinct factors: declining birth rates, the aging of the "Baby Boom" cohort, better disease prevention and treatment, and improved nutrition and sanitation. The global average age of death has increased by 35 years since 1970, and by 2020 in the United States, life expectancy is predicted to be 82 years of age for women and 77 years of age for men (He et al., 2016). Such changes in demographics will continue to present both opportunities and challenges for medical and mental health care providers.

Nearly 20% of adults 65 and older live with one or more mental health or substance use disorders, and the rate of completed suicides is highest in adults 65 and older (Conwell, 2014; Fässberg et al., 2012; Sachs-Ericsson, van Orden, & Zarit, 2015; World Health Organization, 2014). Such disorders are frequently comorbid with physical illness and chronic pain (Hansen et al., 2016), and the impact can be profound, negatively affecting overall health and leading to more hospitalizations, emergency room visits, and significantly higher healthcare costs (Bartels & Naslund, 2013; Institute of Medicine, 2012).

There is ample evidence supporting psychotherapy as an effective intervention for treating mental health and substance use disorders in older adults (Bartels & Naslund, 2013; Choi & DiNotto, 2013; Myers & Harper, 2004; Pinquart et al., 2007; Roseborough et al., 2013), but despite the prevalence and impact of these disorders, adults 65 and older receive mental health services at a lower rate than any other age demographic (Karel et al., 2012). The reasons for this gap in care are complex, and include both structural (e.g., limited Medicare coverage, transportation barriers), and psychosocial factors, such as the interest in and attitudes toward older adults of the professionals tasked with serving them, as well as the attitudes of elders themselves (Solway et al., 2010).

The Institute of Medicine described the healthcare needs of older Americans as being "inadequately addressed by today's health care system" (Institute of Medicine, 2012, p. 242). As many as half of all geriatric medical and psychiatry fellowships go unfilled each year (Bartels & Naslund, 2013) and, although the total number of available Accreditation Council for Graduate Medical Education (ACGME) geriatric medicine fellowships grew by 21% between 2001/2002 and 2008/2009, the lack of student demand for geriatrics training has resulted in an increasingly insufficient number of advanced geriatrics fellows who are well-trained and prepared to serve a growing population of older adults (Bragg, Warshaw, Meganathan, & Brewer, 2010). The American Geriatrics Society has predicted that, by 2030, there will be one geriatric psychiatrist for every 6000 adults 65 and older living with mental health and substance use disorders (Bartels & Naslund, 2013). In Chapter Two of the 2008 Report of the American Psychological Association Presidential Task Force on Integrated Health Care, titled, "The Broken

Healthcare System for Older Adults," the "brokenness" of the system was described as "especially evident when examining mental health services for older adults" (Brehm, 2008). By some calculations, including projections from 1999, in order to avoid a "crisis in late-life mental health" (Schmutte, O'Connell, Weiland, Lawless, & Davidson, 2009, p. 190), the number of gerontological-focused mental health professionals needs to increase by at least 350% (Jeste et al., 1999; Schmutte et al., 2009). Unfortunately, in addition to the lack of student interest in geriatric medicine and geriatric psychiatry, there appears to be tepid student interest in gerontological social work and gerontological psychology (Chonody & Wang, 2014; Ferguson & Schriver, 2012; Nelson, 2016a).

There has been limited research into counseling students' interest in gerocounseling and gerontology-focused curriculum in counselor education (Stickle & Onedera, 2006), but two recent studies are worth noting. Foster, Kreider, and Waugh (2009) found that, of the 385 master's and doctoral-level counseling students they surveyed, the majority were either *very* interested or *somewhat* interested in gerocounseling, although 69% did not feel adequately prepared to work with older adults. Using Foster et al.'s (2009) survey instrumentation with 211 graduate-level counseling/counselor education students, Nielsen (2014) found similar student gerocounseling interest and self-reported preparedness, and asked, "Why does there seem to be a disconnect between the expressed interest of students and counselor education programs' willingness to provide the necessary training for these students?" (p. 67). Unfortunately, for counseling students who are interested in working with elders, gerocounseling is no longer recognized as a specialty in CACREP and NBCC standards

(Bobby, 2013; Foster & Kreider, 2009), and even for counselors who work with older adults, few report having had specific training in gerocounseling (Chonody & Wang, 2014; Fullen, 2016; McBride & Hays, 2012). Potential challenges to integrating gerontology-focused curricula into counselor education programs include budget constraints, a lack of gerontological training in counseling faculty, a lack of departmental interest in gerontology, overscheduled and overworked educators, and ageism within departments (Brown & Brown, 2015; Meredith & Watt, 1995; Zucchero, 1998).

Psychology researchers found a link between faculty attitudes toward gerontology-focused coursework and students' perceived gerontology competency, as well as a link between faculty encouragement of gerontology-focused practice and student interest in working with older adults (DeVries, 2005; Woodhead et al., 2013). In counselor education departments, faculty interests and attitudes may also be very influential on students' interest in and attitudes toward gerocounseling. In counseling departments without gerontological-focused coursework, an easy-to-administer gerontology-focused intervention that could be integrated into existing coursework could serve as a catalyst for enhancing students' awareness of their own attitudes about aging, while providing students with an opportunity to consider gerocounseling as a focus of practice.

With an impending crisis in mental health care for older adults, well-trained gerontology-focused counselors could play a role in helping to meet the needs of an expanding demographic. The increasingly diverse cohort of adults 65 and older (Colby & Ortman, 2015) will experience a wide variety of mental health care needs. For counselor

educators who are committed to moving the counseling profession toward "dismantling the mechanisms of discrimination" (Boysen, 2009, p. 211) by training students to be ready to serve this diverse population, it will be important to teach students about development *throughout the lifespan,* including changes in health and ability that frequently occur in later life.

Changes in Later Life

Physiological changes of aging are unique to each individual. Although myths about older adults being frail, incompetent, and vulnerable may be overblown (Rupp et al., 2005), advancing age typically brings changes in physical resiliency and function (Bernstein et al., 2006), many of which, including reduced cardiovascular output and diminished muscle mass, can be ameliorated by health-promoting practices (Bernstein et al., 2006; Hyman, Oden, & Wagner, 2010). In one cross-sectional analysis of data collected from older adults in over 20 countries, regardless of health status and changes to physical function, elders' *attitudes* toward such changes (i.e., health satisfaction ratings) were strongly associated with better quality of life, mobility, and energy level (Low, Molzahn, & Schopflocher, 2013). Counselors can help older adults accommodate such physical changes by promoting self-empowerment and helping clients live vibrant lives throughout their later years (Fullen, 2016; Maples & Abney, 2006).

Cognitive changes that commonly occur in older adulthood include slower cognitive processing speeds and changes in short-term memory (Gatz et al., 2016; Norcross & Fiske, 2013). Severe memory loss is not a normal part of aging and may be indicative of Alzheimer's disease or other dementias. Eleven percent of all adults 65 and

older have a diagnosis of Alzheimer's dementia and, of that number, 82% are 75 or older (Hebert et al., 2013). An untold number of unpaid caregivers and family members are also affected by dementia. Although the age-specific risk of dementia appears to have declined (Langa, Larson, & Crimmins, 2017), the total number of adults living with dementia is predicted to increase as growing numbers of Baby Boomers turn 65. As research findings support the value of *dementia-focused* counseling (Chodosh et al., 2015; Karel et al., 2012), the need for well-trained counselors equipped to serve individuals living with dementia and their caregivers will also continue to grow.

Later life can be a time of many major life transitions, including retirement and the death of a partner or friends. Retirement, even when eagerly anticipated, represents a significant shift in role, and for some can result in feelings of sadness, anxiety, and isolation while, for others, retirement can lead to reduced mental fatigue, lower rates of depression, and better sleep (Harma, 2012; Ng et al., 2016). Ng et al. (2016) studied the impact of retirement stereotypes on longevity in more than 1,000 people over 23 years. Positive stereotypes about physical and mental health in retirement were linked to lower mortality compared to "negative thinkers," by 2-1/2 to 4-1/2 years (Ng et al., 2016). In another study (Kornadt, Voss, & Rothermund, 2015), more positive views about one's future-self predicted more engagement in preparatory activities that were designed to create a more positive and meaningful life in later years. According to many researchers, there appears to be a link between retirement and health (Doshi, Cen, & Polsky, 2008; Kachan et al., 2015; Oliffe et al., 2013; World Health Organization, 2015). In one analysis of health data from over 83,000 adults 65 and older between 1997 and 2011,

researchers found that adults over 65 who were still employed were three times more likely than retirees to report being in good health, and were about 50% less likely to be diagnosed with cancer, diabetes, and heart disease than their retired counterparts (Kachan et al., 2015). Researchers who analyzed 10 years of data from the Health and Retirement Study (Doshi et al., 2008) found that late-middle-aged (51-61 years old) workers who were living with depression were more likely to fully retire than those who were not, which suggests that the findings from the Kachan et al. (2015) study may represent the attrition that can occur following a diagnosis of illness. Ng et al. (2016) recommended, "Besides building a nest egg, psychological well-being should feature prominently in recommendations for a good retirement" (p. 82). Whether retirement is eagerly anticipated or comes in response to ill health, counselors can play an important role in helping retirees and soon-to-be retirees maintain psychological well-being.

The death of a partner or spouse can be one of the most stressful transitions in older adulthood. The "widowhood effect," the pronounced increase in survivor mortality in the months and years following the death of a spouse, has been well-documented (see Elwert & Christakis, 2008). Increased feelings of loneliness, lower life-satisfaction, negative affect, and depression are common after the death of a spouse or partner, and may endure for years (Ben-Zur, 2012). Widowed older adults may also face economic insecurity and increased vulnerability to financial abuse (Angel, Jiménez, & Angel, 2007; Rabiner, O'Keefe, & Brown, 2006). For elders who lose partners or spouses to death, attitudinal factors such as willingness to reach out for support, positive perceptions of those supports, and the ability to derive comfort from memories of their deceased partner,

are strongly associated with resilience and healthy psychological function following such a loss (Mancini, Sinan, & Bonanno, 2015). Research findings on the efficacy of grief counseling have been mixed (Jordan & Niemeyer, 2003; Larson & Hoyt, 2007), but especially when grief is prolonged or clients are experiencing complicated grief reactions, counseling can help those who are grieving process the loneliness and changes in role that often accompany such a profound loss (Ben-Zur, 2012; Boelen, de Keijser, van den Hout, & van den Bout, 2007; Fried et al., 2015).

Mental Health Treatment in Older Adulthood

Adults 65 and older are underserved by mental health providers, and less than 3% report seeing a mental health professional (American Counseling Association, 2011; Bartels & Naslund, 2013). Depression and anxiety are the two most commonly diagnosed mental health disorders in adults 65 and older, affecting from 15-20% of older adults in the United States, and yet fewer than half of those affected receive treatment (Geriatric Mental Health Foundation, 2008; Hansen et al., 2016). Left untreated, depression in older adults has been linked to higher rates of disability, increased utilization of healthcare, and early mortality (Hansen et al., 2016; Rybarczyk, Emery, Guequierre, Shamaskin, & Behel, 2013). Rates of anxiety in community-dwelling elders are estimated to range between 1.2%-15%, rates of anxiety for hospitalized older adults may be as high as 43%, and anxiety symptoms that do not meet the Diagnostic and Statistical Manual of Mental Disorders (DSM-V; American Psychiatric Association, 2013) criteria may affect as many as 56% of adults 65 and older (Therrien & Hunsley, 2012). Both depression and anxiety are frequently comorbid with other medical and mental health conditions, including

chronic pain, dementia, substance use disorders, and cognitive decline (Lenze et al., 2001; Therrien & Hunsley, 2012).

When they receive it, older adults respond to treatment for mental health and substance use disorders at least as well as other age cohorts (Bartels et al., 2002; Choi & DiNotto, 2013; Myers & Harper, 2004). Unfortunately, access to treatment for older adults may be limited, and the reasons for this are multifaceted, including both structural and psychosocial factors. There are relatively few substance use disorder treatment facilities with programs tailored to older adults, with as few as one in five offering services tailored to older persons (Schultz, Arndt, & Liesveld, 2003). In the professions of psychology, social work, geriatric psychiatry, and counseling, there is a dearth of adequately-trained gerontological-focused mental health providers (e.g., Bartels et al., 2002; Chonody & Wang, 2014; Foster & Kreider, 2009; Gatz et al., 2016; Karel et al., 2012; Nelson, 2016b; Sivis & McCrae, 2010). Treatment that is tailored to the needs of older adults is preferable, because many researchers have found that mental health services for older adults work best when treatment providers offer non-confrontational, cognitive-behavioral, and motivational interviewing approaches; work at a slower pace; attend to issues of culture, including respectful language and modes of dress; and avoid using psychological jargon without clear explanations of meanings (Blow & Barry, 2012; Center for Substance Abuse Treatment, 1998; Gunter & Arndt, 2004; Han et al., 2009; Outlaw et al., 2012).

Access to mental health care for older adults may be further limited for minority populations, those with limited financial resources, and those who live in rural

communities (Solway et al., 2010). Lack of insurance coverage for mental health services may be an additional barrier to care. Although older adults living with mental health disorders have poorer health outcomes and higher rates of hospitalization than those living with physical illnesses alone, in 2012 mental health services accounted for only 1% of Medicare expenditures (Institute of Medicine, 2012), and Medicare reimbursement for mental health services has been limited (Brehm, 2008). There may also be a gender difference in mental health care access, as older men appear to be less likely than women to seek out mental health services (Oliffe et al., 2013). This is especially troubling due to the high rate of completed suicide in older men, which may be as much as eight times the rate of suicide in older women (Conwell, 2014; Draper, 2014; Oliffe et al., 2013; Sawyer & Williams, 2012; Solway et al., 2010).

Misdiagnosis

Mental health and substance use disorders may be misdiagnosed by medical and mental health care providers who mistake symptoms such as insomnia, changes in appetite, or more frequent falls for expected age-related declines (Jeste et al., 1999; Lenze et al., 2001). The accurate diagnosis of mental health and substance use disorders in older adults is further complicated by the comorbidity of many psychiatric and cognitive disorders such as anxiety, depression, substance use disorders, and cognitive deficits (Karel et al., 2012). Even for clinicians attuned to the possibility of mental health and substance use disorders in older adults, accurate diagnosis using the DSM-V may be inherently difficult. For example, in the criteria for Opioid Use Disorder in the DSM-V, criteria 5-7 describe the impact of opioid use on work, interpersonal, social, and

recreational activities (American Psychiatric Association, 2013). For an older adult who is not employed, lives alone, and does not engage in social activities, gauging the impact of opioid use according to these three criteria would not be useful. It is also important to note that the diagnostic criteria in the DSM were validated on young and middle-age adults (Briggs, Magnus, Lassiter, Patterson, & Smith, 2011). Exclusion of older adults in behavioral research studies and as subjects in clinical trials has been named as one of the many challenges faced by medical and mental health providers to offering the best possible care for this population (Bernstein et al., 2006; Shenoy & Harugeri, 2015).

Integrated Care

Integrated care approaches can be effective in delivering mental health care services to older adults (Croft & Parish, 2013; van Orden & Conwell, 2011; World Health Organization, 2014; Schmutte et al., 2009). For older patients presenting with mental health disorders, behavioral health treatment can reduce medical care costs as much as 16% (Chiles, Lambert, & Hatch, 1999; Goldsmith & Kurpius, 2015). Most older adults who seek out and receive mental health services do so as part of their primary medical care, but in such medical settings, traditional medical providers may be overly reliant on pharmacotherapy approaches and may not utilize psychotherapeutic approaches as frequently as they might for their younger patients (Bartels et al., 2002; Goldsmith & Kurpius, 2015). Integrating professional counselors into such settings is one way to increase access to mental health care for older adults, and there is ample evidence supporting the value of utilizing an integrated, biopsychosocial approach to medical and mental health care (Brehm, 2008; Glueck, 2015; Sawyer & Williams, 2012).

Substance Use in Older Adults

There is evidence that Baby Boomers are continuing to use alcohol and psychoactive medications at a rate higher than previous generations, indicating the potential for serious challenges to the health care system, including an increasing need for more substance abuse counselors and treatment programs (Blow & Barry, 2012). With older adults seeking treatment for substance use disorders at a lower rate than younger cohorts, and with as many as 90% of older adults with substance use disorders receiving no treatment at all, there is compelling evidence for greater attention to this dangerous gap in care (Briggs et al., 2011; Gunter & Arndt, 2004).

Physiological changes typical of advancing age can affect the way an elder's body reacts to substances such as alcohol. A reduction in body water, loss of lean body mass, and changes in metabolism may mean that a given amount of alcohol results in a higher concentration of alcohol in the blood than might have occurred only a few years earlier (Center for Substance Abuse Treatment, 1998). The health risks of alcohol consumption rise with age, and include increased risk for hemorrhagic stroke, cardiomyopathy, malnutrition, liver disease, and gastrointestinal bleeding. Higher rates of alcohol abuse in older adults have been linked to difficult age-related life transitions (e.g., death of spouse, retirement), illness, and lack of social support (Outlaw et al., 2012). Chronic alcohol abuse can lead to permanent cognitive impairment in the form of alcohol-related dementia or Wernicke-Korsakoff syndrome, and alcohol consumption is associated with worsening of age-related sleep difficulties (Center for Substance Abuse Treatment,

1998). Treating elders' sleep difficulties with benzodiazepines increases the risk for catastrophic outcomes when those drugs are combined with even minimal alcohol use.

In addition to sleep difficulties, older adults are more likely to live with conditions that cause serious and chronic pain, and age-related physiological changes such as slowing kidney and liver function can have an impact on how the body responds to medications prescribed to treat that pain (Chang & Compton, 2016). With adults 65 and older using prescription drugs at a higher rate than younger age cohorts (Schepis & McCabe, 2016), they are at increased risk for injury, misuse, and addiction. The prescription of narcotic pain relievers is especially troubling. In one study in which researchers looked at medical records of over 13,000 adults 65-89 living with osteoarthritis from 2001-2009, those patients who were prescribed narcotics for pain had between a 3.3 and 4.1 times greater risk for falls and fractures than those prescribed a non-narcotic pain reliever such as ibuprofen or naproxen sodium (Rolita, Spegman, Tang, & Cronstein, 2013). Over the past two decades, the rate of opioid-abuse hospitalizations has quintupled for adults 65 and older (Owens, Barrett, Weiss, Washington, & Kronick, 2014). Adequate screening and, when needed, intervention for substance misuse as well as substance use disorders, is critical to adequately addressing what appears to be a mounting health concern for older adults (Blow & Barry, 2012).

Suicide in Older Adults

Most older adults utilize strategies that allow them to adequately cope with life stressors, and adults 65 and older are less likely than other age groups to attempt suicide. However, the rate of *completed* suicides is highest in adults 65 and older (Conwell, 2014;

Fässberg et al., 2012; Sachs-Ericsson et al., 2015; World Health Organization, 2014). Because of societal pressure to report geriatric suicide as death by another cause (Sawyer & Williams, 2012), it is likely that these numbers misrepresent the true extent of the problem. The rate of completed suicides for those in the Baby Boom generation has been higher at every stage of life than for previous cohorts, which suggests that the suicide rate for older adults is likely to increase as this cohort continues to age (Sawyer & Williams, 2012; Schmutte et al., 2009; van Orden & Conwell, 2011). In their analysis of 40 English-language studies examining suicide and contact with health care providers, Luoma, Martin, and Pearson (2002) reported that, in these studies, an average of only 8.5% of adults 55 and older had seen a mental health provider within a year of completed suicide. As many as 76% of older adults who committed suicide visited a primary care medical provider within 30 days of death (Conwell, 2001). Integrating counselors into traditional medical care settings could help provide effective interventions against suicide as well as assessment and treatment for mental health disorders, substance use disorders, and substance misuse in older adults (Blow & Barry, 2012; Croft & Parish, 2013).

Later life is frequently accompanied by changes in health and life circumstances. As described above, coping ability and resilience in the face of challenges have been linked to better function and better quality of life in older adults, regardless of health and ability (Kornadt et al., 2015; Low et al., 2013; Mancini et al., 2015; Ng et al., 2016). Such adaptivity may be reflective of the power of accumulated life experiences and one of the many advantages of growing older. “Older adults are more likely to have prior experience with stressors and adversity relative to younger adults and are thus less impacted or more

prepared to handle the stressor" (Rybarczyk et al., 2012, p. 175). Although advancing age may lead to greater resilience and adaptivity, commonly-held perceptions of aging may not be so positively framed.

Attitudes About Aging

Chronological age, along with many other cultural identifiers such as gender, size, religion, and race, "is an…unreliable benchmark of pretty much anything about a person" (Applewhite, 2015, p. 47). With increasing age comes a greater likelihood of functional decline, but changes in health and well-being are unpredictable and affect older adults at different rates and with different levels of impact. Aging itself is not a disease or something to be "cured" (Applewhite, 2015; Hooyman & Kiyak, 2011). As adults age, they become more heterogenous than their younger counterparts in terms of health, financial status, education, and ability (Applewhite, 2015; Lindland, Fond, Haydon, & Kendall-Taylor, 2015), and, in conjunction with current health status, there is compelling evidence to suggest that an older adult's own attitudes or self-perceptions of aging are closely linked with physical and cognitive function, life satisfaction in later life, and mortality (e.g., Levy, Slade, Chung, & Gill, 2015; Levy et al., 2009; Sargent-Cox, Rippon, & Burns, 2014; Uotinen, Rantanen, & Suutama, 2005). These internalized beliefs, both positive and negative, are likely influenced by societal attitudes about aging (Levy & Banaji, 2002; Levy, Slade, & Kasl, 2002).

A Preference for Youth?

In several studies, including a meta-analysis of 232 articles on ageism written prior to 2000 (Kite, Stockdale, Whitley, & Johnson, 2005), researchers have found

evidence to suggest that, in both the young and the old, youth is viewed more favorably than old age. In terms of hiring practices and attitudes toward perceived worker competence, younger workers are viewed more positively (Abrams, Swift, & Drury, 2016; Cuddy, Norton, & Fiske, 2005; Levy & Banaji, 2002). Positive age stereotypes such as the experienced, stable, reliable older worker, may actually be perceived as undesirable in fast-paced, creative, and innovation-focused work environments (McGann et al., 2016; Riach, 2007).

A preference for providing services to younger people rather than older people has been reported for social work students (Chonody & Wang, 2014; Gellis et al., 2003), medical and allied health students (Lin, Bryant, & Boldero, 2011; van de Pol, Lagro, Fluit, Lagro-Janssen, & Olde Rikkert, 2014), public health students (Shreeniwas & Morrison, 2016), and nurses (Ben-Harush et al., 2017). Such preference for the young is found across cultures. In their cross-cultural meta-analysis of 37 studies that compared attitudes toward older adults between "Eastern" and "Western" samples, Norcross and Fiske (2015) discovered that, even in collectivist cultures that have traditionally revered elders, as the population of older adults has increased, attitudes toward older adults have become increasingly less favorable. Attitudes toward older adults were similar across age groups in their analysis, which the authors hypothesized was a possible "temporal era effect, such that people of all ages currently existing in rapidly aging societies come to derogate their aged" (Norcross & Fiske, 2015, p. 1013). Axt, Ebersole, and Nosek (2014) found that, regardless of participant age, for the 49,014 participants who completed an online version of the Implicit Association Test (IAT; Greenwald, McGhee, & Schwartz,

1998), order of age preference was children first, followed by young adults, middle-age adults, and then older adults (Axt et al., 2014). This preference for youth, found across age categories in this study, is an example of how powerful age stereotypes can be when they become internalized and automatic.

The Power of Self-Perception

Self-perceptions of aging include one's subjective age, which is the age one perceives or experiences oneself to be (Kotter-Grühn & Hess, 2012; Montepare, 2009). In middle age and older, self-perceptions of oneself as being younger, what has been deemed "positive self-perceptions of aging" (Kotter-Grühn & Hess, 2012, p. 563), have been associated with better health outcomes (e.g., Levy & Banaji, 2002; Uotinen et al., 2005). "Feeling young is considered a self-enhancing strategy in cultures that stigmatize growing old" (Keyes & Westerhof, 2012, p. 68). Kotter-Grühn and Hess (2012) measured subjective age (comprised of "felt," "desired," and "perceived" age) before and after age stereotype priming. Prior to the priming, middle age and older adults *felt* 16%-17% younger than their chronological age; thought they *looked* between 10% (older adults) and 14% (middle age) younger than they were; and wanted to *be* 31%-34% younger than they were. Following both positive (a picture of a smiling older woman and descriptors such as "active," "family-oriented," and "full of life") and negative (a picture of a sad-looking older woman and descriptors such as "walks slowly," "senile," and "grumpy") age stereotype priming, both middle-aged and older adults felt older than before the priming. Although other researchers have found a positive impact on performance and attitudes when presented with positive age stereotypes (Hess & Hinson, 2006; Levy,

Slade, May, & Caracciolo, 2006), in this study, Kotter-Grühn and Hess (2012) speculated that this "contrast effect" was a result of "upward social comparisons" (p. 568). The researchers explained, "The positive information permits people to see themselves more accurately in terms of age" (p. 568). Perhaps, for participants in the Kotter-Grühn and Hess (2012) study, being presented with positive age stereotypes de-stigmatized advanced age and helped individuals realize that *it is acceptable to be older*.

Keyes and Westerhof (2012) found a positive association between feeling younger and both flourishing mental health and a lower risk of major depressive disorders in 3032 adults aged 25-74. Similar to other findings (e.g., Infurna, Gerstorf, Robertson, Berg, & Zarit, 2010; Uotinen et al., 2005), in this sample, the researchers found a positive correlation between chronological age and adults *feeling* increasingly younger and wanting to *be* increasingly younger. Weiss and Lang (2012) described this phenomenon of subjective age as a "possible paradox of aging, that is, older adults do not identify with their age peers and, as a consequence, do not consider themselves as being as old as 'the other old people'" (p. 153). This incongruence between chronology and self-perception may be best understood in the context of ageism.

Ageism

Ageism, a term first coined in 1969 by psychiatrist Robert Butler and later described as a "social disease" (Palmore, 2015, p. 874), was initially defined as "prejudice by one age group toward other age groups" (Butler, 1969, p. 243). "Like racism and sexism, ageism is a socially constructed idea that has changed over time and…serves a social and economic purpose" (Applewhite, 2015, p. 9). In their conceptual

analysis and broader definition of ageism, Iversen et al. (2009) reviewed 27 definitions of ageism, including updates by Butler (1975, 1980, 1995), and redefined ageism within four dimensions: cognitive; affective; behavioral; and social network, institutional, and cultural discrimination. This broadening of the concept may be a useful framework for researchers investigating the societal influences and institutional factors that affect how older adults are perceived and treated by others, and how they in turn perceive themselves.

Examples of ageist beliefs and behaviors can range from a hair stylist telling a customer that a hairstyle isn't "age-appropriate," to ad campaigns touting a new eye cream guaranteed to "stop aging," to an employer who chooses to promote a younger worker because of the belief that older workers aren't as flexible or innovative (Applewhite, 2015; Palmore, 2015). In a content analysis of publicly accessible groups on Facebook, 98.8% of group descriptions about older adults were found to be negative (Levy, Chung, Bedford, & Navrazhina, 2013). Social media may be designed to bring people together, but perhaps only ones who are young. Ageism, like other forms of discrimination, "legitimizes and sustains inequality between groups" (Applewhite, 2015, p. 9).

Although the term "ageism" is relatively new, prejudice against older people is not a modern invention. Prolonging youth and slowing the aging process has been the topic of study for philosophers and scholars for centuries. In Neolithic cultures, those who could not contribute to the survival of the collective group were cast out to die alone (Achenbaum, 2015). Cicero (106-43BC) conditionally praised old age as "respectable as

long as it asserts itself, maintains it rights, is subservient to no one" (Agronin, 2014, p. 30), casting an unflattering light on elders who demonstrate less power. Until recently, it was quite unusual for someone to live longer than 65 years, and when someone did live to an old age, he or she posed little burden to the society at large (Nelson, 2005). In 1900, only 4% of the population was 65 years or older, and a baby born that year could expect to live to be 47 (Hooyman & Kiyak, 2011). Perhaps the rarity of old age enhanced the value of elders in years past when those fortunate enough to have lived longer than most might be the keepers of history and tradition for a family or a community, cherished as wise, and even favored by the Divine (Nelson, 2016a). With the industrial revolution and two World Wars, attention shifted from the stable past to a mobile future at a time when families in search of work moved to cities and away from farms, sometimes leaving their older relatives behind (Nelson, 2005). As technology and the focus on "youth culture" have become commonplace, older adults have gone from representing repositories of skills and wisdom to "a social problem to 'be solved' by programs like Social Security" (Applewhite, 2015, p. 15).

A striking example of how stereotypes of older adults have gone from positive to negative over the past two centuries can be found in a computational linguistics analysis of printed works from 1810 to 2009. In this study, researchers found a linear progression in age-related stereotypes; 1880 was the year when the majority of stereotypes in printed works went from positive to negative (Ng et al., 1995). Ng et al. (1995) found the increase in the population of adults 65 and older to be significantly associated with this shift, which is troubling. Every day in the United States, as many as 10,000 people

celebrate their 65th birthdays (Cohn & Taylor, 2011), and the population of people 85 years of age and older, sometimes referred to as the "oldest old," has grown more than any other age group (Hooyman & Kiyak, 2011). "The people society now considers older and irrelevant are about to become far more common and visible" (Norcross & Fiske, 2012, p. 986).

Bernstein et al. (2006) listed seven categories in which ageism negatively affects elders: elder abuse, health care discrimination, discrimination in nursing homes, discrimination in emergency services, workplace discrimination, discrimination in the media, and discrimination in marketing. Of the United States respondents aged 60-93 ($\overline{X}$ = 75) who completed the Ageism Survey in 2001 (Palmore, 2001), 84% reported experiencing at least one incidence of ageism (Palmore, 2004), from being patronized or ignored to being denied a promotion or access to medical care. The most frequent incidents of reported ageism in the survey were disparagement humor in the form of ageist jokes and ageist birthday cards. Geriatrician Matthew McNabney (2012) described age-related disparagement humor as corrosive, and argued that the acceptance of such biases contributes to age discrimination in other forms, and that, unlike other "isms" such as sexism and racism, there appears to be a tolerance for ageist remarks and humor. McNabney is not alone in his appraisal of the ubiquitous nature of ageism, and his sentiments were mirrored by Applewhite, who wrote, "Racist and sexist comments no longer get a pass, but who even blinks when older people are described as… 'out of it', or boring, or even repulsive?" (2015, p. 10).

The Roots of Ageism

Some authors have maintained that humans automatically catalog one another into three primitive categories: race, gender, and age (Bargh et al., 1996; Iversen et al., 2009; Nelson, 2005). In his introduction to the "Ageism in America" report of The International Longevity Center (2006), Robert Butler wrote, "it must be noted that the status of older persons and our attitudes toward them are not only rooted in historic and economic circumstances. They also derive from deeply held human concerns and fears about the vulnerability inherent in the later years of life" (Bernstein et al., 2006, p. 1). Some theorists have conceptualized these deeply held fears about aging through the lens of terror management theory (TMT; Martens et al., 2005).

According to TMT (Martens et al., 2005), human beings are aware of the inevitability of our own death, and we must somehow manage our resulting death anxiety. To do so, we build psychological protections through the adoption of symbolic constructs such as faith or nationalism to elevate ourselves from being mere *mortal* mortals into something that feels more special and less mundane, thereby constructing "a symbolic solution to the problem of death" (Martens et al., 2005, p. 224). When we are confronted with mortality reminders (e.g., images of open caskets, an older adult struggling to navigate a busy subway station), we instinctively engage in defensive behaviors such as denying our vulnerability to death (e.g., "I always wear sunscreen, so I will never get skin cancer"), or focusing on a faith tradition (e.g., "God will continue to bless me and keep me safe from harm"), or clinging to a salient cultural worldview (e.g., "I'll be OK, I'm a US citizen!"). A large body of research supporting this theory suggests

that when faced with mortality reminders, we are also more likely to hold negative biases toward those who are different than we are, whether those differences are racial, physical, religious, or chronological (Martens et al., 2005). In fact, when faced with a death reminder, researchers have found evidence suggesting that, in order to protect our own self-esteem and worldview, we are much more likely to act on negative biases through physical aggression (Solomon, Greenberg, & Pyszczynski, 2000).

In one study, when exposed to images of older adults, participants were much more likely to complete word fragments with death related words than when they were exposed to images of teenagers. For example, when participants were presented with the word fragment "GRA_ _," those who were presented with images of elders were significantly more likely to complete the word "GRAVE" than "GRAPE" or "GRAIN" (Martens et al., 2004). In a later follow-up study (Martens et al., 2005), these results were not supported, but the researchers contended that, at least in some circumstances, images of older adults are associated with death. The hypothesized connection between a fear of death and physical aggression (Solomon et al., 2000) is especially concerning in light of the prevalence of elder abuse in the United States, where as many as one in ten older adults have experienced abuse and most researchers agree that many more cases go unreported (Bernstein et al., 2006; National Council on Aging, 2016).

Attitudes and beliefs about age begin to develop in childhood and are reinforced through "stereotypically congruent" (Levy, 2003, p. 203) information. In an early analysis of 656 children's picture books (Ansello, 1977), when older characters appeared (at a rate of only 16.46% throughout the books analyzed), they were typically described

using words such as “old,” “little,” “ancient,” small,” “poor,” and “sad.” The author described these words as “noncreative and boring,” stating, “The cumulative impression of the older character to be derived from this body of literature is one of a relatively unimportant, unexciting, and unimaginative entity” (Ansello, 1977, pp. 269–270). Without a need for the young reader to defend against such stereotypes, as they apply to a group to which the child does not belong, such attitudes about aging can remain persistent throughout the lifespan and may overshadow conflicting information (Levy & Banaji, 2002). In a more recent analysis of 710 children’s books, there was evidence of a shift toward more positive portrayals of elders (Danowski, 2011), although the depiction of elders in children’s television shows (Bishop & Krause, 1984) and in social media (Levy et al., 2013) may also contribute to negative stereotypes of older adults. Researchers who conducted a content analysis of Disney films suggested that, although portrayals of older adults in more recent films appeared to be more positive than those of characters in earlier ones, in the Disney films analyzed, there continued to be frequent negative age stereotyping, as well as marginalization of female and minority older characters (Robinson, Callister, Magoffin, & Moore, 2007). The power of childhood exposure to aging stereotypes is reflected in the establishment of The Association for Gerontology in Higher Education’s (AGHE) Book Award for Best Children’s Literature on Aging, which is awarded every two years in recognition of positive portrayals of older adults in children’s literature (AGHE, 2017).

Although most older adults defy common ageist health-related stereotypes (Bernstein et al., 2006), when young people come into contact with such an elder, instead

of rethinking their stereotypes, they may choose to categorize the older person as an exception to the rule (Levy & Banaji, 2002) to reduce dissonance in their beliefs (Levy, 2003). This failure to question one's own bias even when presented with information that is in opposition to that bias not only allows prejudices to remain unchallenged; it may reinforce them. Researchers studying the effects of confronting or not confronting the sexist expressions of others found that those who *failed to confront* sexist bias increased its perceived favorability and were more likely to view the *perpetrator* of the bias more favorably (Rasinski, Geers, & Czopp, 2013). Perhaps altering bias is not as simple as exposing those who are biased to alternative, conflicting information. Perhaps, to establish real paradigm shifts, more self-awareness is required.

The Role of Contact and Knowledge in Ageism

In several research studies, ageism and age-related stereotypes have been linked to a lack of quality interactions with people who are older and limited knowledge about aging (Nelson, 2016b; Norcross & Fiske, 2013; Ory, Kinney Hoffman, Hawkins, Sanner, & Mockenhaupt, 2003). No matter their inspiration, such beliefs can have a profound impact on the old and the yet-to-be-old. Ageist stereotypes, whether directed toward elders by younger persons or health care workers or employers or internalized by the elders themselves, "have been demonstrated to cause real harm to the mental health of older persons, reduc[ing] their will to live, impair[ing] memory, and lead[ing] older persons to avoid preventive health behaviors" (Nelson, 2016a, p. 280).

Some researchers have posited contact with older adults as an intervening force against ageism for young adults, but the evidence has been mixed. In one study of 55

undergraduate students, although there was not a significant relationship between frequency of contact with older adults, attitudes toward older adults, and behavioral intentions (e.g., interest in spending time with older adults), there were significant positive associations between the *quality* of contact, attitudes, and behavioral intentions (Bousfield & Hutchison, 2010). In another study with 113 undergraduate students, attitudes toward older adults were more positive for those who worked with older adults, but more negative for those who *lived* with older adults (Allan & Johnson, 2009). Attitudes toward older adults were not predicted by level of contact for 172 first-year graduate social work students in another study (Gellis et al., 2003). If quality and not quantity of contact is useful in altering ageist attitudes, for counselor educators who believe that integrating immersive experiences with older adults into curricula will reduce ageist beliefs and increase student interest in working with this population, the onus is on those educators to provide the highest quality experiences possible to avoid *negatively* influencing attitudes (Chonody, 2015).

Misinformation about older adulthood is prevalent in young people, as described by researchers who studied undergraduate psychology students over ten years (Wurtele, 2009). A consistent pattern emerged in the 1,340 students who were asked to list five activities common to older adults. Every semester, the same five activities were the most frequently listed: socializing, exercising, watching television, sleeping, and reading. Notably absent from this list was work, volunteerism, travel, and sexual activity. Using a case study approach with six public health master's students, Shreeniwas and Morrison (2016) examined the impact of adding gerontology-focused content to an international

service learning course on students' interest in working with older adults. Shreeniwas and Morrison (2016) found that the addition of course content and improvement of aging knowledge was not effective at enhancing interest, but that, through reflective journaling, the students demonstrated an increased ability to critically analyze and contextualize issues of aging.

In one study, although undergraduate students enrolled in an introductory semester-long gerontology course ($N = 51$) increased knowledge about aging and improved explicit attitudes toward older adults compared to a control group ($N = 58$), implicit attitudes measured by the Implicit Association Test (IAT; Greenwald et al., 1998) were not improved (Merz et al., 2016). Greater aging knowledge has been associated with more positive attitudes toward older adults in some studies (Allan & Johnson, 2009; Cummings, Kropf, & De Weaver, 2000; Gellis et al., 2003), but in one study with 146 undergraduate students enrolled in a semester-long lifespan course, attitudes toward older adults were not improved with increased knowledge about aging (Cottle & Glover, 2007). Neither contact nor knowledge alone may be enough to influence attitudes toward older adults and, perhaps as was demonstrated in the study by Shreeniwas and Morrison (2016), critical self-awareness developed through reflective writing and other activities might prove more useful in shifting attitudes than increasing contact, even high-quality contact, and knowledge alone. For counselor educators committed to training counselors who are qualified to serve diverse clients, including older adults, fostering students' awareness of their attitudes and biases and encouraging development of an empathetic attitude are essential to enhancing counselor identity

development and training culturally competent counselors (Sivis & McCrae, 2010; Sue et al., 1992).

Empathy

Carl Rogers defined empathy as one of the core conditions for therapeutic change (Rogers, 1957). Even though psychotherapist empathy has been positively associated with better client outcomes in a number of studies (e.g., Gerdes & Segal, 2008; Moyers et al., 2016; Watson et al., 2014), its definition continues to be debated (Teding van Berkhout & Malouff, 2016). Trent et al. (2016) described empathy as being composed of three distinct components: cognitive empathy, in which one can *imagine* the emotional experience of another through perspective taking; affective empathy, the *co-experiencing* of feeling what another is feeling; and motor empathy, the *kinesthetic mirroring* that can occur when two people are in contact with one another, as in when a counselor unknowingly shifts in his/her seat to better match a client's posture. Decety and Moriguchi (2007) identified four components of empathy: affect sharing, mental flexibility and perspective-taking, self-awareness, and emotion regulation. In their review of existing definitions and measures of empathy, social work researchers Gerdes, Segal, and Lietz (2010) wrote, "conceptualisations and measurement techniques for empathy vary so widely that it is difficult to engage in meaningful comparisons or make significant conclusions about how we define and measure this key component of human behaviour" (p. 2327).

