Good Practice in Action 081
Commonly Asked Questions

Working with older people in the counselling professions

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Commonly Asked Questions:
Working with older people in the counselling professions

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Context

This resource is one of a suite prepared by BACP to enable members to engage with BACP's *Ethical Framework for the Counselling Professions*.

Using Commonly Asked Questions Resources

BACP members have a contractual commitment to work in accordance with the current *Ethical Framework for the Counselling Professions*. The Commonly Asked Questions resources are not contractually binding on members but are intended to support practitioners by providing general information on principles and policy applicable at the time of publication, in the context of the core ethical principles, values and personal moral qualities of BACP.

Specific issues in practice will vary depending on clients, particular models of working, the context of the work and the kind of therapeutic intervention provided. As specific issues arising from work with clients are often complex, BACP always recommends discussion of practice dilemmas with a supervisor and/or consulting a suitably qualified and experienced legal or other relevant practitioner.

In this resource, the word 'therapist' is used to mean specifically counsellors and psychotherapists and 'therapy' to mean specifically counselling and psychotherapy.

The terms 'practitioner' and 'counselling related services' are used generically in a wider sense, to include the practice of counselling, psychotherapy, coaching and pastoral care.

Introduction

There is no generally agreed definition of 'older people'. A BACP scoping exercise of research literature, statutory bodies and Third Sector agencies found a wide range of definitions from 50 years upwards. Older people do not represent an homogenous group experiencing a wide range of variables in both their cognitive and physical abilities. Longevity, however, increases the likelihood of experiencing events and milestones that can challenge resilience and have an impact on mental health.

Research also shows us that older people are less likely to recognise symptoms of common mental health problems, and when they do are less likely than younger people to seek help (Royal College of General Practitioners, 2014).

Those older people who do seek help from their GP are more likely to be prescribed medication than be referred to therapy (Collins and Corna, 2018). Ageist attitudes in society continue to suggest that decline and depression are inevitable consequences of ageing. It is therefore important to consider our approach to working with older clients and how we may need to adapt practice to increase access and opportunity for all older people who can benefit from counselling.

The aim of this resource is to highlight some of the factors that you need to consider when you are working with older people, particularly where transitions and challenges of ageing are having a significant impact on their lifestyle and wellbeing.

Mental health conditions in general are under-diagnosed, and in later life depression in care home residents in particular is under-reported (Hill and Brettle, 2004). Some studies cited within Hill and Brettle's review suggest that this may be due to mental health conditions carrying a stigma amongst some older people, or societal perceptions that therapy would not work with this age group. No tangible evidence exists to show that older people benefit less from talking therapies: in fact, multiple sources state they may benefit more than younger populations. General Practitioners have indicated that when an older person presents with symptoms of depression, they may be more inclined to write a prescription for medication than refer them to talking therapy (Collins and Corna, 2018).

Published statistics relating to the mental health of older people include:

- Approximately 40% of older people visiting their GP, half of the older population in non-specialist hospitals and 60% of care home residents have some kind of mental health problem (Age UK, 2016).

- Depression affects 22% of men and 28% of women aged 65 or over in England, and 40% of older people in care homes (Age UK, 2018a).

- Although 50% of younger people suffering from depression are referred to mental health services, just 6% of older people are (Royal College of Psychiatrists, 2009).

- The 2011 target of 12 per cent of referrals to IAPT (Improving Access to Psychological Therapies) in England being people aged 65 or over remains a long way off. This stands at just 6.5% (NHS England 2020).

1. Agreeing to work with older clients

Q1. What do I need to think about when making the agreement to work with an older person?

The *Ethical Framework* commits members to agreeing with clients on how we will work together (Commitment 3c)

Older clients who rely on carers, or who have family supporting them may wish to have that support also at the contracting stage, so think through how this can be accommodated, and how it may impact on the therapeutic process. Ensure expectations around sharing information about the sessions are clearly discussed and agreed prior to work commencing. This might be especially important if a family member is responsible for the money used to pay for the sessions. See, point 5 Q1. *What should I do if I have concerns over my client's capacity to make independent decisions?* for more information about what to do if you do not think your client has capacity to agree to the therapy or making the contract. As with all clients, if the older person has been referred by their GP or social services you need to ensure that any limits to confidentiality are explained. You can find more general information about making the contract in Good Practice in Action resources 039 and 055. Collaboration with other agencies may be needed, particularly where the referral comes via the client's Care Programme Approach (www.nhs.uk/conditions/social-care-and-support-guide/help-from-social-services-and-charities/care-for-people-with-mental-health-problems-care-programme-approach), as the client's progress in therapy may affect other aspects of their care, and vice versa. Obtaining written consent before information is shared is advisable, where possible.

Q2. My client has never had counselling before and doesn't want to sign a contract but wants to talk. What should I do?

What are their concerns? It is important to find some way of agreeing with your client how you will work together, and you will need their informed consent to keep any form of records.

If a formal written contract is inappropriate, you may need to think through whether there are any other ways to record what you have agreed with the person you are working with in respect of: what records you keep, confidentiality – who you may need to share information with and what they can expect from you, how many sessions you will have etc. The problem with not having anything written down is that you both have to remember what has been agreed, and this could prove very difficult if there were a disagreement, or complaint, or if you needed to share information. Should your client be unable to physically sign a contract, you could ask them whether they would like a carer, or family member to witness the discussions and, if needed, sign on their behalf, or you could perhaps record your conversation giving a copy of the recording to your client – they can then refer back to it if needed.

