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ARTICLES

# Wellness During Midlife and Older Adulthood: A Different Perception

Thomas W. Foster and Justin E. Levitov

*The authors explored how midlifers and older adults perceive wellness by factor analyzing the Perceived Wellness Survey (PWS; Adams, Bezner, & Steinhardt, 1997). Results indicated a 4-factor solution different from the 6 originally proposed wellness dimensions of the PWS, suggesting that wellness perceptions change as people age. Suggestions for further research are proposed.*

*Keywords:* wellness, Perceived Wellness Survey, midlifers, older adults, counseling

Do midlifers and older adults perceive wellness differently than existing wellness models portray? If they do, what are the implications for treatment? Although counselors may have a heightened interest in these questions because the concept is so central to their profession, answers to these questions are also valuable because the population of midlifers and older adults in the United States continues to increase (Committee for Economic Development, 1999; National Institute on Aging, 2006). With these demographic changes, the need for mental health services will grow (National Institute of Mental Health, 2005), and counselors will be called to help midlifers and older adults adjust to the challenges of aging.

Wellness delineates professional counseling from other mental health disciplines. Many definitions and models of wellness exist (Adams, Bezner, & Steinhardt, 1997; Archer, Probert, & Gage, 1987; Ardell, 1988; Dunn, 1961; Myers, Sweeney, & Witmer, 2000) and all share the concept that wellness is multidimensional in nature, encompassing dimensions such as the physical, mental, social, and spiritual. Wellness and wellness counseling help to define the counseling profession (Myers, 1992; Myers & Sweeney, 2004; Sweeney, 2001; 20/20: A Vision for the Future of Counseling, 2010, para. 2) and offer a unique guide to professional counselors' practice. Like most terms that define

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elements of the human experience, *wellness* is a plastic concept. In other words, how individuals perceive wellness changes over time.

However, current wellness models do not account for developmental changes that would transform their structure and applicability with clients. For example, the Perceived Wellness Model (PWM; Adams et al., 1997) is a recently developed model consisting of six discrete theoretically (systems and salutogenic theory) derived wellness dimensions: (a) physical, (b) psychological, (c) emotional, (d) spiritual, (e) intellectual, and (f) social. These dimensions operate independently, but also coexist within a larger system and contribute to overall wellness. The problem with the PWM is that most of the research that attempted to substantiate the existence and discreteness of these dimensions was conducted using a younger sample, and no research exists that focuses on an older population. From a clinical perspective, this poses a standard of care issue for any counselor who would use a wellness model designed for younger adults with older clients. Would an older client see the psychological, emotional, and intellectual dimensions of wellness the same way as a younger client? If not, what clinical implications would this present if a counselor assumed that an older client did and based his or her treatment on this false assumption?

## WELLNESS OVER THE LIFE SPAN

The life span development literature provides some theoretical explanation for why wellness perceptions might change over time. As individuals move across the life span, they experience many life events and challenges that will modify their view of wellness. For instance, Erikson (1959/1980) noted within his psychosocial theory that specific goals must be met within each of the eight life stages to successfully advance to the next stage. Individuals in the identity versus role confusion stage strive to develop a positive and independent identity, whereas those in the intimacy versus isolation stage seek to meet the goal of developing intimate and loving relationships with others. Both of these goals associate with and contribute to an individual's sense of wellness (Myers & Sweeney, 2004), but their levels of importance vary depending on where a person lies on the life span. This concept also applies to midlife and older adulthood. Midlifers struggle with generativity versus stagnation, with the goal being to help create a positive change in others, whereas older adults face ego integrity versus despair, working to gain a sense of fulfillment about their lives (Erikson, Erikson, & Kivnick, 1986). Both goals to help others and find life satisfaction contribute to overall wellness, but from Erikson's perspective, these goals weigh differently at certain times of life and thus change how individuals perceive wellness.

Another life span theory that explains how wellness perceptions change is the Model of Optimization in Primary and Secondary Control (Heckhausen, 1999; Heckhausen & Schulz, 1993). Some researchers see control as a part

of wellness (Myers & Sweeney, 2004) and how individuals of all ages must exercise some amount of primary control to achieve emotional satisfaction (Heckhausen, Wrosch, & Schulz, 2010). *Primary control* is defined as changing one's environment to make it congruent with one's desires (Rothbaum, Weisz, & Snyder, 1982). As individuals age, their primary control decreases as their need to maintain control remains. Normally, midlifers and older individuals will compensate for this loss by using secondary control strategies. Heckhausen et al. (2010) redefined the concept of secondary control, seeing it as a mechanism that either supports primary control strategies or, more important, helps an individual disengage from unattainable goals by redefining expectations and moving motivational resources to other endeavors. Therefore, as individuals age, they modify their use of control strategies and thus change how control influences wellness. For instance, young adults who mainly use primary control strategies may also report a higher wellness level, whereas older adults may possess little primary control in life but still report a high wellness level because they use secondary control strategies. Their criteria and perceptions of wellness will change because they adjusted their use of control.

