CHAPTER 10

Professional Practice With Goals for Older Adults

"Age is no barrier. It is a limitation you put on your mind."

—Jackie Joyner-Kersee

Learning Objectives

After reading this chapter, you will be able to

1. Analyze the goals and common approaches of psychosocial interventions
2. Explain the stages of the helping relationship and challenges that may arise
3. Examine common issues that cause clients to seek counseling

INTRODUCTION

The emerging professional practice of gerontological counseling requires highly trained, knowledgeable, and caring practitioners. These practitioners must possess the knowledge, skills, attitudes and behaviors that create an environment that supports the older clients' willingness to divulge intimate life details. A genuine respect and appreciation for older adults and their abilities is a fundamental requirement in initiating dialogue. Counselors must have intangible qualities and a flexibility to perform numerous roles, as well as the ability to work as a member of a multidisciplinary team. Though gerontological counselors are few in number in comparison to other professionals, they are able to provide the interventions to promote and enhance the quality of life for older persons experiencing internal and external challenges.

PSYCHOSOCIAL INTERVENTIONS

An intervention is the introduction of a preventive or therapeutic regimen designed to effect a change in the status of a target individual. It is generally believed that psychosocial interventions recognize the interrelated nature of the physical, psychological, and social dimensions of human behavior and functioning and typically strive to achieve effects in multiple outcome domains. In contrast, many medical interventions (e.g., surgery, pharmacology) are more restricted in their approach and their objectives.

Psychosocial interventions targeted at older adults aim to maintain or enhance their quality of life. Such interventions are commonly an outgrowth of descriptive or correlational research, which has identified factors that significantly impact quality of life and seem to be amenable to change. Psychosocial interventions are increasingly used as an alternative or supplement to surgical or pharmacological approaches because of their general efficacy and relative cost-effectiveness.

Common Goals of Psychosocial Interventions

The vast majority of psychosocial interventions focused on older adults emphasize maintaining or improving physical health, mental health, and social functioning or cognitive functioning, promoting adaptive function, and increasing the likelihood of making healthy life choices that enhance quality of life (Carr, 2009; Sheder, 2010; Wampold, 2010). Of these three goal domains, physical health promotion is the most common, as illustrated by interventions to reduce falls, enhance urinary continence, lower blood pressure, detect prostate cancer, lower cholesterol levels, increase muscle strength, increase peak pulmonary expiration flow rate, increase bone mineral density, enhance self-care behaviors (e.g., medication compliance, exercise), and reduce risky health behaviors (e.g., smoking, alcohol use). Due to the growing number of older adults coping with chronic illnesses that require self-management or that can be prevented to some extent, there are many psychosocial interventions aimed at physical health promotion. From a societal perspective, the ultimate objective of such interventions is to extend the time that the older adult can live independently and thus delay institutionalization.

Guided Practice Exercise 10.1 familiarizes counselors with community services to increase the potential that their older client can remain in their preferred community environments.

Guided Practice Exercise 10.1

Altering the traditional counseling setting is sometimes necessary to reach older potential clients. Many older persons may live in the community but are unable to reach the various mental health centers for services. Visit an older person in his or her home. Assess the individual's needs and strengths to determine the types of services required and what he or she may be willing to accept. This requires the counselor to become familiar with resources in the community, such as Meals-on-Wheels, homemaker services, senior companion and/or phone reassurance services, and other services available in the community. Supportive services will encourage independent living within the community.

Examples of the goals of mental health interventions of older adults include the reduction of anxiety and depressive symptomatology, enhancing sleep quality, and increasing feelings of global or domain-specific satisfaction and perceived control. Some psychosocial interventions are directed at improving quality of life in individuals suffering from or who are at risk for psychiatric illness due to common late-life stressors such as chronic illness, spousal caregiving, and bereavement (refer to Chapters 4–7).

Common goals of psychosocial interventions to support social functioning are enhanced social support, increased recreational or leisure activity, and improved cognitive functioning (e.g., verbal and nonverbal memory, visuospatial ability, overall performance on standardized neuropsychological tests, improved driving skills). Social functioning is important for older adults to live a meaningful life in today's society. It enhances overall well-being, improves self-esteem, encourages the development of meaningful relationships, encourages creative expression, and enhances emotional well-being.

Common Psychosocial Intervention Approaches

Common intervention approaches include behavioral training, physical activity training, peer support for dealing with specific stressors, education, and counseling or psychotherapy (e.g., psychodynamic, cognitive-behavioral, and interpersonal therapies) in an individual or group setting. Educational interventions are perhaps the most general approach, as individuals can be educated on a multitude of issues, such as managing medications, coping with grief, and modifying the home to make it more accessible. In educational interventions, a needs assessment is sometimes conducted with focus groups before developing the intervention content to identify the most important issues faced by the given population.

Because of the high prevalence of physical and psychiatric comorbidity in late life, intervention approaches that treat problems in either of these domains are likely to have effects on both domains. Therefore, multidisciplinary geriatric assessment and treatment programs are becoming more common in health care systems (Devons, 2002; Ward & Reuben, 2015).

There is a history of research on psychosocial interventions aimed at enhancing perceived control, especially with older adults in long-term care settings who have little actual control over their social and physical environment. The increased use of interventions that encourage self-management of health and illness illustrates that there has been a shift toward interventions that focus on the use of various strategies to maintain a sense of control in the face of essentially uncontrollable events.

Other approaches to enhancing quality of life for older adults that are receiving increased attention include reminiscence and life review, preventive health screening, special packaging of medications, pet therapy, music therapy, light therapy, visual stimulation through art, intergenerational programs, adult day care, and cognitive therapy. It is becoming more common to focus on older adults, through changes in their environment, or to focus on multiple individuals simultaneously (e.g., the older adult, informal or formal caregivers, and the physician) during therapeutic interventions.

Psychosocial interventions have been used effectively in the treatment of older adult issues. The ultimate goal of any of the identified psychosocial modalities is to improve the overall well-being of older adults and enhance their quality of life.

STAGES OF THE HELPING RELATIONSHIP

The helping relationship established between the counselor and his or her client is unique. This relationship is built on mutual trust and respect and lays the foundation for all future therapeutic work. Clients are provided with a safe environment to express and explore their innermost thoughts, feelings, fears, and accomplishments. The stages of the helping relationship are similar to counseling other populations; however, the approaches may vary. It remains important to establish rapport, conduct assessments, interview appropriately, set goals, and provide closure. However, unique considerations are required when addressing the needs of older clients. Older clients will vary in their cognitive, physical, social, and functional ability, which require accommodations. Assessment instruments should be those measures normed to older adults. Goal setting will vary due to age-related changes in vision, hearing, cognition, and sight. Environmental adaptations may necessitate wider doors. Counselors will need to examine their feelings and comfort level in discussing delicate issues (i.e., death and dying) with older clients. Therefore, the therapeutic relationship is essential to facilitating the changes required to enhance the well-being and development of older clients.

Creating Therapeutic Relationships

The significance of the therapeutic relationship in effective counseling and psychotherapy with older adults cannot be overstated. The personal relationship is a key factor in helping older adults. Warren (2001) reports that the relationship between the quality of the patient–therapist relationship and the outcome of treatment has been one of the most consistently cited findings in the empirical search for the basis of psychotherapeutic efficacy with older adults. Writing about the power of the therapeutic relationship, Saleebey (2000) argues that if healers are seen as nonjudgmental, trustworthy, caring, and expert, they have some influential tools at hand, whether they are addressing depression or the disappointments and gains of unemployment. Glicken (2009) identifies the importance of the relationship:

> The relationship is a bond between two strangers. It is formed by an essential trust in the process and a belief that it will lead to change. The counselor's expertise is to facilitate communications, enter into a dialogue with the client about its meaning, and help the client decide the best ways of using the information found in searches for best evidence. (p. 50)

In describing the client-centered approach with older adults, Dacey and Newcomer (2005) report that forming a relationship with the older client requires that we establish rapport, set an agenda for discussion, respect the client's freedom of choice, and by carefully listening to the client, seek to understand and encourage the client to make his or her decisions. Practitioners give advice to their clients as part of the counseling intervention, and this advice should always be given in a nonjudgmental manner.

As practitioners, an understanding of how the client makes sense of his or her world is important. By understanding the client's frame of reference, practitioners are in a better

position to facilitate change and life-span development. Being empathic with clients also assists with establishing rapport. If a client does not sense that the counselor understands and appreciates his or her dilemmas, then relationship building is jeopardized. A sensitivity to the tension between the body's physical decline and the simultaneous capacity for growth and maturation is important (Agronin, 2010). Effective listening skills are extremely important, and demonstrating patience to allow clients to express themselves is vital to the interaction. Older clients may need additional time to share their feelings, establish a rapport because traditionally they have underutilized the services of counseling professionals. Establishing rapport is an important initial step in the counseling process, and if this rapport is not established, there exists a strong likelihood that the older adult may not attend future counseling sessions. This is particularly important for counselors working with older adults, given their limited experience with the mental health system and their reluctance to discuss personal issues with outside professionals.

Guided Practice Exercise 10.2 provides experience in establishing rapport through a role-play scenario. The relationship is an essential component of the clients' ability to make progress during treatment sessions.

Guided Practice Exercise 10.2

The goal of this exercise is to establish a rapport with your partner, which is an initial step in relationship bonding. One individual is the speaker, and the other is a listener. Choose a partner unlike yourself in age, gender, and experiences. The speaker relays "who he or she is" to the listener. He or she tells the listener how he or she feels about himself or herself, how he or she feels about the individuals around him or her, and his or her self-views in relation to the important aspects of his or her life. The speaker is practicing self-disclosure and is engaged in personal communications. The listener attempts to accurately repeat what has been conveyed, and the speaker will affirm the accurate remarks. The listener attempts to show concern and respect for the speaker. After 10 minutes, roles are reversed. Once completed, discuss experiences of the exercise and what was learned.

Since therapeutic relationships are the foundation for counseling, there continues to be research on this topic. This allows the development of treatment protocols possible, increasing treatment efficacy, influencing the training of psychotherapists, and providing standard treatment protocols for the purposes of further treatment process research (Warren, 2001).

Therapeutic Relationship and Treatment Outcomes

The adult psychotherapy literature supports the central role of the therapeutic relationship within the psychoanalytic framework, the client is expected to talk freely and be interested in cognitive reflecting on the past as well the current situation (Parsons & Zhang, 2014). American theorists agree on the importance of building a collaborative relationship

in which the counselor and client initiate the process of building an egalitarian relationship. Additional phases are investigating the lifestyle, gaining insight, and reorientation (Mosak & Maniacci, 2008; Sweeney, 2009). Existential theory promotes the concept of wellness and living an authentic life (Miars, 2002), and it is developmentally sensitive to life transitions. Central to the practice of existential psychotherapy is the authentic nature of the client–counselor relationship (Parsons & Zhang, 2014). Carl Rogers's client-centered therapy emphasizes the centrality of the relationship between client and therapist as the most important factor in therapy. Rogers (1959) proposed that clients are innately motivated to actualize their potentialities assuming that a psychological climate conducive to growth is provided. The person-centered approach is built on a basic trust in the person (Rogers, 1986) and researchers (Elliott & Freiere, 2010; Wampold, 2001) emphasize the relationship as the factor that makes the greatest contribution to outcome. The Gestalt approach emphasizes that anyone willing to increase his or her awareness can be taught about the cycle of experience and can discover the benefits of increased growth (Melnick & Nevis, 2005). Cognitive-behavioral theories (CBT) principles and constructs are taken from cognitive therapy, which focuses on thoughts, with those of behavioral therapy, which focuses on actions (Parsons & Zhang, 2014). CBT helps clients examine their thinking so they can choose healthy, rational thoughts and beliefs that will result in healthier emotions and behaviors. Behavioral therapists' central assumption is that all behavior, adaptive or maladaptive, is learned. It is therefore believed that maladaptive behavior can be changed through learning (Parsons & Zhang, 2014).

