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From the Editor

We are very pleased to present this special edition on caregiver wellbeing. Family caregivers comprise an essential component of long term care. In the U.S., over 65 million people provide care for a family member or friend who is disabled or chronically ill. On the average, they devote approximately twenty hours a week in the delivery of this critically needed care. Adding to the many challenges of providing support to a family member or friend, caregivers are often elderly themselves, or struggling to manage their own chronic conditions. Identifying and supporting caregivers is critically important, yet many times these family caregivers are invisible to us in our practices. This special edition will shed light on the needs of family caregivers, and provide the reader with strategies to support them.

In this issue we also continue to feature our Elder Care Provider Sheets – practical, evidence-based short clinical guides for health science students and clinicians, funded by grants from the Arizona Geriatrics Workforce Enhancement Program and the Donald W. Reynolds Foundation. Elder Care topics are highly relevant for health professionals caring for older adults and we encourage you to check them out!

As always, we welcome journal contributions on aging related topics from all of our readers, whether you are a student, researcher or a practicing clinician. Please contact us with any questions.

We hope you find this issue educational and valuable!

Mindy J. Fain, MD

The Arizona Geriatrics Society Journal, an official publication of the Arizona Geriatrics Society, is committed to publishing quality manuscripts representing scholarly inquiry into all areas of geriatrics. The journal is published twice a year. We encourage submissions of all research, best practice, review of literature, and essays. Manuscripts should be prepared according to the AMA Manual of Style: A Guide for Authors and Editors, 10th Edition (2007) and emailed as a Word attachment to Mindy Fain, mfain@aging.arizona.edu, and Lisa O’Neill, loneill@aging.arizona.edu. The first page should include the title and a 50-100 word abstract. Manuscripts are generally limited to 4,000 words and should not be under consideration for publication elsewhere. Manuscripts are reviewed by members of our interprofessional editorial team whose evaluations will provide a basis for the publication decision. We are committed to a rapid review process. Thank you.
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To advance healthcare practices for Arizonans by supporting the education of interprofessional healthcare providers in issues concerning older adults.

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• Expand the geriatrics knowledge base through continuing education programs for interprofessional healthcare providers.

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• Recruit physicians and other healthcare professionals into careers in geriatrics.

• Raise public awareness of the need for high-quality, culturally sensitive, interdisciplinary geriatric health care.

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Forward: The Paradox of Self-Care

Pauline Boss, Professor Emeritus
University of Minnesota
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This edition of the Arizona Geriatrics Society Journal focuses on one of the most important issues for our aging society today—the issue of caregiver well-being. For professionals in geriatrics and gerontology today, this translates to the topic of self-care for family and informal caregivers. By definition, caregivers are people who give to others with their labors and caring, but we know from research that caregiving by family members can be dangerous to their health (Boss, 2011; Schulz & Beach, 1999). For various reasons—a selflessness or socialization toward filial piety—family caregivers often resist focusing on themselves. Many see it as selfish. Taking time off or asking for help or respite care is resisted. For this reason, we devote this journal issue to informing professionals how to more effectively encourage self-care in family caregivers. The goal is to increase their sense of empowerment and provide more techniques to support a healthy lifestyle despite the hard work and isolation of caregiving. We acknowledge and honor the monumental contributions that caregivers give, not only to their families, but also to our entire society. The well-being of family and informal caregivers is in everyone’s best interest. This issue of the Arizona Geriatrics Society Journal is devoted to that goal.

Toward this end, the theme of this series—empowering potential to engage informal and family caregivers in self-care—focuses on how to empower family and informal caregivers. The goal is to increase their sense of empowerment and provide more techniques to support a healthy lifestyle despite the hard work and isolation of caregiving. We acknowledge and honor the monumental contributions that caregivers give, not only to their families, but also to our entire society. The well-being of family and informal caregivers is in everyone’s best interest. This issue of the Arizona Geriatrics Society Journal is devoted to that goal.

In my 2011 book, Loving Someone Who has Dementia, I wrote directly to family caregivers about the immense stress of caring for someone who is “here but also gone,” what I call ambiguous loss (also see Boss, 1999, 2006, 2016). Previously, in 2006, I wrote a book for professionals about how to help family members increase their resilience when loved ones are lost, not from death, but from being missing in body or mind. My respect for family caregivers is exceeded only by my concern for their health and well-being. Why do family caregivers resist taking care of themselves? To answer that question, we must first understand why a person may take on the role of caregiver in the first place. In 2011, I wrote:

Nel Noddings, a Stanford professor who wrote about the ethics of caring, says that the act of caregiving doesn’t fit psychology’s theories of motivation, because it goes beyond the motivations of self-preservation and profit (Maslow, 1943; Noddings, 1984). People give care even if doing so is not in their best interests. What is it then that makes caregivers continue even when their own finances and health are in jeopardy? These are typical responses I have heard in my practice: “I promised ‘in sickness and health, till death do us part,’ so I’m going to honor that promise” or “I believe in ‘honoring thy father and mother,’ so I take care of them.” Still others say they give care because they think it’s simply the right thing to do. (p. 162)

Whatever the motivation, family and community caregivers need more empowerment to take on their dual role—taking care of themselves and the person who is ill. As professionals, we can begin this process by acknowledging them as part of the team, for caregivers are one of the most valuable resources we have in an aging society.

To help empower family and informal caregivers toward self-care, the articles in this issue are written by university educators and researchers from disciplines of nursing and counseling psychology who work interprofessionally to develop innovations for caregiver health and empowerment. First, nurse educator, researcher, and clinician Dr. Julie Fleury addresses “Empowering Caregiver Self-Care: Strengths-Based Perspectives”; second, Arizona State University professor in Nursing and Health Care Innovation and Counseling psychologist Dr. David Coon and his colleagues offer "CarePRO: Embedding an Evidence-Based Intervention for Caregiver Empowerment”; third, researcher, educator, and clinician Dr. Carol Long discusses "The Spiritual Self: Pathways to Inner Strength for Caregivers”; fourth, Dr. Teri Pipe, educator and researcher and Dean of College of Nursing...
and Health Innovation, Arizona State University, writes about "Mindfulness Strategies that Revitalize Internal Awareness and Self-Care"; and fifth, nurse clinician Tanie Sherman and Dr. Julie Fleury offer "Empowering Motivation to Reduce Sedentary Time in Older Adult Caregivers."

This special issue of the Arizona Geriatrics Society Journal provides an overview of research and practice as it relates to reducing caregiving stress. Whether using physical, psychological, or spiritual approaches, these researchers/practitioners give us evidence-based information for self-nurture and resilience-building practices of caregivers who are older adults. From mindfulness to spirituality to physical strengthening, they suggest various means for family caregivers to stay healthy and resilient despite their work and the stress of ambiguous loss—caring for someone who is "physically present but psychologically absent" or said another way, "here but also gone" (Boss, 1999, 2006, 2011, 2016).

I congratulate the editors and authors for this informative issue of the Arizona Geriatrics Society Journal. May it inform professionals toward the urgent goal of healthier, stronger, and more resilient informal caregivers, at home or in the community. Millions are now caring for the very ill beyond the usual motivations and relational expectations.

References
Empowering Caregiver Self-Care: Strengths-based Perspectives

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This manuscript offers a perspective on research and practice promoting strengths, abilities, and potential for self-care among older adult informal caregivers. Approaches to self-care that move beyond disease and deficit to promote continued growth in older adulthood are needed. Empowering potential for self-care offers a perspective on caregiver growth consistent with valued goals that facilitate new health patterns.

Key words: empowerment, strength based approach, caregiver self-care, caregiver growth

By 2060, there will be almost 98 million older adults in the U.S., more than double those in 2013. Those 85 years and older are projected to more than double from 6 million in 2013 to 14.6 million in 2040. These demographic changes are marked by increases in chronic illness, and associated social and medical needs. Two of three older adults have multiple chronic conditions associated with poor quality of life, functional disability, psychological distress, and increased morbidity and mortality.

As the U.S. population ages, there will be an increased need for informal caregivers. Family caregivers serve as a vital resource to family and society, allowing a person to remain at home across the course of chronic illness. However, older adult informal caregivers are at risk themselves for worsening chronic conditions, lower levels of self-care activities designed to promote physical, mental and emotional well-being, and increased mortality.

Self-care has been defined as actions taken to promote health and prevent disease, including the maintenance of wellness and the management of chronic conditions. The extent to which older adult caregivers engage in self-care is a key determinate of how and whether the care recipient can remain at home. Informal caregivers are a vulnerable population, and should be recognized as care recipients in their own right. However, research is lacking exploring caregiver strengths and resources apart from the care recipient. Further, caregiving research typically focuses on reducing negative aspects of caregiving, such as burden, depression and stress, rather than fostering caregiver strengths and resources to engage in self-care as a basis for promoting caregiver well-being. Approaches to self-care do not yet integrate strategies that promote continued growth in older adult caregivers; focusing on problems and deficits alone limits the exploration of individual strengths, thereby compounding the risk for vulnerability.

Wellness motivation theory (WMT) provides a perspective on promoting self-care consistent with individual goals, thereby fostering well-being. The WMT acknowledges the person interacting with their environment through personal resources, environmental resources, behavior change processes, and engagement in self-care. Health empowerment emerges from the recognition of personal resources and environmental resources, facilitating purposeful participation in goal attainment, thereby promoting self-care and well-being. Purposeful participation in goal attainment is manifested through awareness, choices, freedom to act intentionally, and involvement in creating change.

Despite vulnerabilities, older adult caregivers have strengths that can be built upon to foster self-care promoting well-being. Approaches that promote strengths support the recognition and development of personal capacity and environmental resources. The goals of a strengths-based approach are to raise awareness of strengths in self-care promoting well-being, rather than focusing on problems of nonadherence or noncompliance with a medical regimen.

Older adults have capacities, competencies, possibilities, visions and hopes. All environments contain resources, supports, and opportunities. A strengths perspective allows us to recognize possibilities rather than problems, options rather than constraints, and wellness rather than illness. A strengths-based approach to self-care in older adult caregivers involves identifying and building on strengths, exploring strengths when addressing risks and needed behavioral changes, and focusing discussions to strength promotion. It is from a position of strength that older adult caregivers may
identify and leverage the resources available to them. A strengths-based approach seeks to support these processes instead of simply modifying risk behaviors, thereby fostering self-care and well-being.  

Personal resources are those unique characteristics of older adults, which comprise more than demographic factors. Recognition of self-capacity and building on strengths fosters participation in self-care. In a study of older women, Shearer found that personal resources reflected unique characteristics such as self-capacity. Self-capacity included promoting change and growth through acknowledging personal strengths and advocating for self. Women viewed themselves as strong individuals, with a purpose in life, and protectors and caregivers to their family. As a personal resource, recognition of self-capacity enhanced their ability to participate in problem solving to make meaningful changes in well-being. The theme of embodiment among older women represented a form of experiencing the world in light of a changing physical self and environment. Women noted self-care as a source of pride, reflective of self-organization, person environment interaction, and innovative change.

Personal resources for engaging in self-care involve self-knowledge, motivation appraisal, and self-regulation, which reflect the older adult striving toward new goals for self-care, and moving beyond goals achieved. Self-knowledge provides a context for meaning through which older adults acknowledge their hopes and fears for future health outcomes and self-care goals. Motivation appraisal reflects intention formation for self-care behavior consistent with personal beliefs and values, self-care goals, and available resources. Through motivation appraisal, individuals assess their goals, make judgments about the means best suited to attain goals, generate plans and strategies for goal attainment, engage in problem solving, and determine commitment to outcomes. The creation and commitment to a plan for achieving self-care can activate information about the self and relevant resources to mobilize goal-directed behavior. Through self-regulation, goals for self-care are transformed into personalized action. Self-regulation reflects a process through which older adults attempt to make strategies for self-care congruent with goals, particularly when goals conflict or change over time.

Environmental resources contribute to building individual and collective capacity through opportunities to engage in self-care behaviors, to create and sustain valued friendships, and to stay mentally and physically active. Environmental resources are significant in creating a supportive personal and ecological environment to promote self-care. Social resources include support from the social network and support systems consistent with cultural factors and norms. Support systems among individuals and groups assist older adults in managing life’s challenges, difficulties, and transitions. Social service utilization includes knowledge of and access to needed health and material resources. In a study of participants in a senior congregate meal program, social resources fostered empowerment through consistent availability and support in negotiating life changes within the aging process. Support included providing information, feedback, and reinforcement as well as acknowledging and encouraging the open expression of feelings.

