Education and training of aged-care providers

By: Jane E. Myers

Myers, J. E. (1994). Education and training for aged care providers. *Disability and Rehabilitation, 16*(3), 171-180.

Abstract:
Population ageing has become a global concern. As persons age they are likely to experience multiple changes, declines, and losses, resulting in multifaceted needs. Psychosocial needs are varied and diverse, reflecting the extreme heterogeneity of the older population and the frequent co-morbidity of physical and mental problems. Training of care providers to work with older people requires an interdisciplinary focus, with biological, psychological, and social aspects of ageing as integral parts of the curriculum. Models for training of aged care professionals include the integration, separate course, area of concentration, and interdisciplinary approaches. In addition, supervised experiences and training in interpersonal skills are required for all service providers. The applications of training models in gerontological and counselling training are described. Implications for education and training of aged-care providers are discussed.
Keywords: careers, elderly, training

Article:

Introduction

As a group, older persons (i.e. those 65 years of age and older) are known to experience the greatest amount and type of disabling conditions and to require proportionately more care services than persons of other ages. For example, older persons account for 36% of total personal health care expenditures, with an average of four times more dollars spent for each person over 65 years than for each person under that age. Older persons average more contact with physicians and account for 34% of all hospital stays and 45% of all days of care in hospitals .[1]

Among the more than 26 million older Americans, at least 86% experience one or more chronic physical conditions which limit their daily living activities.[2,3] In spite of these conditions, most are functionally independent. However, 23% of older people living in the community have health-related difficulties with one or more personal care and home management activities. While less than 5% of all older persons live in nursing homes, over 80% of such individuals require assistance with daily living activities.[4]

Physical illness and disability do not occur in isolation. Rather, biological processes are known to interact with psychological and social factors. Epidemiological studies by mental-health researchers have drawn attention to the interaction between physical and mental-health problems, which leads to substantial co-morbidity among older adults.[5,6] That is, physical problems can lead to mental and emotional disturbance, emotional distress can exacerbate physical symptoms, and the combination of both can lead to significant clinical impairments. If effective services are to be planned and provided for older persons, it is necessary to assess and evaluate the synergistic impact of both physical and mental conditions.[7] No single discipline — psychiatry, medicine, nursing, biology, sociology, counselling, rehabilitation — can claim to provide a comprehensive explanation of older individuals, the multiple determinants of their behaviours, or the multiple treatments they may require.[8] Such assessments require multidisciplinary teams working together, often using standardized multidimensional functional assessment strategies.

How professionals are trained to be members of interdisciplinary assessment and treatment teams for older persons is an important consideration. This paper discusses the psychosocial needs of older persons and considers the implications for curriculum development required to prepare aged-care professionals to deal with the concerns of their clients. Although the paper focuses on training in the United States, population statistics and projections reveal that ageing is a global phenomenon. The United States ranks fifteenth of 25 nations in percentage of population aged 65 years and over, with almost 13% of its population in this age range. Sweden's population includes almost 18% over the age of 65. Other developed nations with more than 14% of their population over age 65 include Norway, Germany, Denmark, the United Kingdom, and Switzerland.[9] Comparative studies of ageing in the United States and elsewhere reveal that, while differences in service delivery systems exist, the problems facing older disabled individuals are relatively constant across cultures.[10,11] All countries, for example, face the dual problems of persons who became disabled in later life as well as those who became disabled and then grew old.

Psychosocial aspects of ageing and the rehabilitation process

The older population is extremely heterogeneous and diverse. Although older persons experience many common life circumstances, their reactions are unique and individual. In part this is true because older persons experience multiple problems and stresses at a time when their resources to cope are declining." Social withdrawal and isolation, common reactions to changing social support networks, can exacerbate existing physical and mental problems. Certainly, most older persons are not isolated; nor are they abandoned by family and friends. At least two-thirds of older persons in the United States live with their families,[8] and more than 80% of the care needed by older persons is provided by family members.[12] These facts should not be taken as all positive, since they leave 20-30% of older Americans at-risk for a variety of disabling conditions. These conditions, while often due to physical illness or injury, always have multiple psychosocial components which affect the rehabilitation process. As Kemp[5] noted,

> psychosocial factors are some of the most limiting causes of handicap among disabled persons, and it is possible that older people are even more handicapped by these than younger persons. Regardless of how much effort is devoted to correcting 'mental health problems' surrounding rehabilitation of older persons, ultimate improvement must come from also addressing the psycho-social factors adding to problems that lie outside the older person's control (p. 123).

