



The Aging Process

Transfer of Learning Guide

We create experiences that transform the heart, mind and practice.

Module 4

Aging Workbook –Kathy Sniffen

The Topic: By the end of this training, participants will be able to:

- Identify one's personal values and biases regarding aging and describe the public perception of aging.
- Describe the changes in functional capacity and disability associated with aging. Recognize and assess effects of the aging process on a client's ability to care for self.
- Describe the difference between depression, delirium and dementia.
- Evaluate the impact of separation, loss and grief on a client's well-being.

Supervisor Activities:

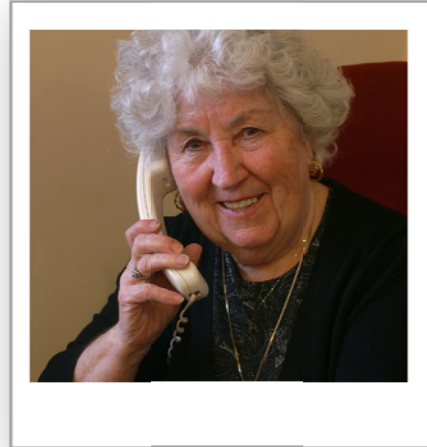
The following pages contain a variety of activities that may be used with new workers and processed in individual or group supervision.

Learning objective #1:

Identify one's personal values and biases regarding aging and describe the public perception of aging.

United States culture places a high value on youth and expresses negative attitudes about growing old. Older persons are perceived as unimportant and without merit as expressed by such terms as "old fogey" and "over the hill". Prejudice toward older persons is called "ageism". Ageism includes the wide range of attitudes that prevent people from accurately assessing and responding to social problems and

conditions of older adults. Ageism can be reflected in discriminatory practices in housing, employment, and services of all kinds.



One key concept to understand is that older adults are a diverse group and there is no single way to describe this population. The cumulative effect of years of individual experiences makes this age group more different rather than more alike. It is important to understand that stereotypes can be self-fulfilling. If we expect old age to be debilitating and lonely it is more likely that will be our experience. Our attitudes toward aging will affect how we age and how we interact with older people. Older adults can be active, vibrant and interesting. To be sure there are challenges, changes, and difficult life events that come with aging but most older adults, given adequate support and resources, have the capacity to cope with even the most difficult situations.

Identification of our own biases, misperceptions, and fears about aging is an essential step toward changing attitudes and eliminating ageism.



ACTIVITY

Ask new workers to consider the following statements that are commonly heard and represent ageist remarks. Ask participants to identify the specific bias or misperception of aging that the statements make.

- You are in pretty good health for your age.
 - Implies that one cannot expect to remain healthy in older age and should "accept" that health will fail
- You must be very lonely at your age.
 - Implies that older adults are no longer socially valued or engaged, based solely on their age status
- I must be having "a senior moment".
 - Implies that older adults are unable to remember or retain information
- You certainly don't look like you're 68 years old
Implies that older age is not attractive so if you "look good" you must look

younger than your chronological age.

- You don't still drive your car, do you?
 - Implies that age alone is the determining factor for ability to drive safely
- 1. Ask new workers to notice and keep a log of examples of ageism in conversations, media, advertising, and workplace environments during the next few days. Re-convene the new workers to discuss: How do these ageist representations shape one's personal perceptions and fears of aging? How does it shape the public's perception? Ask workers what age sensitive processes they can implement in their interactions to reduce ageist attitudes.
- 2. Review agency policy and procedures and discuss those related to reducing age discrimination with personnel and consumers. Ask for feedback on how these processes are perceived and implemented by staff.



ACTIVITY

Share Handout *Facts on Aging Quiz and Answers*, with the new worker.

Ask them to complete the quiz and select one or two facts that are new information to them. Ask workers to give some specific examples of how they can use this new information to better inform their daily practice with older adults.

<http://cas.umkc.edu/AgingStudies/AgingFactsQuiz.asp>

Facts on Aging Quiz

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There have been a number of versions of quizzes on aging that are patterned after Erdman Palmore's landmark "Facts on Aging Quiz" that appeared in two issues of *The Gerontologist* (1977; 1981). About half the items in the following quiz are similar or identical to his. The other half represent issues that have received more attention since Palmore developed his quiz or were judged by the authors to be of significant interest now. The authors have drawn on current research and texts to answer the questions, and their bibliography is included at the end.

Answers to Facts on Aging Quiz are at the end of this handout.

- T F 1. The majority of old people (over 65) have Alzheimer's disease.
- T F 2. As people grow older their intelligence declines significantly.
- T F 3. It is very difficult for older adults to learn new things
- T F 4. Personality changes with age.
- T F 5. Memory loss is a normal part of aging.
- T F 6. As adults grow older, reaction time increases.
- T F 7. Clinical depression occurs more frequently in older than younger people.
- T F 8. Older adults are at risk of HIV/AIDS.
- T F 9. Alcoholism and alcohol abuse are significantly greater problems in the adult population over age 65 than under the age of 65.
- T F 10. Older adults have more trouble sleeping than younger adults do.
- T F 11. Older adults have the highest suicide rate of any age group.
- T F 12. High blood pressure increases with age.
- T F 13. Older people perspire less and so are more likely to suffer from hypothermia.
- T F 14. All women develop osteoporosis as they age.
- T F 15. A person's height tends to decline as they age.
- T F 16. Physical strength tends to decline with age.
- T F 17. Most old people lose interest in and the capacity for sexual relations.

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- T F 18. Bladder capacity declines with age leading to more frequent urination.
- T F 19. Kidney function is not affected by age.
- T F 20. Constipation increases in more people as they get older.
- T F 21. All five senses tend to decline with age.
- T F 22. As people live longer they face fewer acute conditions and more chronic health conditions.
- T F 23. Retirement is detrimental to health- e.g. many people seem to become ill or die soon after retirement.
- T F 24. Older people are less anxious about death than younger and middle-aged adults.
- T F 25. People 65 years of age and older make up 20% of the U.S. population.
- T F 26. Most older people are living in nursing homes.
- T F 27. The modern family no longer takes care of its elderly.
- T F 28. The life expectancy of men at age 65 is about the same as that of women.
- T F 29. Remaining life expectancy of blacks at age 85 is about the same as for whites.
- T F 30. Social security benefits automatically increase with inflation.
- T F 31. Living below or near the poverty level is no longer a significant problem for most older Americans.
- T F 32. Most older drivers are quite capable of operating a motor vehicle safely.
- T F 33. Older workers can not work as effectively as younger workers.
- T F 34. Most old people are set in their ways and unable to change.
- T F 35. The majority of old people are bored.
- T F 36. In general most old people are pretty much alike.
- T F 37. Older adults (65+) have a higher rate of victimization than adults under 62 do.
- T F 38. Older people tend to become more religious as they get older.
- T F 39. Older adults (65+) are more fearful of crime than are people under 65.
- T F 40. Older people do not adapt as well as younger age groups when they move to a new environment.
- T F 41. Participation in voluntary organizations (churches and clubs) tends to decline among older adults.
- T F 42. Older people are much happier if they are allowed to disengage from society.

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- T F 43. Geriatrics is a specialty in American medicine.
- T F 44. All medical schools now require students to take courses in geriatrics and gerontology.
- T F 45. Abuse of older adults is not a significant problem in the U.S.
- T F 46. Grandparents today take less responsibility for raising grandchildren than ever before.
- T F 47. Older persons take longer to recovery from physical and psychological stress.
- T F 48. Most older adults consider their health to be good.
- T F 49. Older females exhibit better health practices than older males.
- T F 50. Research has shown that old age truly begins at 65.

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Answers to Facts on Aging Quiz

1. **False.** Almost 90% of people who are 65 years of age do NOT have Alzheimer's Disease.
2. **False.** Although there are some circumstances where the statement may hold true, current research evidence suggests that intellectual performance in healthy individuals holds up well into old age. The average magnitude of intellectual decline is typically small in the 60s and 70s and is probably of little significance for competent behavior. There is more average decline for most abilities observed once the 80s are reached, although even in this age range there are substantial individual differences. Little or no decline appears to be associated with being free of cardiovascular disease, little decline in perceptual speed, at least average socioeconomic status, a stimulating and engaged lifestyle, and having flexible attitudes and behaviors at mid-life. The good news is that research data now indicate that intellectual decline can be modified by modest interventions.
3. **False.** Although learning performance tends on average to decline with age, all age groups can learn. Research studies have shown that learning performances can be improved with instructions and practice, extra time to learn information or skills, and relevance of the learning task to interests and expertise. It is well established that those who regularly practice their learning skills maintain their learning efficiency over their life span.
4. **False.** Personality remains consistent in men and women throughout life. Personality impacts roles and life satisfaction. Particular traits in youth and middle age will not only persist but may be more pronounced in later life.
5. **True.** As one ages there is modest memory loss, primarily short-term memory (recent events). Older adults are more likely to retain past or new information that is based on knowledge acquired or builds upon their life course or events. Retrieval of information may slow with age. The causes of these changes are unknown, but may include stress, loss, physical disease, medication effects and depression. Lack of attention, fatigue, hearing loss, misunderstanding are among factors impacting memory loss in persons of all ages. Strategies such as activity and exercise, association, visualization, environmental cueing, organization by category and connection to a place may help to prompt memory. New research has revealed that 40% of persons diagnosed with mild cognitive impairment (beyond what is expected for a person of that age and education) are likely to develop Alzheimer's disease within 3 years.
6. **True and False.** Reaction time is the interval that elapses between the onset of a stimulus and the completion of a motor response, such as hitting the brake pedal of a car when the traffic light turns yellow or red. When processing ordinary stimuli, adults do show large increases in response time with increasing age.
7. **False.** Depression does NOT occur more often in older adults than younger groups. However, it is the most frequent mental health problem of older adults. Depression may vary from feeling "blue" from grief over a loss to a diagnosis of clinical depression by the DSM IV criteria. Accurate diagnosis and treatment options are often hindered by the resistance to mental health intervention and situational depression in older adults as they react to isolation, role change, illness and medication effects.
8. **True.** Blood transfusions and unprotected sex put older adults at risk for HIV/AIDS as in

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other populations. It is estimated that as many as 10 percent of all persons diagnosed with HIV/AIDS are over 50 years of age.