A strengths-based approach to self-care is initiated by defining what behaviors or outcomes are important and relevant to the caregiver. The desired outcomes are based on the self-care goals that older adult caregivers set for themselves. Although desired outcomes are highly individualized, in a strengths-based perspective older adult caregivers want choices and the power to choose options based on the self-care goals they set for themselves. To achieve these outcomes, the focus of intervention is on understanding and promoting goals, dreams, and aspirations; both the being and becoming aspects of life.

Approaches to Building Strengths among Older Adult Informal Caregivers

The goal of a strengths-based approach to self-care among older adult informal caregivers is not just to promote specific behavioral changes, but to prepare the older adult to live a healthy and fulfilling life. Instead of a focus on fixing what is wrong, the emphasis is on recognizing and enhancing the strengths of individuals, families, and communities. Fostering strengths transcends a specific disease process or behavioral change need, focusing instead on developing strengths and assets needed for self-care. A strengths-based perspective changes our approach to interacting with older adult caregivers, moving from problem-focused to potential and solution-focused.

The focus of a strengths-based perspective changes the nature of the discussion with the older adult caregiver from problem-focused to potential and solution-focused, to allow the older adult to engage according to personal needs and values. Self-care is facilitated by building on strengths manifested in other areas of life, and bringing these strengths to bear on the behaviors involved in self-care. A transition can be made, moving away from a focus on behavioral deficits or weaknesses to empowerment.

The acknowledgement of strengths begins with an understanding of the values, goals, and aspirations of the caregiver, as well as the personal and environmental resources that can help them to achieve their goals. Priorities for self-care are identified by the caregiver, including both short and long-term goals. The concept of motivation has been used as a guide, where self-knowledge leads to understanding the motivating factor, or reasons for planning and integrating self-care into everyday life. Personal strengths may include personal qualities, how one responds to life’s challenges, as well as trials by fire. Environmental strengths include social network support, and identification and development of environmental resources. Strengths emerge from acknowledging and embracing the lives lived, including accomplishments and shortcomings.

Approaches to identifying and building strengths include conversation about personal and environmental resources and strategies for self-care goals. Empowering education has been used as a reflective approach for providing information, anticipatory planning, and problem solving, consistent with caregiver goals. In a review of literature on empowering
African American women caregivers, Chadiha and colleagues recommend storytelling as an empowering practice to raise critical group consciousness, make sense of life experiences, raise awareness of those experiences, and identify personal and environmental strengths. Stories are elaborated by group members, relating them to experiences in caregiving, as well as future goals and action. Recognizing individual strengths and capacity as resources through the process of storytelling also facilitate collective action to help caregivers obtain needed environmental resources. Strengths and strategies to promote and the adoption and maintenance of self-care occur through problem solving, goal determination and shaping, strategy formation, self-regulatory strategies, self-monitoring, and anticipatory problem solving. Motivation is fostered through focus on goals, concerns and priorities, and development of skills to achieve valued goals; such as emphasizing family role and health of family, or caring for oneself as a way to care for others. Self-regulation is promoted through problem solving strategies specific to cultural, contextual or environmental barriers, as well as targeting barriers, resources, and concerns identified by caregivers. Strategies include cognitive, affective and behavior strategies consistent with valued goals, even when goals conflict or change. A strengths perspective identifies and develops natural capacities, building on existing resources, and increasing well-being. Caregivers may identify their own strengths by thinking about what motivates and drives them, their talents, or how they have approached other challenges – “How have you managed thus far?” An assessment of caregiver strengths along with self-care goals provides a basis for exploring resources and strategies. Exploring caregiver goals, ability, social and cultural meaning of self-care practices is essential. The creation of strategies for self-care behaviors may include anticipatory problem solving and choice from options supporting self-care. Relevant strengths, goals, and strategies can be determined through exploration of expectations, intentions, and actions. While environmental strengths exist outside the older adult, they represent resources that can assist the older adult in being able to meet their goals. Some examples include a support system, community, and a safe place to live and engage with others. Communities possess a unique set of resources, skills, and assets. These strengths are embodied in the individuals, families or households, networks, and association and institutions that comprise the community.

Conclusion

Family caregivers serve as a vital resource to family and society, allowing loved ones to remain at home across the course of chronic illness. However, this commitment often places older adult informal caregivers at risk themselves for worsening chronic conditions, lower levels of self-care activities and greater risk of mortality. Informal caregivers are a vulnerable population, and should be recognized as care recipients in their own right.

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CarePRO: Embedding an Evidence-Based Intervention for Caregiver Empowerment

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CarePRO (Care Partners Reaching Out) is an evidence-based, psychoeducational skills-building intervention for family caregivers of individuals with Alzheimer’s disease or another dementia that fosters caregiver empowerment. Offered in English and Spanish, CarePRO has been embedded into local Alzheimer’s Association Chapters across Arizona and Nevada. This group-based intervention teaches caregivers both direct and indirect self-care strategies to (a) reduce caregiver stressors and related distress and (b) enhance positive coping and emotional well-being. Direct self-care strategies include daily pleasant events scheduling, stress management techniques (e.g., Mindful Breathing, Gentle Stretching, and Guided Imagery), and ways to change unhelpful thinking. Caregivers also learn and practice indirect self-care strategies such as effective methods to manage care recipient behavior problems and to communicate assertively with providers, family members, and friends. Findings with over 600 initial CarePRO participants demonstrate the feasibility of its translation into the community and show high levels of caregiver perceived benefit.

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Evidence-based Interventions for Family Caregivers of People with ADRD: An Ongoing & Growing Need

In 2016, approximately 5.4 million Americans were living with Alzheimer’s disease (AD). With the aging of our society, the US percentage of persons age 65 and older with AD is expected to grow 40% to 7.1 million by 2025. Larger increases are expected in Arizona (53.8%) and Nevada (56.1%), the two states targeted in the proposed project, with only Alaska (61.8%) estimated to have a greater increase. These estimates expand substantially when combining AD with other related dementias (ADRD) and including cases among individuals under the age of 65. In these states and the US as a whole, the majority of people with ADRD are non-Hispanic whites; however, within racial/ethnic group, Hispanics/Latinos and African Americans are more likely to be living with ADRD, probably due to the greater prevalence in these populations of Type II diabetes and high blood pressure, which increases one’s ADRD risk. Moreover, there is evidence that missed diagnoses are more common among Latino/Hispanic and African American/Black populations, and this is of particular concern, given the projected growth of older adults in these minority communities, particularly the Latino/Hispanic community. Forthcoming increases in the prevalence of ADRD will have a marked impact on the family members and friends serving as informal caregivers of people living with dementia. Informal caregiving comes with economic, social, and health costs, as family caregivers experience job and financial loss and strain, depressive symptoms, worry, and frustration; poorer health and health-related self-care; and social withdrawal and isolation. In response, caregiver intervention researchers have tested an array of approaches to alleviate caregiver distress, enhance caregiver coping, and foster caregiver resilience and empowerment. Recent meta-analyses and reviews of caregiver research, including those by our team, show that several
Development and Delivery of the CarePRO Intervention

CarePRO (Care Partners Reaching Out) is a time-limited, psychoeducational skills-building, group-based intervention for family caregivers of people with ADRD. CarePRO is based on Coping with Caregiving (CWC), a 10-session, psychoeducational skills-building, group-based intervention that was tested against an Enhanced Support Group (ESG) in a clinical trial as part of the 5-year NIH-funded REACH (Resources for Enhancing Alzheimer’s Caregiver Health) project at the California site. CarePRO, like CWC, draws on cognitive behavioral intervention strategies and self-care techniques to help reduce negative affect, increase positive mood, enhance coping, and empower family caregivers.

As part of the community translation process, the first author refined CWC into CarePRO through feedback from both community providers and caregivers who expressed an interest in reducing the number of group sessions and providing individual coach calls to help caregivers directly apply the skills to their daily caregiving situations. CarePRO was pilot tested with diverse groups of men and women in both San Francisco and Phoenix and achieved positive outcomes very similar to those from the original REACH CWC trial.

In contrast to CWC’s 10-session group format, CarePRO combines a series of 5 group sessions with alternating weeks of 5 individual coach calls to each group participant. CarePRO begins with a group session in Week 1 and ends with a final coach call in Week 10. Ideally, CarePRO groups comprise about 8-12 caregivers and are co-led by two trained facilitators who take turns delivering the group session material. Each participant is assigned one of the group leaders as their telephone coach for the duration of the series. To address the needs of smaller communities, smaller groups (groups of less than 8 caregivers) can be led successfully by one facilitator. In any case, leader and participant manuals with detailed agendas and related materials help keep the intervention on track so that it can achieve its goals.

CarePRO Components

Tailored to be culturally responsive, CarePRO is available in English and Spanish and teaches caregivers both direct and indirect self-care strategies. Direct self-care strategies include stress management techniques, daily pleasant events scheduling, and strategies to change unhelpful thinking. Caregivers also learn and practice indirect self-care strategies such as ways to manage care recipient behavior problems and effective methods of assertive communication for use with providers, family members, and friends. Additional information on CarePRO’s key components appear below.

Understanding Caregiver Frustration. CarePRO begins with basic education on two key topics to help ensure that group participants and their co-leaders are all on the same page with (a) dementia and the cognitive, behavioral, and emotional changes that accompany it and (b) sources of stress and frustration in family caregiving (e.g., lack of knowledge or skills, past relationship with the care recipient).

Mindful Breathing & Stress Management. The first author developed Mindful Breathing techniques that are similar to techniques modified from CWC for the NIH REACH II trial. However, CarePRO’s Mindful Breathing and related stress management activities ask caregivers to focus on changes beyond just tension alone by encompassing changes in other types of stress and upset. Mindful Breathing asks caregivers to use their breath to clear both their minds and bodies and to become aware of changes in their bodies, their minds, and their emotions. Mindful Breathing is combined across CarePRO’s five group sessions with Stretching, Music, and Guided Imagery relaxation approaches.

Pleasant Events. As caregivers become more and more engaged in their caregiving role, they drop many of their own interests and activities to focus on their care recipients. As a result, their lives become imbalanced with too many unpleasant events and too few pleasant ones. CarePRO helps participants identify simple, everyday pleasant events and activities (e.g., gardening in the back yard, watching a favorite TV show, listening to their favorite music) that they can schedule and reintroduce into their own lives without negatively impacting their loved one’s care. They also identify pleasant activities to share with their loved ones (e.g., take a walk, go for a ride, play with the family pet), although activities may need to be modified to suit their care recipient’s level of impairment. Engaging daily in simple pleasant events has been demonstrated to enhance mood in both caregivers and care recipients.

Changing Unhelpful Thinking. Caregivers can easily beat themselves up with unhelpful thoughts about their caregiving situations and about themselves, leading to increases in caregiver guilt, burden, worry, and the blues. Derived from cognitive therapy strategies, CarePRO teaches participants new forms of “self-talk” to help support themselves throughout their day. Participants learn to (a) stop when negative emotions arise (e.g., anger, worry) and identify unhelpful thoughts that are running through their minds about their situation, themselves, and the future; (b) challenge and replace these unhelpful thoughts with more helpful ways of thinking; and (c) recognize how changing these thoughts impacts how they feel (e.g., less anger or worry). Even in situations that are valid—“My dad is getting worse”—caregivers are asked to consider that ruminating over thoughts that are valid can still be unhelpful and negatively impact their mood and behavior. Instead, caregivers are encouraged to take appropriate action steps (e.g., make an appointment with the care recipient’s provider) and change their thoughts to more helpful thinking (e.g., “I made an appointment” and “Dad still enjoys our daily walks to the park.”).
Managing Challenging Behaviors. Caregivers are taught skills to help them manage the challenging behaviors that often arise as dementia advances. For example, caregivers learn ways to identify changes in the environment around their care recipients (e.g., increased noise, presence of visitors) that might trigger challenging behaviors (e.g., vocalization, repetitive questioning) and in turn implement strategies to help avoid or change those triggers (e.g., move the source of noise, identify pleasant distractions to occupy the care recipient during visits). Similarly, participants use other CarePRO skills such as Mindful Breathing to help them stay calm when challenging behaviors occur.

Communication Skills. CarePRO teaches participants the differences between passive, aggressive, and assertive communication and integrates IDEAL communication (a strategy developed by the first author for REACH II13) to improve interactions with providers and others in the participants’ social networks to help rally tangible, informational, and emotional support and foster socially based pleasant events. CarePRO also helps caregivers learn more effective ways to communicate with their care recipients (e.g., speaking more slowly or breaking information into smaller chunks to meet their needs).