## PURPOSE OF THIS STUDY

Taken together, these theories of development lend credence to the possibility that individuals' perceptions of wellness change as they age. These theories also suggest where the changes may be located and how they may change over time. However, at this time, no wellness model exists that specifically depicts how midlifers and older adults perceive wellness. Wellness models substantiated by research was typically done using a large sample of individuals from all points on the life span (Myers & Sweeney, 2004), which may overlook differences in wellness perceptions based on age. By analyzing the construct validity of an existing wellness instrument using a midlife and older adult sample, we sought to gain some insight into how midlifers and older adults perceive wellness. The Perceived Wellness Survey (PWS; Adams et al., 1997) is a wellness instrument based on the PWM and is intended to measure overall wellness and each wellness dimension of the PWM using six subscales (i.e., Physical, Psychological, Emotional, Spiritual, Social, and Intellectual). We performed an exploratory and confirmatory factor analysis of the PWS to determine whether midlifers and older adults produced different factor scores from those of the originally proposed subscales of the PWS. We used the following research questions to guide our study:

*Research Question 1:* Are the subscales of the PWS different when applied to a midlife/aging population?

*Research Question 2:* If such differences exist, how would these differences be explained using Erikson's (1959/1980) psychosocial theory of development?

## METHOD

### Participants

Participants ( $N = 170$ ) were recruited from the northeast Ohio region through a convenience sample. The mean age for all participants was 60 years ( $SD = 5.13$ ). Forty-seven percent of participants ( $n = 80$ ) ranged between 50 to 59 years and fell within the time of midlife (Menon, 2001), whereas 51% ( $n = 87$ ) were between 60 and 78 years old and qualified as older adults. Three participants did not give their age. Sixty-four percent of participants ( $n = 108$ ) were male, and 36% ( $n = 62$ ) were female. When asked about with which racial group they identified, 95% ( $n = 161$ ) of participants reported European American, 3% ( $n = 5$ ) reported African American, and 2% ( $n = 4$ ) reported Asian American.

Overall, participants revealed a diverse range of education levels, with their highest reported degrees pertaining to a high school diploma ( $n = 30$ ), some college ( $n = 46$ ), a bachelor's degree ( $n = 43$ ), a master's degree ( $n = 32$ ), and a doctorate ( $n = 19$ ). Regarding job type, 95% of participants labeled themselves as working in a white-collar career, such as management ( $n = 37$ ), professional ( $n = 65$ ), service industry ( $n = 30$ ), sales ( $n = 7$ ), and administration ( $n = 23$ ); 5% of participants listed their jobs as blue collar, working in farming ( $n = 1$ ), construction ( $n = 1$ ), installation ( $n = 1$ ), and production ( $n = 5$ ). Participants' annual income was as follows: 10% ( $n = 17$ ) reported earning \$0–\$39,999; 34% ( $n = 58$ ) reported earning \$40,000–\$79,999; 31% ( $n = 53$ ) reported earning \$80,000–\$119,999; and 25% ( $n = 42$ ) reported earning more than \$120,000. With respect to marital status, 84% ( $n = 143$ ) were married, with the remainder reporting being single ( $n = 7$ ), engaged in a relationship ( $n = 7$ ), separated ( $n = 2$ ), divorced ( $n = 9$ ), or widowed ( $n = 2$ ).

### Instrument

The PWS contains 36 items and takes 15 minutes to complete (Adams et al., 1997; Harari, Waehler, & Rogers, 2005). Each of the six subscales contains six items. Each subscale represents a specific dimension of the PWM. Items are rated on a Likert-type scale ranging from 1 = *very strongly disagree* to 6 = *very strongly agree* (Bezner, Adams, & Whistler, 1999). After items are scored, the PWS provides an overall composite score of wellness and six subscale scores. Composite scores range from 3 to 29, with higher scores suggesting a higher level of wellness. The items making up the six subscales are randomly ordered in the test instrument.

