VOLUME 31, NUMBER 1

Spring/Summer 2016

THE SAN DIEGO PSYCHOLOGIST

The Official Newsletter of the San Diego Psychological Association

In this issue

President's Corner

by Ellen Colangelo, Ph.D.

This is an exciting time as we launch the online edition of *The San Diego Psychologist*. Our new editor, Gauri Savla, has researched and designed the most user friendly way to publish the newsletter. You may agree that she has managed to retain the attractiveness and journalistic quality that we have enjoyed over the years in the hard copy versions. Historically, each editor has brought his or her own unique style and flavor to *The San Diego Psychologist*. This is what keeps it vibrant and alive and motivates us to want to read it.

Gauri's intent as editor is to have a theme to each edition; She has selected *Aging* for the current, *Spring/Summer 2016* issue. As the boomers move into the final quarter of their lives, we begin to see more and more of the Medicare crowd in our practices, struggling with the gradual decline of strength and flexibility, minor to major cognitive decline, financial concerns, loss, and spiritual challenges that come with the existential awareness of life as impermanent. As one who is in this generation of Elders, I look forward to reading this maiden, online edition of *The San Diego Psychologist.*

Congratulations, Gauri, on a job well done. Special thanks to our previous editors, especially Karen Fox, our outgoing editor, who continued the strong tradition of quality that is the foundation of this publication.

The San Diego Psychologist

Editor: Gauri Savla, Ph.D.
www.thesandiegopsychologist.com

The SDPA offices are located at
4699 Murphy Canyon Rd.
San Diego, CA 92123.

Editorial

by Gauri Savla, Ph.D.

Dear SDPA Members and Guest Readers,

I am thrilled to debut the online edition of *The San Diego Psychologist.* As the new editor of this beloved newsletter, I had the daunting task of not only carrying on the legacy of past editors, but to do it in an unprecedented medium. Putting together this issue has consisted of numerous hours of research, trial and error, eureka moments, and consultation with friends and colleagues who have more experience with online media than I do. I am grateful to have had the guidance of Kenny Leepier-Freemen, SDPA's intrepid office administrator, as well as that of Ellen Colangelo and Brenda Johnson, current and past presidents of the SDPA, respectively, who looked through many early drafts of the website and shared their feedback.

One of the many changes to *The San Diego Psychologist* is the introduction of themed issues. I wanted to begin my tenure as editor with a topic close to my heart, so the theme of the *Spring/Summer 2016* issue is *Aging.* We solicited some of the articles from experts in the field, and other contributors reached out to us at an opportune time. We selected the six best articles to include in this issue.

Aging is a universal experience; we begin to age the moment we are born. As medical breakthroughs and robust lifestyles are prolonging lifespans in the developed world, more and more people are living into their 80s and 90s. There are currently 40 million people over the age of 65 living in the United States. That number is projected to nearly double to a staggering *72 million* by the year 2030. With age, comes physical and mental slowing, loss, and, sometimes, the resurfacing of old psychological issues or the emergence of new ones. Resources for emotional and mental health are neither ubiquitous nor sufficient to meet the needs of this population.

San Diego has always been one of the hubs of research with older clinical populations (e.g., University of California, San Diego housed the only research center in

the country focusing on older adults with primary psychotic disorders for over 20 years). More recently, there have been multiple efforts to study other general medical, neurological, and psychiatric conditions in aging populations spearheaded by UCSD, San Diego State University, and the VA San Diego Healthcare System. Yet, as a former researcher who worked with seniors, and now clinician in private practice, I find myself struggling to find appropriate referrals for older patients. There is a nationwide dearth of geriatric psychiatrists and psychologists, as well as allied professionals, especially those who accept Medicare.

The goal of this issue is twofold; (1) to shine a spotlight on the unique needs and characteristics of the seniors who live among us, so that we are aware of the resources that are available and of those that are not, but necessary, and (2) to encourage early career professionals to consider serving this specific population and obtain the training necessary to do so.

Personally, working with seniors has been the highlight of my professional career; I am humbled by the wealth of life experiences they bring to each session, and honored that they come to me for help. As the author of one of the articles in this issue writes, serving seniors is mutually beneficial to both, client and therapist.

Each contributor to this *Aging* issue has expertise in his or her field, and the passion for and experience with working with older adults. Dr. Tayer has written a passionate essay on why there is a great need for therapists in geriatric psychology and has shared her wisdom in the hope that it will not only guide new therapists in the field, but also encourage more practitioners to work with seniors. Dr. Pates, a veteran clinical psychologist and currently on the board of the SDPA, has written about the unique approach to establishing therapeutic alliance with older adults in skilled nursing facilities. Ms. Chappell Marsh is a licensed marriage and family therapist and an expert in Emotion Focused Therapy (EFT); her article uses a case example to highlight the conflicts experienced by older couples and the effective use of EFT in helping them achieve emotional closeness. Dr. Nunnink is a clinical psychologist, also an expert in EFT, who has penned a thoughtful essay on sexual intimacy among older couples and the role of EFT in helping couples regain an often-neglected but important aspect of their relationship. Dr. Uslander is a trained emergency room physician who changed career paths to serve older adults who are terminally ill and in the last stage of life; he discusses the needs of these individuals to achieve peaceful, "good" deaths and indeed, the need to open up the discussion about end of life issues. Finally, Dr. Bangen (in collaboration with Dr. Palmer and myself) has written about the role of neuropsychology in clinical practice.

I hope you find this issue educational and insightful. We welcome your feedback. You may leave a comment on the online newsletter at www.thesandiegopsychologist.com or email us at TheSanDiegoPsychologist@gmail.com.

The Surprises of Serving Seniors

by Wendy Tayer, Ph.D.

