# Ageism and the Counseling Profession: Causes, Consequences, and Methods for Counteraction

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**As the number of older adults increases, it is important to understand how attitudes toward aging influence society, the aging process, and the counseling profession. Ageism—defined as social stigma associated with old age or older people—has deleterious effects on older adults' physical health, psychological well-being, and self-perception. In spite of research indicating that the pervasiveness of ageism is growing, there are few studies, whether conceptual or empirical, related to the impact of ageism within the practice of counseling. This article includes an overview of existing literature on the prevalence and impact of ageism, systemic and practitioner-level consequences of ageism, and specific implications for the counseling profession. Discussion of how members of the counseling profession can resist ageism within the contexts of counselor education, gerontological counseling, advocacy, and future research will be addressed.**

*Keywords*: **ageism, aging, older adults, gerontological counseling, advocacy**

Currently, there are approximately 47.8 million adults age 65 and over living in the United States, and this number is expected to grow to 98 million—or more than one in five Americans—by 2060 (Administration on Aging, 2017). Much of this growth can be attributed to the aging of the boomer generation, the age cohort born between 1946 and 1964. Approximately 10,000 boomers turn 65 every day (Short, 2016). Increases to the average life span also have expanded the number of older Americans, with a person age 65 now living an average of 19.4 additional years, and many living well beyond that age (Administration on Aging, 2017). Nonetheless, many misconceptions remain about the aging process, and recent research demonstrates that the prevalence of ageism is growing (Ng, Allore, Trentalange, Monin, & Levy, 2015). Ageism—defined here as social stigma related to old age or older people (Widrick & Raskin, 2010)—is associated with the lack of mental health services available to older adults (Bartels & Naslund, 2013), and when negative attitudes toward aging are internalized by older adults, significant consequences to health and well-being may occur (Levy, 2009).

Within the counseling literature, there appears to be a lack of research on ageism and its impact on older adulthood. A keyword search of leading counseling journals dating back to 1992 results in a single publication on the topic of ageism within the American Counseling Association's Journal of Counseling & Development (Saucier, 2004), as well as a single empirical study in Adultspan Journal (McBride & Hays, 2012). Therefore, to elucidate the effects of ageism, as well as its role within the field of professional counseling, this article will provide a review of existing literature on the prevalence of ageism, its consequences among mental health professionals, and the impact of internalized ageism on older adults. The article concludes with recommendations for how counselors, counselor educators, and counseling students can mitigate the effects of ageism and promote positive perceptions of aging.

## Prevalence and Impact of Ageism

### Prevalence of Ageism
The term "ageism" was first used in the late 1960s to describe discriminatory beliefs or practices that are predicated on the age of a person or group (Butler, 1969). Like racism or sexism, prejudice

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associated with age is both pernicious and challenging to quantify. Many myths about aging are assumed to be true without additional consideration, leading to a "commonsense reality" about old age or older people that is then perpetuated throughout a society (Angus & Reeve, 2006, p. 141). Moreover, scholars argue that ageism is currently met with less disapproval than racism or sexism (Cuddy & Fiske, 2002; Nelson, 2016; Palmore, 2005), although more recent empirical research is needed to substantiate this hypothesis. Nevertheless, research indicates that views about aging are becoming more negative (Ng et al., 2015). Dominant myths include the notion that older adults are: (a) lonely and depressed; (b) increasingly similar as they grow old; (c) sick, frail, and dependent; (d) cognitively and psychologically impaired; (e) sexless and boring; and (f) unable to learn or change (Thornton, 2002; Whitbourne & Sneed, 2002). These myths persist in spite of research that demonstrates that older adults are heterogeneous, possess many psychosocial resources, frequently have high levels of self-rated and objectively measured health, and mostly do not experience dementia or other forms of cognitive impairment (Whitbourne & Sneed, 2002).

Stereotypes about older adulthood are transmitted throughout society and may lead to detrimental consequences for the health and well-being of older people. For example, media representations of older adults are likely to reinforce negative views about older adulthood. Television shows, movies, and advertising depict older people according to stereotypes about aging—or omit them altogether (North & Fiske, 2012)—and older people who watch more television over the course of their lives tend to view aging in a more negative light (Donlon, Ashman, & Levy, 2005). Ageism is transmitted through social media as well. References to older adults on Facebook are commonly comprised of references to cognitive or physical debilitation, the infantilization of older people, or suggestions that older adults be banned from public activities like driving or shopping (Levy, Chung, Bedford, & Navrazhina, 2014).

