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PRACTICE

Counseling for Wellness With Older Adults

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Resulting from the assumption that older adulthood is a time of decline, there is a dearth of research on the application of wellness counseling with older adults. This article reviews the literature on wellness and older adults, synthesizes wellness with adult development theory, and describes wellness counseling with older adults.

Keywords: older adults, adult development, mental health of adults

A longevity revolution (Butler, 2008) is occurring across the globe. Because of factors ranging from the reduction of early-age mortality to an increase in life expectancy at later ages, most of the world's population is now living longer than preceding generations (Bengtson, 2014). There are currently more than 44 million older adults—typically defined as persons 65 years and older—living in the United States, and this number is expected to increase to 98 million by 2060 (Administration on Aging, 2016). Although most older adults report higher levels of life satisfaction than do younger or middle-aged adults (George, 2010), between 5.6 and 8 million older Americans have a diagnosable mental health or substance use disorder (Bartels & Naslund, 2013). Furthermore, because of the rapid growth of the older adult population, this figure is expected to nearly double by 2030 (Bartels & Naslund, 2013).

Mental health care is effective for older adults, and evidence-based treatments exist to address a broad range of issues, including anxiety disorders, depression, sleep disturbances, substance abuse, and some symptoms of dementia (Myers & Harper, 2004). Counseling interventions may also be beneficial for nonclinical life transitions, such as coping with loss, adjusting to retirement and a reduced income, and becoming a grandparent (Myers & Harper, 2004). Yet, older adults are underserved when it comes to mental

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health treatment (Bartels & Naslund, 2013; Myers & Harper, 2004). In fact, fewer than 3% of older adults report seeing a mental health professional for treatment, the smallest percentage of any age group (American Counseling Association, 2011). Untreated mental health and substance use conditions are associated with negative outcomes that include emotional distress, physical health impairment, increased mortality, rising costs due to hospitalization and nursing home placement, and suicide (Institute of Medicine, 2012).

As the elder boom continues, researchers expect that the treatment of older adults' mental health needs will be inadequate because of both the dearth of mental health professionals trained to work with older adults (Bartels & Naslund, 2013; Boswell, 2012; Institute of Medicine, 2012) and the relatively higher utilization of mental health services by members of the baby boom generation (Institute of Medicine, 2012). One reason for the inadequate supply of mental health services for older adults may be the erroneous assumption that older adults' needs are primarily physiological. Historically, the biomedical model dominated the study of aging, influencing how both researchers and practitioners defined successful aging (Longino & Powell, 2009). Quality of life research focused primarily on the biological domain (Wiggins, Higgs, Hyde, & Blane, 2004), and the dominant definition of how to help older people age successfully, as articulated by Rowe and Kahn (1997) in their theory of successful aging, emphasized physiological and functional health at the expense of other domains (Martinson & Berridge, 2015). It is likely that the undue focus on physiological aging has influenced how practitioners, including counselors, view the aging process. Practitioners who work with older clients may assume that their needs are exclusively physical, resulting in the neglect of psychological, social, or spiritual needs (Kelley-Gillespie, 2009; Strout & Howard, 2015). Moreover, the narrow focus on older adults' physiological needs may contribute to negative attitudes toward older adults. According to research, a focus on aging as a medical problem, rather than as a normal part of the life span, predicts ageism within a society (Ng, Allore, Trentalange, Monin, & Levy, 2015). Negative assumptions about later life are cited as a reason that students do not express an interest in working with older adults (Gonzales, Morrow-Howell, & Gilbert, 2010; McBride & Hays, 2012). When older adults do present for mental health treatment, mental health professionals may lower their expectations about the effectiveness of the counseling process (Woolfe & Briggs, 1997), assume that older clients have a poorer prognosis than younger clients despite the same presenting issues (Danzinger & Welfel, 2000), and question whether older clients are capable of developing a therapeutic relationship (Helmes & Gee, 2003).

Despite the dominance of the biomedical conceptualization of aging, when older adults are asked to define what it means to age well, they identify a broad range of values and experiences that span biological, psychological,

social, spiritual, and other domains (Phelan, Anderson, LaCroix, & Larson, 2004; Reichstadt, Depp, Palinkas, & Jeste, 2007). Therefore, in contrast to the narrow, deficit-based assumptions of the biomedical model, the wellness movement provides a multidimensional, strength-oriented lens for understanding how older adults age successfully (McMahon & Fleury, 2012). However, although there is substantial literature describing the use of a wellness approach with a variety of age and demographic groups, a dearth of research exists on how to apply wellness counseling with older adult clients (Granello, 2013; Myers & Sweeney, 2005). Furthermore, it is rare to find research that synthesizes the wellness approach with a specific theory of adult development focused on the needs of older adults (Grove, Loeb, & Penrod, 2009). To address this gap in the literature, I review previous literature describing older adults and wellness, introduce a specific adult development theory related to older adulthood, and discuss how wellness can be applied with older adults.