Empathy Enhancing Interventions

Despite the challenges of clearly defining or measuring empathy, empathy has been accepted as essential to effective mental health and medical/allied health practice, and many researchers have studied ways to enhance it. Active learning interventions such as role-playing games and skits have been shown to be effective in enhancing empathy in medical students and upper-level undergraduate students in several studies (Block-Lerner, Adair, Plumb, Rhatigan, & Orsillo, 2007; Junn, Morton, & Yee, 1995; Shapiro & Hunt, 2003; Shapiro, Morrison, & Boker, 2004). In one qualitative study, 18 master's counseling students enrolled in a multicultural counseling course engaged in a 15-minute cross-culture counseling role play in which the counselor was White and the client was Hispanic (Rapisarda et al., 2011). Researchers conducted 30-minute interpersonal process recall (IPR; Kagan & Kagan, 1990) interviews following the role plays. In this study, students demonstrated greater awareness of the importance of empathy in building rapport and trust with a culturally different client (Rapisarda et al., 2011). Students who took the perspective of the culturally different client reported feeling surprised by their emotional reactions, and expressed heightened personal awareness and cultural sensitivity. This response aligned with Bowman's (2010) support for such interventions, who wrote that experiential role-play offered "players the capability to see reality through new perspectives and experience it empathetically through different eyes" (p. 59). Such perspective-taking and increased self-awareness can make an "out group" seem more like the "in group," which may decrease stereotype accessibility as well as expressions of stereotypes.

Daniau (2016) suggested a link between role-playing games and empathy development in adult learners, and proposed that a debriefing conducted immediately following the role-playing game could allow participants to synthesize their experiences with their learning and awareness. Such mindful awareness has been linked to the development of empathy in master's counseling students (Fulton & Cashwell, 2015; Greason & Cashwell, 2009; Ivers, Johnson, Clarke, Newsome, & Berry, 2016). In their analysis of 27 empirical studies using simulations (including role-plays) to enhance empathy in pre-service health professionals, Bearman, Palermo, and Williams (2015) concluded that role-play activities that included a debriefing component were especially useful in engendering students' perspective-taking and increased empathy. Through empathy building activities, especially when they are paired with classroom debriefings and opportunities for self-reflection, students may develop a greater understanding of those who are different and reflectively consider how their attitudes and beliefs may have an impact on their work as professionals (Arthur & Achenbach, 2002).

Although many researchers have explored the use of active learning interventions to enhance empathy toward racial and ethnic minorities in undergraduate and graduate students in psychology, counseling psychology, and counselor education programs (e.g., Garriott, Reiter, & Brownfield, 2016; Junn et al., 1995; Paone, Malott, Gao, & Kinda, 2015; Villalba & Redmond, 2008), research on enhancing empathetic awareness and improving attitudes toward older adults in master's level students in counselor education has been sparse. Enhancing empathy in master's level counseling students could have a profound impact on those students' attitudes toward older adults, as in several quasi-

experimental and correlational studies, researchers have found empathy to be inversely correlated to ageist attitudes and negative stereotypes toward out-groups (Batson et al., 1997; Bodner & Cohen-Fridel, 2014; Tam, Hewstone, Harwood, Voci, & Kenworthy, 2006).

Empathy and Attitudes Toward Older Adults

Researchers explored the role of perspective taking on reducing ageist bias in undergraduate psychology students ($N = 82$; Galinsky & Moskowitz, 2000). Students were invited to self-identify on a seven-point Likert-type scale from "extremely unlike" to "extremely like" using a set of 90 traits. Next, they were presented with a black and white photograph of an older man (target) seated near a newspaper stand. Students in the experimental group were asked to write a narrative essay describing a typical day in the target's life from the perspective of the target, to "imagine a day in the life of this individual as if you were that person, looking at the world through his eyes and walking through the world in his shoes" (Galinsky & Moskowitz, 2000, p. 711). Students in the control group were asked to write a descriptive essay describing a typical day in the life of the target and were given no further instructions. Following some "filler tasks," both groups were asked to use the same 90-item trait scale to describe the older man. The perspective-taking students' self-descriptive traits overlapped with those they assigned to the target much more than was seen in the control group, and the perspective-taking students demonstrated much less ageist bias than the control group. These results were in keeping with the earlier research of Davis, Conklin, Smith, and Luce (1996), who found that perspective-taking led "to a merging of the self and the other, in which the

perspective-taker's thoughts toward the target bec(a)me more 'selflike'" (Davis et al., 1996; Galinsky & Moskowitz, 2000, p. 709). Such perspective taking has been described as an essential component to empathy (Arthur & Achenbach, 2002; Bearman et al., 2015; Decety & Moriguchi, 2007; Rapisarda et al., 2011; Trent et al., 2016).

Some social work, nursing, and psychology researchers have investigated the effectiveness of active learning interventions on enhancing empathy toward older adults, with promising results. In one study (Kane, 2003), social work undergraduate and master's students ($N = 26$) were presented with role-playing vignettes in which they took turns playing either the group leader of six challenging clients with dementia, or one of the six group members. In the role as group leader, participants took the perspective of someone leading a group of six diverse memory-impaired elders, and in the roles of the group participants, students took the perspectives of the elders themselves, considering the "why" of the elders' challenging behaviors (e.g., wandering, verbal agitation). Following the role-play, the participants engaged in collective discourse and then provided written responses to open-ended questions about what they learned from the intervention. Post-intervention qualitative analyses indicated a reduction in students' fear of working with memory impaired elders as well as increased empathetic awareness about the diversity and needs of this population.

In a study conducted by Henry and Ozier (2011), pre-professional nursing students ($N = 127$) were enrolled in a semester-long course in which the course content subject areas were connected to life stage topics in nursing and nutrition. After random assignment to the intervention and control groups, researchers investigated whether

students' self-reported attitudes toward older adults and empathetic reflections differed depending on whether they participated in the "Aging Game," an aging simulation intervention (McVey et al., 1989; Pacala et al., 2006), or an alternative activity. For the experimental group, the "Aging Game" was presented in the second to last week of the semester and lasted approximately 90 minutes. In this simulation game, following a 15-minute introduction, participants were assigned conditions such as vision loss, cognitive impairment, and postural difficulties; were given condition-appropriate props and prompts; and were then invited to participate in stations representing scenarios common to community dwellers, such as bus stops, medical offices, and restaurants. The simulation activity lasted approximately 45 minutes, after which subjects participated a 15-30-minute debriefing session, during which they discussed their experiences and feelings in the game. In the alternate activity, which lasted 75 minutes, instructors presented information, asked true-false questions regarding aging, and invited participants to imagine themselves as older. The control group participants also engaged in small group discussions. The intervention and control groups were asked to write reflections on their experiences. In the written reflections, there were marked differences in the two groups in terms of cognitive processes and awareness. "Aging Game" participants described their experiences in terms of how the experience allowed them to *feel like an older adult*. "Dealing with the functional challenges left deep impressions" (Henry & Ozier, 2011, p. 938). The control group participants reflected more on content knowledge. Quantitative analysis of three survey measures for the two groups was inconclusive, but for students who participated in the brief simulation activity, their

reflections indicated an increased awareness of and empathy toward the *experience* of being an older person.

Social work researchers (Friedman & Goldbaum, 2016) conducted a role play intervention in a graduate seminar on aging after about 12 hours of traditional didactic classroom presentations. Students were divided into groups of three or four and each participant took on one of several roles: an elderly relative; a younger family member (adult child or grandchild of the elderly individual); a therapist; or a partner, spouse, or sibling of the elderly individual. Each group agreed on a scenario and engaged in the interactive role play for 30-45 minutes, after which the groups reunited and processed their experiences. For these students, the role-playing activity resulted in enhanced clinical awareness, perspective transformation, and increases in self-reported empathy for older adults.

Australian psychology researchers (Brinker et al., 2014) developed and tested a role-play intervention designed to improve attitudes toward aging and reduce aging anxiety by presenting undergraduate psychology students with a more balanced view of later life than the more deficit-focused perspectives provided by other aging role-play activities such as the "Aging Game" (McVey et al., 1989; Pacala et al., 2006). In two studies ($N = 120$; $N = 94$), first-year psychology students enrolled in a "Psychology of Aging" course were first asked to write a hypothetical summary of their life as if they were 65 years old, including life events and personality traits. This pre-reflection was designed as an "immersive activity" (Brinker et al., 2014, p. 93) for students to imagine their lives at a different developmental stage and to consider their beliefs about aging.

Next, tutors presented the board game "The Game of Late Life." Game play involved small groups of three or four players taking turns moving about the board and landing on various "life event" spaces in which players interpreted the impact, either positive or negative, of events such as divorce and taking care of grandchildren, and collaboratively discussed and shared perspectives on those events. Players' collective interpretations of events determined the direction of game play. A negative interpretation resulted in moving forward toward death (labeled on the game board as "The End" and "Sailing off into the Sunset"), while a more favorable interpretation meant moving away from "The End." Improvements in self-reported attitudes toward older adults, as measured by the Attitudes to Aging Questionnaire (AAQ; Lucas-Carrasco, Laidlaw, Gómez-Benito, & Power, 2013), were significantly improved in the first study. Using participant feedback to refine the intervention, researchers instructed tutors to put more emphasis on fostering meaningful discussion among the participants, and, in the second study, both self-reported attitudes toward older adults as measured by the AAQ and self-reported aging anxiety as measured by the Anxiety about Aging Scale (AAS; Lasher & Faulkender, 1993) were significantly improved. The enhanced discussion facilitation was correlated with improved attitudes, highlighting the value of facilitated collaborative discussion for learning. Although this game was designed to influence students' attitudes about their own aging, Brinker et al. (2014) recommended further investigation into the influence of the intervention on career choice as Australia, like the United States, is experiencing a shortage of mental health care providers who are well-prepared and interested in working with older adults.

Gerontologists Schmall, Grabinski, and Bowman (2008) highlighted several advantages of games as learning tools in gerontology-focused education, including increasing empathy and improving attitudes toward older adults. Schmall et al. (2008) highlighted the role of the facilitator in creating an open and accepting climate of learning and stressed the importance of debriefing after game play as an opportunity for players to reflect on their experiences, share their feelings with one another, and discuss how their attitudes have been challenged and/or changed.

In the studies described above (Brinker et al., 2014; Friedman & Goldbaum, 2016; Galinsky & Moskowitz, 2000; Henry & Ozier, 2011; Kane, 2003), simulations, games, and role-play activities, combined with collaborative decision-making, collective discourse, perspective-taking, and facilitated debriefing in the context of a safe and supportive learning environment, have demonstrated promise in improving self-awareness, improving attitudes, and enhancing empathy toward older adults. In the five-page Association for Counselor Education and Supervision (ACES) Best Practices for Clinical Supervision (2011), "self-awareness" appears six times. "Culture," "cultural," and "multicultural" appear a total of 24 times. This attention to self-awareness and culture represents the counseling profession's commitment to developing counselors who are aware of their own attitudes and capable of providing culturally-competent counseling to all their clients. Our profession's commitment to culturally competent practice *with older adults* may not be as evident in counseling and counselor education competencies, counselor supervision standards, and counseling textbooks.

Age as a Cultural Consideration in Counselor Education

Along with the rest of the population, the rapidly expanding cohort of older adults is increasingly diverse in terms of race and ethnicity (Colby & Ortman, 2015), and with such dramatic demographic shifts have come new challenges to medical and mental health professionals who are tasked with serving them. Changes that typically occur in later life include an increase in the incidence of chronic medical conditions (Nelson, 2017), mental health and substance use disorders (Institute of Medicine, 2012), and Alzheimer's disease and other dementias (Taylor, Greenlund, McGuire, Lu, & Croft, 2017). In response to this so-called "silver tsunami" (Comlossy & Walden, 2013), counselor educators will be called to respond to the increasing need for qualified professionals to serve this expanding demographic. CACREP-accredited counselor education programs have been charged to train counselors who are ready and able to work with a broad range of clients from diverse backgrounds. As the population of adults 65 and older increases, the demands on counselor educators to train adequately-prepared counselors to serve this population will grow. Just over 30 years ago, the counseling profession responded to another significant cultural shift in a way that has influenced client care and counselor education in profound and lasting ways. Cultural considerations of age, however, have made only intermittent appearances in counseling standards.

Multicultural Counseling Competencies in Counselor Education

In 1982, in response to increasing cultural diversity in the United States, Sue et al. introduced a Tripartite Model of Cross-Cultural Competence, in which cross-cultural counseling was defined as "any counseling relationship in which two or more of the

participants differ with respect to cultural background, values, and lifestyle" (p. 47). A decade later, the introduction of the Multicultural Counseling Competencies (Sue et al., 1992) was instrumental in integrating multicultural awareness and perspectives into the counseling profession, and helped to shape the American Counseling Association's Code of Ethics (ACA, 2014). Within the ACA Code of Ethics, the competencies were updated to "reflect a more inclusive and broader understanding of culture and diversity" (Ratts et al., 2015, p. 28), and to highlight the importance of social justice concerns as they relate to mental health and well-being. Greater awareness of the centrality of multicultural counseling competence to ethical practice has resulted in an expanding research base focused on counseling diverse populations, including research into the origins of bias, ways to assess multicultural competence, and interventions designed to develop multicultural counseling competence. Although much of the research on these competencies has focused on racial and gender differences, years before Sue et al.'s (1982) position paper, *age* as a cultural consideration was the focus of another call to action.

Gerontological Competencies in Counselor Education

In 1975, in response to their study of counselors' attitudes toward aging, Blake and Kaplan challenged the counseling profession to attend to the needs of older adults, calling them "forgotten and ignored" (1975, p. 156). Over the next 20 years, with grant funding from the US Administration on Aging and under the leadership of Jane Myers, more than 3,200 counselors were trained in gerontological counseling and interest in providing gerocounseling services appeared to be building momentum. In 1986, the

Association for Adult Development and Aging (AADA) was chartered as a division within the American Counseling Association. In 1990, NBCC began offering the National Certified Gerontological Counselor (NCGC) credential, and in 1992 CACREP developed a Gerontological Counseling accreditation standard for Community Counseling programs (Bobby, 2013; Myers, 1995). By 2001, however, due to a lack of institutional commitment (Bobby, 2013), both the NCGC credential and the CACREP Gerontological Counseling accreditation standard had been discontinued. The retirement of both the NCGC credential and the CACREP Gerontological Counseling accreditation has been described by Foster and Kreider as "puzzling" (2009, p. 179).

More than 15 years later, multicultural competencies have remained at the forefront of the ethical standards in counseling and CACREP requirements in counselor education. Even so, throughout professional counseling organizations, there is an inconsistent emphasis on age as a cultural consideration. Section 6 of the Association for Counselor Education and Supervision (ACES) 2011 Task Force Report (Supervision Best Practices Guidelines: Diversity and Advocacy Considerations) reads, "The supervisor attends to the full range of cultural factors, including race, ethnicity, gender, sexual orientation, socioeconomic status, privilege, ability status, family characteristics and dynamics, country of origin, language, historical processes (e.g., history, migration), worldview, spirituality and religion, and values" (p. 9). Age is not mentioned. The 2016 CACREP standards have named "Social and Cultural Diversity" as foundational to professional counseling identity without naming any *specific* cultural considerations (CACREP, 2015). In the 2015 ACA Code of Ethics, age *is* listed as one aspect of cultural

diversity. This inconsistent focus on gerontological counseling is occurring during a time in which the proportion of older adults is growing faster than in any other recorded time period (He et al., 2016). "The quality of lives of older persons and their families is at stake, but, sadly, counselors…seem uninterested in this minority that all of us hope that we will one day join" (Nelson, 2017, p. 328).

Growing older is part of the human condition and takes place within and across all other cultural considerations. "Gerontology is an interdisciplinary field" (Nielsen, 2014, p. 21). Therefore, as the inevitability of aging is universal, cultural considerations of age are intrinsically present in all of the eight common core areas representing the "foundational knowledge required of all entry-level counselor education graduates" (CACREP, 2015, p. 8) in CACREP standards. Cultural considerations, *including* cultural considerations of aging, are inherently present in all counseling coursework, whether emphasized by counselor educators or not. In an analysis of eight counselor education textbooks used in 11 CACREP-accredited counseling programs in the United States, Fahr (2004) examined how older adults and aging were being represented, how the textbooks supported or negated ageism, missed opportunities to include issues of aging and older adults, and how inappropriate representations found in the textbooks might be corrected or improved. Fahr (2004) described the representation of older adults in the textbooks as infrequent compared to other diverse groups, and found the representations were "sometimes ageist and rarely non-ageist" (p. 181). In some cases, the age representations *perpetuated* myths about aging. Although Fahr acknowledged that this qualitative analysis was limited by a small sample size and potential researcher bias, as with a

previous analysis of social science and psychology texts in which the researchers found evidence of *sexist* language (Campbell & Schram, 1995), there was evidence of ageist language in the counselor education textbooks. Such biased representations of elders in counseling textbooks could be perceived by students as acceptable if counselor educators are not both aware of their own attitudes toward aging and attuned to the existence of such biases in required readings. In conclusion, Fahr (2004) wrote, "Since multicultural competence and a sensitivity to diversity issues is at the heart of counseling training programs, counselor educators are key in remembering to include the elderly into special and diverse populations" (p. 183).

Gerontological Competencies in Other Mental Health Professions

In contrast to what appears to be a distancing between a gerontological focus and the counseling profession, inspired by the Hartford Foundation's 1999 "Strengthening Aging and Gerontology Education for Social Work" (SAGE-SW) project, gerontological competencies have been integrated into curriculum requirements for both geriatric social work and generalist social work practitioners by the Council on Social Work Education (Damron-Rodriguez, 2007; Galambos, Curl, & Woodbury, 2014). Even with this professional commitment to gerontological competencies (Damron-Rodriguez, Goodman, Ranney, Won Min, & Takahashi, 2013; Galambos et al., 2014), Chonody and Wang (2014) found that only 5.4% of over 1000 social work students surveyed named aging as their primary professional interest.

In 2014, the American Psychological Association (APA) revised their 2003 "Guidelines for Psychological Practice with Older Adults" (APA, 2004). Although

"aspirational in intent, they are intended to facilitate the continued systematic development of the profession and to help ensure a high level of professional practice by psychologists" (APA, 2014, p. 34). These 21 guidelines and the "Resolution on Ageism" adopted by the APA Council of Representatives in 2002 (APA, 2002) signify the APA's commitment to meeting the mental health needs of older adults. Even so, only 4.2% of 6334 psychologists surveyed in the 2008 APA Survey of Psychology Health Service Providers named older adults as their primary population of clinical focus (APA, 2014; Michalski et al., 2010).

Reintegrating Gerontology into Counselor Education

Gerontological competencies are no longer a part of CACREP and NBCC standards (Bobby, 2013; Foster & Kreider, 2009), but multicultural counseling competencies have been highlighted as *essential* to professional counseling identity in the 2016 CACREP standards (CACREP, 2015; Ratts et al., 2015). Counselor educators have been charged "to serve as gatekeepers to the profession of counseling" (McCaughan & Hill, 2015, p. 28), carefully screening potential candidates, monitoring the development of admitted students, and training students to be multiculturally competent. Such attention to matters of culture and social justice in counselor education can help counselor trainees "gain insight into the inequities experienced by clients from marginalized groups as well as the privileges bestowed to clients from privileged groups" (Ratts et al., 2015, p. 36). Oppression of marginalized groups can come in the form of "isms" such as racism, sexism, and ageism, both at the individual and systems level. No matter the form, "isms" of any kind can have a "devastating influence on the mental

health of historically marginalized individuals and communities" (Ratts et al., 2015, p. 32). For adults who are older, such marginalization can contribute to reduced physical and mental well-being. For those who are old as well as those who are yet-to-be-old, internalization of such oppressive beliefs can plant seeds that may blossom years later in the form of devastating health consequences.

Regardless of the presence or absence of officially endorsed gerontological competencies within CACREP or NBCC standards, counselor educators who are committed to the multicultural and social justice competencies our profession promotes are nevertheless called to address diversity in *all its forms*, including the cultural considerations of aging. Several models of integrating gerontological competencies into counselor education have been suggested.

Integrating Gerontological Competencies into Counselor Education

The *integration* or *infusion* model blends gerontological competencies into existing core curricula such as developmental or multicultural counseling courses. One advantage of this model is that all students enrolled in these courses are exposed to the gerontology-focused coursework (Foster et al., 2009; Zucchero, 1998). One disadvantage of this model is that busy educators who do not hold a particular interest in gerontology may not provide adequate time or attention to the topic. The *separate course* model allows for extended exposure to issues of gerontological counseling, giving those students who are interested in working with older adults ample opportunity to expand on their learning. There are several disadvantages to this model also. There may not be adequate space, faculty interest or expertise, or scheduling availability for an extra course

(Stickle & Onedera, 2006), and only those students with an expressed interest and schedule availability would benefit from the class. The *cognate* or *area of concentration* model involves counseling faculty providing several gerontology-focused courses within the department (Foster et al., 2009; Stickle & Onedera, 2006; Zucchero, 1998). An advantage of this approach is that interested students and faculty would have an opportunity to deepen their focus on gerontology and counseling. As with the separate course model, the cognate model could be difficult to maintain in busy departments with faculty who are already stretched to teach required core counseling courses within space and time limitations. The final model is the *interdisciplinary* model, in which departments that teach gerontology-focused courses would welcome counseling students into those courses to benefit from more focused study. "With departments working together and combining their expertise from their fields of study, students…gain an understanding of gerontology that is relevant and meaningful to their chosen profession" (Foster & Kreider, 2009, pp. 182–183). One disadvantage of this model could be a lack of space for counseling students in other departments' classes. Additionally, students who are sent outside their departments to seek gerontological education that their own department does not provide could feel that gerontology competencies are not valued in counselor education.

Zucchero's (1998) integrated model of counselor training goes beyond teaching facts about aging to students, and encourages deeper engagement with the subject on a more personal level. In this model, which incorporates experiential learning and immersion experiences in conjunction with more traditional coursework, gerontology

competencies would be woven throughout coursework and would be offered to *all* students, not just the ones interested in working with older adults, providing the opportunity to expose more students to gerontological competencies in a way that could reduce possible student resistance (Zucchero, 1998). Challenges to this approach include a lack of interest in or a lack of training in gerocounseling by counseling faculty (Meredith & Watt, 1995), overscheduled and overworked educators, and institutionalized ageism within departments (Brown & Brown, 2015). This last point, ageism within counselor education, may be an especially difficult challenge to overcome.

Zucchero (1998) conceptualized traditional counselor education pedagogies as maintaining a myopic focus on the acquisition of knowledge and skills. He suggested that such programs ignored the *gestalt* of the learning experience by neglecting to attend to students' emotional awareness. As noted earlier, neither contact with elders nor knowledge about aging may be sufficient to improve attitudes toward older adults (Cottle & Glover, 2007; Merz et al., 2016; Shreeniwas & Morrison, 2016). Whether gerontological competencies are ever reintegrated into counselor education or not, *age is a cultural consideration*. As more and more adults turn 65, the need for enthusiastic, well-trained gerocounselors has never been greater.

Infusing gerontological competencies back into professional counseling standards will only happen with dedicated, tenacious, and fearless leadership from those who share a willingness to defy the ageist norms espoused by the dominant culture. Although no educational paradigm can guarantee transformations in student empathy and attitudes toward older adults, for counselor educators who seek to encourage perspective-taking,

foster greater personal insights, enhance learners' self-awareness, and set the stage for expanded world views in their students, transformative learning theory (Meyers, 2008; Mezirow, 2000; Taylor, 2008) provides a useful theoretical framework and guide.

Transformative Learning Theory

Mezirow's theory of transformative learning was born from research he conducted in the 1970s on the "consciousness raising process" (Christie, Carey, Robertson, & Grainger, 2015, p. 11) of transformation experienced by women returning to school at mid-life (Mezirow, 2000). According to transformative learning theory (TLT), the process of transformative learning begins in response to an acute crisis or a series of challenges to existing worldviews (Taylor, 2008), known in TLT as a *disorienting dilemma.* When learners become aware of inconsistencies in their beliefs and views, such awareness can lead to self-examination and critical reflection on assumptions and ultimately, one's personal *meaning schemes*, "the many, varied constructs that make up our self-concept, identity and orientation to inner and outer worlds" (Jaruszewicz, 2006, p. 362). In counselor education, intense classroom experiences in which students are presented with viewpoints that differ from their own can serve as disorienting dilemmas, drawing students toward critical reflection (Cohen et al., 2015).

Next, through group discourse with other learners, a student may come to realize that his/her feelings of discontent, in response to challenged assumptions and meaning schemes, are also shared by others. In counselor education, facilitated small process groups can offer students opportunities to engage in collaborative discourse that can challenge existing perspectives while supporting the risk-taking that is required for

learners to be candid in their self-disclosure. A culture of safety is key for transformative learning to take place, as, "It is through building trusting relationships that learners develop the necessary openness and confidence to deal with learning on an affective level, which is essential for managing the threatening and emotionally charged experience of transformation" (Taylor, 1998, p. 37).

After recognizing that he/she is not alone in the process of transformation, the learner may then begin to explore "options for new roles, relationships, and actions" (Mezirow, 2000, p. 22). Next, he/she may plan a new course of action, acquiring the knowledge and skills necessary to put the intended plan into motion. In the final phase of personal transformation, the learner feels both emancipated and empowered as he/she integrates transformed perspectives and updated meaning schemes into his/her life. Although many TLT theorists agree that transformative learning does not always occur in the linear fashion described here (e.g., Cranton & King, 2003; Jaruszewicz, 2006; Nicolaides & Dzubinski, 2016; O'Connell, 2010), the importance of a disorienting dilemma, critical reflection, group dialogue, and a safe and supportive learning environment as central to transformation was highlighted throughout all the TLT literature reviewed for this chapter.

Transformative Learning in Counselor Education

Three key concepts define a framework to best foster transformative learning: "promoting inclusion (giving voice to the historically silenced), promoting empowerment (not self-actualization but belongingness and equity as a cultural member), and learning to negotiate effectively between and across cultures" (Taylor, 2008, p. 9). Transformative

learning is “grounded in the nature of human communication” (Taylor, 2007, p. 173), and TLT’s emphasis on group discourse, interpretation, negotiation, and problem-solving (Kozub, 2013), lends itself to application and further study in counselor education. Its focus on challenging hierarchy; fostering emotional flexibility; and developing a culture of inclusivity, trust, and safety to empower students (Mezirow, 2003), aligns with our profession’s emphasis on social justice and commitment to multiculturally-competent practice.

Awareness of one’s attitudes, frames of reference, values, and biases is an essential part of counselor identity development, and CACREP requires its accredited programs to include “strategies for identifying and eliminating barriers, prejudices, and processes of intentional and unintentional oppression and discrimination” (CACREP, 2015, p. 9). TLT directly addresses the essential nature of challenging existing frames of reference, such as personal prejudices and biases, as critical to development within the adult learner. “TLT is an adult model of learning that provides a theoretical lens to inform the pedagogy of counselor educators seeking to invoke the principles and core conditions espoused by Rogers” (Fazio-Griffith & Ballard, 2016, p. 226; Rogers, 1969).

Further aligning with our profession’s values, according to Mezirow (2003), the adult educator serves “both as facilitator of reasoning in a learning situation and as a cultural activist fostering the social, economic, and political conditions required for fuller, freer participation in critical reflection and discourse by all adults in a democratic society” (p. 63). If critical reflection and discourse skills are not present in adult learners, according to Mezirow (2003), it is up to educators to create conditions for such high-level

reflection and discourse. TLT is intentionally aligned with adult learning capabilities of critical self-reflection, reflective judgment, and metacognitive reasoning (Mezirow, 2003), all of which are reflected in the ACA 2015 Multicultural and Social Justice Counseling Competencies (Ratts et al., 2015).

According to TLT, educators can serve as facilitators or *provocateurs*, "engaging students in learner-centered, participatory, and interactive experiences that require group problem-solving, autonomous thinking, critical reflectivity, and discourse" (Slavich & Zimbardo, 2012, p. 579). Essential to TLT's framework is "the need to develop communicative skills so that internal and external conflicts, which result from changes in perspective, can be resolved via rational discourse rather than force" (Christie et al., 2015, p. 11). When facilitating for transformation in counselor education, the facilitator's role is to foster the learners' skills and disposition so that students may become more active and rational learners, ultimately relying less on the opinions, beliefs, and values of others, and becoming more proficient at making their own judgments (Alden & Toth-Cohen, 2015; Mezirow, 2000).

TLT's egalitarian approach to learning fosters openness and confidence in students, and supports active discourse regarding learners' feelings in conjunction with their cognitions (Taylor, 1998). When counselor educators encourage students to step outside of their existing set of beliefs, such as when students are challenged to rethink their beliefs about older adults, focusing on the learner's *emotional* experience may help to reduce reactive resistance to culturally accepted norms such as ageism. Mezirow's (2003) views on the role of educators as facilitators and provocateurs are in keeping with

those of Carl Rogers, who wrote, "the facilitator who cares, who prizes, who trusts the learner, creates a climate for learning so different from the ordinary classroom that any resemblance is 'purely coincidental'" (1969, p. 111). Mezirow (2003) has called the person-centered work of Rogers "a transformational pedagogy" (p. 64).

Critical self-reflection is central to both transformative learning and to becoming more culturally competent and is an essential element of professional counselor identity development described by Rogers as crucial to developing empathy and congruence (1957). Empathy, "a sophisticated human relating skill" (McAllister et al., 2011, p. 22), is essential for transformative learning to occur, and is evident in critical reflection and discourse in which learners consider the perspectives of others in order to better understand them. Counseling students who engage in perspective taking and recognize previously unacknowledged or unchallenged ageist biases may be reluctant to admit to such prejudicial beliefs for fear of repercussions from faculty and fellow students (Cherry et al., 2016). That is why it is essential for counselor educators and facilitators who wish to foster transformation and enhance gerontological counseling competency in their students to create safe learning environments that support what can be a difficult process of increasing self-awareness and personal growth. When such perspective shifts occur within the context of a safe learning environment that provides a balance of challenge and support, the emancipatory process of transformative learning can occur (Kitchenham, 2008). In counselor education, TLT may serve as a useful theoretical framework with which to design interventions that enhance empathy and improve attitudes toward older adults by challenging existing frames of reference, fostering greater self-awareness,

encouraging meaningful group discourse, and supporting critical reflection in counselor trainees.

Transformative Learning Research

Research into the process and effectiveness of transformative learning can be found across many disciplines. Provident et al. (2015) conducted a qualitative analysis of 113 written reflections of occupational therapy clinical doctoral students enrolled in an online program from 2007 to 2013. In their analysis, the researchers found evidence of transformative learning in students' descriptions of grappling with a *multitude* of disorienting dilemmas, including the decision to return to graduate school, feelings of trepidation once in the program, and struggling to gain mastery. Student reflections highlighted the utility of a cohort model in providing both support and challenge, and the role of instructors in facilitating transformative learning. Critical reflection and collaborative discourse, as well as increased self-awareness and perspective transformation, were also central themes of students' writing. One limitation acknowledged by the researchers was the possibility of social desirability bias (Crowne & Marlowe, 1960), as the students' reflections were read and evaluated by their instructors, which might have influenced their responses.

Kozub (2013) described a transformative learning activity using event analysis with nurses. The intervention was designed to enhance multicultural competence and empathy toward patients. With the support of a moderator who served in a non-evaluative capacity, each participant was invited to describe an interaction with a patient (including thoughts, context, and actions). Following a group discussion, the event was then retold

by other participants from the perspectives of different stakeholders, an act that introduced challenges to previously held assumptions. This event analysis blended empathy, self-awareness, and reflection with already meaningful events/lived experiences, leading to altered perspectives and meaning making in both the participants and the moderator.

Lim (2008) found that the process of gathering personal information, constructing, and then presenting their completed genograms to a practicum group was an effective means of sparking transformative learning and increasing empathy toward clients in master's-level counseling trainees. Anchored in life experience, essential for transformation to occur, the creation of the genograms led to greater self-awareness and counselor identity development in the students. Perspective transformation and increases in empathetic awareness were also demonstrated in an exploratory, qualitative study of supervision with 13 mental health professionals from several disciplines who engaged in a dialogical mindfulness-based role play activity (MBRP; Andersson et al., 2010). In this study, participants attended an introductory workshop in which they were presented with the conceptual framework of MBRP and opportunities to practice dialogical mindfulness, described as, "the application of mindfulness in a dialogue between two people, either when they are both present or when one of them is only imagined to be present, as in a role-play" (Andersson et al., 2010, p. 288). Next, each participant engaged in a supervision session role play in which he or she played both him/herself as therapist and as one of his/her clients, similar to the Gestalt technique of "empty chair." Supervisors/facilitators guided the role plays, encouraging participants to attend to the

phenomenological experience of each of the roles. Almost all participants reported feeling greater empathy toward their clients after role playing from their perspectives. The perspective-taking that occurred in this intervention provided students with an opportunity to see reality through different eyes and connect empathetically with the experience of another (Bowman, 2010).

Counselor educators are called to provide both content instruction and opportunities for students to process and reflect on that content (Fazio-Griffith & Ballard, 2016). Interactive group activities can challenge beliefs, assumptions, and perspectives and may lead students to question themselves, and when such challenges are presented within a culture of safety, support, and learner empowerment, transformation can occur (Cranton, 2002). Transformative learning involves both self-examination of feelings when faced with a disorienting dilemma, and perspective transformation, which requires learners to integrate new roles and beliefs into their worldview. Critical examination of one's feelings and integrating new perspectives into one's worldview may best be accomplished by developing greater empathetic awareness.

The perspective shifts and empathetic awareness that occurred in these studies suggest that a contextually-meaningful gerontology-focused transformative learning intervention could be effective at challenging counseling students' existing meaning schemes. Challenges to students' meaning schemes regarding older adults, when presented within the context of a supportive learning environment within a counselor education program, could be useful in enhancing empathy and improving attitudes toward

older adults, and could ultimately result in graduates who are better prepared, enthusiastic, and ready to serve the rapidly expanding population of adults 65 and older.

Conclusion

"It is the ethical duty of…counselor education faculty to serve as gatekeepers to the profession of counseling" (McCaughan & Hill, 2015, p. 28), carefully screening potential candidates, monitoring the development of admitted students, and training students to be multiculturally competent and able to serve a broad range of clients, including older adults. Despite the best efforts of counselor educators to abide by professional standards including social justice competencies (CACREP, 2015; Ratts et al., 2015), a well-designed curriculum and enthusiastic educators is not sufficient to produce quality gerocounselors if students' attitudes toward older adults impede their willingness to consider working with elders. Attitudes, "psychological tendency[ies] …expressed by evaluating a particular entity with some degree of favour or disfavour" (Eagly & Chaiken, 1993, p. 1), may be linked to counseling students' decisions regarding whether or not to work with older adults (Chonody & Wang, 2014). Awareness of one's attitudes, values, assumptions, and biases is an essential part of counselor identity development (Sue et al., 1992). Providing students with ample opportunities to become aware of and evaluate their attitudes toward older adults early in their counselor training could play a valuable role in developing gerontological counseling competence.

Influenced by social desirability factors and self-presentation bias (Soubelet & Salthouse, 2011), counseling students may overstate their perceived cultural competence (Cartwright, Daniels, & Shuqiang, 2008), and may deny harboring ageist beliefs, making

it difficult for counselor educators to adequately address any implicit biases that may influence students' development. However, because the impact of ageism on older adults can be devastating for health and overall well-being (e.g., Levy et al., 2009; Tomko & Munley, 2012), counselor educators committed to ethical and competency standards are charged to move the profession one step closer to "dismantling the mechanisms of discrimination" (Boysen, 2009, p. 211), including discrimination against older adults.

Creative, transformative learning interventions (see Empathy Enhancing Interventions), such as role plays, film screenings, creations of genograms, and simulation games, have been found to be effective at enhancing cross-cultural empathetic awareness in mental health and medical students and professionals (e.g., Daniau, 2016; Junn et al., 1995; Paredes, 2010; Villalba & Redmond, 2008). Researchers have found a link between greater empathy and a reduction of ageist stereotypes (Bodner & Cohen-Fridel, 2014; Tam et al., 2006), as well as a reduction of negative stereotypes toward other out-groups (Batson et al., 1997). Interventions that effectively enhance empathy and improve attitudes toward older adults have not been adequately studied in the counseling literature, and, as the growth in population of older adults continues, the gap between adequately-trained gerontology-focused counselors and the needs of that population will only broaden. An easy-to administer gerontology-focused empathy-building intervention could be useful in helping to narrow that divide.

Thus, the goal of this feasibility study is to test the preliminary effectiveness of a three-part transformative learning intervention, "The Game of *I am*" (Bailey, 2016c) which is designed to enhance empathy and improve attitudes toward older adults in first-

year master's counseling students enrolled in first-semester coursework at two CACREP-accredited universities. Through the process of pre-reflective journaling, participating in a gerontology-focused transformative role-playing game, engaging in collective group discourse, and post-reflective journaling, I hope to see greater improvements in self-reported empathy and attitudes toward older adults when I compare pre-intervention and post-intervention measures. If successful, such an intervention could be integrated into existing coursework in counselor education programs as one way to help bridge the broadening divide between a rapidly expanding cohort of older adults and qualified gerocounselors who are well-prepared and ready to serve them.

CHAPTER III

METHODOLOGY

The rationale and need for the study presented in Chapter I, in conjunction with the review of literature in Chapter II, highlight the value of enhancing empathy and improving attitudes toward older adults in first-year master's counseling students. Developing a gerontological-focused transformative learning intervention that can be integrated into existing coursework in counselor education programs could help narrow the gap between the rapidly expanding population of adults 65 and older and master's-level counselors who are well-prepared and willing to work with them. This chapter will include a detailed description of the methodological plans for the current feasibility study, including research questions and hypotheses, participants, intervention development, results from an initial implementation study, instruments, procedures, statistical analyses, and results from two pilot studies.

Research Questions and Hypotheses

Research Question 1: Will participation in "The Game of *I am*" result in significant pre-post intervention mean differences in self-reported empathy as measured by the Toronto Empathy Questionnaire (TEQ; Spreng et al., 2009) in first-year master's counseling students?

Hypothesis 1: Participation in "The Game of *I am*" will result in significantly higher mean differences in self-reported empathy as measured by the TEQ in first-year master's counseling students.

Research Question II: Will participation in "The Game of *I am*" result in significant pre-post intervention mean differences in self-reported attitudes toward older adults as measured by the Fraboni Scale of Ageism (FSA; Fraboni et al., 1990) in first-year master's counseling students?

Hypothesis II: Participation in "The Game of *I am*" will result in significantly higher mean differences in self-reported attitudes toward older adults as measured by the FSA in first-year master's counseling students.

Participants[1]

The initial population of interest for this feasibility study was first-semester, first-year master's counseling students currently enrolled at two full-time CACREP-accredited counseling programs in the southeastern United States. The Department of Counseling and Educational Development (CED) at The University of North Carolina at Greensboro (UNCG), the researcher's CACREP-accredited university, has a 2017-2018 first-year master's cohort enrollment of 33, with all master's students enrolled in all but one of the same courses during the first semester. UNCG is a regional public university which is minority-serving at the undergraduate level, and has an enrollment of approximately 20,000 students. Wake Forest University (WFU) is a private liberal-arts university with an enrollment of approximately 7,600 students. The WFU Department of Counseling is

[1] See Addendum A, p. 108

CACREP-accredited, and has a 2017-2018 first-year master's cohort enrollment of 16, with all master's students enrolled in the same coursework during their first semester.

In this feasibility study designed to test the preliminary effectiveness of a three-part transformative learning intervention at enhancing self-reported empathy and improving self-reported attitudes toward older adults in first-year master's counseling students, a convenience sample of 49 students from UNCG and WFU was to be recruited in the fall of 2017. Issues of statistical power will be addressed later in this chapter (see Power Analysis).

