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As the U.S. population ages, counselors must begin structuring their interactions to meet the unique needs of older adults, especially in the area of crisis intervention. The authors propose a new crisis intervention model that accounts for the needs of older adults in crisis by giving special attention to the roles of advocacy, education, and prevention.

Currently, 12.4% of the U.S. population consists of older adults (age 65 and above), a number that has tripled in the past century (Administration on Aging [AoA], 2008). Within the next 30 years, nearly 20% of the American population is projected to be over the age of 65 (AoA, 2008). The cohort of older adults itself is also aging rapidly, with the biggest shifts occurring among adults over age 85. At 5.3 million persons, this group is 43 times larger than it was in 1900 (AoA, 2008). In light of shifting demographics, there is an unprecedented need for counselors to be educated about how to respond to the unique mental health concerns of older adults. Crisis intervention is one specialization within the mental health delivery system that must be considered if counselors are to work competently with the older population.

Crisis has been defined in the literature in a variety of ways (e.g., see Roberts, 2005; Slaikeu, 1990); however, it generally can be described as an occurrence or perception of an occurrence that overwhelms a person's immediate resources and coping abilities (James & Gilliland, 2005). Stone and Conley (2004) suggested that as a lived reality, a crisis is an event that does not reflect any of an individual's prior life experiences; it leads to questions such as, "What am I going to do now?" and "How do I respond to what just happened?" Emphasizing a more covert aspect of crises, Thompson and Thompson (1999) suggested that crises, while overwhelming a person's coping mechanisms, are also turning points that can become moments for personal growth and change.

Although crises can occur at any phase in the life span, older adults tend to face environmental and personal factors that place them at risk of experiencing a crisis and of receiving inadequate intervention services. Physically, there is a great likelihood that older men and women will encounter health challenges. Statistics indicate, for instance, that most older adults are diagnosed with at least one chronic health problem; among the most frequent are hypertension (48%), arthritis (47%), heart disease of all types (29%), cancer of all types (20%), and

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diabetes (16%; AoA, 2008). Additionally, frailty associated with aging leaves older adults susceptible to falls in their homes; when the consequences of a fall are severe enough, these individuals may be faced with a sudden and unexpected decision about late-life relocation.

Related to chronic medical conditions are mental health problems, for which older adults have historically been underserved by counseling professionals (Gatz & Smyer, 2001; Myers & Harper, 2004; Myers & Schwiebert, 1996). Older adults receive only about 2% of private mental health services, 6% to 8% of community mental health services, and 7% of inpatient mental health services (Bartels & Smyer, 2002; Myers & Harper, 2004; Robb, Chen, & Haley, 2002). These statistics are troubling because untreated mental health challenges, especially depression, are major contributing factors in suicide among older adults (Hoyer & Roodin, 2003). According to the National Institute of Mental Health (NIMH; 2008), non-Hispanic White men over age 85 have the highest suicide rate among any age group (15.8 deaths per 100,000 in 2004 vs. 11 deaths per 100,000 in the general population). Overall, older adults are disproportionately more likely than the general population to commit suicide (NIMH, 2008). These statistics raise concerns that residual mental health problems in the older population that are not attended to could erupt into crisis events or pose a significant strain to family and caregiver support systems.

An elevated risk of experiencing late-life crises is also apparent for older adult persons in some minority groups. For example, the AoA (2008) found that women over 65 had a higher poverty rate (11.5%) than men did (6.6%) and that at least half of older women lived alone. Ethnic minorities also tend to be at or near the poverty level in later adulthood. These socioeconomic factors place women and some minorities at an increased risk for experiencing situational crises related to housing and other issues.

