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Utilization of the Social Determinants of Mental Health Framework with Older Adults for Assessment, Case Conceptualization, and Treatment Planning

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Keywords

Older Adults, SDOMH, Gerontological Counseling, Mental Health

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CONCEPTUAL ARTICLE

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Abstract

This conceptual paper will aid counselors and mental health professionals in obtaining insight to utilizing a Social Determinants of Mental Health Framework with older adult clients. Further, the article incorporates the Multicultural and Social Justice Counseling Competencies to further contextualize the therapeutic alliance. The authors utilize the Social Determinants of Mental Health Framework to frame counseling assessment, case conceptualization, and treatment planning to improve the mental health outcomes of older adults. The article utilizes a specific case example to assess, conceptualize, and plan treatment for an older adult client contextualized in their environment.

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According to the World Health Organization (WHO, 2017), the population is aging at an accelerated rate, with a projected doubling in the older adult population from 1 billion in 2019 to 2 billion by 2050. The National Institute on Aging defines an individual 65 years old and older as an older adult (Figg, 2020). Historically, older adults have underused mental health services due to stigma and other barriers to service. However, given the increase in the older adult population, a greater use of mental health services is expected (Institute of Medicine, 2012; Wagner et al., 2019). Additionally, with the newly passed Mental Health Access Improvement Act, which provides coverage for mental health counselors and marriage and family therapists services under Medicare, these providers can now receive reimbursement from Medicare clients (Thompson, 2022).

With the expected growing need for clinical services for older adults, it becomes essential that counselors learn new ways to serve this demographic. These strategies must contextualize the struggles this population often faces with intersectional conflicts of adult development, social determinants of health (SDOH), and social determinants of mental health (SDOMH). Although some researchers have separated these constructs, there is a complex bidirectional effect and strong overlap, because they both address components within individuals' lives that affect their health and wellbeing (Jeste & Pender, 2022). The nuanced differences between these constructs, which relate to policy implications (Jeste & Pender, 2022) and etiology (Handerer et al., 2022), are beyond the scope of this paper. However, becoming familiar with SDOH and SDOMH can foster more holistic client conceptualizations and increase treatment intentionality. Additionally, considering the disproportionately high rates of poor health and mental health among Black, Indigenous, and People of Color (BIPOC) and marginalized individuals such as aging adults, the Multicultural and Social Justice Counseling Competencies (MSJCC; Ratts et al., 2016) offer one framework to aid mental health professionals working with the elderly. This framework encourages counselors to consider their own biases and to understand how perceptions of power, privilege, and broader societal biases could influence clients, both individually and within the counseling relationship. The MSJCC also emphasize counselors' roles in empowering clients to advocate for their own needs (Ratts et al., 2016). This article provides an overview of the literature related to SDOH and SDOMH in the context of counseling older adults, contextualizes the MSJCC framework as it relates to this population, and provides a case study to illustrate the application of SDOMH considerations and aid in treatment planning for aging clients.

Overview of Potential Older Adult Concerns

As the population continues to age, examining specific physical and mental health challenges older adults face is essential, because physical and mental health are inextricably linked. The WHO (2017) noted that 20% of adults over 60 have a mental or neurological disorder. Currently, depression, dementia, self-harm, anxiety, and substance abuse are recognized as the most common mental health concerns among older adults (WHO, 2017). Additionally, other mental health concerns, such as cumulative stress and loneliness, exacerbate the mental health challenges of some older adults (R. R. Chen et al., 2022; Prohaska et al., 2020).

Notably, more than 58% of older adults believe that depression is a normal aspect of aging (Mental Health America, 2016). According to Cross-Denny and Robinson (2017), ethnic minority older adults have more risk factors for the co-occurrence of depression and anxiety, including symptoms of higher stress, somatization, and impaired social functioning. Depression also has an association with lower income and education levels across the lifespan (Davison et al., 2019). Unemployed individuals have higher rates of depression than those with jobs, and many older adults experience unemployment due to retirement, ageism in the workplace, or a lack of jobs in their communities. Depression among ethnic minority older adults can be attributed to their awareness of the interplay between elderly and racial stereotypes (Kang et al., 2014).

Other sociocultural influences, such as ethnicity, religious affiliation, and language acculturation, add further barriers to mental health access. According to Tieu and Konnert (2014), "Among ethnic minority older adults, cultural factors, such as reluctance to discuss mental health issues with non-family members, and systemic issues, such as limited mental health programs for ethnic minority elderly, likely impact mental health utilization rates" (p. 140). Additionally, older adult clients who have not fully acquired advanced language skills, thereby facing communication challenges, are less likely to seek mental health services (Hansen & Aranda, 2012). Furthermore, clients who hold specific spiritual beliefs might perceive their problems as

spiritual rather than psychological or prefer to consult clergy and other spiritual leaders instead of clinicians (Nakash et al., 2019). Clinicians can use the MSJCC to further address these cultural barriers to accessing clinical services.

