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Counseling protocol for the older adults during the covid-19 pandemic and similar future situations

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Abstract
COVID-19 has presented many unique challenges for the older adults since early 2020. The difficulties this group is facing, especially due to social isolation, are contributing negatively to their mental health outcomes. To date, a comprehensive treatment plan for older adults that deals with their special issues during the pandemic has not been developed. An integrated review of existing counseling techniques for the older adults during the COVID-19 pandemic was conducted and a research-based treatment plan was developed. This protocol can be used during the COVID-19 pandemic as well as during the other similar situations.

Keywords: COVID-19, Coronavirus, Pandemic, Mental Health, Telephone Therapy.

Introduction

COVID-19 or coronavirus changed all people's lives in early 2020, but one group that has been hit harder than others is the older adults. As of August 7, 2021, the Centers for Disease Control and Prevention (CDC) reported that of all the deaths attributed to COVID-19 in the United States, 79.6% were in the 65 and older age group despite this group making up only about one eighth (13.4%) of the total number of COVID-19 cases [1]. After 17 months (since April 2020) of dealing with the COVID-19 restrictions, the CDC continues to urge the use of masks and social distancing even for the vaccinated persons because of the concerns about the highly contagious Delta variant of COVID-19. Currently, the highest percentage of people who are fully vaccinated are 65 years or older (80%) [2]. Despite the high vaccination rate among the older adults, more constringent procedures remain in place to protect them and other at-risk populations. Therefore, counselors and other mental health practitioners need a mental health treatment protocol for the older adults impacted by the COVID-19 and the life restrictions.

To date, no comprehensive treatment plan has been developed for the older adults that deals with their special issues. Since COVID-19 is not going away anytime soon [3], counselors working with this group cannot afford to wait until the disease passes. Thus, after an integrated review of the existing counseling techniques for the older adults, our aim was to develop a science-based treatment protocol for the older adults needed during the COVID-19 pandemic. This generic protocol will also be suitable for any other future pandemics.

Counseling Techniques Used During the Pandemic.

Counseling procedures had to be altered due to the pandemic. The primary change discussed in the literature is the switch to telehealth and videoconferencing technology to perform therapy with clients. According to Banducci and Weiss [4] video conferencing technology was found to be ideal primarily due to the visual aspect of the technology; unlike therapy over the phone, video conferencing allowed counselors to view body language Because not everyone has access to videoconferencing technology, so telephone therapy is required at times. However, therapy over the phone can be less successful than therapy with video conferencing because of the aforementioned lack of viewable body language. Krompinger et al. [5] found telehealth useful when providing exposure and response prevention therapy to their clients. They explain that no evidence to date has been found to support the treatment via telehealth, but considering the science as a whole, it is highly likely that the treatment will preserve its integrity. Scientists working with the Chinese government have concluded that online and video counseling measures were useful for maintaining quarantines and expanding access to mental health services to Chinese citizens during COVID-19 [6]. Psychologists in China have used these services to deal with psychological stress caused by COVID-19, which has helped calm the public.

Changes other than going virtual have also been attempted. Some psychiatrists providing electroconvulsive therapy (ECT)

have created a plan to allow their patients to continue treatment. Burhan et al. [7] state that ECT is difficult to perform with patients wearing masks, so creative alternatives were required to prevent spreading COVID-19. They carefully selected patients for treatment based on the severity of their psychiatric symptoms and tested each patient before each of their appointment. Only those with a negative test were allowed to get the treatment. The therapists wore full personal protective equipment (PPE) and sanitized the equipment after each patient during the treatment. To maintain the client-therapist relationship, they followed up with the patients online that tested positive for COVID-19 and did not receive ECT using telehealth counseling methods. These creative counseling protocol changes allowed Burhan et al. to treat patients that could not wear masks because they were under anesthesia. Weinberg et al. [8] worked with Alzheimer's patients, and they also tested their patients who could not wear masks each time they came in. They also discussed how similar methods could be used by the employers and institutions. Another change in traditional counseling protocol is presented by Robertson and Colburn [9] in their report about changes they have experienced in their practice by asking questions they would never have asked their geriatric patients before COVID-19, such as "whom do you want to make decisions for you if you were to get sick?" and "do you have your affairs in order just in case?" This change was made primarily because many of their clients did not think of these issues until after the pandemic began.