Years of clinical experience have taught me that people enter psychotherapy feeling disempowered in some way. This characterization is especially true for seniors. They seek or are referred for mental health treatment for a variety of reasons, including depression, anxiety, grief, and disability. Often, those seeking therapy are isolated, widowed, struggling with caregiving burdens or feel disconnected from their community after retirement. This population is aging in a rapidly changing world of technology, mass communication, busy distracted family members and a society that does not revere aging. These circumstances create numerous challenges in addition to the expected declines in functioning due to aging.

Our elder population is growing; according to the APA Office on Aging (2011), people over 65 years old are the fastest growing segment of our population and and will comprise 20% of our nation's population by 2020. They are grossly underserved in the arena of mental health, so much so that the APA advertises this specialty, established in 2010, as one of the chief areas for job growth in clinical and research psychology. The APA materials explain the demographics and needs of the population but they don't convey the experience of working with seniors.

I believe that in order to draw more psychology students and newly licensed psychologists into the field of geropsychology, it is helpful to share my experience in working with seniors for 10+ years. I have done so with my supervision students in informal ways over the years with positive results. This article is intended to be a qualitative reporting of my many rewarding years of working with seniors. Research findings are interspersed to support and validate my experience.

Americans tend not to welcome aging or revere our seniors; in fact, we worship youth and often go to great lengths to prolong the appearance of youth, evidenced in our media. But aren't aging and the passage of time the most fundamental aspects of our life on this planet? These are some of the topics that I explore with seniors. Whether it is the retired physician in chronic pain or the lonely, frustrated widow or the man who cannot bear the thought of his wife dying – we find ways to explore their dissatisfactions, fears, memories and strengths in order to find points of connection and enrich their lives.

This population is characterized by rich, complex personal histories of coping, family life and personal struggles in addition to the challenges of facing personal and familial morbidity and mortality. (American Psychologist, 2014). And, they come into therapy ready to engage in "life review" work or reminiscence therapy, both of which are strategies for reviewing old memories and mementos while seeking connections, meanings, and summing up one's life in search of resolution. This work is often profound for seniors, and the literature documents its efficacy in treating depression and enhancing well-being among cognitively intact seniors (Oxford Handbook of Clinical Geropsychology, 2014). My role is typically characterized by offering reality testing, socialization, and support to seniors who often feel disenfranchised. Frequently they tell me that I am the only or one of the few people in their lives who sits and listens to

their struggles, offers empathy, unconditional acceptance and steps toward resolution. Often they describe their families as resentful, impatient, intolerant or just too busy to listen and attend to their needs, or include them socially.

Seniors today are a product of their experience and a 20th century worldview. We engage in much verbal unravelling of experience and personal stories to help them heal or uncover new ways to understand and carry their life story. We also discuss ways to adapt to the 21st century. They are digital "newbies," which I consider to be one of their strengths, as they understand the value of interpersonal connection; this appreciation for connection also yields a more positive result from our therapeutic relationship. Their generation understands personal responsibility and commitment; they show up for therapy, are goal-directed, do the work and tend to be more satisfied with psychotherapy than younger adults (New York Times, 2013). However, elders vary in their technological skill level. I spend many sessions offering tutorials in smart phone or PC utilization in order to foster more independence. Recent research findings indicate that utilization of technology is cognitively and emotionally beneficial to seniors (Oxford University Press USA, 2014).

The therapeutic alliance is a critical element with seniors. I have not encountered much data on this topic but can speak from years of experience. Seniors are unique in that they can be isolated and a third of them use some kind of device to help them ambulate (Purdue University, 2010). Thus, psychotherapy with them requires us to rethink the traditional rules of psychotherapy. For example, in most clinical settings, we typically would not touch our patients. However, seniors can have limited opportunities for socialization and human connectivity, especially affection or touch, this point commonly referenced on nursing home and caregiving websites. Thus, it is not unusual for female seniors to ask for a hug or for me to offer a reassuring pat, these gestures serving as vehicles for building and maintaining an emotional connection. Often, seniors come to my office with wheelchairs, walkers, canes and leg braces. They often need assistance and express gratitude for the acknowledgement of their "helping" device.

Seniors face the challenges of permanent life changes that threaten their autonomy. In my experience, one of the most prominent concerns is the loss of function, independence and ability to be self-sufficient. Surrendering one's driver's license and moving an elder out of his or her home into an assisted living facility are probably the most emotionally charged losses for seniors. Other common themes are cognitive and sensory decline, death and dying, and grief about ill and deceased loved ones, including pets (APA Office on Aging, 2011). These patients often have outlived their peers and feel disconnected and alone. And they are at various stages of aging and retirement. Some are adjusting to retirement after a long purposeful, satisfying career. Others are trying to renew themselves and establish new avenues of expression or contribution to their community.

According to the APA and other literature, the interventions that we use with other populations are applicable to seniors (American Psychologist, 2014). However, they are adapted to meet the needs of our aging population. For example, we may spend more time on review of life events and memories than with younger people. And we may slow down the

process of teaching them a new coping skill. I apply an array of evidence-based strategies such as journaling, CBT, humor therapy, mindfulness, ACT, and supportive psychotherapy. A mix of these strategies along with an acknowledgement and exploration of their existential issues, especially morbidity and mortality, is very effective with elders (American Psychologist, 2014).

I especially enjoy sharing the most recent advances in neuroscience with seniors. We have evidence that acquisition of new information enhances cognitive functioning (Psychological Science, 2014) and that the brain is neuroplastic across the lifespan. (SharpBrains.com, 2016) The influx of new information about our brains offers tremendous hope for easing the aging process and offering more fluid, flexible interventions for optimizing the aging brain. For example, we know that starting exercise regimens as a senior can improve memory processes and quality of life (University of Montreal, 2012). These are just a few of the recent research findings on this exciting topic.

