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Taking Access to the Community: An Ecological Systems Framework for In-Home Counseling with Older Adults

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PRACTICE

Taking Access to the Community: An Ecological Systems Framework for In-Home Counseling With Older Adults

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Bronfenbrenner's (1977) ecological systems theory is a holistic framework placing an individual in a system's context to address their concerns. This article offers a case study demonstrating use of the theory with older adults and the in-home setting. Implications for the counseling field and future research needs are discussed.

Keywords: in-home counseling, Bronfenbrenner, ecological systems theory, older adults, community counseling

Pre-1940s counseling was restricted to inpatient psychiatric hospitals, office settings, and locked wards historically known as asylums (Accordino, Porter, & Morse, 2001). Following the end of World War II, the United States witnessed servicemen and women returning from the war with mental illnesses; however, mental health systems were inadequate to meet these needs (Accordino et al., 2001; Torrey, 1997). In an effort to improve the mental health system, the federal government enacted several laws and legislations that helped fund outpatient/community agencies to treat individuals within their community or the "least restrictive environment" (Gutman, 2011, p. 235). Policy makers believed individuals could be effectively treated in their communities with the assistance of their family and friends (Kepic, Randolph, & Hermann-Turner, 2019; Qualls, 2016). Throughout the 1940s, various legislations were enacted to provide vocational services and outpatient treatment centers for veterans or other individuals struggling with mental illness (Worth & Blow, 2010).

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The next step in improving mental health within the United States was demonstrated through the deinstitutionalization movement (Accordino et al., 2001; Farmer et al., 2017; Hudson, 2016). The movement was a shift in location of services from hospitals to community/outpatient agencies (Canales, 2012). Coinciding with the deinstitutionalization movement, the National Mental Health Act of 1946 was enacted, which funded current outpatient treatment centers and supported the opening of new outpatient programs (Hudson, 2016). By 1949 in the United States, all but five states had at least one outpatient clinic, which began to be state supported throughout the 1950s.

Moving forward into the 1970s, communities began to see a rise in abuse and neglect toward children due to the increase of drug use among adults (Tyuse, Hong, & Stretch, 2010). To meet the needs of the communities facing these stressors, the federal government assisted with developing family preservation programs. The goal of the family preservation programs was to stabilize and rehabilitate the family to keep the child within the home rather than placing the child out of the home (Rodriguez-Keyes, Gossart-Walker, & Rowland, 2012). Interventions by trained counselors were conducted to help families develop parental skills and social supports to keep the family unit intact (Tate, Lopez, Fox, Love, & McKinney, 2014).

Around the 1990s, the in-home approach, which was designed to meet the needs of clients for whom previous forms of therapy had not worked, allowed professionals to recognize the importance of working with all age groups in the home as members of the larger family system (Worth & Blow, 2010). In-home services also broaden the comprehensive nature of services to reach a wide spectrum of needs and clientele. Although it is one of the fastest growing types of services provided, it has limited research and a lack of standard definitions and professionalization (Bowen & Caron, 2016; Hammond & Czyszczon, 2014).

In-home counseling is a problem-solving approach that combines structural and behavioral family systems theory to help families with multiple problems focus and prioritize their issues (Boyd-Franklin & Bry, 2019). Characteristics of in-home counseling are as follows: (a) the family of the child or adolescent referred for services is the focus of treatment; (b) the services are delivered in the home of the family rather than in the counselor's office; and (c) the services are delivered by master's-level counselors with (at minimum) informal training in the fundamentals of systems theory and structural family therapy (Bowen & Caron, 2016; Woodford, 1999; Worth & Blow, 2010).

In-home counseling provides solutions for common physical, psychological, and emotional barriers to attending counseling (Macchi & O'Conner, 2010; Mattek, Jorgenson, & Fox, 2010; Maxfield & Segal, 2008). Lack of transportation, living a far distance from the office, or having a family member who has limited mobility are physical barriers to clients coming to a counseling office (Sue & Sue, 2016). Clients may not have the means—or may not be able to pay for the means—of transportation to travel to an office. Another common

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barrier is difficulty finding an adult to watch their children or other problems with caregivers (Bordonada, Feather, Ohrt, & Waddington, 2018). In addition, employment and school commitments can deter clients from coming to an office for counseling.

Psychological and emotional barriers can also exist as they relate to attending counseling services within the office (Macchi & O'Conner, 2010). Including key family members within a client's clinical treatment can be crucial for the success of counseling (Boyd-Franklin & Bry, 2019). If key family members are resistant to attending sessions in an office, this issue can deter treatment (Macchi & O'Conner, 2010; Mattek et al., 2010). In addition, for many marginalized and vulnerable populations, counselors represent an established system that does not intend to help communities or does not fully grasp their experiences (Trott & Reeves, 2018). Clients may have a fear or distrust of social services and counseling services based on historical and previous experiences (Worth & Blow, 2010). Many clients have a cultural belief that attending an office will jeopardize their perceived security within their system (Hammond & Czyszczon, 2014). For example, a client from a family with a defined conceptualization about family boundaries in which one must seek help from within the family rather than outside to resolve an issue may not seek counseling services based on this family belief (McGoldrick & Hardy, 2019; Sue & Sue, 2016).