Many factors, including finances, transportation, resources, and stigma, impede older adults' access to mental health services (WHO, 2017). As people age, they might encounter health issues, reduced mobility, bereavement, and shifts in socioeconomic status due to retirement. These factors significantly influence accessibility of services and affect help-seeking behaviors. As the cost-of-living increases, another key concern with aging populations is financial resources, since many older adults lack sufficient retirement savings. Additionally, loneliness—which occurs when an individual lacks adequate, meaningful interpersonal connections, such as connections with a partner, family members, friends, or community members—is one of the largest factors affecting older adults today (Cacioppo et al., 2010; Prohaska et al., 2020). Although social engagement through social media became more prevalent during the COVID-19 pandemic, many older adults experienced isolation and fear of community engagement due to their susceptibility to the virus (Lebrasseur et al., 2021). Several factors affect loneliness, including neighborhood design, community safety, access to civic spaces, transportation, access to activities, and spaces for community engagement (Prohaska et al., 2020). Consequences of loneliness include stress, sleep, cognitive impairments, premature mortality, and depression (Cacioppo et al., 2010). Counselors are equipped to address these issues and can tailor their clinical approaches to consider how aging can exacerbate myriad mental health concerns.

Gerontological Counseling

Addressing the ever-present "graying of America" and growing literature on counseling and aging, the Association for Adult Development and Aging (AADA) argued for implementing gerontological counseling specialization standards to the Council for Accreditation of Counseling and Related Educational Programs (CACREP; Bobby, 2013; Myers, 1992). However, the gerontological counseling emphasis under community-counseling-focused programs and gerontological counseling standards, initiated in 1992, were terminated with the 2001 CACREP Standards due to statistics showing disinterest and low program participation (Bobby, 2013)(Bobby, 2013). Foster et al. (2009) highlighted the need for training programs to engage students in developing a greater understanding of older adult clients.

Therefore, training programs must address continued biases towards older adults. For instance, older adults often receive poorer prognoses, and their symptoms of depression are frequently downgraded even when they meet the criteria for extreme depression. Studies have indicated counselors are predisposed to believe that older adults are less likely to make progress and engage in a robust therapeutic relationship (McBride & Hays, 2012). Addressing these biases in counselors should begin in counselor training programs. Foster and Kreider (2009) discussed the need for counseling programs to infuse information about older adults into current courses and offer specific courses to help future counselors understand the unique needs and challenges this population faces. Moreover, they suggested the counseling profession reconsider the idea of a certification targeted toward counselors who work with older adults. Notably, the older LGBTQ+ population faces additional challenges beyond aging, as this group continues to face oppression and discrimination (Chan et al., 2021). This highlights the importance of counselors using a holistic approach when working with older adult clients, with consideration given to the strengths the client has and the unique challenges of each individual client. These skills need to be learned in training programs.

However, the current reality reveals that counselors-in-training often exhibit a lack of interest in working with older adults. This interest is partially contingent upon counselor self-efficacy, bias, and exposure to older populations (Wagner et al., 2019). Wagner and colleagues coined the term "counseling older adult self-efficacy" (COASE) in reference to counselors' self-perception of their capability to aid older adult clients, which is related to their interest in working with older adult clients. Wagner et al. (2019) predicted that increasing counselors' self-efficacy in counseling older adults would pique their interest in working with this population, finding a positive correlation between counselors' COASE and interest. The amount of perceived frequent contact with older adult clients also influences counselors' interest in working with this population. Finally, both positive ageism (i.e., biasedly viewing older adults empathically as cute and wise), and negative ageism (framing old age as an unfavorable identity), affect counselor interest in gerontological counseling (Cherry & Palmore, 2008; Wagner et al., 2019). Consequently, to increase counselor interest, community agencies are encouraged to offer training, supervision, and experiences for gerontological counselors. Additionally, counselor education programs need to incorporate topics on counseling older adults and ageism intentionally into courses. Moreover, to engage in assessment, case conceptualization, and treatment

planning for older adult clients, counselors can use the awareness of SDOH and SDOMH to provide a context for older adult clients and create effective practices and interventions.