Related to providing psychoeducation to seniors, I have developed a modest session goal over the years, which usually is well-received. I aim to offer my patients one suggestion or piece of information to take away and mull over until the next session. It focuses us on the experiential and relational elements in therapy. In this vein, I make it a point to capitalize on their strengths and emphasize a mindful, accepting approach. I enjoy humor and share laughter with seniors in session if they are amenable to it, thus incorporating a bona fide mood booster for all parties involved!

I learned how to work with seniors on the job, sitting with my patients, attending geropsychology seminars, reading the literature and consulting with colleagues. There is a great deal of information about gerontology that this article space does not allow, including the role of medications and substances, cognitive decline, assessment, caregiving, and potential financial and physical abuse. My aim was to touch on some key experiential themes that resonate with me as a clinician. I am constantly learning more about this multifaceted, largely unappreciated population group. They teach me valuable lessons every week for which I am eternally grateful. These therapeutic relationships are mutually emotionally beneficial. My newest tidbit for sharing is Dr. Amy Cuddy's power pose after listening to her speak recently. A Harvard Business School social psychologist, her research focus is the universal role and potential of nonverbal behavior to empower us, and her TED talk is the second most watched TED talk on the web. I also recommend her book entitled "Presence." This intervention is an especially enlivening and well-received addition to our sessions.

If you are interested in a career or specialization in geropsychology, acquaint yourself with the literature and online resources such as APA and The Gerontological Society of America. Attend conferences, find a mentor, spend time with seniors and read both fiction and non-fiction about aging and seniors.

Please see the online version of the article for references and suggested readings.

Ethical Considerations in the Treatment of Geriatric Patients

by Hugh Pates, Ph.D.

I have had the opportunity to treat geriatric patients in skilled nursing facilities (SNF) for the past 15 years of my 40-plus career as a practicing clinical psychologist. In the course of my experience, I have encountered ethical dilemmas that have led me to make subtle and significant changes in my practice of therapy with this group of patients.

My goal in writing this article is to highlight some of the common considerations in working with patients in SNFs, and my suggestions for how to address them.

Confidentiality

As any practicing clinician knows, confidentiality is the cornerstone of the therapeutic relationship, and is strictly maintained (with the usual legal limitations) in general clinical practice at all times. The SNF, however, is powered by a team of professionals, all of whom play vital roles in a patient's care. Confidentiality, in such settings, are between the patient (and his or her family) and a team of healthcare professionals, rather than a single therapist.

Before any discussion about confidentiality is broached, I always like to gauge whether the patient has the competence for talk therapy, often with the aid of a Mini Mental Status Exam (MMSE). I then ask the patient to sign a waiver of confidentiality to allow me to communicate with medical personnel associated with the patient's care and "others" as needed. "Others" generally include appropriate family members and/or conservators. Consultations of this nature are necessary in order to improve the medical care of the patient, and to also help family members understand what is going on with their loved one and assuage any fears or doubts they may have.

The most striking difference in keeping records of therapy sessions (in the form of progress notes) when working with patients in SNFs is that any professional involved in their care has access to them. This makes a team approach to a patient's care seamless. Both these practices are clearly different among therapy patients in SNFs than those in a typical, outpatient/community practice.

Suitability for Talk Therapy

Sensory impairment (particularly hearing) or cognitive impairment pose challenges for talk therapy, therefore, an evaluation of a patient's ability to participate in and profit from talk therapy is essential. These challenges tend to be present more frequently among seniors at SNFs.

When I began my work in SNFs, I was concerned about the ethics of working with someone who may not benefit from therapy; as it turned out, I have seen substantial improvements in the quality of life among numerous patients in a skilled and supportive therapeutic milieu.

The initial diagnostic interview is the ideal way to evaluate the manner in which a person is able to articulate their thoughts and goals, and recall personal historical information. This is

also a good opportunity to determine the extent of hearing impairment, if any, and the modifications necessary to render talk therapy and appropriate mode of treatment. Additionally, a cognitive screen such as the MMSE is a quick and effective way to assess a patient's basic cognitive skills, attention and orientation, and short term recall and recognition. I have found that an MMSE of 18 (out of a possible 30 points) is the minimum score required to proceed with therapy.

Gift Giving

Gift exchanges, particularly accepting gifts from patients has always remained a gray area in the therapeutic relationship. However, among older patients in SNFs, distributing small gifts can serve to strengthen and enhance therapeutic alliance. Candy (when appropriate), other edibles, or flowers are usually the types of gifts that are appreciated and tend to facilitate swift positive changes in behavior patterns that in turn, can improve mood (e..g, reduced expression of anger, willingness to participate in activities, more cooperation with caregivers).

Touch

Touch, like gift exchanges, fall into that controversial, gray area in general clinical practice. However, physical touch (patting someone on the shoulder, holding a hand, or a hug) among geriatric patients, in both outpatient and inpatient (e..g, SNF) settings can be a powerful way to build the therapeutic relationship. Older adults respond more positively to interventions when they see their therapists as caring and concerned about their well-being, and gentle, caring touch when they are experiencing an emotional moment, or at the conclusion of the session goes a long way in maintaining rapport.

Personal Disclosure

I have consistently found that revealing details from my own life with geriatric patients has a hugely beneficial effect in moving therapy forward. Patients tend to become more energized, alert, and involved when they see therapists as people they can have a connection with; I share tidbits from my own life, such as escapades with my grandchildren or my interest in various athletic activities. I direct my own experiences to those they have had in the past or are currently experiencing, in order to engage them in dialogue about goals for the session at hand.