Kemp identified three factors which affect the process of rehabilitation in older persons. The first, which he considered to be the most important, is 'devaluation'. As is well known in rehabilitation, persons who are disabled are often viewed as inferior to, or less worthwhile than, persons who do not have disabilities. Ageing is also devalued in many cultures, including the United States. Persons who are both old and disabled experience a situation described as 'double jeopardy', being devalued for multiple reasons.[12] If they happen also to be members of a minority ethnic group, females, or in some situations widowed or single, they may experience additional discrimination. Clinicians who ascribe to these prevalent negative attitudes may, unconsciously, avoid working with older clients, fail to accept their concerns as important, spend less time with them, and consider them to be unable or unwilling to change.[6]

Devalued groups characteristically internalize prevalent societal values and beliefs; hence older persons are inclined to internalize the negative perceptions of others. As a result they may experience a decline in their sense of self-esteem and feelings of self-worth.[12] Feelings of vulnerability and inferiority make them less able to be assertive with care providers to obtain the services they require.

The second psychosocial factor Kemp identified as affecting the rehabilitation process and outcomes is a general lack of interest in the problems of older persons combined with pervasive negative attitudes towards older people. The concept of ageism, similar in nature to racism and sexism, explains the negative, stereotypical views in which aged persons are considered to be unattractive, unhealthy, unproductive, depressed, and unlikeable. Unfortunately, such beliefs tend to discourage service providers from working with older people, considering their complaints and concerns to be `normal' aspects of ageing rather than treatable conditions.

The third major psychosocial obstacle is lack of opportunity, reflected in under-service of older persons in rehabilitation programmes. In 1980 less than 5% of all rehabilitants in the United States state-federal system were over age 65. This under-service reflects both negative attitudes and the orientation of the rehabilitation system to full-time employment as a rehabilitation outcome. Older persons are viewed as being poor candidates for this vocational objective.[13] On the other hand, rehabilitation services also include independent living as a goal for some disabled individuals. Denial of the benefits of rehabilitation's philosophy and services to individuals who have reached an arbitrary chronological age is difficult to justify. As the older population increases in size, this arbitrary distinction will become increasingly indefensible, and the likelihood of older persons seeking and receiving rehabilitation services will increase.

To serve them effectively, rehabilitation service providers need to understand the needs of older persons and the heterogeneity of the older population. Accurate assessment by care providers requires, in fact mandates, the ability to listen sensitively, carefully, and patiently while older persons tell their individual stories. An important key to proper diagnosis, and hence appropriate treatment, lies in an accurate understanding of the biological, psychological, and social factors affecting functioning in older persons. Developing such understanding requires both didactic coursework, and contact with older individuals and their unique circumstances and concerns.[14]

Training gerontological care providers

Sterns and Atchley[15] noted the critical importance of multidisciplinary training for all professionals providing services to older individuals. The traditional single-discipline perspective, while important, is insufficient to provide adequate training in response to the diverse needs of the older population. A review of the curricular requirements of several disciplines (e.g. occupational therapy, counselling, pharmacy, geriatric medicine, public health, health, physical education, recreation and dance, social work, nursing, and general medicine relative to ageing-specific education reveals commonalities in content and also in delivery of training programmes.[14] Content requirements reflect biopsychosocial needs of the older population, as well as substantial overlap among disciplines in the specific curricular content in these areas. For example, units addressing physiological changes and ageing may be found in the curriculum of counselling, social work, physical education, and recreation and dance, as well as in nursing and medicine, though the focus and depth of the content in the various disciplines is understandably different.

MODELS OF TRAINING

Training programmes in different disciplines include one or more delivery models, and supervised experience designed to help integrate knowledge with practice. Four models stand out in the literature as appropriate for the preparation of professionals to work with older adults.[16,17] These include the integration, separate course, area of concentration, and interdisciplinary models. Each has its own advantages as well as problems. As a result, some may be assimilated more readily by certain academic disciplines, while others may be more appropriate in specific academic departments or within the confines of specific institutional programmes. Frequently the models may be combined for a more comprehensive, diverse, and flexible approach to training.

The integration model

In the integrated model, existing courses in a department or discipline are adjusted to include relevant information about older persons, such as their environment, their actions, feelings, and behaviours, and methods for working to help them within the context of the discipline. Those disciplines which have a standard curriculum core would have the content of each core area adjusted to include a focus on lifespan and late-life issues. In this manner all students in the discipline would learn about the needs of older persons and how to address those needs. Since ageing is really *a part of* rather than *apart from* the rest of the lifespan, this model is often both appropriate and desirable. In addition, this model does not require the development of new courses, a desirable feature given funding limitations and already full curricula in many academic settings.

An assumption underlying the integrated, or *infusion* model is that all practitioners in a discipline may expect to encounter older persons, their families, or individuals having significant relationships with older persons as clientele. For example, even school counsellors will work with students who have grandparents or are living in

multigenerational households. Public-housing planners will encounter needs to serve the older population with specialized housing. The integrated model thus has substantial advantages for training all practitioners in a discipline to a minimal level of competence in service to older people.

