STRENGTHS PERSPECTIVE

IN SOCIAL WORK PRACTICE WITH OLDER ADULTS

by

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Abstract

The purpose of the Master of Social Work Practicum II that took place with the Elderly Services Team of the Regional Mental Health and Addiction Services of the Northern Health Authority in Prince George was to learn about and be part of the Team's work; specifically, to participate in assessments, to co-facilitate and participate in the Older Women's Support Group, as well as to provide assistance with the Older Women's Support Group New Members Curriculum Research Project. Further, the practicum included a pilot study about the effectiveness of individual therapy based on the strengths perspective and cognitive therapy in social work practice with older adults. Nine older adults were provided with six individual therapy sessions to address issues such as depression, anxiety, adjustment problems, grief, and loss. Effectiveness of the therapy was measured by analyzing statistical significance of the difference between participants' pre-test and post-test mean scores on the Geriatric Depression Scale and Life Satisfaction Index. T test analysis revealed that there was no statistically significant improvement in participants' depression and life satisfaction. However, follow up interviews with research participants indicated that participants had a positive experience with individual therapy, and that they would recommend therapy to other older adults.

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Introduction

The population of older adults (65 years old and older) in British Columbia is growing more rapidly than other sections of the population in the province (British Columbia Ministry of Health Services, 2002), resulting in an increased need for a progressive mental health policy and services for the elderly. Lack of attention to mental health needs of the elderly, relative to younger adults and children, is reflected in the dearth of education, literature, and services in this area (Rogers, 1999).

Often, we do not have a true opportunity to see what 'normal' aging can be like. This is because the social climate has been inordinately stressful in regard to inadequately developed social and health services networks for the older people, housing dilemmas, financial strain, transportation difficulties, and associated problems. The outcome has been a combination of increased stress for elderly people, and emphasis on mental illness in the literature about older people's problems and treatment options which obstructs their opportunities for further growth and development as a part of normal aging. Thus, in an effort to balance this deficit, older persons' strengths and potentials, rather than their mental health problems, have been emphasized in this practicum that took place with the Elderly Services Team of the Regional Mental Health and Addiction Services of Northern Health in Prince George, from April 1 to July 20, 2004.

The purpose of this practicum was to learn about and participate in the Team's work, including participation in the assessments, learning about standard psychometric tools, co-facilitation and regular participation in the Older Women's Support Group, and assistance in the Older Women's Support Group New Members Curriculum Research Project. One of the goals of the practicum was to undertake a research component

examining whether or not individual therapy is effective in the treatment of older adults and elderly who experience problems such as depression, anxiety, grief, and loss, and adjustment problems. In the research aspect of the practicum, nine older adults/elders were each provided with six individual therapy sessions. The applied therapy approach undertaken was based on a cognitive therapy model, which hypothesizes that people's emotions and behaviors are influenced by their perception of events (Beck, 1995); and a strengths perspective, in which clients' positive attributes and abilities are emphasized (Saleebey, 1992). The Life Satisfaction Index (Corcoran & Fischer, 2000) and Geriatric Depression Scale (short version) (Schneider, Tariot & Olin, 2001) were used as pre-test and post-test measures of the effectiveness of the applied therapy method.

There is a significant gap in the literature about psychotherapy with older people. Thus, the research component of the practicum has implications for the development of future programs and policies in elderly mental health, which may add to existing mental health services for older people who reside in northern British Columbia.

Chapter One

Literature Review

The literature review briefly examines a broad range of literature regarding aging and mental health, as well as psychotherapy options available to elders.

Aging and Mental Health Problems

The idea of old age has many negative connotations (Hess & Blanchard-Fields, 1999). Chronologically, old people do not feel or admit to themselves that they are old, in part because oldness has a pejorative connotation (Montigny, 1997). Another conception of old age is that it should be a good time, that people should experience 'a good old age' (Rubinstein, Kilbride, & Nagy, 1992), which may put significant pressure on older persons or result in feelings that they are not achieving societal expectations.

Although the elderly generally define their life events as being less stress producing than do younger adults (Wasylensky et al. 1990), the later years bring many changes, stresses, and challenges which can threaten an individual's self-esteem, and personal coping skills. Health related events are among the most common and most stressful events experienced by older persons and, when they occur, they have more depressive effects than other types of events or stresses (Gatz, 1995). Network losses involving friends and kin are the most keenly felt by women, while the loss of a spouse has a depressive effect on men and women alike (Gatz, 1995). Loss of employment through retirement, loss of companionship, loss of social life through ill health of self or others, widowhood, and loss of familiar surroundings through relocation are all potential stressors for the elderly (Richardson, 1999). Role strains are ongoing problems that may

arise within the context of institutionalized social roles, especially those involving family relationships. Other strains commonly found in late life are financial hardship, and lack of formal and informal support, including barriers to access health services. Faced with increased stress from different sources, older individuals experience a diminished sense of mastery over their internal and/or external environment. With diminished mastery, older persons experience increased feelings of helplessness (Solomon & Zinke, 1991). Contributing to helplessness is the social stereotype of the elderly. Health care providers and elders' caregivers frequently create and reinforce learned helplessness in them (Saul & Saul, 1990).

The phrase "Elderly people with mental health problems" is used to describe people 65 years of age and older who have emotional, behavioral or cognitive problems which interfere with their ability to function independently, which seriously affect their feelings of well-being, or which adversely affect their relationships with others (British Columbia Ministry of Health Services, 2002). People under the age of 65 who have conditions more commonly seen in elderly people, such as dementia, are included in this group (British Columbia Ministry of Health Services, 2002). Several factors place older individuals at risk for development of mental illness, particularly depressive syndromes: demographic variables such as female gender, being 70 years old or older, loss of financial resources, and loss of social support network (Rogers, 1999). Other factors include chronic and acute stressors resulting from multiple losses and lack of social support (Rogers, 1999). A particularly salient issue facing seniors, especially older, more frail seniors, is maintaining optimal physical health, which may assist in preventing mental health problems. Researchers have found that a diagnosis of mental illness is often

accompanied by one or more physical aliments (Rogers, 1999). Particularly, depression frequently accompanies episodes of serious physical illness and/or injury (Beaver & Miller, 1992).

Onset of mental health disorders may occur in early adult life and follow a clinical course into older age, or onset may occur during the older age (Gatz, 1995). Beaver and Miller (1992) discuss four common anxiety disorders seen in the elderly: phobic disorders, anxiety disorder, adjustment disorders, and somatic presentation of anxiety (somatic complains/symptoms such as tremor, tic, dizziness, blurred vision, neck or back pain, are present without any known physical or physiological cause of the symptoms). In general, mental health disorders in elderly people are more prevalent in women than in men, but the relationship between gender and mental illness is not completely clear (Gatz, 1995). There is evidence, however, of a great increase in risk of depression among older men (Gatz, 1995). The prevalence of mental health problems affecting elderly in British Columbia is between 17 and 30 per cent, depending on the health region and the number of available services (British Columbia Ministry of Health Services, 2002).

Alcoholism has only recently been recognized as a serious problem among elderly. Older people who misuse alcohol are much less visible than their younger counterparts because many of them do not work, do not drive, and live alone (Beaver & Miller, 1992). Alcohol use by elderly also involves a unique set of characteristics when compared to other populations. For example, the elderly have less tolerance for alcohol (Giordano & Beckham, 1985). Alcoholism Type I represents about two thirds of the elderly alcoholics who have misused alcohol through their life, and who have continued to misuse it in the old age, while the Type II alcoholism (also labeled as reactive or

geriatric) occurs later in life, is associated with later life stresses, and is found in a smaller subgroup of the elderly (Giordano & Beckham, 1985). Alcohol abuse and medication misuse are frequently viewed as 'hidden' problems among older adults. Medication misuse is often considered unintentional recognizing that older adults may have numerous prescriptions, adverse drug reactions, an inability to understand instructions, or may fail to take medications, or to fill prescriptions (Schonfeld, Rohrer, Zima, & Spiegel, 1993).

Bereavement in older adults is an important area for consideration, given the high prevalence of bereavement experienced by this population (Lichtenberg, 1999). It is critical to make a distinction between depression and grief both in terms of definition and treatment when addressing complicated bereavement (Lichtenberg, 1999). Unfortunately, the limited research on this topic and lack of continuity in definitions of bereavement make the process of assessing and treating bereavement in older adults a daunting one. Similarly, post-traumatic stress disorder (PTSD) has scarcely been researched in the elderly, although it is a common disorder that often follows a chronic course of illness, and impairs functionality and mental health of older individuals (Van Zelst, De Beuers, Beekman, Deeg, & Dyck, 2003). According to Van Zelst et al., PTSD may have several courses in older people. It may be a chronic disorder with symptoms emerging after trauma earlier in life or it can have an intermittent course with symptoms that return after a new triggering trauma in late life. It can start in late life after a recent index trauma (severe trauma with significant effects for personal functioning), or the symptoms of PTSD can emerge in late life for the first time, after an index trauma that happened earlier

in life, interacting with long-lasting vulnerability factors in concert with exposure to more recent stressors (Van Zelst et al.).

Suicide among elderly people accounts for about 13 per cent of all suicides in British Columbia (British Columbia Ministry of Health Services, 2002). Research shows that older adults are at higher risk for suicide than any other age group, and that the most significant risk factors for suicide in older adults are: mental health problems (primarily, psychotic illnesses such as schizophrenia and delusional disorder), physical illness, and impaired social functioning (Conwell, Duberstein, & Caine, 2002). Specifically, stressful life events, and lack of social support constitute risk factors and/or buffers to suicide in late life, but the extent to which their effects may be mediated by association with other factors, including depression, is unclear (Conwell et al.). Richman (1994) criticizes the literature about suicide assessment in older adults for not paying enough attention to the context in which suicide occurs, especially the family context and social support available. Consequently, it is strongly recommended that the assessment of assets for suicidal older individuals include evaluation of resources and potential recovery factors (Richman, 1994).

Old Age Depression: Risk Factors, Assessment and Treatment

Depression is one of the most common mental health disorders among elderly persons in Canada (Canadian Association on Gerontology, 2002). Estimates suggest that over 10 per cent of the elderly may suffer from a clinical depression, and this incidence appears to be much higher in residential care facilities in North America (Mithani & Misri, 1999). Both cross-sectional and longitudinal data have shown an age-related

increase in the number of depressive symptoms reported by the rural elderly (Wallace & O'Hara, 1992). Elderly patients with depression often present nonspecifically with a behavior dysfunction, most commonly agitation and aggression. In addition, cognitive impairment, especially disturbance of memory and attention, sometimes leads to an inappropriate diagnosis of dementia and Alzheimer's disease in people who are actually depressed (Mithani & Misri, 1999).

Research about risk factors for depression in older adults suggests psychosocial origins of the disorder, or that risk factors are the stresses that interact with some biological diathesis to produce the disorder (Gattuso, 2001). When discussing depression in the elderly, one of the major risk factors is the role of medical problems. With aging, there is a rapid increase in the prevalence of certain medical disorders such as cancer, heart disease, Parkinson's disease, and arthritis (Krishnan, 2002). Depression occurs frequently among patients with chronic illnesses and tends to be persistent. For example, depression is common among diabetic patients (Charlson & Peterson, 2002). Also, depression has been reported to lead to increased cardiac mortality for older people without cardiac disease at baseline (Charlson & Peterson, 2002). Another area of concern that has received considerable attention is the notion of vascular risk factors. The concepts of vascular depression (Krishnan, 2002) and post-stroke depression are not new, but the nature of the mechanism linking stroke and depression has been debated in the literature for several decades (Whyte & Mulsant, 2002). Researchers have split into two groups with opposing views; some propose a primary biological mechanism, according to which ischemic insults directly affect neural circuits involved in mood regulations, while others propose a psychosocial mechanism according to which the social and psychosocial

stressors associated with stroke are considered the primary cause of depression (Whyte & Mulsant, 2002).

Many specific psychosocial risk factors for depression fall under the general category of life stressors, which are defined as life events or disruptive experiences that necessitate changes and readjustment (Bruce, 2002). Across numerous studies, the death of one's spouse or other loved one is consistently and strongly associated with subsequent depression (Segal, Bogaards, Becker, & Chatman, 1999). The impact of the loss may be bigger if the loss occurs in conjunction with other stressors associated with late life stage including financial strain, adjustment to retirement, loneliness, or physical illness (Segal et al.). Disability can interact with other risk factors for depression, such as declining health or social isolation (Bruce, 2002). Consequently, understanding of the chain of events leading to depression is very important in its assessment and treatment in the elderly.

In studies about the risk of late life depression, lack of social contacts is associated with increased risk of depression in some, but not in all studies. Dean, Kolody, and Wood (1990) reported that support from a spouse, from friends, and from adult children rank in descending order of magnitude in terms of positive effect on depression. Further, it has been found that a low level of support from available children increases the risk of depression, but being childless, does not (Dean et al.). These findings suggest that depressive effects of low support from an available social network are distinct from the effects of unavailable social resources. This may be partly a function of expectations of support. Hays, Saunders, Flint, Kaplan, and Blazer (1997) explain that depression may subvert the perception of social support, and that this sense of inadequacy of social

support may increase vulnerability to functional dependence among depressed persons, regardless of the social support and resources available. It has been found that depressive symptoms and a lack of social support have increased the risk of functional impairment among community-dwelling elders in the North Carolina (Hays et al.). Social isolation may mediate the impact of medical illness and dependency on depression, while coping skills may moderate or influence the strengths of the relationship between spousal loss and depression (Reynolds & Charney, 2002).