WELLNESS AND OLDER ADULTS

The modern wellness movement began more than 50 years ago with the idea that health is not merely the absence of disease, but also the presence of salutogenic factors that can help individuals attain healthier, happier lives (Granello, 2013; McMahon & Fleury, 2012). The wellness paradigm focuses on integrating a person's needs across a variety of life domains, highlighting the importance of prevention and health promotion, and assessing and using an individual's strengths and resources to accomplish goals. By including multiple domains of personhood, including emotional, social, spiritual, and physical domains, as well as client strengths, the wellness paradigm provides an alternative to many of the negative assumptions associated with aging.

HOW OLDER ADULTS DEFINE WELLNESS

Several studies have described how older adults conceptualize wellness. Myers and Degges-White (2007) used Myers and Sweeney's (2004) Indivisible Self model to explore the wellness of older adults living in an upscale retirement community. The Indivisible Self model is based on Adlerian theory (Adler, 1927/1954) and emphasizes the holistic nature of personhood. The model includes an overall wellness construct, in addition to second- and third-order factors that are organized as follows: the Creative Self (Thinking, Emotions, Control, Work, and Positive Humor), the Coping Self (Leisure, Stress Management, Self-Worth, and Realistic Beliefs), the Social Self (Friendship and Love), the Essential Self (Spirituality, Gender Identity, Cultural Identity, and Self-Care), and the Physical Self (Exercise and Nutrition). Using this

model, Myers and Degges-White measured the wellness of older adults ages 73 to 101 years. They then compared the sample's wellness with that of a younger norm group, and correlated it with scores on their participants' perceived stress and sense of mattering to others. When compared with the younger norm group, the older adults scored significantly higher on the Coping Self, Social Self, Physical Self, Essential Self, and Total Wellness, as well as for many of the third-order factors included within these domains. No significant correlations were found between wellness and perceived stress. However, numerous significant correlations were found between sense of mattering to others and the Creative Self, Coping Self, Social Self, Essential Self, and Total Wellness. Myers and Degges-White concluded that older adults generally experience high levels of wellness, which is consistent with previous research on well-being in later life (George, 2010). They also explained that a sense of mattering to others appears to be particularly important to well-being in later life.

Foster and Levitov (2012) used factor analysis to determine whether middle-aged and older adults perceive wellness differently than do younger groups. The authors used the Perceived Wellness Model (Adams, Bezner, & Steinhardt, 1997), which includes the domains of physical, emotional, social, spiritual, intellectual, and psychological wellness. Foster and Levitov's sample included adults who ranged in age from 50 to 78 years, with a mean age of 60 years. The authors found that their participants' scores clustered around four primary factors. The first factor, Optimism, related to "themes of purpose, mission, intellect, a positive view of the future, security, and expecting the best" (p. 71). The second factor, Existential Despair, was used to define "hopelessness, self-degradation, and inferiority" (p. 72). The third factor, Physical, focused on individuals' perceptions of past, present, and future health. Finally, the Family/Friends factor described items related to how older adults perceived their relationships with family and friends. On the basis of these results, Foster and Levitov concluded that perceptions of wellness may change over time. The authors argued that although middle-aged and older adults recognize physical and social wellness domains, they may not distinguish between the dimensions of emotional, spiritual, intellectual, or psychological wellness, but rather may integrate elements of each of the domains into either a positive (Optimism) or negative (Existential Despair) attribution of life.

Foster, Galjour, and Spengel (2015) used an exploratory factor analysis to examine how older adults define holistic wellness. They used a sample of 229 adults ranging in age from 60 to 97 years who completed the Perceived Wellness Survey (Adams et al., 1997). Results of the analysis demonstrated a four-factor model for wellness consisting of Existential Success, Existential Despair, Physical Wellness, and Future Physical Wellness. The authors found similarities between their findings and those of previous research (Foster & Levitov, 2012). However,

they noted that the items that had previously loaded onto the Family/Friends factor were now accounted for on the Existential Success and Existential Despair factors.