Reality therapy is a present-centered mode of therapy whose goal is to empower clients to take responsibility for their choices as well as learn and implement healthier behaviors and decisions to fulfill universal needs (Scott & Barfield, 2014). Reality therapy is the therapeutic practice based on choice theory (Wubbolding, 2007). Choice theory revolves around the concept of internal control (Glasser, 1998), and other person's reactions and behaviors are simply information that helps us make informed decisions and evaluations about how we behave and what we believe. Solution-focused therapy, rather than focusing on problem formation and resolution, takes an active stance toward helping the client. Solution-focus represents a strengths-based approach in which counselors emphasize the resources their clients possess and how their strengths can be applied to create change (de Shazer, Berg, & Lipchik 1986). Using what clients possess to help them meet their own needs and build satisfactory lives for themselves is a fundamental premise of this approach, and the popularity of this approach lies in its flexibility, collaborative nature, and focus on client strengths (Kim, 2008). Counselors focus on resolving current problems by looking forward rather than backward. The client and counselor work to find solutions with the greatest likelihood of producing change and in co-constructing solutions, clients can find the ones that fit their particular worldview (DeJong & Berg, 2001).

Relational cultural theory (RCT) is guided by the principle that individual growth occurs in and through relationships. The overarching goal of the therapy process is to attain the mutual empowerment that results from increased connection (Miller & Stiver, 1991) and to grow further in relational competence. RCT's emphasis on understanding and evaluating the impact of cultural identity makes it useful for working with diverse cultures and populations. Family systems therapy is used extensively in counseling settings because many clients place great value on their families and need to be considered within the context of

the family system for optimal treatment to occur. The family systems approach is beneficial in that it does not place blame for existing problems on either the family or individual members (Corey, 2012). It is understood that each family member and subsystem contributes to overall family dynamics, and no single entity is responsible for all dysfunction within the system.

Many graduate students and early counseling professionals struggle to decide what counseling theories they will use in their counseling sessions. What makes a theory useful to one person and his or her personality will not necessarily be the same for another person. Depending on how to use a specific theory will depend on many factors. The personality and needs of the client, the counselor's personality and knowledge pertaining to a specific theory are just a few of the variables to ponder when choosing a theory (Parsons & Zhang, 2014).

Special Concerns About the Therapeutic Relationship With Older Adults

Despite the strategies and suggestions available for developing a relationship with an older adult, it may not be easy. There are a number of challenges that may be faced in building rapport with members of this population.

Counselors are usually younger than their older adult clients and need to consider how their differences in age and life experience influence the counseling relationship (Myers & Harper, 2004, p. 208). Consequently, more time and sensitivity are required to build rapport with these individuals who may be less comfortable with seeking help, sharing feelings, or asking questions of "authority" figures, particularly in clients who are reluctant to seek help. Younger professionals also need to be prepared to deal nondefensively with older clients who might view them as unable to understand the lived experiences of old age. Older clients may not be familiar with counseling, or they may have problems discussing and dealing with feelings, as is the case with older adults from more traditional cultures and some male clients.

Older persons may view human service workers in the same way they view medical personnel, anticipating that the relationship will be hierarchical and directive, and they may experience some degree of difficulty coping with counselors who ask their opinion or give the client a great deal of personal authority (Myers & Harper, 2004). This can be managed by explaining how the clinician works and why it is so important for the client to have maximum input. Oftentimes, however, older clients are very therapy-savvy, having seen therapy on television and in various films.

Though young-old adults, those aged 65 to 74, tend to have similar concerns as younger persons, the aging process can create complications in treatment planning even for healthy older adults. Physical limitations that affect a client's ability to sit for long periods may require changes in the length of sessions or cognitive or sight impairments may require changes in the assessment process. It may also be wise to focus discussion on a single topic and not let the session flow into other issues, since memory may be impaired and too many subjects may cause confusion.

Other accommodations that may need to be made include lengthening the sessions in individual counseling and increasing the number of sessions for support groups or other

group therapy formats, which is more important in reducing relapse for older clients than for younger ones. Psychological treatments should be modified as well. Many traditional counseling approaches can be accommodated to meet the needs of older clients (Gellis & Kenaley, 2008; Kennedy & Tannebaum, 2000).

Client Assessment

The next stage in the helping relationship is assessment. Psychological assessment pervades nearly every aspect of psychotherapeutic work with older people. Thorough evaluation of the psychological status and functioning of an older person is a vitally important but complex process, even for experienced clinicians. The purposes of assessment are to clarify current symptoms and problems, formulate a diagnosis, develop case conceptualization and intervention plans, and evaluate effects of treatment. Some of the major challenges in working with older adults include choosing appropriate tools for the assessment; engaging the right persons in the process; assessing the full range of cognitive, social, functional, and psychological problems; and differentiating disorders from normal aging. Traditional assessment procedures require some modification for older persons. Older adults with less formal education may require a lengthier explanation of any types of assessments administered. For any type of testing (i.e., neuropsychological testing), older adults should be given advanced notice to be prepared with any assistive devices required (i.e., eye glasses, hearing aids). If English is not the native language of the older adults, an interpreter who is bilingual will be needed. While assessments may be given at designated times, flexibility is required for older clients based upon other appointments he or she may have and when they function at their best. Multiple sessions may be required for older clients, especially if they fatigue quickly. Environmental modifications may require wider doors for wheelchair accessibility, enhanced lighting, and positioning client to avoid glare.

Case Illustration 10.1 demonstrates the availability of the counselor to engage with his or her client in a nursing home environment and ascertain appropriate assessments to use in treating a potentially depressed client.

CASE ILLUSTRATION 10.1

A staff member has contacted you (the counselor) to visit a resident who has become withdrawn and complains of lethargy and lack of interest in activities and has a decreased appetite. These behaviors have been observed by the nursing staff for the past 2 weeks. When you visit the resident, she questions her worth, shares that she hopes she doesn't wake up the next morning, and expresses that her family doesn't care about her. As the counselor, how would you interpret her presenting problems? What would your next step be in the process of helping her? Are there assessments or specific appraisals you would use? Is there a need to explore the family dynamics and if so, in what manner?

Clinical Interview

The clinical interview is perhaps the most important and informative strategy during an evaluation of an older person. During the interview, the clinician gathers information about the person's current difficulties, including a history of the problem and attempts at coping. Other topics include an in-depth personal history; mental health history (including interventions); marital, family, social, and work history; and a mental status examination. Collateral interviews with concerned family members or caregivers are a common and very informative component of geriatric assessments.

To facilitate rapport, clinicians should explain clearly the purposes and procedures of the assessment, address any concerns the person may have about the evaluation, and be especially flexible when engaging older persons and their family members. Being generous with warmth, support, and reassurance (when needed) also helps with rapport.

Interviewing older clients requires effective communication, and while effective communication is necessary in counseling all age groups, there are specific recommendations for counselors to enhance their interactions with older clients. Improving interactions with older adults requires recognizing the tendency to stereotype older adults, and it is necessary to conduct an independent assessment and also avoid speech that might be seen as patronizing to an older person (elderspeak) (Williams, Herman, & Gajewski, 2009). Improving face-to-face communication with older adults involves monitoring and controlling nonverbal behavior, minimizing background noise, facing older adults when you speak with them, and paying close attention to sentence structure when conveying critical information. Also use visual aids such as pictures and diagrams to help clarify and reinforce comprehension points and ask open-ended questions and genuinely listen (Duffy, Gordon, & Whelan, 2004; Harwood, 2007; Houts, Doak, & Doak, 2006).

Optimizing interactions between health care professionals and older patients involves many areas. It's important to express understanding and compassion to help older patients manage fear and uncertainty related to the aging process and chronic diseases (Fowler & Nussbaum, 2008). Inquiring regarding an older client's living situation and social contacts is important. When dealing with older adults and their families, remember to always include the older adult in the conversation. Seek information about cultural beliefs and values pertaining to illness and death (Langer, 2008) and engage in shared decision making. The counselor needs to strike an appropriate balance between respecting clients' autonomy and stimulating their active participation in health care (Osborn & Squires, 2012). Avoiding ageist assumptions when providing information and recommendations about preventive care is important (Centers for Disease Control and Prevention [CDC] et al., 2011). Use of direct, concrete, actionable language when talking to older adults, verifying older clients' comprehension, and setting specific goals for client comprehension will enhance the therapeutic encounter (Speer, Reynolds, & Swallow, 2009). Providing quality clinical services is enhanced when the focus remains on the older client. When counseling ethnic minority older clients who are from other cultures, counselors must remember to use humor (which eases tension) and direct communication (preferable in the United States) with caution. This sensitivity to cultural considerations is essential during the counseling process (Pecchioni, Ota, & Sparks, 2004). Providing Internet-savvy older clients with chronic diseases support in locating reputable sources of online support and facilitating collaboration with systems and older clients are also important (Madden, 2010).

Specific recommendations for counselors counseling older adults with dementia involve maintaining a positive communication tone and avoiding speaking slowly to older adults with dementia (Small, Gutman, & Makela, 2003). When communicating with older adults with dementia, simplify sentences and use verbatim repetition or paraphrase sentences to facilitate comprehension in older adults with dementia (Bourgeois, 2002; Savundranayagam, Ryan, & Ana, 2007). Professional counselors provide an unmet need when counseling older clients. Modifications may be required based on the uniqueness of the older client and his or her situation. Specific communication strategies identified will enhance the interview process and potentially facilitate positive outcomes.

The therapeutic relationship is a special bond that exists between the client and the counseling professional. This relationship, if appropriately established, can facilitate the achievement of positive treatment outcomes. However, adaptations or adjustments by the counselor may be required to accommodate the unique needs of older clients.

Comprehensive Geriatric Assessment

Comprehensive geriatric assessment (CGA) is defined as a multidisciplinary diagnostic and treatment process that identifies medical, psychosocial, and functional abilities of an older person in order to develop a coordinated plan to maximize overall health and aging (Devons, 2002). The health care of an older adult extends beyond the traditional medical management of illness. It requires evaluation of multiple issues including physical, cognitive, affective, social, financial, environmental, and spiritual components that influence an older adult's health. CGA is based on the premise that a systematic evaluation of older persons by a team of health professionals may identify a variety of treatable health problems and lead to better health outcomes (Ward & Reuben, 2015). Counselors working with older clients can use this assessment process to identify areas which require intervention for older clients.