Q3. What setting is most appropriate for an older person?

If you are working with a person who has a disability, or mobility issues then you will need to find out from them what may be possible and consider whether this is practical, safe and something you could do. You have legal duties in respect of disability that are set out in the Equality Act 2010 and a commitment under the *Ethical Framework* to:

'make adjustments to overcome barriers to accessibility, so far as is reasonably possible, for clients of any ability wishing to engage with a service' (Good Practice, point 22f).

You can find out more about this within Good Practice in Action 080 Fact Sheet: *Reasonable adjustment in the counselling professions.*

Potential locations for therapy could include your regular consultation or therapy room (if it is accessible to the client), the client's home, somewhere in the community (e.g. a GP surgery, day-care centre), a hospital or a residential care home. Multiple sources state that the majority of less mobile clients prefer sessions in their own homes. However, consider any safety aspects; do you need a risk assessment first and, if so, who should do that? Many residential and hospital locations are not ideal, as finding a quiet room where you won't be disturbed can prove challenging. Be prepared to be flexible in terms of location, times of sessions (these may need to vary each week due to medical or other appointments), length and intervals between sessions.

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2. Common issues brought by older clients

Q1. What are the most common mental health issues seen with elderly clients?

Multiple sources state that depression is the most prevalent mental health issue facing older people, along with bereavement and grief work.

Anxiety, confusion, dementia, bipolar disorder and alcohol or substance misuse are other common problems also encountered with older clients.

Q2. What are the common underlying issues?

Many situational issues and external factors, often interconnecting, give rise to the above mental health problems, including:

- ***Bereavement and loss.*** These are often multiple: clients may over the years have lost a partner, siblings, friends or adult children, or may continue to mourn the loss of a child from years ago.

- ***Loneliness and isolation.*** The death of a spouse, illness, giving up work, driving, or lack of mobility may all lead to the loss of a social life, which can be hard to rebuild. Approaching old age with no friends or family nearby can seem very daunting.

- ***Adjustment difficulties.*** Older people experience many changes through their lifetime, due to bereavement, retirement, needing or even becoming a carer and financial uncertainty.

    - **Bereavement** – Adjusting to changing roles due to bereavement or illness in later life can bring about a significant reappraisal of beliefs and values. Fox (2014) explains how many older clients describe a conflict between their inner younger self and the restrictions that come with the ageing process, presenting potential areas for exploration during therapy.

    - **Retirement** – Working years provide a structure and routine that is hard to recreate after retirement, and loss of it may cause a loss of identity, especially in older people whose lives revolved around their careers (Fox, 2014). Although retirement is usually a predictable event, its reality is often hard to adjust to. Working with clients on the process of gradually separating themselves from their working role and replacing this with new opportunities could be beneficial.

    - **Medical conditions** – Some suffer long-term and increasingly debilitating diseases such as COPD, Cardio-vascular disease, diabetes, dementia, Alzheimer's disease, Parkinson's disease, terminal illnesses (for example, the prevalence of many cancers increases with age), chronic pain conditions and sensory disabilities such as acquired deafness and sight loss due to macular degeneration, which can lead to communication difficulties.

    - **Loneliness** – More than one in three people, aged 75 and over, say that feelings of loneliness are out of control, *Independent Age* (2016)

    - **Violence** – Past or current domestic violence is more common in older age groups than may be apparent, as, unfortunately, are attacks on older people by strangers. Also, it is not uncommon for childhood traumatic experiences to often resurface during later years.

Q3. Isn't a certain amount of depression just a normal part of ageing?

No. Multiple sources report how this is not the case. Symptoms of depression are often mistakenly believed to be an integral part of getting older or seem to happen at the same time as a significant life event or a medical diagnosis, and therefore depression as a separate medical condition in its own right is often ignored and undiagnosed.

Q4. What if my client has sleep problems and is too lethargic for sessions?

Insomnia and interrupted sleep are more common in some older people, (Richards, Demartini and Xiong, 2018) especially those who are ill. Some medications given to aid sleep can have side effects such as memory impairment and problems in functioning. There is some evidence to suggest that cognitive–behavioural techniques and sleep hygiene education (National Rheumatoid Arthritis Society www.nras.org.uk) can help reduce daytime sleepiness. Also try to schedule sessions for the time of day when your client feels most alert and consider agreeing to shorter sessions if they struggle concentrating.

Q5. How common is it for older people to have problems related to alcohol or substance misuse?

We often return to past patterns of behaviour to help us to cope. For example, if your client used illegal drugs or alcohol in their youth to help them get through difficulties, as they approach older age they may well try using them again. Dependency on alcohol by older people is fairly common, but Fox and Wilson (2011) explain how the symptoms of drink problems may be misinterpreted by professionals and friends and family as other aging-associated difficulties, such as the confusion seen in dementia, depression or falls. Also, some medication commonly taken by older people makes alcohol use inadvisable or even dangerous.

