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Teaching Gerontology in Counselor Education

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TEACHING GERONTOLOGY IN COUNSELOR EDUCATION

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Mental health needs of older persons are projected to grow significantly over the course of the next years. Consequently, the need for training counselors to work with the aging population is presented. Addressed are 4 curriculum models, as well as areas of training related to geriatric counseling, that can be incorporated into counselor training programs. Finally, specific suggestions and procedures for counseling the elderly are included.

Both researchers and clinicians have published a number of articles and have done much to correct the stereotypes and myths regarding aging. However many negative stereotypes of the aged still exist. Many of these negative stereotypes—such as older people being depressed, unintelligent, neglected, and alone—have resulted from overgeneralized reactions and fear of getting older (Myers & Schwiebert, 1996; Pipher, 2005). Other stereotypes might include the perception that the aging process is synonymous with progression in pathology (Knight, 2004). On the contrary, the majority of older Americans function well, lead productive and meaningful lives, and are able to live independently. In an attempt to root out ageism, however, the mental health needs of older persons should not be ignored. They are an important population who, on occasion, may benefit from mental-health counseling.

According to Waters and Goodman (1990), there are several reasons why older clients might seek counseling. Such reasons can include temporary crisis, long-term problems, normal and abnormal

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transitions, and internal needs. Temporary and long-term problems might include incidences of chronic illnesses, or many other kinds of 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 satisfied. In addition, stroke victims may feel a special anger over the sudden and crippling effects of their stroke.

All of these long-term problems can affect the independence of older persons, as well as their ability to cope with other life changes and transitions. In addition, they may feel angry at the body that betrayed them, 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; Waters & Goodman, 1990).

An abrupt termination of a person's interests and occupation, unless it is handled carefully, can have disastrous personal effects. The experience of being unwanted, and the loss of incentive and of 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 life-style changes that require a high degree of adjustability. The effects of these life-style changes may include the following: 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 (Myers, 1990; Serby & Yu, 2003).

Many of these transitions, along with acute and chronic problems, may constitute 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.

In addition, many older persons find themselves isolated. 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

(Bengtson, 1973; Zeiss & Steffen, 1996). 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 that the physician may not have time to listen to an older person anyway (Myers, 1990). In fact, it is estimated that 20% of all seniors do not report problematic mental conditions (American Counseling Association [ACA], 2003).

According to Feinauer, Lund, and Miller (1987), older persons typically go to their families as their first and only resource. Incidentally, the intimate and affectionate contact is one of the most fundamental tasks in adulthood (Feil, 1992). Often, however this need for love is not met. Families that have a history of healthy and mutually supportive interactions might provide older persons with the capacities and resources to cope with some of the more elementary physical demands of life. However, the lack of relationships, due either to deaths or alienation, may leave some older persons with no one to confide in concerning their depression, discouragement, or decreased self-efficacy.

THE NEED FOR GERONTOLOGICAL COUNSELOR TRAINING

Certainly older persons may experience debilitating physical and emotional effects of aging. As professional counselors, however, we have opportunities to meet the needs of older adults. We can do this by providing counseling, facilitating discussion among family members about caregiving choices and the needs of all involved, and being a resource who can direct clients to additional services and support (Myers, 1989; Rikers & Myers, 1990).

The need for counselor training in gerontology is daunting. According to Taylor and Hartman-Stein (1995) and Roybal (1988), older persons are the most underserved population within mental health services. According to the American Counseling Association ACA (2003), the number of older persons with mental illness is projected to increase from 4 million in 1970 to 15 million by 2030. In addition, the suicide rate among older persons is estimated to be six times greater than the general population.

Recent studies imply that many counselor-education programs, as well as clinical and counseling-psychology programs, across the country are not training students to meet the needs of this growing

population of aging adults (Zucchero, 1998). According to a study of 458 counselor-preparation programs conducted by Myers, Loesch, and Sweeney (1991), 1 in 5 programs offered a specialization in gerontological counseling, and 31% reported coursework in gerontological issues. In a study of practicing psychologists in a southwestern city, 85% reported that they served older adults; however only 27% reported that they had formal training (Gatz, Karel, & Wolkenstein, 1991). Finally, it should be noted that there is a lack of current research addressing the nature of gerontological training counseling students are receiving, and how they are receiving it.