According to Devanand (2002), data from community-based epidemiologic studies consistently show that in elderly depressed participants, the prevalence of alcohol use is three to four times greater than in elderly non-depressed participants. Depression can predispose older adults to alcohol use, and alcohol use can predispose them to depression. A family history of alcoholism is significantly less common in late onset compared to early onset alcoholics (Devanand, 2002). The literature suggests that the presence of anxiety increases the likelihood of developing a depressive disorder in late life, and that it may worsen the prognosis. Anti-anxiety medications are commonly prescribed in the elderly, particularly benzodiazepines. These medications, which have addictive potential, can worsen cognitive abilities (Devanand, 2002) and can foster other adverse outcomes such as sedation, falls, and other accidents (Unutzer, 2002). Depression itself can also affect the manifestation of symptoms of, and traits that lead to, a personality disorder (Devanand, 2002). This particularly applies to the older people who have chronic depression dating back to childhood or adolescence (Devanand, 2002). In this regard, it remains unclear if personality disorder induces or triggers depression, or whether depression predisposes to the development of personality disorder (Devanand,

2002). According to Reynolds and Charney (2002), the most common co-morbid psychiatric disorders in late life depression include alcohol abuse, anxiety disorders, and personality disorders (especially avoidant and dependent types).

Studies suggest that many depressed older adults are not recognized or diagnosed in primary health care. A number of reasons for this problem have been proposed, including differences in the presentation of depression between younger and older adults; limited knowledge and training of primary care physicians to diagnose and treat depression; and attitudes that reduce the likelihood of recognition (Huffstetler, 2001). Because of its slow development and because most older depressed people exhibit physical signs of depression rather than overt sadness, the illness often goes undetected (Huffstetler, 2001). Older adults and their physicians often attribute old age depression to 'normal aging', grief, physical illness, or dementia, and assume that under such circumstances, treatment for depression will not help (Unutzer, 2002). Other barriers to recognizing and diagnosing depression in older adults include a complex differential diagnosis that includes grief and bereavement, as well as medical conditions that can cause or worsen depressive symptoms or 'compete' for the primary physician's attention during a time-limited office visit (Unutzer, 2002). Physical symptoms and medical disorders can mimic or mask depression, and can lead to misattribution of depressive symptoms to medical causes. This is particularly the case for symptoms of loss of interest, low energy, changes in appetite and sleep, weight loss, or difficulty with concentration (Alexopoulos, et al., 2002). Some symptoms of depression overlap with behavioral manifestation of dementia, including apathy and loss of initiative (Alexopoulos et al. 2002). At the physician's level, inadequate awareness and skills

contribute to under-recognition of depression, while, at the system level, lack of access to mental health services and lack of mental health professionals, are barriers to adequate diagnosis and treatment (Alexopoulos et al. 2002).

According to Unutzer (2002), successful treatment of depression requires engagement of the client and, sometimes, family members as active partners in treatment. The efficacy of psychotherapy for the treatment of late life depression has been a topic of lively debate. According to Gattuso (2001), medical treatment of older adults with depression can be very successful, but there is an accompanying need for psychological support and the learning of new social and life skills. In 1991, the National Institute of Health ranked psychotherapy as a third in a line of treatment options for old age depression, with antidepressant medication first, and electroconvulsive therapy second (Arean & Cook, 2002). In many studies, the focus has been on evaluating cognitive-behavioral therapy and interpersonal psychotherapy and, to a lesser degree, brief dynamic therapy, and concurrent anti-depressant medication and psychotherapy. Studies suggest that life review therapies, including reminiscence therapy, may be useful in reducing depressive symptoms among community dwelling and residential cognitively impaired older adults with milder levels of depressive symptoms (Arean & Cook, 2002). Preliminary research data suggest that, for certain populations of older adults, combined antidepressant medication and psychotherapy is better than mono-therapies in the treatment of late life depression (Huffstetler, 2001; Arean & Cook, 2002).

In cross-sectional survey data collection from 1999 to 2001, as part of a depression treatment effectiveness trial, most participants from 1801 clinic users indicated a preference for counseling or psychotherapy over antidepressant medications,

but only eight percent had received such treatment, and only one percent reported receiving four or more sessions in counseling (Unutzer et al. 2003). Harman et al. (2001) reported low rates of use of psychotherapy for many mental health disorders among elderly patients, including depression.

Blazer (2002) explains that depression in late life is strongly associated with sadness and loneliness, which is the response to a discrepancy between, desired and achieved levels of social contact. Further, Blazer (2002) talks about the importance of maintaining self-efficacy or control over one's life and changing view of life, which preserves a sense of control in the face of limits that may accompany the aging process. Consequently, he recommends social skills training, such as through interpersonal and cognitive-behavioral psychotherapy, and development of positive relationships with others as important elements in the treatment of depression (Blazer, 2002).

Even when primary care physicians recognize and treat depression, only about one third of the older patients diagnosed receive antidepressants (Huffstetler, 2001). Consequently, under-treatment of depression in older adults remains the issue that should be addressed in future research and policies in elderly mental health. Some authors talk about effectiveness of support groups (Blazer, 2002), educating families of older people about management of depression, and advocating for more training of professionals who work with older people through continuing education, conferences, and workshops (Huffstetler, 2001). There is little published information on the effectiveness of health promotion interventions for older people. Instead, most researchers emphasize assessment characteristics, treatment, and management of depression in older adults. Gattuso (2001) explains that psycho-education approaches have been successful in preventing

progression from mild to moderate depression, or moderate depression to major depression.

Psychotherapy with Older Adults and Elders

Individual psychotherapy interventions.

A growing literature has documented the effectiveness of psychotherapy with older adults. In general, older adults respond as well to psychotherapy as younger individuals (Haley, 1999). However, a recurring concern in the literature has been that older adults rarely present to mental health settings. Rather, older adults present their psychological problems predominantly in medical settings (Haley, 1999).

Traditional belief in psychodynamic therapies has been that old age is essentially a regression to increased dependency (Sperry, 1992). The neglect of older people by psychotherapists has been attributed to Freud's dismissal of the capacity of older people to change, imbedded in his view of the increasing cognitive rigidity of older persons coupled with concerns regarding the sheer volume of life experiences to be covered (Woods, 2003). Consequently, older people have not been considered "candidates for real psychotherapy" (Sperry, 1992, p.155), since it has been assumed that they were too rigid and set in their ways, and that, because of the cognitive decline, they were no longer capable of insight and change. Several psychotherapy systems are based on models of personality that focus on childhood development, which extends to early adulthood with little or no articulation to middle and later adult years. In contrast, the Adlerian psychotherapeutic approach looks at aging as a developmental process, and 'teaches' the older adult client to think and act 'non-pathologically' (Sperry, 1992). Similarly, for

Erikson and other developmental theorists, understanding the nature of development, changes and transitions that happen in the final life stage, called integrity versus despair (when the person weighs positive and negative aspects of one's life) is the primary goal in therapy with older individuals (Gutheil, 1994). Viewing aging as a developmental process, wherein maturing is a life-long task, challenges the psychotherapist to assess the strengths and life experiences that older people bring to the therapy (Sperry, 1992).

The biological and social realities of the lives of people in advanced years may be very different from their younger days. Health problems may affect multiple physical systems and may be chronic, mobility problems may exacerbate isolation, financial constrains may further curtail activity (Garner, 2003). These realities need to be acknowledged in the therapy with older people. According to Garner (2003), older clients may require some adaptation of the therapy and of the therapy setting. Ideas of therapeutic change may need to be refocused and different goals set (Garner, 2003). Further, in this area, the client will inevitably be older, possibly much older, than the therapist (Garner, 2003). Many authors and researchers have discussed the countertransference (projections of the therapist's past relationships and reactions to the relationship with a client) and transference (the client's attitudes and reactions transferred from some past relationship into the present one). Genevay & Katz (1990) explain that acknowledging countertransference feelings can help us come to a deeper understanding and appreciation for each person's experiences. When we can face our own intense emotional reactions and their meanings without feeling too threatened, we can engage in a respectful therapeutic relationship that enables us to grow as persons and professionals (Genevay & Katz, 1990). Knight (1999) has developed a trans-theoretical framework

about elements that are needed in psychotherapy interventions with older adults; specifically, contextual influences including the therapist's general familiarity with the distinctive social milieu of older adults; cohort-based effects, which refer to the ability to separate the effects of maturation from the effects of cohort membership; maturity which includes memory changes, personality changes, and improvement in crystallized intelligence; and specific challenges such as therapy adaptation because of the nature of the problems that older adults bring to therapy. On the other hand, Laidlaw (2001) argues that there is no empirical evidence or therapeutic necessity to adapt cognitive therapy in order to make it suitable and accessible for older adults without cognitive impairment. The structural elements of standard cognitive therapy - the use of agenda setting and the centrality of the concept of collaborative empiricism, are equally important in their application with younger, and with older adults (Laidlaw, 2001).

Cognitive-behavioral therapy has been shown to be a valuable therapeutic technique in treating patients with late-life depression, obsessive-compulsive disorder, agoraphobia, and generalized anxiety (Kennedy & Tanenbaum, 2000). Older adults suffering from these illnesses might have isolated themselves for years, often proving resistant to treatment, especially if supportive services from visiting nurse or "Meals on Wheels" are in place (Kennedy & Tanenbaum, 2000). However, it is important to be aware that frail persons of advanced age may have realistic fears of being out of their homes alone (Kennedy & Tanenbaum, 2000). In the treatment of late-life depression, cognitive behavioral therapy seeks to alleviate dysphoria by 'attacking' what Beck referred to as a cognitive triad of negativism: negativism toward self, environment, and the future (Kennedy & Tanenbaum, 2000). In the comparison study of individual

cognitive psychotherapy and bibliotherapy (therapy in which therapist recommends books and other literature to the client for reading and discussing in the therapy sessions) for depressed older adults, both treatments have been found superior to a delayed-treatment control (Floyd, Scogin, McKendree-Smith, Floyd, & Rokke, 2004). Individual psychotherapy was superior to bibliotherapy at post-treatment on self-reported depression, but there were no differences on clinician-rated depression (Floyd et al.). Another comparison study, about the effectiveness of individual cognitive behavioral psychotherapy with younger and older adults, has not shown significant differences in therapy outcomes apart from home adjustment measures where older adults have shown greater improvement (Walker & Clarke, 2001). Also, younger adults have shown significantly higher rates of therapy non-attendance and had higher dropout rates (Walker & Clarke, 2001). Landerville & Gervais (1997) recommend behavioral therapy for depression in older adults with physical disabilities. They explain that, because some activities could no longer be performed due to the loss of physical ability, pleasant activities that the client could still accomplish, such as hobbies and social interactions, should be identified, encouraged, and positively reinforced (Landerville & Gervais, 1997).

Bibliotherapy, reading a self-help book for the treatment of psychological problems, has shown effectiveness as a 'stand-alone' treatment for depression in older adults (Floyd, 2003). However, therapists should be cautious in the application of this therapy because there is the potential to offend clients. They may perceive that the therapist does not want to work with them directly or they may lack adequate reading skills (Floyd, 2003). Guided autobiography, the educational-counselling program, based

on the idea of life review, a process of evaluating one's life (goals, accomplishments, failures, and regrets), has been successfully applied in work with older adults (Malde, 1998). In this program, older adults are given lectures about the definition of autobiography, types and purposes of autobiography, writing principles, personality development, maturity, and personal values. Unfortunately, there is no literature explaining how this program could be adapted to meet the needs of older adults who have different writing skills, different interests in writing, and different abilities for expressing themselves in writing. Haight, Michel, and Hendrix (2002) suggest that the life review process through telling their life story can help older people adjust to change and resolve crisis, which can lead to wisdom, peace, and integrity. Similar to the life review process, reminiscence therapy, an interpersonal or communicative psychological approach, has proven to be a valuable intervention for institutionalized, rural-dwelling elders, who often resist traditional mental health treatments (Davis Jones & Beck-Little, 2002). According to Davis Jones and Beck-Little (2002), reminiscence therapy is effective in preventing and reducing depression, increasing life satisfaction, improving self-esteem, and helping older adults deal with crises, losses, and life transitions.

Narrative therapy is an approach that focuses on clients' stories with the goal of challenging existing meaning systems and creating more functional ones (Osis & Stout, 2001). The interventions used are commonly referred to as two processes: deconstruction (the process of challenging or 'questioning' taken-for-granted realities and practices), and reconstruction or re-authoring (the process of co-authoring with clients' new stories about themselves) (Osis & Stout, 2001). According to Osis & Stout (2001), if "we are biographical beings as much as we are biological ones", and if "we not only have stories,

but are stories" (p.284), then it would follow that narrative therapy practices and theories would be appropriate to address the various issues and concerns of older adults. Unfortunately, there has been only limited application of narrative therapy in work with older individuals (Osis & Stout, 2001).

Narrative gerontology is described as an emerging sub-field within the multidisciplinary field of gerontology (Osis & Stout, 2001). A basic assumption of narrative gerontology is that storytelling and story listening are not just things we do occasionally; rather they constitute the process by which we create and discover our personal identities (Kenyon, 2003). The focus of guided autobiography, one of the interventions in narrative gerontology, is on getting the story 'out', rather than on analyzing or interpreting that story (Kenyon, 2002). According to Kenyon (2003), there are many examples of older people who have radically restored their lives by telling their life stories in an accepting story listening environment.

In recent years, interpersonal psychotherapy, which emphasizes the interplay of the individual and the social environment, and which views interpersonal relationships as important in the origin and development of psychiatric disorders, has been used as a psychotherapy approach for depressed elderly (Hinrichsen, 1999). Interpersonal psychotherapy is especially well suited and recommended for elderly persons diagnosed with major depressive disorder, adjustment disorder, and for those dealing with life changes that many people experience in their later years (Hinrichsen, 1999).

However, it is important to acknowledge that verbal therapy may be a difficult modality for elders. The discussion of feelings and problems may be taboo for them; they may not be verbal, or they may have speech difficulties. Weiss (1984) describes

scribble drawing, group mural, journaling, creative writing, self-portrait, use of music and movement, as techniques used in creative arts therapy with elders. Unfortunately, there appears to be no literature that discusses the effectiveness of this therapy.

