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Victor Molinari, PhD, ABPP
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Dear Dr. Molinari,

Please find attached, a Table of Contents, my Professional Self Study Statement and 3 work samples demonstrating my skills and accomplishments in the field of geropsychology.

The first sample is an article I wrote with the help of 3 of my colleagues at Heritage Clinic: "Providing Psychotherapy to Older Adults in Home: Benefits, Challenges and Decision-Making Guidelines." While this article is co-authored with Dr. Jamie Garis, Dr. Cynthia Jackson and Dr. Regina McClure, it was based largely on my work, and I was the lead author. This article references my competence in the areas of assessment, intervention (and some in consultation) The article discusses recommendations for thoughtfully intervening with older adults who are homebound, suggesting ways to think through clinical, ethical and legal challenges to the treatment process. It discusses suggestions for assessing the meaning of client behaviors and

requests in the context of in-home work, leading to appropriate treatment responses. Also included are suggestions for responding to uninvited interdisciplinary consultations with other persons in clients' homes.

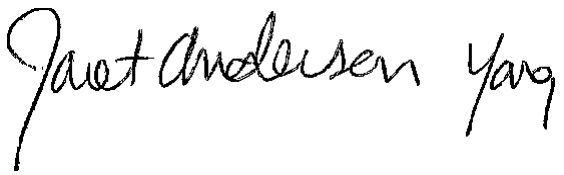
Secondly, I am submitting the power point for a presentation I deliver frequently, on working with cognitively impairment older adults: "Working with Older Adults with Cognitive Impairment." This presentation indicates my knowledge of how to assess and provide treatment with cognitively impaired elders, and provide advocacy for these elders. It discusses assessment of dementia and distinguishing dementia from delirium. It discusses a number of screening tools for assessing cognitive impairment and compares their practical utility for use in public mental health agencies. I discuss the California form for assessing persons for conservatorship (i.e., guardianship). I summarize a number of methods useful in providing mental health interventions for elders with cognitive impairment, and I also indicate my advocacy for services to underserved cognitively impaired elders who can still benefit from psychological services.

My third work sample, a power point presentation for "Culturally Competent Recovery Oriented Services for Older Adults with Mental Illness," demonstrates my understanding of assessing, intervening and consulting with regard to cultural diversity issues. I discuss methods of assessing clients' cultural identify and assessing their explanatory models of illness. The presentation discusses cultural formulation as part of a multiaxial diagnostic assessment. I make suggestions for providing culturally proficient treatment for diverse older adults. In the area of consultation, the presentation suggests ideas for recommending systems level interventions appropriate

for use with consulting at the organizational level, as well as possibilities for consulting with common community partners when working with culturally diverse populations. As an indication of teaching and supervision, I arranged for two of my interns to take part in giving this presentation and participate in training other mental health service providers.

Thank you for your consideration of my submission.

Sincerely,



Janet Anderson Yang, **Ph.D.**

Janet Anderson Yang

Professional Self Study Statement

Professional Activities

My professional activities as a licensed psychologist have occurred primarily at a community based clinic, since 1993. This clinic is an older adult service agency with 2 adult day care centers for dementia clients, and 4 offices from which field-based mental health services are provided. Services include mental health community outreach and engagement of severely mentally ill elders, in-home and in-clinic assessment and psychotherapy, mental health case management, psychiatric care and mental health rehabilitation.

In the recent 13 years, I have been the Clinical Director, Training Director and HIPAA Officer. As Clinical Director, I oversee the clinical aspects of the agency, supervising 11 staff directly, and supervising the supervision of 25 staff, indirectly. I set clinical policies, promote ethical and legal conduct and documentation and supervise all clinical aspects. As Training director I oversee training for psychology practicum students, psychology post doctoral residents, social work and marriage and family therapy students and our APA accredited doctoral internship. I recruit, interview, choose, train, supervise and evaluate trainees. I teach a weekly geropsychology clinical seminar.

Additionally, I conduct assessment and psychotherapy with between 5 to 10 clients weekly, including older adults with disorders such as depression, anxiety, PTSD, adjustment disorder as well as younger adults. I am also trained and on call to assess for involuntary psychiatric hospitalization of clients in crisis.

I seek board certification support the growth of the field. I participated in the Pike's Peak Conference in 2006, and the Council of Professional Geropsychology Training

Programs over the past 9 years. I believe seeking board certification and increasing the numbers of psychologists board certified in geropsychology will help to increase the stature of the field. I hope this will also encourage more young professionals to go into geropsychology, particularly given that I am a model for my trainees.

Professional Development

While of course my childhood development plays a role in leading me towards geropsychology, I more specifically relate beginning toward this specialty to my freshman counselor in college. She suggested I volunteer visiting homebound older adults. This led to a three year relationship visiting “Mrs. Cote” in her home, and then conducting my Senior Thesis with Dr. Judith Rodin assessing the nursing home environment on resident behavior. Subsequently I worked as a nursing aide and a recreation therapist in convalescent hospital, a director of a small senior center, and a mental health clinician in community mental health center, providing therapy in older adults’ homes and in senior centers. I then decided to pursue a doctorate in clinical psychology.

In graduate school, while working with Dr. George Niederehe, at the Texas Research Institutes of Mental Sciences, in Houston Texas I had the opportunity to gain

an overview of clinical geropsychology and to learn about geropsychology research. Working with Dr. Asenath La Rue and Dr. Gary Small at the UCLA Neuropsychiatric Institute, I developed further research understanding and skills, and was able to go further with geropsychology. During internship and post doc at UCLA NPI, I also gained skills in psychotherapy, psychodiagnostic and neuropsychological assessment with older adults, research (memory loss & cognitive screening), and consultation on medical units.

While I was exposed to behavioral, cognitive-behavioral, systems and ego psychology during graduate school, I became more specifically interested and trained in psychodynamic/object relations approaches at UCLA. I have maintained an affinity for relational approaches based on attachment theory during the course of my career, while learning and integrating additional techniques. These include grief therapy, life review therapy, mindfulness techniques, Interpersonal Psychotherapy and Emotion Focused therapy.

When I came to Heritage Clinic in 1993, I was director of this small older adult clinic. I was newly licensed, and new to administrative, fund raising and supervisory duties. One of my first supervisees was a licensed marriage and family therapist, with 15 years more clinical experience than myself, and the clinic was facing a significant budget cut. I had to push myself to gain skills in public speaking, lecturing, training, supervising, seeking funding, and budgeting. While these duties challenged me, I was deeply satisfied to be helping provide mental health and dementia care services to disempowered older adults.

Early on, I helped the agency gain funding to outreach to victims of elder abuse, to provide advocacy and psychological services to these victims. I then secured additional foundation funds to expand our outreach to a wider array of older adults who were identified by third parties (i.e., “Gatekeepers”) as needing but refusing formal mental health services.

As Training Director, I led our APA internship accreditation application and 7 years later, our renewal. This led to my interest in attending the Pikes Peak conference in Colorado Springs in 2006, where I participated in various work groups to help develop the Pike’s Peak competencies, and then became a member of the Board of the Council of Professional Geropsychology Training Programs for 5years. I have had the privilege of being a part of the early formalization and growth of the field of geropsychology, as well as participating in the development of the Pikes Peak Competency Assessment tool (Karel et al, 2012).

Another significant opportunity contributing to my professional development is the Mental Health Services Act (MHSA) in California, a law passed in 2004, significantly increasing funding for mental health services for low income seriously mentally ill persons. For the first time, the California public mental health system was legally required to set a certain percentage of funds specifically older adult mental health services. I consulted and advocated for how this law was set in place with regard to older adult services. Because of the increase in funding from MHSA, our agency opened 7 new offices, learned to incorporate the Recovery Model into all of our services, developed services for homeless older adults, and instituted Wrap Around services for severely mentally ill elders.

Services to the Profession

I have participated in a number of multidisciplinary committees, providing psychological consultation and advocacy to improve the lives of older adults, in Pasadena city, Los Angeles County, California, and nationally.

Locally, I served as our agency representative to the Pasadena Senior Commission for 6 years. Working with lay seniors and agency representatives, we made recommendations to the Pasadena City Council. I worked with multidisciplinary committee to develop a “Postal Carrier Alert” program.

I co-chaired the West San Gabriel Valley Elder Abuse Task Force for 5 years, during which I organized and facilitated a multi disciplinary team to address elder abuse issues. I provided mental health consultation to the discussions on how to intervene in elder abuse situations, and I used my psychological skills to facilitate the case discussions among a set of professionals who were quite competitive.