Strout and Howard (2015) used Hettler's wellness model (National Wellness Institute, n.d.) to examine older adults' cognitive health. Hettler's model includes physical, emotional, social, spiritual, occupational, and intellectual domains, and was originally developed for use with college students (Granello, 2000). Strout and Howard examined the association between wellness domains and cognition among older adults using all domains except occupational wellness. They identified a hierarchical regression model that accounted for 5.4% of the variance in cognitive health after controlling for participants' age and education. Emotional wellness—as measured by questions related to life satisfaction, feeling valued, stress level, and looking forward to new challenges—was the variable most strongly associated with cognitive health. Physical and spiritual wellness were also positively associated with cognitive health, whereas intellectual wellness and social wellness were not. The authors then compared a cognitive healthy group with a cognitively impaired group using Hotelling's T^2. They found that emotional, physical, spiritual, and social wellness were all significantly different between the groups.

Finally, McMahon and Fleury (2012) performed a concept analysis to better understand how wellness applies to older adults. The authors found that wellness was consistently defined in the literature as a process of becoming, integrating, and relating. They defined *becoming* as the ongoing development of older people, including a recognition of their personally defined potential. The authors described *integrating* as the process of synthesizing a person's past, present, and future values in a manner that promotes a sense of wholeness and control. This process includes the integration of body, mind, and spirit, as well as relational and contextual variables, to support ongoing purpose in life. Finally, *relating* was described as the dynamic person–environment interaction that promotes the older adult's growth and development. Relating is fostered by social support and maintained by meaningful communication. McMahon and Fleury went on to explain that to strengthen the processes of becoming, integrating, and relating, older adults must be able to connect with others, imagine new opportunities for their lives, recognize strengths, and seek meaning. Without these antecedents, older adults may struggle to move toward wellness. Finally, McMahon and Fleury argued that the consequences of becoming, integrating, and relating are being well and living out values. The authors defined *being well* as a quality of personal indivisibility, as well as the ability to place one's wellness in the foreground even while living with a coexisting illness. They described *living out values* as the ability to live each day according to one's personally defined values, including those values related to their health.

APPLYING WELLNESS WITH OLDER ADULTS

Some researchers have developed wellness-oriented programs that demonstrate how to promote older adults' holistic well-being. In 1984, Barbaro and Noyes introduced a wellness program consisting of health education related to several health conditions that were common within a continuing care retirement community. They justified their approach to prevention services by identifying the cost-effectiveness of participants maintaining control over their health and retaining independence for a longer period of time. Participants reported making significant changes to some of their health behaviors, including nutrition, exercise, skin care, and the prevention of digestive problems. Similarly, Kogan et al. (2012) used a wellness intervention that was focused on health behaviors, but notably added depression. The program consisted of biweekly sessions of low-impact physical activity and nutrition education, including a nutrition counseling session with a registered dietitian. Over the course of the program, participants' depression levels decreased.

Chapin et al. (2013) developed an intervention based on pairing an older adult participant with an older adult volunteer who served as a peer support. The volunteer received training in the use of a strength-based approach, mental health and aging, goal setting and attainment, community resources, and safety. The authors found that the intervention was effective based on participants' significantly reduced depression scores and improvements to their health-related quality of life and physical functioning. Likewise, Zechner and Kirchner (2013) studied a pilot wellness program used at a geriatric psychiatric hospital. The program included nine domains of wellness, including spiritual, physical, emotional, intellectual, social, occupational, environmental, metabolic health, and sexuality. Over the course of 11 weeks, the participants were provided with education about skills related to these domains and the construction of a personal wellness plan. Participants reported that the program broadened their perspectives on health and well-being. Finally, Silva-Smith et al. (2011) described an interdisciplinary wellness model that was based on the pursuit of holistic wellness that includes social, spiritual, physical, emotional, intellectual, and occupational domains. The wellness model included a health clinic that provided assessment and collaborative care; a wellness program that included health promotion classes, personal training, massage, and physical therapy; a cognitive fitness program that included cognitive assessment, brain fitness activities, and behavioral consultation; and community engagement that included service activities and event outings.