Negative stereotypes may lead to age-based discrimination, a phenomenon that experts describe as both "understudied" and "surprisingly pervasive" (North & Fiske, 2012, p. 983). For example, Posthuma and Campion (2009) described several workplace-based stereotypes that exist, in spite of a lack of supporting evidence. These include the notion that older workers have lower levels of ability and motivation, lower productivity, and greater resistance to change. Within the realm of health care, physicians may be less likely to offer particular medical treatments to older patients because of a belief that certain ailments are the inevitable consequences of natural aging (Bowling, 2007). Ageism may result in elder abuse, both within care facilities and among family members; however, it is underreported because of a lack of awareness among health and social service providers (Nelson, 2005).

Negative stereotypes about aging develop in a manner that parallels stereotypes like racism or sexism. Levy's (2009) stereotype embodiment theory suggests that ageist views may be transmitted culturally and internalized by older adults, leading to significant changes to health and functioning. Older adults are first exposed to negative stereotypes about aging when they are young. As individuals age into older adulthood, their negative beliefs about aging become increasingly salient and self-directed. On the other hand, if an individual is socialized to hold more positive views toward aging, these viewpoints may serve as a buffer against internalized ageism (Levy, 2009).

Furthermore, stereotype embodiment theory (Levy, 2009) suggests that when stereotypes are assimilated from the surrounding culture, they eventually become self-definitions that influence a person's functioning and health. Stereotype embodiment theory concludes that: (a) stereotypes are internalized throughout the life span; (b) they are likely to operate unconsciously; (c) as views of older age become increasingly relevant to a person's identity, the age stereotypes become more

salient; and (d) self-referential views on aging are developed via pathways that may be both top-down (i.e., societal perspectives are passed on to the individual) and longitudinal (i.e., views on old age begin in childhood).

Cuddy, Norton, and Fiske (2005) argued that groups within a society are often categorized based on two traits—warmth and competence—and the authors found that most participants rated older adults as warm, but incompetent. Contrary to the belief that ageism is only a concern in Western countries, Cuddy et al. reviewed a large-scale international study that included college students in Belgium, Costa Rica, Hong Kong, Japan, and South Korea. Across samples, participants viewed older adults as significantly more warm than competent, non-competitive, and having lower social status. Within their study, this trend persisted even when looking at cultures and countries that are typically described as more collectivist (i.e., Hong Kong, Japan, and South Korea).

Research indicates that ageism is prevalent within environments where older adults receive housing and health care services. In an ethnographic study on the impact of age and illness within a residential care setting, Dobbs et al. (2008) found that some family members, staff, and residents held negative attitudes about aging that resulted in an environment affected by ageism. In their study, examples of negative age bias included neglecting to gather resident input prior to making decisions, using infantilizing speech with older people, and stigmatizing residents because of dementia or physical disability. In a similar study completed within a multi-level care setting, Zimmerman et al. (2016) found that the use of multi-level, stepped care (i.e., adults with differing independence levels residing within the same setting) reinforced stigma related to age and health, with older adults differentiating among themselves based on which levels of care were required.

**Impact of Social Forces**

Scholars posit a wide range of hypotheses to explain the prevalence of ageism, but two systemic processes—modernization and medicalization—are identified in the literature as the most likely catalysts of negative attitudes toward aging (Cuddy & Fiske, 2002; Ng et al., 2015). In regard to modernization theory, Cuddy and Fiske (2002) explained that views of older adulthood have changed as a result of the shift from an agrarian society to an industrial society. Technological advances, increased literacy rates among young people, and a trend toward urbanization resulted in greater competition between young and old generations, as well as weakened intergenerational social ties between young people and their families of origin. The sum of these social changes led to decreased status for older people, resulting in the "warm, but incompetent" stereotype that is now associated with them (Cuddy et al., 2005).

Relatedly, improvements in health care have extended the life span and increased the ratio of older to younger people. Previous research shows that as the ratio of older adults to younger adults increases, views about older adulthood become increasingly negative (Ng et al., 2015). Given that the number of older people will increase markedly in coming years, it is possible that negative attitudes toward older people will continue to grow unless intervention occurs.

The second major social force described in the literature is the medicalization of aging, which refers to associating old age with a person's physical health or illness, to the detriment of other aspects of well-being (Ng et al., 2015). The dominance of medical conceptualizations of old age is described as one of the "master narratives" associated with the modern study of aging (Biggs & Powell, 2001, p. 97). Although the causes of medicalization are many and complex, they can be summarized by the shift from viewing old age as a natural part of the life span to the viewpoint that old age, and even death itself,

are problems that modern medicine may be able to solve (Ng et al., 2015). Past research indicates that the medicalization of aging predicts negative attitudes toward aging and consequentially leads to "the objectification of older adults as patients rather than as individuals with interesting life experiences" (Ng et al., 2015, p. 2).