- 9. False.** There is no substantial support for this idea. A growing body of evidence suggests that, although the majority of older adults are not abstinent, the frequency and quantity of alcohol consumed tends to decrease with age. This is at least partially explained by changing patterns of sociability with age, age related health problems, and complications associated with alcohol interacting with prescribed medications. Problems with drinking later in life appear usually to be a continuation of drinking patterns established in the earlier adult years and not with late onset drinking. Therapeutic intervention is at least as effective with older adults as with adults generally.
- 10. True.** Older adults are more prone to sleep complaints: insomnia due to changing sleep patterns of frequent awakenings, earlier rising, emotional problems. The quality of sleep declines with age. It becomes particularly more difficult to stay asleep. Daily sedation, boredom, loneliness, illness, time changes, work schedules, physical changes and alcohol or medication may affect sleep patterns. Sleep behaviors common to older adults may include increased napping, periods of sleep apnea (stopped breathing), more frequent awakenings, lengthened onset of sleep, increased time in bed and increased total sleep time. Current research verifies that REM (sleep in which dreaming takes place) deep sleep, in older adults may be half what it is in younger persons.
- 11. True.** The national suicide rate is about 12 per 100,000 population, while it is 1.3 for those aged 65 to 74 and 23 per 100,000 for those over age 85. It has been estimated that 17 to 25 percent of all reported suicides occur in persons aged 65 and older. (Hooyman, 178). However, older white males largely account for this high rate. For white women and for men and women of all other races, the suicide rate peaks earlier in the life span. Older adults also have a higher ratio of completed to attempted suicides than younger groups. The higher suicide rates might be explained by a variety of factors, including the loss of roles and status, chronic illnesses that diminish one's sense of control, and social isolation.
- 12. True and False.** There is evidence that high blood pressure does increase with age. However, there is controversy over the criteria for high blood pressure. Studies and physicians differ in their definition of high blood pressure. Most consider a person's age plus 100 as a reasonable systolic reading with diastolic of 90 mm. The systolic (higher number) measure is the pressure when the heart is stressed as it contracts and is recorded when the pressure cuff is first released after being tightened. The diastolic (lower number) is the blood pressure when the heart is at rest and is derived when the blood pressure returns to normal after the first rush of blood upon release of the cuff. The Fifth Report of the Joint National Commission on Detection, Evaluation and Treatment of High Blood Pressure states young and old have the same blood pressure, so 140/90 is a standard benchmark. It is thought that more than 50% of persons over 65 years in industrialized society have greater than 140/90.
- 13. True.** Perspiration and quenching of thirst help to combat overheating. Older adults perspire less, are less aware of thirst and less able to feel or adapt to extremes in temperature than younger persons. Less sensitive skin sensors and less insulation of fatty deposits under the skin and the less efficient functioning of the hypothalamus (the temperature regulating mechanism in the brain) occur in older

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adults. Prolonged time for older adults to return to core temperature after exposure to extreme heat or cold begins at age 70 years and increases thereafter. Education and taking precautions may prevent most deaths related to temperature extremes. Increased fluid intake, gradual accommodation to climate change, rest, minimizing exertion during heat, use of fans and/or air conditioning, wearing hats and loose clothing and avoidance of alcohol are some strategies for hyperthermia.

- 14. False.** There is a gradual loss of bony tissue, which causes brittle bones that fracture more easily in both men and women as they age. Osteoporosis develops more often in women when calcium is lost (following hormonal change after menopause) or insufficiently taken and absorbed. Deficiency in bone mineral density occurs in 50% of women over 50 years to 57% of women 70 years or older, but decreases to 45% for those over 80 years. Women rarely develop osteoporosis until age 70 years. A test of bone density (absorptiometry) can measure bone mass by x-ray or computer analyzed e-ray. Prevention of osteoporosis begins with adequate Calcium intake in one's teens and thereafter with increased attention after menopause. Weight bearing exercise, hormone replacement therapy (HRT), decreased alcohol, protein, salt and caffeine consumption, smoking cessation and adequate Vitamin D intake may minimize bone loss. HRT may offer some protection against heart disease, cognitive impairment and bone loss, but also may present risks for cervical cancer. Risk factors of osteoporosis include excess alcohol, little physical activity, deficient calcium intake, no pregnancies, no breast feeding, fair complexion, blond or red hair and of European nationality.
- 15. True.** Due to osteoporosis, osteoarthritis and a lifetime of wear and tear, upper vertebrae are weakened; joint spaces and buffering tissues wear and muscles are lost. These changes foster decreased padding between vertebral discs, which accounts for a loss of height. The height changes and imbalances contribute to pain and stress on the lower back with advanced age.
- 16. True.** Muscle mass declines, cartilage erodes, membranes fibrose (harden), and fluid thickens. These contribute to stiffness, gait problems, lessened mobility, and limited range of motion. From age 30 years, muscle mass declines to almost 50% in old age. Research shows that weight bearing exercise, aerobics and weight resistance can restore muscle strength, increase stamina, stabilize balance and minimize falls.
- 17. False.** Recent studies validate that more than 70% of men and women continue sexual activity after 65 years. Men and women over 70 are still considered potentially "sexy." Reasons for limited sexual activity include loss of partners, illness and medications. Most older adults consider intimacy crucial to relationships and emotional well being. Intimacy may be satisfied by other means than sexual relations, such as touch, hugging and holding.
- 18. True.** The muscle of the bladder loses elasticity and tone. Hence, the bladder holds almost 50% less urine (causing more frequent urination) and empties less completely. The warning period between the urge and actual urination is shortened or lost as one ages. Muscular disability, spinal cord effects on the bladder muscle, tumors, infection, anatomic damage to the sphincters and/or bladder neck may cause incontinence in advancing age. Other risks for incontinence in old age include chronic disease, cognitive impairment, medications, smoking, pelvic muscle weakness, low fluid intake and environment.

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- 19. False.** The *amount* of blood flow through the kidney and ability of the kidney to *filter* blood is about *half* that of younger ages. This is caused by the age related structural and anatomic changes within the kidney. Some studies show that as much as one third of older adults have no change in their urine creatinine (creatinine clearance is a measure of how well the kidney is able to filter the blood, the glomerular filtration rate or GFR). However other studies show decline that begins at 40 years. Age related kidney changes create more risks for fluid and electrolyte imbalance and renal damage from medications or diagnostic contrast materials. Disease, surgery or fever may stress and interfere with the kidney's
- 20. False.** Cultural notions about "daily regularity" held by the current cohort of older adults makes the myths of constipation and the elderly seem more important and credible. However, age related changes in the gastrointestinal system are *less* responsible for constipation in older adults than factors such as activity, diet, and medication. Decreased intake and absorption of vitamins, proteins and other important nutrients and dental issues present greater health threats to older adults. Despite a decrease in gastrointestinal muscle strength and motility, lax sphincters, lowered digestive juices, the gastrointestinal system is better able to compensate for the harmful effects of these changes.
- 21. True.** While there is considerable individual variation, on average sensory processes (vision, hearing, taste, smell, and touch) don't work as well as people get older. Another way to say it is that the threshold at which we take in stimuli increases with age. The eye lens, for example, is less able to change shape so as to adjust to close and far objects, and the size of the pupil narrows so as to let in less light. Hearing loss begins at age 20, and for many involves growing inability to hear higher frequencies as sensory receptors in the ear and nerve cells in the auditory pathway to the brain are lost. Taste buds become less sensitive with aging, and after age 80 more than 75 percent of older adults show major impairment in their sense of smell. Many of these normal changes can be compensated for through increasingly sophisticated assistive devices (hearing aides, glasses, etc.) and through modifications of the older person's environment.
- 22. True.** The incidence of acute or temporary conditions, such as infections or the common cold, decreases with age, although those that do occur can be more debilitating and require more care. Older people are much more likely than the young to suffer from chronic conditions. These are long-term (more than three months), often permanent, and leave a residual disability that may require long- term management or care rather than cure. More than 80 percent of persons age 65 and over have at least one chronic condition, with multiple health problems being common. Arthritis is the most commonly occurring chronic condition.
- 23. False.** Health decline is related to age or previous health problems, not retirement per se. Retirement may actually improve functional health by reducing stress on the individual.
- 24. True.** Although death in industrialized society has come to be associated primarily with old age, studies generally indicate that death anxiety in adults decreases as age increases. Among the factors that may contribute to lower anxiety are a sense that goals have been fulfilled, living longer than expected, coming to terms with finitude and dealing with the deaths of friends. The general finding that older adults are less fearful of death than middle-aged counterparts should not obscure the fact that some subgroups may have considerable preoccupation and concern about death and dying. Some fear the process of dying much more than death

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itself.

- 25. False.** People over age 65 currently make up about 13 percent of the population. However, as the "baby boom" generation begins to turn 65 in 2011 the proportion of older adults will grow dramatically. It is estimated that by 2030 adults over 65 will compose 20 percent of the population
- 26. False.** According to the U.S. Bureau of the Census, slightly over 5 percent of the 65 population occupy nursing homes, congregate care, assisted living, and board-and-care homes, and about 4.2 percent are in nursing homes at any given time. The rate of nursing home use increases with age from 1.4 percent for the young-old to 24.5 percent of the oldest-old. Almost 50 percent of those 95 and older live in nursing homes.
- 34. False.** The majority of older people are not "set in their ways and unable to change." There is some evidence that older people tend to become more stable in their attitudes, but it is clear that most older people do change. To survive, they must adapt to many events of later life such as retirement, children leaving home, widowhood, moving to new homes, and serious illness. Their political and social attitudes also tend to shift with those of the rest of society, although at a somewhat slower rate than for younger people.
- 35. False.** Older persons are involved in many and diverse activities. After retirement many participate as volunteers in churches, schools or other nonprofit organizations and report themselves to be "very busy." As they age most persons are likely to continue the level of activity to which they were accustomed in middle age.
- 36. False.** Older adults are at least as diverse as any other age group in the population, and on many dimensions they may actually be more diverse. People vary greatly in their health, social role, and coping experiences. As the older population becomes more and more ethnically diverse, differences could be even greater. It is very misleading to talk about older adults as "the elderly," for this term may obscure the great heterogeneity of this age group.
- 37. False.** Although the media may leave the impression that older adults are a major target of violent crime, annual data from the national Crime Victimization Surveys consistently indicate that violent crime, personal theft, and household victimization rates for persons aged 65 and older are the lowest of any age group. Data indicate that this holds true for virtually all categories of criminal victimization: rape, robbery, aggravated assault, simple assault, and personal larceny without contact. Only for the category of personal larceny with contact (e.g., purse snatching and pocket picking) is the victimization rate higher for persons aged 65 and over compared to those aged 25 to 64. Nevertheless, the health and financial consequences may be greater for the older victim.
- 38. False.** Studies have found *no* increase in average religious interest, satisfaction or activities among older people as they age. The present generation of older persons (cohort) tends to be more religious than younger generations due to their upbringing, i.e., *they have been more religious all their lives rather than becoming more religious as they aged.* However, research has indicated that religion does seem to become more important with age and older adults do rely on their faith to cope with losses.