Social Determinants of Health (SDOH)

The conditions in the environment that often affect individuals are broadly termed social determinants of health (SDOH). SDOH are psychosocial and socioeconomic factors that contribute to people's health, well-being, and quality of life (U.S. Department of Health and Human Services, 2022). In an individual and collective sense, these factors significantly affect the older adult population. Although several determinants influence outcomes in the general population, their effect is particularly intensified in the older adult population, whether by choice or circumstance. One example is the burden older adults face in coping with multiple chronic health conditions. Without effective health care management to support them, family caregivers, and clinicians collaboratively identifying needs and implementing individualized care plans, some older adults struggle to access higher-value health care to address high medical costs and quality-of-life decline. Notably, there is a dearth of adequately prepared professionals, including geriatricians, nurses, social workers, and public health professionals. As indicated by Rowe et al. (2016), the number of board-certified geriatricians is estimated at 7,500, less than half the estimated need. Consequently, understanding and properly addressing these disparities is essential for counselors who serve older adult clients (Bodner et al., 2018).

Domains of SDOH

The concept of SDOH encompasses a broad array of socio-ecological occurrences that affect individuals in various ways. Many forms of inequality—such as low income, social exclusion, unemployment, and food scarcity, among others—all lead to poor health outcomes for some disadvantaged segments of the population (Shim & Compton, 2018). Specifically, the Centers for Disease Control and Prevention (CDC, 2020, 2021) has defined five domains of SDOH: *economic stability, education access and quality, health care access and quality, neighborhood and built environment, and social and community context. Given this context,* it is critical to consider how these factors influence individuals and groups across their lifespans. Notably, there is a growing need in counseling to view later adulthood and retirement years as areas of increased importance for both clients and therapists (Sarantakis, 2019). A particular area of concern within this spectrum is economic stability.

Economic Stability

Economic stability refers to lived experiences related to factors like poverty, retirement, and available resources. The CDC (2021) noted that those who have steady employment are less likely to live in poverty. However, people with disabilities, injuries, or chronic health issues might be limited in securing and maintaining employment. The American Psychological Association (APA, 2014) provides examples of health compromises in later adulthood, including sensory acuity, body composition, hormone levels, the performance capacity of most body organ systems, immunological responses, susceptibility to illness, and cognitive function. With evidence linking SDOH to poor mental health outcomes (Shah et al., 2021), mental health care providers could enhance their service to clients by expanding client conceptualizations to consider SDOH.

Education Access and Quality

Education access and quality domains consider the influences of factors such as language and literacy, early childhood development, and education, as well as enrollment in higher education. Notably, adult lifespan trajectories are shaped by early and accumulated inequalities. The WHO (2017) noted that "disadvantage starts before birth and accumulates throughout life" (p. 9). Inferior education levels increase the likelihood of subsequent unemployment, low income, and poor healthcare access, and further pose a risk factor for Alzheimer's disease. Scholars have also linked SDOH to health issues such as heart disease and depression (Sarantakis, 2019; Shah et al., 2021; Shim & Compton, 2018).

Health Care Access and Quality

The healthcare access and quality domains include unique concerns related to healthcare access, access to primary care, and health literacy (CDC 2020). Notably, the United States does not provide universal health care, and many citizens in the

country do not have access to needed healthcare (CDC 2021). Additionally, mental health has been reported as the leading cause of unnecessary emergency department (ED) visits. The costs for patients entering the ED with behavioral health needs can be more expensive compared to community services (Institute of Healthcare Improvement and Well-Being Trust, 2020). This financial burden imposes a tremendous cost on society (De Silva, 2015; Fink-Samnick, 2020).

By the year 2060, nearly 1 in 4 American citizens will be 65 or older. Even more striking, the number of American citizens aged 85 and older will triple by this time (U.S Census Bureau, 2019). With this shift in demographics, the United States could face greater demands for healthcare, in-home caregiving, and assisted living facilities. These changes could affect Social Security, with the U.S. Census Bureau (2019) projecting 3.5 working-age adults for every older person eligible for Social Security in 2020. This ratio of working-age adults to older persons will further decrease by 2060, with an expected reduction to 2.5 working-age adults for every older person (U.S Census Bureau, 2019).

Neighborhood and Built Environment

The neighborhood and built environment domains also have unique obstacles for SDOH, especially for older adults. Factors such as access to healthy foods, quality of housing, crime, violence, and environmental conditions all contribute to older adults' health outcomes. Specifically, older adults struggling with chronic housing insufficiency could be forced to rely on shelters and hotels to avoid homelessness. Additionally, a scarcity of available housing options can result in individuals residing in unsafe communities or living conditions, circumstances that heavily influence susceptibility to illness onset and severity (Fink-Samnick, 2020).