Planning for the Future. The final group session reviews and reinforces CarePRO skills and provides important information for future planning (e.g., options for care, legal issues relevant to care planning). The session also introduces TIPS (Talk, be Informed, Prepare, and Share) to help caregivers have discussions with care recipients, providers, and other family and friends about future plans for care and end-of-life decisions, so that decisions can be made and steps can be taken before a pressing situation or crisis arises.

Coach Calls & Home Practice. While each group session includes active in-class participation to learn skills, coach calls and home practice exercises focus on a caregiver’s particular situation. They are designed to help caregivers apply and reinforce the skills to their daily lives. Just as in the group sessions, coaches are encouraged to do role plays and other interactive practice on the phone to enhance participant skill acquisition. Coach calls also provide the opportunity to reinforce that caregivers often have other roles (e.g., worker, grandparent, volunteer) and most of CarePRO’s skills are skills for life—not just family caregiving—and can be applied to many of life’s other situations and settings.

CarePRO Partners

Initially funded in Arizona and Nevada through U.S. Administration on Aging Alzheimer’s Disease Supportive Services Program (ADSSP) grants, CarePRO has been successfully translated into urban, suburban, and rural settings across both states. Original partners include the state units on aging from both Arizona and Nevada; the Desert Southwest Chapter of the Alzheimer’s Association; the Northern Nevada Region of the Northern California/Northern Nevada Chapter of the Alzheimer’s Association; the Cleveland Clinic Lou Ruvo Center for Brain Health in Nevada; and the Arizona Association of Area Agencies on Aging representing the local area agencies on aging in the state. The roles of each of the partners are described briefly below.

Arizona and Nevada State Units on Aging. The state units on aging served as the fiscal agent for the ADSSP projects and were responsible for their overall management, including preparing and submitting required budgetary and programmatic reports, managing project timelines, monitoring progress, documenting outcomes, and monitoring collaboration with key partners. They assisted with outreach and recruitment efforts as well. Their role continues by providing connections across the Long Term Supportive Services (LTSS) network to incorporate CarePRO into dementia-capable system plans for the states.

Alzheimer’s Association Chapters. The Desert Southwest Chapter of the Alzheimer’s Association serves the southern half of Nevada and all of Arizona and incorporates the following regional offices: Southern Arizona, Central Arizona, Northern Arizona, and Southern Nevada. The Northern California/Northern Nevada Chapter of the Alzheimer’s Association serves the northern half of the state through its Northern Nevada Regional Office. The Chapters were actively engaged in project outreach and over 42 staff (including staff who were replaced due to staff transitions) were trained and delivered CarePRO across both states, serving a wide range of communities and clientele.

Arizona Association of Area Agencies on Aging. The Arizona Association of Area Agencies on Aging in Arizona supported the project with outreach and referral activities. In addition, the CarePRO project model was adapted to meet the differing LTSS systems. For example, respite options and opportunities were discussed and facilitated by Arizona’s local area agencies on aging for caregivers who wanted respite assistance while they attended CarePRO group meetings. Please note that Nevada does not have local area agencies on aging, and therefore the two Alzheimer’s Association Chapters served in this capacity in the state of Nevada.

Arizona State University (ASU) and the Cleveland Clinic Lou Ruvo Center for Brain Health (CCLRCBH). Through ASU, the first author provided the initial training, conducted the first round of CarePRO interventions for co-leaders in each of the Chapter regions in both states, and implemented a train-the-trainer model for ongoing dissemination. He then provided group biweekly and ad hoc consultation for Chapter interventionists during their first independent CarePRO intervention and then monthly afterwards. Experienced CarePRO interventionists subsequently co-led a CarePRO series with new staff as they joined the Chapters. In addition, he trained and supervised the staff who provided outreach as well as screening and baseline and follow-up assessments via telephone for all Arizona participants in the Initial Phase of the project. In Nevada, data was collected primarily by CCLRCBH staff trained by the first author. He also supervised the CCLRCBH staff periodically on IRB, interview, and/or data management issues. ASU staff who conducted CarePRO interviews in Arizona provided initial telephone interviews in Nevada when staffing challenges emerged unexpectedly due to
health-related concerns. CCLRCBH staff also helped provide outreach and recruitment support to the Chapters in Nevada.

Outcomes and Sustainability

The initial REACH trial at the California site involving Coping with Caregiving (CWC) focused solely on women, enrolling 91 Latinas and 122 Non-Hispanic White women. CWC psychoeducational, skill-building groups were compared to Enhanced Support Groups (ESG) that were patterned after traditional caregiver support groups found in community settings. Both Latinas and Non-Hispanic White CWC participants, when compared to their ESG counterparts, reported significant improvements that included reductions in depressive symptoms, negative coping strategies, and negative interactions with people in their social networks and increases in positive or adaptive coping strategies.12

The partners enrolled over 600 caregivers across Arizona and Nevada in the CarePRO ADSSP project. Pre/post analyses after completion of CarePRO’s 5 group sessions alternated with its 5 coach calls demonstrate that CarePRO’s combination of skills-building workshops and telephone coach calls produced significant improvement on the key outcomes identified in the CWC REACH trial outlined above. In terms of acceptability, well over 95% of CarePRO participants described not only overall benefit from their CarePRO participation but also specific benefits in terms of increasing their understanding of memory loss and its effects on people; building their confidence in dealing with their loved one’s problems; making their lives easier; and enhancing their ability to provide care.11 Given that it was a group-based model, CarePRO costs are likely to be substantially lower than more intensive individualized in-home interventions. In addition, CarePRO was based on a train-the-trainer model in which a CarePRO-trained professional co-leads the intervention with a new leader, thereby serving caregivers while they are sharpening their CarePRO leader skills. This reduces training and supervision costs for new interventionists.

In terms of sustainability, the partners worked together to create a plan to transition the project’s screening and assessment activities to the Chapters. The Chapters worked with the first author to create short “sustainability” screens and outcome evaluation tools for ongoing administration as part of CarePRO’s overall sustainability. In addition, the CarePRO partnerships remain very strong and the project lives on with both the Desert Southwest Chapter and the Northern Nevada Chapter, which have identified CarePRO as one of their signature programs, embedding it into their program plans. CarePRO has become a key program of the dementia-capable projects in both states, and to date, well over 1,000 caregivers have participated in CarePRO. Connections across partners and with other LTSS partners also remain strong, with LTSS partners continuing to provide referrals and complementary resources. CarePRO is delivered in Spanish by Chapter staff, and the partners are strengthening relationships with promotores (community health worker) networks in the two states to enhance outreach into the Latino/Hispanic community. The partners are also working on opportunities to train regular Chapter support group facilitators on the basics of CarePRO skills to help them interact more effectively with CarePRO graduates who attend their support groups. Moreover, ideas for sustainability are emerging from empowered CarePRO graduates as well. Many participants have formed CarePRO “graduate groups” that continue to meet after the end of their time-limited series of 10 weeks and have approached the partners with the suggestion that they advertise groups that graduates could join that would be facilitated by other CarePRO graduates. Similarly, graduates and community partners have asked the first author to adapt CarePRO for caregivers with loved ones in long-term care facilities and for caregivers of those with Down Syndrome and other intellectual or developmental disabilities who develop dementia. Those adaptations are underway.

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The Spiritual Self: Pathways to Inner Strength for Caregivers

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The connection between the caregiving experience and spirituality has not been widely studied. This paper provides an overview of spirituality as a key dimension of wellness for informal/family caregivers. Through the pathways of searching for meaning, finding hope, addressing loss and grief, and seeking peace and happiness, ensuing strength and resilience evolves into the spiritual self. Spiritual introspection and self-assessment are necessary for healthcare professionals in facilitating spiritual wellness when working with patients and caregivers. Strategies for how professional caregivers can use empathic listening and compassionate presence while promoting self-care strategies for informal/family caregivers are outlined.

Key words: spirituality, meaning, hope, loss, grief, compassionate presence, empathic listening, peace

The rewards and benefits of informal/family caregiving are constant reminders in daily newspapers, newfeeds, professional care journals, and beneath the surface of everyday life. For many caregivers, the toll can be unforgiving with resultant physical sacrifice, stress and burden, and financial compromise. Just getting through the day may be the primary goal in the life of a caregiver, who may often unknowingly neglect their own needs and health for the needs of another. For others, the benefits outnumber the sacrifice and personal growth evolves with a sense of positive well-being. A question emerges: does spirituality play a key role in caregiver wellness? And if so, how can healthcare professionals enhance spirituality in the informal/family caregiving experience?

According to the World Health Organization (WHO), health is not merely the absence of disease. Health, with physical, mental, and social dimensions, is crucial in obtaining and sustaining wellness. Conspicuously missing is a fourth dimension that augments health – spirituality. At the World Health Assembly in 1998, a special group of the WHO Executive Board recommended the inclusion of spiritual wellbeing as an important determinant of health. This is no small consideration as it recognizes the importance of spirituality in the wellness and illness arena.

One aspect of health and self-care essentials for successful caregiving that is largely untapped is spirituality and the spiritual self. Both religion and spirituality are grounded in culture, steeped in traditional and contemporary influences, individual interpretation, and family and societal contexts. For some, religion, a formal expression of spirituality with codified beliefs, structure, a relationship with the divine, a religious text of tradition, and an organized community affiliation provides that connection. For others, the linkages are different, resonating in nature, art, music and other means, but always centering on the individual and the experience. The spirituality dimension calls attention to one’s inner spirit in connection with someone or something larger than themselves. There are numerous definitions for spirituality. In the palliative care community, the consensus definition of spirituality is “the aspect of humanity that refers to the way individuals seek and express meaning and purpose and the way they experience their connectedness to the moment, to self, to others, to nature and to the significant or sacred.”

It is assumed that people can be spiritual without professing a specific religion or belief system. Spirituality encompasses questions about how our existence and how we relate to the rest of creation, such as: “What energizes our lives?” “How do we explain to ourselves the things that happen in life?” “When do we feel most peaceful?” “How can we surmount life’s hardest challenges?” and “What does the future hold?” While these profound questions may remain unanswered, they facilitate a person’s quest for knowing and understanding even when uncertainty and lack of clarity prevails. As such, there is tremendous potential to capture the salient strengths that people find through religion and spirituality as a means of enlightenment, self-care, and resilience.

Researchers are only beginning to uncover the dimension of spirituality within the context of health and well-being. Koenig noted that to date, research studies have identified a positive relationship between religion/spirituality and health, and that only 10% of the studies show an inverse relationship whereas 25% of the studies show no association between religion/spirituality and health. Current research studies focus on religion/spirituality as it relates to different population groups (e.g., patients with cancer, dementia, or heart failure) and varied geographical locations or different healthcare settings. Improved self-esteem, well-being, hope, optimism, and a sense of personal control are positive emotions correlated with improved mental health and religion/spirituality.
examining the relationship between religion/spirituality and social health suggest greater social support for individuals. Physical health, represented by decreased risky behaviors and a healthy lifestyle, may lower the exposure to physical illness.\textsuperscript{9,10} Examining the relevance and impact of religion/spirituality continues to evolve.

However, the positive aspects of religion/spirituality and caregiving have not been widely studied. The potential to connect the elements of spiritual mindfulness, exploring life’s meaning, optimism for the future and finding daily happiness cannot be discounted. Healthcare professionals have a unique opportunity to integrate spiritual assessment, planning and interventions that support the patient and informal/family caregiver experiencing continuing illness and debility or at the end of life. In this paper, four pathways to spiritual strength and resilience for informal/family caregivers are proposed: searching for meaning, finding hope, addressing loss and grief, and seeking peace and happiness. Helpful information regarding assessing and addressing spiritual needs and communication resources are provided for the healthcare professional. The implications of self-care are addressed.

Searching for Meaning

Reflecting upon his own role as a family caregiver, Atul Gawande, MD calls to mind the vast landscape of caregiving challenges in today’s world. In his best-selling book Being Mortal: Medicine and What Matters in the End, Gawande challenges healthcare professionals to help patients in their quest to know what is important in life: to find meaning.\textsuperscript{11} As he masterfully unravels the complex context of today’s healthcare system, Gawande determines that what matters most is what matters to the person: a sense of purpose, the discovery of peace and finding meaning.

The root of deriving meaning emanates from the work of Victor Frankl. As a World War II holocaust survivor, Frankl wrote that suffering destroys man if there is no meaning.\textsuperscript{12} Within that context, an individual’s search for meaning, in good times and bad, evolves into the quest to relieve despair, generate hope and determine life’s purpose. Such may be the caregiver who searches for understanding and meaning in their current role.