These are but a few ways in which my ethical practices differ from those pertaining to other populations I see in my practice. They are modified in the manner described in this article to engage a group of patients traditionally not open to therapy, and to enhance the effectiveness of existing, evidence-based interventions. My hope is that science catches up with the practice of therapy with geriatric older patients, a rapidly growing demographic that is underserved and less understood than any other age group of therapy patients.

The Role of Emotionally Focused Therapy in Helping Older Couples Regain Emotional Intimacy

by Jennifer Chappell Marsh, LMFT

John and Sarah are in their mid 60s and have been married for more than 40 years. They raised three children together, navigated periods of unemployment, the death of their parents, retirement and countless stressors over the course of their marriage. They have come to couples therapy because post-retirement life uncovered the gulf of emotional and physical distance between them. They calmly and matter-of-factly describe the lack of intimacy in their relationship. Sarah says she feels lonely and wants to feel more "together." John agrees, describes their relationship as "roommates."

John and Sarah present the typical issues for older couples that I see in my couples therapy practice. The overall number of older couples seeking therapy is growing. According to the American Psychological Association (APA), "People 65 years old and older are the fastest growing segment of the U.S. population. By 2030, older adults will account for 20 percent of our nation's people, up from 13 percent in 2008." As more and more older couples find their way to counseling, it is promising that older clients generally have a higher satisfaction rate in therapy than younger clients. For these couples, time is precious and they have well defined goals leading them to take couples therapy as a serious investment (Ellin, 2013).

I have found couples therapy, and specifically Emotionally Focused Therapy (EFT), to be highly effective with older couples. Based in attachment theory, EFT was developed by Drs. Sue Johnson and Les Greenberg to address the way couples get stuck in a negative interactional dance, reinforcing emotional disconnection. EFT helps couples to understand how their their attachment longings (to rely, depend, and connect with their partner) influence emotional states and behavioral reactivity; As couples age, their attachment needs become more apparent and there is an increased need for each partner to have the other's support. Studies suggest that given the increased potential for separation, attachment issues are particularly relevant in older adult relationships, especially given the loss and vulnerability associated with aging (Bradley & Cafferty, 2010).

Sarah reports that her memory is fading. John says his hearing is declining. John jokes: "She needs me to remind her of what she's looking for in her purse and then yell to me when she's found it." In times of distress and vulnerability, we look to our partner as our "safe haven". We need to know our partner will be there for us, is responsive to our needs and is emotionally engaged. "As individuals age, many elements of their life that had been constant, begin to change. For many, their support systems (in the form of spouses or friends) begin to disappear. It also becomes harder to remain completely independent, a particularly hard thing for individuals to accept." (Peluso, Watts, & Parsons 2012).

Furthermore, we know that older couples are in an ever increasing state of vulnerability. "As their non-familial network diminishes with age, family relationships (in particular, the martial

relationship) become extremely important sources of emotional support to the elderly." (Canadian Medical Association Journal, 1984). For some couples, like Sarah and John described above, this increased dependance highlights a missing connection in their relationship.

Where primary attachment figures are involved, individuals have strong emotional and behavioral reactions to disconnection. "While individuals may attempt to cope with this vulnerability by using a variety of strategies, two of the more common approaches involve constellations of feelings, thoughts and behaviors related to anxiety (e.g., protesting, clinging, demanding, criticizing, dependency) to avoidance (e.g., withdrawal, affective "cutting off")." (Bradley & Palmer, 2003). These individual attachment systems are likely to be activated in times of distress related to vulnerability, separation and loss. Such strategies, when used to cope with disconnection, create negative interactional patterns between partners.

In older couples, the more common "protest/withdrawal" dance turns into a mutual withdrawal. Attempts to connect fall short over the years. Older couples may also have relatively long histories of marital distress, conflict withdrawal, disengagement, or feelings of resignation to the status quo in one or both partners. (Canadian Medical Association Journal, 1984) So instead of hurling angry criticisms at John, Sarah sighs and says, "I used to get upset when he'd shut down but I guess I'm just used to it now. I've known for a long time that he doesn't really care." John responds, "I want Sarah to be happy. I have just become numb over the years because there's nothing I can do." This pattern of mutual disengagement is more common in older adults; Years of failed attempts at connection leave both parties hopeless about gaining closeness (Bradley & Palmer, 2003).

Older people will use strategies to avoid the experience of negative emotions and, in turn, older couples' interactions are less volatile than their younger counterparts. Couples may "leave well enough alone" by staying in affectively neutral interactive sequences and avoiding escalation to negative affect. In order to avoid high conflict older couples who are unhappy in their relationship are less likely to engage in negative start-up responses to potential discord (Carstensen, Gottman, & Levenson, 1995). A mutual withdrawal is effective at keeping the peace but also maintains distance between couples.

Emotionally Focused Couples Therapy helps to close the gap that forms from mutual withdrawal. Dankoski (2001) points out that EFT is particularly useful for treating couples whose distress is related to major life events. Without a secure base, older adults experience higher levels of distress. The therapist who employs EFT in their practice supports and guides both partners with directly expressing their attachment needs and fears. Thus, each partner learns to risk engaging with their vulnerability.

Let's return to the case of Sarah and John. Sarah finds she is able to open up about her fears of abandonment and rejection. John learns to discuss feelings of helplessness, particularly at meeting Sarah's needs. Through EFT, the therapist explores interactional cycles, allowing the

couple to reconnect with disowned needs, and gain a new experience of connection and attainment (Johnson & Greenberg, 1988). John comes to understand that Susan's past criticisms come from her feelings of abandonment. Similarly, Sarah gains the insight that John's withdrawal is his shield against feelings of helplessness, and of failing her. Through EFT sessions, John and Sarah each gain a greater sense of emotional connection and relational security.

