

Unintentional Harm of Older Adults

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Abstract

Older adults experience changes and challenges affecting their mental health that are different from other age groups. Unintentional harm may be caused by mental health professionals who are not trained to recognize unique mental health issues of older adults, such as: response to chronic illness, depression, results of ageism, ethical dilemmas or the complex dynamics of the late-life family. The accelerated growth of the older population calls for increased awareness and training of mental health professionals to avoid unintentional harm to the elderly.

Introduction

This article summarizes areas of unintentional harm that may be caused to older adults by mental health professionals, and the need for an educational response to prepare workers for this growing clientele. Areas of possible unintentional harm examined include recognizing normal age changes versus illness, the incidence of depression and suicide, ageism, ethical issues unique to older adults, and family dynamics.

The number of older adults in the United States is growing rapidly. In 2010, 13 percent of the US population was 65 years or older. Aging baby boomers are projected to increase this number to 21 percent by 2040 (AoA, 2013). The Institute of Medicine (2012) reports that 14 to 20 percent of older adults have a mental health disorder. Yet most social workers and therapists have not been formally trained in gerontology to work with older adults and their families (Hooyman & Unutzer, 2010). The movement for mental health parity amplifies the need for a qualified behavioral health workforce, especially those trained in geriatrics (Mildred, 2013). Integrating gerontological standards and competencies into relevant curricula can decrease the risk of unintentionally harming an older adult. Mental health professionals can strengthen their understanding of older adults by attending gerontological conferences, choosing gerontology-focused webinars, reading current literature on current interventions with older adults and pursuing certificates in gerontology.

Areas of Possible Unintentional Harm of Older Adults

Recognizing normal age changes versus illness

Mental health professionals often do not understand normal aging. For example, an older adult's slower response time to questions is not a symptom of cognitive changes due to illness but rather a normal change in reaction time. Older adults retain the ability to process information but do so more slowly (Saxon, Etten & Perkins, 2010). The unaware mental health professional may move through a session too quickly, not allowing the older adult time to process what is being asked. Older adults may take time to get to the point and have longer histories, requiring more time in sessions (Zarit & Zarit, 2007).

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Conversely mental health providers who assume that all older adults have significant memory problems may not refer to health providers for assessment of treatable medical conditions, such as urinary tract infections, that

can present as dementia. Other areas to recognize include noting a sudden change in cognitive functioning which may be due to a metabolic cause such as a medication reaction or nutritional deficiency resulting in delirium (McInnis-Dittrich, 2014)

Chronic illness is not a normal aging process; however, eighty percent of those over seventy years have at least one chronic health problem and the number of chronic diseases increases with age (Hooyman & Kiyak, 2011). Chronic physical illnesses engender mental health challenges, such as an increased risk for depression (Arbore, 2014).

Recognizing depression and suicide risk

Life transitions, such as retirement, loss of a spouse and relocation, can impact the emotional well-being of an older adult. These changes increase the risk of depression and anxiety among older adult medical outpatients (Zarit & Zarit, 2007). Physical illness and the accompanying changes in the ability to complete activities of daily living increase the risk of depression for older adults (McInnis-Dittrich 2014). For older adults living in skilled care facilities there is a depression rate of 50 percent (Mildred, 2013). Uninformed health care providers and older adults themselves may think a depressed mood is a natural part of aging and, therefore, not seek treatment (John Hartford Foundation, 2011).

Depression is the leading cause of suicide (Damron-Rodriquez & Carmel, 2014) and characteristics associated with higher risk of suicide for older adults are age, male gender and being white (Conwell, Duberstein & Caine, 2002, p. 200). Additional risk factors that contribute to suicidal ideation include depression, and substance abuse (Arbore, 2014, p. 27). Mental health providers may not consider suicide when meeting with older adults. Often older persons with health problems may not be suspect of a suicide, and yet they have access to prescription medications that increase their risk of overdose.

The literature presents strong evidence that suicide evaluation is important when working with older adults. It is important to assess for suicide at an initial meeting and throughout counseling sessions as an older adult may experience increased health problems or losses which exacerbate suicide risk while in therapy. Training is recommended to increase provider awareness of suicide risk in older adults and to improve provider assessment skills (Huh et al., 2012).

Exploration of suicidal feelings may need to be pursued more proactively because older adults may not share their thoughts and feelings. Cukrowicz, Duberstein, Vannoy, Lin, & Unutzer (2014) discuss the concerns of older adults about the outcomes of suicidal ideation. Some older adults anticipate that inpatient hospitalization will be the immediate response if they express suicidal ideation and are not aware the response may include monitoring the feelings as a first option. Mental health providers are encouraged to educate older adults of the actions that are likely to happen should they express such feelings. Mental health providers may develop anxiety and feel “de-skilled” about possible interventions that are effective with older adults (Laidlaw, Thompson, Dick-Siskin & Gallagher-Thompson, 2003).

Recognizing ageism

Many mental health professionals do not explore the negative views they have of their own aging and of older adults. Tomko and Munley (2013) describe factors that impact attitudes toward working with older adults, including age and gender of the mental health provider, training and experience in working with older adults, fear of death, and multicultural competence. Life transitions of retirement, death of a spouse, or living with chronic illnesses are unfamiliar areas to younger mental health providers. Mental health providers may be challenged by interactions with their own aging parents and counter-transference can occur.

Older adults report being treated as children when the mental health professional responds in a paternalistic manner or as a powerful authority figure (Knight, 1986). Older adults who integrate negative views of aging may question their ability to problem solve (Coudin & Alexopoulos, 2010). Increased dependency may result when a mental health provider also sees the older adult as unable to make decisions and takes a more active role in decision making rather than supporting the older adult’s ability to make the appropriate decisions.