Working with older adults requires some kind of specialized training and preparation (Agresti, 1992; Johnson & Rosich, 1997). Literature suggests several reasons for specific training. First, according to Taylor and Hartman-Stein (1995), social and developmental landscapes of society impact the specific needs of each generation. That is, the needs and issues of the elderly of today may differ from those of tomorrow. Thus, training should include considerations of the societal implications such as socioeconomic status and migration. Secondly, a greater emphasis on training counselors in gerontological issues may move students to challenge any of their assumptions and stereotypes about older persons (Myers & Schwiebert, 1996). Such emphasis may also motivate students and increase their comfort levels in working with older persons.

Counseling students should be able to apply particular ethical principles when working with older adults (Agresti, 1992). Particular ethical decisions and negotiations might be called for regarding an older person's autonomy, or right to self-determination (Schwiebert, Myers, & Dice, 2000). That is, autonomy might be operative in a client's ability to provide informed consent or consent to treatment. If older clients are unable to provide consent due to cognitive impairment, counselors are responsible for working with the various parties involved in any particular client's case. Similarly, in cases where cognitive impairment or diminished capacity are issues, counselors should have the knowledge and skills to assess clients on strengths, deficits, and aging processes specific to older persons (Agresti, 1990; Fruhauf, Jarrott, & Lambert-Shute, 2004).

CURRICULUM MODELS

The literature suggests several reasons why gerontological training is relevant in counselor education. In this section are suggested models of training (Myers, 1994; Myers & Blake, 1986; Zucchero, 1998), as well as considerations of how such models can be incorporated or

generated within counselor-education programs. The following models are discussed: (a) integration/infusion model, (b) separate-course model, (c) area-of-concentration model, (d) interdisciplinary model, and (e) a unique-training model.

INTEGRATION/INFUSION MODEL

The integration/infusion model ensures that information relevant to the counseling needs of older persons is included in all core counseling-preparation courses (Myers, 1994). With such a model, all students within the counseling program are provided with a knowledge and skill base for working with older persons (Myers & Blake, 1986). An example of the integration/infusion model is the infusion of concepts related to counseling older persons into each of the Council for Accreditation of Counseling and Related Educational Programs (CACREP) Standards (2001) specialty areas (Myers, 1989).

For the remainder of this section, brief examples of infusion into selected core areas of the CACREP curriculum are provided. The first core area, professional identity, can be addressed by including information about gerontological counseling in an introduction-to-counseling course. Concepts related to counseling older persons can be infused into the second area of the CACREP Standards, social and cultural diversity. Such infusions could include the consideration the Association for Multicultural Counseling and Development (AMCD) Cross-Cultural Objectives, namely, attitudes and beliefs, knowledge, and skills. In fact, the literature suggests that specific knowledge foundations, skills, and experiential learning conducive to the development of values and awareness are necessary when training counselors to work with older adults (Damron-Rodriguez et al., 2004; Zucchero, 1998).

In the third core area, human growth and development, concepts related to counseling older persons can be infused within the human growth and development course. Zucchero (1998) recommended that aging should be viewed from a lifespan development perspective rather from a perspective that views older persons as unique and in need of special services. From a developmental standpoint, professional counselors can address issues that are specific to older adults while also considering the similarities that this population shares with younger ones.

In the fourth core area of the CACREP Standards (2001), career development, particular concepts related to counseling older persons could be addressed including retirement, life planning, relating to

others, making use of time, managing finances (Damron-Rodriguez et al., 2004; Myers & Schwiebert, 1996; Rikers & Myers, 1990). Finally, concepts related to older persons can be infused within the fifth CACREP core area, helping relationships. In particular, specialized preparation in professional ethics is needed when working with older adults (Agresti, 1992; Kuther, 1999). Such training might include: attention to specific values operating in treatment; ethical frameworks from which the professional counselor can work through; an understanding if the impact of religious values on treatment and interventions; and skills necessary when working with the family members of the older client (Greene & Kropf, 1993). Finally, the authors want to remind readers that this model dates back to the late 1980s/early 1990s. There is need for extensive evaluation of how such a program would apply to present-day counselor-education training programs.

SEPARATE-COURSE MODEL

According to Myers and Blake (1986), the separate-course model incorporates a course that is specifically focused on issues related to older adults. Separate courses might include some of the following: counseling older persons; assessment and intervention of older persons; and the psychology of adult life and aging.