Changing the withdrawal/withdrawal dynamic requires helping older couples to acknowledge their need and desire for closeness. Like narrative-based approaches to psychotherapy, the skilled used of EFT encourages therapists and clients to examine and actively construe their "life stories" in subjective, personal terms. EFT can indeed offer older couples a chance to rewrite the ending to their shared life story.

Please see the online version of article for references.

Integrated Emotion Focused Couples and Sex Therapy in Senior Adults

by Sarah Nunnink, Ph.D.

Mirroring society when it comes to sex and love, senior couples are nearly nonexistent in the couples-therapy literature at large, and conspicuously absent in the specific area of sex therapy. Yet, most older couples (whether gay or straight) report a sexual pulse that, while declining in terms of frequency and intensity, is certainly palpable. This article summarizes the common general and sexual issues that are typically present in clinical work with senior couples. It specifically reviews the Emotion Focused Therapy (EFT) model on the integration of sex and couples therapy for this population.

Older adults are often dealing with major transitional and generational/contextual issues that affect their marital dynamic that can cross over into the bedroom as well.

Some of the prominent challenges faced by older adults in our society are as follows:

- Prejudicial stereotypes of older people as asexual, sickly, irrelevant and unimportant
- Retirement from employment in one or both partners, resulting in a loss of social status, identity, power and self-worth
- Physical illness in one or both partners, leading to an increased need for dependency on loved ones/partner;
- The direct or indirect (e.g., medication-related) effects of physical illness on sexual functioning
- Generational social conditioning of men (especially older men) to be emotionally "strong," avoid expressions of vulnerability and be "emotionally independent" or self-sufficient
- Significant loneliness in older age, and sense of disconnection coupled with a deep human longing for physical contact/touch
- Death of a partner and the need to develop new relationships, as well as the possibility of "blended" families with multiple marriages across the lifetime
- Changes to physical appearance, body, hormones, and sexual physiology that accompany aging or illness, including 1) menopause, lower vaginal elasticity and arousal, greater possibility of dyspareunia for women, 2) declining testosterone levels, erectile difficulties or decreased penile sensitivity for men, and 3) lower desire or frequency of sex for the majority of older individuals. Vasoactive agents (e.g., sildenafil) are often offered as a first line treatment for men and estrogen cream or supplement may help for women - however, given the

contextual issues surrounding sex and the senior couple, even if the "mechanics" of sex improve, often the sexual satisfaction may not

Despite these challenges, older couples also have significant strengths:

- The longer term pair-bonds of older couples, some of whom have been together for decades and have a shared history
- Greater emotional intimacy and the capacity to truly see and be seen by our partners, resulting in the potential of optimal sexuality, and the possibility of intimacy-driven sexual behavior as opposed to strictly mechanistic and performance-based sex

Sex is one of the most sensitive barometers of the general functioning of a relationship; it often serves as the "red flag" that the relationship is in trouble (or has been for quite some time). Historically, the field of couples therapy has often underemphasized the role of sex, whereas the sexual health field originally focused on the mechanisms or "medicalization" of sex, missing the larger contextual framework in which sexual problems arose. Recently, there has been a welcome converging of the fields, and the work of Sue Johnson, Ed.D. using an Emotion Focused (EFT) and Sex Therapy integrated model, is particularly promising.

From an EFT framework, the sexual system is one of the three primary ingredients in the formation of adult romantic bonds, resting between the attachment and caregiving systems. Sex often facilitates the development of the attachment bond between partners, though its significance wanes in later stages of the relationship (Johnson & Zuccarini, 2011). In EFT, a securely attached bond that is defined by emotional accessibility and responsiveness allows integration of all three systems. In an insecurely attached bond, it is common to see couples presenting with sexual complaints, which might include an anxious approach for sex or, alternatively, an avoidant deactivation within the sexual dynamic. In other words, in a distressed couple, one partner might anxiously pursue sex as an attempt at attachment soothing (reassurances of attractiveness, desirability, confirmation of their importance to their partner in order to "calm" fears of abandonment). Conversely, an avoidant partner might present by minimizing internal emotions, sexual cues and needs in order to soothe attachment fears of rejection by partner (avoid sex altogether, focus on the "performance" or mechanics of sex without allowing emotional engagement). Importantly, these dynamics of pursuit and withdrawal, while clearly apparent in the realm of sexuality and the "presenting problem", are also typically more broadly seen within the couple's general relational style with self and other. From an EFT perspective, it is necessary to address such a negative "cycle" both within and outside of the context of the bedroom. Either of the insecure styles of engagement listed above (approach/avoid) often lead couples down a troubling path that includes a general restriction in the possible healthy or optimal ways sex could function in their relationship. In such distressed and insecure bonds, sex can be described as non-pleasurable, pressured, dry

and mechanical, task-oriented, constricted, rigid, "stale," "lonely", burdensome and one-dimensional.

For senior couples, some of the very issues that are contextually relevant to this population might readily "bleed" into bedroom. For example, consider the male partner (in a gay or straight couple) who has grown-up with gender-stereotypical messages of emotional restriction. He is told to "buck up and be strong…boys don't cry," influencing a lifelong stance of unhealthy independence and self-reliance. As this individual ages, imagine the difficulties that might arise when physical illness sets in, he requires a greater degree of reliance and "leaning into" his partner for assistance with tasks of living, all the while experiencing significant internal conflict with this human dependency need, his sexual potency (as a result of general aging/illness AND psychogenic dependency issues) declines and he is operating under the implicit emotional messages from a lifetime of social emotional learning that says "don't reach out" and "don't show weakness." It would not be uncommon in such a scenario for the male partner to present alone in "secret" to his primary care doctor with a request for "Viagra." Yet providing such a prescription may or may not improve the "mechanics" of sex in terms of "performance', and often results in continued complaints of low desire or low satisfaction with sex for one or both partners.