Older men are at greater risk of developing alcohol and illicit substance use problems than older women. However, older women have a higher risk of developing problems related to the misuse of prescribed and over-the-counter medications – *Royal College of Psychiatrists, London (2018) Our invisible addicts, 2nd edition.*

Only six to seven per cent of high-risk people with substance misuse problems, over 60 years of age, receive the treatment that they require – *Royal College of Psychiatrists London (2015) Substance misuse in older people - an information guide.*

3. Type of therapy

Q1. What factors need considering before we agree on what therapy to use?

Consider the client's presenting issues and physical restrictions, which may point to certain kinds of therapy being more appropriate, as well as their personal preferences for location, time, frequency, modality, etc. and your competence to provide specific kinds of therapy. Client availability for sessions should also be considered, for example, do they have any upcoming medical interventions scheduled? Some clients may be more willing or able to do work in between the sessions unaided, or may be keen but need prompting or help, therefore carer availability may also be important.

Q2. Are there any particular modalities or techniques recommended for this age group?

Hill and Brettle (2004) carried out a systematic review which showed that CBT has the strongest evidence base amongst the various counselling approaches and is effective for treating anxiety and depression in older people, outcomes being consistent with results seen with younger clients. This is, perhaps, unsurprising given that CBT is by far the most researched therapeutic modality. These findings were supported in an extensive literature review by Brettle (2010), which also confirmed that the efficacy of other counselling approaches has not been researched in the same depth as CBT. Hill and Brettle (2004) also concluded that there is a lack of research into commonly-used counselling approaches, such as interpersonal, psychodynamic, client-centred, validation, goal-focused and gestalt therapies.

Reminiscence therapy (group reminiscence regarding life experiences or using pictures or music to stimulate memories) and life review work (collating and reviewing past events to build a life story) have been proposed for working with dementia and cognitive decline.

Thompson (2011, 2017) showed how life story work delivered to dementia patients by Admiral Nurses, who provide specialist dementia support (Dementia UK, 2015), within inpatient settings had overwhelmingly positive results. Hill and Brettle (2004), however, concluded that overall evidence for the efficacy of reminiscence and life review therapy may be limited. Further therapies which have been proven to have some efficacy with older adults include memory-training, behavioural management and physical activity programmes. For members who subscribe to BACP's CPD hub, see www.bacp.co.uk/cpd/cpd-hub/older-people/ for further information.

Regardless of which specific modality you use, helping older clients to connect with, and adapt, their previously effective coping skills rather than just teaching them new ones is likely to prove empowering.

4. Specific challenges working with older clients

Q1. How might I need to adapt sessions to ensure best outcomes for the client?

Fox (2014) discusses layering of the self, which explains that how we respond to events depends on our accumulative life experiences. Older clients will have had much life experience, so this offers opportunities to identify previous coping mechanisms that have worked at different stages of their lives and explore why some have worked better than others. It also has the potential for conflict as well as growth, as the older we get the more complex this layering effect becomes, and it is useful to understand this in our therapeutic work with older clients.

If a client tires easily, or sometimes appears confused, it can be helpful to break the work down into smaller, more manageable chunks. This helps to avoid clients feeling overwhelmed. As with all clients, ensure that your language and level of reasoning is matched to the needs of the person you are working with.

If your client has memory loss difficulties ensure that you summarise, for some people offering a written summary of what you have spoken about, or your client keeping a notebook that they can refer back to can be helpful and consolidate understanding.

(See also GPiA 080 *Reasonable adjustment in the counselling professions*.)

Q2. How does age difference between counsellor and client effect the dynamic of the session?

It can sometimes feel challenging for therapists to have clients that are much older (or much younger) than themselves. As with all clients, practitioners need to be committed to building an appropriate therapeutic relationship with their client and to remain self-aware in respect of their own prejudice in respect of old age to ensure these do not intrude into the therapeutic process. There also needs to be an awareness that an older client may have grown up in an era that held different societal values (for example, towards authority, religion, LGBTQ+ issues, and sex before marriage) and some may live in a care home environment having different 'social rules' compared with elsewhere, of which a younger counsellor must be aware.

As with any therapist–client match, the relationship is key. It could be appropriate to ask how the age difference is experienced by your client, or if your older client comments on the age difference, enter into a discussion about it. Ask them what that means to them, what difference could it have on your work and do they have any specific concerns? It can help to explain at the contracting stage how therapy is not about giving advice from your own life experiences: it's about helping another to work out what's happening for them and collaboratively working on a solution. Reiterating this at intervals may be needed. Remain aware of any transference, and your own thinking and prejudice about old age as this could get in the way of the relationship you have with your client.

Q3. What problems with boundaries might be common when working with older people?

Boundary issues are frequently tested in any counselling relationships, and with older clients some issues tend to crop up more frequently:

- **Focus** – Some older people, especially if their short-term memory is poor, find it easy to talk about the past, and can enjoy reminiscing. This can be a helpful therapeutic opportunity giving scope to explore with the client how they have coped with difficulties in the past, and how they can adapt the same skills to coping with the issues they currently face.

  However, if the sessions just become about the person telling stories of their past, this may change the focus of the work into more of a social interaction. Practitioners need to be mindful of what the agreed goals were at the start of therapy and check out with their client whether these are still appropriate.

- **Session length** – As with all clients, keeping agreed boundaries of time are important, you may need to review what has been agreed regularly though – for example if your client is ill and gets extremely fatigued you may need to consider scheduling shorter sessions.

