PsychAGE News

Information and commentary about older adult and carer wellbeing

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The Perfect Storm, **Residential Living,** Types of Distress, Invitations for Engagement, Grief and Loss, Ageism.

Counselling and Psychotherapy with Older People in Care: A Support Guide, Jessica Kingsley Publishers (UK). Excerpt 2: Chapter One, pp.38-41.

RESIDENTIAL LIVING

Have you ever stepped inside a long-term care facility? What sights, sounds and smells come to mind? They are places that many try to avoid. “He doesn’t much like coming here,” a resident might say of her son. Why? “Because he hates the whole lot. I have to say, I can understand what he means,” she says with a rueful look.

Love them or hate them, they are places where many live. They are often a bustle of unceasing activity, a maze of corridors and pin codes. Some rooms can have hold-your-breath aromas that change your mind about lunch. “Help! Please help!” a resident may call out as you pass, and others stare blankly at the television. There is death, there is life. Some staff truly care, some not so much. Each facility has its own culture and way, which can often change depending on who is sitting at the helm. But no matter what colourful mix of the pleasant, unpleasant or neutral, working in them and with them is what psychotherapy for residents of long-term care is all about.

Building trust with staff

If you are a counsellor or psychotherapist for older people in care then you need to work very hard at building knowledge and faith in your service. Why? Because these relationships are central to your referral base. Facility staff are intricately connected to the resident and also their trust in you can significantly affect how supportive they will be of your recommendations. You need to be able to “sell” the benefits of psychological care as just as an important part of wellbeing as physical care. Perhaps more than for any other population, physical and mental health are two sides of the same coin. But care staff are often not aware of how challenging behaviours and psychological distress are so inextricably linked. Staff training is outside the scope of this book but I have developed resources which I have used one on one and in group settings to educate facility staff and increase their skill in managing resident distress. It can take effort and time to get the message across – with high turnover in staff a little hurdle to jump – but building yourself as a trusted resource for staff formally and informally can be well worth it in my experience. This is especially true if you need to take a firm stand on an issue, which is what the next section explores.

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Who is your client?

Services that are limited to individualized models of care, such as through a mental health care plan which is the main mode of accessing subsidized psychological support in Australia, make it all the more challenging to effectively address distress when it bleeds into a wider system such as the family. I fondly remember my days as the social worker/counsellor for the Multiple Sclerosis Society because of the freedom I had in taking a multi-systemic approach to emotional and psychological health. It did not matter if I was conducting individual, couple, family, group therapy or running carer retreats – the focus was exploring the impact and facilitating healing *for all.*

The question "who is your client" can relate to a number of dimensions: the guidelines of the programme or the organization you are working in, who is paying for the service, issue complexity, or personal and professional ethics. Sometimes others (staff, doctor, family) are more distressed than the senior, sometimes concerns are symptomatic of deeper issues (conflicting agendas, grief, family tension), and sometimes the "problem" may be more to do with staff wanting compliance than anything else.

None of this probably surprises you. If you have been a psychotherapist for any length of time (or even just have a few years under your belt) you will know with certainty that human relationships are fascinating if not a little infuriating at times. So many different agendas, communication styles, personalities, histories, health needs, resources and challenges. It really is a wonder that we mostly get along! But, of course, like a courtroom judge, the therapist is exposed to times when things are not going so well. If life is normally a knotty tangle of relationship need, then why should old age be any different? Long-term care facilities are like shrink-wrapped country towns where relationship dynamics are intensified – for better or worse – and there is also the delicate issue of dependency.

Taking a holistic approach to "who is your client" affords you a clearer picture of every terrain, every referral. If it is within your role then spend time with stressed staff exploring options, role model and teach reflective listening skills, have couple or family sessions with the resident (with their consent), offer individual appointments to a distressed wife or son. But keep at the focus – the centre of all you do – the rights and wellbeing of the senior. For, ultimately, they are your client. The following scenario and set of response options sheds light on how multi-faceted questions around "who is your client" can be. Mrs Grout was referred to you because staff were becoming exhausted with her complaints and demands. Family were also feeling exasperated and stressed by her pleas to return home.

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1. *Staff and family are the client.* Mrs Grout is not at all bothered by *her* behaviour. She considers it completely justified. Everyone else is the problem in her opinion. You discover from family that she has always been a glass-half-empty sort of person. Why should now be any different? You support staff and family dealing with a person who does not appear interested in changing but you do not continue with therapy for the resident on the grounds that it would be a violation of client consent: she does not want to see you.

2. *Everyone is the client.* You learn from Mrs Grout that she is done with being nice. She was in a domestic violent marriage for decades and now, at the ripe old age of 90 and with nothing to lose, wants to be free to optimize her wellbeing. You counsel her on how she might go about this without sabotaging her ultimate desire and you counsel others on how they might create boundaries to protect staff and not compromise equity for other residents.

3. *The senior is the client.* After empathizing with Mrs Grout you suspect that there are deeper issues behind her behaviour. She is grieving: for the loss of independence, choice, control, her changed body and life. Getting to the heart of the matter and informing staff of her dilemma (only with her permission) she learns to heal and be more considerate while staff learn to be more understanding.

4. *Everyone is the client.* You learn from family and staff that Mrs Grout's personality has changed in the year she has been at the facility. You observe her memory, logic and lucidity to be "patchy" – sometimes it appears normal and others times it does not. You also observe that she appears to have no insight into the impact of her actions on others. You suspect that she has an unusual dementia presentation that, if diagnosed accurately, could help staff and family develop different expectations and responses (Mrs Grout is not being mean and neither are others if they do not react each time to her calls – Mrs Grout is not able to keep score). You recommend a psycho-geriatrician assessment.

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Perhaps an even more contentious issue is proceeding with psychotherapy if others appear more distressed than the senior. Seniors – especially ones in facilities – can be very vulnerable. Maybe they appear interested in therapy because they are scared of what might happen if they do not participate? Maybe conducting therapy is colluding with notions that the senior is the problem when, really, it is more systemic than that. Knight (2004) presents a poignant example of how staff became annoyed because depressed residents were now cured and becoming too assertive! Could the psychotherapist fix this "problem" please?

Long-term care facilities are like any other organization; they want life to run smoothly. Compliance and efficiency can be agendas that are at odds with a genuine interest in wellbeing for the senior: one that promotes individuality and independence. I am afraid that there are no easy answers to this, but being aware of this minefield is critical if you are to try and navigate through it. Later, we will consider the question of "whose problem is it" in more detail as it relates to determining suitability for therapy. Next, we will continue exploring the need to work as effectively as possible within the constraints of facility living.

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