Social and Community Context

The social and community context domain includes experiences related to social cohesion, civic involvement, and varying types of discrimination (CDC, Centers for Disease Control and Prevention, 2020; Fink-Samnick, 2020; Shah et al., 2021). The CDC (2021) underscores that positive relationships at work, home, and in the community mitigate the negative effects posed by SDOH. Implementing interventions to increase social and community support is pivotal for improving older adults' wellness and overall wellbeing. In fact, some studies have demonstrated that direct and indirect experiences of community violence are significantly associated with symptoms of depression and anxiety (Alegria et al., 2018; W.-Y. Chen et al., 2017). The increased risk for mental health conditions necessitates attention to SDOMH.

Social Determinants of Mental Health (SDOMH)

Although the links between SDOH and more overt physical health conditions and environmental concerns have been well established, the WHO (2014) has also drawn connections between psychosocial/environmental concerns and mental health, explaining the concept of SDOMH: "Many common mental disorders are shaped by various social, economic, and physical environments operating at different stages of life; these risk factors for many common mental disorders are heavily associated with social inequalities" (p. 9).

Supplementing the SDOH examples previously mentioned, other factors such as racial discrimination; poor relations between law enforcement and communities; sexism; and other forms of discrimination, such as ageism, and social isolation, serve as examples of SDOMH (Kirby & Slone, 2021). These factors increase the risk of adverse mental health conditions (Compton & Shim, 2015; Jeste & Pender, 2022; World Health Organization, 2017). Various forms of inequality, rooted in socioeconomic and other social and cultural factors, can affect mental health and present a multifaceted issue (Marmot & Allen, 2014). The effects of these social factors can both increase and hinder people's capacity to be healthy (2019). Additionally, the distinctions between what affects someone's health versus their mental health often become blurred when considering how SDOH collectively affect overall wellbeing (Alegría et al., 2019; Allen et al., 2014; De Silva, 2015).

For example, some social risk factors, such as social isolation or housing instability, are associated with poor health in later adulthood. Social isolation predicts mortality at rates comparable to increased clinical risk factors (Pantell et al., 2013). By directing more attention to helping the majority have an equal chance at living more fulfilling and healthy lives, the risks

associated with SDOH for disadvantaged populations could significantly decrease (Shim & Compton, 2018). Marmot and Allen (2014) highlighted that "to reduce health inequalities requires action to reduce socioeconomic and other inequalities" (p. 517). Some proponents believe in a more holistic approach, suggesting that integrating the SDOH with the SDOMH would create a comprehensive, holistic model (Fink-Samnick, 2020).

Although data have continuously demonstrated that adults grappling with multiple mental health concerns are more susceptible to chronic illness and live with the inequities of SDOH, physical and mental health often remain separated (Fink-Samnick, 2020; Substance Abuse and Mental Health Services Administration (SAMHSA), 2016). Perhaps a more holistic combination of SDOH and SDOMH would reduce mental health stigma and foster greater awareness about the importance of mental health, and how social determinants affect mental health, particularly among vulnerable, disenfranchised, and marginal populations (Fink-Samnick, 2020). Understanding the influences of SDOH and SDOMH is vital for counselors working with older adult clients due to the multicultural and social justice training these professionals receive.

In the search for a framework to address these varied examples of oppression, the MSJCC merit consideration. These competencies guide counselors in their pursuit to consider, understand, and address the constellation of identities of clients and counselors, while recommending interventions that should occur at both individual and systemic levels (Ratts et al., 2016). Counselors can adopt the MSJCC as a framework to address the SDOMH challenges older adults face. The MJSCC framework facilitates the consideration of how societal messages can erroneously depict groups and how stigma can foster negative self-perception, underperformance, and inequity. When individuals become aware of stigmatization against a group, the identified participants perform poorly on ability tasks and report a more negative self-perception (Varela, 2021). Counselors, while confident in their cultural competence and preparedness to counsel older clients, might remain unaware of their biases toward geriatric individuals (Humphrey, 2017; Stuart-Hamilton & Mahoney, 2003).

Multicultural and Social Justice Counseling Competencies (MSJCC)

The MSJCC are an expansion of the multicultural competencies (Sue et al., 1992), providing a framework for conceptualizing and collaborating with the various identities mental health care providers embody (Ratts et al., 2016). It is expected that, under the MSJCC, counselors will address issues of power, privilege, and oppression affecting clients. This treatment can be beneficial for older adults who have privileged and marginalized identities due to the social stigma and other challenges related specifically to aging. The MSJCC create a framework for counseling professionals to view client issues from a culturally contextual perspective and recommend interventions occurring at both individual and systemic levels. This framework becomes particularly helpful when considering SDOMH, as lifestyle, environment, social, and economic factors shape clients' lived experiences.