Because older adults are at the end of their lives, professionals may devalue the benefit of providing services (Laidlaw et al., 2003). These negative attitudes, termed “professional ageism” by Butler and Lewis (1982), continue to impact the desire and expertise of mental health professionals working with older adults. Integrating a resilience approach in assessing the older adult recognizes the strengths and lifelong coping mechanisms of the older adult and family (Greene, 2005).

Recognizing ethical issues

There is potential harm when mental health providers working with older adults are unfamiliar with ethical issues specific to this time of life. Historically, Dell Fitting (1986) delineated the ethical dilemma in counseling older adults as that of respecting the older adult’s autonomy (right to make choices affecting one’s own life) which may be in conflict with the mental health worker’s beneficence (helping by preventing harm and actively intervening). Beauchamp and Childress (2008) added the ethical principles of non-maleficance (doing no harm) and justice (advocating for availability of resources). Mental health providers must be prepared to determine which principle is to be upheld and can play an important role in helping older adults weigh risks against benefits of choices, while honoring the choices of the older adult.

Issues around finances, health care and end-of-life options create ethical dilemmas for older adults and their families (Bradley, Whiting, Hendricks & Wheat, 2010). Older adults may express wishes regarding their health care that mental health providers and family members find difficult.

Recognizing family dynamics in later-life

The growing older adult population impacts older adults’ families and friends who are a vital part of the older adult’s support system. Mental health professionals work with adult children of aging parents who are looking for support in integrating the needs of their aging parents into their own lives. Caregiving can affect the dynamics among adult siblings, within the caregiver’s immediate family, and between adult child and parent. The older adult and adult children may be disconnected or alienated leading to a failure of the developmental process of family integrity (King & Wynne, 2004). When adult children are integrated in care, the parent may prefer one adult child as the primary source of support, however, why this one child is preferred and the willingness of the child to be available may not have been discussed among the family (Pillemer & Sutor, 2006) or may reflect poor decision-making patterns (Pecchioni & Nussbaum, 2000; Cicirelli, 2006) .

When counseling adult children, the mental health professional may harm the family unit if family history and the strengths of the older adult are ignored. A family counseling session can help family members share caregiving tasks, understand the older adult’s preferences for care, and decrease conflict among parents and adult children. The older adult and children “work through” losses or relational conflicts which help build family integrity (King & Wynne, 2004). A useful tool to incorporate into a family session is a later-life assessment instrument that helps identify areas of support in an older person’s network (Mulligan & Carpenter, 2011).

Mental health providers need to have a basic understanding of the range of long term care services and housing for older adults such as, assisted living, skilled nursing care and continuing care retirement homes. The mental health provider must also be knowledgeable about third party reimbursement for services, e.g. Medicare and Medicaid, and the limited financial assistance for long term care in order to assist with realistic plans for care needs.

Discussion

Historically, older adults have not accessed mental health systems at the same rate as younger individuals. Older adults are more likely to consult with their physician regarding their mental health issues (Huh et al., 2012). However, it is anticipated that baby boomers, who have been using more mental health services than the current older population, will have a higher access rate. Additionally, the Affordable Health Care Act requires mental health parity and offers incentives for older adults to focus on their behavioral health which is likely to create greater demand for mental health care services to older adults (Mildred, 2013).

Mental health providers are reminded that no population is more diverse than older adults. Specific populations such as older gay and lesbian individuals, older adults living in rural areas and older veterans bring unique needs and strengths. Lifelong experiences create individualized coping skills gained throughout the life course. Workshops that explore the normal physical changes of aging will assist the mental health provider in understanding that many challenges of the later years are actually disease focused rather than normal changes of age. Certificates in gerontology are offered at community colleges and universities throughout the country to strengthen knowledge and skills in working with older adults. The Council of Social Work Education (CSWE) Gero-Ed center has created Gerontology Competencies to assess needed practice behaviors for social workers working with older adults (CSWE, 2014). The Council for Accreditation of Counseling and Related Educational Programs (CACREP) provide standards for gerontological counseling programs (CACREP, 2001).

Mental health providers need to be diligent in assessing their own ageism. Many studies show that social workers and other mental health care providers who have clinical experiences with older clients are more likely to continue to work with this population (Koder & Helmes, 2006.) Mental health providers can explore training programs that offer opportunities to work with older adults. Clinicians benefit from having a better understanding of older adult's attitudes toward mental health care, such as assessing their own depressive symptoms or anxiety as not severe and attempting to solve the problems without professional support (Garrido, Kane, Kaas & Kane, 2011). It is also important for mental health providers to examine how culture impacts an older adult's stigma of mental illness and what culturally tailored approaches in outreach and treatment are most successful in reaching older adults (Jimenez, Bartels, Cardenas & Alegria, 2013).

Conclusion

The number of older adults in the United States is growing, spurring a need for mental health professionals trained in gerontology. Baby boomers are expected to access mental health services at higher numbers than the current older cohorts. Mental health clinicians can prevent unintentional harm to older adults by continually assessing their competence in working with older adults and learning about the unique physical, mental and social aspects of aging. Increasing competency also includes recognizing one's own ageism, identifying ethical dilemmas that may arise when working with older adults, assessing elders for depression and suicide risk, and understanding the later stages of the family life cycle. The increase in resources and websites focusing on older adults and aging offers mental health providers opportunities to develop strong skills in working with our aging population.

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