Often our human existence drives the existential need to ascertain what brings meaning to life, and particularly when times are tough or uncertain. The quest for meaning may be a fundamental part of the caregiving journey. For example, in ordinary life stories of hospice patients and informal/family caregivers, spiritual themes emerge whereby individuals assign meaning and value in life, experience meaningful connections and move to a transcendent realm, a dimension beyond the self.\textsuperscript{13-15}

Creating self-awareness is the first step in building inner spiritual strength. Healthcare professionals have the unique opportunity to assist both patients and caregivers in exploring meaning and how to maximize their ability to understand this phenomenon through the means of compassionate presence, fed by positive regard and a supportive relationship that nurtures the spiritual self.\textsuperscript{16-19} Caregivers may benefit from interventions that facilitate their ability to find contentment in their caregiving experience, thereby improving their spiritual adjustment and quality of life.\textsuperscript{20} Interpersonal communication that centers on helping them to reframe their caregiving experience may help to reduce associated burden and stress, find meaning in their role and “hope in the midst of the storm.”\textsuperscript{21} Thus, hope becomes an essential part of the equation and an underpinning in creating the spiritual self.

Finding Hope

An Internet quote from noted author and transformative healer, Deepak Chopra, MD, states “You must find the place inside yourself where nothing is impossible.” Spiritual beliefs and practices are important components in how an individual defines hope, healing and the potential for peace as a true possibility.\textsuperscript{15} Finding ways to live with hope creates the simultaneous need to cope with uncertainty, ultimately challenging one’s beliefs. Researchers and self-help authorities continue to investigate and uncover how hope, even in uncertain and stressful circumstances, is relevant to the spiritual self and buoys inner strength to deal with life’s challenges.

Threats to hope are numerous, including isolation from social networks, questioning one’s beliefs, and the losses of health, income and potentially, companionship, which may lead to negativity and increased strain.\textsuperscript{22} Using the strengths-based family resiliency conceptual framework, researchers determined that family caregivers who were religious/spiritual, hopeful, and use effective coping strategies, experienced improved marital satisfaction.\textsuperscript{23} Within a palliative care context, caregivers who were prepared and coached in their role experienced higher levels of hope and felt more rewarded in a spousal caregiving relationship.\textsuperscript{24} Thus, fostering the hope pathway becomes an essential part of the spiritual self.

Addressing Loss and Grief

Grief is the reaction to loss.\textsuperscript{25} The response is personal and subjective, anticipated and perceived, but clearly real. Caregivers may experience numerous personal losses in their caregiving journey. The physical, emotional, and social losses may be theirs alone or those they witness in the person for whom they are caring. Informal/family caregivers may try to understand the “why me, why now?”, grapple with their caregiving identity, and seek to establish life-order during the grieving process.

Unlike older theories of loss and grief that were task or stage-oriented, contemporary theorists are recognizing the growth that a person can experience through meaning reconstruction and the resolution of current life circumstances.\textsuperscript{26} The concept of resilience, a “process where people bounce back from adversity and go on with their lives” is also instrumental in preserving function and moving forward.\textsuperscript{27,28} Boss’s work in ambiguous loss in caregivers of persons with dementia, whereby the person is physically present but mentally absent, tells us that hope is possible and coping with stress and grief necessitates a spiritual worldview, being “mindful of what
cannot be solved.” Thus building resiliency through loss and grief, can lead to personal and spiritual growth.

**Seeking Peace and Happiness**

Through enlightened spirituality, the benefits of the caregiving experience may generate a deeper connection and commitment to the person being cared for and an enhanced relationship. It may augment ones previously unknown self-awareness of strength and capabilities, and heighten the ability to attribute meaning and understanding when difficulties arise. Coping strategies become galvanized in the face of despair. In Gail Sheehy’s best seller, *Passages in Caregiving: Turning Chaos into Confidence*, the author described her experience in taking care of her husband for 17 years as “walking the labyrinth.” Sheehy relays that the labyrinth, with its abrupt twists and turns, actually has a defined path to the center. While the path was unpredictable for the author, it was also peaceful and fulfilling with a sense of hope, acceptance and purpose. Thus, reality becomes transformed, by recognizing the need for self-care, whole person-centeredness, and healing.

For some, the journey may be troublesome. Spiritual pain or distress is real. In its simplest sense, it is the loss of meaning and hope and it translates into fear of the unknown with a lack of purpose and direction. Individuals may experience abandonment, sadness and suffering. When spirituality has been threatened and healing hindered, suffering results. Suffering can be physical, with somatic manifestations, emotional; such as in depression and anger, behavioral, as with self-harm or isolation, or a combination of these. Suffering threatens the intactness of a person. Resolving these challenges requires a renewed sense of meaning through transcendence that capitalizes on one’s resources of inner strength and a sense of purpose. Even in times of greatest despair and suffering, deriving meaning enhances the spiritual self and serenity is achievable with a state of inner happiness and peace.

**Maximizing the Opportunity for Spirituality for Healthcare Professionals**

Healthcare professionals may feel awkward and uncomfortable when thinking, let alone doing anything about spirituality, or these four pathways, in the clinical setting. Challenged by their own self-doubt or reticence to discuss what is considered a personal topic, healthcare professionals may retreat when spirituality is broached by patients or is a necessity, as required in a care plan. Self-assessment of one’s spirituality and the existential dimension is necessary so to promote personal and professional growth and to recognize how this belief system may affect the caregiving experience. Spiritual introspection enables the healthcare professional to explore the spiritual dimension of wellness with and for patients and informal/family caregivers.

Patients report that they feel cared about when medical personnel are interested in their spirituality. However, they seem to prefer that such discussions occur in the context of ordinary conversation and human sharing. The same may be true for caregivers. Some healthcare settings, such as hospice and palliative care units, include spiritual assessment as an essential element of holistic care. Currently vetted standards and guidelines specify the importance and relevance of a spiritual assessment and addressing them through strengthening these pathways and managing distress when it occurs. The *Clinical Practice Guidelines for Quality Palliative Care* provide this mechanism with the expectation to access trained spiritual care services through organized spiritual counseling or the person’s own clergy for individuals in distress. An interdisciplinary approach is necessary to assess and address mechanisms to explore and promote spiritual wellness in informal/family caregivers. (See Table 1).

Here are some simple guidelines for discussing spirituality with a patient or informal/family caregiver:

1. Have the conversation. Be authentic and genuinely interested in learning about their religion/spirituality, leaving judgment aside. Listen with compassion and establish therapeutic presence to learn and understand. Complete a spiritual screening using a spiritual assessment tool such as FICA: ask about one’s Faith or Beliefs, the Importance and influence of their faith or beliefs, if they belong to a religious/spiritual Community and how the patient/caregiver would like their strengths and concerns Addressed. Healthcare professionals who become informed about the person’s spirituality can then provide a means to augment strengths and decrease distress.

2. It is believed that the Greek philosopher Epictetus said: "God gave us two ears and one mouth, so we ought to listen twice as much as we speak," dispelling the notion that talking is more important or valuable than listening. Remember that this is their story. Use empathic listening by creating a cognitive connection with the person’s feelings. Ask open-ended questions and listen in the spirit of seeking to understand the person, the experience, and their values. Listen to their fears, losses, grief, hopes, and dreams and what brings meaning to their life.

3. Seek to hear unspoken questions, fears, worries, the need for forgiveness and spiritual distress. Sometimes a person’s existential issues are not communicated in words. Some may have unspoken questions such as: “Will I be able to fulfill my dreams someday?” “Do you know how much I struggle?” and “Do I have the inner strength to conquer my fears and understand the unknown ahead?” Center on compassionate presence that is reflected in empathic listening, bearing witness, and being in the moment, allowing for further exploration to evolve.

4. Be inspired by the process. Immersion in these conversations can help healthcare professionals explore their own meaning or spirituality. With increasing familiarity, spiritual conversations can become part of everyday encounters in helping informal/family caregivers finding meaning, hope, peace and happiness and a resolve to help individuals deal with loss, grief, uncertainty, loneliness and spiritual distress.
Table 1. Assessing and Addressing Spirituality

Assessing Spirituality

As part of a vetted caregiver spiritual history process, conduct a spiritual assessment. Ask the person about their faith; formal religious practices and ways spirituality promotes self-care and health.

- If the person belongs to a specific faith, ask about formal religious practices, leaders and places of worship that offer strength, peace and fulfillment.
- Inquire as to how the caregiving experience has impacted his/her spiritual life. Use life review as a mechanism for assessing what brings meaning in their life, hope for the future and resolve in the caregiving relationship.
- Obtain insights on a person’s perspective of hope and its place in their perspective now and in the future.
- Ask about loss and grief and its relevance in the caregiving experience.
- Identify the means that the caregiver uses to buoy their day when they are troubled or down such as the creative arts, music, or humor.
- Inquire what means the caregiver uses for inner strength, including song, prayer, meditation or other rituals.
- Gather information on traditional healing practices that the person uses that could be augmented to improve spiritual health.
- Ask about internal and external sources of strength and ways of coping and self-care.
- Openly inquire about the presence of spiritual distress and coping skills when under duress and what brings peace and happiness.

Addressing Spirituality

- With the informal/family caregiver promote the utilization of self-care measures that stimulate spiritual connections and inner strength.
- Explore with the person ways to maintain and sustain a positive outlook and hope in the face of adversity.
- Help the person to enumerate and focus on pleasant events and current joys.
- Consider sharing with caregivers’ ways to use positive affirmations and expressions of gratefulness as a mechanism for daily reflection and inner joy.
- Encourage caregiver connectedness with other individuals who provide strength and support, as able and beneficial.
- With the caregiver, explore the use of spiritual healing practices that support person-centeredness and meaning.

- Identify and help the caregiver to use spiritual self-care methods that promote peace and happiness.
- Establish compassionate presence and reaffirm with the person that his/her life has meaning.
- Engage other professional healthcare team members to implement a care plan that supports spirituality within the goals of care.
- Gather and relay community spiritual and supportive care resources to the person.
- Advocate for the caregiver to reach-out to a faith-based community for support/guidance.
- Use pastoral care teams, chaplaincy services, or religious from local community churches, temples or mosques to assist in working with patients and/or caregivers to strengthen spirituality, reconfirm beliefs and manage spiritual distress.

Summary

The caregiving journey is unique with challenges and accompanying opportunities for spiritual growth and fulfillment. Spiritual wellness is an important health outcome when healthcare professionals work with informal/family caregivers and patients. Through creating awareness, facilitating the quest for meaning, elevating hope, managing life’s challenges, loss and grief, and seeking peace and happiness, the spiritual self evolves. Possessing the requisite tools, such as creating compassionate presence and using empathic listening can help the healthcare professional masterfully understand their own spirituality and the prospect to explore this with informal/family caregivers.

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Mindfulness Strategies that Revitalize Internal Awareness and Self Care

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This article suggests some ways that mindfulness can be incorporated into self-nurture and resilience-building practices of people who are caring for individuals with dementia. The article provides a brief overview of the science on stress as it relates to caregiving, mindfulness as an evidence-based approach to reducing caregiving stress, and gives specific practical applications of mindfulness for caregivers to try.

Stress and Caregiving

In addition to coping with a loved-one’s illness and providing care, caregivers are subject to declines in their own health and well-being. The negative effects of stress on immune and cognitive function in informal caregivers have been documented. Family caregivers are subject to significant declines in physical functioning and higher morbidity rates compared to non-caregiving peers. Chronic stress endured by spousal caregivers has been shown to promote premature aging of the immune response, with related compromise persisting years after caregiving roles have ended. Similarly, in both younger and older adults, chronic stress is associated with compromised cognitive functioning, immune suppression, and degenerative changes in brain structures responsible for storing new information. Landmark studies suggest such consequences may stem from the effects prolonged stress exerts at a cellular level, specifically targeting genetic markers of biological aging.

Within our rapidly aging society, the sheer number and scope of costs associated with caring for individuals with Alzheimer’s disease is sobering. In 2000, 4.5 million Americans carried a diagnosis of Alzheimer’s disease (AD). The prevalence of Alzheimer’s disease is expected to increase by 27% in 2020, by 70% in 2030, and by 300%, afflicting 13.2 million Americans, by 2050. Advances to slow degenerative progression, as well as treatments improving survival of individuals with other age-related disorders may further extend the length of time in the caregiving role.