Early in the fall 2017 semester, after the planned recruitment strategy was initiated as described, permission to recruit from WFU was rescinded. This led to a necessary shift in recruiting. Therefore, after securing approval from my dissertation committee, in addition to a convenience sample of 33 first-year master's counseling students at UNCG, a convenience sample of 25 first-year master's students enrolled in the Student Affairs Administration in Higher Education (SAAHE) M.Ed. program in the School of Education at UNCG was recruited for this study (see Addendum A., p. 108). Resulting changes to research questions and hypotheses, as well as a discussion of the need for increased empathy and improved attitudes toward older adults in student support professionals will be presented in Chapter V.

Intervention Development

"The Game of *I am*" (Bailey, 2016c) grew out of a doctoral-level research class assignment in the spring of 2016. In this assignment, I wanted to bring attention to issues common to female workers in mid-life by developing an interactive in-class activity that

would spark critical reflection and group discourse. I created a board game activity using prompts that were designed for my fellow doctoral students (aged 24-35) to take the perspectives of middle-aged women. After receiving positive feedback regarding the transformed perspectives experienced by my fellow doctoral students after playing the game, I began to consider ways to develop a transformative learning game-based intervention that could be used in counselor education to help bridge the gap between the expanding cohort of adults 65 and older and the growing need for qualified gerocounselors.

The stages of "The Game of *I am*" (Bailey, 2016c) intervention development were aligned with Bartholomew, Parcel, and Kok's Intervention Mapping (IM) model (1998, 2011). IM was initially designed as a model for developing, implementing, and evaluating health promotion programs (Koekkoek, Van Meijel, Schene, & Hutschemaekers, 2010). The six steps of IM are: (1) conduct a needs assessment through initial review of empirical literature; (2) establish objectives for behavior change; (3) ground the intervention development with a thorough review and assessment of relevant theories and empirically evaluated behavior change methods and strategies; (4) develop intervention materials by translating the methods, strategies, and theoretical constructs into an organized intervention; (5) create a plan for adoption, execution, and sustainability of the intervention; and (6) test the intervention (Bartholomew et al., 2011; Koekkoek et al., 2010; Song, Choi, Kim, Seo, & Lee, 2015). "Even though Intervention Mapping describes six steps, the process is iterative rather than completely linear. Program developers move back and forth between tasks and steps as they gain new

information and perspectives" (Bartholomew et al., 2016, p. 12). According to this model, "interventions should focus on changeable behaviors and objectives; be based on critical, empirical evidence…; be relevant to the target populations; and have the potential to meet the intervention's goals" (Bowen et al., 2010, p. 2).

I conducted an initial literature search to determine the need for such an intervention in counselor education and to establish desired change objectives for participants (i.e., improved empathy and attitudes toward older adults; IM steps 1 and 2). Next, I conducted a more thorough literature review to explore relevant theories and empirically-supported interventions (see Chapter II; IM step 3).

To create a targeted transformative learning intervention that was grounded in the literature, I began to develop game prompts that reflected ageist attitudes and behaviors commonly encountered by older adults. I incorporated the scholarship of ageism researchers (e.g., Applewhite, 2015; Butler, 2012; Chonody, 2015; Levy et al., 2009; Nelson, 2016a; Rupp et al., 2005); my personal experiences of ageism as a middle-aged woman and graduate student; examples of ageist behavior I had witnessed directed toward my mother, who is in her mid-90s, as well as other elders; and my experiences providing counseling to older adults (IM step 4). I tested the feasibility of implementing the game into a counselor education classroom as a standalone activity in the fall of 2016 (see Initial Implementation Study; IM steps 5 and 6). To continue to refine and develop the intervention (IM steps 5 and 6), I presented the game at three regional and national conferences (Bailey, 2016b, 2016c, 2017); in two undergraduate gerontology classes at UNCG; in a master's-level multicultural counseling class at WFU; and to professional

facilitators and staff in the Office of Leadership and Service Learning at UNCG. Feedback from participants in these settings included the suggestion to add "move backwards" to game play to enhance competitiveness, and a recommendation to rewrite the vignettes without descriptors of likely reactions to the ageist behaviors and attitudes to allow players to reflect on their own authentic emotional experiences. After further review of relevant TLT intervention literature, I added both a pre-reflective and post-reflective component to the original game activity to create the current three-part intervention design (IM step 4). To further refine the game prompts for this study within the framework of TLT, I solicited feedback from content experts (see Pilot Study One; IM step 4). To test the intervention game using the updated, expert-reviewed prompts, I conducted a second pilot study with undergraduate students enrolled in a gerontology class (see Pilot Study Two; IM step 6). The current feasibility study was designed to test the preliminary effectiveness of the full three-part intervention with first-year master's counseling students and first-year master's students training to be student support professionals (IM step 6).

Initial Implementation Study

In the fall of 2016, I conducted a research study with the Counseling Diverse Populations class (CED 605) at UNCG. This course met once a week for 15 weeks, and I presented the intervention game during the 13th class meeting late in the semester. The study, entitled "Integrating Gerontological Counseling Competencies into Multicultural Counseling Curricula" (IRB #16-0264; see Appendix A: Initial Implementation Study Documentation), was designed to test the feasibility of implementing the in-class game-

play component of what would become the full, three-part "The Game of *I am*" (Bailey, 2016c) intervention with the first-year master's counseling students, and to inform intervention development and administration. After securing IRB approval and permission from the instructor on record to present the game, students were provided a verbal recruitment script describing the study's purposes and procedures, and listing the risks and benefits of participation. Students were assured that participation in the study was entirely voluntary and would not affect their grade in CED 605, and they were also assured that no identifying information would be collected. The course instructor was not present for the activity. After reading the consent form, students who wished to participate were invited to remain in the classroom, while students who did not wish to participate were instructed to step out of the classroom until the activity was finished. All students present ($N = 31$) remained in the classroom and participated in the activity.

After dividing the students into four teams, participants played "The Game of *I am*" (Bailey, 2016c; see Procedures). Game play lasted approximately 25 minutes. The winning team was presented with a small prize (bags of candy that were shared with the whole class), and the students assembled back at their desks, at which time I facilitated a discussion about the students' experiences and emotional reactions to the game and the prompts. After 20 minutes of group discussion, I shared a brief 10-minute presentation on aging and ageism, sharing demographics information as well as the history of gerontological competencies in counselor education.

Following the game-play activity, students received a link to a Qualtrics survey along with an informed consent for anonymous participation in the survey. The survey

consisted of eight questions. The first seven were close-ended questions using a seven-item five-point (1 = *not at all likely*, 5 = *very likely*) Likert-type answer scale. The final open-ended question asked, "What suggestions do you have for improving any aspect of the in-class activity?" Twenty-one students responded to the Qualtrics survey.

In response to the survey question, "How likely are you to provide counseling for older adults?" all but four students (80.9%) answered, "moderately likely," "pretty likely," or "very likely." In response to the question, "*Prior* to the in-class activity, how likely were you to consider age as a cultural consideration?" 15 respondents (71.4%) answered either, "not at all likely," "a bit likely," or "moderately likely." Responding to the question, "*After* the in-class activity, how likely are you to consider age as a cultural consideration?" all but one student (95.2%) responded, "pretty likely" or "very likely." As the intervention game took place toward the end of the semester, students in the course had already completed the bulk of their coursework and had been exposed to many aspects of multicultural counseling theory, research, and practice. It is possible, however, that some students may not have been exposed to the idea of *age* in the context of culture before playing the game.

Participants' suggestions for improving the game included facilitating greater engagement among the participants, using "chance" cards so that the game felt more competitive, and adding a "move backwards" option during game play. The survey responses collected from this initial implementation study supported the potential value of integrating the concept of age as a cultural consideration into counselor education through game play (see Appendix B: Initial Implementation Study Survey Responses).

In response to survey feedback, I made several changes to the original game. I also expanded the intervention into three stages to encourage greater perspective-taking and more opportunities for critical self-reflection. First, in keeping with the survey responses from my initial implementation study as well as TLT literature, during the game play as well as in the pre-reflective journaling, group discourse, and post-reflective journaling, student engagement was highlighted. Connecting learners to their emotions is essential to transformative learning, and increased attention to students' affective experiences is central to the utility of "The Game of *I am*" (Bailey, 2016c) as a disorienting experience for learners. In response to student suggestions to make the game feel more competitive, I added a "move backwards" option. In the initial implementation study, the prompts included vignettes followed by descriptors of likely reactions to the ageist behaviors and attitudes presented in the vignettes. To better foster co-creation of knowledge and enhance personal awareness of existing beliefs, the game prompts were rewritten without likely reactions. Further refinement of the content of the game prompts was addressed in the first pilot study (see Pilot Study One).

Variables and Instruments

Empathy

To answer the first research question, I used the Toronto Empathy Questionnaire (TEQ; Spreng et al., 2009). The TEQ is a 16-item, five-point (0 = *never*, 4 = *always*) Likert-type self-report measure assessing "comprehension of others' emotions, experience of sympathetic physiological arousal, altruism, prosocial behavior, understanding of emotional states in others based on sensitivity responses, and the extent

to which a person experiences the same emotional state of another" (Bui, Kalpidou, Devito, & Greene, 2016, p. 121). Higher scores represent higher levels of self-reported empathy. Items include, "I enjoy making other people feel better," and "I find that I am 'in tune' with other people's moods" (Spreng, 2009). The items in the TEQ "encompass a wide range of attributes associated with the theoretical facets of empathy" (Spreng et al., 2009, p. 68). In response to the lack of consensus among researchers on the interconnected processes that contribute to empathy (e.g., Preston & de Waal, 2002; Rankin, Kramer, & Miller, 2005), the TEQ was developed by factor-analyzing responses made on 11 other empathy questionnaires, including Hogan's Empathy Scale (1969), the Jefferson Scale of Physician Empathy (JPSE; Hojat et al., 2001), Mehrabian & Epstein's Questionnaire Measure of Emotional Empathy (1972), and Reynolds's Nursing Empathy Scale (1999). Spreng et al. (2009) developed the TEQ as a unidimensional tool to measure empathy at its broadest level. Spreng et al. (2009) reported internal reliability coefficients from .85 to .87 and high test-retest reliability ($r = .81$; $p < .001$). Although the TEQ was normed with undergraduate psychology students ($N = 200$, $\bar{X}$ age = 18.8 years), it demonstrated good internal consistency as well as strong and significant correlation with the JPSE (Hojat et al., 2001) in a five-year study with medical students in which 49% of students were 22 years of age or older (Youssef, Nunes, Sa, & Williams, 2014). In their research study with teachers who had an average of 15½ years of teaching experience, Kourmousi et al. (2017) found the TEQ demonstrated good construct validity, and internal consistency reliability of the TEQ was satisfactory at $\alpha = 0.72$. In a study of empathy in a group of young adults ($N = 144$, $\bar{X}$ age = 19.50) and older adults

($N = 120$, $\bar{X}$ age = 68.75), for both groups, TEQ scores positively correlated with the Empathic Concern and Perspective Taking subscales of the Interpersonal Reactivity Index (IRI, Davis, 1983). The TEQ has shown good convergent validity with two behavioral measures, the "Reading the Mind in the Eyes" Test (Baron-Cohen, Wheelwright, Hill, Raste, & Plumb, 2001) and the Interpersonal Perception Task–15 (Constanzo & Archer, 1994). The value of any self-report measure is greatly improved if it can be associated with task-based measures (Spreng et al., 2009), and this association further supports the usefulness of the TEQ in this study. As discussed previously, the definition of empathy continues to be the subject of debate, but Spreng et al. (2009) have conceptualized the empathy measured by the TEQ as both cognitive and affective. Even so, the vague conceptual definition of empathy threatens the validity of any empathy measure, as does social desirability bias that may be present in any self-report measure. As with other extant empathy measures (e.g., JSPE, IRI, Reynolds's Nursing Empathy Scale), the TEQ was not specifically designed to measure empathy toward older adults.

Attitudes Toward Older Adults.

To answer the second research question, I used the Fraboni Scale of Ageism (FSA; Fraboni et al., 1990). The FSA is a 29-item four-point Likert-type self-report scale with item scores ranging from 1 (*strongly disagree*) to 5 (*strongly agree*; unanswered questions are given a score of 3). Higher scores indicate more negative attitudes. In this instrument, "old" refers to adults 65 years of age and older. The FSA was developed to align with Butler's (1969) seminal conceptualization of ageism and includes both cognitive (e.g., "Old people complain more than other people do") and affective (e.g., "I

don't like it when old people try to make conversation with me") components. Following their factor analysis of the FSA, Rupp et al. (2005) redefined the original FSA three-factor structure (antilocution, discrimination, and avoidance) as *stereotypes* ("Many old people just live in the past"), *separation* ("Old people should find friends their own age"), and *affective attitudes* ("I personally would not want to spend much time with an old person"), to better account for variance in FSA scores (Fraboni et al., 1990). The FSA has demonstrated high internal reliability (McBride & Hays, 2012), and has demonstrated strong correlations with other measures such as the Acceptance of Others Scale (Fey, 1954), Aging Semantic Differential (Lassonde, Surla, Buchanan, & O'Brien, 2012; Rosencranz & McNevin, 1969), and the Facts on Aging Quiz (Fraboni et al., 1990; Palmore, 1977). Naftz and Wurtele (2010) reported test-retest reliability of the FSA at .693. In their study of an implicit assessment of ageist stereotypes, Lassonde et al. (2012) suggested that the FSA was not susceptible to social desirability as measured by the Marlowe–Crowne Social Desirability Scale (MCSDS; Crowne & Marlowe, 1960). In their research, Cherry, Allan, Denver, and Holland (2015) found that although the FSA *total* scores were not correlated with the MCSDS (Crowne & Marlowe, 1960), for the FSA scale scores, the avoidance score was significantly correlated with the MCSDS, indicating a possible social desirability influence on the measure.

For both measures used in this study, the *change in scores over time* (approximately three to four weeks) from pre-intervention assessments to post-intervention assessments were of primary focus, indicating shifts in self-reported empathy and self-reported attitudes toward older adults. Rather than comparing raw

scores between individuals, monitoring growth in this way further reduced the effect of social desirability on instrument administration (Jones, Sander, & Booker, 2013).

Inattentiveness and Social Desirability Measures

Because inattentive or careless responses can obscure results in research studies utilizing self-report measures (Maniaci & Rogge, 2014; McKibben & Silvia, 2015), I integrated directed response items into both the TEQ and the FSA. In their study examining the threat to research power and validity of resulting from inattentive responding, Maniaci and Rogge (2014) found that adding the item, "I read instructions carefully. To show that you are reading these instructions, please leave this question blank," was useful in screening out excessively inattentive respondents. This and other items inviting respondents to skip questions proved most useful in the Maniaci and Rogge (2014) study.

To test for social desirability in responses, I added an item from the Balanced Inventory of Desirable Responses (BIDR; Paulhus, 1984) to both the TEQ and the FAS. I added, "I never regret my decisions" into the TEQ. An answer of "always" would indicate the influence of social desirability. I added, "I have said something about a friend behind his or her back," into the FSA. An answer of "strongly disagree" would indicate the influence of social desirability on responses.

Procedures

After securing UNCG IRB approval for the study (IRB# 17-0374), a convenience sample of 33 first-year master's students in the Department of Counseling and Educational Development (CED) at UNCG was recruited. After seeking WFU IRB

approval to begin recruitment of a convenience sample of 16 first-year master's students in the Counseling Department there, prior WFU faculty permission to recruit was rescinded by the department (see Addendum A, p. 108), necessitating a recruitment shift. After receiving approval to proceed with the modified study from UNCG IRB, a convenience sample of 25 first-year master's students in the Student Affairs Administration in Higher Education (SAAHE) M.Ed. program in the School of Education at UNCG was recruited.

I presented an in-class recruitment script explaining the study procedures, risks, and benefits to each cohort so that I could address any questions or concerns (see Appendix C: Study Documentation). I described the study as a research study designed to learn about master's students' attitudes. I explained that students who consented to participate and completed all study procedures would receive $10 for completing the initial survey instruments, the pre-reflective journaling, and the face-to-face component of the study, and an additional $10 after completing the post-reflective journaling and post-intervention survey instruments.

For the CED cohort, as I had an evaluative role with the students, I then left the classroom and invited an assistant (a fellow doctoral student not directly involved in the study) to pass out and collect informed consent paper forms and scheduling forms. The assistant gave participants instructions regarding selection of a unique alphanumeric identification code that was used throughout study procedures so that no identifying information was linked to students' submitted responses to study instrumentation (i.e., first two letters of middle name, last two letters of last name, last two digits of zip

code; see Brinker et al., 2014). I used the alphanumeric codes to track responses and analyze study data, and was not made aware of the identities of the participants connected with the codes.

Within 48 hours of consenting to participate in the study, each CED participant received a Qualtrics survey link through their university email account, sent by a fellow doctoral student assisting with the study, in which participants were invited to enter their unique alphanumeric ID code and complete a demographics questionnaire along with the two study instruments, the Toronto Empathy Questionnaire (TEQ) and the Fraboni Scale of Ageism (FSA). My assistant sent two reminder emails, one 48 hours following the initial email, and a second 72 hours following the second email. Responses have been stored in a password-protected UNCG Qualtrics account.

For the SAAHE cohort, as I did not have an evaluative function, after presenting the in-class recruitment script to students in HED 602 (Student Development Theory), I remained in the room to collect informed consent and scheduling forms. Because the instructor on record was also my dissertation co-chair, Dr. Laura M. Gonzalez, I invited Dr. Gonzalez to leave the classroom during recruitment. SAAHE participants were given the same instructions regarding selection of a unique alphanumeric code, and were presented with the same instructions regarding compensation for completing study materials. Within 48 hours of consenting to participate in the study, each SAAHE participant received a Qualtrics survey link through their university email account, sent by the researcher, in which participants were invited to enter their unique alphanumeric ID code and complete a demographics questionnaire along with the two study

instruments, the Toronto Empathy Questionnaire (TEQ) and the Fraboni Scale of Ageism (FSA). I sent two reminder emails, one 48 hours following the initial email, and a second 72 hours following the second email. As with CED responses, SAAHE responses have been stored in a password-protected UNCG Qualtrics account.

Pre-Reflection Activity

Approximately one week after completion of the initial survey instruments, all participants received a Qualtrics survey link through their university email account, in which they were invited to write a 250-500-word online journaling post in response to the prompt, "Today is your 75th birthday. Using first-person, 'I' language, describe your life, your personality, your habits, and your health." Email invitations for the CED participants were sent by an assistant, and email invitations for the SAAHE participants were sent by the researcher. A similar pre-reflective writing activity was used in Brinker et al.'s (2014) study to encourage participants to begin the process of imagining themselves as an older person before they engaged in "The Game of Late Life." Participants in the Brinker et al. (2014) study were asked to write a hypothetical summary of what their life had been like up to the age of 65, and to describe their personality and outlook. Brinker et al. (2014) did not explicitly instruct participants to write from a first-person perspective, only to write a summary of how they imagined their life would be. Directed first-person (i.e., using "I" language) perspective-taking in a reflective writing activity was found to reduce ageist bias in undergraduate psychology students compared to non-directed reflective writing in a study by Galinsky and Moskowitz (2000). In the current study, participants were instructed to respond to the journaling prompt from a

first-person perspective. This pre-reflective journaling activity was designed to spark internal dialogue about students' existing attitudes toward their own aging. Journaling has been recommended as a strategy to set the stage for transformative learning and to support ongoing critical reflection following a disorienting dilemma in other transformative learning interventions (e.g., Berger, 2004; Fazio-Griffith & Ballard, 2016; Gravett, 2004). Respondents used their assigned codes when completing this journaling post in Qualtrics. All pre-reflective responses will remain securely stored within a password-protected UNCG Qualtrics account for future analysis.

Game Play

The second phase of the intervention took place approximately one week after the pre-reflective journaling, outside of class time, on the campus of UNCG. Participants from each cohort were scheduled into smaller groups of 2-4 students and each small group played "The Game of *I am*" (Bailey, 2016c). For the CED participants, game play was led by doctoral and second-year master's students who were trained by the researcher (see Appendix D: Facilitators' Guide). As I served in an evaluative capacity as CED 605 Teaching Assistant for the first-year master's cohort, it was important that students did not feel inhibited or influenced in any way by my presence during game play. Neither I nor any CED faculty was present for the face-to-face component of the intervention. Cherry et al. (2016) suggested that counseling students may be disinclined to admit to biases or prejudicial beliefs for fear of repercussions from faculty and fellow students (2016). Therefore, to foster a safe environment in which students did not feel constrained or at risk for negative evaluations by one of their course instructors, trained

facilitators were used for all face-to-face phases of the study with the students from the CED cohort.

For the participants in the SAAHE cohort at UNCG, since I did not serve in an evaluative capacity, I facilitated game play. As described above, the SAAHE cohort was divided into small groups of 2-5, and game play proceeded as described below (see Appendix D: Facilitators' Guide). All facilitated groups were audio recorded.

Game play occurred on a game board that was created by placing four colored squares (one set for each player) on the floor, all leading to the center of the board. The first player to reach the center of the game board won the game and a small prize (bag of candy). After drawing for order, each student took turns selecting and then reading aloud a prompt, a vignette describing ageist attitudes and behaviors directed toward the vignette protagonist. After reading the prompt, the student was invited to describe their emotional experience from the perspective of the vignette character using "I" language. These instructions were similar to those given in the Brinker et al. (2014) intervention, in which students were told "to explore their experience of, and responses to, life events that they may encounter in late life" (p. 93). Transformative learning researchers have emphasized the centrality of affective experience to transformative learning, including the importance of emotional "buy-in" necessary for perspective transformation (Kitchenham, 2008; Mezirow, 2000; Snyder, 2008; Taylor, 2007).

In collaboration with one another, the other players then discussed whether the active player should move forward, stay in place, or move backward on the game board. Determination of the active player's game movement based on group consensus of the

other players enhanced the competitive nature of the game, a suggested element in maintaining student interest that was made by participants in an initial implementation study (see Initial Implementation Study). Players were instructed to base their decisions on their collective interpretation of both the prompt and the active player's response to the prompt. This collaborative decision-making afforded all players the opportunity to reflect on and discuss both the impact of ageism on older adults and to consider their fellow game players' emotional responses to the prompts. No further instructions for determining game movement were given, aside from reminding the players that game movement was to be determined by group consensus and that, to win the game, a player must reach the center of the game board. Players were instructed that it was *up to them* to determine the final criteria for game movement. This element of game play, in alignment with TLT, was designed to create a learning environment in which students were co-creators of their own knowledge, further enhancing potential perspective shifts and transformation.

Following approximately 30 minutes of play, the player who reached or moved closest to the center of the game board received a small prize (a bag of candy), and then game play ceased.

Next, with the facilitator, each group engaged in group discussion and debriefing (see Appendix D: Facilitators' Guide), in which participants were invited to share their experiences with the game. Because the game was designed to elicit emotional reactions from the players, existing beliefs and biases were shared during the group discussion. Beliefs about aging and attitudes toward older adults could have been challenged by

fellow group members, potentially creating or perhaps enhancing a disorienting dilemma and leading to critical self-reflection (Taylor, 2008). This small group setting allowed for deeper processing of shared experiences, as have comparably-sized groups in similar studies in counselor education (e.g., Lim, 2008; Paredes, 2010). The group discussion and game play were audio recorded. Recording of interviews has been cited as a boon to trustworthiness in qualitative research (Shenton, 2004), and, although this study was quantitative in nature, as Snyder (2008) wrote, "it is difficult to measure the level of transformation among participants when transformation is perceived as an end state" (p. 172). This collected qualitative data will allow for future analysis of the *content* of pre- and post-reflective journals and group discourse to further expand upon the quantitative analysis conducted in this feasibility study. After about 30 minutes of collective discourse, the group discussion ended, and each participant was given $10 in cash for completing the first three elements of the study protocol. All audio recordings of the facilitated game play were uploaded to a password-protected UNCG Box account for future analysis.

Post-Reflection Activity

Approximately a week following participation in "The Game of *I am*" (Bailey, 2016c) and the group discourse, CED participants received a Qualtrics survey link through their university email account, sent by a fellow doctoral student assisting with the study, and were invited to write a second online 250-500-word reflective journaling post. They were asked to respond to the prompt, "How would you feel about working with a 90-year-old client who presents with symptoms of depression?" SAAHE participants

received a Qualtrics survey link through their university email account, sent by the researcher, and were invited to write a second online 250-500-word reflective journaling post. They were asked to respond to the prompt, "How would you feel about working with a 68-year-old student returning to school to complete an undergraduate degree?" This post-activity reflective journal was designed to help students continue to critically question their beliefs about aging and to "grapple with their positions… and…become cognizant of the existence and source of their assumptions" (Meyers, 2008, p. 221). All post-reflective responses will remain securely stored within a password-protected UNCG Qualtrics account for future analysis.

After journaling posts were submitted by participants in both cohorts, all participants received a Qualtrics link through their university email account to complete their post-intervention survey instruments, which were identical to the ones they completed earlier in the semester. An assistant sent emails to the CED participants, and the researcher sent emails to the SAAHE participants. Alphanumeric ID codes were used with these survey responses as well, and survey responses are securely stored in a password-protected UNCG Qualtrics account. All participants received an additional $10 in cash for completing the full study protocol, delivered to CED participants by an assistant, and delivered to SAAHE participants by the researcher.

Later in the semester, after the study was completed, as part of standard coursework in the CED 605 class, all students enrolled in the course received a classroom presentation on ageism and the importance of gerontological competence in counseling. For students in the SAAHE cohort, I have offered an in-class class presentation on

ageism and the importance of gerontological competence in higher education to be conducted in the spring of 2018. During that presentation I will explain more fully the research study intervention and will answer any questions in person or through email communication.

Planned Statistical Analyses

To answer both research questions by measuring changes in pre- and post-intervention test measures for empathy and attitudes toward older adults for both the CED and SAAHE participants, I conducted paired sample *t*-tests with the mean scores on the Toronto Empathy Scale (see Table 4.2; Spreng et al., 2009) and the Fraboni Scale of Ageism (see Table 4.3; Fraboni et al., 1990).

Power Analyses

Using G*Power 3.1 (Faul, Erdfelder, Lang, & Buchner, 2007), an *a priori* power analysis with power set at .80 for a paired sample *t*-test indicated that a sample size of 27 would be needed to detect a moderate Cohen's *d* of 0.5. However, in Pilot Study Two (see Pilot Study Two), I found a small Cohen's *d* for both measures (FSA: Cohen's *d* = .307; TEQ: Cohen's *d* = .346). Two *a priori* power analyses for a paired sample *t*-test with power set at .80 and Cohen's *d* set at .307 and .346 indicated that a sample size of 67 and 54, respectively, would be needed.

Although both the CED and SAAHE participants were included in the main sample of interest for this study, to analyze possible group differences between the two cohorts, I also compared mean differences between the two cohort groups. An *a priori* analysis using G*Power 3.1 (Faul et al., 2007) suggested that for an independent groups

t-test, to reach a power of 0.80 with a moderate effect size (Cohen's $d = 0.5$), I would need a sample size of 102. However, as described in Smith, Constantine, Dunn, Dinehart, and Montoya's (2006) meta-analysis of 37 outcome studies of multicultural education interventions in mental health professions, the average effect size was 0.92 with an average sample size of 58 (*Mdn* = 48; range = 14 to 208). An *a priori* power analysis with power set at 0.80 and a 0.92 effect size resulted in a required sample size of 32.

Addressing Power in Small-Scale Feasibility Studies

Although such a small sample presented potential challenges (e.g., attrition) to statistical power and generalizability of findings, as explained by Bowen et al. (2010), "Feasibility studies are used to determine whether an intervention is appropriate for further testing; in other words…such research may identify not only what—if anything—in the research methods or protocols needs modification but also how changes might occur" (p. 2). Bowen et al. (2010) have suggested that conducting limited-scale experimental feasibility studies, such as the one described here, affords researchers the opportunity to test the potential efficacy of an intervention in a time- and cost-effective manner. Performing such a study may be indicated when "the population or intervention target has been shown empirically to need unique consideration of the topic, method, or outcome in other research" (Bowen et al., 2010, p. 3). As described in Chapter II, the need for well-trained, competent gerocounselors has never been greater, and there is a paucity of gerontological-focused interventions in counselor education. One of the eight key areas of focus for feasibility studies proposed by Bowen et al. (2010) is "limited efficacy," in which researchers investigate whether a new idea, program, or measure

shows promise "of being successful with the intended population" (p. 8). Because the full "The Game of *I am*" (Bailey, 2016c) intervention had not been tested with master's counseling students, this feasibility study was designed to help inform further intervention refinement and future larger-scale studies.

Previous small-scale feasibility studies in which researchers have tested the utility of interventions on enacting behavior change in a target population have represented both innovative uses of existing interventions and pilot testing of newly-developed interventions. Three such studies are described below, providing precedents for proceeding with the planned feasibility study despite the constrained sample.

Precedents for this Small-Scale Feasibility Study

In a pilot study with 29 pediatric medical residents, researchers investigated the feasibility of using a modified communication training protocol to improve the delivery of bad news to patients (Reed, Kassis, Nagel, Verbeck, & Mahan, 2015). The educational intervention, "GRIEV_ING Death Notification Protocol" (Hobgood, Harward, Newton, & Davis, 2005), involved a two-hour educational session including lecture, role play, and group discourse, and had not previously been studied with pediatric residents. Analysis of quantitative assessments indicated significant improvement in communication competence immediately following the intervention and three months after the intervention. Recognizing their small sample as a limitation, the researchers concluded that the pilot test results offered support for further testing of the intervention with larger groups.

Citing the paucity of brief interventions that focused on emotional regulation for individuals experiencing suicidal ideation, Ward-Ciesielski (2013) developed and pilot tested a brief intervention with community dwellers ($N = 18$). In this intervention, participants were taught emotion regulation, distress tolerance, and mindfulness skills, and post-intervention measures indicated a significant reduction in suicidal ideation as well as improved coping skills in the participants who completed all post-intervention measures. Acknowledging the limitations of the small sample size, Ward-Ciesielski (2013) wrote that these preliminary findings "provide(d) an encouraging first step toward further evaluation and development of this intervention" (p. 332).

Burton, Pakenham, and Brown (2010) developed a resilience training program, "READY" (Resilience and Activity for every DaY), as a workplace group-based training. In their pilot study of the READY program, the researchers conducted a single-group pre-post-intervention trial to assess the feasibility of using the program in a workplace setting ($N = 18$). Even with the small sample size and a lack of control group, changes in resiliency scores over the 13-week intervention period indicated potential for the READY program to be implemented in other workplace settings. In the three examples described here, researchers conducted small-scale feasibility studies in order to test existing and newly-developed interventions with targeted populations; to inform intervention refinement; and to support future, larger-scale studies.

These studies are only three of many small-scale feasibility and pilot studies represented in the literature across disciplines that present support for feasibility research with existing and newly-developed interventions. Although feasibility studies conducted

with convenience samples and with limited statistical power (Bowen et al., 2010) can be useful for informing future larger-scale research, challenges to statistical power represent potential limitations to the generalizability of findings of any study, including the one described here, and are acknowledged as a potential limitation (see Chapter V: Limitations).

Pilot Studies

From its inception as an in-class presentation on issues of women at mid-life to its current form, development of "The Game of *I am*" (Bailey, 2016c) has been an iterative, and decidedly non-linear process. In Bartholomew et al.'s six-step Intervention Mapping model, "Each step provides the basis for the next; each step also generates new information that may suggest revision or embellishment of a previous step" (2016, p. 31). The original gerontology-focused game intervention was developed after an initial literature review and implementation study. I conducted a more thorough review of the literature (see Chapter II), engaged in ongoing discussions with my dissertation committee, and solicited feedback from attendees at the presentations where I presented my game intervention. As a result, the intervention developed into a three-part intervention with greater emphasis on critical self-reflection and facilitated group discourse. To more fully refine the intervention before further feasibility testing, two pilot studies were conducted.

Pilot Study One

After reviewing findings from the initial implementation study, feedback on the intervention game from participants at multiple presentations, and input on prompt

content from my dissertation committee, the first pilot study was designed to further refine and support the content validity of game prompts by seeking expert perspectives. Based on Surowiecki's (2004) recommendations for "wise crowds," Jorm (2015) recommended that, for the judgment of expert panels to be the most useful in mental health and medical research, the panel members must have a diversity of experience and expertise, be independent decision makers, and work in a decentralized way and not in a group with other panel members. I solicited expert feedback from a group of six content experts in the fields of gerontology, counselor education, and ageism research. The experts were located in the Northeast, Southeast, Upper Midwest, and the Pacific Northwest in the United States, and were not made aware of the others' recruitment or participation.

In preparation for the first pilot study, I consulted with the UNCG Office of Research Integrity. They informed me that the study was not considered human subjects research per the federal regulations and did not require IRB review (see Appendix E: Pilot Study One Documentation).

I sent each expert an anonymous Qualtrics survey link in which each was invited to use a non-delineated sliding scale (*poor fit* to *good fit*; 1-100) to assess the fit of the 60 game prompts in the four areas of:

> **Content**: How well does the content of the prompt address circumstances/ageist bias typically experienced by adults who are older?

Language: How clear is the language/wording used in the prompt?

Culture: How well does this prompt respect cultural differences?

Disorienting: How well does this prompt encourage critical reflection by challenging stereotypes and highlighting ageism?

Experts also received a word document with the 60 game prompts in which they had the opportunity to comment on and offer specific or more global revision suggestions for the vignettes in an open-ended format. None of the respondents returned this document for feedback. After two weeks, I sent a second invitation to participate. After five weeks, four participants had completed the survey.

Expert feedback and consultation have been incorporated into several stages of intervention development in other studies utilizing the Intervention Mapping (IM) model (Bartholomew et al., 1998). Researchers in the Netherlands (Walters, Dijkstra, de Winter, & Reijneveld, 2015) used IM as a framework for developing a training intervention for home health care workers. The program was designed to train workers to motivate older adults to adopt healthy lifestyle habits. Using the IM model, the researchers described soliciting expert feedback in three of the six stages: (1) conducting a needs assessment; (2) establishing objectives for behavior change; and (4) developing intervention materials. Rothman and Wang (2016) used IM as a framework for developing a hospital-based motivational interviewing intervention to reduce the incidence of adolescent dating

abuse. The researchers reported soliciting expert feedback during two stages of intervention development: (1) conducting the needs assessment and (4) developing the intervention materials. Nursing researchers (Song et al., 2015) used the IM model to develop an intervention to help improve the self-management of diabetes in community dwellers. Song et al. (2015) described soliciting expert feedback during both the needs assessment and the intervention materials development stages.

For this pilot study, I was interested in using expert feedback, combined with the accumulated feedback I have received over the past year of presenting my intervention game, to refine and finalize the game prompts for use in the current feasibility study. Specifically, I wanted to know if the prompts were a good fit with my intervention design in terms of content, language, cultural considerations, and potential for inciting a disorienting dilemma in game players.

Data from the first pilot study are presented in Appendix E. Overall, aggregated expert ratings of the game prompts in the four areas of interest (content, language, culture, disorienting) were high ($\bar{X}$ = 85.41 on a 100-pt non-delineated sliding scale). One expert rated all the prompts very low on the "culture" scale, and offered the feedback, "From my perspective many of the questions were based on outdated stereotypes." I consulted with my dissertation committee and went back and reviewed current literature on the impact and prevalence of ageism. Although there appears to be some increasing emphasis on ageism research and awareness of outdated stereotypes, ageist stereotypes as presented in the game prompts are still prevalent (see Chapter II, Ageism). This participant's response to the stereotypes in the prompts suggests that they

had an impact, albeit in a way that caused the expert to find them culturally insensitive. From the perspective of multicultural and social justice counseling competencies, as well as from my own perspective as a counselor and human being who is growing older, ageist attitudes and behaviors *are* culturally insensitive. Within the framework of TLT and my desire to create a disorienting dilemma during game play, this expert's feedback supports my hypothesis that the blatant ageism represented in the prompts had the potential to be both disturbing and disorienting to study participants.

Other written feedback included a suggestion by one expert to remove one of the two prompts describing ageist language in the context of a car purchase, and the suggestion by another expert to add a prompt that described ageism in the context of caregiving. In response to these suggestions, I added a prompt reflecting ageism in the context of being the caregiver to an older loved one, and removed one of the car purchase-related prompts. The full list of expert-reviewed proposed study prompts can be found in Appendix F.

Pilot Study Two

To test the preliminary effectiveness of the intervention game as a standalone activity using the updated, expert-reviewed prompts, early in the fall 2017 semester, I conducted a second pilot study entitled, "Student Empathy and Attitudes Toward Older Adults in an Undergraduate Gerontology Class Following an In-Class Game Activity." After securing IRB approval (IRB #16-0264) and instructor permission, I recruited from a convenience sample ($N = 18$) of undergraduate students enrolled in a gerontology class (GRO 201: Envisioning Your Old Age) at UNCG on a day the instructor was absent. At

the start of class, I provided students with a verbal consent form (see Appendix H: Pilot Study Two Documentation) describing the study's purposes and procedures, listing the risks and benefits of participation. Students were assured that participation in the study was voluntary, that their instructor would not be made aware of who did or did not choose to participate in the study, and that their decision regarding participation would have no bearing on their grade in GRO 201. I then explained the procedures I would be using to deidentify study artifacts (i.e., having participants select an alphanumeric code for instrument tracking). After I read the consent form to the class, I invited students to ask questions. None were asked. Students who wished to participate in the study ($N = 17$) completed written versions of the TEQ and FSA. I instructed participants to write their self-selected alphanumeric code on their forms, and I collected the completed assessments and invited students to join me in the center of the room for game play.

After I divided the class into four groups, I explained game procedures (see Appendix D: Facilitators' Guide), and students took turns selecting and reading prompts and expressing their initial emotional reactions to the prompts. The other students then collectively determined game movement. The ambiguity of the game play instructions caused the students to ask questions about decision-making during game play, and when I did not offer definitive answers, participants discussed among themselves how they would determine game movement. Students discussed how their own reactions might differ from those of the other students, and some students shared personal stories that were aligned with the themes of the game prompts. In my role as facilitator, I encouraged rich collective discourse by reflecting participants' comments and I linked common

themes that arose from the discussions. I assured the participants that just as there was no "right" emotional response to the prompts, there was also no "right" decision about game movement. In this way, I supported the co-creation of knowledge and the democratization of learning that is key in transformative learning. I intentionally stepped out of my expert role and invited the participants to take ownership of their own learning and their own decision-making. After 30 minutes of game play, I thanked participants, and invited them to return to their seats.

Next, I re-administered the two written measures, once again instructing participants to write their self-selected alphanumeric codes on the forms. I collected completed forms and then opened further discussion about game play and answered questions about the game and my proposed dissertation study. This discussion lasted approximately ten minutes. I then presented a brief lecture about ageism and gerontological competencies in helping professions.

All 17 students who consented to participate in the study completed both the pre- and post-game intervention written assessments. To measure changes in pre- and post-game intervention scores on the FSA and the TEQ, I conducted paired sample *t*-tests using SPSS version 25. Analysis of the collected data indicated that the reduction in self-reported ageism as reported by the FSA was significant ($\alpha = .05$). Improvement in self-reported empathy as reported by the TEQ was also significant ($\alpha = .05$). However, effect size for both was small (FSA: Cohen's $d = .31$; TEQ: Cohen's $d = .35$).

In this second pilot study, I presented the game intervention and did not administer the pre- or post-game intervention reflective journaling components, and

readministered the FSA and TEQ before the ten-minute facilitated group discourse. Because of the short span of time between initial and follow-up administration of the two instruments, I did not expect to see large shifts in attitudes, and it is possible that participants recalled their previous responses. None of the participants' responses to either of the two instruments was identical from pre- to post-game intervention. The largest shift from pre- to post-game intervention measures was a 6-point (10.67%) improvement in empathy in the TEQ for two participants. The largest shift from pre- to post-game intervention for the FSA was a 12-point (9.67%) reduction in ageist attitudes for one participant. In this pilot study, the participants were undergraduate students who were not enrolled in master's-level coursework. These results suggested that the game may have the potential to be a useful, standalone intervention in undergraduate classes, and provided support for further testing. With the addition of the two reflective journaling components and presented within the first semester of a master's program, I anticipated improvements in both the self-reported TEQ and FSA scores from pre- to post-intervention for master's students.