Core components of CGA that should be evaluated during the assessment process include functional capacity, fall risk, cognition, mood, polypharmacy, social support, financial concerns, goals of care, and advanced care preferences. Additional components may also include evaluation of nutritional or weight change, urinary continence, sexual function, vision and hearing, dentition, living situation, and spirituality (Ward & Reuben, 2015). Functional status refers to the ability to perform activities necessary or desirable in daily life, and functional status is directly influenced by health conditions, particularly in the context of an elder's environment and social support network. Changes in functional status (e.g., not being able to bathe independently) should prompt further evaluation and intervention. Measurement of functional status can be valuable in monitoring response to treatment and can provide prognostic information that assists in long-term care planning. In addition to measures of activities of daily living (ADLs), gait speed alone has been shown to predict functional decline and early mortality in older adults (Studenski, Perea, & Patel, 2011).

Approximately one-third of community-dwelling persons age 65 years and one-half of those over 80 years of age fall each year (Ward & Reuben, 2015). Persons who have fallen or have a gait or balance problem are at a higher risk of having a subsequent fall and losing independence. An assessment of fall risk should be integrated into the history of all older patients.

The incidence of dementia increases with age, particularly among those over 85 years, yet many patients with cognitive impairment remain undiagnosed (Ward & Reuben, 2015). The value of making an early diagnosis includes the possibility of uncovering treatable conditions. The evaluation of cognitive function can include a thorough history, brief cognition screens, a detailed mental status examination, neuropsychological testing, tests to evaluate medical conditions that may contribute to cognitive impairment (e.g., B12, TSH), depression assessment, and/or radiographic imaging (CT or MRI). It is clear that the extent of assessment and areas of focus of assessment are more extensive for older clients; therefore, counselors must be prepared to make their contributions and make referrals as appropriate.

Depression in the elderly population is a serious health concern leading to unnecessary suffering, impaired functional status, increased mortality, and excessive use of health resources. Depression in the elderly may present atypically and may be masked in patients with cognitive impairment (Arroll, Khin, & Kerse, 2003).

Older people are often prescribed multiple medications by different health care providers, putting them at increased risk for drug-drug interactions and adverse drug events. The counselor should review the patient's medications at each visit. The best method of detecting potential problems with polypharmacy is to have patients bring in all of his or her medications (prescription and nonprescription) in their bottles. Elderly patients should also be asked about alternative therapy (Ward & Reuben, 2015).

The existence of a strong social support network in an elder's life can frequently be the determining factor of whether the client can remain at home or needs placement in an institution. A brief screen of social support includes taking a social history and determining who would be available to the elder to help if he or she becomes ill. Early identification of problems with social support can help planning and timely development of resource referrals. For clients with functional impairment, the counselor should ascertain who the person has available to help with activities of daily living. Caregivers might experience symptoms of depression or caregiver burnout and need referral for counseling or support groups. Elder mistreatment should be considered in any geriatric assessment particularly if the client presents with contusions, burns, bite marks, genital or rectal trauma, pressure ulcers, or malnutrition with no clinical explanation (Ward & Reuben, 2015). The financial situation of a functionally impaired older adult is important to assess, and also elders may qualify for state or local benefits, depending upon their income; therefore, counselors may be asked to assist with securing benefits on behalf of their older clients.

The primary goal of the comprehensive geriatric assessment is promoting wellness and independence. A client's goals in sessions are often positive (e.g., regaining something lost, attending a future event). Frequently, social (e.g., living at home, maintaining social activities) and functional (e.g., completing activities of daily living without help) goals assume priority over health-related goals (e.g., survival) (Reuben & Trinetti, 2012).

Counselors should begin discussions with older clients about preferences for specific treatments while the client still has the cognitive capacity to make these decisions. Clearly timing of this discussion is important because a positive, trusting relationship must be firmly established prior to discussing sensitive issues regarding advanced care planning. These discussions should include choosing an appropriate decision-maker (i.e., appointing a durable power of attorney, also known as a health care proxy, to serve as a surrogate in

the event of personal incapacity), clarifying and articulating clients' values over time, and thinking about factors other than the clients' stated preferences in surrogate decision-making (Sudore & Fried, 2010).

Unique Challenges for Assessment

A key issue in assessments of older adults is to select tests that possess evidence of reliability and validity with older adults and furnish age-appropriate norms. Tests developed specifically for older adults, such as the Geriatric Depression Scale, have excellent norms. Likewise, standard intelligence tests now have extensive age norms. Many other psychological and neuropsychological tests did not initially furnish norms for older adults, but researchers have since provided norms for them. However, some psychological tests are still inadequately normed by age or by other relevant characteristics (e.g., gender, ethnicity) for older adults. The Beck Anxiety Scale is brief and easily administered, but results should be viewed with caution in the assessment of frail and less educated older adults. The Rorschach Inkblot Test should only be used with caution in assessing the personality or disordered thinking of older adults, because age-related norms have not been established for the widely used system and psychopathology can easily be over diagnosed by inexperienced examiners testing older adults who are uncomfortable with unstructured tasks. Clinicians and researchers are encouraged to review carefully the technical manual of tests they use to determine if evidence of reliability, validity, and relevant norms for older persons is available. If not, they should be cautious in interpreting scores.

All psychosocial data must be viewed within the context of physical health. Information about medical illnesses is important because many problems, such as thyroid dysfunction, multiple sclerosis, and hypoglycemia, can cause psychiatric conditions (American Psychiatric Association, 2000). Likewise, many medications commonly taken by older adults can cause psychological symptoms. For example, some antihypertensive drugs can induce depressive symptoms, and some analgesics and anticonvulsants can cause anxiety symptoms (American Psychiatric Association, 2000).

Lyness (2004) advises medical and counseling professionals who work with an older population to screen routinely for depression and other mental health issues because mental health concerns can be the underlying cause of many other presenting problems. Due to age-related increases in the frequency of many chronic medical conditions, older adults consume a large amount of prescribed and over-the-counter medications. With increased medication use, older persons are at increased risk for adverse drug effects because of harmful drug interactions and the buildup of medication in the aging body. Diverse drug interactions can cause memory problems that mimic a dementing illness such as Alzheimer's disease. Older adults are encouraged to bring a complete list of medications to the evaluation. It is wise practice to request that the client sign a release as well, so the clinician can communicate with the client's medical providers. Referral for a thorough medical workup is always indicated if the client has not recently been medically evaluated.

Sensory impairments (e.g., hearing and vision) that are also common among older adults complicate assessment. Difficulties perceiving instructions or testing stimuli can have obvious adverse effects on performance. Sensory deterioration is considered a primary cause of reduced performance on cognitive tasks, and even for certain psychiatric

disorders such as late-onset paranoia. Physical disabilities similarly complicate assessment by limiting response options (e.g., hand movement or writing, constraining reaction time on speeded tasks), limiting access to test stimuli (e.g., standing to engage in a balance task), or limiting stamina for long evaluation sessions procedures. To ensure the person performs optimally, the environment should be adjusted to reduce the impact of any sensory or physical limitations (e.g., brightly lit testing room, minimal background noise, use of large print versions of tests, multiple short sessions, frequent breaks).

Geriatric Assessment Measures

Table 10.1 identifies selected measurements used in assessing older adults that have been normed for older persons.

The Geriatric Depression Scale consists of a 15-item screening tool for depression in older adults (Sheikh & Yesavage, 1986). Each depressive positive answer receives a one, with a score of 10 or higher indicative of the possibility of depression.

The Mini-Mental State Exam (MMSE) consists of 11 questions that test five areas of cognitive functioning: orientation, registration, attention and calculation, recall, and language (Folstein, Folstein, & McHugh, 1975). The maximum score is 30 (all answers correct) and a score below 23 indicates potential cognitive impairment.

The Clock-Drawing Test (CDT) is a quick assessment of cognitive function that is easy to administer and score in the clinical setting. There are multiple ways to score this test;

Table 10.1 Selected Geriatric Assessment Measures

Measure	Instrument
Depression	Geriatric Depression Scale (GDS)
Cognition	Mini-Mental State Examination (MMSE)
Dementia and Delirium	Clock-Drawing Test (CDT) Confusion Assessment Method (CAM)
Functional/Instrumental Activities of Daily Living (ADLs)	Index of Independence of Daily Living (Katz Index of ADL) Instrumental Activities of Daily Living (IADL) Palliative Performance Scale (PPS)
Caregiver Burden	Burden Interview
Nutrition	Mini Nutrition Assessment (MNA) Nutritional Health Assessment
Alcohol	Short Michigan Alcohol Screening Test (Geriatric Version) (SMAST-G)
Sexuality	PLISSIT Model
Life Strengths	Sources of Life Strengths Measure (SLSAS)

however, the method provided is a 6-point scale from Shulman, Gold, Cohen, and Zucchero (1993). The CDT is often given in conjunction with the Mini-Mental State Examination (MMSE), as the CDT detects impairments in visuoconstructional and executive function, while the MMSE shows orientation, memory, and language functions. Because of the CDT's focus on visuoconstructive ability and cognitive function, it may be more useful than the MMSE in detecting dementia in its early stages. The CDT can be used as a quick assessment for dementia in clinical settings (Kirby, Denihan, & Bruce, 2001; Richardson & Glass, 2002; Shulman et al., 1993).

The Confusion Assessment Method (CAM) assesses for the presence of delirium and was created specifically for clinicians without psychiatric training to use with older patients. It was designed for use in various clinical settings such as in making observations during routine clinical care. The CAM is a simple assessment that can be completed in less than 5 minutes (Inouye et al., 1990).

The Time and Change Test (T&C) was developed as a simple measure for detecting dementia in older patients. It has been used in both hospital and outpatient settings. The T&C Test is easy to use, quick to administer, and highly acceptable to patients. In addition, it has been demonstrated to be useful with ethnically diverse patients across educational levels (Froehlich, Robison, & Inouye, 1998; Inouye, Robinson, Froehlich, & Richardson, 1998).

Measures of function are valuable indicators of the changes experienced by aging and chronically ill patients. The Index of Independence in Activities of Daily Living (Katz Index of ADL) was developed to evaluate changes in these populations, assessing a patient's overall performance of six self-care functions: bathing, dressing, toileting, transferring, continence, and feeding. It can be used to assess the need for care as well as the progression of illness and the effectiveness of treatment and rehabilitation. The Katz Index of ADL has been used in many settings, including clinical practice, nursing homes, and rehabilitation settings (Katz, Downs, Cash, & Grotz, 1970).

The Instrumental Activities of Daily Living (IADL) scale measures eight complex activities related to independent functioning, objectively evaluating a patient's ability to perform the functions and assessing how much assistance he or she requires for each activity, if any. The more these abilities are impaired, the more services will be necessary to maintain a person in the community. The Instrumental Activities of Daily Living (IADL) scale is a brief tool that aids in the formulation, implementation, and evaluation of treatment plans. It is useful in elderly community populations and provides information about a patient's need for support services. It can be completed by obtaining the requested information from either the patient or an informant, such as a family member or other caregiver (Cromwell, Eagar, & Poulos, 2003; Lawton, 1971; Lawton & Brody, 1969; Polisher Research Institute, 2005).