Emotional costs, particularly depression and stress, are extremely high among those caring for individuals with Alzheimer’s disease. Adult children providing 36 or more hours of care per week experience twice the rate of depression and anxiety symptoms as non-caregiving peers; in spouses the rate increases six-fold. Other health-related costs to caregivers

Mindfulness-Based Stress Reduction

Mindfulness-based stress reduction (MBSR) is a structured education program founded in 1979 by Jon Kabat-Zinn at the University of Massachusetts Medical Center. The initial program was designed for patients with chronic medical conditions, with the intention of teaching individuals a means of enriching their lives through adaptive coping, focused attention, and a new way to view problems and difficulties, similar to cognitive restructuring.
MBSR education centers upon mindfulness meditation training to enhance individuals’ ability to cope with stress, pain and illness. Mindfulness meditation is specifically intended to deepen the capacity for attention and strengthen present-moment awareness. Underlying precepts are perhaps best described in this way: “Each moment missed is a moment unlived (and)...makes it more likely I will miss the next moment...cloaked in mindless habits of automaticity of thinking, feeling, and doing rather than living in, out of, and through awareness.” (Kabat-Zinn, 2005).15 Thus the ultimate goal of MBSR is to empower individuals with a means of responding consciously (i.e. with full attention) rather than automatically, to both internal and external circumstances. Such responses are useful whether the event is associated with urgent or routine matters, pain, or stress as well as positive experiences such as joy, self-efficacy, and caring. In this way, conscious responses to stressful or otherwise meaningful events are cultivated by strengthening skills that facilitate focused attention.

MBSR training is currently integrated into a number of academic medical centers, producing clinical services of considerable patient demand as well as an ever-expanding body of empirical research. Since the benefits of stress reduction and heightened attention go beyond those sustained in patient populations, an increasing number of healthy individuals, professional organizations, business leaders, and championship athletic teams have participated in or implemented MBSR programs.

Empirical Findings of MBSR Interventions and Education/Training

Mindfulness-based stress reduction has been found to successfully reduce stress and its symptoms in people with breast and prostate cancer, cardiovascular disease, chronic pain, fibromyalgia, rheumatoid arthritis, diabetes, insomnia and other stress-related conditions.18-32 Similarly, significant improvements have been reported in coping skills, immune function, depression, and reductions in disabling symptoms of stress among clinical and healthy populations completing MBSR programs.32-40

Practical Applications

Focusing the attention on the present moment takes away the power of the past to drag us into rumination, and eliminates the pull of the future to take our minds toward worry and anxiety. In this way, practicing mindfulness and attention to the present moment creates the opportunity to respond to the current situation with more objectivity and choice, often resulting in less anxiety, depression and reactivity. Attention-focusing practices are beneficial in many situations and can be easily transferred to such ordinary activities as walking, eating, sitting, preparing for a meal, answering a phone, and even breathing. If we bring our practice with us everywhere we become more alert and alive to all of our daily experiences. Here are six foundational aspects of a mindfulness practice that are good to remember and use every day.

1. Non-judging: be an impartial witness to your own experience
2. Patience: sometimes things must emerge on their own time
3. Beginner’s mind: be willing to see everything as though you’re seeing it for the first time
4. Trust: listen to your own inner self
5. Acceptance: seeing things as they actually are at the present time
6. Letting go: our minds want to hold on to thoughts; release them

For a much more in-depth exploration, many resources are readily available.13-15

When we approach our daily lives through a lens of non-judgment and self-awareness, we experience our world in a whole new way. Becoming more mindful and in the moment provides us with the skills of authentic presence and compassion. Beginner’s mind reflects cultivating a willingness to see everything as if for the first time, and being open to new possibilities. Trust includes recognizing your own authority, intuition, and feelings, even when you make mistakes. A focus on acceptance allows us to see and accept our situation as it is rather than how we wish it was. Acceptance fosters clarity for action. Letting go also allows us to accept our present situation and move forward in a calm and nonjudgmental way.

Some techniques that may help in mindfulness practice include: (a) focusing on the breath; (b) paying attention to the body; (c) using a strategy of intentional awareness of eating; (d) being mindful of movement; (e) concentrating on positive communication; (d) increasing awareness of the senses; (f) implementing mindfulness in everyday routines; and (g) expressing gratitude. 13-15 In a mixed methods study of brief mindfulness training on caregivers well-being, the authors outlined similar but abbreviated techniques in which 11 caregivers completed 4 hours of mindfulness training. These researchers recognized that caregivers have limited time for stress management and modeled their study after Klat, Buckworth and Malarkey’s low-dose MBSR17, using an abbreviated protocol of 4 1-hour sessions held on consecutive weeks. Data were gathered pre-intervention, and post-intervention. Qualitative interviews were also conducted 1month after the intervention. Session 1: Instant Mindfulness included a brief exercise called “Three Breaths.” Emphasis by the instructor was on helping the caregivers to move from their busy world of “doing” to a calmer world of “being.” Session 2, “Safe Harbor” focused on teaching participants to visualize an inner safe harbor and inner signal that can be called upon to move from stress to calm anytime. The other two sessions focused on walking meditations.8 Reported findings from this study of brief mindfulness training included “ . . . increased acceptance, presence, peace, and hope, and decreased reactivity and caregiver burden.” A more extensive discussion of these techniques and the findings are presented in the report.16

Conclusion

Caregiving is often an act of sacrifice, placing another’s needs first. As it turns out, that sacrifice over the long term can have detrimental effects on the person providing the care. However,
there are practical ways to increase the opportunities for self-care and resilience, even in the course of a busy day (and often night) of caring for another. Mindfulness has been shown to be a very valuable, effective and practical approach in providing in the moment self-nurture and resilience building. The research on mindfulness and health continues to expand very quickly, most notably having positive impacts on physical, emotional and cognitive health. The practices outlined in this article are generally essential elements in mindfulness courses, while it is perhaps preferable to attend an in-person course, it is also understood that caregiving roles often leave little time for these endeavors. The practices in this article are offered as a way to enter into or return to the practice of mindful living, and are done so with a humble and sincere salute to the individuals who provide heroic acts of caregiving every day.

References


Empowering Motivation to Reduce Sedentary Time in Older Adult Caregivers

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This manuscript provides a perspective on the health risks and consequences of reduced physical activity and sedentary behavior, and offers practical guidance for clinicians to promote physical activity as self-care among older adult caregivers. While caregiving can be a positive and rewarding experience for the caregiver, inattention to self-care needs may result in reduced physical activity. Motivational strategies for encouraging self-care as physical activity include: 1) caregiver self-assessment, 2) personal goal-setting, 3) recognition and utilization of social contextual and environmental resources in the caregiving environment, 4) appraisal of readiness for change, and 5) encouragement of self-regulation strategies to track increases in physical activity and reduction in sedentary time.

Key words: empowerment, motivation, older adult caregivers, physical activity

The United States population is aging at an unprecedented rate. In 2014, the life expectancy at birth was 76.4 years for males, and 81.2 years for females. The youngest of the Baby Boomer generation will have turned 65 by 2030, shifting the age structure from 13% of the population over age 65 in 2010 to 19% in 2030. Given the incidence of chronic disease, comorbid conditions, Alzheimer’s and other forms of dementia presenting in an aging population, individuals will require additional care, and many will choose to receive that care in the home.

According to a 2015 study targeting U.S. caregivers, an estimated 39.8 million Americans are now caring for an aging adult, and approximately 34.2 million Americans have provided unpaid or informal care to an adult older than 50 years of age in the prior 12 months. The majority of caregivers are female and providing care for a spouse; a growing number of older adult caregivers are 75 years of age or older.

Caregiving can be a rewarding experience, but may also result in negative health consequences. Caregiving for older adults has been associated with increased levels of stress, impaired physical health and immune system function, as well as depression, anxiety, and anger, and increased mortality. Caregiver health may be compromised due to lack of self-care, particularly as related to physical activity. Older caregivers who spend more time providing care are more likely to be sedentary, and are less physically active outside of their caregiving roles.

Regular physical activity is known to mitigate or reduce the risks of cardiovascular disease, diabetes, metabolic syndrome, and reduce overall morbidity and mortality. However, many older adults find it difficult to initiate and maintain a regular physical activity practice. The stresses and demands of caregiving may make it more difficult to meet recommended levels of moderate to vigorous physical activity. Older adults have reported barriers to engaging in regular physical activity, including physical limitations, lack of social support, concerns about ability or competence, low self-efficacy for self-care and physical activity, lack of time, fear of falling, and low motivation for physical activity. Indeed, interventions designed to promote physical activity maintenance behaviors have been generally unsuccessful.

A shift in perspective related to physical activity has occurred, suggesting that encouraging older adults to sit less may result in significant health benefits. The study of sedentary behavior is a newly emerging, innovative focus on physical activity and health, with sedentary activities characterized as those that do not increase energy expenditure above resting metabolic levels. Middle aged and older adults spend more than 50% of their waking hours performing sedentary activities, such as sitting, resting, lying down, working at a desk, and watching television or movies.

Sedentary behavior is independently associated with weight gain, obesity, metabolic syndrome, and increased cardiovascular risk. Adults who are engaged in sedentary time for 4.5 or more waking hours per day on average have a forty percent greater risk of mortality than those who are not sedentary. Further, a gradient effect exists whereby morbidity and mortality risks are higher in those engaging in greater amounts of sedentary behavior, with the risks being independent of regular moderate to vigorous physical activity. Among adults followed over 6.5 years, high levels of TV time were significantly associated with increased all cause and cardiovascular disease mortality. There was a 46%...
increased risk of all cause and an 80% increased risk of cardiovascular disease mortality in those watching four or more hours of TV per day, independent of traditional risk factors. Increases in TV viewing over five years predicted significant adverse changes in waist circumference for men and women, and in diastolic blood pressure and clustered cardio metabolic risk score for women, independent of baseline physical activity and physical activity.31,32 Objective measures support the adverse impact of prolonged sedentary time on cardio-metabolic biomarkers of risk. Owen and colleagues found that sedentary time, defined as accelerometer counts below 100 per minute, was associated with a larger waist circumference, adverse 2-h plasma glucose and triglyceride profiles, as well as clustered metabolic risk score.34

**Interventions to Reduce Sedentary Behavior**

Behavioral research targeting interventions to reduce sedentary behavior is less developed, especially so for adults.35 In a review of physical activity and sedentary behavior interventions in reducing sedentary time, Prince and colleagues found that interventions focused on sedentary behaviors resulted in clinically meaningful reductions in sedentary time, however the quality of the evidence was moderate.18 Key strengths of intervention studies relate to their emphasis on (a) identification of activity approaches including breaks in sedentary behavior, and (b) use of objective measurement approaches to capture sedentary behavior.39,40 Individual motivations and preferences, family and broader social circumstances, the normative climate of the neighborhood and social networks, and the material resources available are important elements that can influence sedentary behavioral choices.36 Everyday movements may provide an innovative and feasible approach to promoting light intensity activities as a way of addressing the health consequences of sedentary time.30,37

**Everyday Movement--Non-exercise Activity Thermogenesis**

Everyday movement has been identified as a promising approach to addressing sedentary behavior and associated health risks. Everyday movement reflects the kinetic energy expended in everyday activities of living, including standing, walking, and upright postural movement; “little movements” rather than purposeful exercise.29,30,38 Light intensity (1.9-2.9 METs) activities are important in maintaining energy homeostasis; supporting the mass of the body in combination with spontaneous movement or low grade ambulation consumes around 1.5-2.5 times more energy than sitting-based activities and is associated with positive health outcomes.39,40 Using data from the 2005-2006 National Health and Nutrition Examination Survey (NHANES), Buman showed that for every 30 minutes of sedentary behavior reallocated to light physical activity there was a 2-4% improvement in biomarkers of risk; 90 minutes of sedentary behaviors reallocated to light physical activity resulted in a 6-12% improvement in biomarkers of risk.31 Accelerometer measurement studies show that breaks in sedentary time, distinct from the overall volume of time spent being sedentary, have beneficial associations with metabolic biomarkers including waist circumference and body mass index.42,43 Breaks in sedentary time can include behaviors that result in a transition from sitting to a standing position or from standing still to beginning to walk.

Older adult caregivers may be active during the time they are providing physical care or assisting in activities of daily living, but are often otherwise sedentary.44 Since sedentary time is an independent risk factor for cardiovascular disease, it is possible to meet the physical activity guidelines while still having excess sedentary time that poses a health risk. Reducing sedentary behavior by a variety of approaches to promote everyday movement responds to health promotion in a unique way, suggesting that engaging in lower intensity activities simply by avoiding or moving away from sedentary ones also are beneficial to health. Focusing on reducing sedentary time through engaging in everyday movement may also help mitigate some of the perceived barriers (available time, pain, fatigue, low motivation, fear of falling) to engaging in more vigorous forms of physical activity, especially in highly vulnerable older adult caregivers. Thus, anyone can benefit from reducing their sedentary time and engaging in more low-intensity everyday movement.