## Consequences of Ageism

### Impact on Older Adults' Health and Well-Being

There is a substantial body of research indicating that age stereotypes influence older adults' health and well-being. For instance, older adults' perceptions of aging are associated with memory performance (Levy, Zonderman, Slade, & Ferrucci, 2011), hearing decline (Levy, Slade, & Gill, 2006), developing Alzheimer's symptoms (Levy et al., 2016), and dying from respiratory or cardiovascular illnesses (Levy & Myers, 2005). In fact, Levy, Slade, Kunkel, and Kasl (2002) found that even after controlling for age, gender, socioeconomic status, loneliness, and functional health, older adults with more positive self-perceptions of aging lived 7.5 years longer than those with less positive self-perceptions of aging.

Conversely, research indicates that positive perceptions of aging may provide a salutatory effect on health and well-being. Older adults with positive age stereotypes are 44% more likely to fully recover from severe disability compared to those with negative age stereotypes (Levy, Slade, Murphy, & Gill, 2012), and older military veterans who resisted negative age stereotypes had significantly lower rates of mental illness compared to those who fully accepted them (Levy, Pilver, & Pietrzak, 2014). These positive differences were found for suicidal ideation (5.0% vs. 30.1%), anxiety (3.6% vs. 34.9%), and PTSD (2.0% vs. 18.5%), even after controlling for age, combat experience, personality, and physical health. In regard to variables that may influence older adults' self-perceptions of aging, Fullen, Granello, Richardson, and Granello (in press) found that resilience—the ability to bounce back from adversity—and multidimensional wellness were significant predictors of positive age perception, whereas increased age and decreased physical wellness predicted internalized ageism. Furthermore, resilience appeared to buffer older adults from experiencing internalized ageism as they grew older. However, older adults may not be exposed to interventions to promote resilience and well-being because of ageism's impact on the availability of mental health services among older adults.

### Impact on Mental Health Professionals

The gap between the mental health needs of older adults and the number of mental health professionals with specific training in working with older adults is on the verge of a "crisis" (Institute of Medicine, 2012, p. ix). Scholars provide a variety of explanations to account for this, including systemic factors—such as inadequate funding and a lack of training opportunities within academic programs (Bartels & Naslund, 2013; Gross & Eshbaugh, 2011; Robb, Chen, & Haley, 2002)—and personal factors, including low interest in working with older adults (Tomko, 2008) and therapeutic pessimism (Danzinger & Welfel, 2000; Helmes & Gee, 2003).

**Systemic ageism.** Although older adults consistently report higher life satisfaction than younger or middle-aged adults (George, 2010), approximately 26% of all Medicare beneficiaries, or more than 13 million Americans, meet the criteria for a mental disorder (Center for Medicare Advocacy, 2013). Yet, mental health services currently account for only 1% of Medicare expenditures (Bartels & Naslund, 2013). Systemic barriers may be partially responsible for the lack of access to mental health services among older adults. For example, inadequate reimbursement rates is cited as one reason for the 19.5% decline in psychiatrists accepting Medicare between 2005–2006 and 2009–2010 (Bishop, Press, Keyhani,

& Pincus, 2014). Similarly, Medicare payments to psychologists for psychotherapy decreased by 35% since 2001, after adjusting for inflation (American Psychological Association, 2014). Older adults are currently unable to use Medicare to access services provided by licensed professional counselors (LPCs) or marriage and family therapists (MFTs; Fullen, 2016b). This translates to an estimate of 175,000 mental health professionals who are unavailable to serve as Medicare-eligible providers (American Counseling Association, n.d.). Clients who age into Medicare coverage after working with these professionals face discontinuity of care caused by having to change providers.

Professional training barriers among the helping and health professions also may reflect systemic ageism. Half of the fellowship positions in geriatric medicine and geriatric psychiatry are unfilled each year, and only 4.2% of psychologists focus on geriatric care in clinical practice (Bartels & Naslund, 2013). Institutional barriers that inhibit student interest in careers related to work with older adults include a lack of visibility for multidisciplinary gerontology programs, the absence of gerontological content within textbooks, few faculty who are trained in gerontology, misconceptions about employment opportunities (i.e., the assumption that the only aging sector jobs available are in nursing homes), and a primary focus on the problems associated with old age when later life is discussed within the classroom (Gross & Eshbaugh, 2011).