The beauty of the EFT model of integrated sex/couples therapy is that the "emotional truth," meaning and relevance of the "presenting sexual problem" is seen within the larger view of the attachment bond. This allows for sex to function as just one of many ways couples can connect. From this viewpoint, compartmentalizing sex as separate from the relationship and from emotional experience is problematic.

Please refer to the online version of the article for references.

"Good Deaths": The Role of Healthcare Professionals in Facilitating Peace in the Last Stage of Life

by Bob Uslander, M.D.

I have spent most of my 25 years as emergency physician, caring for people in crisis. In recent years, I have found my true calling as a physician devoted to caring for and supporting people with complex and terminal illnesses in their own homes. Over the years I have witnessed "good deaths" and "bad deaths."

In the course of my work, and through my discussions with patients and family members, I have identified five primary needs that are universal among people at the end of their life. In my experience, when these needs are adequately met, the final chapter of life can be a meaningful, healing time, both for the person whose life is ending and the loved ones they leave behind. This kind of death could well be considered a "good death." A "bad death" results when one or more of these needs goes unmet, and the opportunity for a peaceful, healing, transformative end of life experience is lost. "Bad deaths" can be challenging for everyone involved, often leaving lingering regrets among surviving loved ones. Once a loved one dies, there is no way of unmaking the decisions we made or undoing the things that were done while they were still alive.

I believe that it is possible to facilitate "good deaths"; This is why I choose to write and speak about dying, and a large part of why I developed my current medical practice. My goal is to ensure that we get it right while we can, so people have the best possible experience as their illness progresses and their life comes to a close, and those left behind can feel that they did everything they could to create that experience.

For the caregivers of a person with a complex or terminal illness, it can be very difficult to accept that there are no remaining cures and that death is imminent. Knowing how to make their loved ones' days more peaceful is empowering. As a professional, my goal is to help loved ones understand the following needs of the ill and dying: (1) Dignity; (2) Understanding; (3) Choice/Autonomy; (4) Planning; (5) Comfort, In my opinion, if these needs are fulfilled, death can be a peaceful experience for everyone involved.

Dignity : We are cared for with awe and reverence at the beginning of our lives, cuddled and sung to, admired and loved. Should we not receive just as much reverence and awe as our life comes to a close? Dignity is critical for a successful and transformative end-of-life experience.

At the end of our life, if we are treated with love and appreciation, we will feel dignified. It shouldn't require any more explanation than that. People who are loved will not be allowed to remain in urine-soaked clothing; they won't be left in isolation or allowed to be in unremitting pain. People who are loved and appreciated—treated with dignity—will receive adequate attention to make sure their needs are being met.

Understanding: People need to know what is happening to them and be told the truth. Well intentioned medical professionals, and certainly, family members and friends often withhold information from a person who is dying in order to offer some sort of hope, or to keep them from feeling upset or sad. Ironically, in these situations, the person who is dying is usually aware that the end is near, and they they are not being told the whole truth. There is a sense of mistrust or betrayal that permeates the relationships in these settings, and the atmosphere becomes more stressful and less healing. Lack of understanding breeds fear.

Dying takes courage. People have a greater ability to handle "bad news" than most people think they do, especially when it relates to themselves and their mortality. We have greater difficulty accepting and dealing with bad news about others than we do about ourselves, which is a major reason why these honest conversations may not take place. It is less often that the individual can't deal with it, and more likely that the family members just aren't comfortable confronting the truth head on.

Creating an atmosphere of truth, honesty and open sharing is one of the pillars of a healing and transformative end of life journey. It can be difficult to make the leap, especially for families who have historically been emotionally reserved and distant. Families may need some guidance and support to start more open conversations, which can then lead to positive emotional changes among all involved.

It is also imperative that the medical professionals actively facilitate honest communication and ensure understanding among patients and family members. They often allow the patients and family members to lead these discussions and only reveal as much information as they are asked to, relieved to say less when allowed. But patients and families will frequently need more information down the line, when it is not readily available from a trusted source, so they will seek that information from less reliable sources. It is our responsibility as health professionals caring for people nearing the end of their lives to make sure they have all the information they need to make the best possible decisions and avoid the typical traps that befall those who are ignorant of this information.

Choice: People want autonomy, i.e., the ability to choose what happens to them for as long as possible. Even in the situation where someone is told their illness has no cure, choices exist. Despite our best intentions, making a choice for someone else robs them of dignity, which can have a devastating impact on a person going through the final stages of their life.

Choice is closely tied to understanding. People can only make appropriate choices about their care and their life when they have a clear understanding of what they are dealing with. Choices differ depending on the projected time left to live; a person given three weeks to live will make very different choices than one given three years. Choices also depend on one's personal values, which may be different from those of loved ones. While a loved one may focus on prolonging the patient's life, the patient himself or herself may focus on their quality of life. For example, if a course of chemotherapy will likely allow them to live for another two

months, but will make them weak and nauseated and unable to do what they enjoy, they may choose not to undergo treatment to better enjoy their time in the present. Indeed, research shows that people tend to choose *quality* of life over *quantity* of life. I have found this to be consistently true in my own professional experience.

Each situation and each patient will be facing different choices, but the concept applies to every situation; giving a person as much free choice as possible near the end of their life is critical for creating the most positive, nurturing and transformative experience possible.

A Plan: In my experience, this need varies among people. There are people who do not need to have a well-developed plan as they approach their final days of life. People who did not set much store in planning, rather, did things more spontaneously, tend to approach the end of life with a similar attitude. For lifelong planners, however, this need may be an important one to fulfill. For these people, having a plan and knowing what it is factors heavily into all of the other needs—understanding, choice, comfort and dignity.