Data from this second pilot study are presented in Appendix I.

Addendum A

To test the efficacy of "The Game of *I am*" (Bailey, 2016c) on enhancing empathy and improving attitudes toward older adults in first-year master's counseling students, I sought permission to recruit students from two CACREP-accredited universities, The University of North Carolina at Greensboro (UNCG) and Wake Forest University (WFU). After securing CED faculty and UNCG IRB approval (IRB #17-0374) to begin study recruitment with CED students at UNCG, I contacted the Institutional Review Board at WFU to secure approval to begin study recruitment with students in the Counseling Department there. Despite having received written and face-to-face faculty permission to recruit at WFU, a key administrator in the Counseling Department at WFU informed me that I would not be allowed to recruit in their department. Because this study was designed to measure changes in empathy and attitudes toward older adults in first-year master's counseling students enrolled in their first semester of coursework, expanding recruitment to the spring 2018 semester or to other counselor education programs was not feasible. Upon consultation with my dissertation committee, I secured permission from faculty and approval from the Institutional Review Board at UNCG to recruit from the M.Ed. program in Student Affairs Administration in Higher Education (SAAHE) at UNCG.

Students in the SAAHE program at UNCG train to become college student support professionals (e.g., academic advisors, Dean of Students, residence life staff). Both student support professionals in higher education and professional counselors share collective roots that go back to the early 20th century. The National Vocational Guidance

Association (NVGA) was founded in 1913, and is considered "the forerunner of the American Counseling Association" (Gladding, 2012, p. 10). In 1952, the American Personnel and Guidance Association (APGA) was established to join "groups interested in guidance, counseling, and personnel matters" (Gladding, 2012, p. 13). The NVGA was one of the four original divisions in the APGA, along with the American College Personnel Association, the National Association of Guidance Supervisors and Counselor Trainers, and the Student Personnel Association for Teacher Education. In 1985, the NVGA became the National Career Development Association (NCDA) and is a current division of the American Counseling Association (Gladding, 2012).

The curriculum of the SAAHE program closely follows the American College Personnel Association/Student Affairs Administrators in Higher Education (ACPA/NASPA) standards, which include professional competency areas that are closely aligned with professional counseling standards such as demonstrating "culturally-inclusive advising, supporting, coaching, and counseling strategies" (Professional Competency Areas for Student Affairs Educators, 2015, p. 37). The program mission of the SAAHE program at UNCG includes promoting "transformative learning…to advance and disseminate cutting-edge knowledge that addresses problems of theory and practice in the fields of higher education and student affairs" (SAAHE, 2017).

This emphasis on transformative learning and a commitment to "holistic, transformative, and integrated learning experiences in colleges, universities, and other postsecondary settings" (SAAHE, 2017) aligned well with my transformative learning intervention. Additionally, both the CED and the SAAHE programs are housed within the

UNCG School of Education. This unexpected shift in recruitment afforded me the opportunity to test the feasibility of using the intervention beyond the confines of counselor education, and to consider the importance of empathy and attitudes toward older adults in the student support professionals who serve them. Therefore, in the revised study, students from both the UNCG CED and SAAHE Departments were recruited.

CHAPTER IV

RESULTS

The initial purpose of this feasibility study was to test the preliminary effectiveness of a transformative learning intervention, "The Game of *I am*" (Bailey, 2016c), on enhancing self-reported empathy and improving self-reported attitudes toward older adults in first-year master's counseling students enrolled in first-semester coursework in a full-time CACREP-accredited counseling program. A second purpose that arose during study implementation was to test the intervention with first-year master's students training to be student support professionals (see Addendum A, p. 108). Results of the study are presented in this chapter, including demographics of study participants, descriptive statistics, and results of the analyses that were used to test the research hypotheses.

Sample

Nineteen CED students and 17 SAAHE students consented to participate in the study. A total of 27 participants completed all study procedures, 14 from the CED cohort and 13 from the SAAHE cohort. Of the entire sample, 23 self-identified as female and four self-identified as male. Ages of participants in the full sample ranged from 22 to 46, with a mean age of 25.86 (median = 24) for CED participants and 23.54 (median = 22) for SAAHE participants. In both the initial and final online surveys, participants were asked to express the likelihood of working with older adults in their professional lives,

choosing from "not at all likely," "a bit likely," "moderately likely," "pretty likely," and "very likely." In the initial pre-intervention survey, 10 participants (~37%) in the full sample of 27 reported "pretty likely," or "very likely." Three (~21%) of the 14 CED participants reported "pretty likely," or "very likely," compared to seven (~54%) of the 13 SAAHE participants. In the final post-intervention online survey, 11 (~41%) of all 27 participants reported "pretty likely" or "very likely," with nine participants expressing greater likelihood and six participants reporting reduced likelihood of working with older adults from initial to final assessment. There was not a statistically significant change in reported likelihood of working with older adults in the full sample ($t = .55$, $p = .59$) or in either the CED or SAAHE cohorts separately (CED: $t = .32$, $p = .75$; SAAHE: $t = .43$, $p = .67$).

Complete demographic data is presented below in Table 4.1.

Table 4.1

Demographic Information for Participants in Full Study

N = 27	*n*	%	*M*	*SD*	*Range*
Age					
Full sample (*N* = 27)			24.74	5.11	22-46
CED	14	52	25.86	6.47	22-46
SAAHE	13	48	23.54	2.88	22-32
Gender					
Full sample					
Female	23	85.2			
Male	4	14.8			
CED					
Female	11	78.6			
Male	3	21.4			

SAAHE		
Female	12	92.3
Male	1	7.7
Race/ethnicity		
Full sample		
Asian	1	3.7
Black/African American	6	22.2
Caucasian/White	19	70.4
Latino	1	3.7
CED		
Asian	0	0
Black/African American	4	28.6
Caucasian/White	9	64.3
Latino	1	7.1
SAAHE		
Asian	1	7.7
Black/African American	2	15.4
Caucasian/White	10	76.9
Latino	0	0

Testing of Hypotheses

All survey responses were visually inspected for outliers and missing data. One participant with missing TEQ and FSA survey responses was removed from the data set. Potential outliers were noted and will be discussed in this chapter. Analyses were completed for each research question and corresponding hypothesis.

Research Question 1: Will participation in "The Game of *I am*" result in significant pre-post intervention mean differences in self-reported empathy as measured by the Toronto Empathy Questionnaire (TEQ; Spreng, McKinnon, Mar, & Levine, 2009) in first-year master's counseling students and SAAHE students?

Hypothesis 1: Participation in "The Game of *I am*" will result in significant pre-post intervention mean differences in self-reported empathy as measured by the Toronto Empathy Questionnaire (TEQ; Spreng, McKinnon, Mar, & Levine, 2009) in first-year master's counseling students and SAAHE students.

To test Hypothesis 1, a paired-sample *t*-test was conducted using SPSS version 25. Mean, standard deviation, and standard error of the mean (SEM) scores can be found in Table 4.2. Test-retest reliability of the TEQ from pre- to post-intervention with the full sample was $r = .757$.

Mean TEQ scores for all 27 participants decreased by 0.63 points from pre-intervention to post-intervention, indicating a slight decrease in empathy for the group. This result was not statistically significant at the .05 level ($t = -.95$; $p = .35$). For the CED cohort, mean TEQ scores decreased by .07 points. For the SAAHE cohort, mean TEQ scores decreased by 1.23 points. Neither of these results was statistically significant at the .05 level (CED: $t = -.11$, $p = .91$; SAAHE: $t = -1.02$, $p = .33$). Of all 27 participants, 14 (~52%) scored lower on the TEQ post-intervention, indicating a statistically non-significant reduction in self-reported empathy for approximately half of the participants. These results may have been influenced by the small sample size, small effect size (Cohen's $d = .25$), low power (.25), and potential ceiling effect. Hypothesis 1 was not supported.

Table 4.2

Toronto Empathy Questionnaire Scores (Score Range from 0-60)

	$\bar{X}$ Pre	SD	SEM	$\bar{X}$ Post	SD	SEM	Diff.
Full (*N* = 27)	50.26	4.88	.939	49.63	5.02	.965	-.63
CED (*N* = 14)	50.29	5.46	1.46	50.21	5.85	1.56	-.07
SAAHE (*N* = 13)	50.23	4.4	1.22	49	4.08	1.13	-1.23

Research Question 2: Will participation in "The Game of *I am*" result in significant pre-post intervention mean differences in self-reported attitudes toward older adults as measured by the Fraboni Scale of Ageism (FSA; Fraboni, Saltstone, & Hughes, 1990) in first-year master's counseling students and SAAHE students?

Hypothesis 2: Participation in "The Game of *I am*" will result in significant pre-post intervention mean differences in self-reported attitudes toward older adults as measured by the Fraboni Scale of Ageism (FSA; Fraboni, Saltstone, & Hughes, 1990) in first-year master's counseling students and SAAHE students.

To test Hypothesis 2, a paired-sample *t*-test was conducted using SPSS version 25. Mean, standard deviation, and standard error of the mean (SEM) scores can be found in Table 4.3. Test-retest reliability of the FSA from pre- to post-intervention with the full sample was $r = .734$.

Mean FSA scores for all 27 participants decreased by 1.48 points from pre-intervention to post-intervention, indicating a slight improvement in attitudes toward older adults for the full group, but this improvement was not statistically significant

(t = -1.3; p = .21). For the CED participants, mean FSA scores decreased by 3.29 points, but this improvement in attitudes was not statistically significant (t = 1.7; p = .11). For the SAAHE participants, mean FSA scores increased by .47 points, but this slight negative shift in attitudes was also not statistically significant (t = -.33; p = .75). The lack of significance for the full group may have been influenced by low sample size (n = 27), small effect size (Cohen's d = .171), and low power (0.21).

Additionally, there were several outliers in terms of FSA score shifts in the full sample. Four of the 27 participants' scores shifted 12 to 15 points (i.e., -15, -12, +14, +15). When these outliers were removed, the mean shift in attitudes for the remaining 23 participants was -1.83 points, and this improvement in attitudes toward older adults was statistically significant at the 0.05 level (t = -2.57; p = .017). After removing outliers, Hypothesis II was supported. However, when considering the FSA scores from the full sample, Hypothesis II was not supported.

Table 4.3

Fraboni Scale of Ageism Scores (Score Range from 29-116)

	$\bar{X}$ Pre	SD	SEM	$\bar{X}$ Post	SD	SEM	Diff.
Full (N = 27)	51.37	8.17	1.57	49.89	9.16	1.76	-1.48
CED (N = 14)	52.29	7.53	2.01	49	9.21	2.46	-3.29
SAAHE (N = 13)	50.38	9.01	2.5	50.85	9.39	2.6	.47

Assessing Inattentiveness and Social Desirability

Because inattentive or careless responses can obscure results in research studies utilizing self-report measures (Maniaci & Rogge, 2014; McKibben & Silvia, 2015), I integrated directed response items into both assessment instruments. To the TEQ, I added, "I read instructions carefully. To show that you are reading these instructions, please answer 'never.'" To the FSA, I added, "I read instructions carefully. To show that you are reading these instructions, please answer 'strongly agree.'" Across both instruments, all 27 participants followed directions and answered "never" and "strongly agree" as directed, indicating attentiveness by all participants.

To test for social desirability in responses, I added one item from the Balanced Inventory of Desirable Responses (BIDR; Paulhus, 1984) to both the TEQ and the FSA. I added, "I never regret my decisions" into the TEQ. An answer of "always" would indicate the influence of social desirability. None of the 27 participants answered "always." To the FSA, I added, "I have said something about a friend behind his or her back." An answer of "strongly disagree" would indicate the influence of social desirability on responses, and of the 27 participants, none answered "strongly disagree." This suggests that social desirability was not a strong influence on the participants' responses.

Differences Between the CED and SAAHE Cohorts

To consider the differences in pre- and post-intervention instrument score changes between the two groups of participants, I conducted independent groups *t*-tests using SPSS version 25. There was not a significant difference in changes in TEQ scores for the

CED ($\bar{X}$ = -.07, SD = 2.37) and SAAHE ($\bar{X}$ = -1.38, SD = 4.3) participants; $t(25) = .99$; $p = .33$. There was also not a significant difference in changes in FSA scores for the CED ($\bar{X}$ = -3.29, SD = 7.16) and SAAHE ($\bar{X}$ = .46, SD = 4.93) participants; $t(25) = -1.57$; $p = .13$). As predicted in Chapter III, using G*Power 3.1 (Faul, Erdfelder, Lang, & Buchner, 2007), a *post hoc* power analysis for an independent samples *t*-test for the two groups on the TEQ indicated low power and low to moderate effect size (α = .16; Cohen's $d = .38$). For the independent sample *t*-test for the two groups on the FSA, an analysis using G*Power 3.1 resulted in low power and a moderate effect size (α = .33; Cohen's $d = .61$).

CHAPTER V

DISCUSSION

In Chapter II, I highlighted the potentially devastating effects of ageism on older adults (e.g., Levy et al., 2009; Tomko & Munley, 2012), described the need for addressing age as a cultural consideration in counselor education, and provided support for a link between empathy and attitudes toward older adults. I explained my rationale for developing a creative, transformative learning intervention to enhance empathy and improve attitudes toward older adults and described intervention development using Bartholomew, Parcel, and Kok's Intervention Mapping (IM) model (1998, 2011). In Chapter III, I presented data from an initial implementation study and two pilot studies. My intention in conducting this feasibility study was to test the preliminary effectiveness of "The Game of *I am*" (Bailey, 2016c) with first-year master's counseling students, and I hypothesized that participants would demonstrate enhanced empathy and improved attitudes toward older adults following the intervention. Following an unexpected shift in recruitment, I expanded the study to include students training to be student support professionals in the M.Ed. program in Student Affairs Administration in Higher Education (SAAHE) at UNCG. This chapter provides a summary of study findings, including facilitators' observations, comparison with other studies, implications for professional practice, study limitations, and suggestions for future research.

Summary of Study Findings

Using my three-part transformative learning intervention, "The Game of *I am*" (Bailey, 2016c) in this small-scale quasi-experimental feasibility study, I tested the efficacy of the intervention at enhancing self-reported empathy and improving self-reported attitudes toward older adults with first-year master's students training to be counselors and student support professionals. As reported in Chapter IV, there were not the statistically significant shifts in empathy and attitudes that I predicted, and therefore neither of my hypotheses was supported. Because this feasibility study was quantitative in nature, I conducted paired-sample *t*-tests and independent sample *t*-tests. I did not analyze data collected from online journaling or the face-to-face game play or group discourse for this dissertation study, so qualitative evidence of transformation that may be present in the written or recorded artifacts is not presented in this analysis. However, later in this chapter I will share some of what I and the other facilitators witnessed in our facilitation of the participants' game play and discussions. Suggestions for future analysis of collected data as well as future studies will be presented later in this chapter as well.

Overall, pre- and post-intervention TEQ scores were essentially unchanged, with approximately half of the 27 study participants demonstrating a slight, statistically nonsignificant downward shift in empathy after the intervention. Attitudes toward older adults as measured by the FSA improved slightly for the full sample, although for the SAAHE cohort, FSA scores indicated a slight negative shift in attitudes following the intervention. None of these results was statistically significant, and these results may have been influenced by the small sample size, low power, and small effect sizes found in

the study. Despite these challenges, as explained by Bowen et al. (2010), "Feasibility studies are used to determine whether an intervention is appropriate for further testing…[to] identify not only what—if anything—in the research methods or protocols needs modification but also how changes might occur" (p. 2).

Although there was not a significant improvement in empathy or attitudes toward older adults following the three-part intervention, by conducting this study, I was able to test the potential efficacy of the intervention in a time- and cost-effective manner for the first time with first-year master's students across two academic disciplines. In doing so, I gained invaluable knowledge about the administration and delivery of the intervention. As reported previously, Snyder (2008) suggested that capturing the process of transformation within the course of one semester was unlikely, and that the *content* and *context* of discussion might be more useful in gauging the process of transformation as opposed to quantitative self-report measures such as those used in this study. However, because the purpose of the intervention was to positively influence self-reported empathy and attitudes toward older adults as measured by the TEQ and FSA, it is essential to consider aspects of the intervention that could have influenced the lack of statistically significant findings. One area for such exploration lies with the observations by those who facilitated game play and group discourse.

Facilitators' Observations

In debriefs with the CED facilitators and reflecting on my experience as facilitator for the SAAHE face-to-face game play groups, it appears that many participants had visceral reactions to the ageist prompts, such as shaking their heads and furrowing their

brows. Many players appeared willing to immerse themselves into game play and imagine themselves as an older person on the receiving end of ageism. Many participants mentioned being surprised at how much the game affected them on an emotional level, as they were exposed to a form of prejudice to which they had formerly been less familiar. Some participants expressed surprise that playing a game could stir up so much emotion, and, overall, game players seemed willing to be vulnerable as they shared their reactions. Stories of parents, grandparents, and other loved ones who had been the targets of ageism were shared. Two SAAHE participants told me that, after playing the game, they felt led to phone their grandparents to check on them. Several participants said that the game play was fun, and that they were glad they were participating in the study. From an empathy-building perspective, in the room with the SAAHE participants, this seemed to be a positive outcome of the intervention, as participants appeared to have developed a clearer picture of the reality of life as an older adult and seemed to have developed greater empathetic awareness.

Although there seemed to be evidence of increased ageism awareness and empathy by many participants in the face-to-face game play, according to the CED facilitators, some participants in their groups were more focused on game strategy than on engaging with the examples of ageism presented in the prompts. One CED facilitator explained that, in her group, the participants remained confused about the rules of game movement. As described in Chapter III (see Intervention Development), in keeping with TLT, the rules for game play were left deliberately ambiguous to foster participants' ownership of their own decision-making, thereby creating a democratized learning

environment, believed to be essential in transformative learning. In the SAAHE groups, I observed some minor confusion at the beginning of game play, but, after a few minutes, players seemed to take charge and focus on the prompts and not the rules. However, in both the CED and SAAHE groups, the potential distraction such ambiguity may have presented could have had an effect on participants' engagement in the process of developing empathetic awareness during game play. Future analysis of audio recordings may provide greater insight into further intervention refinement. Comparison with prior studies may also prove useful in understanding and hypothesizing what may have influenced the outcome of this study.

Comparison with Prior Studies

Similar perspective-taking interventions have been used successfully to enhance empathy in medical students, undergraduate students, and master's counseling students (e.g., Block-Lerner et al., 2007; Junn et al., 1995; Rapisarda et al., 2011), including my second pilot study with gerontology undergraduate students (see Pilot Study Two). In that study, in which only the face-to-face game play was presented, improvements in scores on both the TEQ and FSA were statistically significant at the $\alpha = .05$ level (TEQ: $p = .036$; FSA: $p = .044$). The slight decrease (albeit a statistically nonsignificant one) in overall empathy as measured by the TEQ in the current study as well as a nonsignificant improvement in attitudes toward older adults as measured by the FSA was surprising. Several possible reasons for the lack of statistically significant findings are presented below.

The Impact of Time

In the second pilot study that I conducted with gerontology undergraduate students (see Pilot Study Two), participants completed their post-intervention TEQ and FSA instruments immediately following the face-to-face game play, and there were statistically significant changes in both the TEQ and FSA. In the current study, what might have happened if the TEQ and FSA had been administered in the room immediately following game play? Is it possible that what was witnessed in the face-to-face interactions with participants was representative of genuine emotional reactions and increased empathetic awareness, and that the lack of statistically significant findings in this study was as much an indicator of the difficulty of *measuring* empathy and attitudes as it was reflective of flaws in the intervention? The delay in measurement of empathy and attitudes in this study also meant that participants were closer to the end of a busy semester, during which stressors such as final projects and exams may have become more salient. The timing of instrument administration is important to consider going forward with intervention refinement. For this study, which was temporally restricted, such an impact could not be avoided; however, to continue to improve and refine the intervention, it is important to look more closely at the elements of the intervention itself.

Inadvertent Pathologizing?

Brinker et al. (2014) investigated the impact of a role-play intervention on undergraduate psychology students' attitudes toward aging. The researchers described their intervention, which included a pre-reflective journaling activity, as presenting a more balanced view of later life than more deficit-focused perspectives offered by other

aging role-play activities. According to Brinker et al. (2014), activities such as the "Aging Game" (McVey et al., 1989; Pacala et al., 2006) and the wearing of "aging suits" portrayed a one-sided view of getting older, highlighting physical declines and social isolation and ignoring the resilience and creativity that can come with advanced age. Influenced in part by their research as well as research by Galinsky and Moskowitz (2000), during intervention development I integrated pre- and post-reflective perspective-taking journaling activities into "The Game of *I am*" (Bailey, 2016c) to provide participants with an immersive activity prior to and after the face-to-face game play and group discourse. In keeping with Galinsky and Moskowitz's (2000) research on the impact of *first-person* reflection on improving attitudes toward older adults, I instructed participants to write both the pre- and post-reflective journals in first-person language. However, in reflecting on the prompts used in the face-to-face game for this study, I wonder if the fact that all the prompts represented examples of *negative* age-related biases directed toward elders might have portrayed aging in a more negative light than I intended.

In Brinker et al.'s (2014) study, players moved around a game board and landed on "life events" spaces, in which players individually and collaboratively *interpreted* the impact of events such as divorce and taking care of grandchildren. More positive interpretations resulted in players moving away from "The End" (i.e., death) and more negative interpretations resulted in players moving closer to "The End." Attitudes toward older adults were significantly improved following the pre-reflective perspective-taking journaling activity and game play. In "The Game of *I am*" (Bailey, 2016c), however, all

the game prompts represented examples of ageism directed toward older adults. Although interpretation of emotional reactions to the prompts was left up to game players, all the prompts represented relatively unpleasant interactions with others. It is possible that by associating older adulthood with such negative interactions, participants reacted as terror management theorists (Bodner, 2009; Martens et al., 2005; Solomon et al., 2000) might predict, by moving *away* from and "othering" the feared target (the older person). Did this reaction impede potential increases in empathy? Additionally, did the negative association between ageism and older adulthood impact the attitude scores on the FSA? Even with the slight reduction in ageism across the full sample, is it possible that by presenting participants with a host of ageist scenarios, improvements in attitudes were stunted? In other words, when it came to enhancing empathy and improving attitudes, did my intervention backfire?

A Backfire Effect? Time to Backtrack?

In her dissertation research, Tse (2014) discovered the potential for a backfire-effect of perspective-taking empathy interventions when those interventions only focused on the *disadvantages* of racial minority status individuals, leading to racial majority status individuals feeling pity toward and a lack of respect for minority targets. In three related experiments, Tse found that when White subjects were presented with information on the *disadvantages* of Black individuals, and were then asked to take the perspective of those individuals, they were more likely than control groups to view the Black targets with paternalistic prejudice. This was reflected in lower ratings of Black targets' competence and warmth. By presenting White subjects with a deficit-focused portrayal of

a Black target and then asking them to take the perspective of that target, White subjects felt pity and less respect toward the Black target. Even though the current study was focused on older adults as minority status individuals, the findings of Tse's research offer an alternative perspective to possible intervention refinement. They also present a contrasting perspective regarding one change made to the intervention during the intervention development process as reported in Chapter III.

During the early stages of intervention development, "The Game of *I am*" (Bailey, 2016c) prompts included both an example of ageist language or behavior *and* a possible response. These prompt responses were intended to reflect either more adaptive or maladaptive reactions to ageism. For example, a more maladaptive prompt response might be, "When I took out my checkbook to pay for my groceries, someone behind me in line mumbled 'old fart.' I kept my head down, wrote the check as quickly as I could, and rushed out of the store with my bags, vowing to avoid that store in the future." An alternative more adaptive prompt response might be, "When I took out my checkbook to pay for my groceries, someone behind me in line mumbled 'old fart.' I turned my head, smiled at the speaker, and said, 'You're in a hurry today. I'll be done in a moment.' I then completed my transaction, smiled again at the speaker, and walked confidently to my car."

At conferences where I presented my game, several attendees suggested that I remove pre-scripted prompt responses and instead allow game players to come up with their own responses. In response to these suggestions, and in keeping with TLT, to better foster co-creation of knowledge and enhance personal awareness of existing beliefs, the

game prompts used in the current study were rewritten *without* responses. Without a pre-scripted response, players could respond in ways that felt more authentic to their own experiences and perspectives. In the current study, therefore, participants' emotional reactions were self-generated in response to an ageist prompt in which the players behaved as if they were the recipient of ageist comments or behaviors. Using Tse's (2014) research to consider the results of the current study, by highlighting the *disadvantaged* status of minority status individuals (older adults), instead of engendering greater empathy and more positive attitudes, the face-to-face game play prompts may have caused players to have more pity and less respect for older adults. Without pre-scripted adaptive responses to ageism, players were not presented with illustrations of elders responding to prejudice in positive, empowered ways, but only with examples of elders on the receiving end of ageist language and behaviors.

Robert Butler wrote, "the status of older persons and our attitudes toward them are not only rooted in historic and economic circumstances. They also derive from deeply held human concerns and fears about the vulnerability inherent in the later years of life" (Bernstein et al., 2006, p. 1). In reflecting on Butler's words, terror management theory (Martens et al., 2005) offers a useful theoretical framework with which to consider the impact of the intervention on both participants' TEQ and FSA scores.

Considering the Study Through a TMT Lens

According to terror management theorists (Bodner, 2009; Martens et al., 2005; Solomon et al., 2000), when faced with mortality reminders, we are more likely to hold negative biases toward those who are different than we are, whether those differences are

racial, physical, religious, or chronological (Martens et al., 2005). In the current study, game players were instructed to take the perspectives of elders on the receiving end of (and therefore by their very chronology *inherently vulnerable to*) ageist comments and behaviors and then process their emotional reactions to the prompts as if they were older adults. This required some vulnerability on the part of game players, and overall (see *Facilitators' Observations*, p. 115), participants seemed to embrace the challenge. In facilitating game play and post-game play discussion with the study participants, the facilitators and I witnessed what appeared to be profound emotional reactions by players who were adept at responding *as if* they were marginalized older adults. In this study, empathy was defined as imagining, co-experiencing, and sensing the undeclared feelings and thoughts of another. Participants in the game play and facilitated discourse appeared to be doing just that, connecting empathetically with the lived experiences of older adults and coming to understand that they, too, would one day be older adults. However, this observed empathetic reaction was not borne out in the post-intervention TEQ and FSA scores.

Viewing the study findings through a TMT lens, might stepping into such a feeling state and connecting that state with loved ones (and with one's future self) have triggered death anxiety in some participants? Instructed to respond to the pre-reflective journaling and game play prompts from a first-person perspective, participants were asked to engage in both cognitive (imagining the emotional experience of another through perspective taking) and affective (co-experiencing what another is feeling) empathy (Trent et al., 2016). Perhaps as participants became open to the impact of

ageism on older adults, and then connected ageism's impact to the lived experience of loved ones who are growing older, death anxiety was triggered. Additionally, describing how one would feel as the *target* of negative age-related stereotypes and the recipient of ageist comments and behaviors, could have further triggered participants' death anxiety. This could have sparked fear in participants and a need to create a buffer between self and *self as older*. According to TMT theorists (Martens et al., 2005), avoidance of, repulsion by, and prejudice toward older adults has been hypothesized as a way to manage death anxiety. By stereotyping elders as being different, one can create the illusion of distance and guard against, at least temporarily, the threat of one's own mortality (Bodner, 2009). Considering the results of the current study through this lens, perhaps instead of enhancing empathy and improving attitudes, the opposite occurred, at least in some participants. By inviting participants to tap into the current reality of older loved ones and the potential reality of their future selves as vulnerable to ageist comments and behaviors, fears may have been triggered and buffers engaged.

Perhaps, to integrate findings from both Tse (2014) and TMT researchers, a future iteration of "The Game of *I am*" (Bailey, 2016c) could include the current game prompts with the addition of more positively framed prompts representing scenarios in which elders are treated with respect rather than dismissal or contempt. Additionally, reintegrating prompts that incorporate possible *reactions* to ageism would provide players with examples of how older adults might respond. Such examples of potential responses, both adaptive and maladaptive, could offer game players a broader view of possible responses to ageism. Perhaps a blend of these three prompt styles could prove useful in

future intervention development. Additionally, perhaps a closer look at perspective taking in this intervention may provide further insights into intervention refinement.

Refining Perspective Taking

During intervention development, one addition that I made to the full intervention was inspired by Galinsky and Moskowitz (2000), who explored the role of perspective taking on reducing ageist bias in undergraduate students. They found that students who wrote a descriptive essay about an older person using first-person language demonstrated a reduction in ageist bias compared to a control group that used third-person language. However, Skorinko and Sinclair (2013) conducted a series of experiments based on Galinsky and Moskowitz's research and found that participants who were asked to take the perspective of an *unambiguously stereotypical* outgroup member (e.g., an older frail-appearing man in a hospital bed) were more likely to engage in stereotyping than those who were asked to take the perspective of a more *stereotypically ambiguous* outgroup member (e.g., an older man sitting on a bench, as in Galinsky and Moskowitz's experiment). Taking the perspective of an older target who fit common stereotypes about older adults (e.g., ill, weak, incompetent) triggered increased stereotyping, whereas taking the perspective of an older target who was portrayed as more neutral did not.

Although neither of the reflective journaling prompts used in the current study presented a stereotypically unambiguous target, by participating in face-to-face game play, participants were presented with more stereotypically unambiguous presentations of older adults as being disrespected victims of prejudice. As discussed previously, all the game prompts used in the current study presented older adulthood as a time of

unrelenting ageism, which could be interpreted as a stereotypically unambiguous representation of older adults. The increase in paternalistic prejudice demonstrated by those exposed to more stereotypically unambiguous targets in Tse's (2014) study may help explain what occurred in the current study.

The results of the current study lend support for the findings of the research by both Tse (2014) and Skorinko and Sinclair (2013). When presented with a negative stereotype, subjects instructed to take the perspectives of those targets may have exhibited greater bias rather than less. Perhaps this, along with the perspectives offered by TMT, may help explain the lack of statistically significant improvements in empathy and attitudes toward older adults in this study and may help in intervention refinement for future research. However, even though the scores from the TEQ and FSA were not indicative of transformation in empathy and attitudes, according to some TLT theorists, it remains possible that transformation *did* occur, and that by analyzing the qualitative artifacts collected throughout this study, evidence of attitude and empathy shifts may become apparent.

Considering the Study Through a TLT Lens

According to transformative learning theory, in the face of a disorienting dilemma, learners may be led to examine and critically reflect on their beliefs and assumptions, which ultimately shape their concept of self, identity, and orientation to their inner and outer worlds (Jaruszewicz, 2006). In the first part of the current study intervention, to initiate a disorienting dilemma, participants were instructed to take the perspective of themselves as an older adult in their pre-reflective response to a journaling

prompt. Next, during game play, a second potentially disorienting dilemma was presented to participants when they were invited to take the perspective of an older adult targeted by ageism. As described in Chapter III (see Pilot Study One), the prompts used in the game were deemed impactful and disorienting according to the panel of experts who gave feedback on the prompts. However, it is possible that, despite the observed emotional reactions and engagement by many of the participants, described by some TLT researchers as central to the process of transformative learning (Kitchenham, 2008; Mezirow, 2000; Snyder, 2008; Taylor, 2007), the pre-reflective journaling prompt and/or the game prompts may not have represented a true disorienting dilemma for some participants.

According to TLT, the process of transformative learning begins after a challenge to existing worldviews (Taylor, 2008), and is best supported by educators and facilitators who serve as *provocateurs*, engaging learners in interactive experiences that call for group discourse and problem-solving as well as critical reflection and autonomous thinking (Slavich & Zimbardo, 2012). Within a culture of safety, transformation can take place and is supported through building trusting relationships and developing openness and self-confidence (Taylor, 1998). In the current study, facilitators were instructed to foster a non-hierarchical environment of safety and support and "to maintain a healthy group dynamic in which all participants' voices [were] offered ample space to be heard" (see Appendix D: Facilitators' Guide, p. 227). Until qualitative data is analyzed, I can only hypothesize about whether or not this was the case in all facilitated groups. It will be

important to assess recorded data in order to develop the most effective model for group facilitation that will best support safety, engagement, and transformation.

In the face-to-face game play, facilitators were encouraged to allow participants to express their honest emotional reactions to the prompts and to collaboratively determine game movement. This was in keeping with TLT's egalitarian approach to learning and was designed to support active discourse regarding learners' feelings as well as their cognitions (Taylor, 2008). Presenting participants with ambiguous instructions about how to determine game movement was intended to offer players greater ownership of game play, but, as mentioned earlier, for some participants, this may have hampered deeper emotional connection with the prompts. In reflecting on my own facilitation experiences as well as in debriefs with other facilitators, it does appear that the open-ended discussion prompts (see Appendix D: Facilitators' Guide) sparked participants' engagement in rich collaborative discourse and post-game processing, but this too presents an area for further analysis.

Limitations

There were limitations to this study that are important to consider. Because I served in an evaluative role as CED 605 Teaching Assistant for the first-year master's counseling cohort, I recruited master's and doctoral CED student facilitators to distribute online survey instruments and lead the face-to-face component of the intervention with the CED participants. In the informed consent, I clarified that I would not be aware of who participated in the study, and that all assessment and narrative artifacts from the study would be deidentified before submission. Even so, it is possible that my

relationship with students in the CED 605 class could have had an impact on students' decisions to participate in the study and may have influenced their responses to the survey instruments, pre-reflective journaling, group dialogue during the face-to-face facilitated group discourse, post-reflective journaling, and post-intervention survey instruments.

The study had several components. In addition to the online pre- and post-intervention surveys, the intervention was conducted in three parts, with two online journaling activities, and a one-hour face-to-face activity. Because of the demands of the study, I offered cash incentives at two different time points to encourage completion of all study procedures (see Procedures), but participant attrition still occurred. Additionally, the face-to-face facilitated game play was time-limited and students who were unavailable to participate on those days were not included in the study.

The full study protocol lasted seven weeks, from the time I received initial UNCG IRB approval to begin recruitment until the final online surveys were completed. Because I wanted to study first-year master's students enrolled in their first semester of graduate school, recruitment and intervention delivery had to occur in the first semester of the 2017-2018 academic year, and, within the limited time frame of a 15-week semester, this posed a logistical challenge to recruitment, especially after I was denied recruitment access at a second university. With more time, I might have sought and been given permission to recruit participants from other counselor education programs, which could have resulted in a larger number of participants. With a larger sample, statistical power

could have been enhanced and the study might have resulted in statistically significant findings.

Because the study design necessitated using trained facilitators to lead the CED groups, I developed a facilitators' guide, with which I trained facilitators for this study (see Appendix D: Facilitators' Guide). Even with the manualized training protocol, however, because the CED groups were facilitated by four different facilitators and I facilitated all the SAAHE groups, consistency across face-to-face groups may have been threatened. Additionally, because I developed the intervention and had many opportunities to conduct the face-to-face game play activity, it is possible that my familiarity with the game influenced players' experience with the game as well as their responses. Future analysis of audio transcripts from game play will provide useful data in considering future administration of the intervention.

I recruited participants from two master's programs that utilize a cohort model, both located within the School of Education at UNCG. The full participant pool was somewhat homogeneous, mostly White (70.4%), and mostly female (85.2%), which could reduce the generalizability and transferability of study findings. Additionally, because the study was conducted within a CACREP-accredited counselor education department and the SAAHE program that closely follows the American College Personnel Association/Student Affairs Administrators in Higher Education (ACPA/NASPA) standards, study findings may not be generalizable to programs that do not adhere to such standards and programs that do not utilize a cohort model. Although both programs reside within the UNCG School of Education, there are differences in

coursework in each department, and those differences were not considered in data analysis for this study. However, to consider the differences between cohorts in pre- and post-intervention measures, I conducted an independent groups *t*-test (see Chapter IV). As predicted in Chapter III, this analysis was underpowered, increasing the risk of a Type-II error. The absence of a control group further restrained the potential generalizability of research findings in this study.

It would most likely be impossible to completely isolate the empathy and attitude changes that occurred throughout the study from the changes that occurred as part of the transformative process of being in graduate school. Because the experience of being in graduate school has been named as a potentially disorienting dilemma for students by some researchers (Mezirow, 2000; Provident et al., 2015), this may have had an impact on assessment measures as well as empathy development and attitude shifts in the first-year graduate students in this study. Graduate students are likely to experience high levels of stress and anxiety (Garcia-Williams & Moffitt, 2014), and may be especially vulnerable to depression and burnout. In this study, end-of-semester fatigue may have been heightened by stressors such as final exams and projects (Eisenberg, Gollust, Golberstein, & Hefner, 2007), as the post-intervention measures were completed approximately three weeks before the semester ended. Additionally, exposure to professional counseling and higher education standards as well as multicultural, social justice, and advocacy competencies as part of first-year, first-semester coursework may have affected student development of empathy and attitudes, perhaps leading to empathy fatigue. Stebnicki (2008) has argued that counselors who have completed their graduate

training in programs that are nationally accredited (i.e., CACREP) may be especially vulnerable to "empathy fatigue because the concept and practice of empathy is inherent in various parts of the curriculum" (p. 23). Perhaps a "perfect storm" of mid- to late-semester stressors, the disorienting dilemma of being a first-year graduate student, and the focused attention on empathy as central to competent practice in professional helpers was reflected in the reduction of measurable empathy in this study. For CED participants, the end of the first semester also marked a significant transition in their graduate experience from engaging in counselor role play with their peers to seeing clients in the department's training clinic. Anticipation of this role shift may have added to end-of-semester stress for the CED participants.

Another limitation of this study may lie with the process of transformation itself and the time limitations of this study. In her analysis of ten TLT studies, Snyder (2008) maintained that, for research on transformative learning interventions, attention to the centrality of discourse and context to the process of transformation must be given. Snyder also cautioned, "it seems unlikely that transformation can be prompted and brought to fruition within the span of one semester" (2008, p. 176). In the current study, Snyder's prediction seems to have been supported, at least in terms of *measurable* transformation. Areas for future study will include examining the *content* of the collected data from pre- and post-reflective journaling and group dialogue, as well as conducting larger-scale, longitudinal random-control studies on the long-term effects of "The Game of *I am*" (Bailey, 2016c) on self-reported empathy and self-reported attitudes toward older adults in students throughout their master's programs and into their post-graduate professional

lives. Observational studies in which student and professional *behaviors* toward older clients are evaluated after participating in "The Game of *I am*" (Bailey, 2016c) represent another area for future study.

As with any self-report data, responses to the TEQ and FSA were potentially vulnerable to social desirability bias. The addition of one item from the Balanced Inventory of Desirable Responses (BIDR; Paulhus, 1984) to both the TEQ and the FSA was designed to test for social desirability in responses. In both pre- and post-intervention measures, participants' responses to these items indicated that social desirability was not a strong influence on survey responses. Also, rather than comparing raw scores between individuals in this study, measuring change over time further reduced the potential effect of social desirability on instrument administration (Jones, Sander, & Booker, 2013).

In research studies utilizing self-report measures, inattentive or careless responses can obscure results (Maniaci & Rogge, 2014; McKibben & Silvia, 2015). To assess respondent attentiveness, I integrated directed response items into both the TEQ and FSA. Survey responses to these items in both pre- and post-intervention measures indicated respondent attentiveness. However, the potential for both inattentiveness and social desirability bias cannot be ignored in any study using self-report survey data.

It is important to note that the TEQ was not developed as a gerontology-specific instrument. In the literature to date, researchers who have investigated the effectiveness of interventions at enhancing empathy and improving attitudes toward older adults (see Chapter II: Empathy Enhancing Interventions, p. 46) have used a variety of empathy assessment instruments, none of which has been specifically designed to measure

gerontological empathy. Development of a psychometrically-sound empathy instrument that measures empathy toward adults who are older represents an area for future research.

