Understanding generational nuances will help clinicians treat older adults, says Felicity Chapman.

Taking a holistic approach

Mental health clinicians need tools for successful treatment when given the green light to provide psychological services in residential aged care, writes FELICITY CHAPMAN.

Understanding how to approach an advanced senior about receiving a mental health service is critical if this cohort is to benefit from the proposed funding injection to increase access to psychological services for residents of aged care facilities.

Ask anyone 85 years or over if they would agree to see a clinician for counselling to treat suspected depression and you are likely to get one of four responses: a polite blank stare, a version of, "If that's helpful for you dear," a fumbling assertion about being okay or a point blank declaration about not being crazy.

Felicity Chapman

It's easy to forget that anyone over 60 grew up in a time where the phrase cognitive therapy had not even been invented. Other terms such as personal growth, wellbeing and counselling are equally as foreign. Insanity isn't though. No one wants to be 'one of them'; those poor folks locked up and attended to by people in white coats.

We know the need. We know that over half of residents in Australian care facilities are experiencing symptoms of depression, which is likely to be a gross underestimate. We know that men over the age of 85 in Australia have the highest suicide rate.

We know that a move to residential living, especially following a sudden hospital admission, is likely to render a once active senior into someone even they don't recognise.

But do we understand how to sensitively invite them into a therapeutic relationship to explore the psychological?

Do we understand the mindset of a group whom psychologist and social researcher Hugh Mackay called 'the lucky generation' for how they described their own lives, and who are likely to be suffering the twin effects of internalised ageism and a life turned upside down by the move into care; to speak nothing of watching as your close friend numbers become zero?

They have grown up taking pride in their ability to weather adversity. They might not have a strong sense of entitlement but they do have a strong sense of self. They don't want their frailty to define them, nor have they been socialised to share their feelings. And they might not be as enthusiastic to explore goals as someone who has their whole life ahead of them.

How comfortable and relevant, therefore, is it to kick contact off with an overt helper and helpee relationship? With talk about disorders or at best about symptomology?

What advanced seniors need, especially at the initial phase of contact, is dignity. Take a genuine interest in them as a person before you look at them with your client glasses on.

Granted, this can be difficult if diagnosis is the ticket needed for intervention to commence but you can explore with them changes that they have noticed about themselves recently instead of rebranding their confessions to fit the pathological or leaving them with a neon sign over their head that spells deficit.

You let them try before they buy. Give them an experiential understanding of what it feels like to be heard before expecting them to get on board with talk about treatment.

> "Take a genuine interest in them as a person before you look at them with your client glasses on."

Effectively engaging advanced seniors in psychotherapeutic encounters is like being an undercover agent because overt engagement might scare them away. You might be upfront about things like your role and your concerns but timing, delivery and wording is critical. You can speak about your role as someone to talk to or a counsellor instead of a mental health clinician or psychologist.

The Life Story Interview can be helpful especially for this initial phase of engagement. It is a biographical enquiry similar to Reminisce Therapy, which is explored in my book *Counselling and Psychotherapy with Older People in Care: A Support Guide*. Also in my book are these five guiding principles:

1. Dignity: how can you build them up? But not in a patronising or unauthentic way.
2. Choice: how can you help them feel like they are in control of the process?
3. Value: what is it about their conversation that speaks of important values?
4. Trust: what opportunities are there to reaffirm their trust in you?
5. Permission to talk: how can you comfortably invite them into conversation?

Added to this is the Flexicare Model, which is an integrated treatment approach I developed. It stresses the importance of combining informal or implicit engagement with formal or focused engagement that draws on evidence-based modalities which can be adapted to suit complex physical and neurological or aged-related presentations.

The Flexicare Model is also strongly informed by a mental health social worker perspective, which is an emerging field well positioned to benefit an ageing population.

There are growing numbers of mental health social workers whose skill sets straddle the psychological and sociological interested in working with older adults. Not only can they successfully treat a range of psychological issues, but they consider problems holistically and actively address vulnerabilities or systemic inequities.

Accredited mental health social workers are eligible to offer a Medicare rebated psychological service to older adults, alongside registered psychologists and other providers, under the Better Access initiative.

By understanding generational nuances and adapting skill sets, mental health clinicians will be ready to successfully treat older adults in the exciting, complex and progressive aged care space. ■

Felicity Chapman is an accredited mental health social worker and a sessional lecturer at the University of Adelaide.