Many older adults do not meet the recommended guidelines for physical activity, but they can still be more active than they otherwise would through engaging in more everyday movement, based on valued goals for their own health.18 Reduction of sedentary behavior and encouragement of everyday movement at the lower spectrum of energy expenditure represent a new paradigm in health promotion. From a practical perspective, if older caregivers have challenges in being more physically active, perhaps switching the mindset to the idea that one could be less physically inactive could encourage valued activities to “keep moving”, or at least sitting or resting less.

**Motivating Older Adult Caregivers to Engage in Everyday Movement**

Health care professionals and clinicians can provide older adult caregivers with practical, theory-based strategies and techniques for reducing their sedentary time and increasing everyday movement. Such interventions empower older caregivers to improve and maintain their own health as they take on increased responsibilities in the care of others.

**Wellness Motivation Theory** The wellness motivation theory (WMT) provides an appropriate theoretical perspective for delivering these message points. The WMT aims to foster and empower social contextual resources and behavioral change process skills.45 This theory conceptualizes the process of behavioral change within culturally and environmentally relevant contexts, while recognizing the bidirectional influence of personal and environmental factors on behavioral patterns. The WMT addresses individual motivation and goals, processes of behavioral change, social support and norms, and community and material resources that influence behavioral choices, and has empirical support in promoting physical activity.46,47 Social network support, empowering education, and motivational support are intervention strategies directed toward facilitating the development of social support and community resources, as well as improving behavioral change processes of self-
knowledge, motivation appraisal, and self-regulation. Social contextual resources, self-knowledge, motivation appraisal and self-regulation are key theoretical concepts, reflecting the mechanisms through which individuals create and evaluate valued goals, establish personal standards for behavior, determine strategies for change, and strengthen and regulate patterns of behavior over time.45,48

Tips for Promoting Everyday Movement Among Older Adult Caregivers

There are some tips as well as intervention strategies for clinicians who would like to encourage older adult caregivers to reduce their sedentary time and increase everyday movement for their health. Specific message points derived from the literature on sedentary behavior suggest that individuals should take breaks from sitting every 20 minutes, and not be in a seated or lying down position for more than 4.5 waking hours per day. Types of everyday movement include activities such as mild housework, activities of daily living, standing, low intensity walking, stretching, low intensity yoga, gardening, and moving from seated to standing positions, and replacing sitting time with low level movement.

Intervention strategies include social support, empowering education, and motivational support for caregiver: 1) self-assessment and self-knowledge; 2) personal goal-setting 3) recognition and utilization of personal, social, community, and environmental resources; 4) readiness for change; and 5) self-regulation to promote behavior change maintenance. These intervention strategies are certainly not exclusive to older adult caregivers, and are beneficial for anyone who would like to change or modify a health behavior, in this case, sitting less and moving more.

Five easy messages that clinicians can provide to caregivers to help them decrease their sitting time include the following:

<table>
<thead>
<tr>
<th>Step</th>
<th>Message</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Assess your self (Self-assessment, self-knowledge)</td>
</tr>
<tr>
<td>2.</td>
<td>Make a plan (personal goal setting)</td>
</tr>
<tr>
<td>3.</td>
<td>Identify your resources (social contextual resources, environment)</td>
</tr>
<tr>
<td>4.</td>
<td>Take a stand—then do your plan (motivational appraisal-readiness)</td>
</tr>
<tr>
<td>5.</td>
<td>Monitor your progress (self-regulation)</td>
</tr>
</tbody>
</table>

Conclusion

Caregiving can be a rewarding experience, but may also result in negative health consequences. Caregiver health may be compromised due to lack of self-care, particularly as related to physical activity. Older caregivers who spend more time providing care are more likely to be sedentary, and are less physically active outside of their caregiving roles. A shift in perspective related to physical activity has occurred, suggesting that encouraging older adults to sit less may result in significant health benefits. Motivational strategies for encouraging self-care as physical activity include: 1) caregiver self-assessment, 2) personal goal-setting, 3) recognition and utilization of social contextual and environmental resources in the caregiving environment, 4) appraisal of readiness for change, and 5) encouragement of self-regulation strategies to track increases in physical activity and reduction in sedentary time.

References


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16. McMahon S. Enhancing Motivation for Physical Activity to Reduce Fall Risk Among Community Dwelling Older Adults. ProQuest UMI Dissertations Publishing; 2012.


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Conducting Family Meetings
Ishna Poojary MD, Cara Levin BS BA, and Linda Snyder MD, University of Arizona College of Medicine

Family meetings play an important role in the care of seriously ill hospitalized patients and patients with advanced disease. The meetings help identify patient-centered goals and guide decision making. They also improve patient’s and family’s satisfaction with their care.

What is the Purpose of a Family Meeting?
Family meetings are an opportunity for the patient, family, and health-care team to share their knowledge and concerns about all facets of a patient’s care including physical and psychosocial aspects. Family meetings can prevent fragmentation of information in a rapidly changing clinical environment. They can also minimize misinformation, assist in care transitions, help patients and families navigate complex medical decisions, and provide support for those facing serious life-limiting diseases.

When is it Appropriate to Have a Family Meeting?
There are many situations in which a family meeting should be considered as part of a patient’s care. They include the need to share prognosis, explain changes in clinical status, or discuss the need to revisit care goals. It is particularly important to hold a family meeting, and to do so early in the course of care, when a patient is at high risk of dying. Family meetings are also helpful when there has been fragmentation of care, frequent readmissions, and/or situations causing family stress and anxiety.

Another important trigger for a family meeting is when your answer is “no” to the following question: “Would I be surprised if this patient died within the next year?”

Format of an Effective Family Meeting
It is important that family meetings include decision makers (e.g., medical power of attorney) and all pertinent stakeholders in the decision making process. It can also be helpful to ask the patient (if communicative) who they want to be present and to identify who they want to be a spokesperson to relay information to extended family or friends. Once participants are identified, several steps should be followed for effective family meetings:

Step 1. Prepare. Before the meeting you should have a solid foundation of knowledge about the patient, review advance care planning documents, and reconcile opinions and recommendations from inter-professional team members.

Step 2. Setting. Hold the meeting in an appropriate setting, assuring privacy and seating for all present, and making sure that phones and pagers are silenced.

Step 3. Introductions/Goals. Have all participants introduce themselves and identify their relationship to the patient. This is also a time to review your goals for the meeting and ask if the family has additional expectations.

Step 4. Assess Understanding. Assess what the patient and family know and how much they understand about the patient’s medical situation. As an example, you can ask the patient to “tell us how things have been going over the past few months” or ask the family to “tell us what you understand about [your family member’s] medical condition.”

Step 5. Review Medical Condition and Prognosis. Once you have learned the patient’s and family’s level of understanding, you can present accurate information about the patient’s medical condition. This should include succinctly outlining the current clinical situation, anticipated risks, and expected outcomes and prognosis. These explanations must be given in plain language, without medical jargon and technical detail.

After providing this information, it is important to give the patient and family time to react and ask questions. You also should allow time for silence as family members absorb what you have told them. Empathetic statements and clarifying misunderstandings is often necessary and useful. Be prepared for emotional reactions and questions.

Step 6. Present Management Options. It is important to present treatments that align with the patient’s goals and values. If the patient has decision-making capacity, you can ask the patient “what decisions are you considering?” and then continue to discuss goals, options for care, and

TIPS FOR CONDUCTING FAMILY MEETINGS
- Prepare for the meeting by thoroughly reviewing the patient’s history and current condition. Hold the meetings in private, with phones and pagers turned off.
- Assess the patient’s and family’s understanding about the patient’s medical condition, and when explanations are needed, give them in easy-to-understand language without medical jargon.
- Present management options that align with patient’s and family’s care goals.
trade-offs based on what the patient has told you. If the patient does not state clear goals, you can help the patient develop goals by inquiring about what is important to the patient.

If the patient lacks decision-making capacity, you will need to explain the concept of surrogate decision making to the family and use known or expressed patient values and goals to establish a care plan. Often, this requires that you ask questions such as “what would your loved one say or think about her serious illness and current condition?”

Either way, you will often need to make medical recommendations based on your knowledge and experience. But, a shared decision-making strategy is generally the preferred approach.

**Step 7. Formulate a Care Plan.** Further discussions center on translating the patient’s and family’s goals into a treatment plan. This will often include discussions about whether it is appropriate to perform cardiopulmonary resuscitation, additional diagnostic tests, or interventional treatments. The language used in discussing the plan is important and some tips for discussing goals of care are outlined in Table 1.

**Step 8. Review the Plan and Document.** At the close of the meeting, review what will be done to achieve the patient’s goals and what will indicate if goals are being met and/or if the patient’s condition is changing. If necessary, schedule a follow up meeting and be sure to document all discussions in the medical record. Encourage the family to consult with important people in their life (e.g., religious leaders or other family members) not present at the meeting.

**Useful Mnemonics**

Finally, there are several useful mnemonics that can help guide you through the key aspects of family meetings. These mnemonics (SPIKES and VALUE) are outlined in Table 2.

### Table 1. Language to Use and Avoid When Formulating Care Plan

<table>
<thead>
<tr>
<th>Statements to Avoid</th>
<th>Preferable Alternate Statements</th>
</tr>
</thead>
<tbody>
<tr>
<td>There is nothing more we can do.</td>
<td>We will do everything we can to treat your symptoms and support you and your family.</td>
</tr>
<tr>
<td>We will do everything</td>
<td>We know we can’t slow down the disease, but there is a lot we can do to help you feel more comfortable.</td>
</tr>
<tr>
<td>What is most important to you now?</td>
<td>I recommend stopping those treatments that will not help to reach your goals.</td>
</tr>
<tr>
<td>I recommend that we withdraw care.</td>
<td>I recommend stopping those treatments that will not help to reach your goals.</td>
</tr>
<tr>
<td>Do you want us to shock your heart and put you on a breathing machine?</td>
<td>We want to do treatments that are likely to help in your situation. A breathing machine and shocking your heart won’t help because they won’t stop your disease and may lead to more suffering.</td>
</tr>
</tbody>
</table>

### Table 2. Mnemonics to Aid in Family Meetings

<table>
<thead>
<tr>
<th>SPIKES (from Buckman reference below)</th>
<th>VALUE (from Lautrette reference below)</th>
</tr>
</thead>
<tbody>
<tr>
<td>S-Set up meeting: do what you need to prepare</td>
<td>V-Value family statements</td>
</tr>
<tr>
<td>P-Perceptions: find out patient/family perceptions</td>
<td>A-Acknowledge family emotions</td>
</tr>
<tr>
<td>I- Invitation: invite information sharing and preferences</td>
<td>L-Listen</td>
</tr>
<tr>
<td>K-Knowledge: give information in easy-to-understand terms</td>
<td>U-Understand patient as a person by asking questions</td>
</tr>
<tr>
<td>E-Empathy: respond to emotion with empathic statements</td>
<td>E-Elicit family questions and concerns</td>
</tr>
<tr>
<td>S-Summarize: outline next steps and plan of care</td>
<td></td>
</tr>
</tbody>
</table>
Discussing Cognitive Aging with Patients and Families
Tigist Hailu, Penn Memory Center, University of Pennsylvania and Oluwatobi Akindoju, Yale College

What is Cognitive Aging?
The term cognition refers to a wide array of mental capabilities. They include, but are not limited to, memory, decision-making, processing speed, wisdom, and learning. Cognitive aging is the process of cognition changing over time. It occurs in all individuals over their life span and is not explained by neurologic or psychiatric disorders.

Cognitive aging generally refers to age-associated decline in an individual’s “fluid intelligence,” which is the ability to reason, think logically, and find solutions to novel problems. It differs from “crystallized intelligence,” which has to do with the ability to use learned skills.

Cognitive aging has both positive and negative effects. Older adults might experience lapses in memory or difficulty learning new material. But, they tend to experience few of the negative emotions often associated with youth, such as anger and worry, and commonly report higher general life satisfaction.

When discussing the topic of cognitive aging, it is important to convey that it is a complex process that affects all individuals, but does so in unique ways. The process of cognitive aging is highly variable from person to person, and can change from year to year.

It is also important to recognize that cognitive aging is often asymptomatic, and thus it is not always obvious that it is occurring. Over time, however, these cognitive changes can influence the ability of a person to perform regular activities, such as driving, taking care of personal finances, and following medical prescriptions. For individuals and families dealing with cognitive aging, it is important to overcome misconceptions, seek knowledge, and take action to promote cognitive health.

How is Cognitive Aging Measured?
Measures of cognition that can detect subtle changes over time are difficult to standardize because of many factors, such as culture, education, literacy, that can influence test performance. In addition, the cognitive measures used might not represent real-life situations that demonstrate whether cognitive aging has an effect on daily function.