When my patients and families need a plan laid out, I take the opportunity to discuss the different paths their journey could follow, and we do some planning around each possibility. The end-of-life journey seldom follows a straight and predictable path, but we do the best we can. There are usually twists and turns, both major and minor, that need to be navigated.

Most patients and families who are forced to navigate this end of life journey have far too little guidance when it comes to planning. This promotes confusion, anxiety and fear, which as I have already discussed, can interfere with the peaceful, transformative experience we should be striving for.

Comfort: Both physical and emotional comfort are important for a person's well-being at the end of the their life, and must be met as best as possible for a positive experience. When physical pain, or other distressing symptoms, such as nausea, shortness of breath, itching, etc., are poorly controlled, there is really no way for the experience to be peaceful or transformational. Similarly, when someone is feeling emotional discomfort or spiritual unrest, transformation is impossible to achieve. There will still be a transition, but without a transformation.

In Abraham Maslow's theory of the hierarchy of needs, physical security is near the base of the pyramid—it is quite literally, the basis of our other experiences. Just as in every developmental stage of life, as a person approaches death, their safety, security and physical comfort are among their most urgent needs. Until we address those, the rest of the needs can never be adequately met.

Getting to know each individual we care for is crucial for providing adequate comfort. What is comforting for one person will differ from what is comforting for another person. It is up to the team supporting each patient, including his or her loved ones, to determine what they

need for maximal comfort, and to make sure it is provided for them.

For one patient it will be relief of pain, for another patient it will be knowing that their legal affairs are in order, while for another it will be will be an honest discussion about past regrets or unresolved issues. For some people, massage will be comforting, or music, or watching old movies. For others, narrating a life history or spending time with friends will provide comfort. We are all comforted by different things, though as we near the end of our lives, our focus shifts, and those around us must recognize this and respond accordingly.

When the needs of those facing the imminent end of their life go unmet, it is usually because of a lack of knowledge about what is needed and what is available, and/or a lack of funds available to pay for these services. The only way to ensure that you are able to have these needs met is to be a strong advocate for yourself or your loved one, and to ask for the commitment and partnership of your health care provider. It may take a little effort to find the provider who is willing to have an open discussion with you and address your needs. Caring for sick and dying people is very much part of a medical professional's job description, but few have the necessary training and capacity to be of optimal help. Professional care managers such a nurses, social workers, and geriatric specialists with training and experience in advocating for and navigating people through the health care system may be a good option.

The goal of this article is to primarily educate other professionals, family members, and patients themselves, in order to minimize "bad death" experiences. I hope to also bring awareness about professionals such as myself, who are devoted to caring for the dying, and expanding the conversation about these important end of life issues.

Death should not be the taboo subject it is in our society. It should be recognized for what it is: a fundamental and transformational part of life.

Neuropsychological Evaluation in Older Adults

by Katherine Bangen, Ph.D., Barton Palmer, Ph.D., & Gauri Savla, Ph.D.

With advances in medicine during the last century, people are living longer, and are often active well into "old age," often considered to be 65 years of age and older. Older adults are at risk for cognitive deficits related to cerebrovascular, systemic, psychiatric, and neurodegenerative illness. Therefore, clinical care of older adults should almost invariably include some consideration of the presence and impact of cognitive deficits. Cognitive decline is a central feature of many conditions that increase in prevalence with advancing age including neurodegenerative conditions such as Alzheimer's disease, dementia with Lewy bodies (DLB), and Parkinson's disease, as well as cardiovascular conditions such as stroke. In addition, chronic metabolic illnesses (e.g., diabetes) and long-standing autoimmune diseases (e.g., multiple sclerosis) may also be associated with cognitive impairment.

Psychiatric disorders, such as primary psychotic disorders or severe mood disorders, that typically begin earlier in life and often extend into later life are also often (but not always) associated with cognitive deficits. In general, these deficits tend to remain relatively stable over the course of the illness. In other words, there are rarely sharp declines in cognitive functioning in later life in the absence of a new-onset neurodegenerative illness or other condition contributing to cognitive decline. The emergence of such a new-onset decline should therefore alert the clinician to the possibility of a secondary acquired condition. One potential exception being that cognition in bipolar disorder may continue to deteriorate over time, with repeated mood episodes. This finding, if confirmed via prospective research studies currently underway, may be particularly relevant for those older adults with bipolar disorder who have lived with the condition for decades. In either case, an important point to consider is that cognitive deficits in outpatients with schizophrenia or bipolar disorder are more predictive of level of adaptive functioning (i.e., practical everyday skills) than symptoms of the primary psychopathology. The bottom-line is that, in geriatric mental health settings, assessment of neuropsychological functioning should be a key component of diagnosis and long-term treatment planning.

What is a Neuropsychologist?

Neuropsychology is a sub-specialty of clinical psychology and is concerned with relationships between the brain and behavior. The term "neuropsychologist" refers to a clinical psychologist, who, in addition to the broader training required for a doctorate and licensure in clinical psychology, has also completed additional specialized training in basic neuroscience, neuroanatomy, neuropathology, and neurobehavioral syndromes, and their psychometric assessment. A neuropsychologist, therefore, is an expert in brain-behavior relationships, their standardized assessment, as well as cognitive interventions.

What is a Neuropsychological Evaluation?