In the County of Los Angeles, I have served on workgroups and committees providing older adult input to the Department of Mental Health policies. These include helping to develop the set of outcomes which would be used to evaluate the effectiveness of the older adult programs, setting guidelines for training and workforce development, and developing guidelines for how to assess and treat older adults with dementia and SNF residents. One advocacy theme I have repeatedly acted upon is bringing appropriate mental health services to persons with cognitive impairment. Early on, the Department of Mental Health stated that we could not provide psychotherapy to any client with a diagnosis of dementia. I have worked to elucidate ways in which

clients with some degree of dementia can benefit from psychotherapy and other psychological services, and now the Department policy has changed.

I have recently been appointed to be the Mental Health Representative to California State Alzheimer's Committee, in which capacity I provide a mental health perspective to this committee, which reports to the state government on policy and budget suggestions.

Nationally, I was a delegate to the National Conference on Training in Professional Geropsychology in June, 2006. Following, I was nominated for election to the Board of the newly formed Council of Professional Geropsychology Training Programs (COPGTP), on which I served for 2 years as the Intern representative, and 3 years as Secretary.

Continuing Education:

I developed, facilitated and taught 3 96-hour Certificated Older Adult Mental Health courses in 2008, sponsored by Heritage Clinic, an APA approved sponsor of continuing education. These courses included didactic lectures and experiential components, and covered the following topics: Mental illness, Spirituality and existential issues, Recovery principles, Mental health interventions, including grief therapy, Evidenced based practices, Outreach & engagement of hard to reach older adults, Boundary issues in providing field based services, Working with clients with dementia & psychotic disorders, and Interventions in institutional settings, Life cycle developmental processes, Caregiving, Substance abuse, Cognitive disorders, Psychopharmacology, Legal and ethical issues, Community resources, Medical disorders, Multicultural issues,

Problem Solving Therapy, Cognitive Behavioral Therapy, Intensive Community Services, and Life review & Reminiscence Therapy.

I have also attended the following workshops: Grief Therapy and the Reconstruction of Meaning (7 credits); Aging Well in Communities (2.75 credits), Medicare guidelines (3 credits), psychopharmacology with older adults (2 units), hoarding in older adults (2 credits), older adults and memory impairment (9.75), among others.

Scientific Base:

While I am not primarily a "researcher," I use scientific findings in my work. I participated in committees to make recommendations to our agency, the County and the State of California Departments of Mental Health as to what outcomes would be most appropriate for measuring the effectiveness of the new services designed for older adults.

I have participated in program evaluation projects at Heritage Clinic. This includes program assessment for our Clinical Mental Health Outreach Program (published article: Yang, J, Garis, J, & McClure, R. (2006), and our project: Eliciting Change in At Risk Elders (ECARE), submitted for publication.

As Training Director, I have evaluated, recommended, arranged for and participated in several evidenced based practice trainings, including Interpersonal Psychotherapy, Problem Solving Therapy and PEARLS. I have personally received training in Interpersonal Psychotherapy, which is an evidenced based practice for older adults. This included a 2 day workshop and a 1 day booster training from Dr. Scott

Stuart, and I have submitted my case study materials to become certified as an IPT provider. Attending national conferences, such as APA and GSA, reading on the Clinical Geropsychology list serve and the Psychologists in Long Term Care list serve, and perusing journals, I try learn and incorporate new research findings.

Ethical Base:

One ethical challenge I have faced involves balancing an older adult's need for safety versus autonomy, which includes the consideration of ethical principles Beneficence and Nonmaleficence (principle A), confidentiality (4.01), appropriate use of assessment using appropriate norms (9.02), multiple relationships (3.05), Avoiding harm (3.04) and informed consent (3.10), among others.

For example, Mr. T was an 80 year old, bilingual Mexican born gentleman, and was a client of an intern I supervised. He drank heavily and frequently, during which times he neglected to eat nutritiously and take insulin for his diabetes. He fell a number of times, and was found disoriented and with elevated blood sugar levels. I supervised my intern to complete a brief cognitive screening with the MMSE and the Neurobehavioral Cognitive Status Exam (NCSE). Under ethical principle (9.02) we sought to choose a screening instrument which was valid and reliable for this client, but we did not have a staff person who competent (ethic 2.01) to administer tests in Spanish, his primary language, nor to administer a more complete psychological assessment. We attempted to refer him to a Spanish speaking psychologist, but none were available under his insurance. On these screening measures, Mr. T did not show statistically significant cognitive decline. Additionally, when he was sober, he was able

to articulate that he understood the risks of staying at home, saying he wanted to remain at home, and he wanted to be able to continue to drink as he choose, even given the risks of falling and perhaps injuring himself. The dilemma I felt was whether or not to advocate for him to be conserved. From the clinician's assessment, he seemed to retain his capacity for deciding to take the risks of living at home. Another agency, a case management agency, however, did not agree, and asked for our help to have him hospitalized involuntarily to maintain his safety and to pursue conservatorship. In the course of working with this other agency, the ethical issue of confidentiality (4.01) arose. Mr. T had given consent to share minimal information with the other agency, but not to detail what we know about the extent of his drinking. The dilemma of conflict of interests (3.06) also arose, in that I wanted to maintain a working relationships with the other agency, our biggest referral source, but also wanted to advocate for Mr. T.'s best interests

I chose to advise Mr. T's clinician to provide close psychotherapy services, and to treat his depression, and use a motivational interviewing & harm reduction approach to encourage him to reduce his self harmful drinking behavior. We did not advocate for hospitalization or conservatorship, believing that he retained capacity to make his own decisions. I also choose to instruct the intern to share only minimal information with the case manager, despite the impact this could have on our mutual referral relationship.

Another meaningful and challenging ethical dilemma I encounter concerns guiding trainees and staff as they conduct psychological assessment and psychotherapy in client residences. Ethical Principle D of Justice instructing

psychologists that persons are entitled to access and benefit from the contributions of psychology, and Principle A of Beneficence and Non maleficence propel us to extend our services as much as is feasible to older adults, including those who are home bound. However, several challenges arise, including possible conflict between ethics and regulating agencies (1.02), multiple relationships (3.05), third party request for services (3.07), cooperation with other professionals (3.09), informed consent (3.10), maintaining confidentiality (4.01), and minimizing intrusions, privacy (4.04).

For example, client JW was referred to us by a case management agency and assigned to an intern I supervised. JW accepted services, but did not want us to tell the referring agency anything, including whether or not she was receiving our services. When my intern was asked by the case manager for an update (third party requests for services (3.07), I suggested to the intern to be very circumspect (confidentiality (4.01), which irritated the case manager, and interfered with her agency feeling trust in the communication between our two agencies. I felt a conflict of interest (3.06) between maintaining the trusted referral source and the client's right to confidentiality. I decided to talk with the case manager's supervisor and reiterate our agency's legal and ethical requirement to maintain confidentiality. When we started services with JW, her daughter was present in the living room, where the elder sat, and she was unable to move without enormous difficulty (confidentiality, 4.01). The intern and I discussed asking the daughter to leave the room, but there was no other room available in the small apartment, and asking the daughter to leave seemed likely to threaten the client's willingness to continue services (Principle A, Beneficence). I recommended to the clinician to provide conjoint interventions at first, and then after gaining more rapport

and trust, to ask the daughter to arrange to be out of the apartment for some individual therapy sessions. Multiple relationships (3.05) also had to be grappled with. JW asked my intern to take her to the social security office, saying she did not want to bother her daughter who might abandon her if she were too demanding, and did not want to ask the case manager. I recommended that that intern help the client arrange para transit, and thus minimize the multiple relationships between the clinician and client.

Complex Relationships:

As Clinical Director, I oversee the programming and clinical work for 4 offices of our agency. They are staffed by clinicians licensed at the doctoral level, Masters level and case managers. Last May, I was told by a staff member in one of these offices, that one of the clinicians seemed to have developed an intimate relationship with one of his former clients. With some investigation, I determined that it had been only 1 1/2 years since this woman had been a client. This led me to need to report this clinician to his professional board, and to fire him. However, within a day from when I learned of this relationship, the therapist, an older adult himself, died. I then had to determine what was the most ethical, legal and clinically appropriate approach to responding to the woman, our previous client. How should I provide for the treatment services for the deceased therapist's "girlfriend" who had been and wanted to return to being a client of our clinic? On the one hand, this woman was desperately grieving and traumatized by a bloody death, and needed mental health services. However, given the remote location of this community, there were no other service providers available to her that she could afford through her insurance. While I generally do not provide intervention services for clinic clients, I felt that it would be too clinically and ethically complex to ask any other of the

staff to provide treatment for the woman who had been the girlfriend of their fellow staff member, who had just died.