IN-HOME COUNSELING AND ECOLOGICAL SYSTEMS THEORY

A model that expanded the understanding of human development in its full social context is Bronfenbrenner's (1977) ecological systems theory (EST). This model does have a parallel history with in-home counseling, as it emerged in the late 1970s once clients began to be considered within their social context. As clients began to integrate back into their environmental system, there was a need to see and understand how that context would affect someone struggling with a mental illness (Canales, 2012). This model provides a multiperson and multisystem interaction between the individual and environment by examining an expanded model and convergence of the environments situating the individual (Bronfenbrenner, 1977). The macrosystem is the ideologies and attitudes of the overall culture, which affects the exosystem; the mesosystem is recognized as the system of microsystems that expands anytime a person gathers a new role or has a change in their setting; the microsystem is the immediate environments in which the individual is situated (e.g., family, schools, spiritual systems, health care systems, peers); and at the center of the model is the individual and their personal characteristics (C. D. Chan, 2017; C. D. Chan & Daniels, 2019; C. D. Chan, DeDiego, & Band, 2019; Lau & Ng, 2014). This nested system recognizes that environments are not stagnant, which most directly affects older adults in the mesosystem (Joosten, 2015).

W. Y. Chan, Hollingsworth, Espelage, and Mitchell (2016) argued that a community-based approach coupled with an ecological approach helps to emphasize the influence of the collective systems and focus on how individual health and community well-being are interconnected. Woodford (1999) specifically highlighted the benefits in combining a multisystemic intervention approach, which includes an ecological factor, with home-based family therapy and demonstrated utility with children and adolescents. Although an ecological approach would be relevant for home-based treatment, there is a gap in the literature suggesting how this approach would apply to the older adult population. Examining an older adult client through this lens allows counselors to investigate multiple systemic factors connected to the ecology of the client in addition to leveraging connections within the natural social system of the client to help facilitate change (Woodford, 1999).

In particular, the mesosystem, or system of microsystems, expands greatly as people change their setting or assume new roles (Bronfenbrenner, 1977). Older adults have lived a longer life and have had the opportunity to greatly expand their mesosystem through an interrelation of family experiences, new relationships, and work and educational experiences (W. Y. Chan et al., 2016). The exosystem should be taken into consideration as the greater societal structure, including industry, media, and government, has greatly influenced experiences for older adults and their individual identity development (Bronfenbrenner, 1977). The macrosystem, largely based on cultural influences, has set the pattern for discussion and interactions among the other systems (Bronfenbrenner, 1977). It is important to note that for an older adult, the macrosystem may have changed greatly across the life span. For example, cultural attitudes about sexual and affectional identities have changed greatly in the last 20 years, which for an older adult may have been only a small portion of their overall life (Dispenza, Dew, Tatum, & Wolf, 2015; Hensen & Koltz, 2018). This extensive systems model acknowledges the changing environments and social, political, and cultural implications for experiences of older adults.

Counseling practices associated with older adults relate to a significant gap considering the recency of the baby boomer generation and of generational cohorts living longer (Foster, Evans, & Chew, 2014; Kepic et al., 2019). Researchers have also alluded to the growing disparities in counselor education, supervision, and training for addressing factors of wellness and development among older adults (Fullen, 2016). Unlike young and middle-aged adults, older adults have experienced a wide variety of generational changes and life transitions influenced by their contextual environments. For this reason, a focus on family members and caregivers has been more concentrated among older adults, considering that accessibility to counseling can be a barrier for older adults due to legislation, physical issues, and grief and loss (Kepic et al., 2019). Greater mental health attention is needed to address various areas, such as medical and mental illness, elder abuse, and other psychosocial factors (e.g., suicide; Fullen, 2018; McBride

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& Hays, 2012). The following case example serves as a basis to examine EST as a foundation for applying practices associated with in-home counseling among older adult clients. It is a hypothetical case example to illustrate the conceptualization of EST applied to counseling practice with older adults.