The Palliative Performance Scale (PPS) (Anderson, Downing, & Hill, 1996) was designed to assess the physical and functional status of patients receiving palliative care. It has been used to evaluate progression of disease, symptom management and other care needs, prognosis, and the timing of hospice referral. Scores are given in 10-point increments, ranging from 0 (death) to 100 (full or normal, no disease). Five categories of function are scored, and lower scores indicate greater functional impairment (Moody & McMillan, 2003; Virik & Glare, 2002; Wilner & Arnold, 2004).

The Burden Interview has been specifically designed to reflect the stresses experienced by caregivers of dementia patients. It can be completed by caregivers themselves or as part of an interview. Caregivers are asked to respond to a series of 22 questions about the impact of the patient's abilities on their life. For each item, caregivers are to indicate how often they felt that way (never, rarely, sometimes, quite frequently, or nearly always). The Burden Interview is scored by adding the numbered responses of the individual items, and higher scores indicate greater caregiver stress. Estimates of the degree of burden can be made from the following: little or no burden (0–20), mild to moderate burden (21–40), moderate to severe burden (41–60), and severe burden (61–88). The screening is used to determine if the caregiver needs additional help or respite and to monitor the quality of caregiving (Brown, Potter, & Foster, 1990; Council on Scientific Affairs, American Medical Association, 1993; Cummings, Frank, & Cherry, 2007; Rankin, Haut, Keefover, & Franzen, 1994; Zarit, Reever, & Bach-Peterson 1980).

The Mini Nutritional Assessment (MNA) is a screening tool which is an abbreviated version of the longer version (DETERMINE Checklist) (Nutrition Screening Initiative, 1991). The short version consists of seven questions, and five of the seven questions address mobility, weight loss, food intake, psychological stress, and the presence of neuropsychological problems, such as dementia and depression. The other two questions require objective data in the form of body mass index (BMI) and calf circumference (Bernstein & Munoz, 2016). The benefits of the MNA are that it is designed specifically for older adults; its short form takes less than 5 minutes to administer; it takes into account items such as mobility, depression, and dementia; and finally, it is available in several languages.

The Nutritional Health Assessment (NHA) is a screening tool that is both a patient education tool and a quick, convenient means to identify patients who have risk factors for poor nutritional status. The assessment is a brief, 10-statement form that is completed by the individual and returned to his or her clinician (Nutrition Screening Initiative, 2007).

The Short Michigan Alcohol Screening Test (Geriatric Version) (SMAST-G) is a 10-question screening test for potential alcohol problems in older adults (Blow, 1991). Two or more yes answers warrants further assessment of drinking behavior.

Sexuality assessment for older adults can be conducted with the PLISSIT model, which can assess and manage the sexuality of adults (Annon, 1976). The model includes suggestions for initiating and maintaining the discussion of sexuality with older adults. The PLISSIT model stands for: P—obtaining permission from the client to initiate sexual discussion, LI—providing the limited information needed to function sexually, SS—giving specific suggestions for the individual to proceed with sexual relations, and finally IT—providing intensive therapy surrounding the issues of sexuality for that client. Questions to guide assessment among older adults include: Can you tell me how you express your sexuality? What concerns or questions do you have about fulfilling your continuing sexual needs? In what ways has your sexual relationship with your partner changed as you have aged? What interventions or information can I provide to help you to fulfill your sexuality? (Wallace, 2000).

The older adults' appraisal of their life strengths are at the very basis of older adults' identity development and contribute significantly to their perceptions of empowerment (Aspinwall & Staudinger, 2003; Seligman & Csikszentmihalyi, 2000). The life strengths perspective recognizes that even in the most difficult circumstances, there is reciprocity

between older adults' personally constricted views of reality and their social environment (Schlegel & Hicks, 2011; Ungar, 2012). The Sources of Life Strengths Appraisal Scale (SLSAS) consists of nine scaled appraisal measures and is a promising instrument for appraising older adults' sources of life strengths in dealing with stresses of daily life's functioning, and it is a robust measure for predicting outcomes of resiliency, autonomy, and well-being. It is brief, simple, and easy to administer (Fry & Debats, 2014).

Counseling older clients requires a comprehensive approach to examination and identification of strengths, issues, supports, and coping mechanisms. The clinical interview and environment accommodations are essential to this process. Numerous age-appropriate assessment measures have been developed and are useful in the counseling process.

Goal Setting

Counselors and their clients work jointly in devising counseling plans that offer reasonable promise of success and are consistent with the abilities, temperament, developmental level, and circumstances of clients. Counselors and clients regularly review and revise counseling plans to assess their continued viability and effectiveness, respecting clients' freedom of choice (American Counseling Association, 2014). If no agreement can be reached, the counselor should consider referring the client to another professional, rather than continuing a relationship in which a problem exists.

Defining a client's problem is very similar to reflecting content. It requires listening for the central issue to emerge from the elderly client's communications. Many times, however, the older client has multiple problems. Often his or her problem is so complex that many issues and problems arise during the course of discussion. When this occurs, divide the problem into manageable components and ask the client which of those components he or she would like to discuss first. When one problematic situation has been discussed and defined, the counselor and client can move into the next step—clarifying the issues involved in the problem.

Issues may accompany problems, and solutions can become more difficult and complicated. If people's problems were always simple and clear, they would rarely need the help of counselors to solve them. However, once the client's problem has been identified, setting a goal can be a simple matter. Common goals seen in working with older adults include alleviating depressive symptoms; decreasing feelings of anxiety; alleviating pain; improving memory, communication, and sleep patterns; adjusting to the aging process, retirement, and widowhood; decreasing relocation trauma; alleviating guilt over issues of neglect; decreasing perceived caregiver burden; improving functional ability; managing health conditions; navigating the aging network of services; re-entry into the workforce post retirement; engagement in meaningful leisure activities; improving issues related to intimacy; and decreasing pharmacological and substance abuse problems. Goals should be concrete, specific, and easily attainable for clients to feel a sense of accomplishment. Goals should be developed collaboratively between the counselor and the older client. Family members are encouraged to participate in this goal-setting process to reinforce their loved one, and to assist in monitoring their progress. The counselor can turn the problem around and make its solution the goal of the counseling session.

Goal setting is a very important component of the counseling process. Goals are mutually established between the counselor and the client. Goals are specific and worked on in a stepwise succession, and once one goal is achieved, another goal is accomplished.

Intervention and Evaluation

Once the counselor and client have examined the problem and formulated a counseling goal, the next step is to create alternatives, or the steps the client may take to achieve the goal. The counselor may help a client create a method for alternatives by stating the counseling goal and asking the client to list all the possible ways (alternatives) he or she can think of to achieve that goal. After the client has exhausted his or her list of possible alternatives, the counselor can add alternatives that the client omitted. It is preferable to make a written list of the alternatives. One method for examining alternatives is to state the alternative, list positive and negative consequences, and discuss them in depth with the client.

Interventions will be used and will vary based upon the individual client goals. An evaluation of these interventions is required to ensure that the intervention is appropriate for accomplishing client goals. However, interventions will be adjusted if they are observed to be ineffective. The primary goal is for the client to feel a sense of accomplishment, improve his or her self-perceptions, and ultimately enhance his or her physical and emotional well-being.

Termination and Providing Closure

The final stage, termination, involves providing closure and ending the counseling relationship. This stage occurs after the counseling goals have been achieved. Some counseling relationships are short-lived. Many clients have simple, unidimensional problems they wish to explore. Once they explore their problems, they make a decision and do not return for further counseling. It is not unknown for clients to receive the help they require in one session. However, most counseling relationships last for many sessions (McDonald & Haney, 1988).

Ending the counseling relationship is not the same as ending a business partnership. The client has let the counselor into his or her most personal world. It is for that reason that the counselor is a special person to him or her. Counselors terminate a counseling relationship when it becomes reasonably apparent that the client no longer needs assistance, is not likely to benefit, or is being harmed by continued counseling. Counselors may terminate counseling when in jeopardy of harm by the client or by another party with whom the client has a relationship, or when clients do not pay fees as agreed upon. Counselors provide predetermination counseling and recommend other service providers when necessary (ACA, 2014). It may happen that while exploring one problem, several more emerge. The older client may wish to continue the counseling relationship in order to explore the other problems. If the counselor feels that this is beneficial and if he or she wishes to continue, then new goals are defined and the relationship continues. If it happens that the counseling goals are accomplished and both client and counselor agree to terminate the relationship, then the counseling moves into the stage of closure (Parsons & Zhang, 2014).

A guide for the closure process might include tying up loose ends if there is unfinished business. Being sensitive to the feeling of the client about ending the relationship, therefore timing is important. Careful consideration must be given in ending a close relationship that always involves a sense of loss. Referral may be necessary when you feel you have gone as far with a client as is necessary to accomplish the goal(s). Some clients may not appear for a final session, therefore you attempt to reach the client, however without a positive outcome. Speaking with a supervisor and/or professional colleague would be beneficial to process the dynamics of closure with his or her client. After you have terminated a client, it is a thoughtful gesture to follow-up to see how he or she is doing. This thoughtfulness on your part is an indication of your caring.

Providing closure or terminating a client is a delicate process. The counselor and client have engaged in a meaningful relationship that must come to an end. When goals have been attained, there is a sense of accomplishment, however sadness due to a relationship coming to an end.

Alternative Counseling Approach

No particular counseling approach is mandated in working with older clients, therefore counselors choose the approach that best fits their style and their client's needs. Counselors working with older clients help them to adjust successfully to new stages of life. Blando (2011) focuses on the main stages of treatment and allows counselors to alleviate fears and show clients what opportunities await them in old age. Stage 1 is the beginning phase in which the counselor establishes a relationship with the client, identifying their needs and developing an initial analysis and focus for future sessions. For example, an older man might enter the counselor's office reporting feelings of loneliness and boredom. In initial discussions with the man, the counselor might discover these feelings began shortly after he retired from his career. After clearly identifying the source of the client's problem, the gerontological counselor then begins to introduce ideas and solutions. In the case of loneliness stemming from career loss, the counselor might present community resources that allow the client to return to work in some capacity (Blando, 2011).

In Stage 2, Blando (2011) discussed that returning to work for many older adults seems daunting, especially since they had looked forward to retirement. To assist the older gentleman decide on a new plan of action, his counselor might engage in a "pro/con" exercise with him. A pro/con exercise is either a verbal or written exercise that measures the negatives and positives of two options. For example, when constructing a pro/con list about returning to work, a pro might be feelings of accomplishment and self-worth, while a con might be loss of free time. The older adult would continue to add to the list, considering all changes that a return to work might bring to his life.

The final stage of counseling involves reaching a conclusion and acting on it (Blando, 2011). After weighing the pros and cons, the gentleman might reach the conclusion that coming out of retirement isn't the best choice. Unfortunately, this conclusion doesn't solve his initial problem of loneliness, requiring the counselor to consider additional options. For example, while the older client doesn't wish to follow a set work schedule that takes away his free time, many volunteer opportunities exist for older adults. Contacting various senior centers and volunteer groups, his counselor would connect him with organizations in the

community, giving him a new sense of purpose, while allowing him to remain flexible with his time. While meeting with clients on an individual basis might increase their personal happiness, gerontological counselors also hope to increase the well-being of older adults on a much wider scale. By reaching out to leaders in the community and beyond, gerontological counselors enact societal changes that have far reaching effects beyond individual counseling sessions.