I consulted a mental health lawyer, a psychologist with an expertise in ethics and another psychologist with an expertise in boundary issues, and 3 additional psychologists with experience in the Recovery Model. While in one of these consultations I was strongly urged to not provide mental health services to this woman, due to the conflict of interest I would have in that clinically appropriate treatment might encourage her to get in touch with anger and possibly sue our agency, there also was an absence of other options for treatment for her. I decided to provide short term grief therapy and then seek to make alternative arrangements for longer term therapy if she so desired.

Another aspect of the complexity of relationships included what I did and did not tell the other staff persons in this office. They were grieving the loss of their co-worker. I deliberated about whether to tell them that the deceased therapist's "girlfriend" had been a client of the therapist. I decided that I needed to tell them, given that he had behaved unethically, by having sexual intimacies with a recently prior client, because I felt it was important to be very clear that this behavior was not acceptable, and would be followed by termination and report to the appropriate professional board.

I have since done a lot of reflecting on these events. What did I fail to do that this relationship occurred in the agency? What did I fail to do such that this went undetected? Follow up action has included watching case assignment more closely, supervising the clinicians in this outlying office on a more frequent basis, conducting treatment team meetings on a weekly basis, and providing agency wide training on boundary issues, within the Recovery Model.

Individual and Cultural Diversity:

Cultural diversity has been an important concern of mine for a very long time. Following college, I worked in a volunteer program and lived as a minority in an African American neighborhood (I am Caucasian), working in the local senior citizen center. In graduate school I studied under Dr. Thomas Parham and learned about “Black Psychology” including how psychology had historically contributed to perpetrating racism and discrimination. I studied under Dr. Gail Wyatt at UCLA, and received her supervision as I worked with an African American older woman during internship.

At Heritage Clinic, I try to apply my awareness and knowledge of cultural diversity with clients, trainees and staff. I encourage management in the agency to pay a incentive stipend to persons with bilingual abilities. I encourage multi cultural persons to apply for training positions and jobs. I try to facilitate a milieu of respect and openness about diversity among staff and an increased ability to talk openly about race and ethnicity, and other aspects of diversity. I facilitate multi-cultural discussions at staff meetings and staff retreats, as a step towards increasing the comfort level of staff and trainees to address ethnic and other cultural issues openly. I have made efforts to provide multicultural staff and trainees with modifications to their positions which

enhance the likelihood of them continuing at the clinic. I also teaching supervisors to include multi cultural issues in supervision

A recent example of how my work in Geropsychology is informed by awareness of and sensitivity to diversity occurred this past month. In hearing the acquittal verdict in the George Zimmerman trial, I encouraged a supervisee who is working with an African American grandmother, to bring up this current event in therapy. I suspected that my supervisee's client, who has teenage grandsons, would be experiencing a variety of feelings related to the case verdict, and to the discriminatory treatment of young black males. This supervisee reported to me the next week, that her client became noticeably more engaged in treatment after the therapist had addressed and shown her client that she could understand the importance of how Black men are often treated in a negatively stereotyped way.

Self Assessment:

My experiences and opportunities have led me to be a geropsychologist who has a heart for enabling disenfranchised and hurting older adults, to develop more satisfying lives. I believe that people can and want to heal and change, that relationships are key to bringing about healing as well as an essential part of life to strive for. I believe in equal access to service, despite obstacles such as impoverishment, cognitive decline, physical decline, injustice, language, and other barriers. Theoretically, I have embraced Interpersonal and emotion focused models, including Object Relations, Attachment Theory, and Interpersonal Psychotherapy.

I entered the field of psychology in general, and geropsychology more specifically, from the standpoint of enjoying listening to people's stories, empathizing with their emotions and seeking to help them, from a one-on-one standpoint. With time, with mentors and with opportunities, I have gained experiences which have expanded my skills and perspective. Soon after becoming licensed, I found myself in a position of supervising, administrating and managing a small clinic. Of necessity, I pursued skills in administering, supervising, managing, teaching and fundraising, even before I felt I had had abundant experience conducting psychotherapy directly. Over the years, I have supervised and/or supervised the supervision of, perhaps 200 staff and trainees, supervising the clinical work of perhaps 1,000 clients. This has given me a broad clinical perspective. I have developed confidence in my supervision skills, my staff management skills and providing training. I greatly enjoy helping staff and trainees develop their own style and confidence, while learning the boundaries and parameters of clinical efficacy, legal and ethical practice and gaining gero-specific skills. Being in the field during the advent of the Mental Health Services Act in California and the development of the field of geropsychology nationally, has afforded me opportunities to further the field of geropsychology by helping to shape the service delivery model for older adults and training professionals of many different disciplines.

Now my professional life is shifting. While I juggled active motherhood and professional work over the past 22 years, my youngest child just started college and I am now more free to focus on career, creating good timing to pursue board certification. I anticipate being able to invest more time in contributing to the development of the field of geropsychology. I am also planning on increasing my direct psychotherapy skills.

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ARTICLES

Providing Psychotherapy to Older Adults in Home: Benefits, Challenges, and Decision-Making Guidelines

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Mental health service providers have begun serving older adults in their places of residence. Providing psychotherapy in an eider's home presents numerous benefits and challenges, compared with in-clinic work. Because many of these differences are complicated, clinicians must make quick decisions and can benefitfrom guide-lines to formulate responses. Based on each of the four authors' 10 to 15 years of experience, this article presents advantages to be gained by providing services in the home, including development of rapport, accessibility of information, and participation by the client with tramportation challenges. Tbe authors present a number of challenges such as interruptions, maintenance of professional boundaries, difficult tramferences and countertransferences, threats to confidentiality, and safety issues. Decision-making guidelines are offered.

KEYWORDS aging, decision-making guidelines, in-home psychotherapy

INTRODUCTION

Older adults comprise 12.6% of the population in the United States, and that figure is estimated to reach 20% by 2030 (Administration on Aging, 2007).

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Research indicates that elders who receive mental health services can achieve a higher quality of life, while reducing depression (Scogin et al., 2005), anxiety (Ayers et al., 2007), and insomnia (McCuny et al., 2007). Reducing mental illness can improve an eider's health (Zarit & Zarit, 2007) and may lengthen the duration of independent living. While mental health services provided to older adults involve many of the same approaches used with younger adults, adapta- tions are required (Knight, 2004; Laidlaw, Thompson, Dick-Sisken & Gallagher- Thompson, 2003; Yang & Jackson, 1998). These include more frequent grief therapy; devoting more time for transmission of life stories; accommodating slower cognitive processes, sensoty impairments and medical conditions; and overcoming this cohort's stigma against mental health services. Because of several of these aspects of aging, mental health service providers are offering services to elders in their places of residence.

In-Home Mental Health Services

Mental health setvices provided in older adults' homes have begun to be documented (Ammerman et al., 2007; Banerjee, Sharmash, Macdonalc\, & Mann, 1996; Burns et al., 2001; Craman, 1992; Dittbrenner, 1994; Kaufman et al., 2000; Knapp & Slattery, 2004; Lipsman, 1996; Muijen et al., 1992; Maxfield & Segal, 2008; Rosqvist et al., 2002). Some of the literature pro- vides data for effective application of initially in-clinic, evidenced-based treatments in home settings. Steinberg and her colleagues (2007) provided screening and assessment, psycho-education, referral and linkage, and behavioral activation to depressed, frail older adults in their homes, leading to decreased depression (Quijano et al., 2007). Ciechanowski et al. (2004) pro- vided home-based treatment to depressed, chronically ill elders and found that brief problem-solving therapy decreased depression. Reminiscence inter- ventions have also shown effectiveness in in-home settings (Haight, 1988, 1992). Although addressing a younger adult population, Burns et al. (2001) also found that regular home visits from mental health se1vice providers con- tributed to decreased psychiatric hospitalization. Little research has tested the application of cognitive-behavioral therapy (e.g., Laidlaw et al., 2003) or inter- personal psychotherapy (e.g., Hinrichsen & Clougherty, 2006) in home-based settings, although Maxfield & Segal (2008) provided a clinical case study of cognitive-behavioral therapy's effectiveness in the home. Interpersonal psy- chotherapy also offers promise for in-home work, but fu1ther research is needed to investigate the transfer of in-clinic research to the home setting.

Benefits of In-Home Mental Health Se1vices

Providing mental health se1vices in older adults' homes presents a number of benefits. Setvices can be offered to elders unable to drive, use public transportation, or access para-transit. Elders may participate for whom going

to an office is stigmatizing and/or requires too much energy. Rapport-building can be heightened, thus reducing suspiciousness or hesitancy. Services can be made more accessible to older adults with cognitive impairment. In all cases, clinicians stand to gain a wealth of first-hand information.