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- 39. False.** Although several surveys show that fear of crime exists among some older adults, there is no substantial evidence that older people are more likely to be afraid of crime than younger people are. One survey examined different types of victimization and found no increase in fear among older adults in any of the types. Studies that have shown an increase in fear of crime in later life possibly have used measures of questionable validity.
- 40. False.** While some older people may experience a period of prolonged adjustment, there is no evidence that there is special harmfulness in elderly relocation. Studies of community residents and of institutional movers have found an approximately normal distribution of outcomes -- some positive, some negative, mostly neutral or mixed and small in degree. For many relocation brings a better fit between personal needs and the demands of the physical and social environment. Research generally has demonstrated that adjustment to residential relocation is determined, at least in part, by perceived predictability and controllability and by the similarity between the originating and receiving environments.
- 41. False.** Women in their 30s and 40s comprise the greatest *number* of volunteers. However, forty percent of older adults volunteer. Older adults may be less likely to belong to organizations than younger persons, but more consistent in their activities and loyal to groups from middle age until their 60s. Volunteerism is correlated with life satisfaction, usefulness, physical and mental well being and a sense of accomplishment. Persons with higher education and income levels, histories of volunteerism and broad interests are more likely to volunteer. Health problems, lack of transportation and limited income may limit volunteer activities.
- 42. False.** This view is based upon an early theory called "disengagement theory" which said that it is normal and expectable that the older person and society withdraw from each other so as to minimize the disruption caused by the older person's death. Although many people obviously do scale back certain activities, particularly if health deteriorates, there is substantial evidence that many who remain active and engaged have higher levels of function and happiness. For many staying involved physically, cognitively, socially, and spiritually in the social group is a basis for happiness.
- 43. True.** Geriatrics refers to the clinical aspects of aging and the comprehensive health care of older persons. Study of geriatrics actually began in the early 1900s, although formal training in geriatrics is relatively new. A Certificate of Added Qualifications (CAQ) in Geriatric Medicine or Geriatric Psychiatry is offered through the certifying boards in family practice, internal medicine, osteopathic medicine, and psychiatry for physicians who have completed a fellowship program in geriatrics.
- 44. False.** Although a number of medical schools require course work in geriatrics/gerontology, many still have only elective courses or no courses at all. Incentives in the form of materials support and grants have come to some medical schools to develop and institutionalize formal curricula from such organizations as the Association of American Medical Colleges, the American Geriatrics Society, and the Association for Gerontology in Higher Education, as well as foundations such as the John Hartford Foundation. Top- ranked medical schools for geriatrics training include Harvard, Duke, Johns Hopkins, Mount Sinai (NY), UCLA, University of Washington, Michigan, Wake Forest, Pennsylvania, and Yale.

- 45. False.** The low numbers of reported cases of elder abuse belie the magnitude of elder abuse in this country. Latest figures estimate more than 551,000 reported cases of abuse (physical, verbal and sexual types of neglect or abuse) to persons over 60 years per year. (There are more than 30 million Americans over 60 years.) Actual reported cases represent a fraction of what is thought to occur due to perceived fearful consequences and inconsistent and inefficient report mechanisms. Self neglect and exploitative types of abuse, were not part of the above study and yet are more common. Men and women are equally culpable in the perpetration of abuse.
- 46. False.** The longevity revolution has increased the number of three-, four-, and five-generation families. This, along with a growing incidence of divorce and remarriage, drug and alcohol addiction, AIDS, incarceration, and unemployment within the parental generation has resulted in grandparents stepping into the surrogate parent role with increasing frequency. Census figures estimate the number of grandchildren living with their grandparents (about one third without a parent present) to be as high as 5.5 million, with African American grandchildren being slightly more than three times more likely than their white counterparts to be in this type of living arrangement. There are grandparent- headed households in every socioeconomic and ethnic group.
- 47. True.** Older adults do experience multiple losses of loved ones and friends, illness, relocation, retirement, income, change and decline in abilities. It may take an older adult longer to adjust to a major change or recover from prolonged and intense physical and emotional stress. The recovery of an older body from a traumatic event may be delayed due to age related decreases in cardiac output and heart rate and more vulnerability to disease with a less effective immune system. However, the many older adults who have developed active and healthy lifestyles may be able to resist/mitigate some of the negative effects of stress or illness due to their physiological fitness. Likewise, coping skills that have been honed during a lifetime may lessen the damage of psychological stresses and ease adjustments to loss and change.
- 48. True.** The majority of older adults perceive their health to be good to excellent, as they do not compare their current condition to former states, but rather to their peers their ages and older who may be "worse off." The "ratings" are not a medical assessment. While chronic disease, frailty and disability are correlated with advanced age, the *Myths and Realities 2000* study discovered that 84% of all Americans would *like* to live to 90 years and half of persons over 65 years described their lives as "the best years of my life." Disease and disability are being delayed and functional levels are improving, especially in persons over 80 years. Less than 10% of non-institutionalized persons 70 years and over are unable to perform one or more activities of daily living (ADLs). Disability does increase to 22% for those 85 years and older.
- 49. True.** In general women throughout adulthood are more likely to attend to minor symptoms than are men. Men are more likely to have been socialized even as children to be stoical, and consequently are less likely to see a doctor for nonferrous health problems. When they do get sick, they are likely to have more and longer hospital visits. Women, on the other hand, are more likely to have had regular contact with the health care system through childbirth, attending to their children's health, and having regular screening procedures for cervical and breast cancer. Although women report more chronic conditions than men in later life, the severity of their problems tends to be less than that of same age men, probably

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due to their earlier health care practices -- hence the phrase "women get sicker, but men die quicker."

50. False. Old age is a social construct. Meanings, definitions, and experiences of aging vary across cultures and throughout history. What people consider to be "old" has changed significantly just within the past 100 years in the U.S. as people live longer and healthier. Being identified as "old" is related not only to chronological age, but also health, functional ability, social roles, and self perception. Age 65 is an arbitrary marker that has been associated with eligibility for governmental programs such as Social Security and Medicare (although the age of eligibility for Social Security is gradually being raised to 67 by 2027)

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Learning objective #2:

Describe the changes in functional capacity and disability associated with aging. Recognize and assess effects of the aging process on a client's ability to care for self.

The following list provides a number of ways that workers can adapt to accommodate the functional and sensory changes experienced by many older adults.

1. Look for clues to an elder's cognitive and physical limitations
2. Remember that seniors cannot change their impairment - we must adapt our processes to them
3. Respect an older adult's limitations and abilities
4. Be patient, probe, listen carefully and using empathy statements
5. Promote independence
6. Ask yourself if your work processes meet these criteria? If not what can be changed?

ACTIVITY

Share Handout *Barthels Activities of Daily Living* and Handout *Communicating with People with Hearing Loss*, with the new workers.



1. Ask workers to consider a recent case that required an evaluation of the client's ADL. What is the worker's level of comfort in obtaining ADL information? Does the worker think that an accurate assessment was made? Why or why not? Ask for examples of how the information was collected.

ACTIVITY

2. Invite new workers to role play an ADL assessment with one worker being the "consumer" and the other being the "APS worker". Handout copies of *Role Play: Assessing ADLs*.

Observers can provide feedback on:

- How did the worker establish rapport with the consumer?
- How did the worker adapt the process for someone who had an impairment (hearing, vision)?
- How did the worker convey respect for the consumer's limitation and abilities?
- Was the worker able to be patient, probe, listen and use empathy as tools for gathering information?
- Did the worker promote independence where appropriate. (Perhaps they discussed with the consumer the importance of "use it or lose it" for those ADLs that the consumer is "able" to do but does not engage in.)
- Physical limitations impact the ability to perform routine grooming and household tasks. For instance, if a person is unable to raise her arm over her head she will have difficulty washing her hair or putting away the dishes. If a person is unable to lift 10 pounds then grocery shopping, doing laundry, and changing a cat box may require assistance. Ask workers to identify how MaryAnn's physical limitations translate into daily activities that require assistance or adaptation.
- Are any other assessments needed for MaryAnn?

Barthel Index of Activities of Daily Living

Instructions: Choose the scoring point for the statement that most closely corresponds to the patient's current level of ability for each of the following 10 items. Record actual, not potential, functioning. Information can be obtained from the patient's self-report, from a separate party who is familiar with the patient's abilities (such as a relative), or from observation. Refer to the Guidelines section on the following page for detailed information on scoring and interpretation.

Bowels

- 0 = incontinent (or needs to be given enemata)
- 1 = occasional accident (once/week)
- 2 = continent

Patient's Score:

Bladder

- 0 = incontinent, or catheterized and unable to manage
- 1 = occasional accident (max. once per 24 hours)
- 2 = continent (for over 7 days)

Patient's Score:

Grooming

- 0 = needs help with personal care
- 1 = independent face/hair/teeth/shaving (implements provided)

Patient's Score:

Toilet use

- 0 = dependent
- 1 = needs some help, but can do something alone
- 2 = independent (on and off, dressing, wiping)

Patient's Score:

Feeding

- 0 = unable
- 1 = needs help cutting, spreading butter, etc.
- 2 = independent (food provided within reach)

Patient's Score:

Transfer

- 0 = unable - no sitting balance
- 1 = major help (one or two people, physical), can sit
- 2 = minor help (verbal or physical)
- 3 = independent

Patient's Score:

Mobility

- 0 = immobile
- 1 = wheelchair independent, including corners, etc.
- 2 = walks with help of one person (verbal or physical)
- 3 = independent (but may use any aid, e.g., stick)

Patient's Score:

Dressing

- 0 = dependent
- 1 = needs help, but can do about half unaided
- 2 = independent (including buttons, zips, laces, etc.)