- **Privacy** – Depending on the location of the sessions, it can be hard to find a private, peaceful space where you won't be overheard – particularly in hospitals or care homes. Inform the person in charge that you are working with the person, and if possible hang a 'Please do not disturb' sign on the door. It may be possible to schedule the sessions around any medical interventions your client needs.

Q4. My older client wants to talk about sexual issues

Many practitioners who have not trained in psychosexual therapy feel awkward talking about sexual issues with clients, this can be heightened when the client is an older person. Sexual activity in advanced years however is common, but unfortunately the older a person gets the more likely they are to encounter problems of some kind. Men can experience impotence, sometimes as a result of medical conditions, and some women find that post-menopausal changes in their body make intercourse painful. It is likely to be a very difficult subject for them to broach, and your initial reaction is vital to ensuring that they are able to voice any concerns in this area. If the emerging issues are purely psychosexual, you may need to consider with your supervisor if you have the competence to work with them, or whether you need to refer them to someone with specialist training in the field.

Remember that when many older clients were growing up it could have been at a time when within society it was frowned upon to talk about sex and sexuality. For example, homosexuality between two men over the age of 21 was only decriminalised in 1967 and the age of consent for male homosexuality was made consistent with that for heterosexuals (16 years) as recently as 2000 (Stonewall, 2015). So, a younger therapist may consider that a client coming to terms with their homosexuality may be 'no big deal', but to an older client who has likely hidden their sexuality from family and friends for years, it could be the most courageous thing they have ever done.

Q5. How should I work with the debilitating medical conditions my client might have?

Age UK (2016) reports that approximately half of people over 50 years and 80 per cent of those over aged 65 have comorbidities. More alarmingly, over 20 per cent of patients over 85 diagnosed with a mental health condition also had at least six other significant health conditions, such as cancer, dementia, heart failure, diabetes mellitus and epilepsy (Age UK and University of Exeter Medical School, 2015). When a chronic health condition or disability occurs in later life, clients may have less time available to them to learn appropriate coping skills (Fox, 2014). Often particular medical conditions need to be approached and treated together, and medications can have side effects, further complicating matters. Ask your client how their disabilities, medical conditions and medications affect them and check out what their limitations may be. Any work you do with a client has to take into account any physical difficulties imposed by these comorbidities – consider (with the person's consent) contacting the client's GP, or their carer for advice if you are still unsure. In some cases, there may be periods when your client is unable to attend for medical reasons and keeping some kind of shared record may be useful so they (and you) can refer back to them during any gaps in therapy.

Q6. My clients grew up in an era when counselling was rare and attitudes towards it suspicious, to say the least. How can I engage them more fully?

Older clients, just like other age groups, should attend voluntarily and not at the request of a well-meaning relative or friend. Your client may have grown up at a time when there was even more stigma about mental illness than there is today. Some very elderly clients may well remember a time when lunatic asylums were the place you feared going to if you were mentally ill. They may also not have experience, or an understanding of what counselling or therapy is. Indicators from the study in Sussex referred to in Question 5 above, suggest that avoiding the language of 'mental health' and accepting the client's understanding of their low mood is effective in engaging older people.

Also, it is important to give a clear picture of what you do, and how you will maintain their privacy; this may help to ease their concerns. It may also be helpful to have information for them explaining how therapy can be of benefit to people of all age groups.

Fox (2014) explains how the stoic attitudes of some older clients, learned as very effective coping mechanisms during periods of hardship, may reappear in therapy and can be misinterpreted by the practitioner as an aversion to expressing difficult emotions.

He holds the viewpoint that such stoicism offers an insight into how the client communicates and how their background and beliefs can influence their attitude to change, both of which can be explored in therapy.

Q7. My client views domestic violence as normal, how do I work with this?

A report was commissioned by domestic violence charity Safe Lives in 2016, specifically looking at domestic violence in relation to older people

The report showed that:

- victims aged 61+ are much more likely to experience abuse from an adult family member or current intimate partner than those aged 60 and under

- Older victims are less likely to attempt to leave in the year before accessing help, and more likely to be living with the perpetrator after getting support

- Older victims are significantly more likely to have a disability – for a third, this is physical. (Safe Lives, 2016)

Research also shows that older women are far less likely to identify their situation as abuse (Scott, Mckie, Morton, Sedon and Wosoff, 2004); older victims were likely to have grown up in a time where the home was a private domain, and it would not have been deemed socially acceptable to discuss matters that occurred behind closed doors. One interviewee commented that she had experienced abuse for over 40 years and felt as if she could not talk about it due to feelings of embarrassment. (Safe Lives, 2016)

Blood (2004) explains how the needs of older survivors of domestic violence are often overlooked, as they fall in the overlap with 'elder abuse', which tends to focus more on the frustration of exhausted carers or younger family members abusing their power (for example, financial abuse). The signs of domestic violence are often missed by professionals, with physical marks being dismissed as injuries from falls or medication causing confusion, which can cast doubts on disclosures from victims.