Challenges of In-Home Mental Health Services

Despite these benefits, the in-home setting poses a number of challenges (Knapp & Slattery, 2004; Maxfield & Segal, 2008). Because psychotherapists traditionally practice in a clinic or office, they presume a controlled and predictable setting. The therapist generally eliminates interruptions, restricts who is present, and creates and maintains a professional atmosphere. Because individual client homes present unknown and less controllable factors, decision-making demands on the therapist are multiplied and unavoidably immediate. Clear boundaiy-setting is necessary to conduct psychotherapy in the home setting, yet as a paradox, flexibility is also key (Knapp & Slatte1y, 2004; Maxfield & Segal, 2008).

The authors of this article work at a community-based, mental health clinic that serves older adults. Over each of the past 25 years, an average of 50 to 100 older adult clients have received psychotherapy in their homes through this clinic. Each author has supe1vised 40 to 50 therapists (social workers, maniage and family therapists, psychologists, and graduate students) for 10 to 14 years. Based on their experience, these authors discuss clinical, ethical, legal, and risk-management challenges arising during in-home psychotherapeutic work with older adults, along with guidelines to help navigate the unclear territory between flexibility and clear boundary-setting. The recommended approach is to: 1) conduct a traditional assessment leading to diagnosis; 2) establish a conventional treatment plan with treatment goals; 3) apply flexible ideas; and, 4) when unexpected events occur, test these ideas against the t:reatrnent plan, professional ethics, state laws, and agency risk-management guidelines. While flexibility is a hallmark of successful work in clients' homes (Muijen et al., 1992), acll1erence to a well conceived, assessment-based treatment plan is essential to optimal treatment when facing spontaneous decisions in the field. Ofer Zur's principles (2002, 2008) on boundary issues for psychotherapy are highly applicable to work with older adults in the home. While the overall practice of assessment, diagnosis, and treatment planning uses a standard approach, in-home work triggers such frequent and immediate challenges that clinicians must more regularly reference the treatment plan.

CLINICAL ISSUES

Some of the clinical benefits and challenges that uniquely arise in the home are: 1) rapport building, 2) information gathering, 3) access to collateral

significant others, 4) maintaining professional roles, 5) therapy interruptions, 6) pacing needs, and specific 7) transference and 8) countertransference **issues.**

Rapport

In many cases, rapport may be more easily established when working in the client's home. Many homebound elders are isolated; the clinician may be the only person who the elder sees regularly. These clients are often grateful to the clinician for coming to them. Additionally, the clinician can gather information from the home environment to facilitate rapport. For example, noticing and discussing certain artwork on the walls, or sharing apprecia- tion for a pet, can help form a positive bond. In contrast, clients who have difficulty setting limits with others may experience in-home treatment as intrusive and utilize negotiation of space, scheduling, frequency, etc. to modulate their relationship with the clinician.

Information

Unlike the therapist-designed environment of the office, a client's home provides a wealth of direct infonnation about the client. For example, a 60-year-old male client who comes into the clinic may present fairly well; the client and clinician may talk about loss issues and loneliness. But within the home, the clinician may see that the walls are covered with photographs of his deceased mother, that the rooms are filled with aged items, such as old dresses, old medication bottles, books and newspapers, information tl1at the client may not have shared voluntarily. On a cautionaiy note, gathering non-verbalized information from the client's living space may precede the client's intention to share such information. Thus, therapists are encouraged to consider how use of this first-hand information can impact pacing, control, distance, and intimacy within the therapeutic relationship.

Access to Collateral Significant Others

When seeing a client in her home the clinician may encounter relatives, home health aides, neighbors, nurses, etc. On the beneficial side, informa- tion can be gathered, when appropriate and witl1 client consent; collaterals can be accessible to engage in conjoint therapy. For example, while con- ducting therapy with a 94-year-old woman, the client reported that she was aggravated with her live-in caregiver who kept answering the phone *for* her, and talking to the caller *for* her. The opportunity was readily available for the therapist to support the client in talking with her caregiver, an opportunity which would be less likely to arise in an office.

Access to significant others can be challenging. Family members may involve themselves in therapy sessions, uninvited. For example, when a clinician arrived for his first session with a 74-year-old woman who was confined to her home because she was taking round-the-dock care of her quadriplegic son, the client invited the therapist to sit in the same room with her and her son. On the second session, she invited the clinician to sit in the living room in which her husband was watching television and through which other adult children walked. The clinician had to make a clinical decision as to whether to ask the client to meet privately, conduct family therapy, or proceed with individual work in front of other family members. He recognized that developing rapport was the first step in the treatment plan, and so decided not to immediately ask for privacy from the family members. After several meetings, the clinician asked the client and her hus- band to provide time and space for him to see the client privately. Once alone with the therapist, the woman revealed information about marital conflict and a history of domestic violence that had not emerged in the presence of her son or husband.

Maintaining Professional Roles

When seeing clients in an office, a professional, formal relationship is implied. The client announces him- or herself, waits in a waiting room, is called into the therapy room, sees the clinician's diplomas or the agency's licenses on the wall, etc. The clinician or his/her employer manages the seating arrange- ment, type of chairs, distance between the seats, air temperature, size of the roo1n, etc.

In a client's home, these tools for role establishment are absent. The client may perceive the clinician as a friend or family visitor rather than a professional (Maxfield & Segal, 2008). The furniture may be set very close together or very distant; the clinician may need to sit on the bedside. The client may be dressed in night clothes or otherwise scantily attired. The very cues which may enhance rapport building may also lead the client and cli- nician to perceive themselves in a less formal relationship. A more informal relationship can deter the clinician from helping the client focus on the clin- ical treatment plan.

Given the paucity of professional cues, the clinician needs to consider how to establish and retain a professional relationship with the client. Supp01tive stmctures can include dressing formally, sta1ting and ending appointments on time, and explaining the nature of the professional psychotherapist-client relationship, repeatedly when necessary (Knapp & Slattery, 2004; Maxfield & Segal, 2008). Additionally, therapists are encouraged to increase clarity through consultation, whether before, during, or after a confusing therapeutic situation.

Interruptions

Clinicians are not in control of audito1y, visual, interpersonal, and other intermptions in the client's home. Telephones ring; televisions are on; neighbors come to visit; the client gets up to make tea; and so on (Maxfield & Segal, 2008). In responding to these intermptions, clinicians will be aided by referring, physically and/or mentally, to the treatment plan.

It may be helpful to initially observe how the client handles the intermptions the first time or two. This can help to facilitate rapport, increase understanding of how the client handles other people in his or her life and how he or she may be using interruptions to regulate the intimacy with the therapist or the depth of the content discussed. After one or two repetitions of an interruption, the clinician will have more understanding to inform an inte1vention, by a direct suggestion or by an interpretation. For example, when a client's caregiver continues to sit in the same room watching television during the third session, it may be helpful for the clinician to state his or her professional opinion that having the caregiver leave will benefit the client, or the clinician may help the client to ask the caregiver to leave. Alternatively, the clinician may see it as more therapeutic to interpret the client's behavior of allowing an interruption. In another example, while Mrs. S, typically answered the phone briefly and asked the caller to call back later during sessions, one day she took a phone call and engaged in a lengthy conversation, Given such a notable shift in behavior, the clinician noted this change of behavior and suggested this may be a sign that the subject matter being discussed was painful (the conflict in her previous marriage) and that she was seeking to regulate intense affect.

Pacing

Conducting psychotherapy in the homes of frail, isolated, possibly cognitively challenged, elders raises complicated questions about pacing. Clients who come to an office for therapy can discuss emotionally painful material, and leave the environment in which this affect was stimulated and processed. Homebound clients, however, remain in proximity to the same environmental cues reminding them of the therapeutic discussions. Clients confined to their homes often have fewer activities and engagements to help regulate painful material than socially and physically active clients. For example, 85-year-old Mrs. K. told her clinician that she dreaded the afternoon after her therapy sessions because she was filled with upsetting feelings, While the treatment plan included a grief therapy approach to help her mourn her lost husband, Mrs. K's lack of outside activities and sparse remaining friendships made her able to tolerate only a small amount of emotional processing in one session.

Because homebound elders often have limited social resources for support and distraction between sessions, some tools can be used to help manage

the depth of affect when doing in-home, emotionally focused work. These include:

1. Helping clients plan coping activities for after the session (e.g., talking with a friend, writing in a journal, calling the therapist);
2. Reminding clients that the clinician will be working with them on these feelings in subsequent sessions;
3. Helping clients keep associations to the therapeutic work to a certain pa1t of the residence by keeping the therapy session in one area, arranging the furniture in a specific way for the session, and/or encouraging the client to "leave their feelings" in this place; and
4. Using visual imagery to help clients imagine putting their "precious" feelings into a container (e.g., a "treasure box"), which could be imagined to be given to the therapist to keep.

With Mrs. K, above, the therapist and client gradually talked about her feelings related to the loss of her husband. She felt that her lifeline had been taken away. As she talked about her grief of losing him, her depression lessened.