Counselors working with older clients will approach their concerns on individual, group, family, and community levels. While the encounter may be initiated on an individual basis, at some point during sessions, different modalities that extend beyond the client may be required. Counselors will provide advocacy on behalf of their clients to internal and external systems, link older clients to community organizations, provide resources for their use, consult (as needed) on aging and mental health issues, empower older clients to assert themselves in challenging dilemmas, and educate older clients, family members, and community systems to better serve their older clients. The overall goal in the counselor–client relationship is for the client to leave counseling feeling a sense of accomplishment that has a positive impact on personal well-being.

ISSUES BROUGHT TO THE HELPING RELATIONSHIP

There are several reasons why older clients might seek counseling. Such reasons can include temporary crisis, long-term problems, normal and abnormal transitions, and internal needs. Temporary and long-term problems might include incidences of chronic illnesses or many other biological events. Along with these events are the possibilities of great emotional impacts. Poor sight and, especially, deafness can have negative effects on the client. Both of these physiological impairments can affect the individual's social life. In turn, experiences of isolation or loneliness may prevail. Even in a nursing home, where the older adult's basic needs of food, warmth, and shelter are usually met, the need for safety, broadly defined, is not always satisfied.

Guided Practice Exercise 10.3 provides the opportunity to facilitate a cultural shift in a nursing home that will be beneficial to the staff and older residents.

Guided Practice Exercise 10.3

Residing in a residential setting that limits ones autonomy can be devastating for older persons accustomed to maintaining their independence. Counselors may need to intervene with professionals and paraprofessionals to facilitate culture change that is mutually beneficial for older persons and staff alike. Changing attitudes and ways of communication is essential. Hold a meeting with staff and explore feelings that staff have toward older patients in their setting. Then, examine how patients and family members feel as well. The counselor will collect all of the information and develop a plan to facilitate the cultural shift.

Long-term problems can affect the independence of older persons, as well as their ability to cope with other life changes and transitions. They may feel angry at the body that betrayed them and angry at the society that ignores and strips them of their power and status. Much of this anger may be disguised by depression or other somatic symptoms (Boyd & Bee, 2006). Some estimates of major depression in older people living in the community range from less than 1% to about 5% but rise to 13.5% in those who require home healthcare and to 11.5% in older hospital patients (CDC, 2015).

An abrupt termination of a person's interests and occupation, unless handled carefully, can have disastrous personal effects. The experience of being unwanted, and the loss of incentive and opportunities to continue one's accustomed work may precipitate a restlessness that could lead to depression. Someone who begins retirement at 65, although eagerly anticipating the leisure time, may face lifestyle changes that require a high degree of adjustability. The effects of these lifestyle changes may include a sense of isolation; a lack of focus, productivity, or place in the social structure of society; decreased income; and a lack of stature or status (Serby & Yu, 2003).

Many of the transitions, along with acute and chronic problems, may challenge the very livelihood of older persons. Many mourn the death of significant others and fail to make new contacts and relationships (Kraaij & Garnefski, 2002). Parents and spouses may be long or recently passed on, children may be grown with households of their own, and family members may be great distances away. In addition, retirement from work, loss of prestige, decline of motor and sensory functions, increased loneliness, and increasing physical disabilities may make it difficult for some persons to cope with even the most elementary physical demands of life.

There are a number of population groups vulnerable to social isolation and loneliness, and older adults (as individuals as well as caregivers) have specific vulnerabilities owing to loss of friends, family, loss of mobility or loss of income (Age U.K. Oxfordshire, 2011). Social isolation and loneliness impact quality of life and well-being (Cattan, 2005; Findlay, 2003; Pitkala, 2009), with demonstrable negative health effects (Masi, 2011). Loneliness is associated with depression (either as a cause or a consequence) and higher rates of mortality (Greaves & Farhus, 2006; Mead, 2010; Pitkala, 2009). Negative impact on individuals' health leads to higher health and social service use, while lonely and socially isolated individuals are more likely to have early admission to residential or nursing care (Ollonqvist, 2008; Pitkala, 2009; Savikko, 2010). Counseling interventions used to reduce social isolation or loneliness include one-to-one interventions, group services and wider community engagement (Age U.K. Oxfordshire, 2011; Cattan, 2005; Findlay, 2003). Assisting clients in re-engaging in meaningful social activities and involvement in familial activities will improve their quality of life, while it decreases the isolation and loneliness that lead to negative mental and physical health outcomes. As a defense, they become ego-centered and take refuge in the past. In order to not be seen as incapable or disabled, older persons may withdraw from social engagements and involvement. Similarly, because of social labeling, the effects of ageism, and learned helplessness, older persons may refrain from complaining about their lives. For example, they might refrain from making use of a suicide-prevention telephone center because they do not expect to be saved. In addition, older persons might not talk in depth about their concerns with their physician, as they may assume the physician may not have time to listen to an older person anyway. Approximately 15% of adults aged 60 and over suffer from a mental disorder (WHO, 2015), but this number may be low because older adults tend to underreport behavioral health symptoms.

The topics or themes that are likely to emerge in therapy with older clients are numerous (Frazer, Hinrichson, & Jongsma, 2011). Issues may include issues faced by other age groups and those unique to older adults in the later stage of development. Issues that may emerge include decline in activities of daily living, health issues, which decreases functional ability, anxiety, caregiver distress, communication deficits, decision-making capacity/incapacity, depression, disruptive behaviors of dementia, elder abuse and neglect, falls, unresolved grief and loss, interpersonal disputes, life role transitions, loneliness/isolation, medication issues, memory impairment, nutritional deficits, environmental issues, sexual issues and related disorders, sleep disturbance, emotional distress, substance abuse, employment, leisure, widowhood, volunteerism, retirement, and suicidal ideation (Frazer et al., 2011). Selected issues will be discussed, and Chapters 1–8 highlighted the significance of the extensive list of concerns mentioned above.

Health Concerns

The focus of treatment with some older clients is often on health concerns and this may take different forms. Time is spent on gathering information, explaining, and clarifying. Sometimes the counselor may need to assist the physician who needs help understanding the symptoms the client is presenting and sometimes the client needs help to understand what the physician is recommending. A counselor who has taken on a consulting role with clients will review the physician's recommendations with the client and help the client examine his or her choices. If a client is confused about what the doctor said, consulting with the physician and reviewing a copy of the medical records with the client may take place.

Generally, older clients present themselves as having difficulties being straightforward and identifying which complaints are important. Therefore, clinicians may teach clients strategies to communicate with their doctors. Physicians have been trained to listen for certain types of information; when they do not hear that information or receive too many complaints or digressions, they may not be able to determine the root of the medical issue. Instructing clients on how to present their problems effectively is helpful (Zarit & Zarit, 2011).

Guided Practice Exercise 10.4 allows the counselor to teach the older client how to communicate effectively with his or her physician. This will be accomplished by tasks which will lead to successful accomplishments.

Guided Practice Exercise 10.4

Some older persons may question their self-worth when faced with many of life's challenges. They may lose confidence in themselves and their abilities, leading to decreased self-esteem. They may need help with tasks such as communicating their concerns to their physician. As the counselor, you are to design a series of successful experiences for the client. Keep the ideas manageable and simplistic enough to lead to a success outcome. Identify the tasks and use a simple checklist to record and monitor progress. Once accomplished, review this list with your client in the next session.

Whether illness contributes in a primary or secondary way to psychological distress, psychotherapy can be an effective component of treatment. The emotional consequences of illness and the limitations that the illness has placed on daily life are addressed. Sometimes depression is a barrier to seeking treatment or rehabilitation opportunities that may be helpful. When a problem is not reversible or is life threatening, therapists can help clients sort through the variety of practical decisions they are facing and come to terms with the situation (Zarit & Zarit, 2011).

Acute and chronic illnesses come into play in a direct way. Some clients invariably experience an unexpected illness, such as a heart attack or stroke. The therapist needs to be able to deal with clients' health changes, conveying support during the acute phase of their illness and then helping them maximize their potential for recovery. Therapists working with older people need to be comfortable talking about illness and disability and dealing with problems that sometimes cannot be changed.

Some clients talk excessively about somatic symptoms. It is important to listen to these complaints; however, one needs to find out whether something psychological is leading a client to be so focused on a somatic symptom or whether there might be an authentic health condition. Interestingly, many somaticizing older clients do not think of themselves as frail or vulnerable. Rather, they are not good at identifying which complaints are important. When treating older clients with serious illnesses or disabilities, clinicians sometimes focus on how they would feel in that kind of situation. They may identify the situation as hopeless or overwhelming and so might fail to recognize what the client might be feeling or whether there are realistic alternatives to managing the problem. Learning about the illness and the treatment possibilities, however, can contribute to effective psychotherapeutic interventions (Zarit & Zarit, 2011).

DEALING WITH UNCERTAINTY

Another difference with older clients is the amount of time they dwell on possible risks, or uncertainties. This preoccupation is often found when people do not have many activities or a lot of other things that they are thinking about. They focus on the one event far into the future and worry about all the possible things that can go wrong along the way leading up to that event. As an example, an older woman is planning to move from her house to a condominium because it will be easier for her to manage. Although she wants to make the move, she is spinning a series of "what ifs," in which everything starts to go wrong; for example, her house does not sell soon enough or sells too soon, or she will have difficulty getting movers to deliver her things when she needs them. As a result, she dwells on the thought that the move will turn out badly.

Cognitive interventions for uncertainties are generally possible. Continuing with the example of moving, the therapist can begin by suggesting that it is not possible to solve hypothetical problems that might arise in the future. There are too many unknowns that will come up—for example, when the client's house will sell—before the situation reaches the bad outcome that she is imagining. Instead, the therapist would encourage her to focus on the next steps (e.g., getting the house ready to show to prospective buyers) and not worry about a hypothetical outcome. Taking care of the next steps will create a feeling of being in

control and make a positive outcome more likely. Cognitive-behavioral therapy is a highly structured and interactive form of psychotherapy and a relatively short-term treatment that can be administered effectively while the patient and counselor work together to identify and achieve concrete goals for therapy (Chand & Grossberg, 2013; Cox & D'Oyley, 2011). This type of therapy will help the older client identify their automatic thought pattern, and patients are then encouraged to examine the accuracy and usefulness of their thoughts. For example, an exercise might include a thought record in which the patient notes the details of the situation that led to the unpleasant or unwanted emotional reaction itself. The patient then identifies the thinking that might have led to that emotional reaction and examines whether the thought is accurate, appropriate for the context, or useful (Cox & D'Oyley, 2011). In other words, it is possible to help people differentiate between immediate risks that they need to do something about now and far-off risks that are hard to plan for because many other things have to happen along the way to reach that point (Zarit & Zarit, 2011).

