Elder Abuse and Self-care

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Abstract

I will be discussing my personal encounters with elder abuse and due to those encounters, I might find this area challenging or difficult as a counselor. I will also describe my personal reaction to elder abuse, the challenges that it involves, i.e. countertransference and personal feelings. Also, address the kinds of issues that will need to be addressed in my personal counseling that will ensure I am prepared to face issues relating to elder abuse. The second topic of discussion will be self-care. Describing what burnout looks like for a counselor particularly me, vicarious trauma. I will discuss strategies to ensure my own care should I need to respond to a crisis of elder abuse.

Keywords: burnout, countertransference, self-care, vicarious trauma

First let's look at what elder abuse is: elder abuse is defined as intentional actions that cause harm or create a serious risk of harm (whether or not harm was intended) to a vulnerable elder by a caregiver or other person who stands in a trust relationship or failure by a caregiver to satisfy the elder's basic needs or to protect the elder from harm. This definition includes two major points: that an older person has suffered injury, deprivation, or necessary danger, and that another person (or persons) in a relationship of trust was responsible for causing or failing to prevent the harm (Pillemer et al., 2016)

I had two major experiences that may have me apprehensive in being non-biased and reacting out of emotions. The two incidents are attached to my great-aunt and my uncle. Both were elderly and needed care. It was through their period of needing care my bowls of compassion were moved. First was my Uncle William Barber, about the age of 86 he took ill and had to be placed in a nursing home. It was my first direct exposure to elder abuse. The elder abuse was very minimal to my uncle as he had his family to advocate for him and to be there at the facility every day of the week at various unexpected times. The abuse that that I saw some of the elderly was gravely disheartening. The abuse was in various forms, it was verbal/emotional, psychological, physical, and neglect. Then a few years later the same was seen when my aunt had to be placed in a nursing home. Thank God she had us (her family) to stay on top of the

caregivers. But, just to see the mistreatment given to those who don't have anyone to consistently over see their care, it's so sad. At a certain age, and it varies, the elderly can become so helpless like babies. It's so hurtful to see someone whether it be a family member, home attendant, facility worker or any perpetrator take advantage of a person that has contributed to society, worked, raised children, given love and care to others, or whatever capacity, now is not able to do as they once did, and now disregarded, disrespected, pushed to the side, and treated badly. I have seen it done and it rips my heart. I and my siblings had one of the highest honors of taking care of my mom in her elder years. I believe one of the things that kept us, most definitely me on my toes, was, that I seen what elder abuse looked like and was determined that my mom's elder years was going to be the best years of her life. I/we treated her royally. She didn't have to want for anything we paid all her bills out of our money. She would always tell everyone my children treat me like a queen. It was a lot and hard but she was well worth it. Just knowing all the sacrifices she made and her undying love.

So, all of this leaves me with feeling some kind of way about people who are perpetrators of elder abuse. Not many things get to me, but I am glad that I am self-aware that this one does. Therefore, what would it look like in counseling should I have a client that is an elder abuser. This is definitely a high risk of countertransference. I like this definition countertransference: whenever therapy becomes intense, as in crisis work, the potential for countertransference increases. Countertransference is the attributing to the client by the therapist, of traits and behaviors of past and present significant others or events in crisis worker's own life. Countertransference responses may be either positive or negative, spoken or unspoken, conscious or unconscious. They may include physical, psychological, social, gender, racial, moral, spiritual, cultural, or ecological factors that have impacted me through past experiences

and are manifested in the "here and now" of therapy by the client. At times, emotional aspects of the client may agitate feelings, thoughts, and behaviors that are deeply buried within the worker's own personality (James and Gilliland, 2017).

As the clinician I must ask myself as Hass and Malouf (2005) recommend when I'm unsure about my competence with a particular client. The first question I should ask myself is, "Are you emotionally able to help the client?" They suggest that counselors and therapist should ask myself whether I can maintain objectivity in the situation. Perhaps the nature of the client's problem is too close to my own experience to avoid countertransference. To maintain objectivity, I would need to have insight into my own behavior and have a professional support system available to double-check the accuracy of my own interpretations of the client. Even then, some client issues can be strong triggers and those safeguards are insufficient. The second question Hass and Malouf (2005) is, "Could I justify my decision to a group of my peers?" This is often referred to as the "clean, well-lit room standard," which means that any action that I would feel comfortable describing in an open discussion with my peers is likely to be appropriate. Conversely, any activity that I would like to hide or would be ashamed to admit to my peers is probably not a responsible action. These exercises are likely to result in uneasy feelings, and that uneasiness itself is a signal to reevaluate the plan. It may mean I need to just refer the client to another therapist. It's always good to keep peers and the supervisor in the loop.

Self-care, what does this mean? Some might argue that there has not been a well-established definition for self-care for professionals, and he conceptualization of this construct will likely evolve as more research becomes available (Xu, 2020). Based on current (and limited) literature on this topic, selfcare for professionals typically refers to activities or processes that are

initiated and managed by the professional for the purpose of providing stress relief and supporting one's health and well being (Lee & Miller, 2013; Newell & Nelson-Gardell, 2014). It should be noted that a lack of self-care in health service professionals has been considered a cause of compromised quality of service and burnout, and sufficient self-care has been suggested to be a part of ethical practices (Barnett et al., 2007; Wise & Reuman, 2019). There is one more thing to consider: for health care professionals, the concept of self-care has an additional component compared with general populations because the self is divided into the professional self and the personal self, either implicitly or explicitly (Pipes et al., 2005: Skovholt et al.,2001). The professional self engages in working relationships with clients that are guided by professional role expectations of engagement with those client relationships. In contrast, the personal self exists outside the workplace as guided by role expectation influenced by family, and other factors, and other ecologies (Skovholt et al., 2001).

So, what can burnout look like for a counselor? Counselors live in a world of wounds. Like doctors, counselors see horrible accident and psychological scars inflicted by others. So, every counselor must find a way to deal with two aspects of the job:

- Vicarious trauma
- Burnout

Vicarious trauma is caused when the counselor is significantly affected by the experiences of the client. Vicarious trauma is a process that unfolds over time; it is the cumulative effect of seeing so much pain endured by so many people. All counselors who have been in practice have stories of clients who have been in practice have stories of clients who have deeply affected them, both positive and negatively. Although we take great joy when clients overcome adversity, we are often wounded by the stories our clients tell us. It is impossible to

listen to someone's story of abuse, betrayal, or grief and not have it touch our hearts. Recognizing and attending to pain that we can feel when we hear these stories is essential to maintaining our own wellness (Granello and Young, 2012).

Having read this research, I now need to relate this to my issue with those who are elder abusers, and my countertransference. I think it would be good to insist on supervision and peer consultation frequently. As supervision can help deal with the stress or difficult problems, emergencies and dilemmas. Also engaging in professional development. This would me that I would need to develop my own learning plan as well as attending conferences and seminars (Granello and Young 2012). As far as self-care I believe it entails so much and must be done on a continuous basis. It should not be that I'm looking for a plan of self-care only at the point of burnout, especially if I am self-aware, I should see signs that changes are needed from how things are presently being done. Therefore, I need to continuously have things such as maintaining my fitness (gym), eating well, proper sleep habits, for my physical wellness. For my emotional wellness have a component that will reduce my emotional arousal, by taking a walk or finding a minute to pray or meditate, get counseling myself. My intellectual wellness can be enhanced by staying sharp and cognitively engaged. Also, maintaining my relationships. If all of this is done consistently, I really believe the chances of burnout is gravely lessened as self-care is done continuously.

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