Group and family psychotherapy interventions.

The majority of the literature on group work with older persons supports the effectiveness of group approaches with this population. Group therapy has been particularly successful in the treatment of depressed elderly (Solomon & Zinke, 1991), isolated elderly (Ryan & Doubleday, 1995), and elderly women who need support in dealing with grief and loss (Greenberg, Motenko, Roesch & Embleton, 1999). Garrow and Walker (2001) explain that group therapy is effective with older persons because it provides opportunities for restoring and maintaining social interactions; opportunities for friendship for older persons who may suffer from isolation; support for sharing common losses, concerns, and experiences; and a sense of community and belonging, which helps to develop new ways of coping, and discovering the importance of one's uniqueness. Saiger (2001) explains that modifications of interpersonal and psychodynamic techniques are required for work with older adults in order to develop and maintain group cohesion. These modifications include the use of cognitive re-framing, general supportive measures, and accommodations for problems in mobility, hearing, and other disabilities. Further, development of trust and more leader involvement should be more emphasized in group therapy with the elderly (Griffin & Waller, 1985).

According to Leung and Orrell (1993), a brief cognitive behavioral therapy group for depressed elderly patients has been found superior to the other methods of group

psychotherapy. The goals of such therapy are to bring to the awareness of participants their irrational beliefs and interpretations, to encourage development of new coping strategies, and to enable them to gain a more balanced view of their situation. Another study, which investigated the effects of a gestalt therapy group on older adults, has shown that group therapy participants reported less anger control and more overall expression of anger than the control group participants (O'Leary, Sheedy, O'Sullivan & Thoresen, 2003). The ability to express emotions is viewed within gestalt therapy as an important component of healthy living (O'Leary et al.). Garrow and Walker (2001) recommend existential group therapy for death anxiety, which can include many metaphorical meanings such as the end of good health or productive career, loss of dignity, and feelings of abandonment. The goal is to help clients realize that they have the freedom to create their lives and the freedom to change. They explain that the group leader's task is to encourage participants to accept anxiety as growth producing, and to help them find the courage to face and to fully experience their anxieties (Garrow & Walker, 2001).

One of the major categories of group therapy applied in work with elderly is supportive therapy, which focuses on adjustment to late-life stresses as its central task (Cummings, 2003). Supportive therapy emphasizes group therapy members' strengths, gives them opportunity to reconnect with 'forgotten' abilities, and to develop new skills (Cummings, 2003). Unfortunately, there is little information available concerning the effectiveness of such group interventions. Study results suggest that supportive, re-motivational group therapy can beneficially affect elders' psychological well being, (measured by Life Satisfaction Index and Geriatric Depression Scale), as well as enhance their social support network system (Cummings, 2003). In the explanation of the

advantages of support groups for older women, Greenberg et al. (1999) argue that older individuals can experience group work as potentially less threatening than individual treatment, and that the group can provide the elders with the comfort that comes from dealing with the universality of the issues of old age. Sharing their family struggles, health challenges, and friendship histories with one another, gives older people validation, support, information, and sense of belonging. Greenberg et al. (1999) emphasize that creative group work with active leadership participation is an effective, but underutilized, practice method with the elderly population, and that practitioners should validate older women's needs and desires for continued social activity by placing a high priority on this growth enhancing sphere of their lives. On the other hand, Scrutton (1989) criticizes groups for older adults for their limited scope; specifically that older people are expected to play a minimal role in running the group, and in choosing group activities. Insufficient attention is paid to concepts of choice, self-expression, and self-help, which suggests an element of ageism – a view that older people themselves are not capable of organizing and deciding appropriate agendas (Scrutton, 1989).

Qualls and Zarit (2000) explain the importance of families for the etiology, course, prognosis, and treatment of mental disorders in the elderly. Similarly, Qualls (2000) argues that family relationships are often an unrecognized factor in aging families, but that support available within them is a key variable in predicting the well being of older persons. Further, Qualls (2000) suggests that family theories need to better define the later life circumstances in which family structures shift; the challenges to successful outcomes for individuals and families; and the therapeutic interventions that can assist families at various stages. Family treatment based on a social work strengths perspective

has been found successful in work with older adults who have misused alcohol (Perkins & Tice, 1999). Identifying the strengths of both the clients and their families is the goal that guides both assessment and intervention in treatment based on a strengths perspective. Consequently, once the worker/therapist and the client have established a viable working relationship, family, friends, and community networks are included to build upon existing strengths (Perkins & Tice, 1999). According to Zucker-Goldstein (1989), understanding how older people's dependency changes family relationships is often a central issue in family work with older persons. Further, understanding how the family unit has coped with crisis and conflict can help the therapist discover any behaviors that have been successful for the family (Hughston, Christopherson, & Bonjean, 1989). Some of the obstacles to engaging the family in therapy interventions with elders are myths about aging, resistance by the elders, or resistance by family members (Neidhardt & Allen, 1993). Finally, respect for family hierarchy and different cultural values, is one more element that deserves attention in the treatment of elders from ethnic minority groups (Neidhardt & Allen, 1993).

Interventions and support for caregivers.

The research shows that elder depression contributes to the prediction of spouse depression (Goodman & Shippy, 2002). Caregiver stress is defined as stress resulting from care-related stressors, the level of resources available to families, along with other contextual variables (Zarit, Gaugler, & Jarrott, 1999). According to Gallagher (1994), older women's commitment to helping others results in great psychological and physiological distress. This especially applies to women caring for an elderly person with

dementia (Goodman & Shippy, 2002). Compared to caregivers of older people in residential care facilities and institutions, community caregivers report significantly higher lack of privacy and time for themselves, negative impact of care giving on their social relationships, and the sense that their relative or family member has been dependant upon them (Dobrof, 1987). Gender has emerged as a significant correlate of psychological well being of caregivers, in that men have reported lower levels of psychological distress than women (Borden & Berlin, 1990). This finding is consistent with results from a number of cross-sectional studies of dementia caregivers, and reflects outcomes in general studies of gender and adaptational outcomes (Borden & Berlin, 1990). The authors have hypothesized that women may experience higher levels of distress because the consequences of the illness are greater in the context of the female gender role, while men may experience lower levels of distress because they approach the illness in a more active, instrumental fashion, consistent with performance in their occupational roles (Borden & Berlin, 1990). What can go unnoticed when professionals focus on helping older individuals, especially older women who are caregivers of other family members, is the lack of choice in a system that promotes kin-based care (Neysmith, 1999). Studies in which both elderly clients and their families and caregivers have received adequate amounts of help and support have shown consistent positive outcome (Zarit et al.). Similarly, Froggatt (1993) suggests that both sides in the caring relationship need supportive networks. Research about trends and approaches to coping with dependence on caregivers in late life (in which 91 elders and their caregivers participated in in-depth thematic interviews) suggests that talking to caregivers about their needs, problems, and relationships is commonly described as helpful to caregivers

(Cox & Dooley, 1996). Also, over half of the respondents/caregivers stressed the need for learning about health conditions, active involvement in care decisions, as well as the need for advocacy (Cox & Dooley, 1996). These findings illustrate the need to acknowledge mutuality in marital and family relationships; specifically, that care giving for older people, by older people, affects the mental health and psychological well being of the caregivers, who may require additional supports and therapy interventions. The needs of both older people and their family caregivers should be addressed in designing community-based support groups and other interventions.

Therapeutic relationship with older adults.

According to Richman (1994), the therapeutic relationship with older individuals, which includes a caring attitude and commitment to the client, is important for building an alliance, and for effective therapy with older adults. Building a therapeutic alliance and empathic relationship is emphasized in work with the elderly (Levine, 1996). The importance of continuity of work, as well as the therapist's availability, warmth, and encouragement, has been recognized in many therapy interventions (Richman, 1994). A client-centered, non-directive approach, non-judgmental attitudes, unconditional positive regard, empathic understanding, and genuineness, have been recommended in counseling with older individuals (Scrutton, 1989). Further, a combination of the therapist's high general qualifications and specialized training in working with older adults has been associated with above average therapy effectiveness (Pinquart & Sorensen, 2001).

Some authors talk about difficulties in developing a therapeutic and effective working relationship with older people. According to Scrutton (1989), aging people, like

anyone else, can be difficult to relate to; and "not all old people are lovable, contrary to certain public perceptions" (p. 47). This is especially true with people who have severe mental health problems such as delirium and Alzheimer's disease (Ledbetter Hancock, 1990). Stevenson (1989) explains that our reactions and assumptions about elders' experiences as being very different from our own reveal ageism and are barriers to empathy - a prerequisite in forming relationships with others. Also, the therapy relationship with older people should not be a one-way process. There cannot be an expectation that elders tell us about their most guarded thoughts and feelings, if we are not prepared to talk about our own (Scrutton, 1989). Dixon et al. (2001) argue that, in psycho-pharmacological treatment with older adults, self-disclosure may increase rapport, enhance the therapeutic alliance, and increase compliance with medication. Further, gentle physical touch of a hand can reassure and communicate caring and support to older people, and can help build a relationship with them. For example, if an older person is hospitalized or is in an unfamiliar setting with unfamiliar people, the hug or the touch of a hand may be very supportive (Deichman & Kociecki, 1989). However, touch can be depersonalizing if a health care provider is doing it without obtaining permission or explaining its purpose (Deichman & Kociecki, 1989).

Countertransference and transference are frequent experiences in geriatric social work practice where aged clients may represent grandparents and parents (Morris, 2002). Levine (1996) explains that older, pre-feminist women, may have different expectations about marital fulfillment and their roles in the society, than younger female therapists, and that these differences may emerge in the clinical context. But, the effect of countertransference does not have to be negative. It can enable the therapist to help an

elderly client negotiate personal conflicts and alleviate her/his feelings of loss, grief, and guilt (Glezakos, 1995). Failing to address countertransference, such as confronting unresolved parenting issues, positive or negative grandparent countertransference, or fear of death and illness, when it occurs, can have harmful consequences for clients and for the clinician (Knight, 1989). Genevay and Katz (1990) explain that clinicians should be aware when they are playing the role of the 'good child' in work with elderly clients and their families. Further, social workers and other professionals have to be conscious of social stereotypes about elderly, of their own biases based on personal experience, and of the possible impact of these on the therapeutic relationship with older individuals (Gutheil, 1994). In addition to having negative stereotypes about older people, practitioners working with the elderly may elicit negative feelings within themselves, such as fear of the aging process in one's parents or oneself (Schneider & Kropf, 1992). All these factors could be obstacles for building effective relationships with older individuals if they are not dealt with and resolved positively. Professional training, literature, and clinical supervision must place more emphasis on the importance of helping professionals being able to identify, understand, and make effective use of countertransference issues in their work with older individuals (Genevay & Katz, 1990).

Chapter Two

Practicum Placement

Having presented a literature review that highlights aging, mental health issues, psychotherapy options available to elders, the importance of building effective therapeutic relationships with elders, and therapy interventions and support for caregivers, the next section of the report will describe the practicum placement, practicum activities, and learning goals and objectives.

Practicum Placement Description

The Elderly Services Team, located in the Northern Health Authority's Regional Mental Health & Addiction Service, is a multi-disciplinary team (including physicians, nurses, and social workers) that provides assessment and treatment to people with mental health problems who are 65 years old and older, or those of any age who experience a dementing process such that their behaviors or needs exceed the abilities of their primary caregivers. Assessment and treatment are provided in people's homes, in facilities, and in Prince George Regional Hospital. Elderly Services Programs include Assessment and Consultation, Seniors Substance Abuse Program, Life Skills Program, Specialized Residential Services, Adult Protection Services, Men's Group, and an Older Women's Support Group. Using a multidisciplinary approach, the Elderly Services Team provides assessments and treatment recommendations, and follow-up to clients, their families and primary physicians. Specialized counseling in an outreach model, using harm-reduction methods, is provided to seniors with a substance abuse problem. The Life Skills Program includes individual and group services with the goal to maintain independence and

prevent hospitalization. Services can be delivered in the client's home or within a supportive residence. Adult Protection Services coordinates and delivers responses to reports of abuse, neglect, and self-neglect of vulnerable adults in accordance with the Adult Guardianship Act (Staff, 2003a). Some of the goals of the Elderly Services Program are: to maintain people's mental health and independent functioning; to work with a client, the family and the primary physician to provide an accurate assessment and recommendations for management; to liaise with other care providers such as Prince George Regional Hospital, Long Term Care, Adult Day Center; to ensure consistency and timely follow-up; and to use the most current, proven and effective treatments and services.

Summary of Practicum Activities and Learning Goals and Objectives

1. Learning about standard psychometric tools including Geriatric Depression Scale (Corcoran & Fischer, 2000), Brief Psychiatric Inventory (Burns, Lawlor, & Craig, 1999), MMSE (Mini Mental State Examination), 3MS (Modified Mini Mental State Examination), and The clock-drawing test (Burns et al.):

   These tools have been studied and applied in individual assessments of clients' cognitive abilities, and in depression screening. The MMSE, the most widely used measure of cognitive function, has been suggested as a useful tool in the early screening of Alzheimer's disease (Burns et al.). It could be used as a quantitative measure of cognitive impairment in an attempt to measure change, but has not been intended to be used in any diagnostic sense (Burns et al.). The 3MS (short for MMMSE or Modified Mini-Mental State Examination) was developed by

Teng and her colleagues in California. Teng added four questions to the Mini-Mental State Examination, or MMSE. She has also increased the scoring range to improve test sensitivity (Teng, 1987). According to Teng (1987), in a validation study, the 3MS has shown to perform better than the MMSE. The questions in the 3MS are typical of the assessments used by psychologists, and it has been frequently used in population surveys (Teng, 1987). The questions in the 3MS and MMSE 'measure' long-term memory, short-term memory, abstract thinking, spatial and temporal orientation, as well as ability to follow verbal and written instructions. In addition to MMSE and 3MS, the clock-drawing test has been used as a screening measure for dementia (Burns et al.). A standard assessment is that the client is asked to draw a clock face marking the hours, and then to draw the 'hands' to indicate a particular time. The test tends to be non-threatening, but there is a wide variation in the way results can be interpreted (Burns et al.). The Brief Psychiatric Inventory, which is based on both client's self-reports and clinician's observations, has been used as a screening measure for anxiety, depression, somatic concerns, and other psychiatric problems (Burns et al.). The authors of the Geriatric Depression Scale (GDS) are Brink, Yesavage, Lum, Heersema, Huang, Rose, Adey, and Leirer (Corcoran & Fischer, 2000). The main purpose for development of the GDS was to provide a screening test for depression in elderly populations that would be simple to administer and would not require special training for the interviewer. The GDS is a 30-item questionnaire designed to screen depression in the elderly using a yes/no format

(Hemingway, 1998). The GDS has been successfully used with both physically healthy and physically ill older people (Corcoran & Fischer, 2000).