Unfortunately, the importance of creating unique approaches to crisis intervention for older adults may be overlooked because the risk factors for crises, as well as crisis moments themselves, tend to be normalized as part of the aging process. Traditional conceptions of aging tend to be based on socially constructed beliefs that the aging process is a process of decline, not a phase of life (K. J. Gergen & Gergen, n.d.; M. M. Gergen & Gergen, 2003; Thompson & Thompson, 1999). When individuals are expected to encounter health declines or loss experiences, for example, it is easy to understand why these challenges may be seen as typical events and not appreciated for the crisis reactions they may engender in older adults. At work behind traditional conceptualizations of aging are elements of discrimination and ageism. Ageism has had a detrimental effect on the availability of intervention strategies that fit the needs of older adults; it has pushed older adults to the edges of societal attention; and it has left their experiences of loss and crisis relatively underacknowledged or misperceived (Thompson & Thompson, 1999). The purposes of this article, therefore, are to draw attention to the rapidly growing, often disregarded older population and to introduce the Crisis Model for Older Adults (CM-OA), an intervention approach that takes into consideration some of the unique challenges and circumstances of older adults in the United States. The following sections of the article briefly highlight

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some of the theoretical foundations that informed the CM-OA, present the crisis intervention model itself, and apply the model in a case illustration.

THEORETICAL FOUNDATIONS

The theoretical foundation of the CM-OA is that crisis intervention is best approached from a contextual standpoint that honors the effects of crisis on the individual at the center of the activating event; the CM-OA also takes into account the effects of the event on systems surrounding the person in crisis. The crisis in context theory (CCT; Myer & Moore, 2006) provides one framework for thinking about crisis from an ecological point of view and is a useful approach for grounding the CM-OA. CCT is centered on three premises: (a) the impact of a crisis has many layers; (b) in crisis, there is a reciprocal effect between individuals and their proximal systems; and (c) time influences the impact of a crisis (Myer & Moore, 2006).

The first premise of CCT (Myer & Moore, 2006) recognizes the unique nature of each stakeholder's reaction to a crisis. Individuals immediately affected by a crisis event, as well as members of their proximal systems (e.g., families), have their own understanding of the activating event; differences in perception may influence decisions about what actions should be taken in response to a crisis. When working with the older individuals, counselors may easily find that one activating event may actually be perceived as two co-occurring crises—those experienced by the older adult and those experienced by the family.

The second premise suggests that it is important to be attentive to the ways in which a crisis affects interactions between primary and secondary relationships (Myer & Moore, 2006). A *primary relationship* is comprised of persons who are most directly affected by the crisis. For example, a primary relationship might exist between the older adult client and that client's adult child or children. A *secondary relationship* involves persons who are touched by the crisis but are not directly associated with the individual in crisis. For example, a secondary relationship might exist between the adult child and his or her spouse or children. In the event of a crisis involving an older adult, the secondary relationships are not immune from the impact of the crisis because the response of the older person's children to help their parent can temporarily affect the quality of the adult child's interactions with his or her spouse or the amount of time available to spend with children. In addition, the impact of a crisis is related to the level of change brought on by the activating event: the greater the change engendered by the activating event, the greater the impact of the crisis. For example, an older adult who falls and who decides to begin wearing a medical alert button will feel the effects of an in-home fall to a lesser extent than would an older adult who must move temporarily to a rehabilitation facility.

The third premise of CCT (Myer & Moore, 2006) recognizes that the element of time directly influences the impact of a crisis. Typically, 6 to 8 weeks are needed for an individual and those in the proximal system to "bounce back" to precrisis levels of functioning; thus, the passage of time helps to moderate the effects of crises. Existential experience is also an important element of the time factor in that the meaning of a crisis event and feelings that emerge in relationship to the

crisis can be triggered on special occasions (e.g., birthdays, holidays), even after a substantial amount of time has passed since the initial crisis.