Transference Issues

A number of transference projections are more likely with in-home work. While some may be challenging, understanding them can benefit treatment. The greater intimacy of having the therapist in their own space may increase the possibility that in-home clients see the therapist as a friend or relative rather than a professional. Clients may request that the clinician engage in informal activities such as drinking tea or juice, moving chairs or otherwise adjust the environment, reading mail, etc. The intimacy may lead to more frequent offerings of food or gifts, presenting additional decision-making challenges for the therapist as he or she considers the context of the gift to in the in-home setting. The therapist must decide if it is more helpful to the treatment plan to accept or decline such offerings. At times, accepting the offer will beneficially enhance rappo1t. At other times, refusing may be more helpful in setting or maintaining professional boundaries. As a third option, Spandler et al. (2000) suggest holding the gift for a short time to avoid prematurely accepting, rejecting or analyzing it. Discussing the meaning of the offering can enhance understanding within the therapy, but at other times analytical discussions may feel rejecting or insulting to the client. Cultural meanings of food and gift offerings must be considered. For example, in our experience, in many Middle Eastern and Latino cultures, if the clinician questions or refuses an offer of food, the client may likely feel insulted or shamed.

Another transference reaction of an in-home client may be to feel intruded upon. Because in-home clients have fewer mechanisms to modulate the

interpersonal connection via "no shows," there is a greater risk that a therapist will intrude into the client's space when the client otherwise would have avoided an appointment in a clinic. Due to anxiety about a client's welfare, especially a physically frail, isolated elder, clinicians may feel tempted to call the paramedics or law enforcement if a client does not answer the door. The clinician must carefully think through the actual likelihood of real clanger to the client as well as the client's right to deliberately not answer the door,

Countertransference

Going into clients' homes can elicit a number of unique countertransference reactions. In one's own office, a clinician controls his or her own sensory experience: smells, sights, sensations, sounds, even tastes. Some homes have a particular odor which a clinician may find disturbing. In an extreme example, Mr. R.'s plumbing was not functioning and he was too suspicious to allow repair, thus leading to feelings of disgust in the clinician. Therapists may feel guilty, inadequate, or embarrassed if their own health concerns impede engaging a client. For example, clinicians may experience allergies to pet dander, smoke, or perfume; claustrophobic-type responses to small, stuffy, or crowded spaces; or aversive reactions to fleas, cockroaches, or rodents, etc. that interfere with their ability to work with a client.

Clinicians may experience feelings of burden, anxiety, or even depression when learning of a greater level of need by going into the home. Within the office, a clinician may not gather that a client lives with unmet basic needs such as a leaking roof, no heating, broken plumbing, etc, but sees this on an in-home visit. The intensity, immediacy, and wide range of need may feel overwhelming to the clinician, sometimes precipitating action by the therapist to fix the prob- lem, which may not align with a treatment plan of empowering the client.

Given the effort and time of traveling to a client's home, the clinician may feel greater frustration when a client is not available to meet. In response, a clinician may call prior to sessions in order to confirm the client's interest in and availability for meeting, an action that should be considered with reference to the treatment plan. Even when a therapist opts to call ahead to confirm appointments, a clinician may arrive at a client's home and find the client not present or unwilling to have a session. Clients engaging in distracting interruptions may also contribute to feelings of frustration.

ETHICAL ISSUES

Some of the ethical clifficulties frequently encountered during in-home tl1erapy include threats to confidentiality, possibly harmful multiple relationships, and complicated informed consent.

Confidentiality

As previously noted, numerous significant others may challenge confidentiality. When approaching a client's home, a neighbor, apartment manager, or exiting home health aide may ask the clinician "Who are you?" and "Why are you calling here?" The clinician wants both to protect confidentiality *and* gain access to the client. Refusing to answer the question may impede access to the client and/or provoke greater interest and involvement on the part of the concerned other. At our clinic we often use generic but accurate responses such as "I have an appointment with Mr. T," "I am a worker" or "I'm from The Center for Aging Resources." Alternatively we teach our clini- cians to suggest: "Perhaps you can ask Mr. T; he is expecting me." While these brief responses may suffice, sometimes a clinician is pressured to elaborate, requiring on-the-spot ethical decision making as the therapist works to balance the priority of confidentiality with the impact on accessing the client. The clinician may then follow up with the client, outlining the situation and clarifying the client's wishes regarding similar circumstances in the future.

Multiple Relationships

Homebound clients often have numerous needs and few resources. This increases the likelihood that they may either directly ask or indirectly imply a request that the clinician take on additional roles. For example, one of our Center's clinicians rep01ted that his client asked him to buy some kitty litter and to change a light bulb (Maxfield & Segal, 2008). Whereas he refused the former request, deciding it would be more in line with the treatment plan to encourage independence, he felt it was more ethical to comply with the second, in the best interest of the client's safety. Another clinician reported that upon arrival at her client's home, she found that her post-stroke client had sat in her wheelchair all night, and had not eaten since the in-home aide had left at noon the previous day. This clinician felt an ethical duty to fix her client a meal, thus placing her in an alternate role with her client.

Ofer Zur (2002, 2008) distinguished "boundary crossings" from "bounda1y violations" (Guthiel & Gabbard, 1993). He suggested that while "boundary violations by therapists are harmful to their patients, boundary crossings are not and can prove to be extremely helpful. We must carefully think through how to achieve the greatest client benefit." Zur suggested we "take into consideration the welfare of the client, effectiveness of treatment, avoidance of harm and exploitation, conflict of interest, and the impairment of clinical judgment. These are the paramount and appropriate concerns." Sometimes clinicians must ethically meet an alternate need, and other times clinicians must therapeutically set a boundary and problem solve with the client, thus providing greater client empowerment.

Informed Consent and Undue Influence

Providing therapy ethically is based on the client's voluntary, informed consent. Providing treatment in the home may make undue influence a greater risk. While a client may have agreed to participate in therapy, a homebound client may have greater difficulty refusing service. For example, when a Center clinician arrived at her client's gated apartment complex, someone was leaving, so she entered without calling the client from the gate. Upon entering the client's apartment, she saw the client's phone was off the hook, suggesting her client had intended to "no show" by not answering her call from the gate. The client was denied the opportunity to passively avoid the session, thus impinging her ability to refuse se1vice. Therapists conducting in-home sessions must be sensitive to their clients' wish to decline a session without verbalizing the request, i.e., "no show." Additionally, homebound clients' heightened isolation and strong desire for company may coexist with a wish to refuse therapy, thus creating ambivalence that inhibits them from declining therapy.

Older adults who have cognitive deficits present further challenges to obtaining informed consent. Clinicians may need to ascertain who holds the legal right to consent to treatment (e.g., the client, his or her power of attomey, a guardian). If the client is cognitively impaired but does not have a legally appointed surrogate decision maker, the clinician must explore the client's capacity to make the decision to consent to or decline treatment. This exploration could range from an accommodation of additional time to elicit the personal values and preferences of an elder with questionable capacity or a screening and referral for further assessment (American Bar Association Commission of Law and Aging and the American Psychological Association, 2006). For further suggestions on conducting therapy with cognitively impaired persons, please see, for example, Hausman 0992), Solomon & Szwabo 0990) and Carpenter et al. (2004).

LEGAL ISSUES

The need for legally mandated reporting, which varies from state to state, may become more evident during in-home work. For example, clues of possible elder and dependent adult abuse, self-neglect, and child abuse may be more apparent on a home visit. The clinician may see an unhealthy situation such as no plumbing, a fire hazard, extreme hoarding, or no food, that the client may not verbalize. Reporting to the designated agency as required by state law may be required more frequently. Clinicians must understand their reporting duties, as well as clinically useful ways of work- ing with the client when reporting is required. For example, the clinician and client may decide together who will file the report, depending on the client's wishes and the treatment plan. To reduce related anxiety for the client,

and perhaps involved others, the clinician may outline what to expect once a report of suspected abuse is filed, Occasionally, the legal requirement to report suspected abuse may create an insurmountable breach in the thera- peutic relationship, resulting in premature termination,

RISK MANAGEMENT ISSUES

Clinician Safety

Unlike the relatively controlled environment of the clinic or office, the in-home clinician walks into an unknown environment which may include neighbor- hood crime, weapons in the home, emotionally unstable clients, volatile family members, etc. Suggestions for training clinicians to enhance safety include 1) evaluating safety risks with the referring parly, including familiarity with a client's mental health and criminal histories; 2) not entering a home when the therapist senses any clanger; 3) sitting closer to the door; 4) leaving at any moment when clinicians might sense a lack of safety; 5) not fearing supervisory judgment for leaving; 6) feeling the freedom to stop in-home therapy if clinician feels unsafe in a client's house; 7) taking a second staff member if safety may be compromised; and 8) consulting in order to prob- lem solve safety related barriers to treatment where possible. One female clinician had been successfully conducting in-home therapy with a male cli- ent for 5 months. She then reported that the client stood in front of her and refused to move when she was trying to exit. The therapist later reported that 2 weeks previously the client had rearranged the furniture so that a large couch blocked the passageway from the seating area to the door. This clinician feared for her safety, and was supported in her decision to conduct phone therapy until the client became willing and able to secure transporta- tion to the clinic or to another mutually agreeable, neutral meeting place.