Patient's Score:

Stairs

- 0 = unable
- 1 = needs help (verbal, physical, carrying aid)
- 2 = independent up and down

Patient's Score:

Bathing

- 0 = dependent
- 1 = independent (or in shower)

Patient's Score:

Total Score:

(Collin et al., 1988)

Scoring: Sum the patient's scores for each item. Total possible scores range from 0 – 20, with lower scores indicating increased disability. If used to measure improvement after rehabilitation, changes of more than two points in the total score reflect a probable genuine change, and change on one item from fully dependent to independent is also likely to be reliable.

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2

Guidelines for the Barthel Index of Activities of Daily Living

General

- The Index should be used as a record of what a patient *does*, NOT as a record of what a patient *could do*.
- The main aim is to establish degree of independence from any help, physical or verbal, however minor and for whatever reason.
- The need for supervision renders the patient not independent.
- A patient's performance should be established using the best available evidence. Asking the patient, friends/relatives, and nurses will be the usual source, but direct observation and common sense are also important. However, direct testing is not needed.
- Usually the performance over the preceding 24 – 48 hours is important, but occasionally longer periods will be relevant.
- Unconscious patients should score '0' throughout, even if not yet incontinent.
- Middle categories imply that the patient supplies over 50% of the effort.
- Use of aids to be independent is allowed.

Bowels (preceding week)

- If needs enema from nurse, then 'incontinent.'
- 'Occasional' = once a week.

Bladder (preceding week)

- 'Occasional' = less than once a day.
- A catheterized patient who can completely manage the catheter alone is registered as 'continent.'

Grooming (preceding 24 – 48 hours)

- Refers to personal hygiene: doing teeth, fitting false teeth, doing hair, shaving, washing face. Implements can be provided by helper.

Toilet use

- Should be able to reach toilet/commode, undress sufficiently, clean self, dress, and leave.
- 'With help' = can wipe self and do some other of above.

Feeding

- Able to eat any normal food (not only soft food). Food cooked and served by others, but not cut up.
- 'Help' = food cut up, patient feeds self.

Transfer

- From bed to chair and back.

The Aging Process

- 'Dependent' = NO sitting balance (unable to sit); two people to lift.
- 'Major help' = one strong/skilled, or two normal people. Can sit up.
- 'Minor help' = one person easily, OR needs any supervision for safety.

Mobility

- Refers to mobility about house or ward, indoors. May use aid. If in wheelchair, must negotiate corners/doors unaided.
- 'Help' = by one untrained person, including supervision/moral support.

Dressing

- Should be able to select and put on all clothes, which may be adapted.
- 'Half' = help with buttons, zips, etc. (*check!*), but can put on some garments alone.

Stairs

- Must carry any walking aid used to be independent.

Bathing

- Usually the most difficult activity.
- Must get in and out unsupervised, and wash self.
- Independent in shower = 'independent' if unsupervised/unaided.

(Collin et al., 1988)

Donald W. Reynolds Foundation, the Arizona Geriatric Education Center, and the Arizona Center on Aging



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ELDER CARE

A Resource for Interprofessional Providers

Communicating with People Who Have Hearing Loss

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Age-related hearing impairment, also known as presbycusis, affects some 30% of adults aged 65-74 and almost half of those over 75. The hallmark of age-related hearing loss is that speech is not clear. An on-line simulator that shows what hearing is like for a person with hearing loss (PHL) is available on the website of the Better Hearing Institute (see resources list on next page).

Hearing loss impairs ease of communication, not only for the person with hearing loss (PHL), but also for individuals communicating with the PHL. Frustration and even anger may result as communication breaks down. As frustration levels heighten, social activities become more challenging, and the PHL may withdraw or become more isolated because communication is too difficult.

Many of the difficulties involved in communicating with a PHL can be resolved by understanding some key facts about age-related hearing loss, and by following simple communication rules. The goals when speaking with a PHL should always be to (a) increase the likelihood of good communication and (b) decrease the negative emotional responses that occur when communication breaks down.

Key Facts About Hearing Loss

Fact: Age-related hearing loss is typically sensorineural, involving structures in the inner ear or cochlea and/or the auditory pathways to and in the brain. The results are that sound is not loud enough but more importantly, speech is not clear. The person with hearing loss may say, "I can hear you but not understand you". Speaking louder does not necessarily increase clarity and in some cases, may cause further deterioration in understanding of speech.

Fact: The speed of processing speech information slows down. The PHL may always be "catching up," trying to get meaning from a conversation after missing a few key words or phrases. After losing the thread of a conversation, the PHL may try to compensate by bluffing. This allows the PHL to stay physically present in a conversation, but not be an active participant, which is a dysfunctional avoidance strategy, not a coping strategy.

Fact: Hearing aids will help, but cannot completely solve all hearing related issues. Even with well-fitting, high quality hearing aids, most PHLs will experience difficulty understanding speech - especially in poor listening conditions such as background noise.

Improving Your Communication

Several important behaviors can make a big difference in the success of your communication with a PHL. A few of these behaviors are discussed here, and still others are listed in the table on the next page.

Attention First: Start the conversation by getting the PHL's attention and let them know you are talking to them. Be clear about the topic of conversation, and then speak slowly and directly to the PHL. Tactile or visual cues (e.g., a tap on the shoulder or pointing to something) will assist PHLs to focus on you and better understand what you will say.

Speak Slowly: Slowing down your speech rate helps in two ways. First, it naturally enhances the clarity of what you are saying. Second, it allows the PHL more time to process what has been said, to infer meaning, and to fill in the gaps of what has been heard.

Rephrase: If a communication breakdown occurs and the listener says, "huh", "what," or "I didn't get it," repeat your message once more slowly, then rephrase using different words or a different word

TIPS FOR COMMUNICATING WITH OLDER ADULTS WHO HAVE HEARING IMPAIRMENT

Be sure that the individual with hearing loss has undergone a comprehensive audiological evaluation.
Before speaking to a person with hearing loss, get the person's attention first.
Speak slower than usual. When speaking to someone with a hearing aid, it is not necessary to speak louder.
If the person with hearing loss doesn't understand what you are saying, don't repeat the same thing over and over.
Instead, try rephrasing with different words or a different word order.
Get feedback from the person with hearing loss, to be sure they understood what you have said.

Elder Care *Continued from front page*

order. More than one repetition in exactly the same way will not repair a communication breakdown, and it can lead to frustration for both parties. An example of good rephrasing is shown in the box at right. Note in the example that not only has the communication partner given the PHL a clue, but the words have been changed around and information provided in a different way.

Be Careful about Consonants: Poorer hearing in the high frequencies means that certain consonants (such as, “f,” “s,” “t,” “p”) are not heard well, even with good amplification. Thus, words such as “fan,” “sand,” “tan,” and “pan” may all sound the same. Knowing the topic, having context, and seeing the lips will help the PHL be less confused.

Get Feedback: Encourage PHLs to state what they heard and understood. Specific responses and explanation are preferred to simple statements like “I understand”.

Relax: Remember that the goal is communication, not negative emotions. Even if getting a message across requires spelling out words or writing them down, the goal has been met.

Final Comments

Good communication involves the speaker, the listener, and the environment. In ideal communications, all three components are optimized,

Don't Repeat — Rephrase

Example of Repeating:
Caregiver: I'm going to the store, do you need anything?
PHL: What?
Caregiver: I'm going to the store, do you need anything?
PHL: I still didn't get it.

Example of Rephrasing:
Caregiver: Mary (touching PHL on the shoulder and facing her), I'm going shopping.
PHL: I need milk.
Caregiver: OK.

with both the speaker and the listener sharing responsibility for effective communication. For older adults with hearing loss, it may be up to a caregiver to assume a greater responsibility for assuring that all three elements are optimized. Even though it may be frustrating at times, the effort is worth it. Of course, part of communicating well is optimal hearing, so assure that a comprehensive audiological evaluation has been done. It is also essential that hearing aids or other devices have been selected appropriately, fitted properly, are in good working order, and that all persons understand the benefits and limitations of what hearing aids can and cannot do. Hearing aids are discussed in another issue of *Elder Care*.

Other Recommendations for Improving Communication with Individuals Who Have Hearing Impairment	
What to Do	How to Do It
State the topic	Tell the person the topic of the conversation and be clear when you have switched the topic.
Face the person	Be at the same level, facing the person, to provide more visual cues. Don't cover your mouth or chew gum. Speech reading will happen automatically
Find a quiet place	Move to a quiet location if you can, or reduce the noise as much as possible.
Find a well-lit place	Lighting should shine on your face and not in the eyes of the person needing to see and hear you.
Use paper and pen	If you are unsuccessful with spoken communication, write the information.

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Interprofessional care improves the outcomes of older adults with complex health problems

Editors: Rosemary Browne, MD; Mindy Fain, MD; and Barry D. Weiss, MD
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Learning Objective #3:

Describe the difference between depression, delirium and dementia.

One of the myths of aging is that it's depressing. Although many older adults do experience depression, it isn't a necessary or normal part of aging. In fact, most older adults have developed excellent coping strategies that help them to accommodate to changes. Dementia and delirium aren't normal either. These are serious disorders that need to be identified and treated. While it is true that depression, dementia, and delirium are not a normal part of aging, these three are the most common mental health conditions among older adults. These conditions are complex and multi-faceted in older individuals and often are unrecognized and untreated. They may occur simultaneously and overlapping symptoms are difficult to distinguish. Depression, dementia, and delirium negatively impact health, well-being, and quality of life.



ACTIVITY

Ask new workers to review the following handouts: *Depression in Elders*; *Don't Forget Dementia*; and *Delirium- The Sixth Geriatric Vital Sign*.

Hand out copies of *Is it Dementia, Delirium, or Depression?* and *Distinguishing the 3 D's*. Have workers use the handouts as they review the following brief scenarios in the Depression, Delirium and Dementia Activity Handout (on page 6) to determine what type of assessments may be needed. Answers are below:

1. Madge, age 73, who typically has an easy-going personality has been irritable and hard to get along with over the past 3 months. She snapped at her grandson yesterday when he brought her the groceries she requested from the store because he purchased the "wrong" brand of green beans. She is no longer attending her weekly bridge club stating that, "those people are just not interesting, I'd rather talk to myself". Twice this month she forgot her weekly hair appointment and later stated that she couldn't find the car keys. On one occasion her daughter located the keys for her in the medicine cabinet.
 - What factors might lead you to think Madge might be depressed?
 - Irritability, loss of interest in previously enjoyed activities and forgetfulness are indicators of possible depression
 - What factors might lead you to think Madge might have dementia?
 - Losing items and being unable to retrace her steps, or putting items in unusual places may be a sign of dementia.