Many older people are concerned about what would happen to them if they fell or needed help for other types of emergencies. People who already have lost some functioning are particularly concerned about what will happen to them if they decline further. Probably the biggest "what if" is the fear of going into a nursing home. Finding ways of controlling what might happen reduces feelings of helplessness.

Older clients may express concerns regarding their health, which is interfering with their ability to live independently and causes them distress. Many clients will be preoccupied and may overly focus on one issue to the exclusion of others. It remains the responsibility of the counselor to work constructively with older clients to decrease their anxiety and empower them to manage their health issues to increase their autonomy.

Relationship Issues and Sexuality

Though old age is often a time of losses, it is also a period in life when important relationships continue or even when new relationships form. Older clients may be concerned about resolving problems in a longstanding relationship or developing new relationships. They may want to address conflict with a spouse or child, or they may seek help for family strains that have emerged as the result of recent life changes.

Langer (2009) reported that the greater sexual freedom found among baby boomers encourages an emphasis on maintaining sexual activity throughout the life span, and Jacoby (2005) reported that this generation of older adults is revolutionizing sexuality by focusing on overcoming the physical limitations that accompany age. Although the majority of older adults are engaged in spousal or other intimate relationships and regard sexuality as an important part of life (Langer, 2009), negative stereotypes abound in American culture influencing how older adults are perceived by others and how they perceive themselves (Lindau et al., 2007; Watters & Boyd, 2009). Mental health counselors have a responsibility to acknowledge the stereotypes and validate older adults' experiences, but they must also be able to give them accurate information about normative development so that older adults can base their self-assessments on facts rather than myths or unrealistic expectations (Watters & Boyd, 2009).

Besides fulfilling our responsibility to acknowledge all aspects of older clients' cultural identities, it is essential to consider older adults' needs and desires in all areas of functioning:

physical, emotional, and social or interpersonal. An often overlooked area for older adults is sexuality. Counseling can be used to promote healthy sexuality and sexual expression among older adults and especially among members of ethnic or sexual minority groups because sexual thoughts, feelings, and activity are a vital part of the human experience (Langer, 2009; Muzacz & Akinsulure-Smith, 2013; Watters & Boyd, 2009). The desire to express oneself sexually does not decrease with age (Langer, 2009; Watters & Boyd, 2009). Sexuality in its psychological and social aspects can be a means of communicating intimacy, affection, and esteem (DeLamater & Sill, 2005; Watters & Boyd, 2009).

Sexuality and sexual feelings are not frequently part of treatment, but therapists need to be aware that they can emerge as an important issue. Clinicians can also help their older clients with this issue in a number of ways and must convey acceptance of a discussion of sexual feelings. Because of stereotypes about sexuality and aging, some older people believe that they should not have or discuss these feelings. Therapists must help older clients feel comfortable talking about these issues. They also need to be aware of generational differences in sexual beliefs and practices and the degree of comfort different people have in talking about their sexuality.

Case Illustration 10.2 demonstrates sexual activity on the part of one spouse upsetting the comfortable relationship that has endured for years. The counselor will be challenged to avoid taking sides and show empathy to both parties, while helping them to resolve their intimacy dilemma.

CASE ILLUSTRATION 10.2

Mr. and Mrs. Dennis have been married for 45 years and have become comfortable with their current living arrangement. Mr. Dennis snores, so he sleeps in the bedroom adjacent to his wife. However, recently Mr. Dennis has been much more attentive to his wife and expects her to engage in sexual intercourse several times per week. For the past 10 years, they have enjoyed intimacy, but it did not include direct sexual intercourse. Mrs. Dennis is not interested in sex but does not want her husband to engage in an extramarital affair that would emotionally destroy their relationship. She learned recently that he had a prescription for Viagra and now she understands his sudden interest. She is hoping that you (their counselor) can help her husband realize the ridiculousness of his newfound sexual interest. She also wants you to convince him to get rid of "those pills."

As with other problems of aging, sexual difficulties may have their origins in illnesses and/or medications, as well as in the normal processes of aging (Agronin, 2004). The starting point for treatment is a careful medical assessment to determine the extent to which illness and medication may contribute to sexual difficulties. When obvious physiological factors do not play a major role in sexual difficulties, sex therapy techniques that have proven effective with younger clients can be used with older clients. These techniques include the use of specific procedures and exercises to improve functioning, as well as

helping clients recognize and adjust to changes that occur with aging, such as more time needed to become aroused. Although newer medications have shown promise in treatment of erectile dysfunction in men, reports of adverse effects suggest that these medications should be used with caution (Clay, 2012; English & Dean, 2013).

Meaningful relationships add to the quality of life for older adults. Intimacy is expressed in many ways and provides a feeling of closeness to a loved one. Counselors can assist clients in establishing better relationships and work with couples to examine issues that may be problematic within their marriage/union.

Late-Life Transitions

The counseling profession is grounded in a developmental wellness orientation (Locke, Myers, & Herr, 2001); therefore, counselors may be expected to conceptualize client concerns from a nonpathological or wellness orientation. Common late-life transitions include coping with loss, adjusting to retirement and reduced income, grandparenthood, second careers, and creating satisfying leisure lifestyles.

Much of the literature addressing these issues explains the dynamics of and potential problems with late-life transitions and outlines strategies for intervention; however, most recommended strategies are based in theory rather than empirical support. Conclusions from the literature are applied generally rather than specifically to the older population. Brief summaries of the literature on widowhood, caregiving, and grandparenthood provide examples of the types of information available to counselors as a basis for evidence-based practice (Myers & Harper, 2004).

Widowhood

Older women are increasingly represented in today's society and are particularly at risk for a range of chronic health conditions and economic deprivation (Australian Institute of Health and Welfare, 2009). Widowhood is an important, yet common life event that requires a significant amount of adjustment. Despite literature emphasizing the eventual resilience of women (Feldman, Byles, & Beaumont, 2000), where they generally adjust well and continue to live fulfilling lives, there is evidence that the early bereavement period (the first 2 years following death of the husband) carries with it several risks to health, social, and economic well-being (DiGiacomo, Davidson, Byles, & Nolan, 2013). It has been observed that recently bereaved people had increased health risks including increased hospitalization, medication use, changed eating habits, living arrangements, and social relationships (Stroebe, Schut, & Stroebe, 2007).

Women are faced with increased health risks and chronic conditions associated not only with bereavement, but also middle and older age. Older women have higher rates of severe disability, and this continues as they age. Increases in depression, anxiety, and loneliness (Onrust & Cuijpers, 2006; Williams, 2005) have also been reported. Many older women live alone upon spousal bereavement (Gustavson & Lee, 2004), an arrangement that may impact on their daily routines, ability to self-manage chronic conditions, as well as economic resources (Angel, Jimenez, & Angel, 2007). These women often have a decreased income upon spousal death, particularly if they had not been in paid employment and have

no or little retirement savings. They are more likely to live in poverty than men or their married counterparts, and may suffer from financial and housing insecurity and reduced income despite maintained or increased expenses (Lee, 2003; U.N. Department of Economic and Social Affairs [UNDESA], 2010).

These factors mean that older women may be less equipped to address the challenges of widowhood. Poor physical and psychological health outcomes necessitate the need for counseling professionals, not only to be aware of their circumstances, but also to be responsive to older clients who have recently lost a spouse (Williams, 2005). Providing appropriate, timely bereavement counseling is of critical importance to manage this major life transition.

Lund and Caserta (2001) compared two studies of spousal bereavement, including samples of 192 and 339 men over the age of 50 years. For both samples, support groups were beneficial for facilitating the grieving process, and mixed-gender groups were especially effective. The authors noted that men in their 50s were more effective in coping with spousal loss than were men in their 70s.

Coping with widowhood will be an individual experience for older adults, because no two individuals grieve in exactly the same way. Counselors can encourage their widowed clients to express their feelings in a safe atmosphere. They should allow their clients to reminisce on the good times and share their experiences. Counselors can encourage clients to engage in meaningful activities, develop new interests, and explore new territories. They will assist clients in identifying their strengths during this difficult time and identify their resilient nature. Working through the tasks of mourning will assist clients with the reintegration process, which is required to move forward.

Specific strategies to cope with the loss of a spouse include finding support whether it is a family member or friend, religious institution, support group, or talking to a therapist or grief counselor. Another strategy requires the bereaved to take care of himself or herself because the stress of a major loss can deplete energy and emotional reserves. When grieving, it is important to face your feelings, express your feelings in a tangible or creative way (journal), pay attention to your physical health, refrain from allowing others to tell you how to feel, and plan ahead for major milestones that can awaken memories (anniversaries, holidays) (Smith & Segal, 2015).

Caregiving

Caregiving is a vital role in supporting family members who are sick or persons with disabilities (Singleton, Maung, & Cowie, 2002), and an in-depth understanding of how best to care for those who are dependent and racially diverse is needed (Dilworth-Anderson, Williams, & Gibson, 2002). Without a doubt, the families of those with mental disorders are affected by the condition of their loved ones. Families not only provide practical help and personal care but also give emotional support to his or her relative with a mental disorder. Therefore, the older adult is dependent on the caregiver, and his or her well-being is directly related to the nature and quality of the care provided by the caregiver. These demands can bring significant levels of stress for the caregiver and can affect their overall quality of life including work, socializing, and relationships. Research (Oyebode, 2005) into the impact of caregiving shows that one-third to one-half of caregivers suffers significant psychological distress and experience higher rates of mental ill health than the general population.

Being a caregiver can raise difficult personal issues about duty, responsibility, adequacy, and guilt (Oyebode, 2005). Caring for an individual with a mental health problem is not a static process since the needs of the care recipient alter as their condition changes. The role of the caregiver can be more demanding and difficult if the care recipient's mental disorder is associated with behavioral problems or physical disability (Shah, Wadoo, & Latoo, 2010). Counselors familiar with the caregiving role and the impact it has on the older family member and overall family dynamics are in an excellent position to address the perceived burden experienced by family members caring for aging members. Emotional distress and physical exhaustion are experienced by caregivers and must be managed to continue to provide quality care to older family members.

Ballard, Lowery, Powell, O'Brien, and James (2000) reviewed the literature on dementia and perceived burden and concluded that multiple studies point to the success of cognitive-behavioral interventions in reducing the strain of providing care. Among approximately 5,000 articles written between 1995 and 2002 that deal with caregivers and their mental health concerns (reviewed by Myers, 2003), only a handful tested the efficacy of counseling interventions, psychoeducational support group intervention for midlife caregivers with parent-care responsibilities. Using published measures of knowledge of aging, caregiver burden, and coping resources, they found that a time-limited, structured intervention was successful in reducing participants' perceptions of burden and increasing their coping responses.

Coping strategies for individuals experiencing caregiver burden include respite. Respite care for the loved one gives the caregiver a release from caregiving to engage in other responsibilities. Accessing other family members or friends to provide support is helpful, to decrease the feeling of burden. Joining support groups provides the caregiver the opportunity to feel support from others in similar situations. Paying for care providers, if affordable, decreases the responsibility for caregiving. The caregiver needs to also acknowledge his or her limitations, which might include admission of the love one to a supervised facility. Caregiving burden can also be decreased if the caregiver attends counseling sessions to address their issues and caregiver burden can be decreased if the caregiver gets enough rest, eats a nutritious diet, and makes time to exercise and relax. Latina female caregivers use religion to cope with caring for loved ones with dementia (Coon et al., 2004). Evidence-based psychological treatments used in helping distressed family caregivers of older adults include cognitive-behavioral therapy, individual counseling, and support group attendance (Gallagher-Thompson & Coon, 2007).