Research done before COVID-19 found that video conferencing which allowed the therapist to see and hear the clients provided comparable outcomes to in-person therapy across multiple psychiatric disorders [10]. Using this method, the researchers were able to restart all their most severe patients on ECT without any new positive COVID-19 cases. They concluded that although telehealth was a dramatic shift from traditional therapy for both therapists and clients, the evidence suggested that telehealth expanded access to therapy and could be as effective as in-person therapy if done correctly [10]. Switching to telehealth, Dorman et al. [11] reported that telehealth options provided high adherence rates for both patients and caregivers. Researchers from Netherland also reported favorable outcomes in therapy with a group of 64-70-year-old adults in an online group therapy program [12]. The group was able to counteract any technological problems that occurred during therapy, maintain therapy adherence, and receive positive member feedback. The researchers reported that some older adults and counselors in the group held preexisting prejudices about the limited effectiveness of online psychotherapy, but they were able to counter those beliefs and conclude that online therapy was a viable option for the older adults.

Matheson et al. [10] address multiple possible issues with the online therapy, such as finding privacy in the home for the domestic abuse cases where therapy could put the clients in danger, problems with internet connectivity, lack of technology or lack of experience with technology, and competency of the therapists going virtual. In online group therapy, a therapist may lose body language cues because of camera position and clients may be less able to form meaningful relationships with people on screens. These issues would need to be addressed before starting therapy [10]. Regarding telehealth efficacy, Dorman et al. [11] found no statistically significant difference between groups of patients that received teletherapy and those that received no therapy. Banducci and Weiss [4] found that some techniques were not suitable for online therapy, for example, the use of Prolonged Exposure (PE) with the individuals with posttraumatic stress disorder. This is because some exercises, like being in crowded places cannot be done during the pandemic. Also, it might be difficult to maintain drug abstinence without the ability to physically monitor the clients. Interestingly, none of the counseling protocol changes reported above led to an increase in COVID-19 transmissions.

Safety during COVID-19 has been a priority and researchers have made suggestions as to the best ways to accomplish this. Banducci and Weiss [4] considered the virtual therapy to be safest because it allows for no physical contact with clients. However, for those unable to go completely virtual, there are steps for safety. For example, Burhan et al. [7] wore full PPE during ECT sessions, which included: goggles or disposable face shield, N95 facemask respirator or higher, full-body gown, and clean nonsterile or sterile gloves. They also created a special room that provided negative pressure and optimum air circulation. However, the CDC guidelines of social distancing, wearing masks, and remaining home if experiencing COVID-19 symptoms are adequate for prevention of the disease in social situations similar to in-person therapy. Aside from PPE, some therapists have suggested considering the importance of safety plans for each client in case sessions become impossible. Ragavan et al. [13] discussed this point from the perspective of domestic violence victims, but they also stated that every client should have a safety plan during COVID-19 to help keep them stable. Safety plans should include information about support systems, warning signs, contact information, coping mechanisms, and reasons to live. Patients should be sent an email copy of the safety plan and mailed a hard copy as well. Rhodes et al. [14] expanded on identifying support systems outside of therapy by asking about family, friends, spouses, children, grandchildren, coworkers, bosses, and social workers. If a client has none of these support systems, it is important for the therapist to maintain contact with this client. Robertson and Colburn [9] added to the topic of safety plans for the older clients by suggesting that they should have means to have a quick access to emergency services, such as having a necklace with a button on it that connects to 911.

The literature on current counseling measures during the pandemic points to the need for a more generic and detailed counseling protocol for the older adults. Telehealth, telephone, and heavily modified in-person sessions have been tried by counselors working with older clients. For the most part, these strategies have worked to continue counseling while preventing the spread of COVID-19.

General Treatment Considerations

The research discussed below provides many general guidelines for working with older adults. These guidelines are not all necessarily exclusive to any specific treatment protocol, theory, or even for working during a pandemic. However, these suggestions are fully applicable to working with older adults during COVID-19 or other pandemics and should be considered.

The first major consideration is to focus on time and effort on developing a strong therapeutic relationship with older clients.

Research has determined that a strong positive therapeutic relationship decreased dropout rates in clients [15]. Also, multiple studies conducted over the years have concluded that strong therapeutic relationships with clients have predicted positive therapy outcomes independent of other factors in therapy [16-18]. The research conducted specifically with older adults also found that the therapeutic relationship leads to better outcomes in therapy [19].

The second consideration that is widely brought up in the literature, for multiple reasons, is the importance of providing telehealth options to older clients. One main reason for completely going virtual in therapy is to prevent COVID-19 infection [4]. Also, telehealth is more convenient for most older clients than in-person counseling [20]. One study found that when comparing video conferencing to in-person therapy, video conferencing provided comparable outcomes to in-person therapy across multiple psychiatric disorders with no significant differences between the two groups [10]. However, for the online therapy to be successful, the technical support needs to be available to the older adults who have difficulty using certain technology needed for virtual counseling [21].