Within the counseling profession, scholars describe a mixed commitment to gerontological counseling. Going back to 1975, Salisbury (1975) and Blake and Kaplan (1975) described counseling with older adults as an overlooked domain within professional counseling. Twenty years later, Myers (1995) argued that gerontological counseling had evolved from "forgotten and ignored" (p. 143) to a sub-discipline within the profession complete with standards and certification. However, the gerontological counseling specialization that existed between 1992 and 2008 was discontinued in 2009 when only two institutions had applied for accreditation (Bobby, 2013). Perhaps more telling, the 2016 Standards of the Council for Accreditation of Counseling & Related Educational Programs (CACREP) include zero references to the words *old*, *older*, *older adults*, or *ageism*; only one reference each to the words *age* and *aging*; and four references to the phrase *life span* (CACREP, 2015). Nonetheless, Foster, Kreider, and Waugh (2009) found that many counseling students have interest in topics related to gerontological counseling, including grief counseling (70%), retirement counseling (43%), family counseling with aging parents (64%), and counseling caregivers (55%). The same study found that many respondents were interested in working in a hospice setting (39%), a hospital geriatric unit (29%), a nursing home (25%), private practice with older adults (43%), and a community setting with older adults (45%). However, it is unclear whether students who are interested in working with older adults receive training and employment opportunities within these contexts.

**Individual ageism.** Research regarding the prevalence of ageism among individual mental health professionals is equivocal. When mental health professionals' perceptions of clients based on age, gender, and health variables were studied, some researchers found health bias, but not age bias (Robb et al., 2002). Others reported that participants rated older clients as having a greater number of diagnostic problems (Helmes & Gee, 2003) and a worse prognosis than younger clients, in spite of all relevant information being matched across age groups (Danzinger & Welfel, 2000). Helmes and Gee (2003) found large differences in how older people were rated on key therapeutic variables. Older clients were viewed as less able to develop an adequate therapeutic relationship, less appropriate for therapy, and less likely to recover. Respondents in their study also felt less competent in treating older people, and they were less willing to accept older people as clients.

To counteract the potential influence of negative age bias on counseling treatment, McBride and Hays (2012) described the importance of linking work with older adults to multicultural

competence. The authors surveyed 360 counselors and counselor trainees and found a significant, negative correlation (r = -.41) between multicultural competence and negative attitude toward aging. Tomko (2008) found that multicultural competence was associated with improved clinical judgment when working with older adults; however, it did not predict global attitudes toward aging. In sum, considerations of both the systemic and individual aspects of ageism have important implications for the counseling profession.

## Implications for the Counseling Profession

The rapid growth of the older adult population will impact members of the counseling profession in a variety of ways. Shifting age demographics make it imperative that counselors understand how the pervasiveness of ageism impacts key professional values like diversity, social justice, and client advocacy. Four domains are outlined in which counselors may dedicate their attention to generating positive views of aging. These domains include counselor education, advocacy, research, and counseling practice.

### Counteracting Ageism Within Counselor Education

Within counselor training programs, resistance to ageism begins with incorporating discussions about aging and older adulthood into the counselor education curriculum. Therefore, it is important that professional accreditation standards like CACREP adequately reflect the mental health needs of older adults and their families. In its current form, the omission of keywords like *aging*, *older adulthood*, and *ageism* from these standards may send a mixed signal to counselor training programs and their students about social justice and multicultural competencies as they relate to older adults.

Once ageism is identified by a counselor education program as a priority, counselor educators need to develop strategies for incorporating this focus in the existing curriculum. For instance, a life span development course provides ample opportunities to discuss issues such as shifting population demographics, multigenerational families, and how an aging population will impact the counseling profession. Assessing students' current thoughts about the aging process, including both their own aging and that of family members, may create greater empathy for the needs of older adults. Similarly, when instructing social and cultural diversity courses, counselor educators should consider introducing topics such as ageism and age privilege and juxtaposing these constructs alongside dialogue about diversity and intersectionality (Black & Stone, 2005). Furthermore, when developing practicum or internship sites, counselor educators could make a point of developing placements in which older clients will be served. Identifying potential site supervisors who have experience in working with older adults is an important step, as it ensures that trainees are given adequate opportunities to reflect on their own perspectives on aging, disability, advocacy, and related issues.