2. Participation in the assessments of new clients of the Elderly Services Program, including Adult Protection clients:

   This practicum component included accompanying clinicians/case mangers from the Elderly Services Program in their visits to see new clients, performing depression screening, assessing clients' cognitive abilities, and participating in case planning discussions. Assessments were completed with community clients who live independently as well as with residents of the Legion Wing, an apartment building for 22 seniors who are not capable of complete self-care due to alcohol dependency, cognitive impairment, or mental health problems. Service providers for residents at the Legion Wing include a Licensed Practical Nurse, Life-skills Workers, a Recreation Worker, and a Social Worker, while visiting services include Home Support Workers, a Physiotherapist, and an Occupation Therapist (Serge & Glaedinger, 2003). Operations of the Legion Wing belong to the Elderly Services Program. The philosophy of the services at the Legion Wing is based on a respectful, client-centered, multi-disciplinary, harm-reduction approach, with a goal to stabilize and optimize the quality of life for the residents (Serge & Glaedinger, 2003). This approach is applied in client assessments, care planning, and everyday activities with them.

3. Training and everyday use of the electronic file system, Synapse, at the Regional Mental Health & Addiction Services:

This training, provided by Elenor Riley, Synapse Implementation Coordinator, included learning about types of information that are stored in Synapse, how to access information and keep it confidential, how to manage the client browser, enter activity notes and information on a group activity, enter the results on an assessment instrument, correct and delete an entry, view group membership list, view enrollment list by program, select/print reports, and other information. All information from client assessments, individual therapy sessions, and group sessions of the New Comers Group (which has been developed to design the contents of special sessions for new or newer members of the regular Older Women's Support Group) has been entered into Synapse.

4. Literature review of the therapeutic models suitable for the elderly written in the form of annotated bibliographies:

   Information from journal articles about individual, group, and family therapy models applied in work with older adults, and information about their effectiveness, has been reviewed and a collection of materials that can be a useful 'tool' for clinicians at the Elderly Services Program has been developed. This collection includes 30 annotated bibliographies developed from different journal articles.

5. Co-facilitation and regular participation in the Older Women's Support Group:

   The Older Women's Support Group has been developed for women who are comfortable when asked if they would like to attend an Older Women's Support Group for women with depression, anxiety, loneliness, caregiver stress, family discord, worries, and trouble getting used to a new life as a widow (Staff, 2003b).

This group takes place at the Mental Health Center, in Prince George, every Wednesday, from 1 pm to 3 pm. Potential participants should be cognitively intact, have no active personality disorder, and must have an open file at the Mental Health Center. The group uses a psycho-educational approach. Providing information and management strategies for depression and anxiety, as well as basic communication and esteem building techniques allows the women to gain confidence in self-management, increases appropriate use of health services, increases compliance with medication regimes, and allows them to build a network of support among group members (Staff, 2003b). I participated in thirteen group sessions. Some of the topics in these sessions included: challenging negative thinking habits, solving problems effectively, anxiety management techniques, self-care, anxiety and depression management, maintaining personal 'balance', and the use of humor. Also, I facilitated one group session independently. The topic of the session was friendship, and the session included information from research and journal articles about the importance of friendship for older women (Greenberg et al. 1999; Taylor et al. 2000), group discussion about the meaning of friendship, its importance, and different ways of developing friendship. In general, participation in the Older Women's Support Group was a great opportunity to introduce group dynamics, leadership strategies, and the way of learning first hand experience in which group structure and individual client needs affect group dynamics (such as the need for support during personal or family crisis). Further, it gave me the opportunity to experience and compare group and individual therapy processes, including advantages of group feedback

and group support, importance of group leaders' interventions, group leaders' feedback to the group members, sensitivity for individual client needs, and modeling of clients' behaviors.

6. Assistance in the Older Women's Support Group New Members Curriculum Research Project:

   (a) Description of the research project and pertinent activities included:

   The Older Women's Support Group New Members Curriculum Research Project was developed by Karla Staff, project coordinator in Regional Mental Health and Addiction Services, and previous leader/facilitator of Older Women Support Group. The purpose of the project was to design the contents of special sessions of the Older Women's Support Group, aimed at new or newer group members to help them feel more comfortable when joining a group, and to help them take part more fully in the therapeutic benefits possible from attending such a group. Group co-facilitation in five group sessions, and group leadership in one session, as part of this project, resulted in gaining valuable therapeutic and research experience, particularly, learning about group dynamics, its effects on the contents of group sessions, as well as learning about prioritizing and balancing individual client needs, group needs, and the need to accomplish the research project. Further, assistance in this project included contact with group participants in order to obtain free and informed consent for participation in the research, recording group session notes, analysis of group feedback records about the usefulness of the group, and of group members' recommendations for further improvement of the curriculum.

(b) Assistance in writing an introductory curriculum for the new members of Older Women's Support Group, based on the literature reviewed:

The curriculum was designed and applied in six group sessions with older women/clients at the Elderly Service, who participated in this research project. Group session contents included the following topics: group rules, group expectations, assertiveness skills, giving and receiving group feedback and criticism, privacy and secrecy, confidentiality, relaxation and anxiety management. Literature about group facilitation, group leader's interventions, and literature specifically designed to help in learning about and improving assertiveness skills, communication styles, managing anxiety, and adjusting to the new situations, were reviewed and used in development of the curriculum for new members in the Older Women's Support Group.

7. Regular participation in team meetings and staff meetings:

Regular, weekly attendance and participation in team meetings provided an opportunity to discuss shared cases with other clinicians, be introduced to a working atmosphere in an interdisciplinary team of professionals, and to learn about client situations and issues that professionals in the Elderly Services Program deal with on an everyday basis. Regular, bi-weekly attendance in long-term care meetings provided an opportunity to learn about issues faced by professionals working as long-term case assessors, and collaboration between Elderly Services Program, other programs at the Northern Health Authority, and Prince George Regional Hospital. Regular, weekly participation in the clinical meetings at the Legion Wing gave me the opportunity to learn about issues faced

by residents and professionals working in this facility including management of residents' behaviors, organization and planning recreational and other activities with residents, and development of care plans for the residents (e.g., personal care, medication management, financial matters).

Chapter Three

Practicum Research Component

As part of the practicum, pilot research was conducted regarding the effectiveness of individual therapy with older adults utilizing a social work strengths perspective and cognitive therapy. Specifically, individual therapy was evaluated to see if it could help older adults improve their life satisfaction, measured by the Life Satisfaction Index (Corcoran & Fischer, 2000), and decrease their depression, measured by the Geriatric Depression Scale (Corcoran & Fischer, 2000), through the course of six individual therapy sessions. Follow-up interviews with study participants were conducted two weeks after they finished individual therapy.

Significance of the Pilot Research

There are few studies that have evaluated the effectiveness of individual psychotherapy with older adults/elderly and, as a result, there is a serious gap in knowledge. There are still beliefs and stereotypes about the impossibility of changing older people (Neidhardt & Allen, 1993). Stigma toward mental health services and lack of understanding about the service delivery needs of older persons are major barriers to mental health services for the elderly (Rosen & Persky, 1997). On the other hand, elders who experience high levels of stress can maintain their mental health if they are provided with adequate services to help them deal with problems related to old age including grief, loss, caregiver stress, communication problems, and adjustment problems (Wasylensky et al. 1990). Elders can remain interested in sexual relations and social activities, and their life satisfaction can be as high as that of younger people (Wasylensky et al. 1990). They

do not tend to be socially isolated and depressed, or irritated and angry, if they are provided with adequate support in coping with these problems (Neidhardt & Allen, 1993). It has been found that elderly people draw satisfaction from more domains than younger people, and that social relationships and friendships are the strongest predictors of rural seniors' life satisfaction (Michalos, Hubley, Zumbo, & Hemingway, 2001). Comparing eighteen average figures for older people on satisfaction with specific domains of life (e.g., financial security, health, friendships) and life as a whole, with those of average adults in Prince George, in November 1999, it was found that in all but two cases the older people's scores were higher (Michalos et al.). Examples of active, productive, and mentally capable older individuals furnish strong evidence that the association of age with dependency due to senility or mental decay is inaccurate (Montigny, 1997). Older people have much to offer one another and the younger generations (Grand'Maison & Lefebvre, 1996).

Consequently, the goal of this pilot study has been to begin to explore the effectiveness of individual therapy in helping older people, diagnosed with depression, anxiety, alcohol misuse, grief or other adjustment disorders, to achieve a higher level of life satisfaction and to decrease their depression.

However, it should be noted that intervening variables such as a supportive family, a positive social environment and improved physical health, along with other components needed to achieve complete life satisfaction and to decrease depression, were not controlled in this research. Consequently, they may have affected research participants' responses on the Life Satisfaction Index and Geriatric Depression Scale.

Specific research questions:

1. Does individual therapy have a positive effect on elders' life satisfaction as measured by the Life Satisfaction Index - Z?
2. Does individual therapy have a positive effect on elders' depression as measured as by the Geriatric Depression Scale?

Therapy Method

A strengths approach was utilized in this study and is guided by an awareness of, and respect for, clients' positive attributes and abilities, talents and resources, desires and aspirations (Saleebey, 1992). Recognizing clients' strengths is fundamental to the value stance of the social work profession. Further, it provides for a leveling of the power social workers may have over clients, and in so doing presents increased potential for the facilitation of the partnership in the working relationship. Focusing on strengths in therapy with older people provides an opportunity for liberating clients from stigmatizing diagnostic classifications in mental health that often reinforce sickness and weaknesses of older people (Saleebey, 1992). In the strengths approach applied in this study, clients were viewed as experts of their own situation. Also, a strengths approach can afford the therapist the opportunity to enter the reality of the aged person as well as understand how she/he experiences daily life, and what successes and satisfactions she/he finds (Saleebey, 1992). According to Saleebey (1992), we forget too easily that old people with cognitive and physical changes have much strength, as well. The following practice principles explained by Norman (2000) have been used to identify and foster strengths in older persons: identifying indicators of strengths in the clients; involving the clients in

identifying their strengths; helping the clients to identify the areas they can still control; and identifying new, untapped areas of strengths. Also, applied in the therapeutic process were principles of elderly mental health care: to maintain the dignity of older persons; to treat them with respect; and to involve them in care/therapy planning (British Columbia Ministry of Health Services, 2002). Similarly, the goals of Elderly Services Programs were addressed including goals to maintain people's mental health and independent functioning; to work with the client, the family and the primary physician to provide an accurate assessment and recommendations for management; to liaise with other care providers; to provide a multi-disciplinary approach to the needs of the elderly; and to use the most current, proven and effective treatments and services possible.

Despite a growing interest in a strengths perspective, the literature and research has primarily been focused on the persistent mental health challenges facing the general population, rather than on the mental health needs and strengths of older individuals. Further, much of current mental health practice and literature is invested in diagnosing and labeling and tends to view the person as the source of their problem or the pathology named (Perkins & Tice, 1995). When the labels are attached repeatedly, the way people view themselves and how others see them, is altered. In the long run, the labels that clients carry with them shape their patterns of behavior and their relationships. This is especially true for people with mental challenges (Perkins & Tice, 1995). In contrast, the strengths perspective redirects worker's and client's attention from problems, weaknesses or deficits to individual strengths, aspirations and interests (Perkins & Tice, 1995). One of the techniques used in the application of a strengths perspective in therapy with older adults is reminiscence, or reviewing clients' personal histories with them, which helps

clients to see the strengths and skills that they have used to resolve a lifetime of difficult situations (Perkins & Tice, 1995).

Cognitive therapy, which, similar to a strengths approach, teaches clients to be their own 'therapists' (Beck, 1995), was also utilized in the individual therapy with study participants. Cognitive therapy has been found to be the most effective in work with depressed older persons (Williams, 1984; Beck, 1995) and in individual therapy with older people (Pinquart & Sorensen, 2001). As recommended by Wright, Thase, Beck, & Ludgate (1993), cognitive therapy has been adjusted to older persons. Specifically, the therapy framework has been adapted to elders' capabilities. For example, short and more frequent sessions were offered; a variety of techniques and resources were used; and a flexible treatment approach was adopted. Some of the techniques applied included finding negative thoughts (recording thoughts that can help clients to monitor their own self-talk), reality 'testing' (learning that many reactions are based on personal interpretations rather than facts), and cognitive rehearsal (identifying thoughts and feelings associated with doing activities by imagining doing them in every detail during a therapy session) (Williams, 1984). Further, the therapist/researcher strives to establish a warm rather than neutral relationship with the clients, and to build a therapeutic alliance and empathic relationship, as emphasized and recommended for work with older persons by many authors (e.g., Sinclair, Crosbie, O'Connor, Stanforth, & Vickery, 1988; Levine, 1996).