Implications for Professional Practice

Counselor educators serve an important role as gatekeepers to the counseling profession, monitoring student development and training counselors who are multiculturally competent and able to serve an increasingly diverse society (McCaughan & Hill, 2015). As reported in Chapter II, even though multicultural competencies have remained at the forefront of the ethical standards in counseling and CACREP requirements in counselor education, emphasis on *age* as a cultural consideration within counselor education has been inconsistent and research on enhancing empathetic awareness and improving attitudes toward older adults in master's level counseling students has been sparse.

The current increase in chronological diversity, named by some as a "longevity revolution" (Butler, 1969; Fullen, 2016), has also had an impact on higher education. According to a 2009 report by the *Chronicle of Higher Education*, nontraditional adult learners 25 and older will be the fastest growing market in higher education, and, as adults continue to work well into their 60s and 70s, career shifts in later adulthood will become more common, leading to enrollment in postsecondary and postgraduate education (DiSilvestro, 2013; Kasworm, 2008; Wolf, 2009). Similar to the focus on multicultural competencies in counselor education, post-secondary institutions have also made great strides in encouraging racial, ethnic, and socioeconomic diversity in their enrollment. To date, however there has been limited focus in higher education on

encouraging and supporting the retention and success of older students (Chen, 2017; DiSilvestro, 2013; Kasworm, 2010). Additionally, there is a paucity of research on the experience of older students and the presence and impact of ageism in higher education (Chen, 2017).

Since Mezirow's transformative learning theory emerged from witnessing his own wife's return to college as a non-traditional, middle-aged student in the 1970s (Brown & Brown, 2015; Mezirow, 1978), adult learners have comprised a growing segment of college students. Often referred to as "non-traditional," students who are older than the more typical 18-24-year-old student may feel marginalized by that moniker, feeling like, as one author wrote of her own experience returning to school 35 years after completing her master's degree, "a fish out of water, out of time, out of place" (Colvin, 2013, p. 19). Even so, older students represent a rapidly growing segment of enrolled college students, and this is predicted to continue as age demographics continue to shift (van der Werf & Sabatier, 2009). For student support professionals in the 21st century, a "typical" college student may become increasingly difficult to define, and being well-versed in the distinct cultural considerations of older students will be essential for culturally competent practice.

Unlike more traditionally-aged college students who enter postsecondary education immediately following high school, entry into higher education in mid- to late-life may occur in response to a disorienting dilemma such as divorce, job loss, children leaving the home, a decision to work in a new field, or other factors (Brown & Brown, 2015; Kasworm, 2008). Degree-seeking older students who are parents, breadwinners,

and caregivers for older family members can experience a sense of biculturalism or "role strain" as they navigate their many roles (Brown & Brown, 2015; Chen, 2017). For older students who have left careers and lifestyles in which they experienced some sense of power or mastery, stepping into the role of student, in which professors and advisors are at the top of an academic power hierarchy, regardless of age, can be highly unsettling. In Brown and Brown's (2015) qualitative inquiry into the experience of women over 40 who had returned to graduate school to pursue their PhDs, one student expressed her experience of losing power by reflecting, "After faculty meetings, we (students) could go eat the leftover food ... oh my God! I was surprised at how quickly I had lost my power" (p. 144).

Just as professional counselors must be attuned to the distinct needs of their older clients, including those who have returned to school in their later years, so must student support professionals. Attending to the needs of older students requires flexibility and compassion and an awareness of the challenges being an older student can present within the traditional "youth-centric" world of postsecondary education (Chen, 2017). In order to serve this diverse population effectively, student support professionals will need to recognize these obstacles as well as the role conflicts and challenges experienced by older learners. An easy-to-administer gerontology-focused intervention such as "The Game of *I am*" (Bailey, 2016c) could be a useful tool for educators training future student support professionals as well as counselor educators who are committed to fostering gerontological competency in their master's students.

For the purposes of this study, "The Game of *I am*" (Bailey, 2016c) was presented to master's students entirely outside of their standard classroom environments. However, incorporating such an intervention into existing coursework would be as simple as adding two online journaling activities and one one-hour game play activity and group discourse into existing curriculum. This integrated intervention would provide students an opportunity to reflect on their future older selves, to consider the impact of ageism on older adults, and consider themselves as future professionals serving adults who are older.

The face-to-face components of "The Game of *I am*" (Bailey, 2016c) were simple to administer. Although future analysis will add clarity, it appears that the Facilitators' Guide (see Appendix D) used in this study provided facilitators sufficient information to conduct the game play and group discourse. The game play set-up presented no reported problems for facilitators and required only low-cost supplies (e.g., paper game board pieces, printed prompts, candy as prizes; see Appendix D: Facilitators' Guide, Game Set-Up). Although, for the current study, participants received monetary incentives for their time, this would not be the case in a traditional classroom. A low-cost, manualized intervention such as this one could be appealing for educators who wish to introduce active learning empathy-building interventions into their curriculum.

This study demonstrates that the three-part intervention, "The Game of *I am*" (Bailey, 2016c), can be easily and inexpensively administrated within the time frame of one semester and with students in two academic departments. Ideas for further refinement of the intervention as well as areas for future research are presented next.

Areas for Future Research

Blending collaborative play with facilitated debriefing, transformative role-playing games such as "The Game of *I am*" (Bailey, 2016c) emphasize "the authenticity and the conditions of the play experience rather than…predefined educational goals. In other words, (they are) more focused on the journey than on the results" (Daniau, 2016, p. 428). As mentioned earlier, analysis of the qualitative data collected in this study will allow further consideration of the *process* of transformation as expressed in written artifacts and recorded group discourse, and will most likely spark further refinement of the intervention, including potential refinements to facilitation and facilitator training that may positively influence empathy and attitudes. Conducting larger-scale, longitudinal random-control studies on the long-term impact of "The Game of *I am*" (Bailey, 2016c) on self-reported empathy and self-reported attitudes toward older adults in students throughout their master's programs and into their post-graduate professional lives will provide important data to support the utility of such an intervention. Testing the distinct aspects of the intervention may also prove fruitful to consider if game play or journaling alone could be a useful tool in enacting change in empathy and attitudes. Reintegrating more directive game prompts (i.e., with prompt responses included) and adding prompts that portray elders not as victims of ageism but as empowered individuals may elicit more empathy and less pity and paternalistic prejudice (e.g., Skorinko & Sinclair, 2013; Tse, 2014). Observational studies in which student support professional and professional counselor *behaviors* toward older clients are evaluated after participating in "The Game of *I am*" (Bailey, 2016c) represent another area for future study.

Testing the intervention outside of higher education and counseling programs could prove useful as well. The game play prompts could be easily adapted to represent the experiences of any marginalized population, and testing with various targets could prove fruitful. As a low-cost, easy-to-administer intervention, the face-to-face perspective-taking game has already been used and tested as a standalone activity and would be simple to integrate into the training of medical professionals, in business settings, and in community settings with stakeholders who are interested in broadening the conversation about bias and stigma. It could also be adapted to a variety of settings in which the focus is on conflict resolution. Taking the perspective of another has been named as an essential component to empathy (Decety & Moriguchi, 2007), and by considering the perspectives of others, we may better understand them (McAllister et al., 2011). As Brené Brown has written, "People are hard to hate close up. Move in" (2017, p. 63).

With the increasing emphasis on online learning in higher education (Seirup, Tirotta, & Blue, 2016), it will be important to develop and adapt existing interventions to be used with distance learners. I am currently engaged in collaborative research in which we are studying the impact of the online reflective journaling components used in this study on attitudes toward older adults of undergraduate students enrolled in an online class. Data from that study as well as qualitative analysis of artifacts from the current study will prove useful in continuing intervention refinement and future studies.

Final Thoughts

From its first iteration as a class assignment until testing it in its current form for my dissertation, "The Game of *I am*" (Bailey, 2016c) has been a decidedly nonlinear process of discovery. Although the statistically significant results that were hypothesized did not come to fruition, from this study have emerged many ideas for intervention refinement and future study. Conducting this small-scale experimental feasibility study provided an opportunity to test the potential efficacy of the intervention in a time- and cost-effective manner, and, even with the logistical challenges of conducting the study within the confines of a semester and with the last-minute recruitment strategy shift, the successful completion of this study demonstrated that it is possible to integrate such an intervention into an academic program. Because of the scarcity of empirical research on enhancing empathy and improving attitudes toward older adults in counselor education as well as in higher education, conducting the current study represented a valuable step toward addressing this gap in knowledge.

Many TLT researchers have suggested that the process of transformative learning, much like the process of intervention development in this study, may not be a linear one (see Cranton & King, 2003; Jaruszewicz, 2006; Nicolaides & Dzubinski, 2016; O'Connell, 2016). As Snyder (2008) wrote, "it is difficult to measure the level of transformation among participants when transformation is perceived as an end state" (p. 172). However, by testing "The Game of *I am*" (Bailey, 2016c) with first-year master's students training to be counselors and student support professionals, 27 future helping professionals were exposed to the prevalence and impact of ageism and were

invited to share their perspectives about aging and about professional work with older adults, therefore enhancing their knowledge and potentially broadening their self-awareness. In their Tripartite Model of Cross-Cultural Competence, Sue et al. (1982) identified knowledge and awareness of personal beliefs, biases, attitudes, and values as two of the three distinct attributes of cultural competence (Tomlinson-Clarke, 2013). That awareness as well as the exploration of one's own privilege and culture (Black & Stone, 2005; Ratts, Singh, Nassar-McMillan, Butler, & McCullough, 2015), have been named as essential to multicultural competence in counselor identity development. ACPA/NASPA standards also include similar professional competency areas that address "culturally-inclusive advising, supporting, coaching, and counseling strategies" (Professional Competency Areas for Student Affairs Educators, 2015, p. 37). Providing both master's students training to be counselors and master's students training to be student support professionals ample opportunities to become aware of and evaluate their attitudes toward older adults early in their training, as was done in the current study, may play a valuable role in developing gerontological competence. Future analysis of recorded artifacts will provide a clearer picture of the impact that increased awareness had on future counseling and student support professionals in this study.

REFERENCES

Abrams, D., Swift, H. J., & Drury, L. (2016). Old and unemployable? How age-based stereotypes affect willingness to hire job candidates. *Journal of Social Issues*, *72*(1), 105–121. http://doi.org/10.1111/josi.12158

Achenbaum, W. A. (2015). A history of ageism since 1969. *Journal of the American Society on Aging*, *39*(3), 10–17.

ACPA: College Student Educators International & NASPA − Student Affairs Administrators in Higher Education (2015). *ACPA/NASPA professional competency areas for student affairs practitioners.* Washington, DC: Authors. Retrieved from https://www.naspa.org/images/uploads/main/ACPA_ NASPA_Professional_Competencies_FINAL.pdf

Administration on Aging. (2016). *Aging stats.* Retrieved from https://agingstats.gov/

Agronin, M. E. (2014). From Cicero to Cohen: Developmental theories of aging, from antiquity to the present. *The Gerontologist*, *54*(1), 30–39. http://doi.org/10.1093/geront/gnt032

Alden, J., & Toth-Cohen, S. (2015). Impact of an educational module on occupational therapists' use of elderspeak and attitudes toward older adults. *Physical & Occupational Therapy in Geriatrics*, *33*(1), 1–16.

Allan, L. J., & Johnson, J. A. (2009). Undergraduate attitudes toward the elderly: The role of knowledge, contact and aging anxiety. *Educational Gerontology*, *35*, 1–14. http://doi.org/10.1080/03601270802299780

Allen, J. O. (2016). Ageism as a risk factor for chronic disease. *Gerontologist*, *56*, 610–614. http://doi.org/10.1093/geront/gnu158

American Counseling Association. (2011). *The effectiveness of and need for professional counseling services*. Retrieved from https://www.counseling.org/docs/public-policy-resources-reports/effectiveness_of_and_need_for_counseling_2011.pdf?sfvrsn=2

American Counseling Association. (2014). *ACA code of ethics*. Alexandria, VA: American Counseling Association. Retrieved from https://www.counseling.org/resources/aca-code-of-ethics.pdf

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders: DSM-5*. Washington, D.C: American Psychiatric Association

American Psychological Association. (2014). Guidelines for psychological practice with older adults. *American Psychologist*, *69*(1), 34–65. http://doi.org/10.1037/a0035063

Andersson, L., King, R., & Lalande, L. (2010). Dialogical mindfulness in supervision role-play. *Counselling and Psychotherapy Research*, *10*, 287–294. http://doi.org/10.1080/14733141003599500

Angel, J. L., Jiménez, M. A., & Angel, R. J. (2007). The economic consequences of widowhood for older minority women. *The Gerontologist*, *47*, 224–234.

Ansello, E. F. (1977). Age and ageism in children's first literature. *Educational Gerontology*, *2*, 255–274.

Applewhite, A. (2015). *This chair rocks: A manifesto against ageism*. New York, NY: Networked Books, Inc.

Arthur, N., & Achenbach, K. (2002). Developing multicultural counseling competencies through experiential learning. *Counselor Education & Supervision*, *42*(1), 2–14.

Association for Counselor Education and Supervision. (2011). *Best practices in clinical supervision*. (2011). Retrieved from http://doi.org/10.1016/B978-0-08-096676-2.10001-3

Axt, J. R., Ebersole, C. R., & Nosek, B. A. (2014). The rules of implicit evaluation by race, religion, and age. *Psychological Science*, *25*, 1804–1815. http://doi.org/10.1177/0956797614543801

Bailey, S. W. (2016a). *Mid-century modern: Becoming a counselor (and being OK with not being perfect!) at middle-age.* Roundtable presentation at the Association for Adult Development and Aging Conference, New York, NY.

Bailey, S. W. (2016b). *Older exposure: Reimagining gerocounseling in counselor education.* Educational presentation at the Southern Association for Counselor Education and Supervision Conference, New Orleans, LA.

Bailey, S. W. (2016c). *The Game of "I am."* (in development). The University of North Carolina at Greensboro.

Bailey, S. W. (2017). *A new age: Experiential activities to enhance empathy.* Educational presentation at the Southern Gerontological Association Conference, Asheville, NC.

Bargh, J. A., Chen, M., & Burrows, L. (1996). Automaticity of social behavior: Direct effects of trait construct and stereotype activation on action. *Journal of Personality and Social Psychology*, *71*, 230–244.

Baron-Cohen, S., Wheelwright, S., Hill, J., Raste, Y., & Plumb, I. (2001). The Reading the Mind in the Eyes'' test revised version: A study with normal adults, and adults with Asperger syndrome or high-functioning autism. *Journal of Child Psychology & Psychiatry & Allied Disciplines*, *42*, 241–251.

Bartels, S. J., Dums, A. R., Oxman Thomas E, Schneider, L. S., Arean, P. A., Alexopoulos, G. S., & Jeste, D. V. (2002). Evidence-based practices in geriatric mental health care. *Psychiatric Services*, *53*, 1419–1429.

Bartels, S. J., & Naslund, J. A. (2013). The underside of the silver tsunami: Older adults and mental health care. *New England Journal of Medicine*, *368*, 493–496. http://doi.org/10.1056/NEJMp1002530

Bartholomew, L. K., Markham, C. M., Ruiter, R. A. C., Fernandez, M. E., Kok, G., & Parcel, G. S. (2016). *Planning health promotion programs: An Intervention Mapping approach* (4th ed.). Hoboken, NJ: Wiley.

Bartholomew, L. K., Parcel, G. S., & Kok, G. (1998). Intervention mapping: A process for developing theory-and evidence-based health education programs. *Health Education & Behavior*, *25*, 545–563.

Bartholomew, L. K., Parcel, G. S., & Kok, G. (2011). *Planning health promotion programs: An intervention mapping approach.* (3rd ed.). Hoboken, NJ: John Wiley & Sons.

Batson, C. D., Polycarpou, M. R., Harmon-Jones, E., Imhoff, H. J., Mitchener, E. C., Bednar, L. L., … Highberger, L. (1997). Empathy and attitudes: Can feeling for a member of a stigmatized group improve feelings toward the group? *Journal of Personality and Social Psychology*, *72*(1), 105–118.

Bearman, M., Palermo, C. E., & Williams, B. (2015). Learning empathy through simulation: A systematic literature review. *Simulation in Healthcare*, *10*, 308–319.

Beck, R. S., Daughtridge, R., & Sloane, P. D. (2002). Physician-patient communication in the primary care office: A systematic review. *Physician-Patient Communication*, *15*(1), 25–38.

Ben-Harush, A., Shiovitz-Ezra, S., Doron, I., Alon, S., Leibovitz, A., Golander, H., … Ayalon, L. (2017). Ageism among physicians, nurses, and social workers: Findings from a qualitative study. *European Journal of Ageing*, *14*, 39–48.

Ben-Zur, H. (2012). Loneliness, optimism, and well-being among married, divorced, and widowed individuals. *The Journal of Psychology*, *146*(1–2), 23–36.

Berger, J. G. (2004). Dancing on the threshold of meaning: Recognizing and understanding the growing edge. *Journal of Transformative Education*, *2*, 336–351.

Bergman, Y. S., & Bodner, E. (2015). Ageist attitudes block young adults' ability for compassion toward incapacitated older adults. *International Psychogeriatrics*, *27*, 1541–1550.

Bernstein, C., Dennis, E. E., Grossman, L. K., Levy, B. R., McCann, L. A., Rix, S., … Zweig, J. (2006). *Ageism in America*. New York, NY. Retrieved from http://aging.columbia.edu/sites/default/files/Ageism_in_America.pdf

Bishop, J. M., & Krause, D. R. (1984). Depictions of aging and old age in Saturday morning television. *The Gerontologist*, *24*(1), 91–94.

Black, L. L., & Stone, D. (2005). Expanding the definition of privilege: The concept of social privilege. *Journal of Multicultural Counseling and Development*, *33*, 243–255.

Blake, R., & Kaplan, L. S. (1975). Counseling the elderly: An emerging area for counselor education and supervision. *Counselor Education and Supervision*, *15*(2), 156–157.

Block-Lerner, J., Adair, C., Plumb, J. C., Rhatigan, D. L., & Orsillo, S. M. (2007). The case for mindfulness-based approaches in the cultivation of empathy: Does nonjudgmental, present-moment awareness increase capacity for perspective-taking and empathic concern? *Journal of Marital and Family Therapy*, *33*, 501–516.

Blow, F. C., & Barry, K. L. (2012). Alcohol and substance misuse in older adults. *Current Psychiatry Reports*, *14*, 310–319. http://doi.org/10.1007/s11920-012-0292-9

Bobby, C. L. (2013). The evolution of specialties in the CACREP standards: CACREP's role in unifying the profession. *Journal of Counseling & Development*, *91*, 35–42.

Bodner, E. (2009). On the origins of ageism among older and younger adults. *International Psychogeriatrics*, *21*, 1003–1014. http://doi.org/10.1017/S104161020999055X

Bodner, E., & Cohen-Fridel, S. (2014). The paths leading from attachment to ageism: A structural equation model approach. *Death Studies*, *38*, 423–429.

Boelen, P. A., de Keijser, J., van den Hout, M. A., & van den Bout, J. (2007). Treatment of complicated grief: A comparison between Cognitive-Behavioral therapy and supportive counseling. *Journal of Consulting and Clinical Psychology*, *75*, 227–284. http://doi.org/10.1037/0022-006X.75.2.277

Booth, L., & Kada, S. (2015). Student radiographers' attitudes toward the older patient: An intervention study. *Radiography*, *21*, 160–164. http://doi.org/10.1016/j.radi.2014.09.010

Bousfield, C., & Hutchison, P. (2010). Contact, anxiety, and young peoples' attitudes on behavioral intentions toward the elderly. *Educational Gerontology*, *36*, 451–466. http://doi.org/10.1080/03601270903324362

Bowman, S. L. (2010). *The functions of role-playing games: How participants create community, solve problems and explore identity*. Jefferson, NC: McFarland.

Boysen, G. A. (2009). A review of experimental studies of explicit and implicit bias among counselors. *Journal of Multicultural Counseling and Development*, *37*, 240–249. http://doi.org/10.1002/j.2161-1912.2009.tb00106.x

Boysen, G. A. (2010). Integrating implicit bias into counselor education. *Counselor Education & Supervision*, *49*(4), 210–227. http://doi.org/10.1002/j.1556-6978.2010.tb00099.x

Bragg, E. J., Warshaw, G. A., Meganathan, K., & Brewer, D. E. (2010). National survey of geriatric medicine fellowship programs: Comparing findings in 2006/07 and 2001/02 from the American Geriatrics Society and Association of Directors of Geriatric Academic Programs Geriatrics Workforce Policy Studies Center. *Journal of the American Geriatrics Society*, *58*, 2166–2172. http://doi.org/10.1111/j.1532-5415.2010.03126.x

Brehm, S. S. (2008). *Blueprint for change: Achieving integrated health care for an aging population*. Washington, DC: American Psychological Association.

Briggs, W. P., Magnus, V. A., Lassiter, P., Patterson, A., & Smith, L. (2011). Substance use, misuse, and abuse among older adults: Implications for clinical mental health counselors. *Journal of Mental Health Counseling*, *33*(2), 112–127.

Brinker, J. K., Roberts, P., & Radnidge, B. (2014). The Game of Late Life: A novel education activity for the psychology of ageing. *Educational Gerontology*, *40*, 91–101. http://doi.org/10.1080/15402002.2013.795038

Brown, B. (2017). *Braving the wilderness.* New York, NY: Penguin Random House.

Brown, P. P., & Brown, C. S. (2015). Transformative learning theory in gerontology: Nontraditional students. *Educational Gerontology*, *41*, 136–148. http://doi.org/10.1080/03601277.2014.950492

Brueske, L. E. (1999). Specialties & academies update. *The National Certified Counselor*, *16*(1), 1–16.

Bui, P., Kalpidou, M., Devito, L., & Greene, T. (2016). The effects of empathy on disparagement humor. *Psi Chi Journal of Psychological Research*, *21*, 119–126.

Burton, N. W., Pakenham, K. I., & Brown, W. J. (2010). Feasibility and effectiveness of psychosocial resilience training: A pilot study of the READY program. *Psychology, Health & Medicine*, *15*, 266–277.

Butler, R. N. (1969). Age-Ism: Another form of bigotry. *The Gerontologist*, *9*, 243–246.

Butler, R. N. (1975). *Why survive? Being old in America*. New York, NY: Harper & Row.

Butler, R. N. (1980). Ageism: A foreword. *Journal of Social Issues*, *36*(2), 8–12.

Butler, R. N. (1995). Ageism. In G. Maddox (Ed.), *The encyclopedia of aging* (2nd ed., pp. 35–36). New York, NY: Springer.

Butler, R. N. (2012). Dispelling ageism: The cross-cutting intervention. *The ANNALS of the American Academy of Political and Social Science*, *503*, 138–147.

Campbell, R., & Schram, P. J. (1995). Feminist research methods. *Psychology of Women Quarterly*, *19*, 85–106.

Cartwright, B. Y., Daniels, J., & Shuqiang, Z. (2008). Innovations in multicultural research advancements in the measurement of counselors' multicultural competence. *Journal of Counseling & Development*, *86*, 318–322.

Chang, Y. P., & Compton, P. (2016). Opioid misues/abuse and quality persistent pain management in older adults. *Journal of Gerontological Nursing*, *42*(12), 21–30.

Chen, J. C. (2017). Nontraditional adult learners: The neglected diversity in postsecondary education. *SAGE Open, 7*(1), 1-12. doi: 10.1177/2158244017697161

Cherry, K. E., Allen, P. D., Denver, J. Y., & Holland, K. R. (2015). Contributions of social desirability to self-reported ageism. *Journal of Applied Gerontology*, *34*, 712–733. http://doi.org/10.1177/0733464813484984

Chiles, J. A., Lambert, M. J., & Hatch, A. L. (1999). The impact of psychological interventions on medical cost offset: A meta-analytic review. *Clinical Psychology Science and Practice*, *6*, 204–220. http://doi.org/10.1093/clipsy.6.2.204

Chodosh, J., Colaiaco, B. A., Connor, K. I., Cope, D. W., Liu, H., Ganz, D. A., … Vickrey, B. G. (2015). Dementia care management in an underserved community: The comparative effectiveness of two approaches. *Journal of Aging and Health*, *27*, 864–893. http://doi.org/10.1177/0898264315569454

Choi, N. G., & DiNotto, D. M. (2013). Mental health & substance use: Challenges for serving older adults. *Indian Journal of Medical Research*, *138*, 439–442.

Choi, N. G., & Morrow-Howell, N. (2007). Low-income older adults' acceptance of depression treatments: Examination of within-group differences. *Aging & Mental Health*, *11*, 423–433. http://doi.org/10.1080/13607860600963802

Chonody, J. M. (2015). Addressing ageism in students: A systematic review of the pedagogical intervention literature. *Educational Gerontology*, *41*, 859–887.

Chonody, J. M., & Wang, D. (2014). Predicting social work students' interest in gerontology: Results from an international sample. *Journal of Gerontological*

Social Work, *57*, 773–789. http://doi.org/10.1080/01634372.2014.888605

Chonody, J. M., Webb, S. N., Ranzijn, R., & Bryan, J. (2014). Working with older adults: Predictors of attitudes towards ageing in psychology and social work students, faculty, and practitioners. *Australian Psychologist*, *49*, 374–383. http://doi.org/10.1111/ap.12056

Christie, M., Carey, M., Robertson, A., & Grainger, P. (2015). Putting transformative learning theory into practice. *Australian Journal of Adult Learning*, *55*(1), 9–30.

Cohen, A. L., Brown, P. P., & Morales, J. P. (2015). Student journals: A means of assessing transformative learning in aging related courses. *Gerontology & Geriatrics Education*, *36*, 182–203.

Cohn, D. V., & Taylor, P. (2011). Baby Boomers approach 65 – Glumly. *Pew Research*, *107*(22), 1–7.

Colby, S. L., & Ortman, J. M. (2015). Projections of the size and composition of the U.S. population reports, P25-1143. Washington, DC: U.S. Census Bureau.

Colvin, B. B. (2013). Where is Merlin when I need him? The barriers to higher education are still in place: Recent re-entry experience. *New Horizons in Adult Education & Human Resource Development, 25*(2), 19-32.

Comlossy, M., & Walden, J. (2013). The silver tsunami. *State Legislatures*, *39*(10), 14–19.

Constantine, M. G. (2001). Multicultural training, theoretical orientation, empathy, and multicultural case conceptualization ability in counselors. *Journal of Mental Health Counseling*, *23*, 357–372.

Constanzo, M., & Archer, B. (1994). *The Interpersonal Perception Task 15 (IPT– 15): A guide for researchers and teachers*. Berkley, CA: University of California Center for Media and Independent Learning.

Conwell, Y. (2001). Suicide in later life: A review and recommendations for prevention. *Suicide and Life-Threatening Behavior*, *31*, 32–47. http://doi.org/10.1521/suli.31.1.5.32.24221

Conwell, Y. (2014). Suicide later in life: Challenges and priorities for prevention. *American Journal of Preventive Medicine*, *47*, S244–S250. http://doi.org/10.1016/j.amepre.2014.05.040

Cottle, N. R., & Glover, R. J. (2007). Combating ageism: Change in student knowledge and attitudes regarding aging. *Educational Gerontology*, *33*, 501–512. http://doi.org/10.1080/03601270701328318

Council for Accreditation of Counseling and Related Educational Programs. (2015). *2016 CACREP Standards*. Retrieved from http://www.cacrep.org/wp-content/uploads/2012/10/2016-CACREP-Standards.pdf

Cranton, P. (2002). Teaching for transformation. *New Directions for Adult and Continuing Education*, *93*, 63–71.

Cranton, P., & King, K. P. (2003). Transformative learning as a professional development goal. *New Directions for Adult and Continuing Education*, *98*, 31–37.

Croft, B., & Parish, S. L. (2013). Care integration in the Patient Protection and Affordable Care Act: Implications for behavioral health. *Administration and*

Policy in Mental Health and Mental Health Services Research, *40*, 258–263. http://doi.org/10.1007/s10488-012-0405-0

Crowne, D. P., & Marlowe, D. (1960). A new scale of social desirability independent of psychopathology. *Journal of Consulting Psychology*, *24*, 349–354.

Cuddy, A. J. C., Norton, M. I., & Fiske, S. T. (2005). This old stereotype: The pervasiveness and persistence of the elderly stereotype. *Journal of Social Issues*, *61*, 267–285.

Cummings, S. M., Kropf, N. P., & De Weaver, K. L. (2000). Knowledge of and attitudes toward aging among non-elders: Gender and race differences. *Journal of Women & Aging*, *17*(1/2), 77–91. http://doi.org/10.1300/J074v12n01_06

Damron-Rodriguez, J. (2007). Social work practice in aging: A competency-based approach for the 21st century. In R. Greene, H. Cohen, C. Galambos, & N. Kropf (Eds.), *Foundation of social work practice in the aging field: A competency-based approach* (pp. 1–16). Washington, DC: NASW Press.

Damron-Rodriguez, J., Goodman, C., Ranney, M., Won Min, J., & Takahashi, N. (2013). The state of gerontological social work education in California: Implications for curricula evaluation. *Journal of Social Work Education*, *49*, 235–249. http://doi.org/10.1080/10437797.2013.768113

Daniau, S. (2016). The transformative potential of role-playing games: From play skills to human skills. *Simulation & Gaming*, *47*, 423–444.

Danowski, J. L. (2011). *The portrayal of older characters in popular children's picture books*. Brigham Young University.

Davis, M. H. (1983). Measuring individual differences in empathy: Evidence for a multidimensional approach. *Journal of Personality and Social Psychology*, *44*, 113–126.

Davis, M. H., Conklin, L., Smith, A., & Luce, C. (1996). Effect of perspective taking on the cognitive representation of persons: A merging of self and other. *Journal of Personality and Social Psychology*, *70*, 713–726.

Decety, J., & Moriguchi, Y. (2007). The empathic brain and its dysfunction in psychiatric populations: Implications for intervention across different clinical conditions. *BioPsychoSocial Medicine*, *1*(22), 1–22. http://doi.org/10.1186/1751-0759-1-22

DeVries, H. M. (2005). Clinical geropsychology training in generalist doctoral programs. *Gerontology & Geriatrics Education*, *25*(4), 5–20. http://doi.org/10.1300/J021v25n04_02

DiSilvestro, F. R. (2010). Continuing higher education and older adults: A growing challenge and golden opportunity. *New Directions for Adult and Continuing Education, 140,* 79-07. doi: 10.1002/ace

Doshi, J. A., Cen, L., & Polsky, D. (2008). Depression and retirement in late middle-aged U.S. workers. *Health Research and Educational Trust*, *43*, 693–713.

Draper, B. M. (2014). Suicidal behaviour and suicide prevention in later life. *Maturitas*, *79*, 179–183. http://doi.org/10.1016/j.maturitas.2014.04.003

Eagly, A. H., & Chaiken, S. (1993). *The psychology of attitudes*. Fort Worth, TX: Harcourt, Brace, Jovanovich.

Eaton, J., & Donaldson, G. (2016). Altering nursing student and older adult attitudes through a possible selves ethnodrama. *Journal of Professional Nursing*, *32*(2), 141–151.

Eisenberg, D., Gollust, S. E., Golberstein, E., & Hefner, J. L. (2007). Prevalence and correlates of depression, anxiety, and suicidality among university students. *American Journal of Orthopsychiatry, 77,* 534-542. doi: 10.1037/0002-9432.77.4.534

Elwert, F., & Christakis, N. A. (2008). The effect of widowhood on mortality by the causes of death of both spouses. *American Journal of Public Health*, *98*, 2092–2098.

Fahr, A. V. (2004). *Representation of the elderly in counselor education textbooks* (Unpublished doctoral dissertation). Western Michigan University: Kalamazoo, MI.

Fässberg, M. M., van Orden, K. A., Duberstein, P. R., Erlangsen, A., Lapierre, S., Bodner, E., … Waern, M. (2012). A systematic review of social factors and suicidal behavior in older adulthood. *International Journal of Environmental Research and Public Health*, *9*(3), 722–745. http://doi.org/10.3390/ijerph9030722

Faul, F., Erdfelder, E., Lang, A. G., & Buchner, A. (2007). G*Power 3: A flexible statistical power analysis program for the social, behavioral, and biomedical sciences. *Behavior Research Methods*, *39*, 175–191.

Fazio-Griffith, L., & Ballard, M. B. (2016). Transformational learning theory and transformative teaching: A creative strategy for understanding the helping

relationship. *Journal of Creativity in Mental Health*, *11*, 225–234. http://doi.org/10.1080/15401383.2016.1164643

Ferguson, A. J., & Schriver, J. (2012). The future of gerontological social work: A case for structural lag. *Journal of Gerontological Social Work*, *55*, 304–320. http://doi.org/10.1080/01634372.2011.623265

Fey, W. P. (1954). Acceptance of self and others, and its relation to therapy-readiness. *Journal of Clinical Psychology*, *10*, 269–271.

Foster, T. W., & Kreider, V. (2009). Reinventing gerocounseling in counselor education as a specialization. *Education*, *35*, 177–187. http://doi.org/10.1080/03601270802466850

Foster, T. W., Kreider, V., & Waugh, J. (2009). Counseling students' interest in gerocounseling: A survey study. *Gerontology & Geriatrics Education*, *30*, 226–242. http://doi.org/10.1080/02701960903133489

Fraboni, M., Saltstone, R., & Hughes, S. (1990). The Fraboni Scale of Ageism (FSA): An attempt at a more precise measure of ageism. *Canadian Journal on Aging / La Revue Canadienne Du Vieillissement*, *9*(1), 56–66. http://doi.org/10.1017/S0714980800016093

Fried, E. I., Bockting, C., Arjadi, R., Borsboom, D., Amshoff, M., Cramer, A. O. J., … Stroebe, M. (2015). From loss to loneliness: The relationship between bereavement and depressive symptoms. *Journal of Abnormal Psychology*, *124*, 256–265.

Friedman, F. B., & Goldbaum, C. S. (2016). Experiential learning: Developing insights about working with older adults. *Clinical Social Work Journal*, *44*, 186–197. http://doi.org/10.1007/s10615-016-0583-4

Fullen, M. C. (2016). Counseling for wellness with older adults. *Adultspan Journal*, *15*(2), 109–123. http://doi.org/10.1002/adsp.12025

Fulton, C. L., & Cashwell, C. S. (2015). Mindfulness-based awareness and compassion: Predictors of counselor empathy and anxiety. *Counselor Education & Supervision*, *54*, 122–134. http://doi.org/10.1002/ceas.12009

Galambos, C., Curl, A. L., & Woodbury, K. (2014). Research note—Testing for gerontological competencies: A pilot study. *Journ al of Social Work Education*, *50*, 191–196. http://doi.org/10.1080/10437797.2014.856237

Galinsky, A. D., & Moskowitz, G. B. (2000). Perspective-taking: Decreasing stereotype expression, stereotype accessibility, and in-group favoritism. *Journal of Personality and Social Psychology*, *78*, 708–734.

Garcia-Williams, A. G., & Moffitt, L. (2014). Mental health and suicidal behavior among graduate students. *Academic Psychiatry, 38,* 554-560. doi: 10.1007/s40596-014-0041-y

Garriott, P. O., Reiter, S., & Brownfield, J. (2016). Testing the efficacy of brief multicultural education interventions in white college students. *Journal of Diversity in Higher Education*, *9*, 158–169.

Gatz, M., Smyer, M. A., & Digilio, D. A. (2016). Psychology's contribution to the well-being of older Americans. *American Psychologist*, *71*, 257–267. http://doi.org/10.1037/a0040251

Gellis, Z. D., Sherman, S., & Lawrance, F. (2003). First year graduate social work students' knowledge of and attitude toward older adults. *Educational Gerontology*, *29*(1), 1–16. http://doi.org/10.1080/03601270390156782

Gerdes, K. E., & Segal, E. (2008). Importance of empathy for social work practice: Integrating new science. *Social Work*, *56*(2), 141–149.

Gerdes, K. E., Segal, E. A., & Lietz, C. A. (2010). Conceptualising and measuring empathy. *British Journal of Social Work*, *40*, 2326–2343. http://doi.org/10.1093/bjsw/bcq048

Geriatric Mental Health Foundation. (2008). *Depression in late life: Not a natural part of aging*. McLean, VA. Retrieved from http://www.aagponline.org/index.php?src=gendocs&ref=depression&category=Foundation

Gladding, S. T. (2012). *Counseling: A comprehensive profession.* New York, NY: Pearson.

Glueck, B. P. (2015). Roles, attitudes, and training needs of behavioral health clinicians in integrated primary care. *Journal of Mental Health Counseling*, *37*, 175–188.

Goldsmith, J. S., & Kurpius, S. E. R. (2015). Older adults and integrated health settings: Opportunities and challenges for mental health counselors. *Journal of Mental Health Counseling Integrated Health Care*, *37*(2), 124–137.

Gravett, S. (2004). Action research and transformative learning in teaching environment. *Educational Action Research*, *12*, 259–272.

Greason, P. B., & Cashwell, C. S. (2009). Mindfulness and counseling self-efficacy: The mediating role of attention and empathy. *Counselor Education & Supervision*, *49*(1), 2–19.

Green, S. L., & Dorr, N. (2016). Changing attitudes toward older adults through a simulated aging exercise: Implications for family therapy. *Women & Therapy*, *39*, 69–85.

Greenwald, A. G., McGhee, D. E., & Schwartz, J. L. K. (1998). Measuring individual differences in implicit cognition: The Implicit Association Test. *Journal of Personality and Social Psychology*, *74*, 1464–1480.

Gulley, N. Y. (2016). The myth of the nontraditional student. *Inside Higher Ed.* Retrieved from https://www.insidehighered.com/views/2016/08/05/defining-students-nontraditional-inaccurate-and-damaging-essay

Gunter, T. D., & Arndt, S. (2004). Maximizing treatment of substance abuse in the elderly. *Behavioral Health Management*, *24*(2), 38–43.

Gwyn, P. G., & Colin, J. M. (2010). Research with the doubly vulnerable population of individuals who abuse alcohol. *Journal of Psychosocial Nursing*, *48*(2), 38–43.

Han, B., Gfroerer, J. C., Colliver, J. D., & Penne, M. A. (2009). Substance use disorder among older adults in the United States in 2020. *Addiction*, *104*(1), 88–96. http://doi.org/10.1111/j.1360-0443.2008.02411.x

Hansen, M. C., Flores, D. V, Coverdale, J., & Burnett, J. (2016). Correlates of depression in self-neglecting older adults: A cross-sectional study examining the role of alcohol abuse and pain in increasing vulnerability. *Journal of Elder Abuse & Neglect*, *28*(1), 41–56. http://doi.org/10.1080/08946566.2015.1136252

Harma, M. (2012). Is retirement beneficial or harmful to mental health? *Scandinavian Journal of Work, Environment, & Health*, *38*, 391–392. http://doi.org/10.5271/sjweh.3315

He, W., Goodkind, D., & Kowal, P. (2016). *An aging world: 2015*. Washington, DC. Retrieved from https://www.census.gov/content/dam/Census/library/publications/2016/demo/p95-16-1.pdf

Hebert, L. E., Weuve, J., Scherr, P. A., & Evans, D. A. (2013). Alzheimer disease in the United States (2010-2050) estimated using the 2010 census. *Neurology*, *80*, 1778–1783. http://doi.org/10.1212/WNL.0b013e31828726f5

Henry, B. W., & Ozier, A. D. (2011). Empathetic responses and attitudes about older adults: How experience with the Aging Game measures up. *Educational Gerontology*, *37*, 924–941. http://doi.org/10.1080/03601277.2010.495540

Hess, T. M., & Hinson, J. T. (2006). Age-related variation in the influences of aging stereotypes on memory in adulthood. *Psychology and Aging*, *21*, 621–625. http://doi.org/10.1037/0882-7974.21.3.621

Hobgood, C., Harward, D., Newton, K., & Davis, W. (2005). The educational intervention "GRIEV_ING" improves the death notification skills of residents.