The research demonstrating the PWS's psychometric validity is mixed. Adams, Bezner, Garner, and Woodruff (1998) found the PWS to possess adequate temporal stability ( $r = .73$  [university students],  $r = .81$  [business employees]), construct validity, and discriminant validity. Adams et al. (1997) found adequate internal consistency in the overall wellness score of the PWS ( $\alpha = .91$ ), as well as the subscales: Physical ( $\alpha = .81$ ), Spiritual ( $\alpha = .77$ ), Emotional ( $\alpha = .74$ ),

Psychological ( $\alpha = .71$ ), Intellectual ( $\alpha = .64$ ), and Social ( $\alpha = .64$ ). However, Adams et al. (1997) concluded through a factor analysis using younger participants that the PWS subscales produced moderately high intercorrelations because of the nature of the items, suggesting a unidimensional measurement of wellness and a reconsideration to reassess the existing subscales.

Other researchers have obtained similar results. Harari et al. (2005) examined the PWS to evaluate overall, subscale, and criterion validity using a younger sample of participants. Controlling for impression management, Harari et al. found high internal consistency ( $\alpha = .91$ ) and adequate criterion validity when they compared the PWS with other mental health measures, such as the Beck Depression Inventory–II ( $R^2 = .29$ ), the Beck Anxiety Inventory ( $R^2 = .11$ ), and the Hopkins Symptom Checklist–21 ( $R^2 = .18$ ), but their factor analytic results failed to produce all six subscales. For our study, the internal reliability was adequate (Cronbach's  $\alpha = .93$ ).

### Procedure

Survey packets were distributed to local businesses, social clubs, schools, universities, mailing lists, and churches that agreed to participate. The survey packets contained an informed consent letter; the PWS; a demographic form; a self-addressed, stamped postcard; and a stamped return envelope. The PWS and demographic form were randomized to minimize any influence one may have had on the other (Fowler, 2002). Participants who completed their survey packets and mailed them back had the opportunity to enter into a drawing to receive one of six \$25 gift cards. Although midlife ranges from 40 to 60 years old (Menon, 2001), we were interested in understanding wellness during the second half of midlife and older adulthood and required participants be 50 years or older to participate in this study.

Survey packets were given to representatives (e.g., clergy people and human resources) of the noted institutions. These representatives distributed the packets to individuals meeting the criteria for the study within their respective institution. Individuals who chose to participate returned their completed packets using the provided self-addressed, stamped envelope. The directions asked participants not to put a return name or address on the envelope to preserve their anonymity; however, if participants wished to take part in the monetary incentive, they mailed in the postcard (separate from the survey packets they returned) identifying their names and addresses. All names and addresses remained confidential and were destroyed after selection of the six gift card winners.

### RESULTS

In response to our research questions, we completed both a scree test (see Figure 1) and an analysis of the eigenvalues. The scree test offered the most practical and useful solution. On the basis of these results, we factor analyzed the correlation

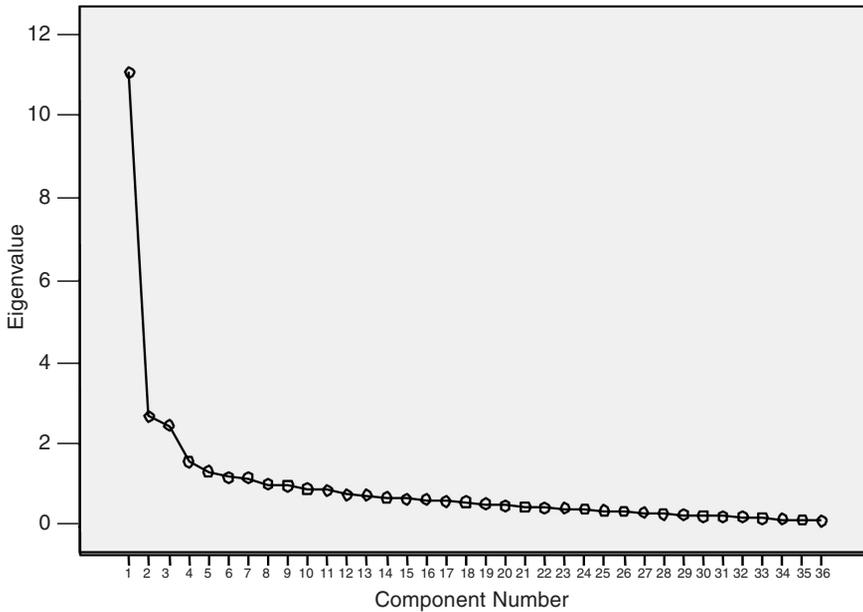


FIGURE 1

**Scree Plot Results From the Factor Analysis**

matrix with the number of factors set to four. We performed an exploratory and confirmatory factor analysis by calculating both a varimax and a promax solution. The similarities between the two were noteworthy. We subsequently selected the varimax solution because it offered the most parsimonious result and the varimax criterion is the solution that is most reproducible (for a more detailed discussion, see Thompson, 2004). Table 1 presents the four-factor varimax rotated factor matrix. Finally, factor score coefficients were also calculated. They are available upon request from the first author if readers wish to use those coefficients to score administrations of the PWS using this solution.