CRISIS INTERVENTION AND OLDER ADULTS: A PROPOSED MODEL

The five-step CM-OA proposed in this article draws on existing approaches to crisis intervention (e.g., Aguilera, 1998; James & Gilliland, 2005; Roberts & Ottens, 2005), as well as on systems and ecological theories, such as Myer and Moore's (2006) CCT. The goal of crisis intervention with older adults (i.e., stabilization and resolution of the crisis) is similar to that of intervention with other populations; however, a major point of differentiation in the CM-OA lies in the area of advocacy, which is best conceptualized as a mind-set that informs the entire process of the counselor's work with the older adult client. The Advocacy Competencies outlined by Lewis, Arnold, House, and Toporek (2003) and endorsed for counselors by the American Counseling Association Governing Council describe multiple levels of advocacy interaction (from microsystemic to macrosystemic levels) and multiple layers of advocacy involvement (from acting with clients to acting on behalf of clients). Advocacy efforts that are part of crisis response with older adults are anticipated to occur primarily on the microsystemic levels because of the immediate stabilization needs of the client. However, counselor stance (i.e., empowering the client or acting on behalf of the client) may vary depending on the prevalence and intensity of external barriers (e.g., ageist stereotypes) that may hinder the client's self-advocacy during the process of planning and enacting crisis interventions. Following is a description of the five steps of the CM-OA: assessment; identification of the context and problem; advocacy, education, and intervention planning; commitment and action; and follow-up, support, and prevention.

Step 1: Assessment

Assessment in crisis intervention always begins with the counselor's quick but thorough evaluation of the lethality of the current situation (Aguilera, 1998; Roberts & Ottens, 2005). The first task in working with older adults in crisis is determining whether or not the client has attempted suicide or has the potential and means to engage in self-injurious behavior in the imminent future. Additionally, the clinician should assess the presence of other types of immediate danger, such as sudden health challenges (e.g., broken bones or inability to get up after a fall), domestic violence, or sexual abuse. The threats of domestic violence or abuse should not be overlooked, because statistics have shown that 4%–6% of older adults are victims of sexual or physical abuse (Erlingsson, Saveman, & Berg, 2005). An initial assessment should yield information about the client's overall physical and mental abilities. The most important goal of assessment is to help clients meet their safety needs.

Step 2: Identification of the Context and Problem

After determining the level of lethality and ensuring the safety of the client, the crisis worker should take stock of the layers of crisis touched by the crisis event. Identifying the key persons in the older adult's proximal system (e.g., family

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members, religious leaders, or health care workers) who either may be a support to the client or may be affected by the crisis event (Myer & Moore, 2006) can be a useful starting point toward this end. Together with the key stakeholders, the counselor and older adult client begin to identify the precipitating events and share perceptions of the crisis moment (Caplan, 1961). Each individual is likely to have a unique way of making sense of the activating event, and counselors need to be attuned to differences in perception, because these can alter the identification of crisis events. It is important for counselors to solicit the input of all members of the proximal system, especially that of the older client. Counselors must be particularly aware that age-related stereotypes can potentially affect the communication process during this phase of intervention. Stereotypic beliefs about senility or the desire to "protect" the older client may lead members of the proximal system to purposefully or unawarely exclude the older adult from early discussions about the crisis or invalidate the older person's perceptions. Carefully ensuring that the older client's input is sought and validated is a responsibility of the crisis counselor during this stage of intervention. Finally, the counselor should summarize the various perceptions of the activating events and help the older client and his or her support system to begin focusing attention on what seem to be the most critical aspects of the crisis event.

Step 3: Advocacy, Education, and Intervention Planning

Although counselors who are working with older adults in moments of crisis are encouraged to approach the entire intervention process from a mind-set of advocacy, it is during the intervention planning phase that this stance becomes particularly critical. Just as the counselor was intentional in garnering the older adult client's perceptions of the activating event, the counselor must also help to ensure that the client is empowered to participate as much as possible in brainstorming potential interventions. When the nature of the crisis includes physical challenges, older clients, especially those in the oldest segment of the older population (age 75 and up), may face the added risk that their physical impairment will be perceived as mental incompetence. Counselors must ensure that, as much as possible, the older client's voice is valued and that his or her intervention suggestions are solicited in the planning phase. Seeking out the client's strengths (e.g., hopefulness, determination, or prior success in recovering from crises) can be an effective means of empowering or advocating on behalf of the client.