In addition to core curricula, many disciplines have specialty curricula for certain students electing to be specialists rather than generalists. Again, the integrated model would imply that lifespan and late-life issues would be infused into the specialty curricular experiences. A further advantage of this model would be that the specific information needed in a given specialty could easily be incorporated into existing specialty courses. For example, standards for professional preparation of counsellors permit accreditation of graduate counselling training programmes in a community, school, and student personnel counselling. Community counselling majors would need to understand the aetiology of mental illness in later life, and specialized techniques for working with older adults in both community and institutional settings. School counsellors would benefit from learning about inter-generational programmes, and the impact of attitudes towards ageing on the development of adolescents and young adults. With the infusion model, specialized curricula could be developed to meet the needs of each of the counselling majors.

Although the integrated model seems to offer the greatest flexibility and the greatest potential to reach the largest number of students, there are also substantial obstacles to implementing this approach. First, it requires broad-based interest and competence in the area of ageing among most, if not all, of the faculty in a discipline/department. Each faculty member must acknowledge the importance of the topic and make a commitment to the integration model. This may require a systematic revision of substantial parts of the curriculum. Often, the specific curricular resources to make this an 'easy' task are lacking. In the author's experience, when the infusion model has been introduced relative to ageing, instructors with other specialty interests, such as multicultural counselling, gender issues, or career counselling, have stated that they would *infuse* ageing concepts when their own special interests also were infused, and to the same extent.

The separate course model

In the separate course model a specific course on ageing is offered within an academic discipline. This model may be the easiest one to implement in academic departments where the addition of new courses is not excessively difficult. It requires only one interested faculty member with the ability to convince others of the importance of ageing issues. It also reduces or eliminates the need for wider course changes and involvement of the full departmental faculty. A major advantage of this model is that it allows more in-depth preparation in ageing of those students who take the course.

If offered as a requirement the separate course could provide a specialized background of information about older people to all students. However, this model most often is implemented with the ageing course as an elective, for students who want more information or who choose to specialize in work with older adults. Other faculties may advise their students to take other courses, particularly if course enrolments are important for course evaluations or continuations. In this case other faculties may support their own special interests rather than a gerontology course.

One of the major obstacles to the separate course approach is that many programmes are already 'too full', or do not have the faculty resources to teach new courses, especially elective courses. It also may be difficult to avoid some overlap with existing courses, as is the case in counselling where a lifespan developmental course is required for all students.

The area of concentration model

The area of concentration model is an approach that includes several courses taught in one department, often incorporating a practical experience component. Students receive both in-depth training and supervised practice in work with or on behalf of older persons. Often, a certificate or specialization complements this model. Where fully implemented the area of concentration prepares students to be specialists in work with older people, rather than generalists. Some professions find this desirable while others are either opposed to, or debating the relative

merits of, the issue. In some instances, professional certification in the specialty may follow completion of the specialized training.[18]

A disadvantage of this model is the relatively small number of students who would receive training in ageing, compared to the integrated model. Further, few training programmes have the commitment and funding required to devote faculty and departmental resources to the creation of a separate specialty. In addition, the numbers of students interested in ageing may be insufficient to warrant a separate specialization. Because it requires a more extensive commitment, and greater resources, this model is less often chosen by academic disciplines.

The interdisciplinary model

By making use of faculty and courses in other departments, the interdisciplinary model reduces the need for involvement in ageing curricula of large numbers of faculty or students in one department. Since any one department is unlikely to have the necessary breadth or depth of expertise to train students to meet the diverse needs of the older population, or perhaps even a large enough number of interested students, this model provides flexible alternatives to students. It is enhanced in institutions which have a gerontology centre, particularly with a gerontology certificate option. To meet the criteria for the certificate, students must select a specified number of courses from a list of approved courses relating to the ageing population. Frequently a research project and supervised experience with older persons are among the certificate requirements. Students receive the certificate of gerontological studies along with a degree in their own discipline.

One of the obstacles to this approach is the reluctance of many educators at the graduate level to have students select courses outside of their own department. Of course, this model presupposes that relevant courses within the academic institution do, in fact, exist. It further presupposes that non-majors may enroll in such courses, and that prerequisites within the offering department are not excessive or even not required. Clearly, the coordinating services of a gerontology centre can enhance the implementation of this particular model. Most such centres adhere to national standards for gerontology education, a major component of which is supervised experience working with older persons .[19]

MODELS OF SUPERVISION

Wendt and Peterson[14] conducted an in-depth survey of the daily work activities and extent of formal instruction in ageing of 2500 professionals working with older persons throughout the United States. They concluded that professional training programmes in all disciplines need to focus on specific areas of knowledge as well as skill development in the preparation of gerontological practitioners. Neither knowledge nor experience alone will suffice to prepare practitioners. In short, 'gerontology education in formal settings integrating declarative knowledge with procedural practice is becoming a necessity' (p. 3).