An analysis of the four-factor solution identified names for each factor. Although some items were multivocal (factor pattern coefficients of  $|\geq .30|$  or greater on more than one factor), we placed each item with the factor with which it rated the highest.

The first factor was termed *Optimism* because it embodies the tendency to take the most hopeful view of life events. Twelve items from the PWS had factor pattern coefficients of  $|\geq .30|$  or greater (see Table 1). We named Factor 1 *Optimism* because the nature of the items' associated fit; themes found within the items revolved around the themes of purpose, mission, intellect, a positive view of the future, security, and expecting the best. Items from five of the six (originally proposed by Adams et al., 1997) subscales correlated to this factor: Intellectual, Psychological, Spiritual, Social, and Emotional.

**TABLE 1**  
**Four-Factor Varimax Solution for the Perceived Wellness Survey**

Item	Factor 1	Factor 2	Factor 3	Factor 4
6	.68			
13	.68			
19	.67			
5	.60			
30	.60			
18	.59			.36
8	.56			.32
35	.56	.42		
23	.54			.30
26	.52	.32	.33	
1	.51	.45		
15	.50			.39
14		.65		
25		.65		
29		.65		
36	.35	.64		
20		.63		
11		.60		.31
2		.59		
12		.54		
7		.52		
17		.50		
31		.48		
16			.81	
22			.74	
4			.68	
34		.36	.62	
28		.30	.61	
10	.32		.55	
32	.38		.43	
9				.69
21	.34			.67
33				.67
3	.40			.49
24	.34			.42
27		.36		.38

Note. Although some items were multivocal (factor pattern coefficients of |.30| or greater on more than one factor), each item was placed with the factor with which it rated the highest. Factor 1 = Optimism; Factor 2 = Existential Despair; Factor 3 = Physical; Factor 4 = Family/Friends.

The second factor, termed *Existential Despair*, represents a more negative perspective about life. The 11 items with factor pattern coefficients of |.30| or greater created themes related to hopelessness, self-degradation, and inferiority. Items from four of the six subscales (Adams et al., 1997) correlated to this factor: Intellectual, Psychological, Spiritual, and Emotional.

We named the third factor *Physical* because it primarily addresses individuals' perceptions of their health in the past, present, and future. Seven items on this factor had factor pattern coefficients of |.30| or greater; all six of the items related to physical wellness (from the Physical subscale originally proposed by

Adams et al., 1997) were present, as well as one item initially proposed under the Emotional dimension of wellness.

The final factor was termed *Family/Friends* because it primarily dealt with items asking individuals to rate their relationships with family and friends. Six items on this factor had factor pattern coefficients of  $|.30|$  or greater; five related to the Social subscale proposed by Adams et al. (1997), and one related to the Intellectual subscale.

## DISCUSSION

We suggest that, on the basis of our sample, the PWS offers a four-factor solution to explain how midlifers and older adults perceive wellness. Here, we discuss these findings.

On the basis of our findings, we propose that midlifers and older adults perceive wellness differently than the PWM describes (Adams et al., 1997). The PWM listed six theoretically discrete dimensions of wellness, but we found that only two of the six original dimensions of the PWM existed within our sample, namely, Physical and Social (i.e., Family/Friends). Thus, midlifers and older adults do not distinguish the wellness dimensions of Emotional, Intellectual, Psychological, and Spiritual as separate entities but integrate these into two dimensions that make up the factors of Optimism and Existential Despair. Specifically, these two new dimensions both consist of items that describe emotional, intellectual, psychological, and spiritual wellness but differ in terms of positive and negative perceptions. Thus, although the PWM proposes that wellness be divided in terms of content (e.g., emotional vs. psychological), midlifers and older adults integrate these dimensions and evaluate them as possible successes or failures.