Caregiving is an important and necessary role for older adults who require assistance. There are advantages and disadvantages to caregiving, and counselors will seek caregivers when his or her demands exceed their emotional and physical resources. Caregiver burden is addressed by counselors to facilitate better care for their client and a decrease in stress for the caregiver. Improving the mental health of the caregiver will enhance his or her ability to provide the needed care for his or her elder.

Grandparenthood

When parents are unable to raise their children, many grandparents assume this responsibility to avoid their grandchildren being placed in the foster care system. Their plan is to keep the family united; however, oftentimes grandparents are ill-prepared to care for one

or more grandchildren. Counselors working with their older clients who are custodial parents will be addressing multiple simultaneously occurring situations that produce stress and diminish the quality of life for their older clients. Counselors will be addressing chronic health problems, decreased social interaction, depression, loneliness, isolation, grieving on several levels, financial and legal dilemmas, coping mechanisms (lack thereof), behavioral issues of the grandchildren, and legal and educational concerns.

Grandparents acknowledge several benefits when raising their grandchildren, and counselors can reinforce these advantages in counseling sessions. These benefits include a sense of purpose, a second chance in life, an opportunity to nurture family relationships, a chance to continue family histories, and receiving love and support (Langosch, 2012). Grandparents also benefit from giving and receiving love (Doblin-MacNab & Keiley, 2009), and perceiving themselves as more effective caregivers (Strom & Strom, 2011). In spite of the benefits, there are real challenges. Brabazon's (2011) study of grandparent-headed families (GHF) in the United States indicate that such families are more economically disadvantaged and have disproportionately high poverty rates, an economic variable strongly associated with poor health outcomes (Longoria, 2009). The economic demands of custodial grandparenting can cause problems with the already compromised health of grandparents as economic support from social service agencies is frequently unavailable or difficult to access. For example, 41% of GHF report having unmet service needs (Yancura, 2013). Counselors will assist their clients in investigating resources for financial support and securing services from social service agencies.

These challenges also extend to one's physical health. Custodial grandparents describe more limitations in performing activities of daily living. Further, caregiving stress may result in exacerbation of health problems (Kelley, Whitley, & Campos, 2010; Williams, 2011). Grandparents in GHF also reported feeling physically tired, having less privacy, and having less time with friends, family, and spouses (Hayslip & Kaminski, 2005). Working with clients who are grandparents raising their grandchildren will require that the counselor work with these clients to alleviate stress that negatively impacts their health.

The challenges faced by caregiving grandparents often influence their emotional and social health (Bundy-Fazioli, Fruhauf, & Miller, 2013). Research has consistently demonstrated that custodial grandparents have high rates of depression (Song & Yan, 2012; Strutton, 2010), with married and older grandmothers experiencing less emotional strain than single or younger grandmothers (Conway, Jones, & Speakes-Lewis, 2011). Custodial grandparents seek health-services less frequently and experience a higher level of distress, emotional problems, clinical depression, and insomnia than grandparents in traditional roles (Song & Yan, 2012). Grandmothers in particular experience higher levels of stress, strain between family members, more severe physical symptoms, and severe depression symptoms (Musil et al., 2011). This is especially true in cases where the grandmother has no high school diploma, is not employed, lives in poverty, and whose grandchildren possess severe behavioral problems (Park, 2009). These grandparents can also experience grief and disappointment over the primary parent's situation, adding to the intense emotional distress (Strom & Strom, 2011). In cases where the primary parent has been incarcerated, used or uses drugs, or suffers from AIDS/HIV, the stress of dealing with the children and the parent's problem can create a tense environment for the custodial grandparent. Additionally, if the child's parent has died, grandparents must simultaneously

cope with their own grief as well as that of their grandchild (Sampson & Hertlein, 2015). Providing a safe environment for grandparents to grieve over their losses will be very important in the counseling relationship.

In addition to impaired physical and emotional functions, intergenerational households headed by grandparents may experience social isolation due to the stigma attached to substance abuse, AIDS/HIV, or incarceration of the absent parents (Harris & Kim, 2011). Custodial grandparents can also become isolated from their peers due to caregiving responsibilities. Such responsibilities may put them off time with their peer group (Backhouse & Graham, 2012). The social isolation that grandparents experience may make management of their physical and emotional issues more difficult.

Grandparents assume responsibility for their grandchildren when their parents are unable to care for them. While grandparents provide the best care possible, at times they are challenged physically, emotionally, socially, and financially. Counselors may offer support services, provide bereavement counseling, teach coping strategies to deal with stress, and provide education to increase knowledge of educational, legal, and social services available. They may need to teach assertiveness training, provide referrals, and become a resource to provide linkage to agencies for support. An integrative approach that utilizes a variety of modalities is needed, which might include psychoeducational, family-systems approach, and cognitive-behavioral therapy.

Terminal Illness

People with terminal illnesses often suffer from an inability to find meaning in the last moments of their lives and are unable to deal with significant issues related to family and other loved ones. Often they feel "cast out" because they are no longer healthy or productive and feel as if they are a burden to others because they are unable to care for themselves, in even very basic ways (Hardwig, 2000).

Caffrey (2000) confirms the role of psychotherapy in work with terminal illness. He believes that "palliative" care alone, the reduction of anxiety and depression related to dying, is short-sighted. Glicken (2009) believes that when a patient is approaching death, this can focus and stimulate life forces in a dying person. Kübler-Ross (1969, 1997) identified the "unfinished business" that keeps dying persons temporarily alive. The unfinished business can be simple or complex, but it usually has deep personal roots. The dying person is concerned, not so much about death per se, but about death as a constraint on life matters that need attending to. Terminal illness offers a patient the opportunity for personal growth in the presence of learning to cope with pain and the possibility of death. Greenstein and Breitbart (2000) write that "patients report reordering their priorities, spending more time with family, and experiencing personal growth through the very fact of having had to cope with their traumatic loss or illness" (p. 486). Suffering may lead to empathy and the willingness to reach out to others and the sense of connectedness among people often becomes an overriding positive experience that helps group members cope with painful and distressing conditions in ways that prolong life and add to its meaning.

Counselors working with older clients who are terminally ill can utilize coping strategies with their clients (Livneh, 2000). Problem-focused/solving coping and information seeking

refers to resolution of the stress and anxiety of illness through information gathering, focused planning, and direct action taking. Fighting spirit and confrontation refers to strategies described as accepting a serious and perhaps life-threatening diagnosis, while optimistically challenging, tackling, confronting, and recovering from the illness. Focusing on positives utilizing positive restructuring and positive reframing is associated with psychological well-being. Self-restraint is a strategy that refers to personal control to cope with the stresses of a serious or terminal disease and is a predictor of lower emotional distress. Seeking social support and assistance from others has been linked to decreased emotional/psychological distress. Expressing feelings or venting has both positive and negative outcomes. Using humor decreases emotional distress and finding increased life meaning, and this potential is realized in terminally ill patients. High levels of spirituality in dying patients lead to hopefulness that resulted in a more cooperative relationship with helping professionals, improved resolution of long-standing emotional problems, and the desire to live longer (McClain, Rosenfeld, & Breitbart, 2003).

Advance directives provide patients with peace of mind and prevent families the burden of making difficult and emotionally intense decisions at the end of life (Kyba, 2002). Patients who perceive themselves as a burden on others often experience depression and anxiety, which can produce a lower quality of life. To prevent this perceived burden, counselors need to help patients find meaning or purpose in their lives (Tomer, Eliason, & Wong, 2008). Counselors who are aware that patients hold different meanings of life and death can respond to them with understanding and compassion, helping them live their best life until they die (Chibnall, Videen, Duckro, & Miller, 2002). One of the most difficult trials humans must face is loss, and with death comes the loss of oneself. Some terminally ill patients turn to religious and spiritual beliefs in order to understand their experiences and answer difficult existential questions about life and death (Tomer et al., 2008). Counselors who create an accepting environment can use the transpersonal model to help facilitate growth to a higher level of development in patients at the end of life. This approach encourages dying patients to explore the meaning of their death and reach a higher level of consciousness, increasing their knowledge of self.

One challenge for counselors who work with terminally ill patients is helping them to maintain a sense of dignity (Bloche, 2005). Although it can be difficult for patients to achieve dignity when they are facing the challenges of a terminal illness, it is important for counselors to recognize and treat patients who are sick and dying with the same dignity and respect as those who are healthy (Bloche, 2005). Dignity therapy is an intervention that encourages terminally ill patients to address psychosocial and existential issues in two to three counseling sessions (Chochinov et al., 2005). Counselors invite patients to talk about things that matter most to them both in the present and from their past, and for what they want to be remembered for. They ask specific questions to encourage dying patients to tell their stories, and then give patients time to think about and reflect upon their answers. The questions pertain to the patient's life history, emphasizing areas of importance such as roles, accomplishments in life, hopes and dreams, and any advice or information they want to pass on to family and loved ones. Some of the routine questions include (1) Tell me about your life history and the parts you feel are the most important. At that point in your life did you feel you were the most alive? (2) Do you want your family to know specific things about you, and what things do you want them to remember about

you? (3) What have you learned about life? (4) What words do you wish to pass onto your loved ones? (Chochinov et al., 2005).

The session is audio recorded then transcribed verbatim by the counselor, who edits the information for clarity, sequencing of life events, and organization of important information. In the next session the counselor reads the document out loud to the patient for accuracy and feedback, allowing him or her to edit any changes (Ando, Morita, Okamoto, & Ninosaka, 2008). When patients hear their words repeated back to them they often become emotional, yet they believe they maintain their dignity, and achieve a better sense of purpose and meaning in life, which can be empowering. Patients also report less anxiety and despair about their impending death after sessions of dignity therapy (Chochinov et al., 2005). Terminally ill patients are able to ensure Erickson's seventh psychosocial state of generativity, where strength comes through care of others and production of something that contributes to the betterment of society, by leaving their created document to family and loved ones as a lasting reminder of who they were and their hopes and dreams for their families' future (Lemay & Wilson, 2008).

Terminally ill patients who desire to avoid further medical treatments have other options than the advance directives for medical care. Suicide and physician-assisted suicide are two choices that have received a great deal of media attention, particularly the physician-assisted suicide cases involving Jack Kevorkian and his suicide machine. The Oregon Death with Dignity Act, first passed in 1994 and went into effect in 1997, allowed a physician to issue a legal prescription to a terminally ill Oregon resident under a very strict set of circumstances (Death with Dignity National Center, 2015). The voters of Washington passed their law in 2008, and it went into effect in 2009. Vermont became the third state with a Death with Dignity law in 2013, and the law went into effect immediately. Montana doesn't currently have a law safe-guarding physician-assisted death. However, in 2009, Montana's Supreme Court ruled nothing in the state law prohibited a physician from honoring a terminally ill, mentally competent patient's request by prescribing medication to hasten the patient's death. Since the ruling, several bills have been introduced to codify or ban the practice, but none of those bills has become law (Death with Dignity National Center, 2015). California's law will take effect 90 days after the state legislature adjourns the special session on health care, which likely will not be until January 2016 at the earliest (ProCon.org, 2015). So currently a total of five states have legalized physician-assisted suicide. Four of these states (California, Oregon, Vermont, and Washington) legalized physician-assisted suicide via legislation and one state (Montana) has legal physician-assisted suicide via court ruling (ProCon.org, 2015).