Another consideration is the importance of examining personal biases or prejudices before beginning therapy. Research has shown that age discrimination exists in America and is a problem for many older people [22,23]. The primary issue is portraying all older adults as one large homogenous group when discussing them [24]. The therapist's bias against older clients and other related prejudices should be examined before working with this specific group to maintain ethical standards and proper levels of care for clients. Stone and McMinn [25] suggest therapists ensure that language used is not anti-older adults by becoming aware of common age discrimination words and phrases.

The final general consideration found in the literature is to try and be aware of older client's stressors outside of therapy. While impossible to fix every stressful situation in a client's life, it is important to be aware of what may be causing their stress outside of mental problems. These stressors matter because they directly affect the client's mental health and can lead to deteriorating situations that can negatively impact their wellbeing. Abuse, medical problems, age discrimination, isolation, and loneliness are stressors in the lives of older clients that should be monitored closely [20].

Development of a Generic Treatment Protocol for Older Clients During COVID-19

The treatment protocol presented below was developed to be a flexible, generic, and detailed plan. It was designed to be modified and adapted to fit any therapeutic orientation and should be seen as a basic plan a therapist can follow when working with older adults during COVID-19 pandemic or similar situations. Some steps and suggestions can also be used outside the bounds of working with older adults or pandemics.

Assessing safety measures against COVID-19 should be the first step and should be completed before any clients are seen by a therapist. The therapist should determine the safety measures and policies to maintain a safe environment for the client and the therapist. As stated above, Banducci and Weiss [20] suggest the safest course of action for therapy during a pandemic is to be completely virtual with no physical contact with clients. This would prevent any possibility of spreading COVID-19 between clients and counselors. However, some older adults do not have access to technology that facilitates video conferencing. If in-person counseling is required, full personal protective equipment (PPE) should be worn by the therapists including goggles or disposable face shield, N95 facemask respirator or higher, full-body gown, and gloves. Maintaining 6 feet distance and wearing a mask has been considered the best practice by the U.S. health authorities. Another alternative is to test clients for COVID-19 before they come in for an appointment [7]. Finally, the American Psychological Association (APA) suggests updating malpractice insurance policies appropriately if the above measures cannot be taken [26].

Once an older adult has begun therapy, it is important to first spend some time providing psychoeducation. Research has shown providing psychoeducation before and during therapy can improve therapeutic outcomes and improve client satisfaction [27,28]. The education can include general information about the client's mental illness, information on the interventions the therapist plans on using during therapy, or information about the therapist's theoretical orientation. Once the therapist has educated the client on the interventions being used, it is important to obtain consent from the client that shows they are willing to be involved in the therapeutic process. Without explicit consent, the therapist is breaking ethical codes.

The next step is to administer preliminary assessments to better understand the older person's specific problem, and to better conceptualize the therapeutic plan moving forward. There are a few recommended assessments that should be used. The first is a risk assessment that includes suicide, abuse, isolation, self-care deficits, and substance abuse [20]. Awareness of any of these problems will inform the therapist of other assessments that should be performed as well as additional steps needed to be taken during the treatment. One other assessment that can be administered is the Center for Epidemiological Studies Depression Scale (CES-DS). According to the APA, this scale is peer-reviewed, has research backing, has been tested across gender and cultural populations while maintaining validity and reliability, and is in the public domain [33]. This brief self-report scale (20 items) is designed to measure symptoms associated with depression experienced in the past week and can be used from the age of 6 to older adults. The use of this test is suggested because many of the problems facing the older adults cause depression.

Finally, when a therapist believes a client is showing signs of an unhealthy level of death anxiety, such as excessive worrying about death or preoccupation with death, it is recommended to administer the Death Anxiety Inventory [29]. This test has been empirically supported in both English and Spanish and measures five factors that account for different areas of death anxiety. The test has been determined to have adequate face validity by 11 experts and was determined by the researchers who devised the test to have proper

internal consistency and stability.

The next step is to create a safety plan for each client for various problems that can arise during the pandemic, such as suicidal thoughts or medical emergencies. This is important during a pandemic because of the possibility of therapy being disrupted or the therapist not being able to be in contact with clients for extended periods. The safety plan will provide the client with ways to cope with the problems the therapists' absence might cause and should include support systems, contacts, warning signs, coping mechanisms, emergency plans, and reasons to live. Ragavan et al. [13] elaborated further on these measures in the safety plan. People in the client's life are the support system that would help the client if a mental health crisis came about, while contacts are these people's phone numbers or emails [13]. Therapists should pay specific attention to identifying support systems outside of the therapy by asking about family, friends, spouses, children, grandchildren, coworkers, bosses, and social workers [14]. Warning signs are behaviors or thoughts clients have when their mental health starts deteriorating. Examples include isolation, increased anxiety, and hopelessness. Coping mechanisms are mental health techniques like deep breathing or journaling that the client can use when they recognize their warning signs. Emergency plans are a part of safety plans that are used when coping mechanisms and support systems fail, and the client cannot stop deteriorating mentally. These emergency plans should include contact information for mental health facilities and ERs. Finally, reasons to live are included in the safety plans for clients to think about them when they are in a crisis and might be having suicidal thoughts. They also suggest emailing a copy of the safety plan to the clients as well as mailing them a physical copy [13].