2. Jose, age 80, lives alone after his wife's death six months ago. His adult children live in another state and visit once or twice a year. The son reports that on his recent visit he noticed several changes to his father in six months time. Jose seems convinced that he is responsible for his wife's death because he went to the pharmacy while his wife was napping and she passed away while he was gone. He believes his wife would be alive today if he stayed at home. He has difficulty sleeping so he now has a "few" beers before bedtime even though it doesn't help much. Jose had difficulty remembering the names of his grandchildren during the visit and sometimes called them by the names of his own two brothers suggesting that they all go swimming in the pond at his childhood home. When the children corrected him, Jose became silent and left the room.

- What factors might lead you to think Jose might be depressed?
 - unusual guilt or self-reproach, that is a change from normal personality, is an indicator of depression. Difficulty sleeping and increased alcohol use/abuse are indicators of depression. Difficulty remembering (grandchildren's names) is an indicator of depression.
- What factors might lead you to think Jose might be dementia?
 - Difficulty recognizing close relatives may be a sign of dementia. Find out more about sleep habits, if it is fragmented this could indicate dementia.
- Must it be either depression or dementia?
 - Depression and dementia may occur simultaneously.

3. Bettie, age 75, was diagnosed with early stage Alzheimer's about 12 months ago. She has diabetes and hypertension which are controlled with several medications. Her eyesight is very poor due to complications of diabetes and she can no longer read the labels on her medications. Bettie is a recovering alcoholic and has been sober for 10 years. She has always been friendly and humorous during previous visits and always shares a story about the latest goings on with her granddaughter. Today, a neighbor answers the door at Bettie's home and says Bettie has been sick with a cold for a couple of days. When you enter Bettie appears disheveled and unfocused. She is not wearing her glasses. Although it is 10:00 a.m., she is drowsy and keeps drifting off. You notice some cold medicine on the kitchen counter. When you ask Bettie about the medicine and if she is running a fever she starts telling you about the lady on TV who is in the closet.

- What factors might lead you to think Betty might be experiencing delirium?
 - Bettie should be examined by a medical provider to assess for delirium. Bettie's condition appears to have changed significantly in a matter of days. She is confused, sluggish, and is unable to provide a coherent answer to your question about the medication. Bettie has a number of risk factors for delirium including dementia, co-morbidities, multiple medications (with the recent

The Aging Process

use of a new medication), functional impairment, and possible sensory impairment because she is not wearing her eyeglasses.

- What factors might lead you to think Betty might be depressed?
 - If Bettie's condition is not caused by delirium then assessment for depression or worsening dementia is warranted.
- Do you think Betty's Alzheimer's might just be worse? Why?



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ELDER CARE

A Resource for Interprofessional Providers

Depression in Elders

M. Jane Mohler, MPH, PHD, College of Medicine, University of Arizona

Depression is commonly described as feeling sad, blue, unhappy, miserable, or down in the dumps. While many of us feel this way for short periods, true clinical depressive disorders are syndromes characterized by the impairment of mood regulation. The most common diagnoses include major depression and dysthymia, a disorder characterized by chronic low mood. Prevalent among older adults, depression is associated with a 1.5–3 times higher incidence of medical morbidity, and the lifetime risk of suicide is reported to be as high as 15%. Depression negatively affects functioning and quality of life, contributes to excess morbidity and mortality, and places extra stress on caregivers and the health care system. Of the estimated 6 million persons over age 65 with depression, only 10% receive treatment. In addition, less than half of hospitalized patients with depression are referred to a psychiatrist, and less than 20% of these are prescribed antidepressant medication.

Epidemiology

Depression is the most common geriatric psychiatric disorder, and can manifest as either minor or major depression. Eight to fifteen percent of the general population over 65 years of age has symptoms severe enough to meet diagnostic criteria for a depressive disorder, and the prevalence of major depressive disorder (MDD) is estimated to be 2%. In the hospitalized population, however, 25–40% manifest minor depressive symptoms. In assisted living and skilled nursing facilities an estimated 30% display mild depressive symptoms and an additional 12% of patients have MDD.

Risk Factors

Major risk factors for depression include the following: female gender, bereavement, stressful life events, social isolation, chronic pain, a past history of depression, fear of death, chronic disease, substance abuse, including alcohol, and being unmarried, widowed or cohabitating.

Signs & Symptoms

Depression in older patients can be difficult to diagnose, as signs and symptoms differ from younger adults, and may not be in accord with DSM-IV or ICD-10 criteria. Additionally, medical illnesses can confound the symptoms of depression. Older adults may not show or express sadness, their mood can be chronically irritable, and depressed elders can lose their ability to respond to positive external events. Somatic

complaints and hypochondriasis are more frequent, and vegetative signs such as anorexia and weight loss may initiate concerns about underlying malignancy. About 10% of depressed elders may display psychotic symptoms. Between 38–58% of aging adults suffering from MDD also have anxiety disorder, which often presents as tension, unrest, feelings of insecurity or fear, irritability, and intense worry rather than as autonomic symptoms.

Screening and Diagnosis

The US Preventive Task Force recommends screening adults for depression only where “there are systems in place to assure accurate diagnosis, effective treatment and careful follow-up care.” A quick, easy, two sentence screening tool is offered under Provider Tips. A positive result should prompt further evaluation and diagnosis. Remember that medical illness can sometimes present as depression. Recommended lab tests to rule out other causes include thyroid, liver and kidney function tests, serum calcium, and B-12 levels (or homocysteine and methylmalonic acid considered when making a diagnosis of depression. It may be difficult to differentiate depression from dementia, and

Depression in Older Adults

- Lack of appetite
- Weight loss
- Fatigue
- Problems with concentration
- Stopping normal activities
- Guilt
- Melancholia
- Suicidal Ideation
- Feeling helpless
- Feeling hopeless



Suicide Risks in Those >50 Years

- Poor Health
- Family conflict
- Money worries
- Male
- White
- Veterans
- >84 yrs have twice the risk

TIPS FOR DIAGNOSING DEPRESSION IN OLDER ADULTS

Asking these two questions may be as effective as using longer screening tools: Over the past 2 weeks, have you ever felt down, depressed, or hopeless?

Over the past 2 weeks, have you felt little interest or pleasure in doing things?

A positive response to either question is a very sensitive indicator of depression, but needs further validation with a more specific diagnostic interview

they may co-exist. Depression can precede, accompany or masquerade as dementia, and treatment of the depression will often improve cognitive functioning. Neuropsychiatric evaluation can help to tease out depression from cognitive deficit. Acute neuropsychiatry or geriatric psychiatry referral should be sought when a patient is suicidal or homicidal, has delusions or hallucinations, or is disabled by vegetative depression.

Treatment

Antidepressant medications are usually the first line of treatment for depressed older adults. Symptom improvement is well documented with serotonin reuptake inhibitors (SSRIs), tricyclic antidepressants (TCAs), and the newer drugs such as mirtazapine, nefazodone, and venlafaxine. Unfortunately, antidepressant medication often takes up to 3 months to demonstrate effect. If, after an 8-12 week therapeutic trial of one drug shows no effect, alternative medications should be prescribed. Once improvement is obtained, a minimum of 6 months of treatment is recommended. At that point a slow and carefully monitored weaning regimen may be attempted. Older patients, especially those with a history of previous depressive episodes, may require a longer duration of treatment. Occasionally combination therapy may be needed, but requires careful monitoring. A geropsychiatry consult can help in these situations. A future provider fact sheet will review the currently available medications with regard to mechanism of action, side effects, and individual indications for use. Uses for electroconvulsive therapy will also be addressed. Psychotherapy can also benefit patients, and small additional therapeutic gains are seen when provided in combination with antidepressants. The evidence base is unclear with regard to the ideal type of psychotherapy, but those aimed at relieving depressive ideation, and efforts

focused on instrumental activities of daily living, can improve geriatric depression. Older adults, however, may refuse therapy, as many in this present generation consider therapy a sign of weakness. Patients with neurocognitive disorder, psychomotor retardation or sensory impairment may not be suitable for psychotherapy. A meta-analysis of MDD trials provides evidence that omega-3 supplementation is safe and reduces symptoms of depression in combination with routine care. In addition, B12 insufficiency has been linked to depression in several small studies. B vitamin supplements are not yet recommended as standard of care, but, as with omega-3s, are easy to prescribe without fear of adverse effects.

Special Considerations Bereavement

Those going through uncomplicated bereavement are likely to experience a lack of energy and concentration, crying spells, and decreased appetite and insomnia. Most will need no formal intervention. Occasionally, such depression may deepen, resulting in overwhelming feelings of sadness, sometimes to the point of suicidal ideation. In this case, it can be helpful to talk with clergy or spiritual healers, or with a social worker, grief counselor, or therapist. Support groups can also be helpful. Antidepressants and counseling have been found to be effective in combination in grief.

Suicide

Nearly 25% of elders suffering from MDD will remit, either spontaneously or after treatment. Another 25% will not respond to any kind of intervention and will continue to manifest severe symptoms. The other 50% will have partial remission, or intermittent recurrence. MDD accounts for 65% of cases of elderly suicide. Screening for suicidal ideation in a depressed older adult is paramount. An acute life threatening illness (e.g., MI, stroke, or cancer diagnosis) may trigger suicidal plans. Don't be afraid to ask.

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ACOVE Quality Indicators

1. IF a vulnerable elder is diagnosed with depression, THEN antidepressant treatment, psychotherapy, or electroconvulsive therapy should be offered within 2 weeks after diagnosis unless there is documentation within that period that the patient has improved, or unless the patient has substance abuse or dependence, in which case treatment may wait until 8 weeks after the patient is in a drug-or alcohol-free state.
2. IF a vulnerable elder is started on an antidepressant medication, THEN refer to ACOVE indicators for a list of medications that should NOT be used.
3. IF a vulnerable elder with a history of cardiac disease is started on a tricyclic antidepressant, THEN a baseline electrocardiogram should be performed prior to initiation of or within 3 months prior to treatment.
4. IF a vulnerable elder is taking a serotonin reuptake inhibitor (SRI), THEN a monoamine oxidase inhibitor (MAOI) should not be used for at least 2 weeks after termination of paroxetine, sertraline, fluvoxamine and citalopram, and for at least 5 weeks after termination of fluoxetine.
5. IF a vulnerable elder is taking a MAOI, THEN he or she should not receive medications that interact with MAOI for at least 2 weeks after termination of the MAOI.