Standardized neuropsychological tests that measure cognitive abilities form the core of neuropsychological evaluation. Major domains that are commonly assessed include general

intellectual functioning, learning and memory, executive functioning, attention/concentration, language, visuospatial abilities, speed of information processing, and motor speed and strength. Data from standardized neuropsychological tests can then be compared with normative databases. However, neuropsychological evaluation involves much more than administrating and scoring standardized tests. Valid and clinically useful interpretation of test performance requires the neuropsychologist to consider the examinee's performance within the broader context of his or her presenting complaint as well as current and prior medical history, psychosocial history, and daily functioning. Therefore, comprehensive clinical neuropsychological evaluations generally include a thorough review of available medical records as well as a clinical interview of the patient and a family member or other collateral information sources. Emotional functioning including mood symptoms is also often assessed via clinical interview, behavioral observations, clinical rating scales, and/or standardized psychological tests. A neuroimaging exam is frequently included in the evaluation to provide additional data that may aid in diagnosis.

Common Clinical Applications of Neuropsychological Assessment

Neuropsychological assessment can be invaluable in geriatric mental health care settings. These assessments assist in distinguishing between normal versus abnormal cognitive and functional changes; aiding in differential diagnosis among neuropsychiatric and neuropathological conditions; informing treatment recommendations; and monitoring an individual's progress. Despite recent technological advances in neuroimaging techniques, their clinical relevance (particularly in regard to diagnostic specificity) remains unclear. For example, a common concern among older patients relates to distinguishing normal age-related cognitive changes from early Alzheimer's disease or other neurodegenerative disorders. A second presenting problem frequently seen in the clinic relates to determining whether an individual's reports of memory or other cognitive changes are due to depression or primary neurocognitive dysfunction. Such distinctions are very difficult, if not impossible, to make based on neuroimaging results alone and often involve considering information from multiple sources including the pattern of neuropsychological test performance together with the individual's medical and psychosocial functioning.

For example, consider an older patient presenting with concerns of "poor memory." "Memory" has a many meanings in colloquial use. These include remembering to perform a task ("prospective memory"); remembering where within one's house an object, such as a set of keys, was left (which may reflect attention or organizational skills rather than memory per se); and remembering recent events or newly acquired information ("episodic memory"). Even when the concern is narrowed down to an episodic memory deficit, it is important to distinguish between a variety of underlying memory-related processes, including difficulties with initial learning or encoding information or difficulties efficiently retrieving previously learned information. Results from standardized learning and memory tests are critical in making such distinctions. For example, if an individual performs poorly on initial learning or recall trials of a memory test yet, after a delay, he or she is still able to recall most of the information he or she learned, then his or her deficit is likely one of learning or encoding

rather than retrieval. Comparison of performance on a cued-recall recognition format relative to free recall (without cues) permits identification of patients with inefficient retrieval rather than an encoding deficit. These distinctions are invaluable in the differential diagnostic process. Rapid forgetting, or the inability to retain recently learned information, is relatively uncommon in normal aging and even in individuals with depression but is very common among patients with some forms of dementia including Alzheimer's disease. One would not make a diagnose based one isolated test score (when given a large test battery, most healthy adults will have one or more "impaired" scores), but the presence of rapid forgetting would be more consistent with the presence of a cortical dementia than with normal aging or depression.

Even in those cases in which an individual's diagnosis is known, neuropsychological assessment can be valuable in the documentation of the trajectory and rate of cognitive change. There is considerable variability among individuals with neurodegenerative conditions in terms of the rate of cognitive decline. Repeat evaluations can be extremely useful in determining how quickly an individual may reach a point requiring a more intensive level of care. Conversely, for an individual who experienced a stroke or other form of brain trauma, repeated neuropsychological assessment can be useful in documenting the rate, trajectory, and degree of recovery of cognitive functioning.

Neuropsychological assessment in geriatric mental health care settings can also be useful in treatment planning and developing strategies for remediation of deficits in everyday functioning. For example, a patient's memory deficit may cause difficulties in everyday functioning (such as missed appointments, missed medication dosages, unpaid bills, etc.). In such instances, a goal of neuropsychological evaluation is to identify areas of cognitive strengths in addition to documenting the type and degree of any cognitive deficits. With information on both cognitive strengths and weaknesses, the specific cognitive processes underlying any apparent deficits in independent functioning can be identified. Information about spared abilities can be used to arrange the environment in a way that draws upon the individual's strengths and reduces any deleterious functional effects related to cognitive deficits.

Issues in the Assessment of Older Adults

Sensory Impairment

Hearing impairment is fairly common among older adults and can considerably complicate administration of verbal neuropsychological measures (e.g., memory measures involving verbal list learning) and the interpretation of results. An examinee's hearing should be at least informally assessed to determine whether it is adequate for the administration of verbal neuropsychological tests. If hearing is deemed too impaired, the individual can still be evaluated using visual tests (assuming he or she has adequate visual acuity). Visual acuity may be informally assessed, for instance, using the Rosenbaum Pocket Screener. Visually impaired patients can be assessed with a variety of tests involving auditory or tactile test materials.

Interpretation of Test Results in the Context of Normal Aging

Normal aging is associated with changes in cognitive functioning including slowing of mental processing speed and psychomotor speed as well as subtle declines in some aspects of memory and executive functioning. A major advantage of the standardized testing emphasized in neuropsychological assessment over other neurobehavioral examinations is that the interpretation of an examinee's responses is not based solely on the absolute level or content of responses but also in reference to the level of performance expected from a neurologically healthy individual with similar demographics. The latter is determined by comparing the examinee's test scores to demographically-appropriate norms (based on age, education, sex, etc.). Most widely-used neuropsychological tests have normative data that are developed and collected using standardized administration and scoring procedures.

This article was adapted from: Palmer, B.W., & Savla, G.N. (2009). (Geriatric psychiatry 54.2e) Neuropsychological evaluation. In B.J. Sadock, V.A. Sadock, & P. Ruiz (Eds.). The Comprehensive Textbook of Psychiatry - 9th Edition (pp. 3989-3994). New York: Lippincott Williams & Wilkins.