As noted earlier, the knowledge base for practitioners working with older persons includes biological, psychological, and social aspects of ageing. The experiential component of training programmes develops trainees' understanding of how these aspects affect the functioning of older individuals, and how interventions may be applied to enhance their levels of functioning. Field experiences offer the opportunity to apply theoretical concepts and practices learned in the classroom setting. They allow the student or trainee to learn what methods and techniques may be most effective. In addition, field experiences help trainees get to know older people as individuals, a process known to be effective in developing positive attitudes towards this population. The evolution of positive attitudes, through appropriate training and supervised practice, will ultimately benefit all those who have the courage to face the challenges of ageing and the complexities of multi-faceted change in later life. The development of effective experiential training requires attention to the setting and types of clientele, supervisor skills, types of supervision intervention, and trainee development.

Setting and types of clientele

The setting in which students obtain experience working with older persons may be any setting in which older people comprise a large portion of the clientele. Longterm care settings, including nursing homes and inpatient

rehabilitation programmes, are obvious choices for students in the medical and allied health professions.[20] The clientele in long-term care and hospital environments include older persons with both acute and chronic medical conditions, all of whom will experience psychosocial as well as medical needs. Custodial settings may be less desirable than those in which rehabilitation is emphasized, as the latter settings can provide greater opportunity for implementing biopsychosocial interventions.

Older persons living in the community come into contact with a variety of health care and social service providers. Any community setting in which older people comprise the clientele is potentially a training site. Some settings, such as outpatient medical and rehabilitative care programmes, will include impaired older persons among the clientele, while others, such as senior centres and congregate meal programmes, will include older persons who have a greater degree of functional independence. Even independent-living older persons may be expected to have biopsychosocial needs. The key to selecting a community setting is related to the training needs of the student and the skills of the faculty and on-site supervisors.

Supervisor skills

Supervision of internships and externships requires skills and processes different from those used in traditional classroom teaching.[21] The available evidence, compiled from literature reviews and national surveys, suggests that most supervisors, whether novices or skilled instructors, have little formal instruction in supervision methods.[22] Borders and Leddick prepared a handbook as a practical guide for both faculty and on-site supervisors. They recommend that all supervisors conduct a self-assessment of their supervision-related knowledge and skills, such as the ability to identify learning needs and learning styles of the supervisee, comfort in an authority role, and the ability to provide constructive feedback.

Supervisors must develop skills in assessment of supervisee knowledge, skills, needs, and level of both personal and professional development. Further, supervisors must be able to develop goals and objectives, in concert with supervisees, to structure the supervision process. Specific supervision interventions, discussed below, must be chosen to meet the identified training needs of the supervisee. Finally, supervisors must develop skills in evaluating supervisees' progress in skill acquisition and development.

Types of supervision intervention

A variety of supervisory interventions may be implemented, depending upon the needs of trainees, skills of supervisors, and available facilities. Both individual and group supervision approaches can be useful, with group methods offering an added advantage of peer supervision and the development of supervisory skills among trainees.[23]

Supervision interventions include self-report, audio-and video-tapes, microtraining, interpersonal process recall, modelling, role playing, and live observation.[22] Self-report relies on the supervisees' abilities to make objective self-evaluations and observations, and report accurately on their own behaviour, thoughts, feelings, and interactions with clients. Audio- and video-tapes offer a variety of objective opportunities to evaluate supervisees from different perspectives, such as their own or client behaviours, both verbal and non-verbal interactions, their relationship with clients, and the overall content and process of intervention sessions. Microtraining is a systematic approach to skill acquisition in which skills are taught individually, practised in isolation, and developed through supervised practice and evaluation. Interpersonal process recall uses audio-and video-tapes to stimulate recollections of thoughts and feelings experienced during a particular session, with a focus on developing and improving interviewing and helping skills. Modelling may be deliberate or unintentional, as supervisees seek to emulate the behaviour of their supervisors in work with older clients. Role-playing provides an opportunity for trainees to observe and model supervisors' behaviours, as well as an opportunity to experience a problem or intervention from a client's perspective.