From the victim's perspective, there could be significant resistance to disclosing violence (physical, financial or emotional) in their relationship or in the home from a carer, and older victims are less likely to take up services or offers of help due to the stigma attached, fears of being alone; of having to give up their home and ending up in a care or nursing home and problems with practical or financial issues (Blood, 2004). Blood also explores how the feelings of shame and self-blame are common amongst survivors of any age: and if the victim of domestic violence is now the main carer for the perpetrator, how would that complicate these emotions? How would this affect your work with the victim? Your client may benefit from understanding how times and attitudes towards domestic violence have changed dramatically and that there is much more help available than 50 years ago, often in the form of local outreach services. They are likely to be unaware of services offered by local Victim Support or Women's Aid at day centres. The take-up of places in refuges by older people is rare, however, as they are not all best suited.

Further points to consider when working with older victims of domestic violence include:

- Where to have the sessions: should they be in the same house as the perpetrator?

- If so, how could this impact on their safety? And on your safety?

- What if the victim needs their carer on hand, but the carer is the perpetrator?

- Could peer support groups or other group sessions be more convenient for some older clients?
- If your client is able-bodied and has full capacity, under what circumstances should you break confidentiality?
- At what point would you break confidentiality if you considered your client was particularly vulnerable?
- Would your response be different if the victim was male?

If your client discloses that they have, in the past, been a perpetrator of domestic violence and want to work through any feelings of guilt they may have, it's imperative that they also understand that this behaviour is now illegal, and for you to understand and share with your client any obligations you may have to report historic abuse. See Good Practice in Action 014 Legal Resource: *Managing confidentiality within the counselling professions* and 030 *Safeguarding vulnerable adults within the counselling professions in England and Wales* and 031 on safeguarding children for more information.

Q8. In my opinion I don't seem to be making much progress and am repeating myself a lot – how can I tell if therapy is working?

If your client has short-term memory difficulties you may need to repeat yourself more than usual. Some older clients may struggle more remembering new information than they do recalling facts from years ago.

Contracting and confidentiality limits may be unfamiliar concepts. By going over the same new ground more frequently you're helping to reinforce the work, and after a while it will become familiar to them.

Be prepared to adapt your measures of progress to the pace at which your client is working. Where a much older client requires additional time to engage with therapy the rate of progress is likely to be slower too. With the client's permission, you could check out with carers or staff how they're doing and use regular reviews with the client to help you keep track of what's happening. Ask your client how they feel they're progressing, as their opinion may be different to yours.

5. Safeguarding considerations

Good Practice in Action 030 Legal Resource: *Safeguarding vulnerable adults within the counselling professions in England and Wales* regards someone as vulnerable if they:

- depend on others for their care or support in everyday life,
- are at risk of, or currently experience neglect or abuse, or
- cannot protect themselves from significant harm or exploitation.

Questions to ask yourself when working with older clients who may be vulnerable include does my client understand what they have come to therapy for? Can they understand and consent to what is agreed in the contracting process? What does their vulnerability mean in terms of confidentiality and how much involvement with the client's carer or those who have legal responsibility for their affairs, is appropriate? If you are in doubt talk to a colleague or your supervisor.

Q1. What should I do if I have concerns over my client's capacity to make independent decisions?

Working with vulnerable older adults is feasible, as long as you are satisfied that they have sufficient mental capacity to understand what it is they are agreeing to. The law on mental capacity is based on principles which assesses the ability to understand information (including risks and benefits associated with any decisions), to retain this information long enough to make a considered decision, and to communicate their intentions (see GPiA 030).

Remember you may have to review this regularly as the person's capacity may change from day to day and may depend on increasing levels of illnesses and/or medication.

The *Ethical Framework for the Counselling Professions* (2018) requires us to:

> *...give careful consideration to obtaining and respecting the consent of vulnerable adult clients, wherever they have the capacity to give consent, or involving anyone who provides care for these clients when appropriate.* (Good Practice, point 28).

Contracting should be comprehensive enough to ensure that both you, and your client are clear about any limits to confidentiality. Clients should also understand that access to their counselling records may be required by law in certain situations.

See also:

- Good Practice in Action 030 (*Safeguarding vulnerable adults within the counselling professions in England and Wales*) for details of the laws governing mental capacity and court orders, contracting and confidentiality;
- Mitchels and Bond (2008) for a discussion of mental capacity and consent, including working with vulnerable adults;
- Bond and Mitchels (2008) for further information on confidentiality dilemmas;
- DH (2014) *The Care Act* at: www.england.nhs.uk/wp-content/uploads/2017/02/adult-pocket-guide.pdf
- DH Mental Capacity Act (2005), which seeks to protect people unable to make decisions for themselves due to dementia or other disabilities; and
- DH Mental Health Act (1983) for key legislation regarding vulnerable adults.

Q2. How should I approach getting other agencies and services involved if I consider my client would benefit from extra support?

Should you see a client in their home and have general concerns about their safety and ability to cope alone, discuss your concerns with your client initially as they may naturally be reluctant to admit they need help. Where your client agrees to additional support being provided, those services can be contacted directly or a referral made, preferably by the client or their carer (or the GP if necessary). Social services can provide contact details of organisations that can help.

As when working with clients with dementia, should you feel that your vulnerable client's issues lie outside your level of competence then you should refer them on to a more suitably qualified therapist.