Academic Emergency Medicine, *12*, 296–301. http://doi.org/10.1197/j.aem.2004.12.008

Hogan, R. (1969). Development of an empathy scale. *Journal of Consulting and Clinical Psychology 33,* 307–316.

Hojat, M., Mangione, S., Nasca, T. J., M Cohen, M. J., Gonnella, J. S., Erdmann, J. B., & Veloski, J. (2001). The Jefferson Scale of Physician Empathy: Development and preliminary psychometric data. *Educational and Psychological Measurement*, *61*, 349–365.

Hooyman, N. R., & Kiyak, H. A. (2011). *Social gerontology: A multidisciplinary perspective* (9th ed.). Boston, MA: Pearson Education, Inc.

Hyman, B., Oden, G., & Wagner, M. (2010). The aging process: Physiological changes and implications for educators and practitioners. *Activities, Adaptation & Aging*, *34*, 148–153. http://doi.org/10.1080/01924781003773815

Infurna, F. J., Gerstorf, D., Robertson, S., Berg, S., & Zarit, S. H. (2010). The nature and cross-domain correlates of subjective age in the oldest old: Evidence from the OCTO study. *Psychology and Aging*, *25*, 470–476. http://doi.org/10.1037/a0017979

Institute of Medicine. (2012). *The mental health and substance use workforce for older adults: In whose hands?* Washington, DC. Retrieved from www.iom.edu/agingandmentalhealth

Ivers, N. N., Johnson, D. A., Clarke, P. B., Newsome, D. W., & Berry, R. A. (2016). The relationship between mindfulness and multicultural counseling competence.

Journal of Counseling & Development, *94*, 72–82. http://doi.org/10.1002/jcad.12063

Iversen, T. N., Larsen, L., & Solem, P. E. (2009). A conceptual analysis of ageism. *Nordic Psychology*, *61*(3), 4–22. http://doi.org/10.1027/1901-2276.61.3.4

Jaruszewicz, C. (2006). Opening windows on teaching and learning: Transformative and emancipatory learning precipitated by experimenting with visual documentation of student learning. *Educational Action Research*, *14*, 357–375.

Jenkins, R. (2012). The new 'traditional student'. *Chronicle of Higher Education,* A31-A32.

Jeste, D. V., Alexopoulos, G. S., Bartels, S. J., Cummings, J. L., Gallo, J. J., Gottlieb, G. L., … Lebowitz, B. D. (1999). Consensus statement on the upcoming crisis in geriatric mental health: Research agenda for the next 2 decades. *Archives of General Psychiatry*, *56*, 848–853. http://doi.org/10.1001/archpsyc.56.9.848

Jones, J. M., Sander, J. B., & Booker, K. W. (2013). Multicultural competency building: Practical solutions for training and evaluating student progress. *Training and Education in Professional Psychology*, *7*(1), 12–22.

Jordan, J. R., & Niemeyer, R. A. (2003). Does grief counseling work? *Death Studies*, *27*, 765–786. http://doi.org/10.1080/713842360

Jorm, A. F. (2015). The role of consensus in medical science. *Australian & New Zealand Journal of Psychiatry*, *49*, 887–897. http://doi.org/10.1177/0004867415600891

Junn, E. N., Morton, K. R., & Yee, I. (1995). The "Gibberish" exercise: Facilitating empathetic multicultural awareness. *Journal of Instructional Psychology*, *22*, 324-329.

Kachan, D., Fleming, L. E., Christ, S., Muennig, P., Prado, G., Tannenbaum, S. L., … Lee, D. J. (2015). Health status of older US workers and nonworkers, National Health Interview Survey, 1997-2011. *Preventing Chronic Disease*, *12*(12), 1–12. http://doi.org/10.5888/pcd12.150040

Kagan, N. I., & Kagan, H. (1990). IPR - A validated model for the 1990s and beyond. *The Counseling Psychologist*, *18*, 436–440. http://doi.org/10.1177/0011000090183004

Kane, M. N. (2003). Teaching direct practice techniques for work with elders with Alzheimer's disease: A simulated group experience. *Educational Gerontology*, *29*, 777–794.

Kaplan, D. M., Tarvydas, V. M., & Gladding, S. T. (2014). 20/20: A vision for the future of counseling: The new consensus definition of counseling. *Journal of Counseling and Development*, *92*, 366–372. http://doi.org/10.1002/j.1556-6676.2014.00164.x

Karel, M. J., Gatz, M., & Smyer, M. A. (2012). Aging and mental health in the decade ahead. *American Psychologist*, *67*(3), 184–198. http://doi.org/10.1037/a0025393

Karel, M. J., Sakai, E. Y., Molinari, V., Moye, J., & Carpenter, B. (2016). Training for geropsychology supervision and practice: Perspectives of geropsychology program graduates. *Training and Education in Professional Psychology*, *10*(1), 37–44.

Kasworm, C. E. (2008). Emotional challenges of adult learners in higher education. *New Directions for Adult and Continuing Education, 120*, 27-34.

Kasworm, C. E. (2010). Adult learners in a research university: Negotiating undergraduate student identity. *Adult Education Quarterly, 60*(2),143-160. doi: 10.1177/0741713609336110

Kessler, E. M., Agines, S., & Bowen, C. E. (2015). Attitudes towards seeking mental health services among older adults: Personal and contextual correlates. *Aging & Mental Health*, *19*, 182–191. http://doi.org/10.1080/13607863.2014.920300

Keyes, C. L. M., & Westerhof, G. J. (2012). Chronological and subjective age differences in flourishing mental health and major depressive episode. *Aging & Mental Health*, *16*(1), 67–74.

Kim, B. S. K., & Lyons, H. Z. (2003). Experiential activities and multicultural counseling competence training. *Journal of Counseling & Development*, *81*, 400–408.

Kitchenham, A. (2008). The evolution of John Mezirow's transformative learning theory. *Journal of Transformative Education*, *6*(2), 104–123. http://doi.org/10.1177/1541344608322678

Kite, M. E., Stockdale, G. D., Whitley, B. E., & Johnson, B. T. (2005). Attitudes toward younger and older adults: An updated meta-analytic review. *Journal of Social Issues*, *61*, 241–266. http://doi.org/10.1111/j.1540-4560.2005.00404.x

Koekkoek, B., Van Meijel, B., Schene, A., & Hutschemaekers, G. (2010). Development of an intervention program to increase effective behaviours by patients and

clinicians in psychiatric services: Intervention mapping study. *BMC Health Services Research*, *10*, 1–11. http://doi.org/10.1186/1472-6963-10-293

Kornadt, A. E., Voss, P., & Rothermund, K. (2015). Hope for the best, prepare for the worst? Future self-views and preparation for age-related changes. *Psychology and Aging*, *30*, 967–976.

Kotter-Grühn, D., & Hess, T. M. (2012). The impact of age stereotypes on self-perceptions of aging across the adult lifespan. *The Journals of Gerontology, Series B: Psychological Sciences and Social Sciences*, *67*, 563–571. http://doi.org/10.1093/geronb/gbr153

Kourmousi, N., Amanaki, E., Tzavara, C., Merakou, K., Barbouni, A., & Koutras, V. (2017). The Toronto Empathy Questionnaire: Reliability and validity in a nationwide sample of Greek teachers. *Social Sciences*, *6*(2), 1–14. http://doi.org/10.3390/socsci6020062

Kozub, M. L. (2013). Through the eyes of the other: Using event analysis to build cultural competence. *Journal of Transcultural Nursing*, *24*, 313–318. http://doi.org/10.1177/1043659613481809

Lakin, M. B., Mullane, L., & Robinson, S. (2008). *Mapping new directions: Higher education for older adults. Reinvesting in the third age: Older adults and higher education—Second report.* Washington, DC: American Council on Education.

Langa, K. M., Larson, E. B., & Crimmins, E. M. (2017). A comparison of the prevalence of dementia in the United States in 2000 and 2012. *JAMA Internal Medicine, 177,* 1, 51. doi: 10.1001/jamainternmed.2016.6807

Larson, D. G., & Hoyt, W. T. (2007). What has become of grief counseling? An evaluation of the empirical foundations of the new pessimism. *Professional Psychology: Research and Practice*, *38*, 347–355.

Lasher, K. P., & Faulkender, P. J. (1993). Measurement of aging anxiety: Development of the Anxiety about Aging Scale. *International Journal of Aging and Human Development*, *37*, 247–259. http://doi.org/10.2190/1U69-9AU2-V6LH-9Y1L

Lassonde, K. A., Surla, C., Buchanan, J. A., & O'Brien, E. J. (2012). Using the contradiction paradigm to assess ageism. *Journal of Aging Studies*, *26*, 174–181. http://doi.org/10.1016/j.jaging.2011.12.002

Lenze, E. J., Mulsant, B. H., Shear, M. K., Alexopoulos, G. S., Frank, E., & Reynolds, C. F. (2001). Comorbidity of depression and anxiety disorders in later life. *Depression and Anxiety*, *14*(2), 86–93. http://doi.org/10.1002/da.1050

Levy, B. R. (2003). Mind matters: Cognitive and physical effects of aging self-stereotypes. *Journal of Gerontology*, *58B*, 203–211.

Levy, B. R., & Banaji, M. R. (2002). Implicit ageism. In T. D. Nelson (Ed.), *Ageism: Stereotyping and Prejudice against Older Persons* (pp. 49–75). Cambridge, MA: The MIT Press.

Levy, B. R., Chung, P. H., Bedford, T., & Navrazhina, K. (2013). Facebook as a site for negative age stereotypes. *The Gerontologist*, *54*, 172–176.

Levy, B. R., Slade, M. D., Chung, P. H., & Gill, T. M. (2015). Resiliency over time of elders' age stereotypes after encountering stressful events. *Journals of Gerontology: Psychological Sciences*, *70*, 886–890.

Levy, B. R., Slade, M. D., & Kasl, S. V. (2002). Longitudinal benefit of positive self-perceptions of aging on functional health. *Journal of Gerontology*, *57B*, 409–417.

Levy, B. R., Slade, M. D., May, J., & Caracciolo, E. A. (2006). Physical recovery after acute myocardial infarction: Positive age self-stereotypes as a resource. *International Journal of Aging and Human Development*, *62*, 285–301.

Levy, B. R., Zonderman, A. B., Slade, M. D., & Ferrucci, L. (2009). Age stereotypes held earlier in life predict cardiovascular events in later life. *Psychological Science*, *20*, 296–298.

Lim, S. (2008). Transformative aspects of genogram work: Perceptions and experiences of graduate students in a counseling training program. *The Family Journal of Counseling and Therapy for Couples and Families*, *16*(1), 35–42.

Lin, X., Bryant, C., & Boldero, J. (2011). Measures for assessing student attitudes toward older people. *Educational Gerontology*, *37*, 12–26. http://doi.org/10.1080/03601270903534796

Lindland, E., Fond, M., Haydon, A., & Kendall-Taylor, N. (2015). Gauging aging: Mapping the gaps between expert and public understanding of aging in America. Washington, DC: FrameWorks Institute. Retrieved from https://frameworksinstitute.org/assets/files/aging_mtg.pdf

Low, G., Molzahn, A. E., & Schopflocher, D. (2013). Attitudes to aging mediate the relationship between older peoples' subjective health and quality of life in 20 countries. *Health and Quality of Life Outcomes*, *11*, 1–10.

Lucas-Carrasco, R., Laidlaw, K., Gómez-Benito, J., & Power, M. J. (2013). Reliability and validity of the Attitudes to Ageing Questionnaire (AAQ) in older people in Spain. *International Psychogeriatrics*, *25*(3). http://doi.org/10.1017/S1041610212001809

Luoma, J. B., Martin, C. E., & Pearson, J. L. (2002). Contact with mental health and primary care providers before suicide: A review of the evidence. *The American Journal of Psychiatry*, *159*, 909–916.

Mancini, A. D., Sinan, B., & Bonanno, G. A. (2015). Predictors of prolonged grief, resilience, and recovery among bereaved spouses. *Journal of Clinical Psychology*, *71*, 1245–1258. http://doi.org/10.1002/jclp.22224

Maniaci, M. R., & Rogge, R. D. (2014). Caring about carelessness: Participant inattention and its effects on research. *Journal of Research in Personality, 48*, 61-82. http://dx.doi.org/10.1016/j.jrp.2013.09.008

Maples, M. F., & Abney, P. C. (2006). Baby Boomers mature and gerontological counseling comes of age. *Journal of Counseling & Development*, *84*(1), 3–9.

Martens, A., Goldenberg, J. L., & Greenberg, J. (2005). A terror management perspective on ageism. *Journal of Social Issues*, *61*, 223–239.

Martens, A., Greenberg, J., Schimel, J., & Landau, M. J. (2004). Ageism and death: Effects of mortality salience and perceived similarity to elders on reactions to elderly people. *Personality and Social Psychology Bulletin*, *30*, 1524–1536.

McAllister, M. (2011). STAR: A transformative learning framework for nurse educators. *Journal of Transformative Education*, *9*(1), 42–58.

McAllister, M., Downer, T., Framp, A., Hanson, J., Cope, J., & Gamble, T. (2011). Building empathic practice through transformative learning theory. *Australian Nursing Journal*, *19*(5), 22.

McBride, R. G., & Hays, D. G. (2012). Counselor demographics, ageist attitudes, and multicultural counseling competence among counselors and counselor trainees. *Adultspan Journal*, *11*(2), 77–88.

McCaughan, A. M., & Hill, N. R. (2015). The gatekeeping imperative in counselor education admission protocols: The criticality of personal qualities. *International Journal for the Advancement of Counselling*, *37*(1), 28–40. http://doi.org/10.1007/s10447-014-9223-2

McGann, M., Ong, R., Bowman, D., Duncan, A., Kimberley, H., & Biggs, S. (2016). Gendered ageism in Australia: Changing perceptions of age discrimination among older men and women. *Economic Papers: A Journal of Applied Economics and Policy*, *35*, 375–388. http://doi.org/10.1111/1759-3441.12155

McKibben, W. B., & Silvia, P. J. (2015). Evaluating the distorting effects of inattentive responding and social desirability on self-report scales in creativity and the arts. *The Journal of Creative Behavior, 51,* 1, 57-69. http://doi.org/10.1002/jocb.86

McNabney, M. (2012). When humor hurts: the problem with geezer jokes. Retrieved from http://articles.baltimoresun.com/2012-11-26/news/bs-ed-ageism-20121126_1_birthday-cards-age-discrimination-ageism

McVey, L. J., Davis, D. E., & Cohen, H. J. (1989). The "Aging Game": An approach to education in geriatrics. *Journal of the American Medical Association*, *262*, 1507–1509.

Mehrabian, A., & Epstein, N. (1972). A measure of emotional empathy. *Journal of Personality 4,* 525–543.

Meredith, S. D., & Watt, S. (1995). The gerontology department project. *Gerontology & Geriatrics Education*, *15*(2), 91–100. http://doi.org/10.1300/J021v15n02_09

Merz, C. C., Stark, S. L., Morrow-Howell, N. L., & Carpenter, B. D. (2016). When I'm 64: Effects of an interdisciplinary gerontology course on first-year undergraduates' perceptions of aging. *Gerontology & Geriatrics Education*, *17*, 1–11. http://doi.org/10.1080/02701960.2016.1144600

Meyers, S. A. (2008). Using transformative pedagogy when teaching online. *College Teaching*, *56*, 219–224.

Mezirow, J. (1991). *Transformative dimensions of adult learning*. San Francisco, California: Josey-Bass, Inc.

Mezirow, J. (2000). *Learning as transformation*. San Francisco, California: Josey-Bass, Inc.

Mezirow, J. (2003). Transformative learning as discourse. *Journal of Transformative Education*, *1*(1), 58–63. http://doi.org/10.1177/1541344603252098

Michalski, D., Mulvey, T., & Kohout, J. (2010). *2008 APA survey of psychology health service providers*. Washington, DC. Retrieved from http://204.14.132.173/workforce/publications/08-hsp/report.pdf

Montepare, J. M. (2009). Subjective age: Toward a guiding lifespan framework. *International Journal of Behavioral Development*, *33*(1), 42–46. http://doi.org/10.1177/0165025408095551

Moody, H. R., & Sasser, J. (2015). *Aging: Concept and controversies* (8th ed.). Thousand Oaks, CA: SAGE Publications, Inc.

Moyers, T. B., Houck, J., Rice, S. L., Longabaugh, R., & Miller, W. R. (2016). Therapist empathy, combined behavioral intervention, and alcohol outcomes in the COMBINE research project. *Journal of Consulting and Clinical Psychology*, *84*(3), No Pagination Specified. http://doi.org/10.1037/ccp0000074

Myers, J. E. (1995). From forgotten and ignored to standards and certification: Gerontological counseling comes of age. *Journal of Counseling & Development*, *74*, 143–149.

Myers, J. E., & Harper, M. C. (2004). Evidence-based effective practices with older adults. *Journal of Counseling & Development*, *82*, 207–219. http://doi.org/10.1002/j.1556-6678.2004.tb00304.x

Naftz, A., & Wurtele, S. K. (2010, April). *Test-retest reliability of the Fraboni Scale of Ageism.* Poster presented at the 2nd annual UCCS Mountain Lion Research Day, Colorado Springs, CO.

National Council on Aging. (2016). *Elder abuse facts*. Retrieved from https://www.ncoa.org/public-policy-action/elder-justice/elder-abuse-facts/

Nelson, T. D. (2005). Ageism: Prejudice against our feared future self. *Journal of Social Issues*, *61*, 207–221.

Nelson, T. D. (2016a). Promoting healthy aging by confronting ageism. *American Psychologist*, *71*, 276–282.

Nelson, T. D. (2016b). The age of ageism. *Journal of Social Issues*, *72*, 191–198. http://doi.org/10.1111/josi.12162

Nelson, T. D. (Ed.). (2017). *Ageism: Stereotyping and prejudice against older persons* (2nd ed.). Cambridge, MA: The MIT Press.

Neuman, D. L., Chan, R. C. K., Boyle, G. J., Wang, Y., & Westbury, H. R. (2015). Measures of empathy: Self-report, behavioral, and neuroscientific approaches. In G.J. Boyle, D.H. Saklofske, & G. Matthews (Eds.), *Measures of personality and social psychological constructs* (pp. 257-289). London, United Kingdom: Academic Press.

Ng, R., Allore, H. G., Monin, J. K., & Levy, B. R. (2016). Retirement as meaningful: Positive retirement stereotypes associated with longevity. *Journal of Social Issues*, *72*(1), 69–85. http://doi.org/10.1111/josi.12156

Ng, R., Allore, H. G., Trentalange, M., Monin, J. K., & Levy, B. R. (1995). Increasing negativity of age stereotypes across 200 years: Evidence from a database of 400 million words. *PLOS ONE*, *10*(2), 1–6. http://doi.org/10.1371/journal.pone.0117086

Nicolaides, A., & Dzubinski, L. (2016). Collaborative developmental action inquiry: An opportunity for transformative learning to occur? *Journal of Transformative Education*, *14*(2), 120–138.

Nielsen, T. A. (2014). *Graduate counseling students' interest in gerocounseling: A quantitative study* (Unpublished doctoral dissertation). North Dakota State University, Fargo, ND.

Norcross, J. C., & Fiske, S. T. (2012). An inconvenienced youth? Ageism and its potential intergenerational roots. *Psychological Bulletin*, *138*, 982–997. http://doi.org/10.1037/a0027843

Norcross, J. C., & Fiske, S. T. (2013). Act your (old) age: Prescriptive, ageist biases over succession, consumption, and identity. *Personality and Social Psychology Bulletin*, *39*, 720–734. http://doi.org/10.1177/0146167213480043

Norcross, J. C., & Fiske, S. T. (2015). Modern attitudes toward older adults in the aging world: A cross-cultural meta-analysis. *Psychological Bulletin*, *141*, 993–1021. http://doi.org/10.1037/a0039469

O'Connell, C. B. (2010). Enhancing transformative learning in physician assistant education. *The Journal of Physician Assistant Education*, *21*(1), 18–22.

Oliffe, J. L., Rasmussen, B., Bottorff, J. L., Kelly, M. T., Galdas, P. M., Phinney, A., & Ogrodniczuk, J. S. (2013). Masculinities, work, and retirement among older men who experience depression. *Qualitative Health Research*, *23*, 1626–1637. http://doi.org/10.1177/1049732313509408

Ory, M., Kinney Hoffman, M., Hawkins, M., Sanner, B., & Mockenhaupt, R. (2003). Challenging aging stereotypes: Strategies for creating a more active society. *American Journal of Preventive Medicine*, *25*, 164–171. http://doi.org/10.1016/S0749-3797(03)00181-8

Outlaw, F. H., Marquart, J. M., Roy, A., Luellen, J. K., Moran, M., Willis, A., & Doub, T. (2012). Treatment outcomes for older adults who abuse substances. *Journal of Applied Gerontology*, *31*(1), 78–100. http://doi.org/10.1177/0733464810382906

Owens, P. L., Barrett, M. L., Weiss, A. J., Washington, R. E., & Kronick, R. (2014). *Hospital inpatient utilization related to opioid overuse among adults, 1993-2012*. Rockville, MD. Retrieved from https://www.ncbi.nlm.nih.gov/books/NBK246983/pdf/Bookshelf_NBK246983.pdf

Pacala, J. T., Boult, Ã. C., & Hepburn, K. (2006). Ten years' experience conducting the Aging Game workshop: Was it worth it? *Journal of The American Geriatrics Society*, *54*, 144–149. http://doi.org/10.1111/j.1532-5415.2005.00531.x

Palmore, E. B. (1977). Facts on Aging: A short quiz. *Gerontologist*, *17*, 315–320.

Palmore, E. B. (2001). The Ageism Survey: First findings. *Gerontologist*, *41*, 572–575.

Palmore, E. B. (2004). Research note: Ageism in Canada and the United States. *Journal of Cross-Cultural Gerontology*, *19*, 41–46.

Palmore, E. B. (2015). Ageism comes of age. *Journal of Gerontology: Social Sciences*, *70*, 873–875. http://doi.org/10.1093/geront/9.4

Paone, T. R., Malott, K. M., Gao, J., & Kinda, G. (2015). Using sandplay to address students' reactions to multicultural counselor training. *International Journal of Play Therapy*, *24*, 190–204. http://doi.org/10.1037/a0039813

Paredes, M. A. B. (2010). *Addressing the professional development awareness needs of school counselors regarding English Language Learners (ELLs): Using the School Cultural Capital Game to enhance level of self-efficacy with ELLs and*

attitudes toward immigrants (Unpublished doctoral dissertation). The University of North Carolina at Greensboro, Greensboro, NC.

Paulhus, D. L. (1984). Two component models of socially desirable responding. *Journal of Personality and Social Psychology, 46*, 298-609.

Pinquart, M., Duberstein, P. R., & Lyness, J. M. (2007). Effects of psychotherapy and other behavioral interventions on clinically depressed older adults: A meta-analysis. *Aging & Mental Health*, *11*, 645–657. http://doi.org/10.1080/13607860701529635

Preston, S. D., & de Waal, F. B. M. (2002). Empathy: Its ultimate and proximate bases. *Behavioral and Brain Sciences*, *25*, 1–72. http://doi.org/10.1017/S0140525X02000018

Provident, I., Salls, J., Dolhi, C., Schreiber, J., Mattila, A., & Eckel, E. (2015). Design of an online curriculum promoting transformative learning in post professional doctoral students. *Online Learning*, *19*(3), 128–143.

Rabiner, D. J., O'Keefe, J., & Brown, D. (2006). Financial exploitation of older persons: Challenges and opportunities to identify, prevent, and address it in the United States. *Journal of Aging & Social Policy*, *18*(2), 47–67. http://doi.org/10.1300/J031v18n02_04

Rankin, K. P., Kramer, J. H., & Miller, B. L. (2005). Patterns of cognitive and emotional empathy in frontotemporal lobar degeneration. *Cognitive and Behavioral Neurology: Official Journal of the Society for Behavioral and Cognitive Neurology*, *18*(1), 28–36. http://doi.org/10.1097/01.wnn.0000152225.05377.ab

Rapisarda, C., Jencius, M., & McGlothlin, J. (2011). Master's students' experiences in a multicultural counseling role-play. *International Journal for the Advancement of Counselling*, *33*, 361–375. http://doi.org/10.1007/s10447-011-9139-z

Rasinski, H. M., Geers, A. L., & Czopp, A. M. (2013). "I guess what he said wasn't that bad": Dissonance in nonconfronting targets of prejudice. *Personality and Social Psychology Bulletin*, *39*, 856–869. http://doi.org/10.1177/0146167213484769

Ratts, M. J., Singh, A. A., Nassar-McMillan, S., Butler, S. K., & McCullough, J. R. (2015). Multicultural and social justice counseling competencies: Guidelines for the counseling profession. *Journal of Multicultural Counseling and Development*, *44*, 28–48.

Reed, S., Kassis, K., Nagel, R., Verbeck, N., & Mahan, J. D. (2015). Breaking bad news is a teachable skill in pediatric residents: A feasibility study of an educational intervention. *Patient Education and Counseling*, *98*, 748–752.

Reynolds, W. J., & Scott, B. (1999). Empathy: A crucial component of the helping relationship. *Journal of Psychiatric and Mental Health Nursing, 6,* 363–370.

Riach, K. (2007). "Othering" older worker identity in recruitment. *Human Relations*, *60*, 1701–1726. http://doi.org/10.1177/0018726707084305

Robinson, T., Callister, M., Magoffin, D., & Moore, J. (2007). The portrayal of older characters in Disney animated films. *Journal of Aging Studies*, *21*, 203–213. http://doi.org/10.1016/j.jaging.2006.10.001

Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology*, *21*, 95–103.

Rogers, C. R. (1969). *The freedom to learn*. Columbus, OH: Charles E. Merrill Publishing Company.

Rolita, L., Spegman, A., Tang, X., & Cronstein, B. N. (2013). Greater number of narcotic analgesic prescriptions for osteoarthritis is associated with falls and fractures in elderly adults. *Journal of the American Geriatrics Society*, *61*, 335–340. http://doi.org/10.1111/jgs.12148

Roseborough, D. J., Luptak, M., McLeod, J., & Bradshaw, W. (2013). Effectiveness of psychodynamic psychotherapy with older adults: A longitudinal study. *Clinical Gerontologist*, *36*(1), 1–16. http://doi.org/10.1080/07317115.2012.731476

Rosencranz, H. A., & McNevin, T. E. (1969). A factor analysis of attitudes toward the aged. *The Gerontologist*, *9*(1), 55–59.

Rothman, E. F., & Wang, N. (2016). A feasibility test of a brief Motivational Interview intervention to reduce dating abuse perpetration in a hospital setting. *Psychology of Violence*, *6*, 433–441.

Rupp, D. E., Vodanovich, S. J., & Credé, M. (2005). The multidimensional nature of ageism: Construct validity and group differences. *The Journal of Social Psychology*, *145*, 335–362.

Rybarczyk, B., Emery, E. E., Guequierre, L. L., Shamaskin, A., & Behel, J. (2012). The role of resilience in chronic illness and disability in older adults. *Annual Review of Gerontology and Geriatrics*, *32*(1), 173–187. http://doi.org/10.1891/0198-8794.32.173

Rybarczyk, B., Garroway, A. M., Auerbach, S. M., Rodríguez, V. M., Lord, B., & Sadock, E. (2013). Primary care psychology: An opportunity for closing the gap in mental health services for older adults. *Clinical Gerontologist*, *36*, 195–215. http://doi.org/10.1080/07317115.2013.767870

Sachs-Ericsson, N., van Orden, K. A., & Zarit, S. (2015). Suicide and aging: Special issue of Aging & Mental Health. *Aging & Mental Health*, *20*, 110–112. http://doi.org/10.1080/13607863.2015.1099037

Sargent-Cox, K. A., Rippon, M., & Burns, R. A. (2014). Measuring anxiety about aging across the adult lifespan. *International Psychogeriatrics C International Psychogeriatric Association*, *26*(1), 135–145. http://doi.org/10.1017/S1041610213001798

Sawyer, P., & Williams, B. R. (2012). Counseling older adults at risk of suicide: Recognizing barriers, reviewing strategies, and exploring opportunities for intervention. *Alabama Counseling Association Journal*, *38*(2), 80–103.

Schepis, T. S., & McCabe, S. E. (2016). Trends in older adult nonmedical prescription drug use prevalence: Results from the 2002–2003 and 2012–2013 National Survey on Drug Use and Health. *Addictive Behaviors*, *60*, 219–222. http://doi.org/10.1016/j.addbeh.2016.04.020

Schmall, V., Joanne Grabinski, C. M., Bowman, S., Joanne Grabinski, C., & Sally Bowman, M. (2008). Use of games as a learner-centered strategy in gerontology, geriatrics, and aging-related courses. *Gerontology & Geriatrics Education*, *293*, 225–233. http://doi.org/10.1080/07399330802359443

Schmutte, T., O'Connell, M., Weiland, M., Lawless, S., & Davidson, L. (2009). Stemming the tide of suicide in older white men: A call to action. *American Journal of Men's Health*, *3*, 189–200. http://doi.org/10.1177/1557988308316555

Schultz, S. K., Arndt, S., & Liesveld, J. (2003). Locations of facilities with special programs for older substance abuse client in the US. *International Journal of Geriatric Psychiatry*, *18*, 839–843. http://doi.org/10.1002/gps.994

Shapiro, J., & Hunt, L. (2003). All the world's a stage: The use of theatrical performance in medical education. *Medical Education*, *37*, 922–927.

Shapiro, J., Morrison, E. H., & Boker, J. R. (2004). Teaching empathy to first year medical students: Evaluation of an elective literature and medicine course. *Education for Health*, *17*(1), 73–84.

Shenoy, P., & Harugeri, A. (2015). Elderly patients' participation in clinical trials. *Perspectives on Clinical Research*, *6*, 184–189. http://doi.org/10.4103/2229-3485.167099

Shenton, A. K. (2004). Strategies for ensuring trustworthiness in qualitative research projects. *Education for Information*, *22*, 63–75.

Shreeniwas, S., & Morrison, S. (2016). Enhancing "gero-interest" among health education graduate students: Is "adding on" aging to international service learning effective? *Pedagogy in Health Promotions*, *2*(2), 137–143. http://doi.org/10.1177/2373379915625073

Simi, D., & Matusitz, J. (2016). Ageism against older U.S. college students: A view from social closure theory. *Interchange, 47,* 391-408. doi: 10.1007/s10780-016-9286-6

Sivis, R., & McCrae, C. S. (2010). Mental health professionals in gerontology: An insight into their perceptions, experiences, and needs. *Clinical Gerontologist*, *33*, 16–20. http://doi.org/10.1080/07317110903344992

Skorinko, J. L., & Sinclair, S. A. (2013). Perspective taking can increase stereotyping: The role of apparent stereotype confirmation. *Journal of Experimental Social Psychology, 49,* 10-18. http://dx.doi.org/10.1016/j.jesp.2012.07.009

Slavich, G. M., & Zimbardo, P. G. (2012). Transformational teaching: Theoretical underpinnings, basic principles, and core methods. *Educational Psychology Review*, *24*, 569–608. http://doi.org/10.1007/s10648-012-9199-6

Smith, T. B., Constantine, M. G., Dunn, T. W., Dinehart, J. M., & Montoya, J. A. (2006). Multicultural education in the mental health professions: A meta-analytic review. *Journal of Counseling Psychology*, *53*, 132–145. http://doi.org/10.1037/0022-0167.53.1.132

Snyder, C. (2008). Grabbing hold of a moving target. *Journal of Transformative Education*, *6*(3), 159–181.

Solomon, S., Greenberg, J., & Pyszczynski, T. (2000). Pride and prejudice: Fear of death and social behavior. *Current Directions in Psychological Science*, *9*, 200–204.

Solway, E., Estes, C. L., Goldberg, S., & Berry, J. (2010). Access barriers to mental health services for older adults from diverse populations: Perspective of leaders in mental health and aging. *Journal of Aging & Social Policy*, *22*, 360–378. http://doi.org/10.1080/08959420.2010.507650

Song, M., Choi, S., Kim, S.-A., Seo, K., & Lee, S. J. (2015). Intervention mapping protocol for developing a theory-based diabetes self-management education program. *Research and Theory for Nursing Practice*, *29*(2), 94–112. http://doi.org/10.1891/1541-6577.29.2.94

Soubelet, A., & Salthouse, T. A. (2011). Influence of social desirability on age differences in self-reports of mood and personality. *Journal of Personality*, *79*, 741–761. http://doi.org/10.1111/j.1467-6494.2011.00700.x

Spreng, R. N., McKinnon, M. C., Mar, R. A., & Levine, B. (2009). The Toronto Empathy Questionnaire: Scale development and initial validation of a factor-analytic solution to multiple empathy measures. *Journal of Personality Assessment*, *91*(1), 62–71. http://doi.org/10.1080/00223890802484381

Stebnicki, M. A. (2008). *Empathy fatigue: Healing the mind, body, and spirit of professional counselors.* New York, NY: Springer Publishing Company.

Steenkamp, J. B. E. M., de Jong, M. G., & Baumgartner, H. (2010). Socially desirable response tendencies in survey research. *Journal of Marketing Research, 47*, 199-214. http://www.jstor.org/stable/25674420

Stickle, F., & Onedera, J. D. (2006). Teaching gerontology in counselor education. *Educational Gerontology*, *32*, 247–259. http://doi.org/10.1080/03601270500493974

Sue, D. W., Arredondo, P., & McDavis, R. J. (1992). Multicultural counseling competencies and standards: A call to the profession. *Journal of Multicultural*

Counseling and Development, *70*, 477–486. http://doi.org/10.1037/0003-066X.59.8.761

Sue, D. W., Bernier, J. E., Durran, A., Feinberg, L., Pederson, P., Smith, E. J., & Vasquez-Nuttall, E. (1982). Position paper: Cross-cultural counseling competencies. *The Counseling Psychologist*, *10*(2), 45–52.

Tam, T., Hewstone, M., Harwood, J., Voci, A., & Kenworthy, J. (2006). Intergroup contact and grandparent–grandchild communication: The effects of self-disclosure on implicit and explicit biases against older people. *Group Processes & Intergroup Relations*, *93*, 413–429.

Taylor, C. A., Greenlund, S. F., McGuire, L. C., Lu, H., & Croft, J. A. (2017). Deaths from Alzheimer's disease-United States, 1999-2014. *Centers for Disease Control Morbidity and Mortality Weekly*, *66*, 521–526.

Taylor, E. W. (1998). *The theory and practice of transformative learning: A critical review. Information Series No. 374.* Washington, DC.

Taylor, E. W. (2007). An update of transformative learning theory: A critical review of the empirical research. *International Journal of Lifelong Education*, *26*, 173–191.

Taylor, E. W. (2008). Transformative learning theory. *New Directions for Adult & Continuing Education*, *119*, 5–15. http://doi.org/10.1002/ace.301

Teding van Berkhout, E., & Malouff, J. M. (2016). The efficacy of empathy training: A meta-analysis of randomized controlled trials. *Journal of Counseling Psychology*, *63*, 32–41.

The University of North Carolina at Greensboro. (2017). *About UNCG.* Retrieved from https://admissions.uncg.edu/discover-about.php

Therrien, Z., & Hunsley, J. (2012). Assessment of anxiety in older adults: A systematic review of commonly used measures. *Aging & Mental Health*, *16*(1), 1–16.

Tomko, J. K., & Munley, P. H. (2012). Predicting counseling psychologists attitudes and clinical judgments with respect to older adults. *Aging & Mental Health*, *17*(2), 1–9. http://doi.org/10.1080/13607863.2012.715141

Tomlinson-Clarke, S. (2013). Multicultural counseling competencies: Extending multicultural training paradigms toward globalization. *Ideas and Research You Can Use: VISTAS 2013*, (3), 1–10.

Trent, N. L., Park, C., Bercovitz, K., & Chapman, I. M. (2016). Trait socio-cognitive mindfulness is related to affective and cognitive empathy. *Journal of Adult Development*, *23*, 62–67.

Tse, C. T. (2014). *When empathy backfires: How (not) to engender warmth and respect for minorities.* (Unpublished doctoral dissertation). The University of Waterloo, Waterloo, Ontario, Canada.

Uotinen, V., Rantanen, T., & Suutama, T. (2005). Perceived age as a predictor of old age mortality: A 13-year prospective study. *Age and Ageing*, *34*, 368–372. http://doi.org/10.1093/ageing/afi091

Vacarr, B. (2014). An aging America: Higher education's new frontier. *Chronicle of Higher Education, 61*(15). Retrieved from https://www.chronicle.com/article/An-Aging-America-Higher/150425

van de Pol, M. H. J., Lagro, J., Fluit, L. R. M. G., Lagro-Janssen, T. L. M., & Olde Rikkert, M. G. M. (2014). Teaching geriatrics using an innovative, individual-centered educational game: Students and educators win. A proof-of-concept study. *Journal of the American Geriatrics Society*, *62*, 1943–1949. http://doi.org/10.1111/jgs.13024

van der Werf, M., & Sabatier, G. (2009). *The college of 2020: Students*. *Chronicle Research Services.* Washington, DC. Retrieved from http://www.uwec.edu/CETL/bundles/upload/college2020-dl.pdf

van Orden, K. A., & Conwell, Y. (2011). Suicides in late life. *Current Psychiatry Reports*, *13*, 234–241. http://doi.org/10.1007/s11920-011-0193-3

Vasiliadis, H.-M., Tempier, R., Lesage, A., & Kates, N. (2009). General practice and mental health care: Determinants of outpatient service use. *The Canadian Journal of Psychiatry*, *54*, 468–476.

Villalba, J. A., & Redmond, R. E. (2008). Crash: Using a popular film as an experiential learning activity in a multicultural counseling course. *Counselor Education & Supervision*, *47*, 264–277.

Wake Forest University. (2016). *2015-2016 Fact book*. Winston-Salem, NC. Retrieved from http://ir.wfu.edu/files/FB15_16.pdf

Walters, M. E., Dijkstra, A., de Winter, A. F., & Reijneveld, S. A. (2015). Development of a training programme for home health care workers to promote preventive activities focused on a healthy lifestyle: An intervention mapping approach. *BMC Health Services Research*, *15*, 1–12. http://doi.org/10.1186/s12913-015-0936-7

Ward-Ciesielski, E. F. (2013). An open pilot feasibility study of a brief dialectical behavior therapy skills-based intervention for suicidal individuals. *Suicide and Life-Threatening Behavior*, *43*, 324–335. http://doi.org/10.1111/sltb.12019

Watson, J. C., Steckley, P. L., & McMullen, E. J. (2014). The role of empathy in promoting change. *Psychotherapy Research*, *24*, 286–298. http://doi.org/10.1080/10503307.2013.802823

Weiss, D., & Lang, F. R. (2012). "They" are old but "I" feel younger: Age-group dissociation as a self-protective strategy in old age. *Psychology and Aging*, *27*, 153–163. http://doi.org/10.1037/a0024887

Wolf, M. A. (2009). Older adult women learners in transition. *New Directions for Adult and Continuing Education, 122,* 50-62.

Woodhead, E. L., Emery, E. E., Pachana, N. A., Scott, T. L., Konnert, C. A., & Edelstein, B. A. (2013). Graduate students' geropsychology training opportunities and perceived competence in working with older adults. *Professional Psychology: Research and Practice*, *44*, 355–362. http://doi.org/10.1037/a0034632

World Health Organization. (2014). *Preventing suicide: A global imperative*. Geneva, Switzerland. Retrieved from http://apps.who.int/iris/bitstream/10665/131056/8/9789241564878_eng.pdf?ua=1&ua=1

World Health Organization. (2015). *World report on ageing and health*. Geneva, Switzerland. Retrieved from http://apps.who.int/iris/bitstream/10665/186463/1/9789240694811_eng.pdf

Wurm, S., Tesch-Römer, C., & Tomasik, M. J. (2007). Longitudinal findings on aging-related cognitions, control beliefs, and health in later life. *Journal of Gerontology: Psychological Sciences*, *62B*(3), 156–164.