Live observation can be conducted using one-way mirrors, with the supervisor invisible to the supervisee and client. Alternatively, live observation can be a part of a co-therapy process, in which both supervisor and supervisee jointly provide biopsychosocial interventions with one or more clients.[24]

Trainee development

The needs of trainees change over time as they develop skills and increased professional maturity and judgement. As a consequence, supervisory needs also change during the course of supervision. Beginning trainees tend to value as well as benefit from supervisor support and a high degree of structure, while more advanced trainees seek technical guidance and less structure in the supervisory relationship.[25] Advanced trainees have a greater level of self-awareness, autonomy, understanding of theory, and ability to apply skills in working with clients.[26] The changing needs of supervisees require the application of developmental concepts, or developmental supervision, in which supervisory methods and interventions change as trainees' learning needs evolve.[27]

The trainees' development of skills has been discussed here in relation to the requirements of a particular discipline. Of equal importance is the trainees' ability to function as members of a multidisciplinary team. Courses in interprofessional knowledge are seldom taught in academic programmes. An alternative means of learning about the unique contributions of various disciplines is through case conferences. Case presentations have proved to be an effective mechanism for improving case conceptualization skills.[28] When presented in a conference format, trainees can benefit from the unique perspectives and contributions of each member of the treatment team. Of course, such conferences are possible only when experiential settings are chosen which include service providers from multiple disciplines. The training of these providers could have been accomplished using any of the training models discussed earlier. How these models are applied in the practice of several disciplines is discussed below.

Examples of training models

In the United States, most instruction in gerontology began after the passage of the Older Americans Act in 1965,[14] which was also the time when the concerns of an ageing population began to be widely recognized and explored. A variety of different training models have been developed and implemented since the 1960s, most employing one or more of the four strategies described above. Two of the more comprehensive models, gerontology and counselling, are described in this section. A brief look at psychiatry, psychology, nursing, and rehabilitation provides additional insights concerning the availability of training in gerontological issues.

GERONTOLOGY - AN INTERDISCIPLINARY MODEL

The Association for Gerontology in Higher Education (AGHE) was formed in 1974 as a multidisciplinary organization with membership from diverse disciplines, all sharing a common concern for the needs of older people. The newsletter of this organization, the *AGHE Exchange,* is an important outlet for published discussions on curriculum and personnel issues in aged care. Over the years the members of AGHE have debated the issue of whether gerontology is a specialty within an existing discipline or a discipline in and of itself. The origins of gerontology are in the traditional disciplines (e.g. medicine, psychology, sociology), and specialty curricula have been developed based on a body of knowledge specific to each discipline. At the same time the body of knowledge about older people has grown significantly. Those who argue for gerontology as a separate discipline have been active in the development of training programmes separate from the traditional disciplines, so that now there are 40 master's and two (2) doctoral programmes in gerontology in the United States.[29]

AGHE has developed and published standards for professional preparation in gerontology, including standards for undergraduate and graduate certificate programmes and degrees.[19] The core curriculum in each area of the standards includes biological, psychological, and social aspects of ageing. Research methods and supervised practica are part of some of the define programmes. Where gerontology departments exist, or where gerontology centres provide courses, an interdisciplinary course in gerontological studies is offered.

The results of a recent study of professional preparation and practice among service providers to older persons, supported in part by AGHE, lend support to the national preparation standards.[14] The results of this study indicated that professionals working with older people need specialized training to do so. The biopsychosocial model and the emphasis on broad-based multidisciplinary studies were viewed as necessary. Among the

knowledge of ageing used daily by respondents, modifications in interpersonal and group communication techniques to meet the needs of older persons emerged as a primary consideration. Over 30% of the respondents indicated needing to make such modifications daily, and over 30% also indicated a need for continuing education to develop both knowledge and skills in this area.

GERONTOLOGICAL COUNSELLING - APPLICATION OF FOUR MODELS

Gerontology emerged as a specialty within the counselling profession in the late 1970s, in response to identified mental health needs of older persons and a lack of trained service providers to meet those needs. Over a 10-year period the American Counseling Association, the national professional association for American counsellors, worked with funding from the United States Administration on Ageing to develop curricula, resources, and models for preparing counsellors to work with older people.

Among the materials produced in a series of five national projects were a curriculum guide and accompanying video-tapes which presented both a model and curricular resources to infuse or integrate gerontological counselling into existing counsellor preparation courses.[30,31]. The national accreditation and professional preparation standards for counsellors formed the basis for development of the curricular units. Training of (interested) counsellor educators in strategies for infusion also was completed. The curriculum guide also presented guidelines for development of specialty curricula to meet either the separate course or area of concentration model for specialty preparation in gerontological counselling.

Having developed curriculum materials, attention was turned to identifying competencies for counsellors in gerontological issues. A national project was conducted to accomplish this goal, resulting in the publication of an extensive set of competencies for (1) training of all counsellors in gerontological issues, per the integration model, and (2)training of specialists in gerontological counselling, per the separate course or area of concentration model.[31] The competencies were then used to develop a national certification process in gerontological counselling, as well as professional preparation standards. The standards allow a subspecialty in gerontological counselling within an existing counsellor training programme. The certification is an elective specialty which National Certified Counselors may choose to pursue.