Interprofessional care improves the outcomes of older adults with complex health problems

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ELDER CARE

A Resource for Interprofessional Providers

Don't Forget Dementia

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Dementia, the progressive loss of cognitive function, occurs more frequently with increasing age. The prevalence of dementia for people in their 60s is 1%. Doubling every 5 years, dementia has a prevalence of nearly 40% for people in their 90s. Dementia currently affects some 3-5 million people of all ethnic origins in the US, and this number will double over the next 5 years. Therefore, a provider treating older adults should be alert to this common and serious problem. To make a formal diagnosis of dementia, a provider must determine the existence of memory impairment, and in addition, detect the presence of significant cognitive dysfunction in any one of the following areas: aphasia (language problems including naming of objects or difficulty with word finding), apraxia (inability to perform a previously routine and well rehearsed task, eg cooking or brushing teeth), agnosia (inability to recognize previously familiar items and people) and/or a decrease in executive function (ability to form and carry out a plan). Many of these symptoms and signs can be elicited by the history from the patient and the caregivers. Unfortunately, providers often do not recognize symptoms of dementia and, therefore, patients do not undergo an appropriate evaluation. Indeed, research shows that providers *identify dementia in fewer than 50% of patients who have the condition*. Even at the point of nursing home placement, up to one-third of patients with dementia have not been previously diagnosed. While there is insufficient evidence to recommend routine screening for dementia in older adults, patients who present with even mild symptoms of dementia should undergo an evaluation of cognitive function. A variety of tests have been recommended for this purpose, and many are listed in Table 1. The Mini-Mental State exam is perhaps the most well known, but many good screening tools exist. Often subtle clues can be discerned from just observing the hygiene and dress of the patient, or evaluating their organizational skills. Simple factual questions can often detect problems with memory, such as asking about medication schedules or important dates.

The Cost Of Missing The Diagnosis Of Dementia

Reversible Causes Go Undetected. Occasional patients – about 1 in 70 - will have a reversible cause of dementia than can be detected with a straightforward diagnostic workup (Table 2). If dementia in these patients is not detected in its early stages, irreparable neurological impairment may occur. Patients may unnecessarily suffer further cognitive decline, loss of social interactions, or undergo nursing home placement.

Safety People with undiagnosed dementia who continue to drive automobiles may present a danger to themselves and others. Firearms present another potential safety problem. Even more commonly, mismanagement of medications can lead to injury. An early diagnosis of dementia can result in appropriately-timed safety interventions and avoidance of injury.

Family Stress The acceptance of abnormal behaviors related to dementia varies widely among cultures. All caregivers/families of patients with dementia, however, ultimately face issues related to a decline in social functioning. Psychosocial or behavior-modifying therapy that might help will not be utilized if dementia goes unrecognized. Additionally, addressing end-of-life issues prior to a serious decline in function can help to clarify the wishes, goals and values of the patient.

Delaying Drug Treatment Although current drug treatments for dementia only delay progression and do not reverse disease, they often prolong the time a patient spends at home prior to institutionalized care. Failure to diagnose dementia in its early stages, however, deprives patients of any such benefit.

Why Is Dementia Under-Diagnosed?

While moderate and severe dementia is obvious to the provider, subtle symptoms can be easily missed—even ones that markedly increase the chance that a person has dementia (Table 3). Dementia of the Alzheimer's type can be particularly difficult to detect, as everyday social interaction is well preserved. Eliciting any of these symptoms should prompt a dementia evaluation with the tests noted in Tables 1 and 2.

TIPS FOR THE EARLY DIAGNOSIS OF DEMENTIA

Don't wait to consider the diagnosis of dementia until a patient has obvious cognitive impairment. Instead, consider the diagnosis when a patient has early symptoms, like falls, failing to appear for appointments at the correct time, dressing inappropriately, or the other symptoms listed in Table 3. If dementia is suspected, confirm the diagnosis using a standardized tool, and evaluate for reversible causes.

Elder Care

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Table 1. Brief Tests to Detect the Cognitive Impairment of Dementia

Cognitive Test*	Time Required (minutes)	Likelihood of Dementia with Positive Test Compared to Negative Test
Mini-Mental State Exam	7-10	4-13 times more likely
Clock Drawing	1-3	4 - 8 times more likely
Memory Impairment Screen	4	15-72 times more likely
Abbreviated Mental Test	5-7	6 - 12 times more likely

*See reference number 3 for details

Table 2. Tests to Exclude Reversible Causes of Dementia

Recommended by American Academy of Neurology

- Thyroid function test
- Vitamin B12 level
- Brain imaging (for NPH)

Recommended by Canadian Consensus Conference on Dementia

- Complete blood count
- Chemistry panel
- Thyroid function test

Recommended when indicated based on clinical suspicion

- Serologic test for syphilis
- Lyme disease titer
- Human immunodeficiency virus test
- Heavy metal assay
- EEG (if prion disease suspected)

Common Dementia Syndromes * **

- Alzheimer's disease
60-80% of all cases
Associated with short term memory loss
- Vascular dementia
10-20% of cases
Associated with HTN, DM, HLD
- Parkinson's Disease
5% of cases
PD patients have 6 fold increase in the diagnosis of dementia
- Dementia with Lewy bodies
Associated with visual hallucinations
Associated sensitivity to neuroleptics
- Frontotemporal dementia
Associated with personality change
- Pseudodementia
Depression presenting as memory loss

* Mixed dementias involve more than one type
** Alcohol excess can exacerbate dementia issues

Check it Out!

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Table 3. Early Symptoms in the Diagnosis of Dementia

- Memory problems or repetitiveness
- Substituting incorrect or unusual words when speaking or writing
- Forgetting directions to a familiar place, or getting lost while going there
 - New or frequent problems with interpersonal relationships
 - Difficulty giving a coherent medical or family history
- Not just misplacing things, but putting or losing them in unusual places
- Failing to keep scheduled appointments at the correct time or day
- Inappropriate dress – over or under dressed for the weather or occasion
 - Difficulty preparing meals, or preparing them incorrectly
 - Falls (people with dementia are at twice the risk of falling)

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ACOVE Quality Indicators

1. IF a vulnerable elder is newly diagnosed with dementia, THEN a serum B12 and TSH should be performed.



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ELDER CARE A Resource for Interprofessional Providers

Delirium, The Sixth Geriatric Vital Sign

Rosemary Browne, MD, College of Medicine, University of Arizona

Delirium, an acute, confusional state, is associated with high morbidity in the elderly. Seen most often in a hospital setting, delirium can occur in up to 30% of elderly hospitalized patients, and in up to 70% of elderly patients in the ICU. Delirium prolongs hospital stays, is associated with functional decline, and results in higher rates of nursing home placement. For these reasons, health care providers who take care of the elderly must work diligently to prevent the onset of delirium, learn to quickly recognize its symptoms and signs, and utilize an effective treatment strategy. The

DSM-IV criteria for delirium, which are based on expert opinion, include the following: disturbed consciousness, cognitive change, rapid onset, and evidence of a physical cause. Efforts to create an evidence based diagnostic tool for delirium have led to the creation of the CAM, or Confusion Assessment Method.³ There are four diagnostic components of the CAM; the first two must be present plus at least one of the third or fourth: (1) acute onset of change in mental status, or rapid fluctuations, (2) inattention, (3) disorganized thinking, (4) an altered level of consciousness. The CAM is a well validated and useful tool to aid in the diagnosis of delirium.

Risk factors for delirium are many, and include male gender, age >80 years, dementia from any cause, alcohol abuse, and those with multiple co-morbidities. Sensory impairment, polypharmacy, dehydration, immobility and

malnutrition also increase the risk.

High risk patients may develop delirium when their baseline homeostasis is disrupted by any of many possible causes, including infection, metabolic disorders, drug and alcohol use, new medications or severe illness. Delirium is frequently seen during the peri-operative period.

Once delirium is diagnosed, a provider should begin treatment by looking for reversible causes. Conditions that can precipitate the onset of delirium are myriad. Evaluate for hypotension, hypoxia, infection, and metabolic causes. Order a complete metabolic panel, blood alcohol level, chest x-ray, and ECG. Don't forget to check for urinary retention and fecal impaction. And, always review medications, especially those that are new. Further testing, including a head CT, lumbar puncture and/or EEG should follow if a treatable cause is not easily identified.

Delirium is categorized as hypoactive, hyperactive, or mixed, with older adults most often presenting in an hypoactive state. An agitated delirium is a true medical emergency, and standard therapy remains 0.25-0.5 mg of haloperidol IM with a maximum dose of 5 mg/24hours. Physical restraints can worsen symptoms and should be avoided.

An elderly inpatient can benefit from simple prevention techniques, listed on the reverse.



Maximize Hearing and Vision



Frequent Reorientation



Treat Disease



Streamline Medications

DELIRIUM—TIPS FOR GOOD PRACTICE

- Don't accept "altered mental status" or "confusion" as a diagnosis; look for the delirium syndrome in your elderly patients. The CAM is a well validated assessment tool.
 - Delirium is a common presentation in elders with multiple comorbidities.
 - Medications are a frequent cause of delirium! Review thoroughly.
- Prevention is far easier than treatment—employ strategies for delirium prevention

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Elder Care

Medications Associated with Delirium

Medications with Anticholinergic Effects

Anticholinergics
Antihistamines
Antipsychotics
Antispasmodics
Cyclic antidepressants
Mydriatics

Traditional Medicines

Burdock root
Black henbane
Atropa belladonna
Mandrake
Jimson weed
St. John's Wort
Valerian

Miscellaneous Agents

Hypoglycemics
Hypnotics
Benzodiazepines
Antiarrhythmics
Beta blockers
Diuretics
Digoxin
Clonidine
Dopamine agonists
Corticosteroids
Muscle relaxants
Anticonvulsants
Antiemetics
H-2 receptor blockers

Using the CAM

- **Acute Change or Fluctuation in Mental Status**—Assess by history and observation. Staff and family can attest to the admission/pre-op or pre-hospital cognitive status of the patient. Any acute confusional state should make the provider consider delirium.
- **Inattention**—Is the patient able to answer a direct question with an appropriate answer? Can the patient stay “on track” in normal conversation? If the answer is no, also look for fluctuations in levels of attention, which can further signal delirium.
- **Disorganized Thinking**—Is the patient’s speech/thought process rambling, unclear, unpredictable, illogical, and/or irrelevant?
- **Altered Level of Consciousness**—Assess the patient for alertness, vigilance, lethargy, stupor, or coma.