Wurtele, S. K. (2009). ‘‘Activities of Older Adults’’ survey: Tapping into student views of the elderly. *Educational Gerontology*, *35*, 1026–1031. http://doi.org/10.1080/03601270902973557

Yep, R. (2008). An ounce of prevention. *Counseling Today*, *50*(6). Retrieved from https://ct.counseling.org/2008/03/from-the-executive-director-an-ounce-of-prevention/

Youssef, F. F., Nunes, P., Sa, B., & Williams, S. (2014). An exploration of changes in cognitive and emotional empathy among medical students in the Caribbean. *International Journal of Medical Education*, *5*, 185–192. http://doi.org/10.5116/ijme.5412.e641

Zucchero, A. (1998). A unique model for training mental health professionals to work with older adults. *Educational Gerontology*, *24*, 265–278.

Zucchero, A., Iwasaki, M., Lewis, M. M., Lee, J., & Robbins, M. J. (2014). Social justice training within geropsychology: Nontraditional pedagogies to cultivate a competent workforce. *The Counseling Psychologist*, *42*, 946–971. http://doi.org/10.1177/0011000014540342

APPENDIX A

INITIAL IMPLEMENTATION STUDY DOCUMENTATION

INTEGRATING GERONTOLOGICAL COUNSELING COMPETENCIES INTO MULTICULTURAL COUNSELING CURRICULA
Fall 2016

Informed Consent Script

My name is Sara Bailey, and I am a second-year doctoral student in the Department of Counseling and Educational Development. For my future dissertation study and my future professional research agenda, I am interested in researching age-related cultural competence in master's students currently enrolled in multicultural counseling courses. I have developed a board-game style in-class activity designed to be used by students in multicultural counseling classes. I hope to continue to develop this in-class activity and invite you to help me assess its feasibility as an empathy-building exercise. For those who choose to participate, I will divide you into small groups or teams, and a representative from each team (aka "designated game player") will move around the game board. Taking turns from team to team, participants will pick a piece of paper from this bowl (a plastic bowl filled with folded paper prompts), and read the prompt on the paper aloud. Immediately after reading the prompt to the group, the participant will be invited to share his or her immediate emotional reaction. Then, depending on the directions of game play, the designated game player will either stay in place, or move forward one space.

After about 30 minutes of play, the game will end, and the participants will be invited to take their seats and participate in a focus group, during which we will discuss and process the activity as a group, including any reactions you would like to share. Any notes that I take during our focus group will contain no identifiable information and will be uploaded and securely stored in my password-protected UNCG Box account. I will invite Dr. Jones (*instructor of record) to step out of the room during our focus group. The focus group

will end after about 30 minutes, and Dr. Jones as well as those who chose not to participate in the activity will be invited back into the room and class will continue as normal.

During game play, if anyone feels the need to further process any emotional reactions to the prompts or the game, we can take time to do that. If at any time anyone feels uncomfortable or chooses to cease participation in the activity, participants are free to do so without penalty.

Participation in this activity is entirely voluntary and your decision to participate or not will not impact your grade in this class. As the principal investigator of this study, I have no evaluative function.

Risks for participation in this activity are minimal, but may include emotional reactions that may be uncomfortable. I invite you to alert me to any difficult emotional reactions, and should there be anything that you would like to process further after the activity and the post-activity focus group, I will be available for further processing, and free counseling services are available through the Vacc Counseling and Consultation Clinic as well as through the UNCG Counseling Center.

I can be reached at swbailey@uncg.edu and in my office in the Vacc Clinic, 223 Ferguson. Dr. Laura Gonzalez is my dissertation chair and faculty advisor for this study, and she can be reached at her office in 215 Curry or at lmgonza2@uncg.edu.

If you have any concerns about your rights, how you are being treated, concerns or complaints about this project or benefits or risks associated with being in this study, please contact the Office of Research Integrity at UNCG toll-free at (855)-251-2351.

If you choose to participate, please join me at the front of the room. If you would prefer not to participate, you are free to step outside the classroom and use the time as you wish. After the activity and focus group time is complete, I will come out to invite you to join the class. The entire activity should take about an hour.

For those who chose to participate in this activity, Dr. Jones will email you a link to an anonymous survey through Qualtrics. The survey will provide you an opportunity to share your evaluation of the activity as well as any suggestions for improvement.

Are there any questions?

Email Recruitment for Qualtrics Survey

Thank you so much for participating in the in-class activity in Dr. Jones' multicultural counseling class on November 14. Your willingness to participate, your feedback, and your insights are invaluable to me. You have played a role in what I hope will become a research agenda that will go far beyond my dissertation study and will eventually have an impact on how counselor educators train counselors to better serve older adults.

In order to gather your input on improving and further developing the activity, I invite you to complete a brief, nine-question, anonymous online survey. The survey should take 15 minutes or less. Risks for participation are minimal and may include emotional reactions to the questions.

If you have questions, you may contact me, Sara Bailey, at swbailey@uncg.edu. Dr. Laura Gonzalez, my faculty advisor for this study, can be reached at lmgonza2@uncg.edu.

Absolute confidentiality of data provided through the Internet cannot be guaranteed due to the limited protections of Internet access. Please be sure to close your browser when finished so no one will be able to see what you have been doing.

Please click on the link below to begin the survey, and thank you for your time.

Approved IRB
10/24/16

Qualtrics Survey Items

1. How well did you understand the purpose and procedures of the in-class activity? [Likert scale from 1 (not at all), 2 (somewhat), 3 (well enough), 4, (almost completely) to 5 (completely).]
2. How well did you understand the risks and benefits of the in-class activity? [Likert scale from 1 (not at all), 2 (somewhat), 3 (well enough), 4, (almost completely) to 5 (completely).]
3. Prior to the in-class activity, how likely were you to consider age as a cultural consideration? [Likert scale from 1 (not at all likely), 2 (a bit likely), 3 (moderately likely), 4 (pretty likely), to 5 (very likely).]
4. After the in-class activity, how likely are you to consider age as a cultural consideration? [Likert scale from 1 (not at all likely), 2 (a bit likely), 3 (moderately likely), 4 (pretty likely), to 5 (very likely).]
5. How likely are you to provide counseling for older adults? [Likert scale from 1 (not at all likely), 2 (a bit likely), 3 (moderately likely), 4 (pretty likely), to 5 (very likely).]
6. How well-equipped do you feel to counseling older adults? [Likert scale from 1 (not at all), 2 (somewhat), 3 (moderately), 4 (pretty well), to 5 (very well).]
7. In your experience, how effective was the in-class activity at enhancing empathy toward older adults? [Likert scale from 1 (not at all), 2 (somewhat), 3 (moderately), 4 (pretty effective), to 5 (very effective).]
8. What suggestions do you have for improving any aspect of the in-class activity? (Open-ended)
9. Please share anything else you'd like to share. (Open-ended)

APPENDIX B

INITIAL IMPLEMENTATION STUDY SURVEY RESPONSES

1. How well did you understand the purpose and procedures of the in-class activity?

somewhat: $n = 1$; almost completely: $n = 6$; completely: $n = 14$

2. How well did you understand the risks and benefits of the in-class activity?

somewhat: $n = 1$; well enough: $n = 2$; almost completely: $n = 1$; completely: $n = 17$

3. Prior to the in-class activity, how likely were you to consider age as a cultural consideration?

not at all likely: $n = 1$; a bit likely: $n = 5$; moderately likely: $n = 9$; pretty likely: $n = 4$; very likely: $n = 2$

4. After the in-class activity, how likely are you to consider age as a cultural consideration?

moderately likely: $n = 1$; pretty likely: $n = 9$; very likely: $n = 11$

5. How likely are you to provide counseling for older adults?

not at all likely: $n = 4$; moderately likely: $n = 11$; pretty likely: $n = 5$; very likely: $n = 4$

6. How well-equipped do you feel to counseling older adults?

not at all: $n = 1$; somewhat: $n = 6$; moderately: $n = 9$; pretty well: $n = 5$

7. In your experience, how effective was the in-class activity at enhancing empathy toward older adults?

moderately: $n = 2$; pretty effective: $n = 8$; very effective: $n = 11$

APPENDIX C

STUDY DOCUMENTATION FALL 2017

Script for Class Recruitment at UNCG

My name is Sara Bailey, and I am a third-year doctoral student in the Department of Counseling and Educational Development at UNCG. For my dissertation study, I am studying empathy and attitudes toward older adults of master's counseling students and would like to invite you to participate in my dissertation research.

I have developed a three-part intervention that includes two brief online journaling activities and a face-to-face board-game style activity. If you choose to participate, I will also ask you to complete an online pre-intervention questionnaire and post-intervention questionnaire. To participate in this study, you must be 18 years or older. As an incentive, I am offering cash at three points during the study. First, for completing the initial online questionnaire, you will receive $5 in cash. Next, for completing the first online journaling activity and the face-to-face board-game style activity, you will receive another $5 in cash. Lastly, for completing the second online journaling activity and the final online questionnaire, you will receive an additional $10 in cash for a total of $20 for completing all study procedures.

Participation in this research study is entirely voluntary and your decision to participate or not will have no impact on your grade in this or another other class. Because I have an evaluative role in CED 605, I have invited an assistant to pass out written informed consent forms and keep track of who agrees to participate in the study. All communications regarding the study will go through fellow graduate students and professional facilitators. All study documentation will be deidentified and tracked using alphanumeric codes that will be explained to you when I leave the room. As the principal

investigator of this study, I will be analyzing data but will not know whose responses I am analyzing.

I can be reached at swbailey@uncg.edu and in my office in the Vacc Clinic, 223 Ferguson. Dr. Laura Gonzalez is my dissertation chair and faculty advisor for this study, and she can be reached at her office in room 308 in the School of Education Building or at lmgonza2@uncg.edu.

If you have any concerns about your rights, how you are being treated, concerns or complaints about this project or benefits or risks associated with being in this study, please contact the Office of Research Integrity at UNCG toll-free at (855)-251-2351.

Are there any questions?

I will now leave the room and my assistant will pass out written informed consent forms as well as instructions for creating an alphanumeric code to be used on all study documentation. Thank you for your consideration.

Approved IRB
10/10/17

Script for Class Recruitment in UNCG HED 602

My name is Sara Bailey, and I am a third-year doctoral student in the Department of Counseling and Educational Development at UNCG. For my dissertation study, I am studying empathy and attitudes toward older adults of master's students training to become counselors and student support professionals, and would like to invite you to participate in my dissertation research.

I have developed a three-part intervention that includes two brief online journaling activities and a face-to-face board-game style activity. If you choose to participate, I will also ask you to complete an online pre-intervention questionnaire and post-intervention questionnaire. To participate in this study, you must be 18 years or older. As an incentive, I am offering cash at three points during the study. First, for completing the initial online questionnaire, you will receive $5 in cash. Next, for completing the first online journaling activity and the face-to-face board-game style activity, you will receive another $5 in cash. Lastly, for completing the second online journaling activity and the final online questionnaire, you will receive an additional $10 in cash for a total of $20 for completing all study procedures.

Participation in this research study is entirely voluntary and your decision to participate or not will have no impact on your grade in this or another other class. All written and survey study documentation will be deidentified and tracked using alphanumeric codes that I will explain to you in a moment. As the principal investigator of this study, I will be analyzing written and survey data but will not know whose responses I am analyzing. Neither your course instructor Dr. Gonzalez nor any UNCG faculty will know whether or not you choose to participate in this study.

I can be reached at swbailey@uncg.edu and in my office in the Vacc Clinic, 223 Ferguson, on the campus of UNCG. Dr. Laura Gonzalez is my dissertation chair and

faculty advisor for this study, and she can be reached at her office in room 308 in the School of Education Building at UNCG or at lmgonza2@uncg.edu.

If you have any concerns about your rights, how you are being treated, concerns or complaints about this project or benefits or risks associated with being in this study, please contact the Office of Research Integrity at UNCG toll-free at (855)-251-2351.

Are there any questions?

I will now pass out informed consent forms.

Approved IRB
10/24/17

THE UNIVERSITY OF NORTH CAROLINA AT GREENSBORO

CONSENT TO ACT AS A HUMAN PARTICIPANT

Written Informed Consent for UNCG

Project Title: The Game of *I am*: Measuring empathy and attitudes toward older adults in first-year master's counseling students

Principal Investigator: Sara W. Bailey, MA, LPCA, NCC

What are some general things I should know about research studies?
You are being asked to take part in a research study. Your participation in the study is voluntary. You may choose not to join, or you may withdraw your consent to be in the study, for any reason, without penalty.

Research studies are designed to obtain new knowledge. New information collected from this study may be of benefit to society by helping researchers understand more about master's counseling students' empathy and attitudes toward older adults. There may not be any direct benefit to you for being in the research study. There also may be risks to being in research studies. If you choose not to be in the study or leave the study before it is done, it will not affect your relationship with the researcher or The University of North Carolina at Greensboro. Details about this study are discussed in this consent form. It is important that you understand this information so that you can make an informed choice about being in this research study.

If you have any questions about this study, you should ask (name and contact info for assistant) so that the researcher does not know who has chosen to participate.

Neither the principal investigator, Sara W. Bailey, or any CED faculty will know who is participating in the study, and your decision to participate will not impact your participation or assignment grades in CED 605 or any other course.

What is the study about?

This is a research project. Your participation is voluntary. The purpose of this study is to learn about empathy and attitudes toward older adults of master's counseling students enrolled in a full-time CACREP-accredited counseling program.

Why are you asking me?

You are invited to participate in this study because you are currently a first-year master's counseling student in a full-time CACREP-accredited counseling program. You must be 18 or older to participate and you must be able to complete online surveys and study procedures that are written in the English language.

What will you ask me to do if I agree to be in the study?

All participants will be asked to complete an online questionnaire that was developed for this study, once at the beginning of the semester, and once at the end of the semester. This questionnaire has 2 parts. In Part 1, you will be asked general demographics questions about yourself. In Part 2, you will be asked to complete two surveys about empathy and your attitudes toward older adults. I estimate that it will take less than 15 minutes to complete this questionnaire.

After completing the initial online questionnaire, you will receive $5 in cash. Next, you will be asked to complete a brief online journaling activity. After that, you will be invited to participate in a face-to-face board game-style activity and discussion. *For UNCG students: The face-to-face activity will be facilitated by another graduate student or a professional facilitator.* and will last one hour, and after the hour, you will receive an additional $5 in cash. Following your participation in the face-to-face activity, you will

be invited to complete a second brief online journaling activity. Lastly, you will be asked to complete a second online questionnaire. After completing all study procedures, you will receive an additional $10 in cash for a total of $20.

Is there any audio/video recording?

The face-to-face activity will be audio recorded by the facilitator. Because the researcher will not be analyzing recorded data for her dissertation study but will analyze written and recorded artifacts as part of follow-up qualitative analyses after the study is complete, the recording will be stored in an encrypted UNCG Box account and will only be accessible by the researcher after the study is complete. This recording will be destroyed after notes are completed and no identifying information will be attached to the recording or any notes that are taken. Because your voice will be potentially identifiable by anyone who hears the recording, your confidentiality for things you say on the recording cannot be guaranteed although the researcher will try to limit access to the recording as described above.

Will I get paid for being in the study?

As described above, for completing all study procedures, participants will receive a total of $20 in cash, presented in three increments throughout the study. The cash will be given to participants by another graduate student and not by the researcher.

What are the risks to me?

The Institutional Review Board at the University of North Carolina at Greensboro has determined that participation in this study poses minimal risk to participants. There is a risk that participants will experience some mild emotional distress resulting from answering questions and participating in discussions regarding empathy and attitudes toward older adults. If you have questions or concerns, Sara W. Bailey can be reached at swbailey@uncg.edu or in her office in the Vacc Counseling and Consulting Clinic, 223 Ferguson Building. Sara's faculty advisor for this study is Dr. Laura M. Gonzalez, and

she can be reached at lmgonza2@uncg.edu, or in her office in room 338 in the School of Education Building. Free on-campus counseling services are available at the Vacc Counseling and Consulting Clinic, located on the second floor of Ferguson Building, cedclinic@uncg.edu or 336.334.5112 and through the UNCG Counseling Center, located on the second floor of the Anna M. Gove Student Health Center, 336-334-5874. For other mental health resources in the Greensboro area, the Mental Health Association in Greensboro has developed an online resource list, which can be accessed at www.mhag.org/wp-content/uploads/2016/10/Resource-list.docx

If you have any concerns about your rights, how you are being treated, concerns or complaints about this project or benefits or risks associated with being in this study, please contact the Office of Research Integrity at UNCG toll-free at (855)-251-2351.

How will you keep my information confidential?

All information obtained in this study is strictly confidential unless disclosure is required by law. Study data will be collected anonymously, meaning that the survey website system will not collect any identifying information about you. Absolute confidentiality of data provided through the Internet cannot be guaranteed due to the limited protections of Internet access. We will store all study-related data securely using password-protected electronic files and locked filing cabinets for storing hard copies of the data.

What if I want to leave the study?

You have the right to refuse to participate or to withdraw at any time, without penalty. If you do withdraw, it will not affect your participation or assignment grades in CED 605 or any other course in any way. The investigator also has the right to stop your participation at any time. This could be because you have failed to follow instructions, or because the entire study has been stopped.

Voluntary Consent by Participant:

By providing your signature below, you are agreeing that you have read and fully

understand the contents of this document, all of your questions concerning this study have been answered, and you are openly willing to take part in this study.

_____ _____

Signature Date

_____

Alphanumeric Code

Instructions for Selecting Alphanumeric Code

If you choose to participate in this research study, to track study artifacts in a way that will protect your anonymity, please choose an alphanumeric code to be used throughout the study. To select a code that you will remember throughout the study, please do the following:

Use the first two letters of your middle name, the last two letters of your last name, and the last two digits of your zip code.

For example, if your name is Chris Alex Jones and your zip code is 12345, your alphanumeric code would be: **ales45**.

I will keep your informed consent forms in a locked cabinet for the duration of the study, so please contact me if you forget your code at any time during the study. Sara will use your code to track study materials but will not know your identity.

Are there any questions?

Approved IRB
10/10/17

Written Informed Consent for HED 602

Project Title: The Game of *I am*: Measuring empathy and attitudes toward older adults in first-year master's students training to become counselors and student support professionals

Principal Investigator: Sara W. Bailey, MA, LPCA, LCAS-A, NCC
Faculty Advisor: L. DiAnne Borders, PhD

What are some general things I should know about research studies?
You are being asked to take part in a research study. Your participation in the study is voluntary. You may choose not to join, or you may withdraw your consent to be in the study, for any reason, without penalty.

Research studies are designed to obtain new knowledge. New information collected from this study may be of benefit to society by helping researchers understand more about master's students' empathy and attitudes toward older adults. There may not be any direct benefit to you for being in the research study. There also may be risks to being in research studies. If you choose not to be in the study or leave the study before it is done, it will not affect your relationship with the researcher or The University of North Carolina at Greensboro. Details about this study are discussed in this consent form. It is important that you understand this information so that you can make an informed choice about being in this research study.

If you have any questions about this study at any time, you should ask me in person or at swbailey@uncg.edu.

Dr. Gonzalez will not know who is participating in the study, and your decision to participate will not impact your participation or assignment grades in this or any other course.

What is the study about?

This is a research project. Your participation is voluntary. The purpose of this study is to learn about empathy and attitudes toward older adults of master's students.

Why are you asking me?

You are invited to participate in this study because you are currently a first-year master's student enrolled in HED 602 in the UNCG School of Education. You must be 18 or older to participate and you must be able to complete online surveys and study procedures that are written in the English language.

What will you ask me to do if I agree to be in the study?

All participants will be asked to complete an online questionnaire that was developed for this study, once at the beginning of the study, and again at the end. This questionnaire has 2 parts. In Part 1, you will be asked general demographics questions about yourself. In Part 2, you will be asked to complete two surveys about empathy and your attitudes toward older adults. I estimate that it will take less than 15 minutes to complete this questionnaire.

After completing the initial online questionnaire, you will receive $5 in cash. Next, you will be asked to complete a brief online journaling activity. After that, you will be invited to participate in a face-to-face board game-style activity and discussion. The face-to-face activity will last one hour, and after the hour, you will receive an additional $5 in cash. Following your participation in the face-to-face activity, you will be invited to complete a second brief online journaling activity. Lastly, you will be asked to complete a second online questionnaire. After completing all study procedures, you will receive an additional $10 in cash for a total of $20.

Is there any audio/video recording?

The face-to-face activity will be audio recorded by the facilitator, Sara Bailey. Because the researcher will not be analyzing recorded data for her dissertation study but will analyze written and recorded artifacts as part of follow-up qualitative analyses after the study is complete, the recording will be stored in an encrypted UNCG Box account and will only be accessible by the researcher after the study is complete. This recording will be destroyed after notes are completed and no identifying information will be attached to the recording or any notes that are taken. Because your voice will be potentially identifiable by anyone who hears the recording, your confidentiality for things you say on the recording cannot be guaranteed although the researcher will try to limit access to the recording as described above.

Will I get paid for being in the study?

As described above, for completing all study procedures, participants will receive a total of $20 in cash, presented in three increments throughout the study.

What are the risks to me?

The Institutional Review Board at the University of North Carolina at Greensboro has determined that participation in this study poses minimal risk to participants. There is a risk that participants will experience some mild emotional distress resulting from answering questions and participating in discussions regarding empathy and attitudes toward older adults. If you have questions or concerns, Sara W. Bailey can be reached at swbailey@uncg.edu or in her office in the Vacc Counseling and Consulting Clinic, 223 Ferguson Building. Sara's faculty advisor for this study is Dr. L. DiAnne Borders. Dr. Borders can be reached at borders@uncg.edu or in her office in room 226 Curry Building. Free on-campus counseling services are available at the Vacc Counseling and Consulting Clinic, located on the second floor of Ferguson Building, cedclinic@uncg.edu or 336.334.5112 and through the UNCG Counseling Center, located on the second floor of the Anna M. Gove Student Health Center, 336-334-5874. For more community mental

health resources in the Greensboro area, the Mental Health Association in Greensboro has developed an online resource list, which can be accessed at www.mhag.org/wp-content/uploads/2016/10/Resource-list.docx

If you have any concerns about your rights, how you are being treated, concerns or complaints about this project or benefits or risks associated with being in this study, please contact the Office of Research Integrity at UNCG toll-free at (855) 251-2351.

How will you keep my information confidential?

All information obtained in this study is strictly confidential unless disclosure is required by law. Study data will be collected confidentially, meaning that the survey website system will not collect any identifying information about you. Absolute confidentiality of data provided through the Internet cannot be guaranteed due to the limited protections of Internet access. I will store all study-related data securely using password-protected electronic files and locked filing cabinets for storing hard copies of the data.

What if I want to leave the study?

You have the right to refuse to participate or to withdraw at any time, without penalty. If you do withdraw, it will not affect your participation or assignment grades in this or another other course in any way. The investigator also has the right to stop your participation at any time. This could be because you have failed to follow instructions, or because the entire study has been stopped.

Voluntary Consent by Participant:

By providing your signature below, you are agreeing that you have read and fully understand the contents of this document, all of your questions concerning this study have been answered, and you are openly willing to take part in this study.

_____ _____

Signature Date

_____

Alphanumeric Code

Instructions for Selecting Alphanumeric Code

If you choose to participate in this research study, to track study artifacts in a way that will protect your confidentiality, please choose an alphanumeric code to be used throughout the study. To select a code that you will remember throughout the study, please do the following:

Use the first two letters of your middle name, the last two letters of your last name, and the last two digits of your zip code.

For example, if your name is Chris Alex Jones and your zip code is 12345, your alphanumeric code would be: **ales45**.

I will keep your informed consent forms in a locked cabinet for the duration of the study. If you forget your alphanumeric code, please contact me and I will invite a fellow graduate student at UNCG to look at your informed consent form and send you your code.

Are there any questions?

Approved IRB
10/24/17

Initial Online Qualtrics Survey

Part 1: Demographics/Interest

1. Please indicate your age in years. _____

2. What is your gender? _____

3. What is your race/ethnicity? _____

4. (CED): How likely are you to provide counseling for older adults?

4. (HED 602): How likely are you to work with older adults as a student support professional?

[Likert-type scale: 1 (not at all likely), 2 (a bit likely), 3 (moderately likely), 4 (pretty likely), to 5 (very likely).]

Part 2: Survey Instruments

Toronto Empathy Questionnaire

Below is a list of statements. Please read each statement carefully and rate how frequently you feel or act in the manner described. Circle your answer on the response form. There are no right or wrong answers. Please answer each question as honestly as you can.

		Never	Rarely	Sometimes	Often	Always
1.	When someone else is feeling excited, I tend to get excited too	0	1	2	3	4
2.	Other people's misfortunes do not disturb me a great deal	0	1	2	3	4
3.	It upsets me to see someone being treated disrespectfully	0	1	2	3	4
4.	I remain unaffected when someone close to me is happy	0	1	2	3	4
5.	I enjoy making other people feel better	0	1	2	3	4
6.	I have tender, concerned feelings for people less fortunate than me	0	1	2	3	4
7.	When a friend starts to talk about his/her problems, I try to steer the conversation towards something else	0	1	2	3	4

8.	I can tell when others are sad even when they do not say anything	0	1	2	3	4
9.	I read instructions carefully. To show that you are reading these instructions, please leave this question blank.	0	1	2	3	4
10.	I find that I am "in tune" with other people's moods	0	1	2	3	4
11.	I do not feel sympathy for people who cause their own serious illnesses	0	1	2	3	4
12.	I become irritated when someone cries	0	1	2	3	4
13.	I am not really interested in how other people feel	0	1	2	3	4
14.	I never regret my decisions.	0	1	2	3	4
15.	I get a strong urge to help when I see someone who is upset	0	1	2	3	4
16.	When I see someone being treated unfairly, I do not feel very much pity for them	0	1	2	3	4
17.	I find it silly for people to cry out of happiness	0	1	2	3	4
18.	When I see someone being taken advantage of, I feel kind of protective towards him/her	0	1	2	3	4

Fraboni Scale of Ageism

Below is a list of statements. Please answer each question as honestly as you can. There are no right or wrong answers. Next to each item, choose the number that best describes your answer based on the following scale:

1 = strongly disagree; 2 = disagree; 3 = agree; 4 = strongly agree

1. Teenage suicide is more tragic than suicide among the old.	**1**	**2**	**3**	**4**
2. There should be special clubs set aside within sports facilities so that old people can compete at their own level.	**1**	**2**	**3**	**4**
3. Many old people are stingy and hoard their money and possessions.	**1**	**2**	**3**	**4**
4. Many old people are not interested in making new friends, preferring instead the circle of friends they have had for years.	**1**	**2**	**3**	**4**
5. Many old people just live in the past.	**1**	**2**	**3**	**4**
6. I read instructions carefully. To show that you are reading these instructions, please leave this question blank.	**1**	**2**	**3**	**4**
7. I sometimes avoid eye contact with old people when I see them.	**1**	**2**	**3**	**4**
8. I don't like it when old people try to make conversation with me.	**1**	**2**	**3**	**4**
9. Old people deserve the same rights and freedoms as do other members of our society.	**1**	**2**	**3**	**4**
10. Complex and interesting conversation cannot be expected from most old people.	**1**	**2**	**3**	**4**
11. Feeling depressed when around old people is probably a common feeling.	**1**	**2**	**3**	**4**
12. I have said something about a friend behind his or her back.	**1**	**2**	**3**	**4**
13. Old people should find friends their own age.	**1**	**2**	**3**	**4**
14. Old people should feel welcome at the social gatherings of young people.	**1**	**2**	**3**	**4**
15. I would prefer not to go to an open house at a seniors' club, if invited.	**1**	**2**	**3**	**4**
16. Old people can be very creative.	**1**	**2**	**3**	**4**
17. I personally would not want to spend much time with an old person.	**1**	**2**	**3**	**4**
18. Most old people should not be allowed to renew their driver's licenses.	**1**	**2**	**3**	**4**
19. Old people don't really need to use our community sports facilities.	**1**	**2**	**3**	**4**
20. Most old people should not be trusted to take care of infants.	**1**	**2**	**3**	**4**

21. Many old people are happiest when they are with people their own age.	**1**	**2**	**3**	**4**
22. It is best that old people live where they won't bother anyone.	**1**	**2**	**3**	**4**
23. The company of most old people is quite enjoyable.	**1**	**2**	**3**	**4**
24. It is sad to hear about the plight of the old in our society these days.	**1**	**2**	**3**	**4**
25. Old people should be encouraged to speak out politically.	**1**	**2**	**3**	**4**
26. Most old people are interesting, individualistic people.	**1**	**2**	**3**	**4**
27. Most old people would be considered to have poor personal hygiene.	**1**	**2**	**3**	**4**
28. I would prefer not to live with an old person.	**1**	**2**	**3**	**4**
29. Most old people can be intimidating because they tell the same stories over and over.	**1**	**2**	**3**	**4**
30. Old people complain more than other people do.	**1**	**2**	**3**	**4**
31. Old people do not need much money to meet their needs.	**1**	**2**	**3**	**4**

Online Pre-Reflection Survey (CED)

Thank you for agreeing to participate in this research study, **The Game of *I am*: Measuring empathy and attitudes toward older adults in first-year master's counseling students**, and thank you for completing your initial survey instrumentation.

For the next step of this study, please respond to the following prompt in 250 to 500 words. Please enter the alphanumeric code you created when you consented to the study (i.e., first two letters of middle name, last two letters of last name, last two digits of zip code) in the space provided.

Today is your 75th birthday. Using first-person, 'I' language, describe your life, your personality, your habits, and your health.

Thank you for completing this activity. Within the next few days, you will receive an invitation to participate in the next face-to-face stage of the research study.

Online Pre-Reflection Survey (SAAHE)

Thank you for agreeing to participate in this research study, **The Game of *I am*: Measuring empathy and attitudes toward older adults in first-year master's students training to become counselors and student support professionals**, and thank you for completing your initial survey instrumentation.

For the next step of this study, please respond to the following prompt in 250 to 500 words. Please enter the alphanumeric code you created when you consented to the study (i.e., first two letters of middle name, last two letters of last name, last two digits of zip code) in the space provided.

Today is your 75th birthday. Using first-person, 'I' language, describe your life, your personality, your habits, and your health.

Thank you for completing this activity. Within the next few days, you will receive an invitation to participate in the next face-to-face stage of the research study.

Face-to-Face Game Play and Focus Group Procedures

See Appendix D: Facilitators' Guide

Online Post-Reflection Survey (CED)

Thank you for agreeing to participate in this research study, **The Game of *I am*: Measuring empathy and attitudes toward older adults in first-year master's counseling students**, and thank you for completing your initial survey instrumentation and the face-to-face game-playing activity and focus group.

For the next step of this study, please respond to the following prompt in 250 to 500 words. Please enter the alphanumeric code you created when you consented to the study (i.e., first two letters of middle name, last two letters of last name, last two digits of zip code) in the space provided.

How would you feel about working with a 90-year-old client who presents with symptoms of depression?

Thank you for completing this activity. Within the next few days, you will receive a link to complete final study instrumentation.

Online Post-Reflection Survey (SAAHE)

Thank you for agreeing to participate in this research study, **The Game of *I am*: Measuring empathy and attitudes toward older adults in first-year master's students training to become counselors and student support professionals**, and thank you for completing your initial survey instrumentation and the face-to-face game-playing activity and focus group.

For the next step of this study, please respond to the following prompt in 250 to 500 words. Please enter the alphanumeric code you created when you consented to the study (i.e., first two letters of middle name, last two letters of last name, last two digits of zip code) in the space provided.

How would you feel about working with a 68-year-old student returning to school to complete an undergraduate degree?

Thank you for completing this activity. Within the next few days, you will receive a link to complete final study instrumentation.

Final Online Qualtrics Survey (CED)

The final online Qualtrics survey for CED participants will include one demographics/interest question from the initial survey (How likely are you to provide counseling for older adults? 1, not at all likely; 2, a bit likely; 3, moderately likely; 4, pretty likely; 5, very likely), as well as the two instruments (TEQ and FSA) and an added note of thanks at the end of the survey for completing all study procedures. (see Initial Online Qualtrics Survey: Part 2)

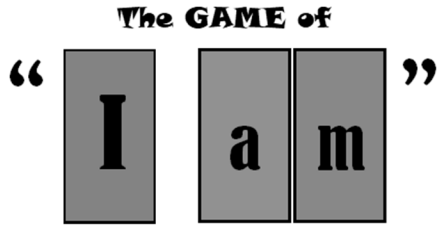
Final Online Qualtrics Survey (SAAHE)

The final online Qualtrics survey for SAAHE participants will include one demographics/interest question from the initial survey (How likely are you to work with older adults as a student support professional?) 1, not at all likely; 2, a bit likely; 3, moderately likely; 4, pretty likely; 5, very likely), as well as the two instruments (TEQ and FSA) and an added note of thanks at the end of the survey for completing all study procedures. (see Initial Online Qualtrics Survey: Part 2)

APPENDIX D

FACILITATORS' GUIDE

Facilitators' Guide



developed by

Sara W. Bailey, MA, LPCA, NCC

The University of North Carolina at Greensboro

Facilitators' Guide

Introduction

The United States is currently undergoing what some researchers have called a "longevity revolution." By 2020, adults 65 and older will outnumber children less than five years of age for the first time in recorded history. With approximately 10,000 adults turning 65 every day, counselors will be called upon to serve this growing population in greater numbers than ever before.

Nearly one in five adults 65 and older lives with one or more mental health or substance use disorders, and adults 65 and older have the highest rate of completed suicides of any age group. Mental health and substance use disorders are frequently comorbid with physical illness and chronic pain, leaving elders double vulnerable. The

impact on older adults is profound and negatively impacts overall health, leading to poorer quality of life, more hospitalizations, more frequent emergency room visits, and significantly higher healthcare costs.

The good news? *Counseling is effective* for treating mental health and substance use disorders in older adults. However, adults 65 and older receive mental health services at a lower rate than any other age group. In addition to structural factors such as limited Medicare coverage and transportation barriers, the reasons for this gap in care appear to include psychosocial factors, such as the interest in and attitudes toward older adults of the professionals tasked with serving them.

Many researchers have found that student and professional interest in working with older adults appears to be lower than for other age groups, which begs the question, "Why the low interest?" With an increasing number of adults living well beyond 65, counselors and those in training to become counselors are called to rise to the challenge and address this widening gap in care. "The Game of *I am*" is an intervention designed to address two components that may contribute to the lack of interest in serving older adults: empathy and attitudes toward older adults.

Empathy, defined as imagining, co-experiencing, and sensing the undeclared feelings and thoughts of another, has been accepted as essential to effective mental health practice. Many gerontological-focused empathy-enhancing interventions have included experiential activities that involve perspective taking through the wearing of "aging suits" and participation in role-playing games, and in some studies, students have reported feeling more empathetic awareness toward elders following such interventions. Empathy

may be very important to consider, as in research studies across disciplines, it appears that in both the young and the old, youth is viewed more favorably than old age. Negative, or ageist attitudes about older adults, have been linked to poorer mental and physical health outcomes, whether those attitudes are held by others or by the elders themselves, and may contribute to a limited interest in working with older adults.

Although the term "ageism" is relatively new, prejudice against older people is not a modern invention. Prolonging youth and slowing the aging process has been the topic of study for philosophers and scholars for centuries. Like racism and sexism, ageism legitimizes inequality between groups. Examples of ageist beliefs and behaviors can range from a hair stylist telling a customer that a particular hair cut isn't "age-appropriate," to ad campaigns touting a new eye cream guaranteed to "stop aging," to an employer who chooses to promote a younger worker because of the belief that older workers aren't as flexible or innovative.

In my educational work with counseling students, as well as in my professional counseling work with older adults, I believe that addressing empathy and attitudes toward older adults in counseling students is one way that we may be able to help bridge the divide between an expanding cohort of older adults and the counselors who will be called to provide culturally competent services to them.

I have developed an intervention that is designed to enhance empathy and improve attitudes toward older adults in first-year master's counseling students. This guide is designed give you some of the theoretical framework on which this intervention was developed, and to walk you through the intervention from start to finish. It will also

provide you with the tools you will need to facilitate the face-to-face component of this intervention.

Background

There are many theories of how learning occurs, but the one that I have found to make the most sense in terms of how I learn and how I have witnessed the process of learning in others is transformative learning theory. Transformative learning theory (TLT) posits that in the face of a disorienting dilemma or "triggering event," we become aware of inconsistencies in our beliefs and views (meaning perspectives), and realize that our previously held frames of reference may have developed outside of our awareness and may not fit with the new information before us.

For example, let's say that you decide to take a spin class, and when you walk into the room, the instructor appears to be in his 70s. You are surprised, and start to wonder if the class will be sufficiently challenging for you, someone who feels fit and youthful. You climb onto your bike, planning to tack on a half hour on the treadmill after class just so you will get a good workout, but before you know it, you are sweating and gasping for air as the instructor leads the class on a very difficult ride. You're astounded that someone who looks old enough to be your grandfather has just given you the best spin class you've ever taken. You realize that you held a previously unchallenged bias against older people, and realize that your beliefs about age and fitness have been turned upside down. You start to wonder what other beliefs you may hold that developed when you weren't even paying attention.

When a disorienting dilemma such as this leads us to experience an emotional reaction, we feel pressure to find ways of making sense of what this new, challenging information. When we are encouraged to take time to critically reflect on what we believe, and then if we are given the opportunity to process our experience in the context of a supportive group of fellow learners, we are more likely to shift our perspectives and reconsider what we believe to be true. In Box 1 you will find a simple example of how transformative learning might take place in the context of attitudes toward older adults in a counseling master's student.

Box 1

Jane is a master's counseling student who grew up being taught that older people are weak, unhappy, unpleasant, and unworthy of attention. Because she has never had these beliefs challenged in any meaningful way, it's no surprise that Jane holds negative stereotypes about older people. One day as part of a practicum placement, Jane finds herself in the presence of a group of elders who are funny, engaged, articulate, and happy. Jane has such a good time that she forgets that she is with people who are much older than she is, and when asked how she's enjoying herself, responds, "This is great!" Afterwards, though, reflecting on her experience, Jane thinks to herself, "That was weird," and believes that what she witnessed was an exception to the rule. However, later in the week when Jane engages in a conversation with fellow students in her counseling cohort about her experience, it is likely that she may find that not everyone holds the same beliefs that she does. In fact, if gently challenged during the course of that group discourse and supported by a caring facilitator, it is possible that Jane may discover that what she believed about older adults was simply the product of her upbringing, and not a belief that she developed from her own experience and thoughtful discernment. In the presence of what was a "disorienting dilemma," and with the support of a group of co-learners who challenge Jane to critically

reflect on her own beliefs, Jane may start to form new perspectives on what she believes to be true about older adults.

Intervention Design

Using TLT as a guide, I have developed an intervention, "The Game of *I am,*" that is designed to engage students in critical reflection, spark a disorienting dilemma, encourage perspective taking, and encourage group dialogue. Early in the semester, I will distribute a demographics questionnaire along with two survey measures that are intended to measure students' self-reported empathy and self-reported attitudes toward older adults. After collecting these measures, the first phase of the intervention will be an online pre-reflective journal activity in which students will respond to the prompt, "Today is your 75th birthday. Describe your life, your personality, your habits, and your health." This activity is designed to encourage critical reflection through the perspective taking of oneself as older. Approximately a week following this activity, you and your fellow facilitators will lead small groups (4-8) of students through "The Game of *I am,*" a role-playing game in which students will engage in perspective-taking as they take turns reading short vignettes describing scenarios in which individuals are faced with negative age stereotypes (e.g., ageist bias from medical providers, ageist disparagement humor). In this training, we will go over and rehearse how this will look when you facilitate your group so that you feel well-prepared to facilitate both game play and the discussion.

Following approximately half an hour of game play, you will lead the students in a half-hour-long group discussion about the experience of playing the game using discussion prompts that are provided below. A week after game play, students will write

a post-intervention reflective discussion in response to the prompt, “How would you feel about working with a 90-year-old client who presents with symptoms of depression?” This activity is designed to encourage students to consider their attitudes toward working with older adults. I will then administer an online post-intervention assessment packet with the two measures.