Interventions should be responsive to the immediate needs of the client (e.g., temporary nursing home stay if rehabilitation is required), but the interventions should not represent permanent changes or decisions. Myer and Moore (2006), like researchers and theorists who preceded them (e.g., Brewin, 2001; Caplan, 1961), drew attention to the factor of time in determining the impact of crises. Typically, 6 to 8 weeks should be allowed for the impact of a crisis to lessen and for a person to "bounce back" to precrisis levels of functioning. Educating the older client, as well as the client's family and support system, of the recovery time required in crisis is critically important in considering interventions. Counselors should attempt to help the client or client system to

consider various interventions that are flexible and that can be reevaluated with the passage of time. Making permanent or irreversible decisions (e.g., moving an older adult into a nursing home *and* deciding to put his or her house on the market) is discouraged.

Step 4: Commitment and Action

In the commitment and action phase, intervention strategies are solidified, decisions are made, and the movement toward implementing the action plan begins. Counselors must be aware that some older clients might feel an internalized sense of powerlessness as a result of the crisis or may have their autonomy challenged by members of their proximal system. Reminding the client and other key stakeholders that the goal of all types of crisis intervention is to return individuals to a precrisis level of autonomy to the extent possible and, therefore, is an important part of implementing action plans. Interventions may include such responses as safeguarding the older individual's environment by removing lethal means of self-injury, adjusting living space to prevent future falls, removing individuals from the environment who are neglectful or abusive, using medication when necessary to help decrease anxiety and sleep loss, seeking rehabilitation services, and examining the meaning-making element of the crisis event (Roberts & Ottens, 2005).

Step 5: Follow-Up, Support, and Prevention

The final step of intervention calls for ongoing assessment of the success of the crisis action plan. It is important for the counselor to schedule a follow-up meeting to support the system and to determine the level of comfort with the action plan. The counselor, the older client, and key stakeholders may need to reevaluate and make necessary adjustments to the action plan after an assessment of the client's overall functioning. The follow-up also provides an opportunity for the counselor to determine the need for additional referrals. Depending on the older adult's prognosis, future preventive measures can be discussed and plans arranged.

CASE STUDY: APPLICATION OF THE CM-OA

> Maryanne (a fictional composite of several clients), 85, lives alone and fell while getting out of her bathtub. Her family found her when they came to her home to check on her. After Maryanne was rushed to the hospital and given medical care, she and her family suddenly were faced with a decision about her living arrangements.

The initial tasks of crisis intervention involve assessing the lethality and imminent danger related to the activating event. In Maryanne's case, because her family took immediate action to get her to a hospital, it is likely that her medical needs were attended to and that she had been stabilized. However, the crisis counselor would still want to assess the precipitating factors; assess the presence of abuse or neglect; and determine Maryanne's overall level of physical, cognitive, and emotional functioning. Adapting and administering a short

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mental status questionnaire (e.g., the Mini-Mental State Examination; Folstein, Folstein, & McHugh, 1975) can be helpful in determining Maryanne's level of alertness and giving the counselor a sense of the extent to which Maryanne will be able to participate in the intervention process.

Next, the counselor will begin to identify the key stakeholders in Maryanne's life and invite them and Maryanne to share their perceptions of and reactions to the crisis. Questions that can be used to explore the problem include the following:

- Is the crisis the fall?
- Is the crisis Maryanne's compromised health and wellness?
- Is the crisis the potential change in living situation for Maryanne?
- How does the family perceive Maryanne's health and physical ability?
- How does Maryanne herself perceive her abilities?
- How does each party feel about the possibility of Maryanne moving out of her home?
- Does Maryanne see the event as crisis-level?

Each family member might identify different crises: Maryanne's children might focus on the physical health side of the event and be concerned with ensuring that Maryanne will not have to face the possibility of falling again without having a trained professional or paraprofessional at her disposal. Maryanne, however, might be concerned with her future living arrangements and with immediate compromises to her autonomy. Thus, it is possible that while Maryanne's children could be focused on her compromised health, she might be experiencing a more existential crisis related to sense of self, independence, and self-sufficiency. It is important for the counselor, therefore, to act as a mediator in the exploration of the problems and to ensure that all stakeholders' concerns and perceptions of the crisis are validated.