Sample

Nine older adults, who access services through the Northern Health Authority in Prince George, participated in the research about the effectiveness of individual therapy in social work practice with the elderly. Participants were recruited from the Older Women's Support Group, Substance Misuse Program, and Adult Protection Program. The sample included eight women and one man with the age range from 62 to 84 years. Three participants had mental health diagnoses obtained through psychogeriatric assessment by the physician of the Elderly Services Program. One participant had a mental health diagnosis/clinical impression obtained through psychogeriatric assessment by the participant's clinician/case manager. The mental health diagnoses of these four participants included: major depressive disorder, major depression with prominent anxiety, adjustment disorder with depressed mood, bereavement, alcohol abuse, alcohol dependence, vascular dementia (uncomplicated), and bi-polar disorder, as explained in the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 2000). Five participants had no formal mental health diagnosis as they had not received a psychogeriatric assessment by the Elderly Services Program physician. These participants reported depression or anxiety as their major problem and reason for attending counseling. Four of these participants were also related taking medications prescribed by their family physician or other physicians. Other characteristics of the sample are presented in Tables 1 and 2 (on the next pages).

Table 1

Sample Characteristic Frequencies

		Frequency	Percent	Cumulative percent
Sex	Female	8	88.9	88.9
	Male	1	11.1	100.0
	Total	9	100.0	
Marital status	Married	3	33.3	33.3
	Widowed	4	44.4	77.8
	Divorced	2	22.2	100.0
	Total	9	100.0	
Medication use	Do not use medication for mental health problem	1	11.1	11.1
	Use medication for mental health problem	8	88.9	100.0
	Total	9	100.0	
Attending group therapy	Do not attend group therapy	5	55.6	55.6
	Attend group therapy	4	44.4	100.0
	Total	9	100.0	
Mental health diagnosis	Self-reported mental health problem/no diagnosis	5	55.6	55.6
	Have mental health diagnosis or clinician's impression	4	44.4	100.0
	Total	9	100.0	

It should be noted that the therapist/researcher was aware that the age difference between herself, a younger adult, and study participants, older adults, could affect their therapeutic relationship. The possibility that different values and beliefs of the therapist and those of the participants could cause transference and countertransference issues were discussed during clinical supervision. Further, some generational differences, including different family values and different expectations from children and other family members, were acknowledged in therapy sessions.

Table 2

Sample Descriptive Statistics

	N	Minimum	Maximum	Mean	Std. deviation
Age	9	60	84	68.78	8.136
Number of years of education	9	2	12	10.11	3.296
Valid N	9				

Instrumentation

The Life Satisfaction Index (LSIZ) is an 18-item instrument (Appendix C) designed to measure psychological well-being of the elderly; specifically, life satisfaction (Corcoran & Fischer, 2000). It may be administered as a self-report instrument verbally, or in writing.

The Geriatric Depression Scale (GDS) used in this research is a 15-item instrument (Appendix B), a short version of the 30-item instrument (Schneider et al.

2001) commonly used self-report measure to assess depressive symptoms in the elderly (Corcoran & Fischer, 2000). The GDS is written in simple language and can be administered in oral or written format (Schneider et al.). The GDS has good internal reliability (alpha = ~ 0.9), concurrent validity (= ~ 0.7), and test/retest reliability (Schneider et al.). Also, it has excellent stability, with a one-week test-retest correlation of .85 (Corcoran & Fischer, 2000). The GDS has also distinguished between depressed and non-depressed physically ill elderly and between depressed and non-depressed elderly undergoing cognitive treatment for dementia (Corcoran & Fischer, 2000).

Sampling and Data Collection

In the pilot study about effectiveness of individual therapy in social work practice with older adults, participants were not randomly sampled or assigned and there is no control group. Participation in the study was voluntary. As a result, it was difficult to find participants for a control group who would match participants in the experimental group in all relevant variables such as age, gender, level of education, or type of mental health problem.

Another factor necessitating this type of research design is that, ethically, random sampling is not possible. All elders/older adults who were interested in participation in the study/accessing individual therapy were provided with individual treatment. It would be unethical to deny treatment to people who need it and who want to receive it. Selection of study participants was undertaken by case managers of the Elderly Services: Older Women's Support Group, Substance Misuse Program, and Adult Protection Program. As the research recruitment was taking place more slowly than expected (four participants

recruited in six weeks), a letter of invitation for participation in the research (Appendix D), and informed consent package (Appendix A), in which participants could find information about this research project, were sent to all clients of the Elderly Services Program identified by their case managers, and referred as possible research participants. This process sought to ensure that all potential participants had both the information and opportunity to join the pilot study. Cognitive screening was conducted by case mangers prior to the research recruitment process in order to insure that all participants were able to make an informed decision about their participation. All participants were informed about the research and their rights, including the right to withdraw from the pilot study at any time without affecting their access to service, as well as the right to continue therapy regardless of the research, if they chose to do so. Once completed, all participants were provided with a copy of their signed informed consent form. Only one participant withdrew from the research after the fourth therapy session, and also decided not to continue therapy. Consequently, nine participants completed the research/therapy.

To measure the effects of the individual therapy, two dependent variables were included in the research design: depression and life satisfaction. Lack of life satisfaction has been associated with many mental health problems in the older age such as depression, anxiety, and adjustment disorder (Saul & Saul, 1990). Also, elders who have a higher level of life satisfaction tend to be less depressed and to adjust better to changes and transitions commonly experienced by older people (Rogers, 1999). Depression, in particular, has been identified as one of the most common problems of older people, associated with loss, grief, substance misuse, and related problems (Wallace & O'Hara, 1992; Mithani & Misri, 1999).

Procedure

All study participants/older adults were provided with six individual therapy sessions. With most participants, these were weekly sessions, over the period of six weeks. A seven or eight week period was required in cases where the participants were unable to attend weekly sessions due to health problems, medical interventions, and family reasons. Each session was about one hour long, but the duration of the sessions was also adapted to participants' needs and capacities (Wright et al., 1993). As a result, the duration of sessions ranged from thirty to ninety minutes with most therapy sessions one hour in length. Study participants could choose to have the therapy sessions in their homes or in the Mental Health Centre at the Northern Health Authority in Prince George. Seven participants chose to attend sessions at the Mental Health Centre, while two participants wanted to be seen in their homes. For each participant, the Life Satisfaction Index and Geriatric Depression Index were administered immediately prior to the first therapy session and again at the completion of the last session. All study participants permanently reside in Prince George. All participated in the telephone follow-up interviews about their experience with the individual therapy. Interviews were each approximately five minutes long.

Quantitative Data Analysis and Discussion

Mean scores of all participants (n=9) were calculated on both dependent variables (i.e., life satisfaction and depression as measured by the Life Satisfaction Index, and Geriatric Depression Scale, respectively) at their pre-test and post-test levels. A t-test was conducted to determine if there was a statistically significant difference between the pre-

test and post-test scores on each variable. Data were analyzed using the SPSS® Student Version 11.0 for Windows®. A dependent t-test, or paired sample t-test, was used because of the single sample consisting of the same people measured at two different points in time (Weinbach & Grinnell, 2004). This research design is also known as a one group pretest-posttest (Weinbach & Grinnell, 2004).

Table 3

Sample Statistics on GDS

	Mean	N	Std. deviation	Std. error mean
GDS pre-test scores	7.33	9	4.359	1.453
GDS post-test scores	5.44	9	2.555	.852

Table 3 presents the basic measures of central tendency (mean) and dispersion (standard deviation) for the pre-test and post-test scores on Geriatric Depression Scale (maximum score is 15; higher score represents higher likelihood of depression). It shows that participants' depression, measured by GDS, decreased from 7.33 (mean score on the pre-test) to 5.44 (mean score on the post-test). A t-test for paired samples was used to determine the statistical significance of difference in mean scores between pre-test and post-test measures on the GDS (see tables).

Table 4

Sample Correlations on GDS

	N	Correlation	Sig.
GDS pre-test scores and GDS post-test scores	9	.434	.243

Table 4 shows the Pearson coefficient of correlation (.43) between the pre-test and post-test measures on the Geriatric Depression Scale. When repeated measures are used, it is possible that they will correlate because the data comes from the same people, resulting in the potential for some consistency in their responses (Weinbach & Grinnell, 2004). SPSS provides the value of Pearson's correlation and the two tailed significance value. For these data, the pre-test and post-test measures on GDS are not significantly correlated: $p>.05$.

Table 5

Differences between GDS Pre-Test Score and GDS Post-Test Score

Mean	Std. deviation	Std. error mean	95% confidence interval of the difference		Paired t-test	Degrees of freedom	Sig. (2-tailed)
			Lower	Upper			
1.89	3.983	1.328	-1.17	4.95	1.423	8	.193

Table 5 presents information on the results of the inferential statistical test - the t-test for dependant samples and shows that the t-value is 1.42, which is associated with

p- value of .193, and a standard error of 1.32. The two-tailed probability, p = .193, means that there is 19.3 % chance that the value of t could have happened by chance alone. It can be concluded that study participants' scores on GDS are not significantly lower on the post-test, in comparison to pre-test scores: t (8) = 1.42, p>.05. However, these results should be taken and interpreted with strong caution because of the very small sample size.

Data analysis shows that results on the Life Satisfaction Index are similar to participants' results on the Geriatric Depression Scale. There was some improvement in participants' life satisfaction on the post-test, but the difference is not statistically significant (maximum score is 18; higher score indicates higher life satisfaction). As it can be seen in Table 6, participants' mean scores on LSIZ increased from 7.11 on pre-test to 7.67 on the post-test.

Table 6

Sample Statistics on LSIZ

	Mean	N	Std. deviation	Std. error mean
LSIZ pre-test scores	7.11	9	3.887	1.296
LSIZ post-test scores	7.67	9	3.742	1.247

Table 7

Sample Correlations on LSIZ

	N	Correlation	Sig.
LSIZ pre-test score and LSIZ post-test score	9	.201	.605

Table 7 indicates that correlation between pre-test and post-test scores on LSIZ (.201) is not statistically significant (two tailed significance value is .605, p>0.05).

Table 8

Differences between LSIZ Pre-Test Score and LSIZ Post-Test Score

Mean	Std. deviation	Std. error mean	95% confidence interval of the difference		Paired t-test	Degrees of freedom	Sig. (2-tailed)
			Lower	Upper			
-.56	4.825	1.608	-4.26	3.15	-.345	8	.739

Table 8 shows that t-value is -.35, which is associated with p value of .739, and a standard error of 1.61. The t-test is calculated by dividing the mean of differences between pre-test and post-test measures by the standard error of differences (Weinbach & Grinnell, 2004). The two-tailed probability is very high (p = .739), and it tells us that there is 73.9 % chance that the value of t could have happened by chance alone. It can be concluded that study participants' scores on LSIZ are not significantly higher on the post-test, in comparison to pre-test scores: t (8) = -.35, p>.05.

In both cases, the measure of depression and life satisfaction described previously, there are other factors that also warrant caution when considering the results. First, there is a high possibility of influence from many intervening variables such as health status, personal issues, and family issues on research participants' scores on the Geriatric Depression Scale and the Life Satisfaction Index. Further, the six week period of the

therapy might be too short for participants to address these complex issues, or too short for some changes and improvements to appear.

Qualitative Analysis and Discussion of Follow-Up Interviews

Telephone follow-up interviews were conducted with all study participants, two weeks after their last therapy session. Participants were asked for feed-back about their experiences with individual therapy, their recommendations for improvement of the therapy, what they found beneficial, and what they would want to be different in the future therapy. Primarily open-ended questions were asked to stimulate participants' responses (Lee, 1993). Five participants indicated that learning about depression and anxiety management, particularly learning and practicing relaxation exercises, was beneficial for them. Two participants reported that in this therapy, they learned about different types of thinking characteristic of depression (e.g., black-white thinking and negative thinking), and strategies for changing them. Two participants indicated that they appreciated the opportunity to experience individual therapy, and to compare it with advantages and limitations of group therapy that they have attended. One participant mentioned that getting information about depression, dementia, and resources available for older people in the community was helpful. One participant indicated that she learned about herself, and the importance of having personal goals to work on. Another study participant explained that she has learned about the importance of self-care versus care for others. Further, three participants indicated that they enjoyed learning about the research project, and its potential importance for older people's mental health services in the future. One participant said that she learned to "stand up for herself" and to rely on

her personal strengths in dealing with difficult situations. Two more participants talked about benefits of emphasizing their personal strengths and getting positive feedback from the therapist. Another two participants explained that talking about their life, reviewing it, and focusing on the positive side of it, rather than on the negative life events, was very helpful for them. Almost all (seven) participants, mentioned they enjoyed getting the emotional support, understanding, and acceptance that they needed.

Four study participants said they would recommend this type of individual therapy to other older people. All participants would recommend individual therapy to other older adults, and would like to have more therapy options available to them through mental health services in the future. All study participants indicated that there was nothing they would like to change in the therapy that they accessed. One participant indicated that the time when she accessed the therapy was not the best time for her, and that perhaps, she would benefit more at a different time, when she would be more ready for the therapy. All research participants were willing to provide the therapist/researcher with their feedback about the individual therapy, along with suggestions for future therapy interventions for the elderly. Although, this was a very small sample of participants, it can be seen that all nine participants reported a positive experience with the individual therapy. Study participants' feedback reveals positive attitudes toward individual therapy. Further, all participants expressed the need for more therapy interventions for older people through the existing and future mental health services.

Storytelling as Therapy

As it can be seen from the follow-up interviews, seven participants indicated that they enjoyed receiving understanding and acceptance in the therapy. Two participants reported that getting positive feedback from the therapist was beneficial for them. Finally, all participants reported a positive experience from the individual therapy that they attended. At least in part, this can be attributed to the opportunity that was given to participants to express themselves, and their unsaid feelings, to pass on wisdom based on their experiences, and to make new connections (Bouchard, 2002).