The MSJCC emphasizes the importance for counselors working with diverse populations to understand intersecting factors influencing these diversities. Four domains might assist professionals to increase their awareness, knowledge, and skills when working with marginalized clients: (a) counselor self-awareness, (b) client worldview, (c) counseling relationships, and (d) counseling and advocacy interventions (Ratts et al., 2016). It is helpful to have this framework, which considers the broader picture of equality while addressing intersecting ecological factors contributing to social and economic class advantages and disadvantages.

Furthermore, this framework encourages counselors to transcend mere awareness and discuss oppression at the interpersonal, community, and international levels (Ratts et al., 2016). Amid the current, stark socioeconomic class differences, allied health and mental health fields could enhance care by recognizing the overlap of SDOH and SDOMH. Per the MSJCC framework, counselors are expected to intervene with and on behalf of clients at the intrapersonal, interpersonal, institutional, community, public policy, and international/global levels (Ratts et al., 2016).

The aging population often has a need to redefine and reconstruct their self-perception when entering older age or retirement, a major challenge. Paring this life transition with SDOH and SDOMH, a sensitive framework like MSJCC emerges as an indispensable guide. The significance of the process of transitioning into older age, with its emotional and social repercussions (Sarantakis, 2019), warrants special care by informed professionals. Therefore, when assessing clients, counselors must consider many different psychosocial and resource concerns.

Application of Frameworks for Counselor Consideration

The initial stages of counseling begin with the counselor's awareness of their own biases, privileges, and areas of marginalization. The MSJCC can augment counselor understanding and cognizance of the broader societal fabric while conceptualizing how various forms of discrimination impact clients. Counselors might consider beginning sessions with a quality-of-life assessment (Flanagan, 1978). Following this, they could provide clients with psychoeducation on the complex interactions of external resources, environment, and psychosocial circumstances on health and mental health.

Furthermore, a clinician should aim to connect clients to community resources (Figure 1) and be mindful to include V-codes and Z-codes when diagnosing clients. These codes are designed to provide more instances or factors that influence care, leading to a more holistic diagnosis and client conceptualization that can be communicated to other providers (Maksut et al., 2021; Weeks et al., 2020). Finally, the clinician can follow up with clients about community resources. For example, clinicians can maintain lists of organizations, food banks, homeless shelters, and other resources and update them with client feedback. The broad framework the MSJCC provide can be used throughout the assessment and diagnosis process.

Assessment Considerations using SDOMH

Evidence has suggested that social risk factors are correlated with mental health outcomes (Shah et al., 2021). In a client relationship, it is vital to consider how various economic, social, and health factors affect clients. Stress affects a person throughout their lifespan, starting from prenatal development up to older adulthood. Allen and colleagues (2014) argued that to a large degree, mental health issues are developed and shaped by experiencing external factors such as low socioeconomic status, environmental factors, and a lack of healthcare. It is crucial to understand that many factors can cause mental health disorders, such as genetics, learned factors, and environmental factors. Moreover, it is important to note that some individuals struggling with mental health issues might refuse treatment due to the stigma associated with seeking help. Counselors must understand that the resources a person possesses to manage stress, such as receiving counseling and other forms of social support throughout their life, can significantly affect their overall mental health (Allen et al., 2014).

Assessing a client involves several steps that enhance understanding the client's experience and uncovering the best way to help them. Further, when assessing a client, counselors often collect substantial information about the client's background and available resources. Counselors must acknowledge each client's needs for different resources and recognize that not every client has the same access. Therefore, to be more effective in assessment, it is important to consider several factors that align with the SDOH model. Accordingly, counselors should ponder certain questions as they work with clients. Below are some basic considerations that can serve as a starting point when working with older adult clients.

1. Counselors should consider what the client has reported about stress-causing issues. The counselor should consider whether the client might be facing persistent life stressors without sufficient help. The counselor asking themselves questions such as, "Would this increase anxiety, worsen feelings of depression, or contribute to feelings of low self-worth?" can be instrumental. How might the counselor factor these aspects into their diagnosis and prognosis? Empowering the client by highlighting their strengths and educating them on simple ways to reduce stress can prove highly beneficial. For example, encouraging the client to take short breaks and meditate can create a routine that facilitates mental decompression for a few minutes and then re-focus on handling the issues and stressors.