The Age UK website explains how older clients can gain access to care packages, GP services, Community Mental Health Teams and Community Psychiatric Nurses, and also has a function where you can find local Age UK support services by entering your post code (Age UK, 2019).

Q3. What should I do if I suspect or they disclose any kind of abuse?

Older people can be particularly susceptible to physical, sexual, emotional and financial abuse. If you think your client is being abused, Good Practice in Action 030 (*Safeguarding vulnerable adults within the counselling professions in England and Wales*) explains how the norm would be that your client would give full consent for information to be shared with a third party, where this is in your client's best interests. If your initial contracting is thorough, this should be straightforward. In the absence of consent from your client the law permits disclosure of information in the public interest. For example, if you suspect your client is being mistreated in their residential care home (and other residents may also be at risk), sharing that information with the relevant authorities (such as certain staff, social services or the police) could be considered to be in the public interest. Consider carefully the impact this may have on your client in the immediate situation – by explaining that you intend to report your concerns, could this make your client more vulnerable? Is your client safe to be left alone while you make that phone call? If you work for an agency, what is their policy in such situations?

If you are in doubt about your legal responsibilities then before you act, discuss with your supervisor and if needed an independent legal advisor (often professional indemnity insurers have legal helplines).

Unfortunately, certain medical conditions may leave your client vulnerable to believing situations to be true when in reality they are not, or they may believe previous traumas are ongoing. For example, a client with Alzheimer's may have very clear memories of being abused as a child by an older family member, but they tell you about the abuse as if it happened to them that morning. In this situation, how can you be confident that the abuse was historical? Discussing such situations with your supervisor or an experienced colleague as a matter of urgency would be advisable before involving third parties.

See GPiA 030 for ethical decision-making advice on confidentiality and disclosures in relation to vulnerable adults.

6. Working with clients who have dementia

The Alzheimer's Society (2014) estimates that 850,000 people will be living with dementia in 2015 and predicts that this figure will increase to over one million by 2025 and two million by 2051.

If you were intending to offer therapy to someone with a diagnosis of dementia, it is important to assess (and continue to review) whether the person had the capacity to agree and engage with the work. You would also need to consider, in consultation with your supervisor, whether you had the necessary competence and training to work with the person (see question 1 below).

If your work was specifically to support them to live with dementia, it would be worth referring to what the NICE guidelines (2018) suggest for promotion of cognition, independence and wellbeing for those with a diagnosis of mild to moderate dementia. The guidelines state the interventions' recommendations are to:

- offer a range of activities to promote wellbeing that are tailored to the person's preferences.
- offer group cognitive stimulation therapy. (This is guided practice on a set of standard tasks that are designed to reflect particular cognitive functions. There may be a range of difficulty levels, to fit the tasks to each person's level of ability).
- Consider group reminiscence therapy.
- Consider cognitive rehabilitation or occupational therapy to support functional ability.

(NICE guidelines at: https://www.nice.org.uk/guidance/ng97/chapter/Recommendations#interventions-to-promote-cognition-independence-and-wellbeing)

Q1. Do I need to be specifically trained to work with people with dementia?

The *Ethical Framework* (2018) states that we need to be, 'competent to deliver the services being offered to at least fundamental standards or better…' (Good Practice, point 13).

Work with dementia clients will inherently need to be adapted for that person's degree of communication, understanding and memory, therefore the Alzheimer's Society (2019a) recommends that therapists have experience of working with dementia. However, there is a widely acknowledged shortage of counsellors specifically trained to work with dementia patients. The Alzheimer Society points out that:

> *Counselling has been shown to be a way for people living with dementia to gain support and make sense of living with the condition. Many people living with dementia struggle to make sense of their diagnosis and how their life is changing. They may feel lost, confused, vulnerable or anxious. Anxiety over what the future might hold is particularly common.* (Alzheimer's Society (2019c))

Although there is not much evidence to show that specific dementia counselling has a significant long-term impact, there is evidence that it can bring short-term benefits to the client (Alzheimer's Society 2019c).

Q2. What work with dementia patients is most appropriate?

The most common kinds of dementia are Alzheimer's disease, vascular dementia, mixed dementia and dementia with Lewy bodies.

Whatever kind of dementia a client suffers from, therapy may be helpful, and should be tailored to the individual's symptoms, whether it be apathy, depression, anxiety or other problems. Depression or anxiety may be caused by dementia-induced chemical changes in the brain. The Alzheimer's Society (2019b) explains how talking therapies such as CBT can help.

It is estimated that 36.6 million people have dementia throughout the world. In the UK, current estimates suggest that 820,000 people have dementia, and this is predicted to double in the next 20 years. The total cost to the UK economy is estimated at £23 billion, which is more than the combined cost of cancer and heart disease. (Subramaniam and Woods (2012))

It is estimated that prevalence of depressive symptoms in people with dementia range from ten to 62 per cent (Enache, Winblad, Aarsland 2011). It has been reported that in people with mild cognitive impairment, depression may be resistant to antidepressants (Devan et al., 2003).

Furthermore, depression and anxiety have been found to predict higher rates of progression to Alzheimer's disease (Lu, et al., 2009). Treatment of anxiety and depressive symptoms have been recommended as essential components of the treatment of dementia (Azermai, et al., 2012). Pharmacological treatments are commonly used but can have side effects and have been reported to be largely ineffective (Banerjee, et al., 2011). A meta-analysis on the effects of psychological treatment for depression in people with dementia and mild cognitive impairment found psychological treatment reduced depressive symptoms (Orgetta, 2015).