### Counteracting Ageism Through Advocacy

In regard to advocacy, counselors should resist ageism at national, state, and local levels. At the national level, the omission of counselors as approved Medicare providers limits the availability of mental health services for older adults and reflects the assumption that older adults' needs are primarily physiological. This issue creates challenges for members of the counseling profession who are interested in providing services across the life span. Mental health advocacy on behalf of older adults includes educating lawmakers about the importance of Medicare reimbursement as a means of creating mental health service access (Fullen, 2016b). Professional organizations continue to support grassroots advocacy, as well as lobbying efforts, to influence Medicare policy on behalf of counselors. In fact, as of this writing there are bills in each chamber of the United States Congress (i.e., S. 1879; H.R. 3032), and a federal advisory group (i.e., the President's Interdepartmental Serious Mental

Illness Coordinating Committee; ISMICC) recently recommended inclusion of counselors within Medicare (National Board for Certified Counselors, n.d.).

At the state and local level, members of the counseling profession should forge partnerships with gerontology professionals. For example, advocacy occurs when professional counselors and counselor educators make connections with members of the local area agency on aging, directors of local assisted living or skilled nursing facilities, or state policymakers who are responsible for budgetary and policy decisions related to aging. These partnerships are mutually beneficial; they provide members of the counseling profession with increased exposure to the diverse needs of older adults in their communities, and they educate local gerontology professionals about the range of mental health services that counselors provide. Additionally, building interprofessional connections may lead to research opportunities that can improve the care received by older adults.

**Counteracting Ageism Through Research**
In spite of the numerous studies indicating that ageism has detrimental effects on older adults, there are currently very few studies that demonstrate the prevalence and impact of ageism within the counseling profession. For instance, research on in-session dynamics between counselors and much older clients could shed light on the ways in which age is broached in a counseling session. Additionally, research could focus on the benefits of professional counseling for older adult clients, as well as the effectiveness of novel interventions that are grounded in counseling theories or wellness (Fullen & Gorby, 2016; Fullen et al., in press). For instance, the development and validation of a wellness-based approach to counseling older adults might mitigate mental health issues or internalized ageism among older clients (Myers & Sweeney, 2005), and it would serve as additional evidence for the necessity of adding counselors as Medicare providers.

At the institutional level, more research is needed to understand the extent to which counselor training programs address ageism, and in which curricular contexts. It is important to understand which pedagogical strategies are most effective, whether these impacts persist over time, and how well training programs make inroads with local agencies that work with older adults. Research into advocacy efforts related to Medicare reimbursement may also advance the profession. Although Medicare reimbursement is described as a priority for the counseling profession, there is currently little research on counselors' knowledge about Medicare or participation in Medicare advocacy.

**Counteracting Ageism Through Counseling Practice**
Finally, it is important to consider how counselors might resist ageism within their counseling practice. Because of the heterogeneity of older adults, counseling services should be tailored to the unique needs of each client. Given that ageism has the potential to influence how older clients are conceptualized by counselors, it is important for counselors to reflect on their own beliefs about aging as well as their assumptions about the ability of older clients to grow and change. Many counselors are not familiar with the wide range of mental health interventions that have been empirically validated with older adults (Myers & Harper, 2004). For example, the SAMHSA-HRSA Center for Integrated Health Solutions (n.d.) provides numerous resources related to providing behavioral health services to older adults. These resources address issues such as evidence-based treatments for late life depression, preventing suicide in older adults, screening for substance misuse, and assessing cognitive functioning.

Given the growing interest in wellness-oriented services for older adults, SAMHSA also provides evidence-based resources related to health promotion and integrated care. Programs that focus on

cultivating holistic wellness or resilience are relatively new, but they also may be worth considering as a means of countering ageism within the practice of counseling. Because the wellness approach incorporates multiple dimensions of functioning, older clients who are experiencing deficits in a particular domain (e.g., limited mobility influencing ability to drive) may find that they can use alternative domains as a means of compensating (e.g., greater reliance on social network to carpool to events; Fullen, 2016a). Similarly, discussion of how older clients have used strengths to navigate loss, overcome adversity, and resist ageism in their own lives may prove to be key ingredients in the therapeutic process. Furthermore, incorporating resilience into an older client's treatment plan may create a buffer against internalized ageism (Fullen et al., in press), as well as an opportunity to highlight older adults' abilities to adapt in the face of adversity (Fullen & Gorby, 2016).

## Conclusion

As the number of older adults grows, members of the counseling profession are increasingly likely to encounter older people who seek to benefit from counseling services. A review of existing research demonstrates that there are numerous causes of ageism, detrimental consequences associated with internalizing negative age stereotypes, and gaps in research related to how the counseling profession should respond. In light of the counseling profession's commitment to diversity, social justice, and advocacy, it is important to better understand the broad impact of ageism. By combating ageism in the domains of public policy, research, teaching, and direct service with clients, members of the counseling profession have the opportunity to counteract ageism's deleterious effects and promote more positive perceptions of growing older.

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