Client Safety

Client safety must also be considered. For example, at our clinic clinicians are trained on what to do if a client is perceived to be having an urgent medical incident (e.g., a fall, trouble breathing, chest pain, loss of consciousness). When does the clinician intervene if the client is unable to verbalize his/her preference or when the client refuses or resists emergency inte1vention? Given the risk management matters involved, each agency will need to set its own unique guidelines.

In summaiy, in-home therapy raises particular clinical, ethical, legal and safety or risk management benefits and challenges. Clinicians will be confronted with unique situations in which they will need to make quick decisions. While bouncla1y "crossings" can be boundaiy "violations" and detrimental to client treatment, bouncla1y "crossings" can also be helpful.

Boundary challenges can be understood to be evidence of the client's personality and behavior patterns, and therefore useful in increasing the therapist's understanding of and ability to help the client. Preparing for such challeng- ing situations and having tools available to consider will help clinicians make decisions that optimize clinical benefit, maintain ethical and legal integrity, and maximize safety.

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Working with Older Adults With Cognitive Impairment

Janet Anderson Yang, Ph.D.

Forms of Cognitive Impairment

- Normal Aging
- Mild Cognitive Impairment
- Dementia
- Delirium

2

Cognitive Changes in Normal Aging

Normal age changes include decreased:

a. speed of thinking & remembering
b. ability to stay focused on a mental task
c. ability to attend to several tasks simultaneously
d. memory for names & words
e. memory when given little time to learn

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Mild Cognitive Impairment

- Memory decline greater than normal aging
- Memory decline does not meet criteria for dementia
- Some estimate that 50% to close to 100% will progress to dementia

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Factors which may contribute to cognitive impairment (MCI &/or Dementia)

- Age
- Genetics
- Diabetes
- Current smoking
- Depression
- High blood pressure
- Elevated cholesterol
- Lack of physical exercise
- Infrequent participation in mentally or socially stimulating activities

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Dementia
Diagnostic Criteria

1. Memory loss
2. At least one other cognitive deficit:
    1. language disturbance
    2. carrying out motor activities
    3. recognizing objects
    4. planning, organizing, following sequences
3. Significant impairment in social or occupational activities
4. Decline from previous functioning

TYPES OF DEMENTIAS

- 55% Alzheimer's Disease
- 15-20% Stroke/Cerebrovascular Dementia
- 4% Brain injury
- 2-10% Frontotemporal dementia (e.g., Pick's disease)
- 6% other (Lewy Body Dementia, HIV associated dementia, Huntington's disease, advanced Parkinson's' disease, etc.)
- Multiple causes

Dementia: Hope through research: national institutes of Neurological disorders and stroke. http://www.ninds.nih.gov/disorders/dementias/detail_dementia.htm

INCIDENCE OF DEMENTIA

- 10% of persons over 65 have dementia
- 40-50% of those over 85 have a dementia
- Early onset Alzheimer's Disease can start as early as in a person's 30's.

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DEMENTIA: WHAT CAN WE DO?

- Treat associated mental illness
- Be alert for & encourage treatment for delirium
- Monitor course of dementia & help client & family plan
- Provide validation
- Reduce behavioral problems
- Reminiscence
- Relaxation
- Help client and staff (family) to understand effects of dementia
- Advocate

Dementia with Co- occurring mental illness

- Approximately 20 - 30% of persons with dementia also have depression
- At least 20 % of persons with dementia also have an anxiety disorder (could be as high as 80%)
- Many persons with dementia demonstrate psychotic symptoms
- Many persons with dementia demonstrate agitation and other behavioral disturbances
- Persons with long term schizophrenia are at higherrisk of developing dementia

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Delirium

- Fluctuating mental status changes
- Disturbed consciousness
- Decreased ability to focus, sustain focus or shift attention and/or
- Perceptual disturbance
- Rapid onset
- Disoriented to time, disturbed sleep, disturbed psychomotor behavior

Delirium: Confusion Assessment Method (CAM)

1. Acute onset or fluctuating course?
2. Inattention
3. Disorganized thinking
4. Altered level of consciousness

Presence of 1 & 2 and either 3 or 4 indicates delirium

DELIRIUM: RISK FACTORS

- Metabolic disturbance
- Older age
- Multiple medications
- Infections
- Anesthesia
- Hip fracture
- Isolation
- Dehydration
- Sensory deprivation
- Unfamiliar surroundings
- Brain injury
- Acute stress
- Poor nutrition
- Substance abuse
- Vascular disorder
- Cancer
- Cardiovascular disease

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DEMENTIA

If dementia is determined to be progressive (e.g. Alzheimer's Disease) monitor the course of the illness to help treatment planning:

- Mini Mental Status Exam
- Clinical Dementia Rating Scale

DEMENTIA

- Mini Mental Status Exam administered annually or bi-annually can monitor of the rate of decline.
- In a typical course of Alzheimer's Disease, the MMSE will decline approximately 4-5 points per year.

Clinical Dementia Rating Scale

(CDR; Hughes et al, 1982)

Clinician rates 6 areas:

- Memory
- Orientation
- Judgment & Problem solving
- Community affairs
- Home & Hobbies
- Personal Care

On 5 levels of impairment:

- None(0), Questionable(0.5), Mild(1), Moderate(2) or Severe(3)

Criteria for inclusion in mental health services?

- As mental health services providers, what criteria do we use to screen a client with dementia in or out of mental health services?

California State Bill 639

- State Bill 639 (2001)
- Report (2003)
- "Improving Access to Mental Health Services for Persons with Alzheimer's Disease and Related Disorders"
- http://www.aging.ca.gov/publications/SB639_final.pdf

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State Bill 639 Report (2003)

"An individual with dementia would not be excluded from receiving mental health services as long as he or she also meet medical necessity criteria for medically necessary mental heath services.

- Medical Necessity criteria are described in Title 9, Chapter 11, Section 1830.205. Medical Necessity Criteria for MHP Reimbursement of Specialty Mental Health Services.
- a. The following medical necessity criteria determine Medi-Cal reimbursement for specialty mental health services that are the responsibility of the MHP under this subchapter, except as specifically provided.
- b. The beneficiary must meet criteria outlined in (1), (2), and (3) below to be eligible for services:
  - (1) Be diagnosed by the MHP with one of the following diagnoses in the Diagnostic and Statistical Manual, Fourth Edition, published by the American Psychiatric Association:

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- (a) Pervasive Developmental Disorders, except Autistic Disorders
- (b) Disruptive Behavior and Attention Deficit Disorders
- (c) Feeding and Eating Disorders of Infancy and Early Childhood
- (d) Elimination Disorders
- (e) Other Disorders of Infancy, Childhood, or Adolescence
- (f) Schizophrenia and other Psychotic Disorders
- (g) Mood Disorders
- (h) Anxiety Disorders
- (I) Somatoform Disorders
- (j) Factitious Disorders
- (k) Dissociative Disorders
- (l) Paraphilias
- (m) Gender Identity Disorder
- (n) Eating Disorders
- (o) Impulse Control Disorders Not Elsewhere Classified
- (p) Adjustment Disorders
- (q) Personality Disorders, excluding Antisocial Personality Disorder
- (r) Medication-Induced Movement Disorders related to other included diagnoses.

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(2) Must have at least one of the following impairments as a result of the mental disorder(s) listed in subdivision (1) above:

- (a) A significant impairment in an important area of life functioning.
- (b) A probability of significant deterioration in an important area of life functioning.
- (c) Except as provided in Section 1830.210, a probability a child will not progress developmentally as individually appropriate. For the purpose of this section, a child is a person under the age of 21 years.

(3) Must meet each of the intervention criteria listed below:

- **(a) The focus of the proposed intervention is to address the condition identified in (2) above.**
- **(b) The expectation is that the proposed intervention will:**
- **(1) Significantly diminish the impairment, or**
- **(2) Prevent significant deterioration in an important area of life functioning,** or
- (3) Except as provided in Section 1830.210, allow the child to progress developmentally as individually appropriate.
- (c) The condition would not be responsive to physical health care based treatment.

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c. When the requirements of this section are met, beneficiaries shall receive specialty mental health services for a diagnosis included in subsection (b)(1) even if a diagnosis that is not included in subsection (b)(1) is also present.

(NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Section 5777 and 14684, Welfare and Institutions Code.)

- It should be noted that this medical necessity criteria does not include the DSM-IV "Cognitive Disorders" category, which includes dementia due to general medical conditions. An individual with dementia may exhibit a mental disorder that meets the medical necessity criteria (e.g., mood disorder, anxiety disorder, etc.). But the DSM evaluation criteria also includes a determination that this mental disorder is not better accounted for by another disorder. This criteria component can be used to argue that the disease causing the dementia (e.g., Alzheimer's, Parkinsons, etc.) better accounts for the depression, delusions, etc.). Such an evaluation would result in the individual not meeting the medical necessity criteria for mental health services.

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MEDICARE DEMENTIA GUIDELINES FOR PSYCHOTHERAPY (2009)

- **Cognitive capacity of patient**
- The person receiving must have the **cognitive ability to meaningfully participate in the therapeutic process**.

MEDICARE DEMENTIA GUIDELINES 2009

- The patient must be:
  - **oriented to person**,
  - be **able to process information**,
  - **recognize different individuals**,
  - **express thoughts** through verbal or nonverbal means, and
  - **retain and apply concepts** from one session to the next.

The patient's capacities must clearly support the expectation of improvement.

The patient must have a primary mental health diagnosis (including depression, anxiety, etc) to which the psychotherapy plan is targeted.

Medicare Dementia Guidelines 2009

- This section does not disallow medically appropriate psychotherapeutic treatment of concomitant disorders, such as **agitation**, **depression**, **anxiety**, **delusions**, **hallucinations**, and **sleep impairment** where psychotherapeutic services *per se* are likely to yield significant benefit.

"Principal Diagnosis"

Principal Diagnosis is often seen as what came first, or what is the primary cause of the problem.

However,

DSM IV TR (p.3):

"When more than one diagnosis is given for an individual in an outpatient setting, the *reason for visit* is the condition that is chiefly responsible for the ambulatory care medical services received during the visit. In most cases, the principal diagnosis or the reason for the visit is also the main focus of attention or treatment. It is often difficult (and somewhat arbitrary) to determine which diagnosis is the principal diagnosis or the reason for visit, especially in situations of 'dual diagnosis.'"

Screening tools

- Mini Mental State Exam (MMSE) (Folstein, 1975)
- Modified Mini Mental Status Exam (3MS) (Teng et al)
- Clock Drawing
- St. Louis Mental Status exam (SLUMS)
- Montreal Cognitive Assessment(MoCA)
- Cognitive Abilities Screening Instrument (CASI)
- Mini Cog (clock draw + 3 item recall)
- Short Portable Mental Status Questionnaire, (SPMSQ; Pfeiffer, 1975)
- Short Mental Status Questionnaire, (Robertson et al, 1982)

Screening tools

- Mini Mental State Exam (MMSE) (Folstein, 1975, 1998, 2001)
  - Standard
  - Commonly understood
  - Body of research
  - Proprietary – copy right issues and or cost (approx. $1.25 each) – PAR: Psychological Assessment Resources, Inc. www.parinc.com

MMSE cut off scores

- Folstein MMSE: score of 23 is often considered a cut off for dementia.
- **However**, normal cognitive performance varies by education level, age, language preference, etc.
- Alternate cutoffs: (Tombaugh, McDowell, Kristjansson & Hubley, 1996)
  - Education: 12 + years 23
  - Education: 9-12 years 21
  - Education: 0-8 years 18-19

Screening tools

- Modified Mini Mental Status Exam (3MS) (Teng et al)
  - Can be used free-of-charge by permission of the author
  - Covers similar domains as MMSE;
  - Longer;
  - Includes additional, clinically useful items

Screening tools

- Clock Drawing
  - Free
  - Brief screening
  - Good diagnostic utility for a brief screen
  - Tuokko, H. et al. The Clock Test: a sensitive measure to differentiate normal elderly from those with Alzheimer's Disease. Journal of the American Geriatric Society, 1992. 40:579-584.

Screening tools

- St. Louis Mental Status Exam (SLUMS)(Tariq, S., et al. The Saint Louis University Mental Status Examination for Detecting Mild Cognitive Impairment and Dementia is more sensitive than the Mini Mental Status Examination. Journal of the American Geriatric Society. Produced in the VA)
  - In the public domain
  - Includes the Clock Drawing
  - Covers range of cognitive domains

Screening tools

- Montreal Cognitive Assessment(MoCA; Nasreddine, Z. et al, 2005, Journal of the American Geriatrics Society, 53:695-699.)
  - In the public domain
  - 30 item instrument.
  - Slightly more broad set of domains than MMSE
  - www.mocatest.org

Screening tools

- Cognitive Abilities Screening Instrument (CASI)
  - Very comprehensive
  - Perhaps too long for usual mental health screening situations
  - Teng, E. et al. 1994. the cognitive abilities screening instrument: a practical test of cross cultural epidemiological studies of dementia. International Psychogeriatrics , 6: 45-58.

Screening tools

- Mini Cog (clock draw + 3 item recall)
  - Good, brief screening instrument
  - Does not give enough range to document change over time

Screening tools

- Short Portable Mental Status Questionnaire, (SPMSQ; Pfeiffer, 1975. Journal of American Geriatrics Society, V 23(10), 433-41.)
  - In the public domain
  - 10 item questionnaire

Screening tools

- Short Test of Mental Status (Kokmen)
  - In the public domain
  - Screening instrument chosen by Stephen Bartels, MD in his comprehensive toolkit

- How often to you screen for cognitive impairment or dementia?
- How does your program decide at what level of cognitive impairment you will discharge a client?

How does a person with dementia feel?

A clinically useful scale to help understand the underlying need: Understanding Alzheimer' Behavior (Lavengood et al., 1994)

e.g., Early Forgetful Stage

Moderate Dementia

Severe Dementia

What is the internal experience of a person with dementia?

- Lives in the moment, without cognitive memory for the past, without ability to predict future
  - **Leads to** fear, anxiety, suspiciousness, loss, anger, loss of self esteem
- Others often treat client with condescension, depersonalization, infantilization
  - **Leads to** loss of contact with others, isolation, shame

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Internal experience of a person with dementia (cont.)

- Loses ability to maintain a memory for significant other
  - **Leads to** a regression in relationships
  - Precipitates anxiety, fear, suspiciousness, separation anxiety, desire for merging
  - Regresses to more primitive coping, such as splitting, projection
  - An overwhelming experience of any of these sequences can lead to a "catastrophic reaction:" an emotional reaction which seems to outside observers to be disproportional to the situation; often includes rage, terror

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Psychotherapy with Clients with Dementia

- Philosophy:

  Respect & Positive regard;

  Holding memory for the person with dementia

  Client may not remember concrete details, but does become affected by communication of respect & by the tone of the relationship

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GOALS OF PSYCHOTHERAPY WITH PERSONS WITH DEMENTIA:

- Prevent or reduce behavioral problems
- Prevent or reduce emotional distress
- Improve relationship(s) with significant other(s)
- Decrease anxiety, fear, terror, agitation, anger
- Ventilate affect to provide relief; decrease intensity of unexpressed & unresolved feelings

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GOALS OF PSYCHOTHERAPY WITH PERSONS WITH DEMENTIA (CONT):

- Facilitate grieving
- Help identify and encourage coping strategies
- Increase self esteem; diffuse self blame, shame, embarrassment
- Help person regain some sense of personal identity
- Provide time within which elder can have some control
- Improve sense of control &/or predictability
- Increase sense of connectedness; decrease sense of isolation

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VALIDATION OR SUPPORTIVE THERAPY

- Connect with client; tune into their reality
- Clarify and articulate the person's thoughts and feelings for/with elder
- While memory for cognitions decreases, memory for emotion is retained longer
- Validate their humanness through creating a respectful relationship

Validation or Supportive Therapy

- Provide an opportunity for catharsis; facilitate accurate expression of emotions; enable grieving
- Holding memory for the person with dementia
- Client may not remember concrete details, but does become affected by communication of respect & by the tone of the relationship
- Case example: MG

Life Review & Reminiscence therapy

- To help dementia client to experience the pleasure of past successes and positive memories
- To aid improvement in self concept, mood
- Case example: FH

Relaxation Skills

- Breathing exercises
- Muscle relaxation exercises
- Audio recordings

Behavioral Interventions

Antecedents:
- What happened before the problem behavior started?
- When did it occur?
- Where did it occur?

Behavior: What actually happened?
- Did it start suddenly or gradually?
- How long did it last?

Consequences:
- What happened after the problem behavior?
- Try to understand the need; try to meet the need without reinforcing the problem behavior.