2. Childcare has become difficult to obtain and extremely costly (Gould & Cooke, 2015). For instance, a custodial grandparent of two young children who must work, yet struggles to find affordable childcare, might struggle in many ways. Such situations can lead to feelings of low self-esteem, depression, and inferiority. Paying for childcare might mean that non-essential items are unaffordable. Counselors can encourage caregivers to consider ways they can work with family, friends, and community members to determine affordable childcare solutions. Remote work options, which might allow for some additional flexibility, should be discussed.

3. Some clients depend on government assistance programs for food, housing, and other items. Inflation further complicates obtaining these essentials. Therefore, counselors should know about resources like food banks and financial aid in their communities. Consider the implications of how asking for help can affect a person's view of themselves. Helping the

client to reframe the act of asking for help as an indication of strength and family care can counteract negative cognitions. Additionally, counselors can encourage clients to consider gardening or participating in community gardens to provide sources of nutritious food..

4. Older adult clients might struggle with loneliness and grief. Sometimes older adults lose their independence and require external assistance. Counselors can consider how to build rapport with the client and understand the effects of social and financial changes on older adults' mental health. Client advocacy, such as connecting clients with resources that provide transportation, estate planning assistance, and peer support, can be beneficial.

5. When clients have unmet basic needs, it becomes hard to focus on their mental health concerns. Therefore, counselors must appreciate the profound effect of such circumstances. Working with community agencies, counselors must help clients in meeting their basic needs, which can help reduce stress and anxiety. In some regions of the country where resources might be limited, continuous advocacy is essential.

6. When conducting an assessment, it is important for counselors to address differences as needed and consider how the client might perceive them. It is a counselor's job to try to understand their clients' worldview and refrain from making assumptions. Asking probing questions, even difficult ones, is necessary to make an accurate diagnosis. At times, an older client might be reluctant to fully discuss age-related issues. Thus, it is important to address identity differences and ensure clients feel safe and comfortable discussing difficult topics by solidifying therapeutic rapport.

7. Assessments and tests are often used in counseling to gather information, clarify or make a diagnosis, measure treatment outcomes, and facilitate clients' self-understanding. However, when using these tools, it is essential to consider cultural factors and ensure the norming group aligns with the client's identities. Additionally, tests' reliability and validity with the client's population must be considered.

8. Lastly, when working with older adult clients, it is vital to consider the potential need for collaboration with other professionals such as medical providers, case workers, caregivers, and local social service agencies. Note that each provider or agency will have its own protocol when assessing needs and determining what needs they can assist in meeting. Therefore, counselors must work closely with the client to enable communication by ensuring informed consent forms are completed. This procedural element allows counselors to help the client to have basic needs such as food, electricity, and affordable medication, as well as more complex needs, met.

Counselors often employ a strengths-based approach, underscoring the need to recognize the client's strengths and build upon them when conceptualizing a case. Effectively working with clients and correctly conceptualizing a case requires that the counselor first build rapport and trust. One step of this process can be acknowledging cultural, racial, ethnic, and other differences. In other words, when counselors address the so-called "elephant in the room" in establishing the relationship, clients are more likely to be honest when answering questions. Consequently, this foundation helps the counselor effectively understand and conceptualize what is transpiring with the client. Moreover, using the Addressing Client Needs with SDH survey (ACN: SDH) provides counselors with a tool to assess their own competency in addressing SDOH with clients. The 22-item survey scores questions on a 1 to 5 Likert scale, with lower scores indicating less competency. Specifically, the survey includes "items that covered SDOH self-awareness and attitudes, knowledge, skills, and behaviors" (Johnson, 2023, p.6).

Case conceptualization is a strategic method clinicians use to collect client information, comprehend a client's issues, focus treatment, anticipate potential challenges in reaching treatment goals, and plan for termination (Sperry & Sperry, 2020). The case presented in the next section affords a valuable opportunity to conceptualize how counselors can incorporate the SDOH model.

Meri's Story

Meri is a 67-year-old widowed woman who spent most of her life as a homemaker. She is the primary caretaker for her two special-needs grandchildren, Ryan and Tatiana, ages 6 and 8. She has been in this role for 5 years. Her husband, Chris, passed away 2 years ago from a major stroke. Meri has two adult children; Erica, a 28-year-old incarcerated for drug trafficking, and Jacob, a 32-year-old accountant. Notably, Jacob is a first-generation college graduate but lives 6 hours away, seldomly

visiting his mother. Jacob is married with two children, ages 4 and 2, and it upsets him that his mother is raising his sister's children on a fixed income. He believes they get more attention from her than his children, putting a strain on the relationship between Meri and Jacob. He does not have time to visit due to his work schedule, and his wife, Suzi, does not want Meri to visit and bring her other grandchildren since they rarely listen, act destructively, and ignore boundaries. In an incident when Jacob's wife Suzi attempted to discipline them, Meri became upset, made excuses for their behavior, and yelled at Suzi. Meri blames Suzi for the relationship stress between her and Jacob because she just does not understand the challenges these children face.