After Maryanne and her family have had the opportunity to share their perceptions and their emotional responses to the crisis, the counselor should begin to summarize what seem to be the recurrent elements of the event. The summary of the event helps give the counselor as well as the client system a sense of direction in their brainstorming about intervention strategies. The following questions can guide the advocacy, education, and intervention planning phase.

- Are Maryanne and the members of her family aware that a typical response to a crisis event will require at least 6 weeks for restabilization?
- Has Maryanne encountered health problems before?
- How did Maryanne and the family handle the situation in the past?
- What strengths or resources does Maryanne possess to help her respond to the crisis?
- What would Maryanne like to do in response to the crisis?
- What solutions do members of Maryanne's family endorse?
- Are the crisis interventions flexible enough to allow for short-term reevaluation?

After summarizing the primary areas of concern and allowing time for Maryanne and her family to discuss intervention options, the counselor should

help the involved parties make a commitment to the action plan. The counselor may also want to help the family think about how the action plan will affect the primary and secondary relationships in their family system. Following are possible interventions that might be considered:

- Contracting with home health services
- Installing practical aids in the home to help prevent another fall
- Moving in with children or seeking temporary placement for rehabilitation, if needed
- Scheduling regular visits by children and other support persons

Finally, in concluding the intervention process, the counselor must be sure to schedule an individual evaluation with Maryanne and follow up with her family and members of her support system. Seeing Maryanne and her family separately allows the counselor to provide support to all members of the system while creating an opportunity for Maryanne to voice any concerns that may require additional advocacy efforts on the part of the counselor. Some evaluation questions might include the following:

- Has Maryanne's health status changed enough to alter the decision about the living situation?
- Have emotional aspects of Maryanne's health problems been addressed sufficiently by Maryanne herself and by her family?
- What ongoing needs do Maryanne and the family members have?
- Have any new crises emerged in response to the action plan?
- Are the family members learning to advocate on Maryanne's behalf and with her input?

FUTURE DIRECTIONS

With any theoretical model, the need for testing is imperative in order to validate applicability and make necessary adjustments to the model. The CM-OA, therefore, requires implementation and testing as a way to lend trustworthiness to its structure and theoretical base. As well, testing the model is important to confirm its user-friendliness with professional counselors and paraprofessionals who are in regular contact with older adults. However, the ethical demand that client care and well-being be placed before research interests provides a challenge for empirical field testing of crisis intervention models because of the critical nature of crisis and the timeliness of intervention response that is called for in crisis situations. Thus, we foresee several research and evaluation possibilities that occur outside the most critical moments in the intervention process. First, qualitative research with crisis counselors who work with the older population might be conducted to tap into their perceptions about the most vital needs of older adults and their families during crisis. Findings from this research might be used to enhance the depth and breadth of the CM-OA's conceptualization of intervention. Second, older adults' descriptions of their experiences of the crisis intervention process when the CM-OA is used (especially with regard to their

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involvement in the process) might be gathered for evaluative purposes during the follow-up and prevention phase of intervention. Third, research on short- and long-term client outcomes (e.g., the need for future crisis intervention services, evidence of stabilization) when the CM-OA has been used might provide data to correlate the use of the model with client resiliency. Finally, with the needs of the older adult in mind, an assessment tool specifically designed to complement this model may be developed as an aid to help clinicians gather information about mental status, as well as cognitive, emotional, and behavioral crisis response.

CONCLUSION

Creating a crisis intervention model, with the older population as its focus, is critical because the challenges older adults face due to ageism and stereotypes may threaten their involvement in the intervention process. Thus, a specialized model of crisis intervention, such as the CM-OA, is needed to help practitioners overcome the shortcomings of traditional approaches and especially to aid them in empowering or advocating on behalf of the older adult. A crisis intervention model developed uniquely for older adults can also remind counselors, as well as family members and caregivers, that crises can be viewed as opportunities for growth rather than unavoidable slips toward inactivity and eventual death.