Training of counsellors to meet the gerontological competencies requires multidisciplinary instruction along with supervised practice in a setting where older persons comprise the majority of the clientele. Students are encouraged to seek elective coursework outside of the counselling department which will help prepare them to meet the biopsychosocial needs of older adults. In some settings supervision is also multidisciplinary, with both medical and allied health professionals participating in individual and group supervision, along with case conferences.

MEDICINE, PSYCHIATRY, PSYCHOLOGY, AND NURSING

Medicine, psychiatry, psychology, and nursing are examples of professions which have struggled to meet the need for providers trained in gerontological issues. Most are still struggling, either with curriculum development or student recruitment, or both. Currently, 17 of 20 family practice training programmes in the United States offer a specialty training programme in geriatric medicine which is accredited by the Accreditation Council for Graduate Medical Education (ACGME), and 79 internal medicine training programmes accredit a geriatric medicine specialty.[32] The American Board of Psychiatry and Nurology began certifying geriatric psychiatrists in 1991,[33] and steps to accredit this specialty are in process by the ACGME. The growth of geriatric specialties within the American medical system parallels the overall growth of medical specialties in the past decade. The number of positions for specialty residents (for supervised practice in medicine) has grown at a rate of 25 o, while the growth of enrolments of residents in graduate medical education has increased only 24%. Consequently, there are more positions available than persons to fill them. Although the American Geriatrics Society has endorsed a requirement for all internal medical residents to receive geriatric medical training,[34] the challenge of recruiting qualified and motivated students for geriatric specialties remains a priority for those interested in the concerns of the ageing population.

Nursing has perhaps the longest history among the health professionals of concern for older people. Gerontological curricula are available in most nursing training programmes, and specialty certification of individuals and programmes is available. Both didactic coursework and supervised experience are included in the national standards for gerontological nursing. Psychology remains in a state of debate, with recent publications recommending in favour of the integration model combined with the separate course model or just the integration model as a means of training geropsychologists.[35]

REHABILITATION COUNSELLORS

The qualifications, credentials, and competence of rehabilitation counsellors were the subject of a recent comprehensive review.[36] Qualified rehabilitation professionals, as defined by the National Council on Rehabilitation Education, must meet rigorous standards of preparation. These individuals are trained according to national preparation standards implemented by accredited programmes. Master's level graduates often seek certification as Certified Rehabilitation Counselors. Although many older persons are disabled and potential candidates for both vocational and independent living rehabilitation, professional preparation standards in the field do not reflect a concern for this population. Neither lifespan developmental issues nor the interaction of ageing and disability are addressed in the current accepted standards for preparation and practice in rehabilitation counselling.[13,36]

Implications for education and training

Older persons with disabilities experience multiple, complex, and interacting physical and mental problems. Consequently, psychosocial rehabilitation with this population is an especially difficult challenge for rehabilitation service providers. Given the high percentage of this population who experience disabling conditions, the potential benefits of rehabilitation in enhancing the quality of later life are especially significant.

Researchers who have studied psychosocial rehabilitation of older persons have concluded that both research and training are important needs.[5,37] Of course, they are interrelated. Research is needed to increase understanding of the ageing process and the complexities of factors which affect the functioning of older individuals. Specifically, research is needed concerning the interaction of ageing and disease processes. Some persons become disabled before they reach old age, some become disabled for the first time in old age. It is unknown how the age of onset of disability affects functioning and rehabilitation outcomes in later life. Such research is essential for determining successful intervention strategies. Training efforts will be informed and improved through quality research in diverse areas.

Kemp[5] suggested that the most critical areas for research at this time include the following: (1) the assessment of rehabilitation services, including policies as well as adaptations in the service delivery system which may be required to serve older disabled persons; (2) assessment of mental health concerns; (3) methods of treatment for emotional problems; (4) patterns of adjustment and intervention strategies with special sub-populations, such as older minority individuals and older persons experiencing depression; (5) effectiveness of mental health interventions in inpatient, outpatient, and multidisciplinary settings; and (6) linkages between care providers and caregiving agencies and systems. Research in these areas would enhance the knowledge base for provision of psychosocial interventions.

Finnerty-Fried[37] reviewed the literature in rehabilitation and counselling with older persons. She included studies of research relative to training rehabilitation professionals, noting that research on the process of training professionals for work with older persons is needed. One of her major observations related to the `serious lack of emphasis on rehabilitation applied to older persons' (p. 18) in the literature examined. She further noted the lack of carefully controlled, theory-based, rigorous research in geriatric rehabilitation. Because of the multifaceted problems of ageing and disability which were mentioned frequently in the literature, Finnerty-Fried concluded that the need for multidisciplinary studies involving collaborative efforts between disciplines is a paramount concern. Certainly, outcome research is an essential consideration if the effectiveness of interventions with older disabled persons is to be determined.