There are several disadvantages related to the separate course noted in the literature, however. For example, space may not exist in the counseling curriculum to add a course related to counseling older persons (Myers & Blake, 1986). In addition, a separate course may not meet the needs of all students involved. In such cases, students in the class may be less inclined to attend to, and learn from, the materials presented in class (Zucchero, 1998). Similarly, the separate-course model is in need of further evaluation within training programs throughout the country.

AREA-OF-CONCENTRATION MODEL

The area-of-concentration model, or cognate, includes several courses taught in the counselor education department (Zucchero, 1998). Such courses within the concentration might include: career counseling for older persons, counseling older persons, or theories and techniques of counseling older persons. In addition to the above mentioned courses, courses that allow for direct application of learning objectives in geriatric settings are typically integrated. This is done in order for students to complete the requirements for the area of concentration. However, in many programs the resources needed to sustain such an area of concentration are limited, if not minimal (Zucchero, 1998). On the other hand, such an area of concentration is needed in order to serve the increasingly growing population of older persons (Myers & Schwiebert, 1996).

It should be noted that the most current CACREP Standards (2001) support this particular training model. However, there has been no documentation that this model is superior to any of the previously mentioned models.

INTERDISCIPLINARY MODEL

Gerontology is an interdisciplinary field (Hill & Edwards, 2004; Zucchero, 1998). In fact, when students have the opportunity to glean information from different departmental or programmatic perspectives, they are also able to see the client from these varying perspectives. Furthermore, training within a diversity of classes also serves the student in achieving a deeper conceptualization of the issues involved in working with older adults. The interdisciplinary model can also reduce the need for coursework in counselor-education departments. This can be achieved by requiring students specializing in gerontological counseling to take coursework in other departments within the university (Karasik, Maddox, & Wallingford, 2004; Myers & Blake, 1986).

The interdisciplinary model requires some kind of collaborative efforts between and among administrators and educators teaching such courses. That is, courses should be designed in such a way that allows for students to continue building upon the knowledge and skills learned from each of the classes (Zucchero, 1998). Minimally, educators from each department should be aware of the learning and teaching objectives required in each of the other courses in order to meet the needs of the curriculum learning objectives.

The authors suggest that courses taken from programs housed in the graduate program of the authors' affiliated institution might be representative of courses within an interdisciplinary model. Examples of these courses include: Counseling the Elderly (department of counseling and student affairs); Adult Development and Learning, Psychology of Adult Life and Aging (department of psychology); Geriatric Communication Disorders, Nutrition for the Elderly (department of communication disorders); Health Problems of the Aged (department of public health); and Grief and Loss (department of social work). Although this is a more current model, no studies

appear to have been done that examine the use and effectiveness of this model within current counselor-education programs.

A UNIQUE-TRAINING MODEL

In 1998, Zucchero described A unique-Training model that would include the infusion of gerontological issues into the general curriculum with opportunities for students to specialize in gerontological mental health. Components of the curriculum would include knowledge acquisition, behavioral practice of skills, and extracurricular experiences working with normal older adults. Students would have opportunities to take courses related to gerontology in multiple disciplines in order to let them see relevant issues from various perspectives. Each course would serve as a building block for further acquired knowledge. The practice of skills would occur within a required practicum and internship component. Individual and group supervision would be provided. In addition, experiential activities would include volunteering in senior centers and/or senior service groups. In addition, students would be required to keep a journal of his/her practicum experiences in order to reflect upon the learning process.

AREAS OF TRAINING ESSENTIAL FOR COUNSELOR PREPARATION

Regardless of the particular model followed, certain areas of information are essential for the preparation of counselors to work specifically with older persons. According to Myers (1989), there are particular areas relevant to specialty training in gerontological counseling. These areas include: normative experience of aging; older persons with impairments; needs and services for older persons; the population and special situations; counseling older persons; and ethics in gerontological counseling.

Acquisition of the basic counseling and relationship skills such as empathy, genuineness, and unconditional positive regard (Rogers, 1951) are also critical for counselors of any special group. Counselors who plan to work with the aging and the aged also need training programs. These should provide a foundation for knowledge about the group and the issues that confront it (Damron-Rodriguez et al., 2004; Waters & Goodman, 1990). Finally, preparation should include the exploration of personal values, attitudes, and biases about aging and the aged (Myers, 1989; Myers & Schwiebert, 1996). Moreover, a training program should provide students with a supportive climate

in which they can evaluate their personal biases, increase their awareness, and develop appropriate counseling techniques, assessments, treatment plans, and intervention activities.