Two research participants specifically indicated that talking about their life and reviewing it was very beneficial for them. During the course of individual therapy, many participants made comments that coming to the therapy and talking about different aspects of their lives was very useful for them. These comments, along with the therapist's observation that the participants often chose to talk about many episodes from different stages of their lives, rather than to talk about their current situation and presenting issues, indicate that the research participants gained significant benefits by talking about their lives, and by telling their life stories. These benefits may include the possibility of restoring a life, promoting healing, creating and discovering the meaning of life (Kenyon, 2002) and developing new, more effective ways of thinking, feeling, and acting (Kenyon, 2003).

According to Osis and Stout (2001), guided autobiography has many therapeutic effects, including a sense of increased personal power and importance, a greater sense of meaning in life, and an ability to face the end of life feeling that one has made a contribution. Additionally, biographical encounters are both possible and meaningful

with people with dementia, as well as, with older people with other mental health problems (Kenyon, 2003). It can be concluded that, in the future, it would be beneficial that the strengths perspective applied in this research project include narrative gerontology interventions, such as guided autobiography (Kenyon, Clark, & De Vries, 2001). This would further explore the opportunities opened by research participants' motivation to talk about their lives, and to share their life stories. Finally, adequate guidelines for the implementation of narrative gerontology interventions should be developed, as suggested by Kenyon (2003).

Ethical Issues

All participants in the research signed informed consent (Appendix A) about their voluntary participation in the therapy and the research. It was explained that the participant(s) could withdraw from the therapy/research study at any time without any impact on the services that they receive from the Northern Health Authority. Participants, who needed further therapy/counseling due to the emotional distress arising from study participation, have been referred to their regular clinicians/case managers for additional support. Other services from the Elderly Services Program have also been available to them. The individual therapy sessions were supervised by an MSW-trained Agency Practicum Supervisor who also helped identify participants who needed additional support, and was able to refer them to the appropriate clinician. Further, this research proposal was reviewed and approved by both the Research Ethics Board at the University of Northern British Columbia and the Northern Health Ethics Review Committee.

Limitations of the Research Design

One major limitation of this design is the small number of participants who were provided with individual therapy. Increasing the size of a sample would reduce the chance of committing a Type II statistical error (concluding that a relationship between variables does not exist in the population, when in fact, it really exists) (Weinbach & Grinnell, 2004). Other limitations include the fact that it is a non-experimental design which included neither a control group, nor randomization. In addition, participants received the same tests twice, which could lead to remembering items on the test; specifically, the potential impact on the second test was due to having seen the test on the previous occasion. Further, a six week period might not be sufficient for the effects of the individual therapy to appear. As well, study participants might need long-term therapy in order to improve significantly in level of depression and life satisfaction. Finally, many intervening variables, which have not been controlled, could affect participants' depression and life satisfaction. These include such things as health problems, housing problems, medical interventions that they have undergone during the time of therapy, family happenings such as visits of their children and other family members, and other events that could be significant for study participants. Consequently, rather than the brief follow-up telephone interview utilized in this pilot project, it would be useful, in future versions of the study, to utilize a longitudinal design in order to follow long term effects of the individual therapy with older adults and the elderly to get a more complete picture of the usefulness of the individual therapy. Qualitative, in depth interviews with older adults concerning the impacts of the therapy on their lives should be included in the future research design.

Other issues that could arise in this research design and that have the potential to affect research results are: transference and/or countertransference issues because of the age difference between participants and the therapist/researcher, selection bias by the case mangers of Elderly Services Program, and experimenter expectancy which could influence participants' behaviors, and answers on the tests. The researcher, the practicum supervisor, and the clinicians of the Elderly Services Program have tried to address all these challenges by meeting regularly for clinical review and debriefing. However, some of the issues might have gone unrecognized, and could affect research results.

Chapter Four

Barriers to Accessing Mental Health Services for the Elderly

According to the literature reviewed, the follow-up interviews with study participants, and my own experience from the Master of Social Work Practicum with the Elderly Services Team of the Northern Health Authority, lack of mental health services for older adults, and barriers that older adults experience in accessing existing services are significant problems that require further attention. In the following sections of this practicum report, underutilization of mental health services for older adults and barriers to their access to the services including negative attitudes and stereotypes about elders and mental health, as well as social work practice with older adults, will be further discussed.

Underutilization of Elderly Mental Health Services

The pattern of underutilization of mental health services by older adults continues to be substantiated. The prevalence of mental health problems among elderly is high, while utilization and availability of specialized psychiatric service is very low (Black & Mindell, 1996). Lack of specialized services and poor coordination of existing services result in mental health problems going unrecognized, undiagnosed, misdiagnosed, and untreated. The likelihood of psychosis, the most serious form of mental disorders, increases significantly after the age of 65, and is more than twice as common in the over 75 age group as in the 25-34 years old group (Biegel, Shore & Silverman, 1989). In addition, 86 per cent of the elderly have chronic health problems of all types, which result in increased stress and depression (Biegel et al.). However, nearly 25 per cent of those 60

years of age and older who experience significant mental health problems are proportionately a much smaller number of mental health service users than younger individuals in the general population (Biegel et al.). This underutilization and/or lack of services result in a significant problem for those elderly in need who are unable to obtain adequate mental health care. Mental health services, as they are currently organized and delivered for elderly people, do not meet the needs of the population of approximately 540,000 seniors living in British Columbia (British Columbia Ministry of Health Services, 2002). In addition, limited curriculum and student specialization opportunities in gerontological concentrations reflect ageism in professional education (Rosen & Persky, 1997). The need for specialized mental health services for elderly people has been well documented in the literature, focusing on three main areas: age-related differences, barriers to receiving care, and age-related developmental and social factors (Canadian Association on Gerontology, 2002).

Husaini, Moore, and Cain (1994) point to three basic reasons for underutilization of formal mental health resources by older people: (1) professional issues including a lack of commitment and competence in working with the elderly, (2) practical issues such as lack of referrals and transportation difficulties, and (3) issues imposed by the elderly such as negative attitudes related to seeking help for psychological problems. Further, they explain that elderly are reluctant to use mental health services and that they stay in treatment for shorter periods of time (Husaini et al.). Service utilization rates are affected by different factors: availability of the natural helping network, socio-demographic factors, awareness and accessibility to services, stigma about mental health, severity of the problem, and older people's education (Husaini et al.). Elderly with psychiatric

diagnoses are significantly more likely to see a psychiatrist or psychologist compared to elders without a diagnosis (Husaini et al.). Other barriers to accessing mental health services are stigma about mental health problems, as well as differences in perception of mental health problems by older people and their health professionals, including mental health professionals' emphasis on people's deficits (Perkins & Tice, 1995). According to Husaini et al. (1994), symptoms indicative of depression for older people may be perceived as 'going through the hard time', and therefore, not constituting a need for mental health services. Consequently, mental health professionals need to consider modifying terminology when inquiring about mental health concerns of older individuals.

Building an effective therapeutic relationship with elderly clients is emphasized (Sinclair et al. 1988; Levine, 1996), but it is unrealistic to expect that this will happen if older people are not able to access mental health services more frequently. Thus, outreach social work practice is necessary, especially in work with the elderly who live isolated and homebound in rural communities, and where transportation is inaccessible or nonexistent (British Columbia Ministry of Health Services, 2002). Many areas in rural British Columbia have virtually no services for seniors, and frequently, the local family physician is the only provider of both medical care and other support services (Hodge, 1995). First Nations seniors who live on reserve constitute a significant proportion of the rural elderly population with no available services (Hodge, 1995). The problems in providing services to rural older people are compounded by their dispersal into small communities in vast geographical areas, and by the historic under-provision of most health care services in rural British Columbia (Hodge, 1995). It seems that a strong system of informal support 'compensates' for a lack of health services for older residents

of rural communities. In an in-depth qualitative study conducted in rural Saskatchewan, all respondents/older adults had at least one member of their large kin network living in close proximity, and thereby available for support and assistance (MacKenzie, 2004). Older people reported that they received most social support from family and friends, not from health care and social services professionals. Further, there is very limited research that has examined the experiences in accessing health services of rural Canadian older people (MacKenzie, 2004).

According to Beaver and Miller (1992), many of the psychosocial problems experienced by the elderly can be resolved by psychosocial treatment provided by clinical social workers. But, government policies on aging, health and social welfare do not allow for sufficient funds to provide adequate psychosocial treatment services for those elderly who are troubled with acute problems or psychosocial functioning. The elderly might be reluctant to seek out psychotherapy, but they might be more willing to request help if it is readily available at their neighborhood senior centers. Mental health centers in general do not make a special effort to reach out to those elderly in need of psychotherapy. Those elderly who find their way to mental health centers are usually treated by therapists who have only a limited knowledge and understanding of the psychosocial nature of aging (Beaver & Miller, 1992). Most outpatient psychiatric facilities do not employ geriatric specialists (Beaver & Miller, 1992). These are all significant societal barriers to the provision of psychosocial services for the elderly.

It can be concluded that the reasons for underutilization of mental health services by older adults are complex, and that an analysis of factors that produce barriers to services can be undertaken by examining the elderly clients themselves, social work

practitioners and other professionals working with elderly, and the service delivery system.

Attitudes about Elders and Mental Health Services

Two areas in which social work practitioners have changed their attitudes toward the elderly are: accepting that the elderly have unique needs and changing negative myths and stereotypes about the elderly (Holosko & Holosko, 2004). However, myths about older people and aging processes are still present in the population of health care professionals and in the general population, and are significant obstacles in providing adequate mental health services to older people (Schneider & Kropf, 1992). These myths include that older people are set in their ways, unable to change, and unresponsive to therapy; that senility is inevitable in old age; or that old age is a time of peace and tranquility.

According to Genevay and Katz (1990), none of us, no matter what our age or professional orientation, is totally free of biases or stereotypical thinking about aging and the elderly. Even older professionals in the field sometimes harbor condescending and patronizing attitudes towards the elderly in general (Genevay & Katz, 1990). It is apparent, by the lack of resources for development of new programs in mental health services for older adults, that there are powerful political and other forces that result in denigration and diminishing of older people. Some of the negative attitudes about elders are rooted in irrational beliefs, and spring from our fears about aging and death, and from the psychological need to distance ourselves from selected groups of socially oppressed

people, such as people that belong to different races, age groups, or different sexual orientations (Stevenson, 1989).

Several authors have identified the stigma against mental health care and have argued that the elderly have misconceptions and an active prejudice against mental health services (Knight, 1989; Robb, Haley, Becker, Polivka, & Chwa, 2003). However, data from a telephone survey conducted on behalf of the American Psychological Association indicated that significantly more older adults (77%) than younger persons (70%) consider access to mental health care for them was "very important", rather than "somewhat important", or "not very important" (Robb et al.). The analysis of perception of personal access to mental health care has shown that younger adults were more likely than the older adults to say that they personally had adequate access to mental heath care (Robb et al.). Also, we should be aware that some elderly may simply not see their problems as psychological, or may be unaware of the existence of outpatient therapy (Knight, 1989). Social and health services are often organized so that the person has to be perceived as a 'problem', 'victim', or 'survivor', in order to access services (Neysmith, 1999). Further, the older person within the health care system could be on unfamiliar territory, and could find professional jargon and the language relating to illness both confusing and unsettling (Deichman & Kociecki, 1989). Consequently, for the mental health professionals trained in gerontology, one of the major methods of explaining psychological problems, and demystifying therapy for the community, is through speaking engagements about normal aging processes, grieving and coping with stress, psychological problems common in late life, or Alzheimer's disease and others dementias (Knight, 1989).

Chapter Five

Social Work Practice with Older Adults

The social construction of aging as a problem of physical deterioration to be treated by medical practitioners has been an obstacle for development of social and psychosocial interventions and services for older individuals for a long time (Neysmith, 1999). It was not until about the 1960s that social work practitioners gave up trying to fit the elderly into their existing practice ideologies and began to modify their assumptions and frameworks to fit the unique needs of the elderly (Holosko & Holosko, 2004). Two areas where such modifications took place are assessment and intervention. A number of standardized measures have been adapted, and new ones developed for conducting assessments with the elderly, as well as the role of the interviewer/assessor being broadened (Watt & Soifer, 2004). In the early 1980s, gerontology was formally established, and dominant medical and social science explanations about aging challenged (Neysmith, 1999). Social workers, like other professionals, have developed practice approaches to intervention based on the unique needs of the elderly whether focusing on mental health needs, individual needs, family needs, or the elderly in general. In 1987, Tobin and Gustafson surveyed 541 social workers, and asked them: "What do social workers do differently with elderly clients?" They reported that five intervention activities were emphasized in social work practice with the elderly: use of touch that reflects a worker's active approach to the elderly needs; greater frequency of activities (more concrete assistance, more reaching out to the families, and more talking by the worker in the sessions); reminiscence (use of the past to help clients to develop ego strengths); and importance of debriefing transference and countertransference issues,

including dependency, helplessness, and concerns with aging parents (Holosko & Holosko, 2004).

Social Work Roles in Work with the Elderly: Linking Social Work Theory with Practice Issues

Social workers have many avenues for intervention with the population of older people who experience mental health problems: in hospitals and mental health clinics, family services, home health and protective services, rehabilitation units, senior citizen centers, public housing, and in their communities as private citizens (Ledbetter Hancock, 1990). Beaver and Miller (1992) describe social work roles as primary intervention roles (consultant, educator and advocate), secondary intervention roles (broker-advocate who mediates between individuals and societal institutions; enabler who helps individuals to articulate their needs, to identify the problem, and to explore resolution strategies; outreach worker; and clinical roles including counseling), and tertiary intervention roles (case management, and role of the mobilizer who organizes people and resources effectively and efficiently). The caseworker or case manager helps clients to use their own resources to find solutions to their problems, and encourages them to seek outside help from health, social services, and recreation services (Beaver & Miller, 1992). When the caseworker is interacting directly with the client, the process almost always includes helping the client to become aware of the available options in his or her environment (Beaver & Miller, 1992). The case management role has evolved to include an important outreach component (Beaver & Miller, 1992) as is the case in the Elderly Services Program at the Northern Health Authority.