CASE EXAMPLE AND ANALYSIS

Nina is a 73-year-old nonbinary Asian American woman who identifies as pansexual and able-bodied. She identifies as having Chinese and Vietnamese heritage and uses the pronouns she, her, and hers. She is single and does not indicate having any intimate partners. She has been living independently in a suburb of East Los Angeles, California. Three months ago, her daughter moved to Kansas City, Missouri, for a new employment opportunity but agreed to help Nina in some capacity financially while regionally away. Three weeks ago, Nina suffered an accident resulting in a fractured arm. Feeling alone, she has been able to participate in some activities of daily living but noticed her mood changing such that she is less excited to see friends. She also noticed she is starting to feel sad about her daughter moving away. Her daughter recommended counseling for her, but she has been facing difficulty with physical movement and does not have economic means to travel to local counseling agencies for services.

Individual Level

Through the EST lens (Bronfenbrenner, 1977), Nina's individual characteristics were stated within the description of the case example, including her age (73), her sexual and affectional identity (nonbinary, pansexual, single), her ethnic identities (Chinese, Vietnamese), a temporary disability (broken arm), indicators of social class (lower middle class, as evidenced by not having the economic means to seek counseling and her daughter helping to support her), and a support system (her daughter and friends). These individual characteristics help counselors to understand the client at a minimal level, but they also need to be discussed with the client more fully in order to understand what each of the identities and descriptors means to the client. Concerns around her social class and her shrinking support system, particularly her daughter moving away, along with a temporary disability can assist a counselor in understanding the growing signs of an impairment as evidenced by her "feeling alone," "mood changing such that she is less excited to see friends," and "starting to feel sad about her daughter moving away." Although the individual level helps counselors to understand direct identifiers, an understanding of the larger microsystem can provide a more comprehensive perspective of the client.

Microsystem

The microsystem within EST highlights the immediate environment Nina is situated within, including her family, health care systems, and peers (Bronfenbrenner,

1977). Nina's family consists of her only daughter, who recently moved for a new employment opportunity but has agreed to assist Nina financially. Nina's health care systems include her primary care doctor. She recently had a fall, resulting in her arm being fractured, and is now experiencing difficulty physically moving and driving due to the accident. Nina's microsystem also includes peers whom she sees regularly but recently has not been able to due to her accident. She identifies feeling less excitement about seeing them due to her changing mood. She is currently experiencing negative mental health symptoms—depressed mood, diminished interest, and loneliness. It is possible that Nina is experiencing symptoms of depression that are exacerbated by her accident. Depression in older adults, as described in Nina's experience, can impact social, emotional, and physical capabilities (Centers for Disease Control and Prevention [CDC], 2009). If left untreated, Nina's symptoms could escalate to suicide.

Mesosystem

The mesosystem within EST (Bronfenbrenner, 1977) is recognized as the system of microsystems that expands when a person gathers a new role or has a change in their setting. Nina has several microsystems that encompass her mesosystem: family, peers, and health care systems. A multidisciplinary team approach would comprehensively address her clinical needs (MacLeod & Douthit, 2015). It is critical for counselors to be aware that working with an older client may result in working with informal or formal caregivers, family members, partners, family friends, or medical professionals (MacLeod & Douthit, 2015). Nina's daughter was a source of major support for Nina, but recently, her daughter moved away. Providing opportunities for Nina to include her daughter within the counseling process may enhance Nina's prognosis. With permission from Nina, an in-home counselor may want to include Nina's daughter in family sessions through phone or video conference.

Additionally, Nina reports having friends with whom she used to spend a great deal of time but now feels a diminished interest in doing so. An in-home counselor may want to explore how healthy those relationships are with her friends and any steps she could take to spend more time with them. It is also critical for the in-home counselor to identify other support systems Nina may have within her reach, such as social services, church, or community resources (Boyd-Franklin & Bry, 2019). With the capacity of in-home counseling, the counselor can discuss local community supports, gain a sense of the local community, and identify the extent of the barriers to accessing specific supports.

Last, Nina has recently experienced a fall that has left her with a fractured arm and difficulty with physical movement. It may be helpful for Nina's in-home counselor to collaborate with Nina's medical providers to eliminate other medical illnesses that could portray themselves similarly to depression (MacLeod & Douthit, 2015; Yimiya, 2000). For example, it is critical for in-home counselors to rule out diagnoses such as substance/medication-induced

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depressive disorder or depressive disorder due to another medical condition (American Psychiatric Association, 2013). Both of these disorders can be ruled out easily by consulting with a medical provider who can identify whether there are medical conditions that would bring on depression and may be more appropriate for Nina than a major depressive disorder or adjustment disorder diagnosis (American Psychiatric Association, 2013).