An added concern is the need to assess the effectiveness of the various models of training discussed earlier. One means of accomplishing such assessments is through competency-based examination of training programme graduates, as occurs with national certification. Medical education and counselling education are examples of professions where national certification in gerontological specialties is now available. Professionals who successfully pass certification examinations attest to the effectiveness of their education in preparing them to meet national standards of knowledge and practice. On the other hand, studies linking specific educational models to examination outcomes have not been conducted. Thus, it is unknown whether one method is superior to others in training aged-care providers.

Biological, psychological, and social aspects of ageing are essential elements of training for all practitioners in this field. Fortunately, statements of competencies for gerontological service providers and standards for training have been developed and can serve as guidelines to help improve the quality of professional preparation in ageing. Methods of preparation also offer structures for disciplines to examine in planning ageing-related training. Regardless of the academic discipline involved, these models and standards provide assistance to curriculum planners to help assure that professionals offering services to older persons have a uniformly high level of relevant expertise. In addition, all disciplines need to incorporate knowledge of the contributions which may be made by various other disciplines to interventions with older disabled adults.

Interprofessional respect and cooperation cannot be assumed; it must be cultivated. Interprofessional conflict is especially counterproductive when older persons are involved, since multidisciplinary approaches are the 'treatment of choice'. Such conflict is also easily activated, since the training required to work with older people, regardless of discipline, will include similar and often equivalent information. It is possible that some academic disciplines will claim 'ownership' of particular topics, wanting them taught within their own discipline and working against the inclusion of 'their' topics in the curriculum of other academic departments. For example, counsellors may believe that interpersonal skills training should always be taught in counselling departments, while nurse educators may consider interpersonal skills to be an important and integral part of nursing training. Nurse educators may assign readings from literature in their own field in which interpersonal skills training is addressed. They also may believe that physiological aspects of ageing should be taught within the nursing profession, while counsellor educators teaching gerontological issues include this information in their own courses, with curricular resources from the available literature in counselling.

It is helpful to remember that each academic discipline contributes uniquely from its own body of knowledge, hence each applies information about ageing in a somewhat different manner. Nurses study physical change and ageing in order to help older persons adjust to changes and follow medical treatment regimens. In so doing they must have adequate interpersonal skills to communicate effectively with their older patients. Counsellors study physical change and ageing in order to help older persons adjust emotionally to the changes they experience, and to understand the difference between normal and pathological changes so that appropriate referrals to medical specialists may be made. Counsellors must be skilled in interpersonal communication and techniques for facilitating behaviour change if they are to be effective in their work, a level of skill development which is qualitatively different from that required for nurses.

Interpersonal communication skills must be a major component of all training programmes, regardless of discipline, if the needs of older persons are to be adequately addressed. The heterogeneity of the older population, the diversity of needs among individuals, and the uniqueness of each older person require that service providers be prepared to listen carefully to older persons and their families in order to determine the nature of each individual's circumstances and needs. Individual attitudes, beliefs, and values are important determiners of rehabilitation outcomes. Service providers must be prepared to listen, in a compassionate and sensitive manner, to determine the individual impact of disability on older individuals. The process of listening, in and of itself, will result in therapeutic outcomes, even in the absence of other interventions.

Older persons will be most effectively helped when a team atmosphere is created and nurtured among all service providers. The interaction of a multidisciplinary team working closely together is essential if the

complex psychosocial needs of older people are to be met. An effectively functioning team presupposes all team members to be appropriately trained in their area of expertise, yet having an understanding and appreciation of the contributions of other members of the team. This training may be accomplished using a variety of models, and with supervised practice as an integral part of the training effort.