Advocacy for older people becomes an increasingly important social work role that involves a series of activities: gathering information about the client's problem, making a decision about the type of assistance needed, determining how assistance will be provided, providing required assistance, and teaching older people how to advocate for themselves (Harbert & Ginsberg, 1990). Harbert and Ginsberg (1990) explain the unique characteristics of the social work roles in work with terminally ill or dying patients, which extend to work with their families, and include addressing problems with both practical and emotional elements such as psychological assistance, legal assistance, and assistance in practical and financial problems.

The educational role in the profession of social work is an important component in prevention of mental health problems. Social workers can develop educational programs for their communities, health professionals, and other human service personnel that address the recognition, assessment, and appropriate treatment needed for mental health problems in older persons (Csikai & Manetta, 2002). Introduction of efforts to minimize the stigmatization of mental health problems among the elderly and other community members, through education, is also essential.

There are many other social work roles such as policy developer, or the activist-organizer who works with community groups to effect changes in social policies. Social workers may also undertake research, engage in community planning, and networking to develop programs for elderly persons (Holosko & Holosko, 2004).

Challenges in social work practice with older adults.

One of the challenges that social workers face in work with older people is a lack of familiarity with mental health disorders that develop as a result of an organic cause (Ledbetter Hancock, 1990). Although progress has been made in understanding many mental health disorders, in terms of both cause and treatment, social workers do not receive adequate education for work with older adults in medical settings (Ledbetter Hancock, 1990). In a study with nursing home social workers, it has been found that many social workers were feeling unprepared for the positions they occupied (Quam & Whitford, 1992). Social workers have many roles in care facilities; for example, as advocates for the residents, counselors to families and residents, and brokers for community services. A strong need has been identified for more education and training of social workers working with elderly with behavioral problems as they seek both to meet the mental health needs of the residents, as well as to work with their families (Quam & Whitford, 1992). Similarly, Tirrito (1996) has reported that social workers do not have adequate knowledge about identification of mental health problems, and behavioral problems in the elderly. It has been recommended that social workers employed in care facilities should have gerontological training (Quam & Whitford, 1992), but the need for specialized training and education about aging and mental health problems could be generalized to other social work roles and positions in gerontological social work practice such as the case management role, as well as individual, and group therapy with older people. The need for other specialists in gerontology has been identified, as well (Fisher & Moak, 1990). For mental health workers who provide services to the elderly clients, the importance of seeking out and being involved in consultative and supervisory roles is

emphasized for effective utilization of services (Unutzer, Katon, & Callahan, 2003). To conclude, clinical training and educational programs have to be expanded in order to meet the needs and demands for specialists in gerontological social work practice.

Gerontological Social Work in the Future

The hallmark of social work evolution has been characterized by its flexibility to adapt to the changing needs and resources of the elderly. Historically, client needs have dictated how the profession has evolved, and the 'troubling' variable is whether there will be adequate resources to do 'the job' in the future. To date, policy makers at both the macro (governmental) and meso (organizational, agency) levels have made sporadic attempts to provide meaningful programs and services for the elderly, and any consideration of whether the profession can adapt accordingly must be framed contextually in whether resources will be made available for such change (Holosko, White, & Feit, 2004). Unfortunately, access to funding for geriatric services has been and is still very scarce. Certainly, not only resources, but also policies which promote such services are equally important factors to consider in this regard. The future of gerontological social work looks very exiting and challenging. Thus, social workers need to evolve and share experiences, knowledge, and wisdom through practicing, researching, and educating themselves, in order to be effective in work with older persons in the future. According to Holosko et al., future practice directions are many and varied, and involve both direct and indirect practice concerns. Since front-line direct practitioners have been on the leading edge of working with the elderly, the impetus for understanding where the profession is emerging in gerontological social work practice is in this area.

However, macro services, the processes of outreach, planning, coordinating, financing, and social change activities on behalf of older adults also seem to be critical parts of the provision of future services to older people (Kim, 1991). The senior citizen movement and programs for older citizens have grown out of political and community activities in the past (Kim, 1991). Today, the Seniors Network of British Columbia is a central advocacy body through which seniors' groups in British Columbia and people advocating for seniors, can discuss their concerns, take action when necessary, and present their common views to various levels of government (Seniors Network of BC, 2004). The purpose of the Council of Senior Citizens Organizations (COSCO) of British Columbia is to assemble, coordinate and advance proposals and resolutions concerned with the welfare of elder citizens, submit them to appropriate government bodies, and to advance the social and physical welfare of all elder citizens in the province of British Columbia (The Council of Senior Citizens Organizations of British Columbia, 2004). COSCO is an 'umbrella' organization made up of various seniors' organizations and individual associate members. It currently has 42 affiliates representing approximately 42,000 seniors. Finally, The National Advisory Council on Aging (NACA) assists and advises the Minister of Health on issues related to the aging of the Canadian population and the quality of life of seniors (National Advisory Council on Aging, 2002).

Gerontological theory in social work focuses attention on current assumptions regarding aging and the elderly in the wider society, and in human service practice. Over the course of its evolution, gerontological theory has come to a richer understanding of the interactive effects of policy, socioeconomic status, culture, history, and individual initiative on patterns of aging (Kim, 1991). Kim (1991) explains that theories of aging:

disengagement theory, activity theory, continuity theory, social and psychological perspectives, the political economy of aging, and sub-cultural theory, have significantly influenced development of human services with older people by moving toward increasing awareness of the complex, dynamic, variable, and socially constructed nature of aging. Today, the goal of human service practice with the elderly should be to emphasize and enhance the autonomy of clients, drawing on their strengths, with respect for their needs, and strengths and needs of their families and caregivers.

Four emerging areas in which social work practice should evolve include: prevention, community-based initiatives, practice consideration (developing the expertise in advocacy, research, writing, public speaking as well as in advanced clinical skills), and education and training (Holosko et al., 2004). According to Kim (1991), a basic challenge for clinical social work practice in the future is to identify the role of the hegemony in disempowering the elderly, and to call for empowerment and involvement of the elderly in the consideration of concrete decisions, such as possible care facility placement, as well as in wider social policy.

Chapter Six

Future Directions in Elderly Mental Health

Importance of Future Social Policies about Aging and Mental Health

According to Black & Mindell (1996), future program services to the elderly will be provided almost exclusively in the older adults' homes or residential care facilities, and will include extensive outreach, linkage and collaboration with community resources, and innovative treatment strategies that provide accessible and culturally relevant services. The effort to maintain clients in the community will require an expansion of the traditional therapist/case manager role to include help with such tasks as banking, home repairs, shopping and food preparation, and help to access medical care (Black & Mindell, 1996). This will be necessary both to meet the needs of isolated older adults and to foster acceptance of mental health services, such as counseling and medication (Black & Mindell, 1996). This will require more professionals working with the elderly and more comprehensive training of professionals. Further, the effects of the numerous provincial government 'cuts' in the health care system on older people in British Columbia should be recognized and dealt with. Specifically, the following concerns requiring Provincial Health Authorities' responses and more funding for development of mental health and other services for older adults, have been identified: the lack of long-term care spaces available to meet the needs of older people, the rapid pace of change in long-term care residency and assisted living, changes in criteria for obtaining placement in long-term care facilities, and the effect it has on elderly individuals and couples (The Council of Senior Citizens' Organizations of BC, 2004).

Mental health programs for older adults will have to be developed to meet the needs of elders who live in both suburban and rural communities. Isolation, transportation difficulties and decreased physical mobility due to co-existing physical problems, which may prevent elders from receiving needed and beneficial services, have to be addressed in future mental health programs. The flexibility of the programs should allow program therapists to call upon elderly clients in their homes, or to arrange transportation for clinic-based appointments (Russell, 1997). The ability to 'evaluate' older persons in their home environment can improve prevention of mental health problems, and can enhance early intervention. A full range of outpatient mental health services should be available to older people, including supportive talk therapy, couples counseling, family interventions, and medication monitoring (Russell, 1997). Finally, the interdisciplinary or inter-professional team model of providing mental health services to older adults should be central to the understanding of how the complex, interrelated, physical and mental health needs of older adults' can best be met. There is a growing body of literature that demonstrates the benefits of this model of care, as compared to multidisciplinary or unidisciplinary care (Zeiss, 2003). On an interdisciplinary team of professionals, there is a much higher degree of collaboration, shared responsibility for the health care recipient, and recognition of the unique strengths of each profession (Zeiss, 2003).

In the future, we should be aware that the needs of elderly people, while not necessarily greater than those of younger persons, are nevertheless different. From a clinical perspective, these needs will require integrated and simultaneous psychiatric and medical treatment (counseling, medications), and modification of treatment techniques, as well as expertise in the recognition and treatment of the interacting physical,

neuropsychiatric, psychological, social, and economic problems that may contribute to mental health problems in the elderly (Fisher & Moak, 1990).

In the century of long-term care, Canada seems to be pursuing a policy of family responsibility and buttressing by formal services to fill in gaps and reinforce areas where family and other informal support are not available (Hendricks & Rosenthal, 1993). The needs of family caregivers of older people, including older people themselves who provide care to their children or spouses, have to be recognized and built into policies and new programs in elders' mental health.

Recommendations for Future Programs and Policies

New efforts to expand the public policy agenda concerning the delivery of services to older adults with mental health problems should embrace some of the following important points:

1. Policy makers should recognize that mental health problems will become the second or third most common problem experienced by the older adult population over the next twenty years (Kaskie & Estes, 2001). The lack of service use must be recognized as a serious problem, and must be addressed (Schrier, 2004).
2. Efforts to promote mental health and prevent mental illness among the elderly should be expanded. Education efforts should be targeted, so that the stigma associated with mental illness is dispelled. Older people and other community members should become familiar with the symptoms of mental health problems, and should be educated about how to seek effective professional help.

3. The rights of older individuals with mental health problems should be protected. Older persons should be given the right to plan their treatment and to 'dictate' the application of advanced directives.
4. An effort must be made to increase service delivery to older people. Policy makers must recognize that two significant barriers to the provision of effective treatment for the elderly are lack of funding and lack of service coordination.
5. Older persons who require mental health care must be provided with services in the most appropriate, least restrictive setting, including their homes. Outreach practice in the profession of social work and in other professions should be expanded and further developed. The Guidelines for Elderly Mental Health Care Planning for Best Practices for Health Authorities identify six principles, based on the British Columbia Psychogeriatric Association's principles that are necessary requirements for the development of best practices in the care of older persons with mental health problems: client and family-centered, goal-oriented services; accessible and flexible services (user-friendly and readily accessible); comprehensive services that take into account all aspects of the person's physical, psychological, social, financial, and spiritual needs; specific services, which recognize that older adults with mental health problems have different needs in comparison to mentally well older adults and the younger population with mental health problems; and accountable programs and services that accept responsibility for assuring the quality of the services delivered and monitors this quality in partnership with the client and family (MacCourt, Lockhart, & Donnelly, 2002).

6. Family and couples interventions and interventions for caregivers of older people have to be developed. Caregivers should be educated about needs of older people to whom they provide care, as well as about their own needs.
7. The need to emphasize older people's strengths and capacities, instead of decline, deficits and mental health problems, should be recognized and included in future programs for older individuals. It is important that older people, and practitioners who work with them, avoid regarding pathology as the inevitable norm (Pushkar & Arbuckle, 2002). Lack of awareness of the range of normal functioning in older people can contribute to over-diagnosis of mental health problems.
8. The position of elders living in rural, remote communities, and their access to mental health services, should be considered. Outreach programs should be developed to meet their health needs. Services and resources that would benefit rural seniors should include: financial and/or other incentives for physicians, particularly specialists including mental health professionals who would provide enhanced services to rural residents; funding for locally available adult day care programs; cost-shared or publicly funded transportation services to enable rural residents to travel to nearby or distant communities for both medical appointments and social opportunities; enhancement of caregiver support groups; development of different housing options in rural communities, and development of preventative health services (MacKenzie, 2004).
9. Older women's needs as caregivers of other family members should be considered and adequate programs of support and assistance developed.

10. Effectiveness of therapy interventions with older people, especially individual therapy interventions, should be further explored in future research.
11. Both quantitative and qualitative research methods should be used to evaluate the effectiveness of narrative gerontology interventions, such as guided autobiography. As a result, adequate guidelines for the implementation of narrative gerontology interventions should be developed.
12. Needs of older people from different cultural and ethic minority groups should be explored and reflected in future programs, policies and research.
13. Social stereotypes and stigma about aging and mental health services should be addressed in future programs, policies, and research.
14. Gerontological education must exist as a continuum of knowledge and skills available through the lifelong process of education to all professionals and paraprofessionals working with older people. Education of professionals working with older people should be more comprehensive, and should include specialized training, and additional educational opportunities.
15. The educational continuum for gerontological social work needs to include more gerontological content at both undergraduate and graduate levels (Quam & Whitford, 1992). This can be provided in existing courses such as through the use of case studies of elderly clients, and through more field placements in agencies that serve elderly clients. It can also be provided by offering elective courses focused on aging and mental health issues.