Despite these limitations, cognitive tests can provide insight into the underlying mechanisms behind age-associated changes in cognition. (Table 1) These tests are particularly useful when assessments are made on several occasions over time.

When selecting a cohort to study for an assessment of the effects of cognitive aging, remember the importance of the cohort’s composition. The goal should be to have a diverse representation of older adults from various ethnicities, education levels, socioeconomic levels, etc. Most importantly, a study on cognitive aging should not include individuals with conditions that impair cognition, such as Alzheimer’s disease. The changes in cognition that occur with these diseases are distinct from changes seen in cognitive aging.

<p>| Table 1. Examples of Cognitive Assessment Instruments |</p>
<table>
<thead>
<tr>
<th>Assessment Instrument</th>
<th>What It Tests</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pattern Comparison Processing Speed Test</td>
<td>Speed of processing</td>
</tr>
<tr>
<td>Connors Continuous Performance Test</td>
<td>Sustained attention</td>
</tr>
<tr>
<td>Stroop Test</td>
<td>Selective attention</td>
</tr>
</tbody>
</table>

**TIPS FOR PROMOTING COGNITIVE HEALTH**
- Avoid prescribing medications to older adults that can interfere with cognitive function. Many medications, notably those listed on Table 2, can have negative short-term and/or long-term effects on cognition.
- Physical exercise and cardiovascular health are critical to maintaining cognitive health as adults get older. Encourage some form of physical activity every day.
- Encourage patients to get adequate sleep and address any disorders that might be interfering with sleep.
- Encourage older adults to participate socially in their community and to seek out opportunities to learn and keep mentally active.
Why Cognitive Aging Is Important

Older Americans are an increasingly large and active segment of our population. Thus, cognitive aging has become important to the overall health of many communities. Research on cognitive aging has the goals of finding ways to improve cognitive health, inform populations about the importance of maintaining cognitive health, and eliminate stigmas surrounding the process of cognitive aging.

Steps to Protect Cognitive Health

It is necessary to disseminate research findings and engage the communities in discussion about cognitive health, and to do so in ways that are culturally acceptable and understandable. Research shows that individuals can take specific actions to improve their cognitive health and limit decline.

One key action is to remain physically active. Exercise has been shown to promote healthy cognition in older adults. Secondly, a reduction of cardiovascular risk factors, like hypertension and diabetes, can support cognitive health. In addition, the careful management of medication, particularly those that have been shown to have an effect on cognition (Table 2) is key to protecting cognitive aging.

Future Directions for Cognitive Aging Research

Research in factors that affect cognitive aging can be used in to create "age-friendly" communities that are welcoming for people of all ages and ability levels. Significant focus should be put on ease of mobility and access, as well as general community education on how to promote healthy cognition as a person ages.

Increased mobility and access to amenities (such as parks, fresh grocers, libraries, and gyms) provides seniors increased opportunity to participate in physical activity, eat healthily, and engage socially in their communities. This is important, as it makes the environment more conducive to cognitively healthy lifestyles, and is inclusive of community members of all ages. Indeed, these factors are very important in creating a community where cognitive health is encouraged.

Table 2. Common Medications That Can Impair Cognitive Function

<table>
<thead>
<tr>
<th>Anticholinergics</th>
<th>Digoxin</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antihistamines (first generation)</td>
<td>Non-Benzodiazepine Sedative Hypnotics</td>
</tr>
<tr>
<td>Antipsychotics</td>
<td>Opioids</td>
</tr>
<tr>
<td>Benzodiazepines</td>
<td>Tricyclic Antidepressants</td>
</tr>
</tbody>
</table>

References and Resources


Nearly 2 million older adults die each year in the United States. Many of the most common causes of death for older adults are life-limiting chronic illnesses, such as heart disease, cancer, chronic lung disease, dementia, diabetes, and chronic kidney disease.

**What is Preparatory Grief?**

Patients with these diseases may not initially recognize them as life-limiting, but disease progression will eventually bring this realization. Preparatory grief is defined as the cognitive, emotional, and spiritual responses to the understanding that one has a life-limiting disease - that death is approaching.

Patients may grieve for the loss of life itself, for the loss of small pleasures like their morning cup of coffee or their familiar routine. They may also grieve for what the loss means to those around them, for a grandchild they will never see grow up or a spouse they must leave behind.

The degree of preparatory grief that a patient will experience partially depends on factors such as their age; experience with loss; their diagnosis and treatment plan; and their religious and cultural beliefs. To provide patients with quality end-of-life care, an understanding of preparatory grief is necessary. The interweaving of curative care, palliative care, and preparatory grief in chronic illness is shown in Figure 1.

**Underestimating Preparatory Grief**

Health care providers routinely underestimate the amount of distress and preparatory grief that patients undergo. Many health care providers are either unaware of preparatory grief, or avoid assessing or discussing it with patients. However, research shows that patients are frequently willing and desire to talk about the grief process they are going through. Advanced preparatory grief is frequently confused with depression, and patients may be inappropriately treated for depression.

**TIPS FOR DEALING WITH PREPARATORY GRIEF**

- Don’t underestimate or discount the possibility of preparatory grief. It is a common experience for patients who have terminal illnesses.
- Allow patients to self-reflect, acknowledge their losses, and discuss their relationships, accomplishments, and missed opportunities.
- Be sure to distinguish preparatory grief from depression. Differences are listed in Table 1.
- Use the RELIEVER mnemonic to guide your conversation with patients who are experiencing preparatory grief.
Assessing Preparatory Grief

Patients at all stages of a chronic disease should be asked questions like “How do you think this disease will affect your future?” or “How does this disease affect the way you think about your future?” The goal is not to force patients to understand that their disease is life-limiting or to break down their “denial.” Rather, it is a good place to start to assess where they are in terms of thinking about their disease progression or the possibility of death. Also ask patients about the way they are feeling about their disease and about their health in general. Ask them about how it affects their lives. Allow patients to vent their frustration with the losses that any disease brings – loss of function, independence, and privacy.

Remain alert for emotional responses such as sadness, anger, anxiety, or regret that may indicate preparatory grief. Research has shown that in patients with preparatory grief, anxiety is the most common emotional response, and if extreme or prolonged, may require treatment with counseling and/or medication.

Distinguishing Preparatory Grief from Depression

Severe depression is not a normal part of preparatory grief. If patients indicate that they have lost all joy in life, are apathetic, or indicate a desire for death, further probing for depression is required. Inquire about their average mood, whether they are able to enjoy daily life, whether they continue to enjoy previously cherished activities and whether they are having any thoughts of suicide. Anhedonia, apathy and suicidal ideation are all indicators of depression and should prompt intervention with counseling and medication. Table 1 contrasts preparatory grief with depression.

Helping Patients with Preparatory Grief

Once you have ruled out depression, you can use the RELIEVER mnemonic as a way to help patients deal with their preparatory grief.

- Reflect by acknowledging the patient’s emotions. Say something like “I can see that you are sad.”
- Empathize, by saying something like “I know this is hard for you.”
- Lead by exploring the patient’s concerns with questions like “What concerns do you have about how your loved ones will cope after you are gone?”
- Improvise by keeping in mind that every patient will experience preparatory grief in an individual manner. Some patients may be more open than others in discussing their grief.
- Educate patients by explaining the grief process and the emotions that accompany it.
- Validate the experience, by reminding patients that their grief is completely normal.
- Recall by helping patients celebrate the life they have lived, and recognize any tasks they still want to complete.

It may also help the patient to discuss practical concerns that arise at the end of life. These include managing symptoms, reconciling differences with family members, financial concerns, and advanced directives.

References and Resources


Table 1. Differentiating Grief and Depression

<table>
<thead>
<tr>
<th>Preparatory Grief</th>
<th>Depression</th>
</tr>
</thead>
<tbody>
<tr>
<td>Waxes and wanes</td>
<td>Consistent sadness</td>
</tr>
<tr>
<td>Sadness about death</td>
<td>Suicidal ideation or active desire for death</td>
</tr>
<tr>
<td>Specific anxieties about dying process and loved ones left behind</td>
<td>Vague pervasive anxieties</td>
</tr>
<tr>
<td>Continued ability to take pleasure in favorite activities</td>
<td>Consistent anhedonia</td>
</tr>
<tr>
<td>Continued involvement with loved ones</td>
<td>Social withdrawal</td>
</tr>
</tbody>
</table>

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

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Aids for Patients with Low Vision
Barry D. Weiss, MD, University of Arizona, College of Medicine

The National Eye Institute reported in 2004 that more than 3 million adults in the US had blindness or low vision, and most of these people were over 65. By 2020, that number is expected to have increased to 5.5 million (Table 1). As noted in a prior issue of Elder Care, age-related macular degeneration (AMD) is the most frequent cause of irreversible blindness among older adults in the US. It affects 30% of people over 75, with 1 in 14 having serious visual impairment.

Table 1. Eye Disease Prevalence and Projections

<table>
<thead>
<tr>
<th>*Number of Adults &gt;40 Years in US</th>
<th>2004 Estimates* (in millions)</th>
<th>2020 Projections* (in millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age-Related AMD</td>
<td>1.8</td>
<td>2.9</td>
</tr>
<tr>
<td>Glaucoma</td>
<td>2.2</td>
<td>3.3</td>
</tr>
<tr>
<td>Diabetic Retinopathy</td>
<td>4.1</td>
<td>7.2</td>
</tr>
<tr>
<td>Cataract</td>
<td>20.5</td>
<td>30.1</td>
</tr>
</tbody>
</table>

Source: National Eye Institute

This provider fact sheet will review several of the most commonly used devices for individuals with visual impairment that cannot be successfully managed with medical or surgical therapies (summary in Table 2).

Hand-Held Magnifiers
A hand-held magnifier is the most basic vision aid. Typical devices have a 3” round or 2”x4” rectangular lens, and magnify objects up to 5x, though some go up to 20x (Figure 1). Many models are illuminated to facilitate use in low-light. Hand-held magnifiers are used to assist with reading and viewing pictures. Their advantages are low cost ($10-30) and portability. The main disadvantage is that they require use of the hands, and so often work poorly when patients have tremor. Also, their narrow field of view requires movement of the device across text during reading, thus reducing reading speed.

Stand Magnifiers
Stand magnifiers are magnifying lenses mounted on a stand that typically sits on a desk top. As with hand-held magnifiers, they can be illuminated. Their main advantage over hand-held magnifiers is that they free the hands and often can be used by people with tremor. Some sit over text on four legs and have large view areas; others are mounted on fixed or goose-neck stands. Cost varies from around $15 for simple models to as high as $200 for more sophisticated models (Figure 2).

High-Powered Spectacles
High-powered spectacles are inexpensive eyeglasses with high-magnification lenses. They do not require the use of hands. Their disadvantage is the need to hold objects close to the eyes, which interferes with illumination for reading. They are relatively inexpensive; prices start at about $20.

TIPS FOR RECOMMENDING LOW-VISION AIDS
- Recommend low-cost magnifiers or high-powered spectacles if they are adequate visual aids.
- Avoid hand-held devices for patients who have tremor.
- Consider spectacle-mounted magnifiers when patients need both near and distant vision aid.
- Check to see if your state commission for the blind will pay for patient’s vision aids.
**Spectacle-Mounted Magnifiers**

Spectacle-mounted magnifiers are small protruding lenses that are mounted on eyeglass frames (Figure 3). The magnifiers can be “microscopes” for close-up vision or “telescopes” for more distant vision, and patients may switch between the two. In microscope mode, patients must hold objects much closer to the eye than normal, which some people find difficult and can interfere with adequate illumination of reading material. Telescope mode is designed for more distant viewing activities like watching television, painting, reading music, and looking at a computer monitor. With both modes, the field of vision is narrow.

Spectacle-mounted magnifiers require prescription by an eye-care professional. They are also somewhat expensive, with least-costly models starting at about $100. Many patients need instruction on how to use these devices correctly.

**Electronic Magnification Units**

Commonly called closed circuit television (CCTV), these devices use video cameras to view objects and project a magnified image of the object on a computer monitor (Figure 4). The camera can be hand held and scanned across text, or it can be mounted in a device similar to the document readers/cameras that are used in lecture halls, enabling an entire page to be viewed at once. High levels of magnification (up to 60x) can be achieved, and the size of print can be increased or decreased with a zoom control. Lower-cost units with a hand-held scanner start at about $200, while more expensive units can cost as much as $2000.

**Insurance Coverage** Unfortunately, most medical insurance plans do not provide coverage for low-vision aids. In many states, the commission for the blind provides devices at no cost to appropriate patients.