Meri visits her daughter in prison monthly despite the 5-hour journey and the financial strain and physical toll these visits take on her. Additionally, both grandchildren were born addicted to drugs and exhibit developmental problems and learning disabilities, adding to the stress Meri has as a caregiver. Living on a fixed income, Meri struggles to afford groceries for herself and her two grandchildren. Jacob, blaming his sister Erica for the issues their mother faces, has offered some financial assistance at times but feels he must prioritize his immediate family. He thinks that Erica's children might be better off in foster care since Meri is struggling to care for them. Before her husband died and she became caregiver to two grandchildren, Meri had a very active social life. She and Chris had friends they vacationed with, and they hosted weekend cookouts. They had a full and active life and planned to travel when they retired. However, having to care for grandchildren, Chris postponed retirement, and Meri believes he died prematurely from overworking. He was complaining about feeling tired before he died but refused to see a doctor due to the cost. He was worried about their family's financial future.

Meri's social life is depleted at this point due to her responsibilities for her grandchildren. Most of her friends do not want them in their homes due to their destructive behaviors. Furthermore, Meri's friends find that Meri has little time to spend with them since securing reliable childcare has been a challenge, and Meri cares for the children herself when school is out and during the summer. She struggles with feeling depressed and overwhelmed by her current situation.

Case Conceptualization

When conceptualizing Meri's case, it is crucial to consider several SDOH. Meri is an older adult who has faced stressors such as the loss of a spouse and the responsibility of caring for her grandchildren. Compared to older adults who are not parenting their grandchildren, grandparents in the parental role tend to have fewer financial resources (Shovali et al., 2019). Meri was looking forward to retirement, traveling, and spending time with her husband. Now, with her husband's death, Meri might feel lonely and overwhelmed due to caring for and being financially responsible for two young children. These circumstances no doubt contribute to feelings of stress, anxiety, and depression. In fact, a meta-analysis of research findings reveals that custodial grandparents often suffer from depression and other mental illnesses (Kelley et al., 2021). Kelley et al. (2021) also noted that even for custodial grandparents with resources, the prolonged stress of caring for children might contribute to mental health issues.

Meri, an older adult with limited resources, is trying to raise two special-needs children. Additionally, she has no family support, which can contribute to stress. For a counselor working with Meri, identifying local support groups for custodial grandparents might be beneficial. While support groups might be accessible in a large urban area, supports could be limited in a smaller rural area. Accordingly, Meri would benefit from having affordable childcare to take a break from her caregiver responsibilities. However, due to the children's behavior, this is a struggle. Children raised by grandparents are more likely to have behavior problems than those not raised by grandparents (Shovali et al., 2019).

Meri's financial constraints increase her stress level. The struggle to provide financially for herself and her two grandchildren could make her question her self-worth. Her strained relationship with her son and his wife adds to her level of stress and isolation. Meri has some close friends and is not often afforded time to spend with them. She is likely feeling lonely and isolated, and isolation is a SDOMH factor that increases the risk of mental health conditions (Compton & Shim, 2015). It would be beneficial for Meri to build a robust support system—a task that a counselor can assist with. Given the stress and pressure Meri faces, she would also benefit from counseling as an outlet to express her feelings and develop coping skills for stress. Areas of concern during counseling would include stress, depression, anxiety, and loneliness.

Treatment Plan

When creating a treatment plan for an older adult client like Meri, a counselor can consider the SDOMH that have affected the client across their lifespan. Additionally, the counselor can apply the MSJCC to examine client privilege and oppression while contextualizing interventions and therapeutic goals within the client's environment. In Meri's case, this entails incorporating interventions that improve her social support in a cost-efficient manner and address her food insecurity within the hierarchy of needs. The example treatment plan created for Meri's case considers various SDOMH while focusing on the primary issues she is experiencing (Figure 1).