WELLNESS COUNSELING AND ADULT DEVELOPMENT THEORY

Although practical applications of wellness with older adults have emerged in various disciplines, there is not currently any research describing wellness

counseling approaches with older adults. Wellness counseling has a strong evidence base and can be incorporated into both individual and group approaches (Myers & Sweeney, 2008). Counselors are prime candidates to incorporate wellness into their professional practice because of the counseling profession's emphases on prevention, the assessment and utilization of client strengths, therapeutic factors such as trust and goal setting, and partnership with clients to determine goals that are attainable and well defined (Fetter & Koch, 2009). Wellness counseling should include the use of a theoretical model of wellness, motivational theory, wellness assessments to identify a client's current level of wellness, and a personal wellness plan that focuses on individual domains but stresses their interconnectedness (Granello, 2000). Several wellness models can be incorporated into counseling, with each model featuring slight variations in the domains that are included (for a review of wellness models, see Roscoe, 2009). However, most wellness models share key attributes, such as a recognition of the multidimensionality of life domains, an awareness of how these domains interact and influence one another, and a focus on how clients may use their strengths to enhance wellness. When using a wellness counseling approach with older adults, counselors should identify a clear connection between counseling practice and a specific theory of adult development (Alley, Putney, Rice, & Bengtson, 2010; Myers & Harper, 2004). Although a typical counseling curriculum includes a course on life-span development, few counselors receive advanced training in models of adult development that focus on how older adults navigate the aging process (Foster & Kreider, 2009; Institute of Medicine, 2012). In the following paragraphs, I describe how to integrate the adult development theory of selective optimization with compensation with a wellness approach to counseling older adults.

SELECTIVE OPTIMIZATION WITH COMPENSATION

The theory of selective optimization with compensation was developed to demonstrate how older people adapt to specific challenges in a manner that promotes well-being (M. M. Baltes & Carstensen, 1996; P. B. Baltes & Baltes, 1990; Blando, 2011). The theory is based on several core assumptions that have empirical support. First, older adults are heterogeneous, and although some people struggle to adapt to the challenges of later life, many older adults demonstrate high levels of well-being. Next, contrary to the cultural myth that older adults are incapable of learning new mind-sets or behaviors, research on cognitive plasticity has indicated that older adults are resilient, capable of learning, and able to adapt late into their lives (P. B. Baltes & Baltes, 1990). Finally, when older adults' internal and external resources are actualized, they are able to experience high levels of quality of life and life satisfaction.

Selective optimization with compensation consists of three primary stages of adaptation in older adult development. *Selection* is defined as the "increasing restriction of life domains as a consequence or in anticipation of changes in personal and environmental resources" (M. M. Baltes & Carstensen, 1996, p. 406). Although selection applies in certain situations to people of all ages, older adults may be more likely to face circumstances that require them to decide where to invest time and energy. For example, restricted mobility may require an older person to select hobbies that require less agility, such as playing pickleball instead of tennis. *Optimization* refers to "the enrichment and augmentation of reserves or resources and . . . the enhancement of functioning and adaptive fitness in selected life domains" (M. M. Baltes & Carstensen, 1996, p. 412). Optimization reflects one's ability to highlight the skills or attributes that maximize satisfaction and identify new areas for growth. An example may be a pianist dealing with arthritis who, instead of using all 88 keys to play a concerto, focuses on a limited range of notes that can still be played at the expert level (Blando, 2011). Finally, *compensation* occurs when an individual uses an alternative method to achieve a particular goal. This process becomes particularly important when "specific behavioural capacities or skills are lost or reduced below the level required for adequate functioning" (M. M. Baltes & Carstensen, 1996, p. 409). Compensation may include learning to read braille after losing one's eyesight or using a cane to compensate for impaired balance. However, compensation is not limited to physical adaptations. Older people may maintain a sense of self-efficacy by delegating specific responsibilities that they can no longer perform to a trusted friend or family member. Likewise, when older adults narrow their range of social contacts, they benefit by focusing energy on social interactions that are most likely to be emotionally gratifying (Carstensen, Fung, & Charles, 2003). In summary, the process of selective optimization with compensation provides a theoretical basis for how older adults adapt and develop in the face of adversity. An example of these processes working together might be an avid athlete, who in older adulthood restricts his activity in sports to playing golf (selection), attends a yoga class to maintain the flexibility required to play on a regular basis (optimization), and uses a riding golf cart instead of walking (compensation). Selective optimization with compensation offers a specific understanding of adult development that blends well with the use of a wellness paradigm.

INTEGRATING WELLNESS AND SELECTIVE OPTIMIZATION WITH COMPENSATION

At the outset of treatment, counselors should introduce key concepts such as holistic wellness, the use of client strengths, and the theory of selective optimization with compensation. Describing the wellness framework communicates to older clients that all domains are available for discussion,

and counseling will include the use of their unique skills. Pairing wellness with selection, optimization, and compensation normalizes the challenges associated with aging, indicates that the counselor is familiar with adult development, and reassures the client that solutions are available. After this introduction, counselors should combine the wellness paradigm with the theory of selective optimization with compensation using a number of integrative strategies.