Types of Delirium

Agitated Delirium: A patient who is restless, picking at his/her bed clothes, and whose behavior is detrimental to his own well-being and safety as well as that of the staff.

Hypoactive Delirium: A patient who demonstrates sluggishness and/or psychomotor retardation, often mistaken for depression or fatigue.

Mixed: A combination of both agitated and hypoactive delirium.

Delirium vs. Dementia

Acute	Chronic
Obvious	Subtle
Reversible	Incurable
	(meds can slow progression)
Fluctuating	Progressive

Delirium, the Sixth Geriatric Vital Sign—Prevention Tips

- Perform admission cognitive function test to establish a baseline
- Treat underlying medical causes
- Remove all lines/catheters as soon as possible
- Obtain a nutrition/dietary consult
- Encourage frequent re-orientation by staff
- Ensure hearing aids, glasses, and teeth are used, and travel with patients on transfer through facilities
- Check for clocks, schedule boards, visible calendar in all patients’ rooms
- Encourage family participation in hospital
- Order physical therapy/early mobilization
- Encourage good sleep hygiene—don’t interrupt sleep for vital signs, blood draws, daily weights

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ACOVE Quality Indicators

1. IF a vulnerable elder is newly diagnosed with dementia, THEN a serum B12 and TSH should be performed.

The Aging Process

- What factors might lead you to think Jose might be demented?
 - Must it be either depression or dementia?
3. Bettie, age 75, was diagnosed with early stage Alzheimer's about 12 months ago. She has diabetes and hypertension which are controlled with several medications. Her eyesight is very poor due to complications of diabetes and she can no longer read the labels on her medications. Bettie is a recovering alcoholic and has been sober for 10 years. She has always been friendly and humorous during previous visits and always shares a story about the latest goings on with her granddaughter. Today, a neighbor answers the door at Bettie's home and says Bettie has been sick with a cold for a couple of days. When you enter Bettie appears disheveled and unfocused. She is not wearing her glasses. Although it is 10:00 a.m., she is drowsy and keeps drifting off. You notice some cold medicine on the kitchen counter. When you ask Bettie about the medicine and if she is running a fever she starts telling you about the lady on TV who is in the closet.
- What factors might lead you to think Betty might be experiencing delirium?
 - What factors might lead you to think Betty might be depressed?
 - Do you think Betty's Alzheimer's might just be worse? Why?

Learning Objective #4:

Evaluate the impact of separation, loss and grief on a client's well-being.

Many older adults experience multiple losses over a short period of time. Losses come in many forms and not all are readily acknowledged in the broader society. One type of loss, such as the death of a spouse, may trigger changes that create other losses. For instance, in addition to the major loss associated with the death of a spouse, it might also mean the loss of financial security, loss of shared experiences and friendship, and loss of social contacts.

Older adults have a lifetime of coping, adaptation and resiliency skills to draw upon to face the age related challenges of separation, loss and grief. Tapping in to these adaptive abilities will help them cope with many types of losses that come from changing circumstances. If asked, a person can usually describe the ways in which he/she coped with a particular life event and even how successful the coping strategy was. Discussing one's success in dealing with

a previous crisis and the coping strategies that were used can help older adults to gain a sense of control over new stressful life events and recognize that they have a "toolbox" to draw from.

For older adults losses often have a cascading effect triggering change and loss in other areas of life as well. For instance, health decline can lead to decline in mobility and independence.

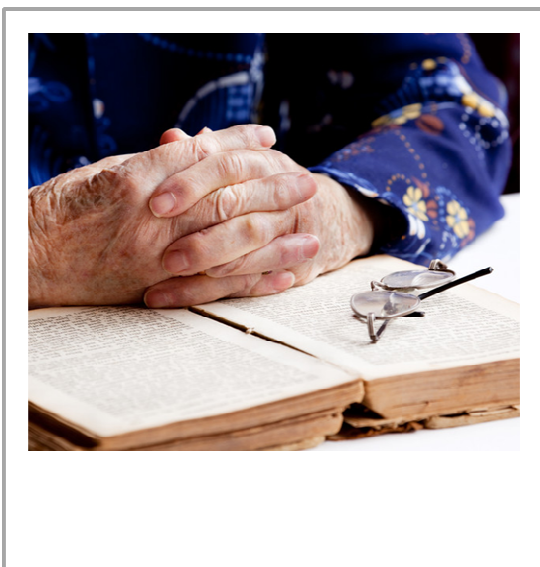
ACTIVITY

Ask workers to review the following handouts: *Unique Challenges of Older Adult Grief* and *Grief: Symptoms, Process, Complications, and Counseling*.

Ask workers to identify some of the changes or stressors that older adults face that may lead to feelings of loss and/or grief.

Answers may include:

- Caregiving (Caregivers have twice the risk as others for mental and physical health problems)
- Changes in health, including one or more chronic diseases
- Negotiating new systems (such as health care benefits)
- Pain or disability
- Increased medication use
- Mobility restrictions (brought on by arthritis, osteoporosis, and other conditions)
- Sensory decline (hearing, vision, touch)
- Loss of loved ones (multiple losses with progressive age)
- Loss of driving privileges
- Increased reliance on others due to functional, health, or financial changes

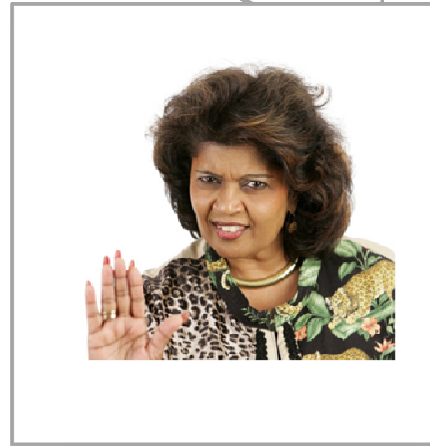


- Retirement
- Income changes
- Housing changes (downsizing, assisted living, moving closer to or in with children)
- Increased leisure time, often with no plan regarding how to structure the time
- Feelings of invisibility due to youth based culture
- Multiple social adjustments with role changes
- Changes in physical appearance
- Development of new relationships

Ask workers how they can provide support to older adults impacted by separation, loss, or grief.

Answers may include:

- Connect to community resources such as support groups, grief counseling, lifelong learning or social activities
- Provide resources to assist with adapting home environments to meet functional needs.
- Providing choices when changes must be made. (i.e., Would you prefer to move to Location A or Location B. What are the pros and cons of each?)
- Allow time for older adults to reminisce about a loved one or process the changes being encountered.
- Ask how they have adapted or coped with change or loss at other times in their lives. Could they use some of those strategies now?



GRIEF SYMPTOMS

WHAT IS GRIEF?

Grief is the emotional reaction to a significant loss, such as the death of a loved one or no longer being independent with activities of daily living. Whether an individual loses a beloved person, an animal, place, or object, or a valued way of life (such as a job, marriage, or good health), some level of grief will naturally follow.

Anticipatory grief is grief that is experienced in advance of an impending loss. People may feel anticipatory grief for a loved one who is dying or for impending declines in functioning due to a progressive illness.

Grieving is the process of emotional and life adjustment one goes through after a loss. Grieving after a loved one's death is known as bereavement.

Grieving is a personal experience. Depending on who the person is and the nature of his or her loss, the process of grieving will be different from another person's experience. Although grief myths suggests the grieving process lasts a year, there is no "normal and expected" period of time for grieving. Some people adjust to a new life within several weeks or months. Others take a year or more, particularly when their daily life has been radically changed or their loss was traumatic and unexpected.

SYMPTOMS OF GRIEF

A wide range of feelings and symptoms are common during grieving. Recognizing these in your clients will help you to normalize their grieving experience.

- While feeling shock, numbness, sadness, anger, guilt, anxiety, or fear, people may also find moments of relief, peace, or happiness. This is one characteristic that distinguishes grief from depression.
- Grieving is not simply sadness, "the blues," or depression, but individuals may become depressed or overly anxious during the grieving process.

Grief is expressed physically, emotionally, socially, and spiritually.

- **Physical expressions** include crying and sighing, headaches, loss of appetite, difficulty sleeping, weakness, fatigue, feelings of heaviness, aches, pains, and other stress-related ailments. The stress of grieving may also weaken the immune system over time results in more frequent episodes of illness. For persons who have a chronic illness, grieving can exacerbate their condition.
- **Emotional expressions** include feelings of sadness and yearning as well as feelings of worry, anxiety, frustration, anger, and guilt. All of these feelings are normal reactions to grief.
- **Social expressions** include feeling detached from others, isolating oneself from social contact, and behaving in ways that are not normal for the individual.
- **Spiritual expressions** include questioning the reason for the loss, the purpose of pain and suffering, the purpose of life, and the meaning of death. After a death, one's grieving process is influenced by how he or she views death.

THE GRIEF PROCESS

Grieving a significant loss takes time. Depending on the circumstances of the loss, grieving can take weeks to years. Ultimately, passing through the major stages of grieving helps people gradually adjust to the loss.

Key Stages of Grief

- Becoming aware of a loss
 - Full awareness of a major loss can happen suddenly or over a few days or weeks.
 - While an expected loss (such as a death after a long illness) can take a short time to absorb, a sudden or tragic loss can take more time.
 - Similarly, it can take time to grasp the reality of a loss that doesn't affect one's daily routine, such as a death in a distant city or a diagnosis of a cancer that doesn't yet make one feel ill.
 - During this time, one may feel numb and seem distracted. He or she may search or yearn for the lost loved one, object, or way of life.
 - Funerals and other rituals and events during this time may help people accept the reality of loss.
- Feeling and expressing grief
 - Each individual's way of feeling and expressing grief is unique to that person and to the nature of her or his loss.
 - People may find that they feel irritable and restless, are quieter than usual, or need to be distant from or close to others, or that they aren't the same person they were before the loss.
 - It is also common to experience conflicting feelings while grieving. For example, it's normal to feel despair about a death or a job loss, yet also feel relief.