'Young dementia' (the term used when the person diagnosed is below the age of 65) may have different meaning and impact to clients. Younger people are more likely to still be working when they are diagnosed. Many will have significant financial commitments such as a mortgage. They often have children to care for and dependent parents too. More information can be found at www.youngdementiauk.org.

Q3. What should I do if I suspect my client has dementia?

If you have concerns as to whether your client has dementia, you may need to raise these directly with them. If your client gives permission, it may then be helpful to share information with a carer: it is likely that the carer also has concerns. If your client does not have a carer, at an appropriate time you could encourage them to talk to their GP about what they think is happening. Often clients are resistant to sharing this kind of information with others, but an early diagnosis could be helpful in getting them the support they need. You would need to consider with your supervisor how appropriate it is to continue the sessions while you have these concerns.

As explained in Good Practice in Action 030 (*Safeguarding vulnerable adults within the counselling professions in England and Wales*), the NHS and local councils are expected to work with local care homes to develop services which meet older people's needs regarding mental health problems, including provision of specialist residential care places for older people with dementia. Confirming a diagnosis can take months however, so ensure there is support elsewhere in the meantime. Also inform the family and/or carer of how Admiral Nurses in the area may be able to help. (See: www.dementiauk.org/get-support/find-an-admiral-nurse for more information.)

Q4. What advice can I give to carers, including carers of people with dementia?

Dementia UK and the Alzheimer's Society both offer invaluable information and guidance covering many practical, financial and social aspects of being a carer. Their advice includes discussing the client's legal options (such as Power of Attorney should they become unable to make their own decisions) with relevant parties, checking out what help is available from your council and social services, and ask for an assessment of what the person with dementia needs. In terms of the carer's work with your client, encourage them to prompt the person with dementia to practise whatever work you do in the sessions; keep them as active as possible, maintain other social contacts, support healthy eating and encourage them to communicate how they're doing. Also recommend that they search online and ask around for information about local day centres.

NICE guidelines (2018) state that carers of people with dementia should also have their own needs assessed, whereby the psychological and psychosocial impact on the carer is determined.

They further recommend that plans for the carers are tailored to the individual, and may include psychoeducation, peer support groups, training courses, respite care, practical help and support as well as access to psychological therapies, including CBT if they show signs of psychological distress. Age UK (2018b provide excellent information for carers and can help with a benefits check. See also Dementia UK (2019).

7. Working with terminally ill older clients

Q1. What kind of work is appropriate with someone nearing the end of their life?

A terminal illness does not necessarily mean that death is imminent: people can live for years and appear perfectly healthy for much of this time.

Be guided by your client's wishes. Some clients may have a very limited time to learn new skills (Fox, 2014) so plan the work and any goals appropriately. Depression and anxiety are often seen when patients are diagnosed with a terminal illness or as their illness progresses, and discussions around pain management, accepting and adjusting to the diagnosis, and differences in how they relate to others and vice versa could help.

Many older people have a wealth of experience and many stories to tell about how their lives have unfolded. Encouraging exploration of their belief systems around these experiences, particularly any contradictory beliefs, may help to resolve any internal conflicts that trouble these clients. It is likely that terminally ill clients will gain enormous relief from being given permission to look at some parts of their lives that they may not have shared with their loved ones, for fear of judgment and potential reprisals. It is impossible to underestimate the beneficial effect of making peace with yourself before death.

Age UK has a section devoted to end of life planning (Age UK, 2018c).

Q2. Do I need to have input or permission from the family to work with a terminally ill older client?

Some older clients at an advanced stage in their illness may have full mental capacity whereas others may show reduced mental capacity and confusion. If your client has limited capacity, it is likely that they arrived at counselling via a referral process, which has already involved consent from the relevant parties.

If your client has full capacity, you are not legally required to inform their family of your work; similarly, if the family approaches you to ask about the sessions, your confidentiality obligation to your client remains absolute. Should your client wish you to inform their family or involve them in the work, consider the need for written consent before you talk to them, including permission for any updates if the client wishes.

Q3. What if they want to talk about their death?

Be prepared to talk about death – including their fears of what their last moments will be like. This will be emotional work for even the most experienced therapist. Carefully plan the time of day when you see such clients and balance their needs with other commitments you may have. For example, a client may be more alert late morning, but think about what impact your work with this client may has on your ability to function later in the day. Use supervision to process anything these discussions leave you with.

Q4. Should I handle suicide ideation differently compared with younger clients?

If a client has received a terminal diagnosis, has a medical condition where their quality of life will be gradually eroded or has experienced an unwanted change in life, thoughts of suicide are normal.

Harwood (at Age UK) estimates that about one in six people over 65 have thought life is not worth living in the past month, with approximately three per cent wishing they were dead. Many sources quote the highest suicide rate as being in the older age range, with attempts more likely to be successful.

As a therapist, you are not legally obliged to disclose suicidal ideation just because your client is older.