There are basic attitudes and values that counselors should be encouraged to examine and challenge (Van Zuilen, Rubert, & Silverman, 2001; Wilber & Zarit, 1987). First, counselor-training programs should provide time and space for students to examine their values around the rights of older clients to develop and work towards their own treatment goals. Second, a gerontological education should teach students that, sometimes, older clients are not coming to counseling only to come to terms with their life and death. They may have other, more pertinent concerns to be dealt with. Third, students should be encouraged to examine their roles as gerontological counselors. That is, counselors should learn not to play the role of the client's supportive network. Rather, they should serve as someone who helps, and provides resources for, the client to develop another, more appropriate, supportive community.

There is considerable variation in the aging process and individual differences must be understand and respected (Myers & Schwiebert, 1996; Serby & Yu, 2003). That is, there are differences between counseling the young and the old. To varying degrees, aging may bring on significant physical changes such as sight, hearing, and memory loss (Waters & Goodman, 1990). In such cases, students should be trained to face the client directly, sit close, and speak especially clearly. The counselor should observe how well the older person can process and digest information. In addition, slower, more distinct, and briefer comments may be necessary from the counselor. Furthermore, counselors should be trained to note differences between sensory impairments and cognitive deficits (Knight, 2004).

The education and familiarity with self-help resources may differ considerably between the older client and the counselor. In fact, Meyers (1990) reported that the popularity and availability of self-help resources have encouraged younger persons to become more knowledgeable and open to their own feelings and stress responses. On the contrary, older persons may have a limited familiarity with such materials. This contributes to their lack of relevant vocabulary; a smaller array of coping mechanisms; and diminished acceptance and awareness of stress-related concerns and/or symptoms. In such cases, students should become knowledgeable about potential resources that older persons might be inclined to use outside of the counseling office. In addition, skills are needed to understand complex feeling states, as well as to be able to communicate this understanding back to older clients. Consequently, counselors should

be trained to communicate and present concepts. They should also know how to deliver methods in concrete, simple, and understandable ways (Stevens-Roseman & Leung, 2004; Wilber & Zarit, 1987).

Older persons may not only need to fight the negative attitudes of society toward the aged, but possibly their own internalized negative attitude towards the aging process (Fry, 1998; Myers, 1989). Such attibutes may affect not only elders' feelings of self-worth, but also their life styles and goals (Myers & Schwiebert, 1996). Counselors may find it important to help some older clients distinguish between the myths or stereotypes and the actual realities of aging. Counselors should develop sensitivity to their own needs and aging process. Consequently, a process around deconstructing, if you will, such myths should take place within counselor education.

As do people of all age groups, older adults often experience developmental crises or transitions. Unlike other age groups, however, the aged face developmental transitions that frequently requirement adjustment to loss. These crises are not experienced by all older persons, nor are they exclusive to the aged population; however, they must be faced by many older persons. Consequently, training in working with adjustment issues in general—as well as specific to the aged population—is imperative.

To establish a relationship conducive to effective counseling, the professional should be skilled in various ways. First, counselors must be able to convey respect for dignity and worth of the older individual. Because some older persons may be reserved and less confident, more time may be needed to establish rapport with them. Addressing the older client by first name, for example, may be interpreted as a lack of respect. In addition, counselors should be trained or have experience employing counseling treatment in flexible settings. For example, some older persons may respond to counseling better if served in their own homes (Wilber & Zarit, 1987). Finally, the typical 50-minute time slot may not be conducive to the client's stamina.

Many older persons are particularly concerned with protecting their right of privacy. Many are not used to openly discussing sexual behavior, financial problems, and personal inadequacies. In fact, they may consider such talk as inappropriate and embarrassing. Counselors should be trained to work delicately with older persons on such issues, while encouraging the client to talk freely in an environment that is understood to be confidential (Pangman & Seguire, 2000). Having the skills to write a story with the client, if you will, on the values, needs, and fears associated with the above mentioned issues, might also be appropriate.

CONCLUSION

With the growing number of the aging population, the need for counselors trained in gerontological counseling is essential. Current studies are lacking that address the effectiveness of the previously mentioned models. Therefore, counseling programs throughout the nation need to pay special attention to their programs and determine if their students are receiving proper training to counsel older persons. As they study the four models of learning, a determination of the most appropriate model for the specific school and program will help guide them in achieving the goal of teaching counselors to work with this population. Regardless of the model chosen, specific knowledge and techniques will assist in providing useful and helpful information to better serve the aging population.

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