First, the process of selection can be operationalized as goal setting (Grove et al., 2009). Goal-oriented discussions should include what the individual wants to accomplish, the motivation of the older adult to reach these goals, an appropriate target date for goal completion, and an optimal method for tracking results. Identifying what motivates a particular client will provide insight into an individual's readiness for change (Prochaska, 1995). When using this approach with older adults, counselors may find it helpful to include questions about quantity of life versus quality of life, trade-offs between present and future health, and specific health and wellness outcomes preferred by the older adult. Similar to younger clients, older adult clients may have differing levels of motivation depending on the particular goal that is being discussed. When family members or a community agency refers older adults for treatment, it is possible that the treatment goals suggested by the referral source are not consistent with those preferred by the client. In this case, counselors should seek to increase the client's investment in counseling by identifying goals that are amenable to the client.

Regarding the nature of older adults' goals, it is important to discuss a broad range of life domains. Formal wellness assessments include questions that initiate goal-oriented discussion across a variety of domains. By conceptualizing the client through various aspects of personhood, a wellness approach mitigates the tendency to view older adults primarily through a physical lens. For example, an older adult client residing in a long-term care facility may have numerous interactions with facility staff that are exclusively focused on physical concerns. The use of a wellness approach allows both the client and practitioner to integrate physical concerns with psychological, social, and spiritual needs. The specific domains that are identified may be influenced by which wellness model is used (Roscoe, 2009). Regardless of which model is selected, counselors should attend to a variety of variables that are closely associated with older adults' longevity and quality of life, including mental and emotional wellness; reciprocal social relationships that are perceived as supportive; participation in preferred religious and spiritual practices that provide meaning and purpose; a belief that one has at least some control over circumstances; physical wellness; an environmental context that is just, equitable, and supportive; and a positive perception of aging.

Next, the process of optimization relates to the wellness philosophy that well-being is not merely the absence of disease, but also includes striving

toward greater realization of one's quality of life potential (Roscoe, 2009). This means that older clients are capable of taking steps to achieve a desired outcome (Grove et al., 2009). Rather than solely focusing on deficits, the counselor and client should also discuss life domains that are currently going well, identify strengths that the client is using, and consider how these strengths might be leveraged within the client's wellness plan. Hirst, Lane, and Stares (2013) described several strategies for incorporating strengths into mental health treatments with older adults. First, a strength-based perspective is one in which the counselor seeks to focus attention on a client's strengths and potential for growth, regardless of the challenges facing the person. The working relationship is collaborative and characterized by empowerment. Second, strength-based assessment tools are an alternative to deficit-based measures and provide both the client and counselor with insights into a client's resources. A strength-based tool seeks to identify those traits or strategies that help an individual survive or overcome challenging situations. Third, strength-based models are conceptual frameworks that can be included at the community-wide level. Finally, strength-based interventions can be used during counseling sessions to improve the well-being of older adults. Strength-based interventions help clients cultivate gratitude, devote increased awareness to what is most positive about oneself, and identify strengths of character. Research has indicated that these exercises increase happiness and reduce depression (Seligman, Steen, Park, & Peterson, 2005).

Finally, the process of compensation refers to the use of strategies or aids to compensate for deficits that may accompany the aging process. A thorough wellness assessment may reveal where deficits are currently occurring. To identify appropriate compensatory strategies, the counselor and client should jointly explore all available internal or external resources that could be used to manage a particular challenge. For example, discussing the client's internal resources, such as courage, perseverance, motivation, or spiritual resources, allows for the older client to have a role in the change process. When paired with the use of optimization, this discussion may enhance the client's self-efficacy and lead to goal attainment. In addition, dialogue about how to incorporate external resources, such as friends or family, neighbors, community support groups, or the Area Agency on Aging, may result in novel ideas about how these supports may be leveraged to address a particular challenge. Counselors can normalize the use of compensatory strategies that may be an inevitable part of the adjustment to advanced age, while also emphasizing the many internal and external resources that may be available to older clients.