References

1 American Association of Retired Persons. *A Profile of Older Americans, 1992.* Washington, DC: Author, 1992.
2 Fulton JP, Katz S. Characteristics of the disabled elderly and implications for rehabilitation, In: Brody SJ & Ruff GE *(eds) Ageing and Rehabilitation: Advances in the State of the Art.* New York: Springer, 1986; 36-46.
3 Brotman H. *Every Ninth American.* Washington, DC: US House of Representatives, 1982.
4 National Center for Health Statistics. *National Nursing Home Survey.* Washington, DC: US Government Printing Office, 1989.
5 Kemp B. Psychosocial and mental health issues in rehabilitation of older persons. In: Brody SJ & Ruff GE (eds) *Ageing and Rehabilitation: Advances in the State of the Art.* New York:. Springer, 1986; 122-158.
6 Cohen GD. Psychopathology and mental health in the mature and elderly adult. In: Birren JE & Schaie KW (eds) *Handbook of the Psychology of Ageing.* San Diego, CA: Academic Press, 1990; 221-291.
7 Verbrugge LM, Lepkowski JM, Imanaka Y. Comorbidity and its impact on disability. *Milbank Quarterly* 1989; **67:** 450-484.
8 Ronch JL, Van Zanten L. Who are these ageing persons? In Hull RH (ed.) *Aural Rehabilitation.* San Diego, CA: Singular Publishing Group, 1992; 235-246,
9 Canadian Association for Adult Education. *Population Aged 65 and Over, 1980-2050.* Kanata, Ontario: Author, 1988.
10 Genskow JR. *Independent Living and Older Persons with Disabilities in Denmark.* New York: World Rehabilitation Fund, 1986.
11 Ruff GE, Geriatric rehabilitation in Great Britain. *Research and Paining Center for Rehabilitation of Elderly Disabled Individuals Newsletter* 1986; 3: 1-3.
12 Myers JE. *Adult Children and Ageing Parents.* Alexandria, VA: American Counseling Association, 1989.
13 Myers JE. Rehabilitation of older people. In: Pan EL, Newman SS, Backer TE & Vash CL (eds) *Annual Review of Rehabilitation* 1985; **4:** 1-54.
14 Wendt PF, Peterson DA, National survey of professionals in ageing network supports need for formal training in gerontology. *ACHE Exchange* 1992; **15:** 1-4.
15 Sterns HL, Atchley RC. The politics of gerontology in higher education in changing times. *ACHE Exchange* 1991; **14:** 1-2.
16 Copeland E. Minority populations and traditional counseling programs: some alternatives. *Counselor Education and Supervision* 1983; 21: 187-193.
17 Myers JE, Blake R. Preparing counselors for work with older persons. *Counselor Education and Supervision* 1986; 26: 137-145.
18 Myers JE. From curriculum to competencies to certification: gerontological counseling comes of age. *Journal of Counseling and Development* (in press).
19 Rich TA, Connelly JR, Douglass EB (eds) *ACHE Standards and Guidelines for Gerontology Programs.* Washington, DC: Association for Gerontology in Higher Education, 1988.
20 McRae TD. Geriatrics in medical education. *AGHE Exchange* 1991; **14:** 7.
21 Scott N. Foreword. *Handbook of Counseling Supervision.* Alexandria, VA: American Association for Counseling and Development/American Counseling Association, 1987.
22 Borders LD, Leddick GR. *Handbook of Counseling Supervision.* Alexandria, VA: American Association for Counseling and Development/American Counseling Association, 1987.
23 Borders DL. A systematic approach to peer group supervision, *Journal of Counseling and Development* 1990; **69:** 248-252.
24 Bubenzer DL. Use of live supervision in counselor preparation, *Counselor Education and Supervision* 1991; **30:** 301-308.

25 Guest PD, Beutler LD. Impact of psychotherapy supervision on therapist orientation and values. *Journal of Consulting and Clinical Psychology* 1988; **56:** 653-658.
26 McNeill BW. Supervisees' perceptions of their development: a test of the counselor complexity model. *Journal of Counseling Psychology* 1985; **32:** 630-633.
27 Hayes RL. Developmental group supervision. *Journal for Specialists in Group Work* 1990; **15:** 225-238.
28 Biggs DA. The case presentation approach in clinical supervision. *Counselor Education and Supervision* 1988; 27: 240-248.
29 Rich DA, Doctoral degrees in gerontology. *ACHE Exchange* 1990; 13: 1-2.
30 Myers JE. *Infusing Gerontological Counseling Into Counselor Preparation: Curriculum Guide.* Alexandria, VA: American Counseling Association, 1989.
31 Myers JE, Sweeney TJ. *Gerontological Competencies for Counselors and Human Development Specialists.* Alexandria, VA: American Counseling Association, 1989.
32 Martini CJM. Graduate medical education in the changing environment of medicine. *Journal of the American Medical Association* 1992; **268:** 1097-1105.
33 Geriatric psychiatry certifying examination. *ACHE Exchange* 1991; **14:** 5.
34 Jahnigan DW, Ward S. Helping to educate the physicians who will care for the elderly: an investment in tomorrow. *ACHE Exchange* 1991; **15:** 1-2.
35 Gatz M, Karel MJ, Wolkenstein B. Survey of providers of psychological service to older adults. *Professional Psychology: Research and Practice* 1991; 22: 413-415.
36 Rehabilitation counselors: qualifications, credentials, and competence. *Rehab Brief: Bringing Research Into Effective Focus* 1989; **XI:** 1-4.
37 Finnerty-Fried P. *Rehabilitation and Counseling of Older Persons.* Washington, DC: Catholic University of America, 1985.