The grieving process does not happen in a step-by-step or orderly fashion. Grieving tends to be unpredictable, with sad thoughts and feelings coming and going, like a roller-coaster ride. After the early days of grieving, people may sense a lifting of numbness and sadness and experience a few days without tears. Then, for no apparent reason, the intense grief may be experienced again.

While grieving may make individuals want to isolate themselves from others and hold all their feelings in, it's important that they find some way of expressing their grief. Encourage people to use whatever mode of expression comes to mind: talking, writing, creating art or music, or being physically active are all ways of expressing grief.

Spirituality often enters into the grieving process. People may find themselves looking for or questioning the higher purpose of a loss. While some may gain comfort from religious or spiritual beliefs, others might also be moved to doubt their beliefs in the face of traumatic or senseless loss.

Adjusting to a loss can take 2 or more years to go through a grieving process. The length of time spent grieving depends on the relationship with the lost person, object, or way of life as well as personality attributes of the grieving person. Even after 2 years, people may re-experience feelings of grief, especially related to the loss of a loved one. It is important that people be prepared for this to happen during holidays, birthdays, and other special events, which typically revive feelings of grief - this is known as an "anniversary reaction."

COMPLICATIONS OF GRIEF

Grief can cause prolonged and serious symptoms, including depression, anxiety, suicidal thoughts and actions, physical illness, post-traumatic stress disorder, and traumatic grief. Intense grief can bring on unusual experiences. After a death, individuals may have vivid dreams about their loved one, develop his or her behaviors or mannerisms, or see or hear the loved one. If an individual feels fearful or stressed by any of these experiences, talking to a professional experienced in grief counseling is warranted. Although it may be possible to postpone grieving, it is not possible to avoid grieving altogether. If life circumstances make it difficult for individuals to stop, feel, and live through the grieving process, grief can be expected to eventually erupt sometime in the future. In the meantime, unresolved grief can affect quality of life and relationships with others. Unresolved grief can lead to complicated grief reactions.

Complications that can develop from grieving include depression, anxiety, suicidal thoughts, and physical illness. These are the type of grief reactions that tend to require therapeutic interventions.

Depression is the most common condition that can develop when a person is grieving.

- Depression is especially common in adults who experience a divorce or death of a spouse.
- It is also very common in relation to developing a chronic illness or disability.

Anxiety also is common during the grieving process. However, anxiety can:

- Last longer than expected
- Become intense such that it interferes with functioning
- Include extreme guilt
- Such disruptive anxiety contributes to a more complicated grief response and can:
 - Make people feel like they are losing control of their emotions. Overwhelming fear is also common.
 - Trigger physical symptoms (anxiety attacks), which might be mistaken for a heart attack.
 - During an anxiety attack, people are likely to have a feeling of intense fear or terror, difficulty breathing, chest pain or tightness, heartbeat changes, dizziness, sweating, and shaking.

Suicidal thoughts

- Sometimes when grieving, people have thoughts of ending their own lives, particularly when they've lost a spouse or have lost a close friend to suicide.
- An individual who has been depressed or has had thoughts of suicide before may be vulnerable to having suicidal thoughts while grieving.
- Any thoughts of suicide must be taken seriously.
- The threat of carrying out the plan is very real if a person is thinking of committing suicide and:
 - Has the means (such as weapons or medications) available to commit suicide or do harm to another person.
 - Has set a time and place to commit suicide.

The Aging Process

- o Thinks that there is no other way to end his or her pain.

Physical Illness

- Grieving stresses the body, weakens the immune system, and generally makes people more prone to illness, aches, and pains.
- People who have chronic medical conditions may have a recurrence or a worsening of their symptoms when they are grieving the death of a loved one.
- Adults who lose a loved one sometimes develop new health problems.

Post-traumatic stress disorder

- People who experience a traumatic loss are at risk for developing PTSD.
 - PTSD is an intense emotional and psychological response to a very disturbing or traumatic event, such as a rape, assault, natural disaster, accident, war, torture, or death.
 - Individuals can develop PTSD symptoms immediately following such an event, or it may develop months or even years later.
- Symptoms of post-traumatic stress disorder may include:
- Persistent and painful re-experiencing of the event through dreams (nightmares) or while awake (flashbacks).
 - Emotional numbness, or inability to feel or express emotions toward family, friends, and loved ones.
 - Avoiding any reminders of the event.
 - Being easily angered or aroused, "on edge," or easily startled (hyperarousal).

Traumatic Grief

Traumatic grief is a syndrome of acute grief and anxiety lasting 6 or more months after the death of a loved one. Traumatic grief may also be called separation trauma, complicated grief, or prolonged-acute grief.

- Symptoms of traumatic grief include:
- A preoccupation with the loved one.
 - Excessive loneliness.
 - Longing and yearning for the loved one.
- Traumatic grief is different than post-traumatic stress disorder (PTSD).
- With PTSD, a person is anxious and fearful that the traumatic event that caused the loss will occur again.
 - In traumatic grief, anxiety results because the person is searching and yearning for their loved one.
- Unresolved grief tends to be more common in people who:
- Are unsure how they feel about the person, object, or situation they lost.
 - Have a negative opinion of themselves (low self-esteem).
 - Feel guilty about the loss, such as people who think they could have prevented a serious accident or death.
 - Think the loss was a result of unfairness, such as losing a job from apparent discrimination or losing a loved one or one's health as a result of a violent act.
 - Experienced the unexpected or violent death of a loved one.
 - As noted previously, people who experience a traumatic loss are at risk for developing PTSD.

The Aging Process

- Experience a loss that others do not recognize as significant, such as a lesbian or gay life partner relationship, retirement, or losses related to aging. This is often referred to as “disenfranchised grief.”
- How people express unresolved grief varies. People may:
 - Act as though nothing has changed. They may refuse to talk about the loss.
 - Become preoccupied with the memory of the lost object or person. They may not be able to talk or think about anything else.
 - Become overly involved with work or a hobby.
 - Drink more alcohol, smoke more cigarettes, or take additional medications.
 - Become overly concerned about their health in general or about an existing health condition and see a health professional more often than usual.
 - Become progressively depressed or isolate themselves from other people.
- Grieving problems
 - In this complex and busy world, it can be difficult to fully grieve a loss.
 - It is also possible to have unresolved grief or complications associated with grieving, particularly if an individual:
 - Has several major losses in a short period of time.
 - Are grieving permanent losses caused by chronic illness or disability.
 - Has lost someone very important in his or her life.
 - Has experienced the unexpected or violent death of a loved one, such as the death of a child or a death caused by an accident, a homicide, or a suicide.
 - Has special life circumstances that act as obstacles to grieving, such as having to return to work too soon after a death.
 - Has a history of depression or anxiety.

GRIEF COUNSELING

Grief counseling is short term and focuses on helping people work through the grieving process related to a major loss. Grief counseling is also called bereavement counseling, but the term "bereavement" usually is used only when referring to the loss of a person through death.

Grief counseling typically has four components:

1. Learning about grief and what to expect when grieving.
 - In grief counseling, people are taught the normal grieving process, including expected feelings and thoughts.
 - They are also taught how to tell the difference between normal grieving and other conditions, such as depression, that can develop from grieving.
2. Expressing feelings.
 - People are encouraged in grief counseling to express all their feelings, whatever they may be.
 - Sometimes people who are having trouble expressing their feelings are encouraged to talk about their loss or to use other means of expressing themselves. For example, they may be asked to speak with the lost person as though he or she were there.
 - Other techniques that help people express their feelings include:
 - Writing letters about their loss or writing to the lost person.
 - Looking at photos and remembering the lost loved one or object, or visiting the grave of a loved one who has died.
3. Building new relationships.
 - This component of grief counseling helps people develop a new relationship with the lost person or object.
 - Since memories usually linger for years and can sometimes be troubling, emphasis is placed on learning how to incorporate memories of the past into the present.
4. Developing a new identity.
 - During grief counseling, people are taught how to develop a new sense of self after a loss.
 - For example:
 - A top corporate executive who retires strengthens his or her self-perception as a grandparent and spouse instead of as a corporate leader.
 - A widow who has lost her husband of 45 years begins meeting with other women in her building for tea every morning.

Excerpted from: Bonifas, R.P., *Grief, Loss, and Bereavement in Older Adults: Reactions to Death, Chronic Illness, and Disability. A Learning Module for Effective Social Work Practice with Older Adults.* Council on Social Work Education (CSWE) Gero-Ed Center. Retrieved April 11, 2011 from <http://www.cswe.org/CentersInitiatives/GeroEdCenter/TeachingTools/TeachingInFusion.aspx>

UNIQUE CHALLENGES OF OLDER ADULT GRIEF

Older adults express their grief in the same ways as younger and middle-aged adults. However, because of their age and other life circumstances, it is important to be aware of other issues that are more unique to this age group.

1. Older adults may experience several losses within a short period of time.
 - Older adults are more likely than other adults to lose more than one friend or family member within a short period of time. This can cause them to grieve the losses at the same time or grieve over a long period of time. It may also cause them to feel overwhelmed, numb, or have more difficulty expressing their grief.
2. Older adults may not be aware that they are grieving or be unwilling to admit it.
 - They may not recognize sadness or other symptoms as grief. It also may be difficult to say that they are grieving. They may not want to tell other people how sad they feel when they see or care for loved ones who are ill or aging.
3. Older adults may experience losses related to the aging process itself.
 - They may need to give up long held roles within their family. They may lose their physical strength and stamina and lose independence in areas that they previously mastered. For instance, the loss of driving privileges is especially difficult.
 - Sometimes older adults seem to overreact to losses that seem minor to others. These seemingly minor losses may trigger memories and grief that are related to previous losses and may intensify the response to the current loss.
4. Older adults may have chronic and/or co-morbid conditions, including physical and mental disabilities, that interfere with their ability to grieve.
5. Older adults may lack the support they once had.
 - Those who depended on their spouse or other family members for social contact may lack a support network after their spouses die or other family members move away or die. They may feel lonely and believe they have no one to confide in.

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