Figure 1: Treatment Plan

Achievable Therapeutic Goals	
Need/Problem: Depressed Mood and Isolation	
Goal 1: Client (CL) will show elevation in mood AEB engagement in regular activities and socialization to decrease feelings of loneliness.	Target Date: __/__/__
Objective 1: CL will be proactive in creating opportunities to socially engage with friends and family.	Target Date: __/__/__
Intervention 1: Increase the number of positive family interactions by planning cost-free activities that promote harmony (e.g., table games, family walks, sharing meals).	Frequency: minimum 1/ per month
Intervention 2: Help CL identify support groups in the community for grandparents raising grandchildren to expand social network and access to grandparenting support and education.	
Objective 2: CL will gain an understanding of where they are in the continuum of the grieving process and verbalize unresolved grief issues that may be contributing to depression.	Target Date: __/__/__
Intervention 1: Educate the client on the stages of the grieving and assist the CL in identifying the stages of grief they have experienced and the stage they are presently working through.	
Intervention 2: Assist CL in identifying and expressing feelings connected with her loss (through a daily grief journal and writing a letter to her husband to express her feelings).	
Objective 3: Learn and implement personal skills for managing stress, solving daily problems, and resolving conflicts effectively.	Target Date: __/__/__
Intervention 1: Assist CL in learning appropriate problem solving/conflict resolution skills (e.g., respectful communication, "I statements").	
Intervention 2: Role play with client as her son, daughter-in-law, and friends to practice learned conflict resolution skills in interpersonal relationships.	
Goal 2: Aid client in addressing experiences with food insecurity.	Target Date: __/__/__
Objective 1: Clinician will discuss local and national food assistance programs with CL (e.g., Meals on Wheels, Supplemental Nutrition Assistance Program)	
Intervention 1: Connect CL to appropriate community resources/agencies to apply for food assistance and obtain affordable groceries in her community.	

Discussion

Research has supported the need for improved mental health care for the gerontological population as it is rapidly increasing (WHO, World Health Organization, 2017)(WHO, 2017). An increase in community agency training and developing more intentional counselor education curricula are two of several steps that can help decrease mental health stigma in the aging population (Bobby, 2013; Foster & Kreider, 2009; Wagner et al., 2019). For example, increased training could help providers shift from an overemphasis on mental health diagnoses to considering the many intersectional and influential factors affecting the aging community. This practice might contribute to specialized interventions and remind other healthcare providers to expand their mission to include SDOH and SDOMH awareness in their treatment planning. There are several implications for counselors working with older adult clients.

First, before diagnosing clients and deciding on a prognosis, simply attributing their condition to a mental health code, counselors might better serve clients by figuratively stepping back and taking a panoramic view of the client's life. Counselors must ask themselves, "How is the client's economic stability? Does the client have access to education? What is the client's level of quality health care? Where does the client live? How is the client's neighborhood rated for crime, food accessibility, and civic engagement opportunities?"

Second, when conceptualizing the client for treatment considerations, the counselor must also inquire about the client's social and community context. This step is necessary because increasing research shows the constant flux between ecological, environmental, and genetic factors (Alderwick & Gottlieb, 2019; Alegría et al., 2019; Fink-Samnick, 2020).

Lastly, when working with the aging population, counselors should consider the four domains of the MSJCC: (a) counselor self-awareness, (b) client worldview, (c) counseling relationship, and (d) counseling and advocacy interventions (Ratts et al., 2016). This consideration could help counselors deconstruct any biases they hold about the aging population. Although bias is a natural phenomenon, it is unprofessional and hinders the client when left unexamined.

The MSJCC encourage counselors to consider the constructs of privilege and marginalization. These constructs create concurrent dynamics in the client's life and counseling sessions, which can be particularly helpful to know when collaborating on treatment plans and better contextualizing the client's narratives. In fact, research has supported counselors in openly discussing oppression at the interpersonal, community, and international levels (2016). This level of awareness could help shift the client's tendency towards self-blame to a more reasonable and holistic systems perspective. Such awareness also ensures practical treatment by providing the client with information about community services such as food pantries, state health insurance assistance, financial assistance, and support groups that could help combat the mental health symptoms associated with SDOH.

Conclusion

In conclusion, a significant portion of the U.S. population is transitioning into older adulthood, and it is imperative for counselors to consider how the SDOH and SDOMH models work with older adult clients to provide them with mental health care. The domains of the SDOMH affect clients from lower socioeconomic backgrounds, encompassing older adults and many minority individuals. Therefore, interventions must consider basic needs and ensure that clients can have these needs met before proceeding to address more complex issues. Additionally, systemic issues that continue to contribute to health challenges and mental health issues must be addressed. Such actions will necessitate that counselors continue to advocate for not only individual clients, but also policy changes.

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