The factors of Optimism, Existential Despair, and Family/Friends lend credibility to Erikson's (1959/1980) two final stages of psychosocial development. During the ego integrity versus despair stage, individuals examine their lives and search for a sense of fulfillment, reconciliation, and meaning; success at this stage leads to wisdom, whereas failure can result in despair (Erikson et al., 1986). High scores on the Optimism factor suggest that individuals succeeded during this stage, because the items of this factor are positive (e.g., "I always look on the bright side of things"; "In the past, I have expected the best"; "I believe there is a real purpose for my life"; and "It seems that my life has always had purpose"). In contrast, high scores on the Existential Despair factor suggest that individuals struggle with finding fulfillment and meaning, because the items of this factor are all negative (e.g., "I sometimes think I am a worthless individual," "I have felt in the past that my life was meaningless," "Sometimes I don't understand what life is all about," and "Life does not hold much future promise for me"). Thus, the factors of Optimism and Existential Despair capture the essence of Erikson's last stage of development and suggest that midlifers 50 to 59 years old are also contemplating these issues.

The ego integrity versus despair stage is also a time when individuals reflect on past and current relationships with family and friends, celebrating successful relationships and mending strained ones (Erikson et al., 1986). The factor of Family/Friends represents this stage because relationships are still important during this time of life. Midlifers and older adults not only may want to reconcile estranged relationships, but also may wonder who will care for them if they become disabled. The highest scoring items of the Family/Friends factor suggest this: “Sometimes I wonder if my family will really be there for me when I am in need,” “My family has been available to support me in the past,” and “My friends will be there for me when I need help.”

During the generativity versus stagnation stage, individuals attempt to contribute to others—typically future generations—for the betterment of society. Often, individuals at this stage of life seek to make their lives matter, usually through career endeavors and/or parenthood (Erikson, 1959/1980). Success during this stage results in feelings of helpfulness and achievement, whereas failure produces a superficial connection with the world. High scores on the Optimism factor suggest that individuals have achieved a sense of generativity (e.g., “In general, I feel confident in my abilities”; “I feel a sense of mission about my future”; and “My friends know they can always confide in me and ask for advice”), whereas high scores on the Existential Despair factor imply an association with stagnation (e.g., “There have been times when I felt inferior to most of the people I knew,” “I rarely count on good things happening to me,” and “My life has often seemed devoid of positive mental stimulation”). In summary, these four factors provide evidence that midlifers and older adults perceive some dimensions of wellness as distinct (i.e., Family/Friends and Physical), but other wellness factors as integrated and evaluative in nature. This evaluative perspective is explained by using Erikson’s (1959/1980) last two stages of psychosocial development, where individuals begin to reflect on their own abilities, contributions, and overall lives.

## A NEED FOR FUTURE RESEARCH

The current study only begins to reveal the perception of wellness during midlife and older adulthood, and many other questions must be answered so counselors can effectively use wellness counseling with these age groups. One possible inquiry that addresses a limitation of our study is factor analytic research on the PWS that separates the midlife and older adult populations. Our sample included both populations, and it is possible differences exist between how midlifers and older adults perceive wellness. If differences existed, they would make a clearer distinction between the age groups and possibly produce a higher standard of care.

Second, further research must consider diversity matters when understanding wellness in the midlife and older adult populations. Although our research

provided an adequate starting point to study wellness perceptions of midlifery and older adults, our sample focused primarily on European American men from a higher socioeconomic status. Further research could focus on how midlife and older adult minority groups perceive wellness, specifically how groups differ on the basis of race, ethnicity, gender, sexual orientation, socioeconomic status, and religious/spiritual beliefs. Understanding these different wellness perceptions would create more competent multicultural counseling strategies, providing counselors with more culturally accurate wellness models to use instead of ones primarily based on Eurocentric perspectives.

Last, research is needed to understand how these newly emerging wellness perceptions of midlifery and older adults relate to other clinical variables, such as depression, anxiety, self-worth, and personality. Understanding the intricate relationships between these variables will help counselors appreciate the complexity of aging and will move the therapeutic process in a meaningful direction for the client.

## CONCLUSION

Do midlifery and older adults perceive wellness differently than existing wellness models portray? We surveyed a total of 170 midlifery and older adults using the PWS, and using an exploratory and confirmatory factor analysis, we found that they do perceive wellness differently. Instead of the original six factors emerging, four factors resulted from the analysis: Optimism, Existential Despair, Family/Friends, and Physical. The factors of Optimism and Existential Despair are integrative and evaluative in nature, which can be explained by the last two stages of Erikson's (1959/1980) psychosocial theory of development. Researchers must continue to explore how midlifery and older adults perceive wellness as separate groups, consider multicultural dimensions (e.g., race, ethnicity, gender, and sexual orientation), and study how other clinical constructs (e.g., depression, anxiety, and personality) relate with their wellness perceptions to provide an adequate standard of care for the current and future aging populations.

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