There are several key elements to transformative learning that are central to this intervention, and they include: critical pre-reflection through journaling, a non-hierarchical learning environment and opportunities for meaningful group dialogue fostered by a caring facilitator, and critical post-reflection through journaling. Your role as facilitator is key in supporting the process of perspective transformation, which can be difficult for students who are faced with divergent opinions and challenges to their existing meaning schemes. As facilitator, you are called to help create a safe space where students feel free to share their perspectives in an honest manner, to maintain a healthy group dynamic in which all participants’ voices are offered ample space to be heard, and to support students in their learning process. Your role is not to influence attitudes or correct what you may believe to be faulty assumptions. You will be a guide, offering reflections, questions for clarification, and assistance in focusing on the affective responses, but not a teacher. In this way, the organic process of perspective transformation will be student-led, which affords our students the best opportunity for real and lasting change.

Part II

Game Set-Up

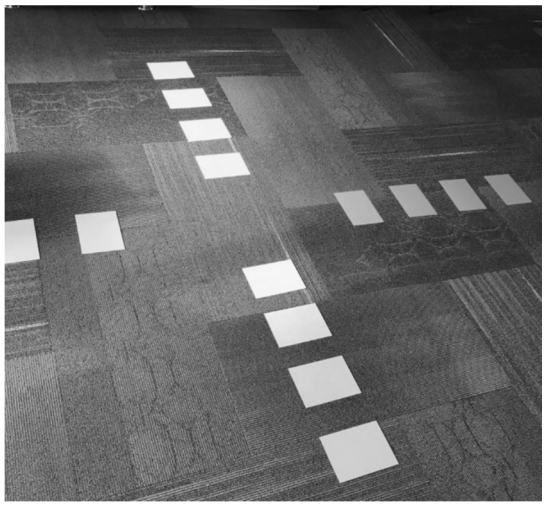
The set-up for game play is simple. Here are the things you will need:

- A room with floor space to accommodate 4-8 game players and you (we will coordinate this ahead of time)
- Master ID code key with an unsealed envelope (you will pick this up from (TBD); the envelope is to be sealed and the seal signed by you immediately following game play)
- Printed "The Game of *I am*" game prompts (provided)
- Audio recorder (your own or you can borrow mine)
- A container to place the prompts for selection (provided)
- Four same-colored game squares for each player (provided)
- A clock, watch, phone, or timer (please provide)
- Prize for the winner (bag of candy, provided)
- $5 in cash for each player (provided)
- Chairs for everyone for post-game discussion

To prepare the room for game play, clear a floor space and set up the game squares as shown in Figure 1, with enough space around each square for players to stand on the squares comfortably. Each player will have four squares of the same color. Game play is from the outside toward the center. I will provide you with a bag of candy as game

"winnings," and you may place the bag in the center. Set enough chairs aside for use following the game play.

Figure 1. Game Set-Up Example for Four Players



After welcoming students, please check off each student by his/her ID code that he/she selected at the beginning of the study. You will be given a copy of the master ID key code by (TBD) for the purpose of keeping track of study data (participants were instructed to create an alphanumeric code by combining the first two letters of their middle name, the last two letters of their last name, and the last two digits of their zip code). Instruct each player to find a color and stand on the most outside square of that color. You may then read the instructions:

You are about to play "The Game of I am.*" As you may remember from the informed consent that you saw when you first agreed to participate in the study, you will notice that I will be audio recording our time together for transcription later. Sara will not have access to the audio transcripts, not the original recordings, until after this*

semester is complete. No CED faculty will never have access to these recordings or the transcripts. Sara will only analyze the transcripts of these recordings after this semester, and any names spoken during our time together will be redacted before she sees the transcriptions. I will turn on the recorder now.

If you look at the game board, you will see that all players' paths lead toward the center, and the center is where you want to be as you move forward in the game. In this game, you will take turns selecting a prompt, reading it aloud, and then sharing your immediate and honest emotional reaction to the content of the prompt from the perspective of the person described in the prompt. Please use "I" language. For example, if you read the prompt, "I am 73 years old and recently I decided to join a gym. When I approached the front desk, the attendants looked at me and one said, 'Are you sure you belong here? The senior center is right down the road.'" you might respond, "I feel angry that they are treating me that way, and kind of sad that people think that I can't do things. Saying I don't belong here is really hurtful, and goes beyond just the basic question of my interest in physical fitness. It's like questioning my right to be." You might also respond, "I really don't care what that person thinks. I'm self-confident enough that such comments don't bother me at all." There is no right or wrong emotional response, but please share your immediate reaction to the prompt as if you were in that scenario yourself. Consider how you would feel if it happened to you. After you have shared, your fellow players will then take just a couple of minutes to decide whether you should move forward, stay where you are, or move back. That decision will be made based on what the group decides. You as a group have the power to determine game

movement, and you can base your decisions on the richness of emotional reactions, how adaptive or maladaptive you believe the emotional responses to be, or some other criteria. Just as there is no right or wrong emotional response to the prompts, there is no right or wrong game movement strategy. Once we start, together you can decide how you would like to decide game play. After your fellow players have decided your move, it's the next player's turn. We will play for approximately half an hour, and whoever is closest to the center of the game board will be declared the winner and will be encouraged to share the prize (candy).

After game play, we will sit down for another half hour to discuss your experience with the game, things you noticed, things you learned. I will share more details about that when we are done with the game. Any questions?

One question you may get early on and throughout the game may be around decision making. Allow the participants to grapple with these decisions. Part of the process of creating a disorienting dilemma for students is encouraging them to tolerate ambiguity. Allowing the players to determine game movement helps give them more ownership of their own experience and fosters their own critical reflection and group processing. It also helps foster team formation when each player is dependent on the others for success in the game. Because the prize stakes are relatively low, pointed challenges to game movement are unlikely, but because there is a competitive element, there may be more engagement than if there was no "winning" involved. If players look to you for decision making advice, reflect and restate what they have shared already.

After half an hour or after one or more players has reached the center, regroup in a circle for group discussion. Here are the instructions you may read as you begin.

Thank you for your participation and thank you to the winner for sharing your prize! For the next few minutes, I'd like to offer you an opportunity to do some group processing around the game, what you heard, what you felt, and what you discovered. There is no right or wrong to way to respond, and although I am still recording, remember that neither Sara nor any CED faculty will hear the audio from this recording, and Sara will only have access to the de-identified transcripts of the recording after the semester is over and final grades are posted. I will start off the discussion with a question or two, but I want you to participate in the discussion in a way that is most meaningful for you. You are not compelled to share, but I encourage you to share. After about 30 minutes, we will end, and if anyone has any questions, please let me know. Are there any questions now?

It's likely that if you tell the group that you have pre-scripted questions for them already, they will relax and not worry about engaging in the discussion "the right way." Even with your reiteration of anonymity, students may be concerned that I will hear what they say and that it may influence their grade in CED 605. Please reassure them that their anonymity is important to me, too, and if it is helpful, tell them that I will not be using any of the recorded data or written artifacts in my dissertation study, but will be analyzing qualitative data after the study is complete. Please do your best not to call on students by name. You may even tell them that you will not be addressing them by name as you begin and during the game. Part of transformative learning that is especially

important is a sense of safety in the learning environment. If students feel free to share without penalty, it is much more likely that transformation will occur. Use your skills to help foster that culture of safety during game play and discussion.

Once any questions are answered, please begin the discussion using these open-ended questions as a guide, with the understanding that as the discussion progresses, there may be other questions or reflections that you feel will encourage deeper processing and more meaningful dialogue. Linking students' responses by summarizing is often helpful in encouraging deeper content reflection, and of course reflecting feelings is often helpful in encouraging deeper emotional reflections.

Discussion Questions

- What surprised you when playing the game?
- As you were reading your prompts, what did you notice about yourself?
- What did you notice about your fellow players as they read their prompts?
- What were some of the emotions you experienced while playing the game?
- Who in your life were you reminded of as you played the game?
- How are some of the scenarios in the prompts similar to things you have experienced or witnessed?
- What did you learn from playing the game?
- How has this intervention impacted your critical reflection around providing counseling services to/working with older adults?

After approximately 30 minutes of group discussion, please read the following instructions:

Thank you for playing "The Game of I am*." In a few days, you will receive an email with instructions on how to complete the next phase of the study, which will take place online. I have $5 for each of you today, and remember, by completing the remaining aspects of the study, you will receive an additional $10 in cash. If you have any questions or want to stay and process anything else, please do so. Otherwise, thank you so much for participating.*

After the group discussion, turn the recorder off. Remain in the room for anyone who wants to process further. If anyone indicates a need for further counseling, please refer them to the Vacc Counseling and Consulting Clinic or counseling services at Student Health (listed in Table 1). Once the students have left the room, gather your supplies, and let me know that you have completed the facilitation via text (Table 1) by simply writing, "We are done." Please do not share any information about the game or the discussion, and please do not share with me who was in your group. Once you have gathered all of your supplies, please place the master ID key code attendance sheet in a sealed envelope (provided), write your signature across the seal, and deliver the envelope to (TBD). Then, deliver the game supplies to my office in 223 Ferguson. You may leave all supplies on my desk. If for some reason you are unable to deliver the envelope to (TBD), please keep it with you until you can do so.

Part III

Overview

Thank you for facilitating "The Game of *I am*," a role-playing game designed to enhance empathy and improve attitudes toward older adults through perspective taking, critical reflection, and group discourse. Your role as facilitator for game play and group discussion is key, and I am grateful to you for your willingness to serve in this capacity. Please remember that I am here to support you. In Table 1, you will find important contact information. In Table 2, I have created a template that gives an overview of the entire intervention. Please let me know of any questions or concerns, and thanks again.

Table 1

Important Contact Information

Sara W. Bailey	Cell: 919-302-5056 swbailey@uncg.edu 223 Ferguson Building
Vacc Counseling and Consulting Clinic	336-334-5112 Ferguson Building, second floor cedclinic@uncg.edu
UNCG Counseling Center	Anna M. Gove Student Health Center, second floor 336-334-5874.

Table 2

Planned Study Schedule

Stage	Task	Who?	When?
1	Recruitment and consent	S. Bailey & L. Land S. Bailey	CED: 10/18 SAAHE: 10/26
2	Initial email dissemination of survey instruments, including ID code selection by participants	(survey) J. Cannon to CED, S. Bailey to SAAHE. (code) Participants will select	CED: 10/19-10/28 SAAHE: 10/27-30
3	Pre-reflective participant journal	Cannon to CED, Bailey to SAAHE; journal content securely stored in UNCG Qualtrics account until after the study is complete (to be analyzed later)	CED: 10/23 SAAHE: 10/30
4	"The Game of *I am*" Game play and group discussion	Facilitators for CED (audio recordings to be transcribed by someone other than Bailey and transcripts stored in secure UNCG Box account for later analysis); Bailey for SAAHE (recordings uploaded to secure UNCG Box account)	(10/26-11/9)
5	Post-reflective student journals	Cannon to CED, Bailey to SAAHE (all journal content securely stored in UNCG Box account until after the study is complete to be analyzed later)	(10/30-11/13)
6	Post-intervention dissemination of survey instruments	Cannon/CEDS; Bailey/SAAHE	(11/02-11/16)
7	Analysis of deidentified survey responses	Bailey	December 2017
8	Presentation of findings at dissertation defense	Bailey	February 15, 2018
9	Qualitative analyses of recorded artifacts from journals and facilitated game play and group discussions	Bailey	TBD

REFERENCES

Colby, S. L., & Ortman, J. M. (2015). Projections of the size and composition of the U.S. population reports, P25-1143. Washington, DC: U.S. Census Bureau.

Fullen, M. C. (2016). Counseling for wellness with older adults. *Adultspan Journal*, *15*, 109–123. http://doi.org/10.1002/adsp.12025

He, W., Goodkind, D., & Kowal, P. (2016). *An aging world: 2015*. Washington, DC. Retrieved from https://www.census.gov/content/dam/Census/library/publications/2016/demo/p95-16-1.pdf

Mezirow, J. (1978). Perspective transformation. *Adult Education*, *28*(2), 100–110.

Nelson, T. D. (Ed.). (2017). *Ageism: Stereotyping and prejudice against older persons* (2nd ed.). Cambridge, MA: The MIT Press.

Teding van Berkhout, E., & Malouff, J. M. (2016). The efficacy of empathy training: A meta-analysis of randomized controlled trials. *Journal of Counseling Psychology*, *63*, 32–41. http://dx.doi.org/10.1037/cou0000093

APPENDIX E

PILOT STUDY ONE DOCUMENTATION

Evidence that Pilot Study One did not require IRB approval

Sara Bailey <swbailey@uncg.edu>

IRB question

Melissa Beck Mon, May 1, 2017 at 4:04 PM

UNCG Mail - IRB question

To: Sara Bailey <swbailey@uncg.edu>

Thanks, Sara. This was very helpful. The part of your project where you ask the questions of experts would not be considered human subjects research per the federal regulations and does NOT require IRB review.

As I mentioned in my previous email, the intervention would be considered human subjects research and would require IRB review.

Have a great evening,
Melissa

Recruitment Email to Expert Reviewers

Sara Bailey "The Game of 'I am'" Pilot Study Qualtrics Link

11 messages

Sara Bailey <swbailey@uncg.edu> Tue, Jul 11, 2017 at 4:35 PM

Happy July!

Thank you for agreeing to participate in my dissertation pilot study. I intended on sending out the survey a month ago, but it turns out I needed to write Chapter Three first...

One learns...

The link to the Qualtrics survey is below. Also attached is a Word document with the prompts that appear in the survey. That document gives you the opportunity to add targeted feedback to the prompts and return it to me, if you would like to do so.

The Qualtrics survey should take less than 30 minutes. I so appreciate your time and your encouragement as I work toward developing my intervention.

You'll read this in the Qualtrics survey as well, but I want to repeat it here. Your time is valuable and your expertise is priceless. As a small token of my great appreciation for your help, I am making a donation to Hospice of Union County, NC.

Many thanks, and please let me know if you have any questions.

APPENDIX F

PILOT STUDY ONE DATA

COLLECTING EXPERT FEEDBACK ON PROMPTS
TO BE USED IN "THE GAME OF *I AM*"

Participants:

N = 4

Age range:

<30: *n* = 1	50 to 60: *n* = 1	60 to 70: *n* = 2

Years working in a gerontology-focused capacity:

<5: *n* = 1	5 to 10: *n* = 1	10 to 20: *n* = 1	30 to 40: *n* = 1

Percentage of professional life spent working with or on behalf of older adults:

<25%: *n* =2	25% to 50%: *n* = 1	75% to 100%: *n* = 1

Highest degree earned:

BA: *n* = 1	MA/MS: *n* = 1	some doctoral work: *n* = 1	PhD, MD, EdD: *n* = 1

Prompt/Item Ratings (60 items)

Focus Area	$\bar{X}$	*SD*	*Range*
Content	92	10.58	53.75 – 99.75
Language	95.57	5.96	86.25 – 99.5
Culture	61.95	38.52	50 – 68.25
Disorienting	92.1	10.85	74.5 – 100

APPENDIX G

"THE GAME OF *I AM*" PROMPTS

I am a 63-year-old engineer working in a large firm where I've been employed for 23 years. I love my work, but am noticing that I am being left out of some of my department's meetings. When I ask my co-worker, she tells me that the meetings are for brainstorming. She then clarifies that my boss is going for a "younger vibe" in the meetings, which is why I've not been included.

I am an 82-year-old piano instructor and am having some difficulty with hand pain. I would prefer to avoid any additional medications. When I visit my doctor, she tells me, "Well, at your age, it's no surprise you have arthritis." She prescribes an opioid pain reliever.

At 88 years old, I live alone. A man comes to the door offering to clean my gutters for $200. He asks for payment up front, and when I hesitate and ask for references before I commit, he says, "Oh, come on. Old people are so paranoid."

I am 67 years old and at the doctor for my annual checkup. The nurse is new, and so I introduce myself as "Alex." The nurse takes my blood pressure and heart rate, and insists on calling me "sweetie" and "honey" and "young lady."

At my annual review, I meet with my boss, 30 years my junior. I feel that my production this past quarter has been my best ever. During the meeting, I make my case and ask for a raise. It's a small company, but profits are up across the board. My boss smiles, pats me on the back and says, "I appreciate that, but you're getting pretty close to retirement, aren't you? Don't you think one of the younger employees could use the money more?"

In a meeting of my neighborhood watch committee, at 71 years of age I am the oldest member by about 25 years. When it is my turn to speak about suspicious activity I've noticed by our neighborhood pool, I overhear a couple in the back whisper, "Elderly people are afraid of their own shadows."

I work hard to stay healthy, eating well and running five miles four days a week. I am in my late 70s. One day I walk into an athletic store looking for a new pair of running shoes, when the salesperson, in her 20s, asks, "How can I help you?" When I say, "I need a new pair of running shoes," she laughs. "You run? At your age?"

My granddaughter is getting married, and I go shopping for a dress to wear to the rehearsal dinner. At the store, I wander around looking at various options, completely ignored by the sales staff. When a couple of younger women walk in, two of the sales staff rush to help them. I find a couple of dresses to try on, and take them to the front to

ask for a dressing room. One of the sales staff smiles at me and says, “Don’t you think those are a little young for you?”

I am at lunch for my 69th birthday and the waiter comes to take my table’s orders. When he gets to me, I gleefully say, “It’s my 69th birthday!” He responds, “Wow! You look good for your age!”

I’m 64 years old and would like to lose some weight. Combined with my inactivity, my diet has left me feeling uncomfortable in my own skin and I am unable to fit into many of my favorite clothes. I mention my concerns to my hair stylist, who says, “You have to get used to weight gain at your age.”

I’ve always wanted to travel, but my partner never had an interest. After her death, I decide, at 77, to take an overseas trip. My children are adamantly opposed, and my son meets with a lawyer to attempt to establish power of attorney. I learn that my son has approached my financial planner, my banker, and my physician, claiming that I am incompetent.

On my 75th birthday I decide to get a tattoo of my late partner's initials. At the tattoo parlor, I'm greeted by a 20-something artist who takes my design idea, adapts it to fit my shoulder, and begins to work on me. Mid-way through the tattoo, the artist says, "You're awfully brave getting new ink at your age."

I'm 68 years old and an old back injury is causing me a lot of distress. I sit down with my doctor, who tells me, "The pain is pretty normal for someone your age."

I am 88 years old and I am in very good health and live alone. I enjoy gardening and yesterday while I was in the vegetable garden, I became overheated and lost my balance. I fell in the soft grass, brushed myself off, and got back up and went inside to cool off. When I mentioned this to my adult children at lunch today, they were very upset and started talking about moving me into an assisted living facility.

At 65, I am the only person over 30 in my PhD program. I recently attended a national conference, at which I presented on my dissertation topic. At the end of my presentation, one of the attendees approached me and expressed surprise that someone "of my age" would be pursuing a PhD.

At 69, I am the oldest employee at the publishing company where I've worked for 15 years. Although I've won several writing awards, in the last year, none of my articles has made it to publication without complete rewrites. When I ask my coworker, who is 35, what is going on, she says, "You write like an old person, and no one wants to read that."

I am 74 years old and enjoy visiting my grandchildren in a neighboring town. This morning, I was involved in a minor fender-bender. Police were called, and the officer determined that I was not at fault, but the driver of the other car got very angry when he

was given a ticket. As the officer handed him the ticket, he said, "It wasn't my fault. Old people drive too slow."

At 70 years of age, I was recently laid off from my job. I'd worked with the same company for 20 years, and with a grandchild in college, need to work another five years or so. I've sent out resumes, attended job fairs, and called on old friends for leads, but so far, no one will even schedule an interview. At a recent networking event, I shared my story with another attendee, who said, "At your age, it's unlikely anyone is going to hire you."

My partner of 30 years and I are having difficulty in our relationship. I ask if she will attend counseling together, and she agrees. At our second counseling session, the counselor states, "I realize you are having difficulty, but don't you think that at your age you ought to stay together anyway? Think of how hard it will be to date again."

After losing my job of 20 years, at 65 I am interviewing for new positions in my field. I have hired a career counselor who has helped me update my resume, and I have attended computer classes at my local community college. During several interviews, I've been asked to explain why I'm looking for a new job at my age. This afternoon, the interviewer asked, "Don't you think you're too close to retiring to start something new?"

My daughter has been struggling, so I've agreed to let my grandchildren live with me for the duration of the school year. At 70, I am retired from my job as an accountant and have the time to devote to caring for them. My grandson is 11 and plays on a soccer team, so I drive him to and from practice every afternoon. I notice that he is being bullied by his teammates and bring it up with the coach, who tells me, "I don’t know how things were done in your day, but in the 21st century, we teach boys to be tough. He'll get over it, and so should you."

I worked as a custodian for 35 years and retired on my 65th birthday. I have a small pension and collect social security, but don't have much extra at the end of the month. My adult son has recently been widowed and is having some difficulty in his job, and I am now taking care of his 8-year old daughter. The additional costs are adding up, and I need to find part-time work to bring in a little extra money. I return to my former place of employment to ask about working a few hours a week, and my former boss laughs and says, "Wouldn't you miss your rocking chair?"

At 80, I have been singing in my church choir for as long as I can remember. Although I wear corrective lenses, it's getting more difficult to read the small print on our sheet music. At choir practice, I mention my challenges, and the group laughs at me, one member saying, "Maybe it's time to hang up the sheet music. How old ARE you, anyway?"

I've been having some difficulty sleeping, and so I make an appointment with my doctor. I am 88 years old and in good health. When I check in to see the doctor, the nurse takes my blood pressure and weight and asks me why I'm there. I explain, and he answers, "Aren't people your age supposed to have a hard time sleeping?"

I am 87 years old and have been going to see the same dentist for 15 years. At my most recent visit, she found a suspicious lump on my tongue. When I asked her what treatment would be needed, she patted my hand and said, “Oh, at your age I wouldn’t worry about treating it.”

At 92, I have a difficult time hearing, and invite my son to accompany me to my annual eye exam in case I can't hear something that is said. My eye doctor does the examination, and after assessing me, turns to my son to explain what she has found, never speaking directly to me.

At 87, my osteoporosis has stabilized, according to my most recent bone scan, but compression in my spine has caused me to lose a good bit of height. At the grocery store, I am unable to reach a top shelf and ask a fellow shopper to help. She does so, saying, "Here you go, sweetie."

My grandchildren live far away, and so I've decided to get a smart phone so I can text and instant message with them. At 80, I've never had anything but a flip phone, so I go to the store to look around. The salesperson laughs when I say I want a smart phone, saying, "Well, isn't that the cutest thing? Someone your age entering the digital age."

My mother, who is 93, lives with me in my home. Because of several health challenges, Mom needs someone to be with her all the time. At 72, I work full-time as the head of maintenance for the local school system and have hired an agency to provide staff to sit with and assist Mom with her needs. Recently, one of the agency staff was sick, and I had to take time off work to stay home. The next day, my boss called me in and said, “You’ve got to pick your priorities. If you keep missing work, you’ll lose your job, and at your age, you’ll be lucky to find another.”

At 71, I am living with several physical challenges including chronic pain. My partner of 36 years died last year, and my job was outsourced when I was 68. I rarely leave my house, and when I do, it’s to see my physician. I don’t know why I’m still alive. At my physical, my doctor tells me that I’m probably depressed, and then says, “But I’m not worried about you killing yourself. You’re too wise for that.”

I am 85 years old, and my adult children think I need to move from my spacious home into a condo. I invite my children to dinner and have an open and honest conversation, sharing with them the ways I am working to stay safe in my home. My oldest child, a financial planner, leaves the table and comes back a few minutes later with my

checkbook and credit cards in her hands and says, "I'm taking these until you come to your senses."

I am 89 years old. The weather is changing, and my winter raincoat has seen better days. I visit a local department store, and the salesperson asks me if I need help. When I say that I would like to look at raincoats, the salesperson guides me to the clearance rack, saying, "At your age, you're probably on a fixed income."

At 85, I am in good health, financially well-off, and I have decided to take a trip to Europe with a tour group. I've never traveled overseas before, and invite my nephew to lunch so I can ask him for advice. When I tell him my plans, he shakes his head and says, "At your age, it's too dangerous to travel that far from home. Maybe a bus tour instead?"

At a birthday lunch for a fellow employee, the topic of discussion shifts to music. I'm 73 and have worked with the company for 27 years. Several folks around the table start making plans to attend a concert, and I ask for details. The person sitting closest to me laughs, pats my arm, and says, "Someone your age wouldn't enjoy it. It's going to be loud."

I am 77 years old. In line at the grocery store, I struggle to open my purse because of a recent wrist injury. As the line grows behind me, I start to hear murmurs. "I hate it when old people hold up the line," and, "Some people need to be in a home."

At 70, I have been retired for five years. I never went to college, and would like to take some classes at the local college. When I meet with an admissions officer, she pats my hand and says, "We aren't used to seeing someone like you on campus. Aren’t you precious?"

I am single for the first time in 40 years. At 73, I am ready to date again and sign up for an online dating site. I mention this to my daughter, who exclaims, "You have GOT to be kidding! What are you going to do about sex at your age?"

After living with my partner for 43 years, I am widowed and interested in dating again, but realize that I am no longer attracted to members of the opposite sex. I mention this to my son, who insists that if I am, in his words, "like that," he will never let me babysit my grandchildren again. "At your age," he asks, "do you really need to be in a romantic relationship again anyway?"

At 70, I've been divorced for three years and am dating again. I find that I am ready to consider physical intimacy, and mention this to my doctor at my annual physical. She laughs, pats me on the shoulder, and says, "Well, isn't that sweet?"

I am 68 years old and am still grieving the death of my best friend, who died six months ago. I’ve noticed that I’m having difficulty focusing. My walking partner, who is 20

years younger than me, made a comment about my forgetfulness during our most recent walk, saying, "You're acting like an old person."

Growing up, I was always last to be picked for the team, but as an adult, I've exercised for the last 50 years and am strong and fit. Some folks at church have established a softball team, so I went to the first practice, clearly the oldest person there by 20 years. When teams were chosen, once again, I was picked last. After a few practices during which my athleticism was clear to the others, one of the team members said, "You don't act old at all."

I have always tried to take care of my skin, and see a dermatologist for an exam every year. At my most recent visit to a new practice, when I sat down with the nurse to complete my intake, he asked me my age. After I told him I was 78, he sat back, shook his head, and said, "You look much younger."

I was recently diagnosed with cancer. At 85, I value my health and try to take good care of myself. At the meeting with my oncologist, she explained traditional treatments and then said, "But at your age, is it really worth it to put yourself through all of that?"

I am 92. After I fell and dislocated my shoulder last month, I've been living with increasing pain in my upper back. Right after the injury, my doctor prescribed a strong narcotic medication for the pain, but the side effects were very unpleasant and I stopped taking them. When I went back to my doctor for help, he suggested I go back on the medication. When I explained that being sleepy all the time is not acceptable, he responded, "Look. You're in your 90s. Most people your age are napping a lot anyway. You want to stop hurting, don't you?"

I am 83 and I learned to type on manual typewriters. Although I've had a laptop for years, I'm experiencing a steep learning curve with my new tablet and its touch screen. I ask my younger neighbor for help, and after five minutes of watching me struggle, he takes the tablet out of my hands and asks, "Are you sure you want to learn something new at your age?"

I am 66. When I was in my 20s and 30s, I was a professional dancer and sustained countless injuries to my feet. I've just moved to a new podiatry practice, and go in for a visit to address pain in my big toe. I explain the pain to the podiatrist, and without even looking at my feet, the podiatrist says, "Well, at your age, you're bound to have foot problems."

Ten years ago at 68, I had a heart attack and a wake-up call. I quit smoking, started exercising, changed my diet, and improved my health. As a challenge for my upcoming 79th birthday, I've decided to enter a 5K. I am a pretty fast walker, but would like an incentive to work even harder and feel like a road race is it. When I log onto the website to sign up for the race, I don't see any age categories beyond 70-75.

I started teaching aerobics in the early 1980s, in the days of legwarmers, and have been an avid fitness buff ever since. My regular gym is closed for renovations, so I've purchased a summer pass to another facility. I am 73 years old. At an exercise class this morning, I stood at the front of the room, and the instructor looked at me when he gave instructions to the class, "This is a very intense class. If you are slower or not as fit, you may want to stand at the back of the class so you don't get in the way."

At 65, I have decided to retire from my position at a local bank and pursue a career in counseling. I have an undergraduate degree in psychology, and would like to apply to a master's program. I schedule an informational interview to inquire about the application process, and the admissions coordinator tells me, "At your age, you'll get in, no worries. Most older people don't go back to school, and we're all about diversity."

I decide it's time to buy a new car, and after researching several models, I'm ready to test drive a mid-size sedan. I am 82. I drive to the local dealer and after walking around for a few minutes, am greeted by a salesperson. I explain what I'm looking for and ask for a test drive. The salesperson agrees, and heads into the dealership to get the keys. I follow, and overhear the salesperson laughing, saying to fellow staff, "Miss Daisy wants to take me on a test drive. Call 911 if I'm not back in 30 minutes."

After a lifetime of attending loud rock concerts, at 66 my hearing is not optimum. I wear hearing aids, and yet I still have difficulty hearing conversations when I'm in a noisy room. Recently at a cocktail party, I approached the bartender to order a glass of wine, and in the loud room had difficulty hearing the bartender's response to my question, "What are your red choices?" We finally understood each other, but walking away, I overheard the bartender laughing and saying, "I don't understand why old people refuse to wear their hearing aids!"

At 70, I am a retired educator and have written a handbook for beginning teachers. I was invited to present a brief synopsis of my book to a group of first-year teachers at the local community college. After my presentation, three different audience members approached me to say things like, "I think it's so cute that you still do this sort of thing," and "Aren't you just adorable?"

At 70, I expected to be an "empty-nester," but my 35-year-old son was laid off from his job and he and his three children have recently moved in with me so that I can help him with expenses and child care. I notice that my grandchildren do not clean up after themselves, and the kitchen counters stay cluttered unless I intervene. I ask my son to speak to them, and he says, "Old folks are too set in their ways. Lighten up!"

I am 72 years old and have skied since I was a child. On a ski trip over the holiday, I collided into another skier and cracked my femur. At a follow-up doctor visit, the nurse looks at my chart, and says, “You know, for someone your age, it’s probably a good idea to stop skiing.”

Six weeks ago, I slipped on my basement stairs and broke my wrist. At 85, this is the first real injury I've ever had, and I am still experiencing some weakness in my hand. In a local diner, I was having a hard time opening a soda when the server stopped at my table, grabbed the bottle from my hands and said, "Arthritis! My grandma has it, too."

At 76, I am the only member of my monthly book club who is over 60. At our meeting last night, we were discussing what book to read next, and one of the younger members winked at her friend, then looked at me and said, "Well, I'd like to read the new book by that author who wrote the sexy detective novels, but someone your age might find it too risqué."

I am 66, a professor at a local university, in a loving relationship with my partner, and in generally good health. Recently, I've been feeling out of sorts, disinterested, tired, just not myself. My mother lived with frequent episodes of depression, and I wonder if that's what is going on with me. At my doctor's office, after I explain my symptoms, my doctor says, "It's not unusual for older people to feel sad. You'll be fine."

I am 70 years old and live in a fairly affluent community with several private pools. I recently attended a public forum to discuss the pros and cons of building a new indoor public pool in our town. During the meeting, tempers flare, and I feel called to say something in defense of the plan. When I stand up to speak, one of the members of the town council says, “We all know how people your age feel entitled to all sorts of public programs, so you need to just sit down.” Several people in the audience giggle.

I am 78 years old and lived alone until my daughter moved in with me. Over the past 20 years, she has struggled with addiction to pain medicine, and last year she spent some time in jail after shoplifting at the local drugstore. Recently, I noticed several pieces of jewelry were missing from my jewelry box. When I asked her about it, my daughter denied taking anything, but I'm sure she is stealing from me. I mention the theft to my financial planner, who says, "Well, maybe, but at your age, don't you think you could have forgotten where you put the jewelry?"

I am 84 years old and drink two glasses of wine every week night, sometimes more on weekends. Wine helps me sleep, and I enjoy it. Recently, I had dental surgery and my doctor prescribed a narcotic pain reliever, which I have been taking as directed. Last night, I tripped over a throw rug and fell into my china cabinet, leaving me with significant bruising and a sore shoulder. At the doctor's office this morning, I was told that I was "at that age" when falls become more frequent, and my physician wrote me a prescription for a walker.

APPENDIX H

PILOT STUDY TWO DOCUMENTATION

STUDENT EMPATHY AND ATTITUDES TOWARD OLDER ADULTS IN AN UNDERGRADUATE GERONTOLOGY CLASS FOLLOWING AN IN-CLASS GAME ACTIVITY

Script for Class Recruitment

My name is Sara Bailey, and I am a third-year doctoral student in the Department of Counseling and Educational Development. For my future dissertation study and my future professional research agenda, I am interested in researching attitudes of students. I have developed a board-game style in-class activity designed to be used by students enrolled in university coursework. I hope to continue to develop this in-class activity and invite you to help me refine it. To participate in this study, you must be 18 years or older. For those who choose to participate, I will ask you to complete two written measures about empathy and attitudes. After you complete the questionnaires, I will collect them and then I will divide you into small groups or teams, and a representative from each team (aka "designated game player") will move around the game board. Taking turns from team to team, participants will pick a piece of paper from this bowl (a plastic bowl filled with folded paper prompts), and read the prompt on the paper aloud. Immediately after reading the prompt to the group, the participant will be invited to share his or her immediate emotional reaction. Then, depending on the directions of game play, the designated game player will either stay in place, move forward one space, or move back one space.

After about 30 minutes of play, the game will end, and the participants will be invited to take their seats and complete the two measures again. Then, I will ask you to participate in a focus group, during which we will discuss and process the activity as a group, including any reactions you would like to share. I will not be taking notes during the activity or during our discussion. The focus group will end after about 30 minutes. Dr.

Adams will not know who has chosen to participate, and she will not have access to any of the written assessments. I will use your assessments to help inform my dissertation study, which will begin this semester.

During game play, if anyone feels the need to further process any emotional reactions to the prompts or the game, we can take time to do that. If at any time anyone feels uncomfortable or chooses to cease participation in the activity, participants are free to do so without penalty.
Participation in this activity is entirely voluntary and your decision to participate or not will not impact your grade in this class. As the principal investigator of this study, I have no evaluative function.

Risks for participation in this activity are minimal, but may include emotional reactions that may be uncomfortable. I invite you to alert me to any difficult emotional reactions, and should there be anything that you would like to process further after the activity and the post-activity focus group, I will be available for further processing, and free counseling services are available through the Vacc Counseling and Consultation Clinic as well as through the UNCG Counseling Center.

I can be reached at swbailey@uncg.edu and in my office in the Vacc Clinic, 223 Ferguson. Dr. Laura Gonzalez is my dissertation chair and faculty advisor for this study, and she can be reached at her office in room 308 in the School of Education Building or at lmgonza2@uncg.edu.

If you have any concerns about your rights, how you are being treated, concerns or complaints about this project or benefits or risks associated with being in this study, please contact the Office of Research Integrity at UNCG toll-free at (855)-251-2351.

If you choose to participate, please join me at the front of the room. If you would prefer not to participate, you are free to step outside the classroom and use the time as you wish. After the activity and focus group time is complete, I will come out to invite you to join the class. The entire activity should take about an hour.

Are there any questions?

Focus Group Guide

Following the activity, I will offer time for group processing of the activity by inviting the students to participate in a focus group. This is the script I will read at the beginning of the focus group, after we have completed the game.

Thank you for participating in the activity. In a moment, I would like to invite you to share your experiences with this activity.

I invite you to share as you're comfortable, with the understanding that although I value and will use your comments to enhance the activity and develop my future dissertation study, I will not save any identifying information about what any one individual shares with the group. What you say while we process the activity together will not be shared outside this group. Your grade in your this course will not be impacted by what you share.

Are there any questions?

I will then ask:

1. What was your experience playing this game?
2. What sorts of things did you notice?
3. What did you learn from your experience playing this game?
4. What surprised you?

5. What else would you like to share?

I will allow a time no longer than 30 minutes for this focus group. I will then thank the participants for their participation.

Approved IRB
8/29/17

APPENDIX I

PILOT STUDY TWO DATA

Participants:

$N = 17$

Demographics:

$\bar{X}$ age = 21; age range 18-27; female: $n = 16$; male: $n = 1$

White: $n = 7$; Black/African American: $n = 3$; Hispanic/Latino/a: $n = 2$; Biracial/Multiracial: $n = 4$; No response: $n = 1$

Fraboni Scale of Ageism (higher scores = less ageism)

	$\bar{X}$	SD	Median	Range
Pre-Intervention	99.71	9.136	100	72-112
Post-Intervention	102.412	8.45	104	79-113

$t = 2.189$, $p = .044$, Cohen's $d = .307$

Toronto Empathy Questionnaire (higher scores = more empathy)

	$\bar{X}$	SD	Median	Range
Pre-Intervention	54	3.953	54	44-60
Post-Intervention	55.47	4.53	56	46-64

$t = 2.289$, $p = .036$, Cohen's $d = .346$

APPENDIX J

EVIDENCE THAT STUDY INSTRUMENTS ARE NOT COPYRIGHTED

The FSA is readily available online.

https://www.researchgate.net/publication/232475847_The_Fraboni_Scale_of_Ageism_FSA_An_Attempt_at_a_More_Precise_Measure_of_Ageism

Below is a screen capture of the response to my request on ResearchGate to receive the full-text FSA from one of the authors, Robert Saltstone.

Updates Messages Requests

Robert Saltstone to you May 21, 2017

Robert Saltstone uploaded the full-text that you requested for this publication:

Article: **The Fraboni Scale of Ageism (FSA): An Attempt at a More Precise Measure of Ageism**

Maryann Fraboni · Robert Saltstone · Susan Hughes

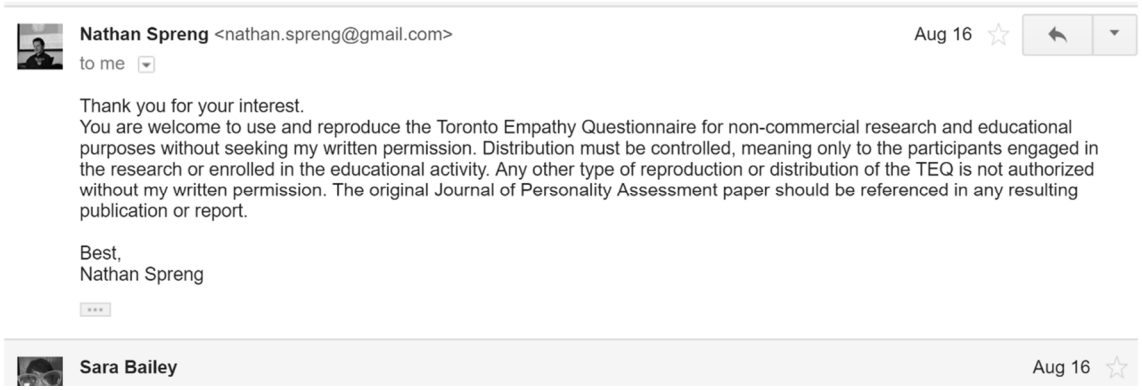
Source

View publication | Recommend article | Say thanks

The Toronto Empathy Questionnaire is publicly accessible as an online measure and in printable written versions as well.

https://psychology-tools.com/toronto-empathy-questionnaire/

Below is a screen capture of an email I received from the TEQ's first author in response to my request for permission to use the scale in my research.



Nathan Spreng <nathan.spreng@gmail.com> Aug 16

to me

Thank you for your interest.
You are welcome to use and reproduce the Toronto Empathy Questionnaire for non-commercial research and educational purposes without seeking my written permission. Distribution must be controlled, meaning only to the participants engaged in the research or enrolled in the educational activity. Any other type of reproduction or distribution of the TEQ is not authorized without my written permission. The original Journal of Personality Assessment paper should be referenced in any resulting publication or report.

Best,
Nathan Spreng

Sara Bailey Aug 16