REFERENCES

Administration on Aging. (2008). *A statistical profile of Americans aged 65+.* Retrieved August 29, 2008, from http://www.aoa.gov/press/prodsmats/fact/pdf/ss_stat_profile.doc

Aguilera, D. C. (1998). *Crisis intervention: Theory and methodology*. New York: Mosby.

Bartels, S. J., & Smyer, M. A. (2002). Mental disorders of aging: An emerging public health crisis? *Generations, 26,* 14–20.

Brewin, C. R. (2001). Cognitive and emotional reactions to traumatic events: Implications for short-term interventions. *Advances in Mind-Body Medicine, 17,* 160–196.

Caplan, G. (1961). *An approach to community mental health*. New York: Grune & Stratton.

Erlingsson, C. L., Saveman, B., & Berg, A. C. (2005). Perceptions of elder abuse in Sweden: Voices of older persons. *Brief Treatment and Crisis Intervention, 5,* 213–227.

Folstein, M., Folstein, S. E., & McHugh, P. R. (1975). Mini-Mental State: A practical method for grading the cognitive state of patients for the clinician. *Journal of Psychiatric Research, 12,* 189–198.

Gatz, M., & Smyer, M. A. (2001). Mental health and aging at the onset of the twenty-first century. In J. E. Birren & K. W. Schaie (Eds.), *Handbook of the psychology of aging* (5th ed., pp. 524–544). San Diego, CA: Academic Press.

Gergen, K. J., & Gergen, M. M. (n.d.). *The new aging: Self construction and social values.* Retrieved October 15, 2008, from http://www.swarthmore.edu/Documents/faculty/gergen/The_New_Aging.pdf

Gergen, M. M., & Gergen, K. J. (2003). Positive aging. In J. F. Gubrium & J. A. Holstein (Eds.), *Ways of aging* (pp. 203–224). Malden, MA: Blackwell.

Hoyer, W. J., & Roodin, P. A. (2003). *Adult development and aging*. New York: McGraw-Hill.

James, R. K., & Gilliland, B. E. (2005). *Crisis intervention strategies* (5th ed.). Pacific Grove, CA: Brooks/Cole.

Lewis, J., Arnold, M. S., House, R., & Toporek, R. (2003). *Advocacy Competencies*. Retrieved October 25, 2008, from http://www.counseling.org/Publications

Myer, R. A., & Moore, H. B. (2006). Crisis in context theory: An ecological model. *Journal of Counseling & Development, 84,* 139–147.

Myers, J. E., & Harper, M. (2004). Evidence-based effective practices with older adults. *Journal of Counseling & Development, 82,* 207–219.

Myers, J. E., & Schwiebert, V. (1996). *Competencies for gerontological counselors*. Alexandria, VA: American Counseling Association.

National Institute of Mental Health. (2008). *Older adults: Depression and suicide facts*. Retrieved September 13, 2008, from http://www.nimh.nih.gov/health/publications/older-adults-depression-and-suicide-facts.shtml

Robb, C., Chen, H., & Haley, W. E. (2002). Ageism in mental health and health care: A critical review. *Journal of Clinical Geropsychology, 8,* 1–12.

Roberts, A. R. (2005). Bridging the past and present to the future of crisis intervention and crisis management. In A. R. Roberts (Ed.), *Crisis intervention handbook: Assessment, treatment, and research* (3rd ed., pp. 3–34). New York: Oxford University Press.

Roberts, A. R., & Ottens, A. J. (2005). The seven-stage crisis intervention model: A road map to goal attainment, problem solving, and crisis resolution. *Brief Crisis Treatment and Crisis Intervention, 5,* 329–339.

Slaikeu, K. A. (1990). *Crisis intervention: A handbook for practice and research* (2nd ed.). Needham Heights, MA: Allyn & Bacon.

Stone, D. A., & Conley, J. A. (2004). A partnership between Roberts' crisis intervention model and the multicultural competencies. *Brief Treatment and Crisis Intervention, 4,* 367–375.

Thompson, S., & Thompson, N. (1999). Older people, crisis, and loss. *Illness, Crisis, & Loss, 7,* 122–133.