**Table 2. Advantages and Disadvantages of Various Low Vision Aids**

<table>
<thead>
<tr>
<th>Device</th>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hand-held magnifiers</td>
<td>Inexpensive; can be illuminated</td>
<td>Must hold at precise focal length from reading material; slow reading; difficult with tremor</td>
</tr>
<tr>
<td>Stand magnifiers</td>
<td>Inexpensive; can be illuminated; No hands necessary</td>
<td>Must set device at precise focal length from reading material; not easily portable</td>
</tr>
<tr>
<td>High-powered spectacles</td>
<td>Inexpensive; no hands necessary</td>
<td>Objects must be close to eye, which interferes with illumination</td>
</tr>
<tr>
<td>Spectacle-mounted magnifiers</td>
<td>Have both “microscope” and “telescope” lenses, so can be used for both near and far vision; no hands necessary</td>
<td>Expensive; objects must be held close to the eyes in microscope mode; narrow field of vision; training required</td>
</tr>
<tr>
<td>Electronic magnification units (closed-circuit TV)</td>
<td>Permit high-resolution images at a customized high-magnification level; both portable and desktop models</td>
<td>Expensive</td>
</tr>
</tbody>
</table>

**References and Resources**

- What You Should Know About Low Vision. Patient education brochure from the National Eye Institute.
Most older adults with hearing impairment have either partial or total damage to the cochlea and/or auditory nerve, causing a sensorineural hearing loss. This type of hearing loss results in several major problems for persons with hearing loss (PHL), as shown in Table 1.

Table 1. Problems Experienced by Older Adults Who Have Hearing Loss
- Inability to hear soft sounds
- Loss of clarity of audible sounds, resulting in distortion
- Decreased ability to separate what they want to hear from a background of noise
- Decreased ability to process or understand speech quickly
- Tinnitus or “ringing in the ears”

While a detailed knowledge about hearing aids is best left to an audiologist, health professionals who provide care for older adults should be familiar with what hearing aids can and cannot do. They should also understand the basic concepts involved in hearing aid selection, care, and troubleshooting.

What Hearing Aids Can and Cannot Do
Today’s hearing aids can compensate for some of the problems experienced by PHLs, but they are limited in what they can do about others. Indeed, even the most sophisticated hearing aids cannot help a PHL hear perfectly in all situations. Rather, hearing aids are tools that assist individuals to communicate effectively in more situations than they can without a hearing aid. Similar to crutches after breaking a leg, they are not perfect but permit PHLs to do more than they could do otherwise. Table 2 lists some of what hearing aids can and cannot do.

Table 2. What Hearing Aids Can and Cannot Do

Hearing Aids CAN…
- make most sounds audible.
- make speech somewhat clearer, by amplifying only the specific speech sounds that are misheard.
- sometimes make tinnitus less noticeable.

Hearing Aids CANNOT…
- make audible sounds completely clear. Sounds that are heard are still processed by a damaged hearing mechanism. Similar to a broken amplifier, increased volume make sounds louder, not clearer.
- separate what individuals want to hear from what they don’t want to hear.
- compensate for the loss of processing speed that accompanies age-related hearing impairment.

TIPS FOR ADVISING PATIENTS ABOUT HEARING AIDS
- Be sure patients know that while hearing aids usually improve the ability to hear speech and music, they do not help an individual to hear perfectly in all situations.
- Advise patients that while they may desire a cosmetically small, in-the-ear hearing aid, the very smallest hearing aids may not be able to provide all the new technology, like directional microphones or manual controls.
- Encourage daily cleaning of hearing aids, and opening the battery compartment to the air when not in use.
- Remind patients to store batteries out of the reach of children and pets.
Volume Control. Modern hearing aids can adjust volume automatically depending upon the sound they receive. But, many people still prefer to adjust the volume themselves. For example, hearing an extremely soft-spoken person across a table may require turning the volume up. Some of the smallest hearing aids cannot accommodate a manual volume control.

Programs. Many hearing aids can alter the way they function, depending on the situation or on listener preferences or needs. For example, by pushing a button or switching a switch, some hearing aids can make it easier to appreciate all the sounds in music. Some hearing aids can make the change automatically, but the more automatic the changes, typically the more expensive the hearing aid.

Size and Shape. Hearing aids come in many sizes and shapes (see figures). There are advantages and limitations to each type. Some are less visible than others, and lack of visibility appeals to many PHLs. But over and above visibility, the most important considerations about size and shape are whether (a) the hearing aid can accommodate the features desired by the PHL (e.g., a directional microphone) and (b) the user can easily manipulate and care for the device.

Care of Hearing Aids

Hearing aids are electronic devices and must be maintained regularly to assure optimal performance. Routine maintenance of hearing aids involves several things.

First, hearing aids and batteries should be stored in a safe place – out of the reach of pets and children. Batteries can be confused with pills and may be toxic if they are ingested and swallowed. Second, open the battery compartment when the device is not in use. This avoids inadvertent battery drain and allows air circulation to prevent accumulation of moisture. Third, each day the hearing aid or earmold (the part that is inserted in the ear canal) should be cleaned using the cleaning tools supplied at the time of purchase. This will help prevent ear wax from accumulating and blocking sound from reaching the ear.

Troubleshooting

Batteries in the smallest hearing aids last only 2–3 days; they last up to 2–3 weeks in larger devices. Most hearing aids give an audible warning when the battery is about to die, and then they die immediately rather than fade out. Simple tests can be performed if a hearing aid is not working. If one ear’s hearing aid is not working but the other is, the first step is to put the battery from the bad hearing aid into the good one. If it works, then the battery is not the problem. If the device doesn’t work, the battery is dead.

You can also insert a new battery and turn the hearing aid on, cupping the hearing aid in your hand and listening for feedback or a squealing noise. If present, the battery is good and the hearing aid is operating. Such feedback sounds should not, however, occur when hearing aids are properly inserted in the ear.

When in doubt, the hearing aid should be taken to the audiologist or hearing instrument specialist to be checked.

References and Resources

University of Arizona, Department of Speech, Language, and Hearing Sciences, Programs and Services for Adults with Hearing Loss. Useful links and information. http://lwhl.arizona.edu/

Images from National Institute on Deafness and other Communication Disorders www.nidcd.nih.gov/health/hearing/hearingaid.html#hearingaid_01
**Research:** Combining cutting-edge research through our biology of aging, clinical, epidemiologic, and health services programs, we bring the bench to the bedside and back again to improve the quality of life and functional longevity of older adults.

Of special note are our Immunobiology and GeriMetrics Programs: Immunobiology research explores age-related changes in inflammation, immunity, bone, muscle, and fat biology. GeriMetrics uses innovative bioengineering tools to address common geriatric conditions and syndromes including imbalance and falls, cognitive deficits, pressure ulcers, polypharmacy management, self-care deficits and frailty.

**Education and Training:** We provide training and continuing education in aging issues to health science students and working professionals across the state. Our Interprofessional Arizona Geriatrics Workforce Enhancement Program and Reynolds Program in Applied Geriatrics help to prepare our state’s workforce in caring for Arizona’s older adults.

**Clinical Care:** We connect older adults with geriatricians and palliative care specialists – providers who are trained to meet the specific needs of aging adults.
• Are you committed to improving and developing health care best practices for older adults?

• Are you serious about advancing your knowledge of geriatric health care?

If so: **JOIN THE AZGS TODAY!!!**

AzGS membership offers a wide array of resources to help you succeed in your health care profession — three annual continuing medical educational opportunities, accreditation options, professional networks, a highly recognized peer-reviewed journal, and dinner programs that offer educational and networking opportunities.

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Email us at: [askus@arizonageriatrics.org](mailto:askus@arizonageriatrics.org)
Give us a call at: (602) 265-0211
The Hartford Center of Gerontological Nursing Excellence

A primary mission of the Hartford Center of Gerontological Nursing Excellence at ASU is to increase the number of quality doctoral and post-doctoral level faculty who focus on the care of older adults to teach in academic nursing programs throughout Arizona and surrounding Southwestern states.

In support of this mission, the center offers pre-doctoral and post-doctoral opportunities with an emphasis on increasing nursing capacity in the area of aging through research, practice and education, and leadership.

Scholarship goals and opportunities, include:
- Teach in graduate and undergraduate academic nursing programs.
- Develop academic career goals and scholarships.
- Develop leadership skills and interprofessional partnerships in the care of older adults.

The center receives grant funding from The John A. Hartford Foundation to support graduate students in gerontological nursing. Financial support through scholarships may be available for one year with option for renewal.

Learn more at nursingandhealth.asu.edu/hartford
Phone: 602.496.2644 or Email: ASUHartford@asu.edu

Visit the website:

1 in 8

The Hartford Center of Gerontological Nursing Excellence at ASU is only 1 of 8 centers funded to increase geriatric nursing faculty capacity.

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Advances in Aging Lecture Series

Schedule

Noon-1 p.m., 2nd Monday of the Month

Oct. 10, 2016  Topic: Minor Neurocognitive Disorder
Corinne Self, MD
Assistant Professor of Medicine

Nov. 14, 2016  Topic: Alzheimer’s Disease Screening in Primary Care
Lisa O’Neill, MPH
University of Arizona Center on Aging
Morgen Hartford, MSW
Alzheimer’s Association

Dec. 12, 2016  Topic: Cross-cultural considerations in older adult mental health
Cheri Wells, LPC
Private Practice Counselor

Lectures are free to the public
**
 A light lunch is served
**
 No registration is required
**

Kiewit Auditorium
University of Arizona Cancer Center
1515 N. Campbell Ave.
**

Please note: We are unable to validate parking for this event.

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Methodology: Lecture
Target Audience: Physicians, Nurses, other health care professionals and interested community members
Disclosure: The University Of Arizona College of Medicine at the Arizona Health Sciences Center adheres to the ACCME standards regarding industry support of CME and disclosure of faculty and commercial support relationships, if any, will be made known at the lecture
CE Accreditation: Provider approved by the California Board of Registered Nursing, Provider Number CEP14824 for 1.0 contact hours
Graduate Education Opportunities

The 2014 *U.S. News & World Report* survey of America’s best graduate schools ranks the College of Nursing and Health Innovation 24th for its master’s of science program in Nursing, the highest ranked program in Arizona.

- **Master of Healthcare Innovation (MHI)** is a fully online program that brings together information from innovation and change theory, leadership, entrepreneurship, application technology, and system design programs, to create innovative solutions to the challenges in health care.

- **Master of Science, Clinical Research Management** (MS-CRM) is a fully online program that prepares graduates to lead complex global clinical research operations at multiple types of employer settings in the rapidly growing clinical research industry.
  - Master of Science, Clinical Research Management with a Concentration in Regulatory Science Degree Program (MS-CRM) - This new degree program concentration beginning Fall 2014 prepares clinical research professionals to specialize in regulatory science.

- **Master of Science, Nursing** – The college offers several concentrations in its MS in Nursing, including: Care Coordination, Nurse Educator and Patient Safety & Health Care Quality.
  - Master of Science, Nursing Education - A pathway designed to prepare the new and experienced nurse to meet demands of the changing health care environment. The degree program is learner-centered, clinically focused, population-specific, and designed for those who initially choose a career as a nurse educator, as well as for nurses in practice who want to make a change.
  - Master of Science, Nursing (Patient Safety and Health Care Quality) Provides nurses advanced preparation to lead effective patient-centered initiatives and seek national certification.
  - Master of Science, Nursing (Care Coordination) - The MS in Nursing, care coordination program provides nurses advanced preparation to lead care coordination programs and seek national certification.

- **Doctor of Nursing Practice (DNP)** program is focused on improving health care through facilitating a culture of best practice, and providing the additional skills necessary to develop advance practice nursing leaders for the future. Post Baccalaureate DNP Nurse Practitioner specialties include:
  - Adult-Gerontology Nurse Practitioner
  - Family Psychiatric Mental Health Nurse Practitioner
  - Family Nurse Practitioner
  - Neonatal Nurse Practitioner
  - Pediatric Nurse Practitioner
  - Women’s Health Nurse Practitioner

- **Post Master’s DNP**
  - Advanced Practice – certified advanced practice nurses with a focus on improving health outcomes of individuals
  - Innovation Leadership – for nurses with a focus on improving health outcomes in organizations or systems

- **PhD degree in Nursing & Healthcare Innovation** is designed for scholars who wish to pursue careers as leaders in health policy, education and research. The degree will also help to address a national need for faculty and researchers who are increasingly in short supply.

For additional information, [https://nursingandhealth.asu.edu/programs](https://nursingandhealth.asu.edu/programs)