If you believe that your client has reduced mental capacity, however, see Good Practice in Action 057 Legal Resource: *Suicide – legal issues when working in the counselling professions in England and Wales*, and consider the implications of the Mental Capacity Act (2005). Discussing the situation with an experienced colleague and/or supervisor is advisable. Questions to consider include:

- Should I inform my client's carer, family or GP? Would this be breaking confidentiality, and are there sufficient grounds to do so?
- Does your client have full mental capacity? If the answer is yes, do you have the right to prevent them from acting out their wishes?
- If you work for an agency, what does the agency's policy state on suicidal ideation, and how have you contracted for this?
- What is your personal stance regarding people taking their own lives?

Good Practice in Action 042 (*Working with suicidal clients in the counselling professions*) explains how to develop a crisis plan with suicidal clients. Harwood (of Age UK) recommends that the client involves friends or family in therapy for additional support. He also encourages maintaining a focus of keeping things in perspective, checking they will ask for help to keep themselves safe, consider potential consequences for others should they end their life and look at what other support services are available in their area. Exploring fears about the future may uncover information that could affect their decision: are there any facts that they are assuming, do they have all the information about their condition that's available, do they know someone who has suffered horrendously from the same illness? Discuss whether they are likely to take action in the short-term: is this a knee-jerk reaction to some horrendous news, or is this a considered and balanced conclusion? If your client plans to kill themselves when their illness reaches a certain point, they may still find it useful to discuss other issues which brought them to therapy. Older people may also wish to talk about their religious beliefs regarding suicide.

Bear in mind that as your client may experience an increasing lack of control over their life and body, perhaps the only autonomous act they have left is to end their own life. Whether you take action or not, look after yourself while work with this client is ongoing.

Q5. If they specifically ask about assisted dying, what should I do?

Assisted dying differs from suicide in that the person who wishes to die will be involving others in actions which lead to their death. Is your client asking you for your help personally, or are they disclosing plans they are making with a loved one to help them die? Do you believe that your client's illness or medication renders them without mental capacity? Assisted dying is discussed comprehensively in the legal resource Good Practice in Action 058 (*Assisted death: Issues for the counselling professions in England and Wales*) and includes some examples of case law.

Key points to take from this excellent resource include:

- Although suicide is not illegal, it is an offence to encourage or assist in someone's suicide or 'mercy killing'.
- Our ethical responsibilities and duty of care point to the use of supervision and/or consulting someone with legal experience in these matters.
- Consider referring your client to more specialised and appropriate services which, depending on the situation and in the public interest, you may do without consent.

If your client tells you they will contact an overseas agency that offers assisted or accompanied suicide, rest assured that these do not immediately assist someone with ending their life: the process takes around three months, or even longer, and involves multiple consultations (Dignitas, 2014). This provides time for you to take whatever action you decide is appropriate. See also *Therapy Today* from September 2016 for opinions around an ethical dilemma regarding assisted dying.

Q6. If a terminally ill client discloses a past crime they committed, what should I do?

Good Practice, point 55d of the *Ethical Framework* (2018) expects we should inform clients of 'reasonably foreseeable' limitations to confidentiality before counselling begins.

Good Practice, points 14f, 23 and 70 make further reference to how our work should operate from within the law. In telling you, their practitioner, of a crime they committed, a terminally ill client may be looking to unburden their conscience. But where does that leave you?

It is impossible to give a yes/no answer to the question of what you should do, as it depends entirely on the situation. Questions to ask yourself for guidance include:

- What does the law state you should do?
- What good or harm would come of informing the police? Could anybody else be at risk if you decide not to disclose?
- What difference, if any, does it make that the client is terminally ill; would your decision be different if the client was young and in good health? If so, why?
- How would disclosing/not disclosing impact on your work with this client?
- Does your client's disclosure put you at risk?

Q7. If they tell me they haven't made a will, how should I handle that?

The law relating to who benefits from someone's estate if they die intestate (without having made a will) is complex and depends on where the person lives, but if there are no living relatives the whole estate may go to the Crown (UK Government, 2017). It would be worth asking your client if they are aware of this, as many people are not, and suggest they talk to a carer or their family. It goes without saying that you are unable to comment on how their estate should be split, but it may be appropriate to signpost them on to someone independent who can help them to organise a will. Some solicitors offer to waive their normal fees in return for a charity donation at certain times throughout the year, and some charities help with will-writing in return for a donation in the will. Age UK (2018d) have a section explaining about making a will.

8. Summary

We are living longer, but gaps remain between quality and quantity of later life. Evidence across the UK indicates that for many in mid and later life, health is not good enough to allow us to do the things that matter (The Centre for Ageing Better, 2019).

Twenty-three per cent of people aged 50-64 have three or more long-term conditions (Department of Work and Pensions, 2017), and there are strong correlations between chronic physical illness and poor mental health.

Older people are less likely than young people to be referred for talking therapies when they consult their GP about symptoms of common mental health problems, despite counselling being effective for older people (Collins and Corna, 2018).

The number of people in the UK aged over 65 is projected to rise by approximately 12% over the next five years, amounting to over one million people (House of Commons Library, 2015). Medical advances now mean that some illnesses previously considered life-limiting can be lived with for years and with the life expectancy for both males and females continuing to increase, the demand for mental health services amongst older people will also increase. As public policy continues to promote parity between physical and mental health, so the requirement for more therapists to work with older clients should continue to grow.

About the author

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