Chapter Seven

Conclusion

The practicum, which took take place with the Elderly Services Team of the Regional Mental Health and Addiction Services of Northern Health Authority in Prince George, was a combination of learning about social work practice with older adults, and research about effectiveness of individual therapy in social work practice with this population. Learning about standard psychometric tools applied in work with the elderly, participation in the assessments of new clients of the Elderly Services Program, assistance in the Older Women's Support Group New Members Curriculum Project, participation and co-facilitation in Older Women's Support Group, and conducting a literature review of the therapeutic models suitable for the elderly, were among the learning objectives of this practicum. The small research component of the practicum was preliminary research considering the effectiveness of individual therapy in social work practice with older adults. The project involved nine participants who attended six individual therapy sessions based on a social work strengths perspective, and cognitive therapy. Effectiveness of the therapy was measured by analyzing statistical significance of the difference between participants' pre-test and post-test mean scores on the Geriatric Depression Scale and Life Satisfaction Index. T test analysis revealed that there was no statistically significant improvement in participants' depression and life satisfaction following therapy. Limitations of the research design have been acknowledged. These include a small sample, lack of randomization and control group, as well as a short time period for therapy which might be insufficient for changes to appear. The researcher has acknowledged that the pilot study should be viewed with caution because of the very

small sample. In contrast to the research result, follow up interviews with research participants indicated that participants had a positive experience with individual therapy, and that they would recommend therapy to other older adults. Research participants reported different benefits that they achieved in the therapy: learning about depression and anxiety management, emphasizing personal strengths, and receiving needed emotional support and understanding. Further, it was concluded that the research participants gained significant benefits from the individual therapy by talking about their lives, and by telling their life stories to the researcher/therapist.

Underutilization of mental health services for older adults, as well as stigma and negative attitudes toward aging and mental health, have been identified in this practicum report as significant barriers for older people's access to mental health services including individual and group therapy. It has been argued that lack of specialized services and poor coordination of existing services result in mental health problems going unrecognized, undiagnosed, misdiagnosed, and untreated, despite the high prevalence of mental health problems among elderly. Lack of literature and research about the effectiveness of therapy interventions with this population (especially individual therapy), along with the lack of therapy interventions for elders who are caregivers of others and for rural elders, has been criticized. Further, myths and stereotypes about older people's decline and inability to learn and change, have been discussed as significant barriers for development and application of therapy interventions for older people.

Development of social work practice with older adults, different social work roles in work with elders, and future directions in gerontological social work have been discussed, and analyzed. Finally, the importance of developing policies and

recommendations for future programs in elderly mental health, have been discussed, specifically, the need for social workers and other professionals to increase their outreach practice with older clients has been identified, especially in work with elders who live in rural and remote communities such as many communities in the Northern British Columbia. Further, the importance of interdisciplinary professional teams, the need for more professionals and specialists working with elders, and increased educational opportunities for advanced training and specialization in gerontological social work and related professions, have been emphasized. With the projection that 22.6 percent of the British Columbia population will be 65 years or older by the year 2031 (British Columbia Statistics, 2004), addressing the mental health needs of older adults, expanding existing services, and developing new mental health programs become all the more critical.

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Appendix A

Informed Consent Package

INFORMED CONSENT PACKAGE

Effectiveness of Individual Therapy in Social Work Practice with Elders

Research Team:

Aleksandra Nikolin, BSc (Psych), MSW (candidate) – Principle Investigator

Graduate student, Social Work Program, University of Northern British Columbia
250 563-8252
205-4280 Quentin Ave., Prince George, BC, V2M 5L3
nikolina@unbc.ca

Karla Staff, MSW – Practicum Supervisor/clinician

Project coordinator, Regional Mental Health & Addiction Services, Northern Health
250-565-2127
1444 Edmonton St., Prince George, BC, V2M 6W5
karla.staff@northernhealth.ca

Dawn Hemingway, MSc (Psych), MSW – Faculty Supervisor

Assistant professor, Social Work Program, University of Northern British Columbia
250 960 5694
333 University Way, Prince George, BC, V2N 4Z9
hemingwa@unbc.ca

TO _____.

As a client at the Regional Mental Health & Addiction Services of Northern Health (Elderly Services Program) in Prince George, **you have been invited to participate in a research project**.

Purpose of the Research Project

This project is designed to see if individual therapy sessions are effective in helping older people to deal with problems such as grief, loss, caregivers' stress, depression, anxiety, communication problems, and adjustment problems.

Time Commitment Requested

You will be asked

1. to attend 6 individual therapy sessions of one hour each,
2. to complete two short questionnaires
3. and to participate in a half-hour telephone interview 2 weeks after your last session.

The sessions are planned to start the week of June 1st, 2004, and to be finished by July 23rd, 2004. Sessions may take place at your home or at any other location you feel is suitable.

Nature of Participation

You may attend other services at the Northern Health including group sessions at the same time with individual therapy, if you wish. Your individual goals will be respected and will be main guide

in the individual therapy. Your individual therapy is based on emphasizing your strengths, potential, and abilities to overcome problems. Some ideas to help you deal with different psychological problems will be applied, too. We hope that your participation in this research project will help us to find out if this therapy is useful, so that it can be applied to other people, too.

We will ask you to complete two questionnaires, once before you start individual therapy, and a second time, at the end of the therapy, after the sixth session. These questionnaires are called Geriatric Depression Scale and Life Satisfaction Index. By comparing your responses on these two questionnaires given before and after the therapy, we will measure whether or not individual therapy has been helpful for you in managing your problems.

All six individual sessions will be provided by Aleksandra Nikolin, a graduate Social Work student. Her goal through the individual therapy sessions will be to support you and help you in managing the issue that brought you into counseling and to learn new coping skills. She will have two supervisors, one at UNBC and one at Northern Health – Elderly Services Program to assist her. Your regular case managers will also work with Aleksandra.

Files, Records and Confidentiality

As this is part of the therapy you have been referred for, the usual details of your attendance and relevant information will be recorded by your therapist in your clinical file. The research project notes, will be recorded separately and will not contain any identifying features at all. A record of your participation will be maintained until the data collection and analysis are complete, and then the records of participants will be shredded. Only the group results (all participants' results together) will be retained and no-one will be able to identify participants. The group results will be analyzed, and written up in Aleksandra's student practicum report about effectiveness of the therapy provided. None of the reports will identify individual participants in any way.

We commit to keeping your attendance and your information confidential from anyone else outside your health care team. Your team includes your physician and any Mental Health clinician assigned to work with you.

Potential Costs, Harms and Benefits of Participation

There is no cost to you to participate in this project. No money will be paid to you. Benefits to you may include the opportunity to

1. discuss some of your personal issues,
2. to learn effective strategies for managing depression, anxiety, grief, loss, or other problems,
3. and to recognize your strengths and potentials for personal growth and development.

Distress resulting from discussing challenging topics is a part of the therapeutic process, and we commit to professional assistance during those moments, should any arise. If needed, additional emotional support will be provided by the regular clinician case managers. Other services from the Elderly Services Program will be available for you, as well. Individual therapy sessions will be supervised by an MSW-trained Agency Practicum Supervisor.

Unlimited Right to Withdraw

You have the right to withdraw at any time during the process. No penalty will result to you, and you will be welcome to attend other services at the Northern Health regardless of your withdrawal from this research project. We want you to know that any medical or other health care services you receive or may receive in the future will not be affected by your choice not to participate in this project.

Free and Informed Consent

If you decide to participate, your signature of consent is required at the end of this document. Additionally, we ask that you initial each page (as indicated by the boxes) that you have read this form entirely. A completed questionnaire is evidence of consent, and its inclusion in the feedback record is assumed. All project data collected is the property of the researchers. Data collected from a participant who chooses to withdraw will be included up to the point of withdrawal. No tapes, video or audio will be made.

Conflict of Interest

The researchers are aware of no conflicts of interest on their part, apparent, actual or potential, in regard to this project.

Final Reports and Results

Publication and/or commercialization of findings: The researchers reserve the right to create academic reports or articles about the research project, while abiding to the commitment to preserve individual anonymity of all members. In plain language, this means that the research team may write an article for a class, a report for partial completion of graduation requirements or a journal article for publication about the subject of the research, but each researcher guarantees that your personal confidentiality will be safe.

You may ask for a copy of the materials resulting from this project. Please call Aleksandra Nikolin at 565-1553.

Authentication

If you wish to confirm the authenticity of this project, you may call Sheena Nolli, Specialty Teams Mental Health & Addiction Services – Coordinator, at (250) 565-2127, or Max Blouw, Ph.D., the Vice-President Research, at (250) 960-5820

If you have any questions:

Any other questions about this project may be directed to Aleksandra Nikolin at (250) 565-1553.

I have read and understood the contents of this invitation to participate in research. I freely give my informed consent:

_____ _____

Name (please print) Date

_____

Signature

Witness:

_____ _____

Name (please print) Date

_____

Signature

Appendix B

Geriatric Depression Scale

Short Form

Geriatric Depression Scale

Choose the best answer for how you have felt over the past week:

1. Are you basically satisfied with your life?	YES / NO
2. Have you dropped any of your activities and interests?	YES / NO
3. Do you feel that your life is empty?	YES / NO
4. Do you often get bored?	YES / NO
5. Are you in good spirits most of the time?	YES / NO
6. Are you afraid that something bad is going to happen to you?	YES / NO
7. Do you feel happy most of the time?	YES / NO
8. Do you often feel helpless?	YES / NO
9. Do you prefer to stay in your room/facility, rather than going out and doing new things?	YES / NO
10. Do you feel you have more problems with memory than most?	YES / NO
11. Do you think it is wonderful to be alive?	YES / NO
12. Do you feel worthless the way you are now?	YES / NO
13. Do you feel full of energy?	YES / NO
14. Do you feel that your situation is hopeless?	YES / NO
15. Do you think that most people are better off than you are?	YES / NO

Appendix C

Life Satisfaction Index

LSIZ

Here are some statements about life in general that people feel different ways about. Read each statement on the list and indicate at left the number that best describes how you feel about the statement

1 = Agree

2 = Disagree

3 = Unsure

___ 1. As I grow older, things seem better than I thought they would be

___ 2. I have gotten more of the breaks in life than most people I know

___ 3. This is the dreariest time of my life

___ 4. I am just as happy as when I was younger

___ 5. My life could be happier than it is now

___ 6. These are the best years of my life

___ 7. Most of the things I do are boring or monotonous

___ 8. I expect some interesting and pleasant things to happen me in the future

___ 9. The things I do are as interesting to me as they ever were

___ 10. I feel old and somewhat tired

___ 11. As I look back on my life, I am fairly well satisfied

___ 12. I would not change my past life even if I could

___ 13. Compared to other people my age, I make a good appearance

___ 14. I have made plans for things I'll be doing in a month or a year from now

___ 15. When I think back over my life, I didn't get most of the important things I wanted

___ 16. Compared to other people, I get down in the dumps too often

___ 17. I've gotten pretty much what I expected out of life

___ 18. In spite of what some people say, the lot of the average man is getting worse, not better

Appendix D

Research Invitation Letter

Date:_____

Dear _____,

We are writing this letter to invite you to take part in the research about individual counseling with older adults. Aleksandra Nikolin is doing this research as the part of her Master of Social Work Practicum with the Elderly Services Team, and you are very welcome to participate. If you are interested, you can attend six counseling sessions with Aleksandra at the Mental Health Centre (Health Unit) or in your home. The goal of the research is to find if individual counseling is helpful for older adults who are dealing with depression, anxiety, caregiver stress, adjustment problems and other issues.

In the previous research, it has been found that older people suffering from depression, anxiety, caregiver burden, and bereavement can benefit from counseling (Kennedy & Tanenbaum, 2000).

Attached is the copy of the consent form where you can find more information about this research project. Please, give Aleksandra a phone call if you have any questions and/or if you are interested in participating. We would appreciate your feedback, concerns and questions even if you choose not to participate.

Thank you very much!

Sincerely,

Sheena Nolli, RN, BSN

Mental Health Specialty Programs

Program Coordinator
Phone: (250) 612 4504
E-mail: sheena.nolli@northernhealth.ca

Aleksandra Nikolin

BSc (Psychology), MSW (Candidate)

Phone: **612 4500 (Elderly Services)**
565 1553 (cell phone)
E-mail: nikolina@unbc.ca

Appendix E

Research Ethics Approvals

UNBC UNIVERSITY OF NORTHERN BRITISH COLUMBIA **RESEARCH ETHICS BOARD**

MEMORANDUM

To: Aleksandra Nikolin

Dawn Hemingway, Supervisor

From: Alex Michalos, Chair
Research Ethics Board

Date: March 26, 2004

Re: Ethics Review E2004.0316.026
Effectiveness of Individual Therapy in Social Work Practice with Older Adults

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Thank you for submitting the above-noted proposal to the Research Ethics Board for review. Approval has been granted.

Good luck in your research.

Sincerely,

Alex C. Michalos, Chair
Research Ethics Board

northern health

Prince George Regional Hospital
1475 Edmonton Street, Prince George, BC V2M 1S2
Telephone: (250) 565-2000, Fax: (250) 565-2343, www.northernhealth.ca

April 7, 2004

Ms. Aleksandra Nikolin
205 – 4280 Quentin Avenue
Prince George BC V2M 5L3

Dear Ms. Nikolin:

Re: Study "Effectiveness of individual therapy in social work practice with elders"

Thank you for submitting your proposal for review by PGRH Research Review Committee. As was discussed during the meeting, we feel this is in addition to clinical care and program content in the North and support your efforts. Approval has been granted, with the request that your review your data collection with a bio statistician with regard to the use of non-parametric measures for pre and post test scores using small numbers of subjects.

We look forward to your results. We ask that upon completion of the study that you notify the Research Review Committee in writing, and that you advise of an anticipated time frame in which you are available to present the results. As well it is required that you submit a copy of the final report within one year of conclusion. Please note that the Research Review Committee will need to see publications before they are submitted to ensure patient confidentiality has been protected.

It is our custom with research applications that we review to request a small donation to our in-house Research Fund, please consider making a donation if at all possible.

Sincerely yours,

Dr. C. Hagen, Chair Research Review Committee PGRH

CH/ll