In summary, the steps of selection, optimization, and compensation can be combined with a wellness paradigm and used to benefit clients. The process empowers clients by giving them an active role in the planning process

(selection), identifying opportunities for strength-based skill development (optimization), and jointly identifying resources that are personalized to the clients' community and values (compensation; Grove et al., 2009). Wellness-oriented selection, optimization, and compensation should lead to the development of a personalized treatment plan based on wellness (Myers, Sweeney, & Witmer, 2000). Older adults may present with complex biological, psychosocial, and spiritual needs, making the plan an important road map for both the client and counselor. Wellness counseling integrates the older adult's physical health preferences with psychosocial and spiritual considerations. This approach allows the client to select from a range of options, optimize outcomes by implementing strengths, and identify strategies for compensation. For example, an individual facing irreversible changes to physical abilities may have to elect whether to remain at home or move into an assisted living community. Discussion of priorities across numerous domains—including physical, psychosocial, or spiritual goals—provides the client with a broader range of options, an opportunity to construct achievable goals, and an awareness of the resources that the client might use to navigate difficult decisions. The personalized wellness plan documents these options, goals, and resources and reminds both the client and counselor of the path forward. The following case study is based on a fictional client.

A CASE EXAMPLE

John, 84, was exhibiting depression symptoms and was referred for counseling by the nurse at his assisted living facility. The counselor described an approach to counseling that emphasized client wellness, which was intended to help John enhance his life satisfaction in a variety of areas. The counselor added that John's treatment would be based on an understanding of adult development and aging that assumes that older people are capable of using skills and strengths to adapt to life's challenges. John was intrigued by the counselor's approach and agreed to try counseling. The counselor began by asking John to complete a wellness assessment that would identify how John's depression symptoms had affected his biological, psychological, social, and spiritual well-being. John's score indicated that he was having trouble in the domains of coping with stress and social wellness; however, the results also showed that John had confidence in his ability to relate well to others and a strong connection to his faith community. John told the counselor that he felt discouraged after moving from his home of 30 years to an assisted living facility. John said the move made him feel "old," and he added that he missed his neighbors and the home where he and his wife had lived before she died. The counselor empathized with John's concerns, and both parties agreed to develop a wellness plan for how John could adapt to his current life by increasing his holistic wellness.

By integrating selection, optimization, and compensation into wellness counseling, John's counselor provided John with the perspective needed to improve his circumstances. Through the process of selection, John identified his role as a grandparent as the area in which he wished to devote his time and energy. With support from his counselor, John used the process of optimization to explore his strengths and develop new coping strategies. John came up with the idea of embracing his new home at the assisted living facility as a place to host family gatherings and special getaways for his grandchildren. Finally, John and his counselor discussed the process of compensation, or using an alternative method to achieve a particular goal. In the past, John prided himself on being able to solve his own problems without any outside help. However, because of his recent transition and the accompanying depression symptoms, the counselor suggested that perhaps John's participation in wellness counseling was itself an appropriate compensation strategy. A month later, John called the counselor to say that wellness counseling had given him the courage to attend a community event hosted by the assisted living facility, where he had used his strength of friendliness. At the event, John ran into a former high school classmate facing similar circumstances. John described how wellness counseling had provided him with new perspectives on how he could use his strengths to make the most of his new setting. He explained that his counselor's approach was based on research about how people age effectively. Later that day, the counselor received a call from John's friend asking for more information about wellness counseling.

CONCLUSION

The number of older adults is growing rapidly, creating both a challenge and an opportunity for the counseling profession. For example, counselors who may lack training in gerontology will nonetheless see more adults 65 years and older entering their clinical practices. Research will be needed to mitigate the influence of ageism on student attitudes so that older adults receive the highest quality of care (McBride & Hays, 2012). Professional leaders will continue to identify strategies to advocate for expanded mental health access for older adults, including the importance of Medicare reimbursement (Fullen, 2016). Despite these challenges, counselors have an opportunity to provide leadership in the areas of research and clinical practice related to aging well. As the number of adults 65 years and older continues to grow, and as older adulthood is increasingly viewed as a time of maximizing both longevity and quality of life, the use of wellness approaches that are multidimensional, preventive, and strength-based will become increasingly appealing to both clients and national stakeholders.

Wellness is an approach to counseling that is proactive, attainable, and inclusive of all people (Fetter & Koch, 2009). To offset the negative assumption that older

adulthood is exclusively a time of biological decline and to reconceptualize later life as a time of growth, counselors should consider using a wellness approach when working with older clients. By incorporating the theory of selective optimization with compensation, counselors can be sure that their wellness work is grounded in an empirically based theory of adult development and aging. Furthermore, by using wellness theories, client motivation, wellness assessments, and a personal wellness plan, counselors will help their clients identify what is most important to them during later life and maximize their ability to attain it.

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