Macrosystem

The macrosystem within EST (Bronfenbrenner, 1977) highlights the attitudes and cultural beliefs in our larger society that affect the exosystem surrounding Nina. In this case example, Nina has likely experienced several long-term stereotypes and forms of oppression related to many of her historically marginalized identities (e.g., age, race, ethnicity, gender identity, sexual/affectional identity). The overall cultural beliefs portrayed in mass media related to the older population relate heavily to ageism (Fullen, 2016). Levy (2009) developed the stereotype embodiment theory, proposing four components about stereotypes: (a) they become internalized across the life span; (b) they can operate unconsciously; (c) they gain salience from self-relevance; and (d) they utilize multiple pathways. Exposure through mass media to negative stereotypes about aging can begin at a young age. These stereotypes can become more salient and self-directed as individuals continue to move through their life span. In addition, certain myths about the older adult population are salient with the larger societal images—with age comes dementia, older adults are frail and ill, older adults are stubborn, or older adults are socially isolated (American Psychological Association, 2014). These messages are further solidified in the media portrayal of older adults having cognitive and/or physical difficulties or being banned from driving alone (Fullen, 2018). Related to the macrosystem, the in-home counselor can broach cultural factors and forms of oppression (e.g., racism, genderism, heterosexism, ageism) with Nina (Day-Vines, Booker Ammah, Steen, & Arnold, 2018). In particular, the in-home counselor can leverage their access to local communities through home visits to firmly grasp community and environmental factors accentuating forms of oppression. Consequently, this information might become relevant to Nina's experience at the larger level of society while allowing opportunities for the in-home counselor to broach these topics.

IMPLICATIONS

Researchers have demonstrated that counselors often overlook mental health symptoms, such as dementia, depression, or suicide, within the older population (Foster et al., 2014). Older adults have higher rates of receiving a diagnosis of dementia and experiencing symptoms such as memory loss;

language disruption; agitation; and personality, emotional, and behavior changes (Abraham, 2005). In addition, depression can impair areas of functioning for older adults socially, emotionally, and physically (CDC, 2009). McBride and Hays (2012) reported that 2.5% of older adults meet *Diagnostic and Statistical Manual of Mental Disorders* criteria for depression, and another 27% have symptoms but do not fully meet the criteria. These symptoms can be brought on by having to deal with the death of friends, partners, or bereavement. The depressive symptoms may also be exacerbated by illness or accidents, causing the older adult to be placed in a nursing home. Older adults at nursing homes are also more likely to experience depression at a 15% to 25% rate (U.S. Department of Health and Human Services, 2000). Finally, older adults can experience suicidal thoughts or attempts. In 2008, the CDC reported that suicide rates are a significant problem among older adults, and in fact, the group with the highest rate in the United States of completing suicide was men ages 85 and older.

It is essential for counselors to first reflect on their own bias and any prejudices they may have toward this population (Fullen, 2016). Assessing one's knowledge and beliefs about a population both personally and professionally can shed light on any negative stereotypes along with implicit or explicit biases (McBride & Hays, 2012). Neglecting to address one's own bias and prejudices can have negative impacts on interactions with the older adult population (Helmes & Gee, 2003). For example, counselors may believe that older clients are less able to develop a therapeutic relationship, that their mental health symptoms are less severe, and that they are often given a poorer prognosis. Fullen (2016) reported several multicultural considerations for counselors, such as a younger counselor considering the impact of age and stage difference impacting the therapeutic relationship. Therefore, building rapport with an older adult client may take longer due to possible perceived sensitivity, negative stigmas surrounding age, or a client's previous experiences related to ageism. Obtaining cultural and historical inferences assists with developing rapport, gaining a trusting relationship, and conveying a sense of connection and safety.

Foster, Kreider, and Waugh (2009) studied counseling students' perceptions of working with older adults. They found four key significant results, including counseling students' reported interest in gerocounseling topics such as family counseling with older adults (63%) and counseling caregivers of older adults (55%). Often, specialized health care is needed for an older adult. An in-home counselor is in a position to bridge the gap among caregivers, medical providers, and mental health treatment. The counselor can provide further assessment of integral aspects of a client's treatment care with support systems, including social service agencies, activities of daily living, the client's ability to manage medications, a description of the home, and particular attention to physical safety issues.

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CONCLUSION

Conceptualizing clients within the in-home setting using Bronfenbrenner's (1977) EST can assist an in-home counselor to better understand older adult clients contextually. The older adult population is exponentially growing along with the need for counselor educators to train and prepare counselors for working with this population (Fullen, 2016; Fullen, Gorby, Chan, Dobmeier, & Jordan, 2019). Using EST can serve as an applicable framework to examine contextual and developmental factors impeding access for older adult communities to mental health care and community supports for wellness. Similarly, EST operates as a tool to broach specific topics associated with cultural factors and forces of oppression pertaining to a wide diversity of older adult communities. EST takes systemic factors into account by considering how ageism results in reduced access and use of mental health care. In-home approaches continue to provide opportunities to build upon community supports, develop client knowledge and empowerment to utilize services, and gain context of local communities by assessing the surrounding environment and home.

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