After creating a safety plan, consider tapping on the community and mental health resources as well. To help reduce social isolation, one researcher suggests finding call centers manned by volunteers that will routinely contact the clients to maintain a semblance of connectedness [30]. Another recommendation is providing online or safe in-person physical activities to keep older adults active [31]. The inclusion of in-person activities is debated in the research. However, most agree that as long as precautions are followed, some in-person interaction with others is a great way to get older adults out of the house [32].

As stated earlier, this protocol is designed to be used with any theoretical orientation. With that being said, when therapists remain consistent with their selected theoretical orientations and interventions, a sense of structure is maintained for the older clients [30]. Evidence supports that older adults are just as responsive to various forms of psychotherapy and psychological interventions as younger adults, specifically cognitive-behavioral, psychodynamic, and problem-solving, among other theoretical orientations [33]. However, it is also important to use interventions that target belonging and self-worth, which tend to help reduce feelings of age discrimination [34].

The final step can be uncomfortable for some people but was found in the research to be important. Therapists should discuss religion/ spirituality with older clients, and determine if any religious interventions are available alongside regular therapy. Research has shown that involvement in a religious institution and increasing belief in their religious teachings are negatively associated with death anxiety and social isolation. The recommendation is to help the older clients access online or radio religious congregations, if they are willing, to help promote their faith and fellowship. Encouraging connectedness with religious organizations can fight both loneliness and death anxiety concurrently [20,35].

Integration of Treatment Protocol into Various Treatment Modalities

The treatment protocol presented above is generic so that it can apply to many different situations and clients. However, it is worth discussing how the protocol can be integrated into different types of therapies while maintaining its integrity.

Individual therapy is often seen as the primary type of therapy, and most research pertained to working with the older adults on a one-on-one basis. Individual therapy is effective with older adults and has been shown to work effectively during COVID-19 and similar pandemics in the past. When working with older adults individually, it is important to remember some older adults will be uncomfortable with one-on-one therapy for cultural reasons [33,20]. An example is how some in the Latin culture believe older adults should be protected for their wisdom and not be alone with strangers [20]. Also, some older adults will not be as open to therapy in this style because of certain beliefs and prejudices they have against psychotherapy [27]. These issues should be discussed with the client before the therapy begins.

Group therapy is another way to work with the older adults, and this method has a large scientific backing to support its use; some finding group therapy as effective as individual therapy or even more effective than individual therapy [36]. Also, it is important to discuss the use of homogenous groups of older adults versus heterogeneous groups that contain different age groups. Groups consisting of only older adults have the same advantages that other homogeneous therapy groups have [37]. Everyone in a homogeneous group is most likely suffering from similar problems, so the conversations can pertain to everyone. Clients perceive other members to be more understanding since they are sharing the same experience, which allows them to share and talk more in a group. However, exposing older adults to members of younger ages in a heterogenous group also has benefits. Malik [38] found that intergenerational contact was found to have the largest effect on age discrimination, thus, these types of groups can lead to fewer feelings of persecution in the older adult population. Also, research shows that as long as everyone in the group has the same ailment, intergenerational groups have comparable outcomes to homogeneous groups [37].

Finally, the treatment protocol can be integrated into family therapy as well. Similar to heterogenous group therapy, family therapy can provide intergenerational contact that can reduce age discrimination [38]. Additionally, researchers made it clear that social support systems like family are important to maintaining mental health for older clients during pandemics [20]. The inclusion of family in any part of the therapeutic process, especially when using a family therapy, can lead to stronger social support for the older adults [20].

Although the treatment protocol proposed in this article is research-based, there are a few limitations with the protocol. The research reviewed to develop the protocol was limited to what was created by others. While not inherently a problem, some topics had to be excluded from the final protocol because no research has been conducted about them. Some studies had methodical limitations. Hopefully, their claims would be investigated and supported in the future. Notwithstanding, this protocol is a good steppingstone. The protocol is generic with the main focus on what needs to be kept in mind while working with older adults during the pandemic and similar situations and it can be adapted to the diverse practices and orientations of the therapists.

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