Counselors, as mental health professionals, may become involved in counseling terminally ill patients, who may express the desire to end their suffering by committing suicide. Assessing suicidal risk in terminally ill patients presents particular challenges; for example, preoccupation with dying or realistic planning for death may not be a true indicator of suicidal intention for terminally ill patients. Many characteristics of terminally ill patients are independent risk factors for suicide in their own right, which include depression, anxiety, delirium, hopelessness, pain and deterioration, and social isolation. Nonjudgmental exploration of the terminally ill patient's suicidal intent is the first step in reducing suicidal risk, and other steps included crises intervention techniques, medication changes focused on reducing physical and emotional discomforts, and advocacy efforts for relieving social and financial stressors.

If the client reveals to the counselor a suicide plan to end his or her pain from a terminal illness, should the client's confidentiality be violated and should the counselor take steps to prevent the client from carrying out the suicide? The ACA Code of Ethics (ACA, 2014) standards expect the counselor to break confidentiality because the client is threatening to harm him or herself. The standard is,

> The general requirement that counselors keep information confidential does not apply when disclosure is required to protect clients or identified others from serious and foreseeable harm or when legal requirements demand that confidential information must be revealed. Counselors consult with other professionals when in doubt as to the validity of an exception. Additional considerations apply when addressing end-of-life issues. (p. 7)

The standard seems clear, but should they apply equally in states with physician-assisted suicide laws? Furthermore, should they apply equally to older adults who have lived long and full lives and who are now making an informed choice to end their lives due to terminal conditions that cause intolerable pain and deterioration? The ACA standards also state that the counselor should endeavor to keep his or her own values from interfering with the counseling relationship. The standard is,

> Counselors are aware of and avoid imposing their own values, attitudes, beliefs, and behaviors. Counselors respect the diversity of clients, trainees, and research participants and seek training in areas in which they are at risk of imposing their values onto clients, especially when the counselor's values are inconsistent with the client's goals or are discriminating in nature. (ACA, 2014, p. 5)

How does the counselor keep his or her values from interfering with a terminally ill person's wish for a right to die?

A very important part of the work of therapists is helping clients negotiate this last transition. Counselors are available to be supportive and to help clients deal with the medical system and any family issues that might arise. In this role, it is very important to stay focused on the quality of life. Most clients do not want their lives artificially prolonged. They reach a point at which they are ready to let go, and the counselor's role is to be an advocate for them. To do that, counselors have to be comfortable talking with them and the people around them about death and with the decision to let them go when it is time (Zarit & Zarit, 2011).

Death and Dying

At the end of life, helping professionals can bring a real advantage to patient care: well-honed communication skills. Patient-centered communication that blends empathic listening with provision of information appears to offer patients the greatest support.

What are the skills helpers need to deliver bad news? It is important to remember that delivering such life-altering news can be very stressful for professionals who are asked to do so. Therefore, awareness of one's own response to dying and understanding of best practices in the area can be useful. Practicing compassion for oneself as well as for clients

and their families is a powerful resource. Barclay, Blackhall, and Tulsky (2007) offer a helpful review of key considerations for culturally appropriate communication of difficult information. It's critical for helpers to understand that not everyone wants to hear the same amount of information about prognoses, symptoms and so forth. Sometimes patients' wishes for information are different from those of families. Carefully inquiring about how much information is desired as the dialogue unfolds is a good practice. Sometimes separate conversations are indicated, provided consistent information is delivered. When prognosis is poor, helpers can support realistic expectations by discussing ways to manage symptoms, providing emotional support, and connecting the patient and family with resources rather than offering unrealistic promises.

Cultures differ with respect to how directly bad news should be delivered, and it is essential for helpers to be sensitive to cultural norms in this regard:

> Here the difference is not only about whether to tell the truth, but also about what it means to tell. Learning the truth in a more direct way may be seen as preferable because the ambiguity allows the patient the possibility of hope. (Barclay et al., 2007, p. 963)

In general, prior preparation of advance directives can provide an opportunity for discussing preferences for truth telling while individuals are still healthy. Difficult information should be conveyed with language and pacing that supports patients' understanding. Communication should be caring yet straightforward. It is suggested that the communicator pause to check for comprehension after every three facts. Summarizing the conversation aids understanding as well. Planning for continuing care that includes the patient and/or family can help convey the reality of continuing support through the process (Broderick & Blewitt, 2015).

Counselors work with clients everyday on issues that disrupt the client's life and shake their sense of self. While each symptom or issue is weighed differently within the lives of clients, the issue of death and dying seems to weigh heavily universally with those dealing with death or dying (Kehoe, 2013). As a professional counselor, death and dying is a reality that counselors across all domains and working with every population will encounter. In working with older adults, issues of death and dying arise quite often and present themselves in numerous ways.

There is the loss of loved ones, which increases as individuals age. Lifelong friends, siblings, cousins, and significant others pass away. The impact of losing a loved one is tremendously difficult, while the weight of multiple losses can feel life ending. Counselors help clients understand the grief process, often presented in stages in which the final goal is that of closure and learning to live without the lost loved one. While some clients do not experience the stages (denial, anger, bargaining, depression, and acceptance) in sequence, other individuals may go through a certain stage more than once or enter into another stage simultaneously (Keefer, 2015). A modern approach to grief counseling is re-membering conversations, which has grown out of aspects of narrative therapy and social constructivism theories that deal with death and loss from an entirely different angle than traditional grief counseling. With re-membering conversations, the focus is not on closure rather than gaining an understanding of the client's relationship with the loved one while they were

living and helping them to now discover the ways in which their lost loved one can still fit in their lives. In essence, a re-developing of the client's relationship with that lost loved one now that they are no longer physically present. While the physical body may be gone, the relationship with them continues to live on.

A death of a client is inevitable when working with clients who are in the process of dying, and this takes a tremendous toll on all involved. A wide range of reactions include: individuals who want to take advantage of every moment to those who appear to shut down and push people away. It is difficult to find a common approach to working with dying persons (Kehoe, 2013). Family members and health care professionals will share comforting words, which may be unrealistic when a terminal diagnosis has been identified, for example, the doctors don't always know everything. Terminally ill clients want an expression of genuineness when interacting with others and acknowledgement that they are going to die. Family counseling sessions can be very beneficial when a client is near the end of life. Having the family or loved ones present provides the counselor an opportunity to ask the client up front how they want to be remembered or what is it they wish for their loved ones when they are gone. This time can be incredibly healing for the family and friends (Kehoe, 2013).

Older clients, even healthy ones, are often concerned about their own deaths or about deaths of people close to them. Much of the literature on this topic is based on case studies of younger people with illnesses that have predictable trajectories, such as cancer. However, older people can have more varied courses of decline. They also may have different ways of dealing with death. Some older people may feel fear and anxiety about death, but these feelings do not seem as common as among younger individuals. Other older people, while not afraid of dying, are often concerned about the circumstances of their deaths. They do not want to endure painful or unnecessary medical procedures and may want to pass away at home rather than in the hospital. They may question why they have been left behind when others have died or believe they cannot go on with their lives. People may also have unfinished emotional business with their families or issues that they want to resolve before they die. These issues can be value laden for both therapist and client. The most desirable therapeutic stance is one of neutrality, allowing the individual the freedom to express his or her own beliefs and explore the possibilities.

Case Illustration 10.3 demonstrates issues of loss, relocation, delayed grief reaction, and psychiatric illness.

CASE ILLUSTRATION 10.3

Counselors perform various roles but are not specialists in everything; therefore, referrals to other professionals may be warranted. Mrs. Lewis moved from Pennsylvania to Florida and was extremely excited for the first 6 months upon arrival. She had saved her money, sold her house and all of her belongings, and moved after the death of her husband of 45 years. She wanted a fresh start.

(Continued)

(Continued)

However, upon visiting her, Mrs. Lewis's daughter noticed that she cried frequently, had become withdrawn and complained of restlessness, had difficulty sleeping, and was just sad all of the time. She also noticed that her mother was having visual and auditory hallucinations. She thought she was seeing her husband and that he was telling her to move back to Pennsylvania.

Mrs. Lewis has no history of any psychiatric disorders, nor was she on any medications. She only ingests a multivitamin, calcium supplement, and Vitamin D supplement daily. As the counselor, what presenting issues would indicate that you need help in this particular scenario? Identify the professionals who you would consult with. How would you interpret Mrs. Lewis's presenting problem(s)?

Therapists need to be comfortable talking about death and dying and letting clients know they can talk about these issues. Someone who is uncomfortable talking about death and dying will convey that discomfort to clients. Therapists also have to know where they stand personally on end-of-life issues. They need to come to terms with their own beliefs and feelings so that they do not distort or misinterpret what clients say or feel and do not let their own beliefs interfere with clients' making their own decisions.

Therapists must be prepared to lose clients. One of the consequences of empathy is that we get attached to clients. Seeing people who are declining and who will ultimately die is not easy and raises complex feelings in therapists. These losses can feel like the death of a good friend. They come to know clients well and are very involved in their lives. With our older clients, death is not just a loss but can be the culmination of a process that ends suffering or frees them from a life they would not want to live. Therapists may need to obtain professional services to assist with the loss of their clients.

Loss is a major theme associated with aging. Older adults, as they age, based on their longevity, will experience the death of spouses, partners, family members, friends, and neighbors. Their resiliency is a testament to their ability to cope with numerous losses and continue to function. Counselors will address issues related to the dying process, advanced directives, and death rituals. It is extremely important that counselor conduct a self-examination to become comfortable addressing these unavoidable issues related to loss and seek professional counseling services to cope with the loss of his or her clients, if it is necessary.

KEYSTONES

- Older adults can benefit from various psychosocial interventions and will have different goals in comparison to younger or middle-aged clients. Physical health promotion is an important goal for older clients.
- Older persons will access the services of professionals if they are experiencing a crisis, are in a transitional phase of life, and/or if some unmet need interferes with their functioning.

- The personal client-counselor relationship is essential in facilitating progress within the counseling session.
- A multidimensional, comprehensive assessment is necessary to initiate any therapeutic intervention with older adults.
- Physical limitations, health concerns, inadequate appraisal and assessments, and environmental issues pose challenges to the professional counselor.
- In addition to establishing a relationship with clients and assessing them, counselors will help clients set goals and create and carry out an appropriate intervention before terminating the relationship.
- The gerontological counselor performs roles of advocacy, consultant, educator, and coordinator and acts as a referral mechanism for older clients. The counselor helps older clients with topics including health issues, uncertainties, relationship issues and sexuality, late-life transitions, terminal illness, and death and dying.

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