Behavioral problems in clients with dementia may be related to:

- Medical conditions
- Constipation or fecal impaction
- Medication effects
- Infections
- Dehydration, thirst
- Pain or discomfort
- Delirium
- Injury
- Hunger, need for warmth, sleep, touch, intimacy
- Need for social contact
- Need for meaningful activity
- Recent changes in family or caregiver relationships
- Depression, anxiety, psychosis,

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Family or staff intervention

- Help staff/family members to understand elder's feelings, needs
- Help client to feel heard
- Teach staff/family members helpful communication skills

R.E.M.
Restore, Empower, Mobilize:

- Psychotherapy for treating depression in long-term care residents with dementia
- B. Carpenter, K. Ruckdeschel, H. Ruckdeschel & K. Van Haitsma (2004)
- Developed to treat depression in persons with mild to moderate dementia in long term care settings
- Clients had MMSE's of 10 to 30, usually above 15, and met criteria for a DSM IV diagnosis of a mood disorder.

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R.E.M.

- Restore: Revive the person's sense of self
- Empower: Enhance the person's perception of personal competence and control
- Mobilize: Encourage resident and environment to make changes
- 16 sessions, 2x week, 20-30 minutes each.

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R.E.M.
Session 1

- Education & orientation:
  - Review reasons of referral
  - Educate about depression
  - Educate about psychotherapy
  - Give information about you and your background
  - Clarify confidentiality, finances, schedule
  - Instill hope
  - Build rapport

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R.E.M.
Restore Sessions

- Develop therapeutic relationship
- Provide empathy of person's experiences, especially including losses

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Restore positive sense of self:

- Be aware of immediate needs
- Provide positive feedback for involvement in tx
- Provide empathy and active listening
- Help maintain continuity of self
- Facilitate search of meaning
- Help o.a. organize thoughts & feelings
- Encourage emotional expression
- Validate & normalize loss
- Enhance self worth

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R.E.M.
Empower Sessions

- Enhance perceptions of personal competence & control:
  - Review past coping successes
  - Emphasize current strengths
  - Identify circumstances where control is possible
  - Discuss preferences for everyday living
  - Encourage o.a. to verbalize concerns
  - Acknowledge limits of control

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R.E.M.
Empower Sessions

- Encourage adaptive coping skills:
  - Help o.a. identify & label emotions
  - Help o.a. express anger in productive ways
  - Use reminiscence as coping tool
  - Help establish & maintain meaningful relationships
  - Enlist staff & family
  - Brainstorm pleasurable & meaningful activities
  - Teach relaxation skills
  - Help adapt environment

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R.E.M.
Mobilize Sessions

- Activate the older adult:
  - Assist o.a. to develop plans to improve circumstances
  - Facilitate action on strategies identified
- Activate the environment:
  - Assess availability of supportive persons in the environment
  - Train staff/family to identify depression and support o.a.
  - Train staff/family to enact strategies
  - Provide support to staff/family
  - Monitor & modify responses to interventions

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Clients with dementia advanced beyond the ability for Mental health services to provide meaningful benefit

- Referrals, resources, etc.
  - Adult Day Health Center
  - Adult Day Care (Social Model)
  - P.A.C.E
  - Alzheimer's Association
  - In Home Supportive Services
  - Public Guardian
  - Skilled Nursing Facilities
  - Area Agency on Aging
  - MSSP (Multi Service Senior Program)

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Documenting Medical Necessity

- Document client's capacity to understand and respond meaningfully in the therapeutic encounter.
- Periodically document patient's functional level
- Document that patient's attention spans the duration of therapy
- Consult with client's physician to coordinate care & document consultation.

Conservatorship

Conservatorship can be LPS Conservatorship or Probate Conservatorship

- LPS conservatorship is undertaken during a psychiatric hospitalization, for psychiatric reasons.
  It must be renewed annually.
- Probate conservatorship is undertaken for issues related to cognitive decline, e.g., dementia
  It lasts until it is revoked.
- Conservatorship can be Conservator of the Person or Conservator of the Estate or Both

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Determination of Capacity

- To determine lack of capacity for probate conservatorship, a medical doctor or psychologist must complete the Medical Declaration form (sometimes referred as the Med Dec)
- http://www.formsworkflow.com/Search.aspx
- http://portal.countyofventura.org/portal/page/portal/VCHSA/ContentPAPG/capacityDeclaration-gc335.pdf

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Medical Declaration of Incapacity :

- Incapacitated person" means an individual who, for reasons other than being a minor, is unable to receive and evaluate information or make or communicate decisions to such an extent that the individual lacks the ability to meet essential requirements for physical health, safety or self care, even with appropriate technological assistance.
- Must be supported by evidence of deficits in at least one of the following mental functions:
  - Alertness & attention which may include impaired
    - Levels of arousal or consciousness
    - Orientation to time, place, person and situation
    - Ability to attend & concentrate

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- Impaired information processing which may include
  - Short & long term memory
  - Ability to understand or communicate with others, verbally or otherwise
  - Recognition of familiar objects and familiar persons
  - Ability to understand & appreciate quantities
  - Ability to reason using abstract concepts
  - Ability to plan, organize and carry out actions in one's own rational self interest
  - Ability to reason logically

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- Thought processes: deficits may be demonstrated by the following:
  - Severely disorganized thinking
  - Hallucinations
  - Delusions
  - Uncontrollable, repetitive or intrusive thoughts.

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- Ability to modulate mood and affect
  - May be shown by presence of pervasive & persistent, or recurrent state of inappropriate
    - anger,
    - anxiety,
    - fear,
    - panic,
    - euphoria,
    - depression,
    - hopelessness,
    - despair,
    - helplessness,
    - apathy or
    - indifference

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- The physician or psychologist must evaluate the person's deficits as being of a degree that they render the person unable to handle their finances or care for themselves orboth.
- Conservatorships can be established for conservatorship of the person (arranging for the care and protection of the living arrangements, health care, meals, clothing, personal needs, etc.) or conservatorship of the estate (managing the finances) or both.

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- Dementia addendum to grant "dementia powers" which includes
  - Placement in a secured facility, only if the court evaluates the evidence as indicating the person lacks capacity o give informed consent, deficit, would benefit, least restrictive
  - Administration of dementia medications

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Duties of Conservator of the Person

- Assess the conservatee's needs
- Decide where the conservatee will live
- Provide medical care to the conservatee
- Work with the conservator of the estate

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Duties of Conservator of the Estate

- Manage the estate's assets, including managing assets as with the care of a "prudent person", keeping the assets separate from their own; managing assets so that they earn interest except for checking accounts to administrate ordinary expenses
- Inventory Estate Property
- Maintain appropriate insurance of assets
- Keep accounting records and submit to court

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Rights Retained by a Conservatee:

- From State form GC-348, the Duties of Conservator:

- Control his or her own salary
- Make or change a will
- Marry
- Receive personal mail
- Be represented by a lawyer
- Ask a judge to change conservators
- Ask a judge to end the conservatorship
- Vote, unless a judge decides the conservatee is not capable of exercising this right
- Control personal spending money, if a judge has authorized an allowance
- Make his or her own medical decisions unless a judge has taken away that right and given it to the conservator.

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Distinction between Power of Attorney versus Conservatorship:

- Power of Attorney for Health Care has the right and responsibility to make medical (including mental health) decisions for the client; this includes signing Care Plans and Consents to Treatment.
- Power of Attorney for Finance has the right and responsibility to make financial decisions for the client, including deciding to pay for services if there is an out-of-pocket cost.
- When Power of Attorney forms are filled out, they may be activated immediately, or they may "spring" into action when the person becomes "incapacitated," that is, when they are determined by a physician or a psychologist to be unable to understand the pros and cons involved in their decision making, whatever the specific area of decision making is in question.

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Delirium vs. Dementia

	Delirium	Dementia
Onset	Abrupt	Gradual
Consciousness	Clouded	Not clouded
Attention span	Very short	Usually preserved
Orientation	Disoriented to time right away	Disorientation later in disease

Delirium vs. Dementia (cont.)

	Delirium	Dementia
Mental status	Moment to moment variability	Generally stable
Sleep-wake cycle	Disturbed hour-to-hour	May show day-night reversal
Psychotic symptoms	May be marked	Paranoia may present later in disease

DELIRIUM

- Balance sensory stimulation:
- Increase sensory stimulation or
- Decrease sensory overload
- Maximize visual and hearing aids
- Encourage physical mobilization, as possible
- Provide relational treatment
- Facilitate social interaction

- Advocate for medical personnel to consider:

adequate nutrition

adequate hydration

appropriate blood sugar level

urinary tract or bladder infection

thyroid imbalance

medication interactions

medication excess

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CULTURALLY COMPETENT RECOVERY ORIENTED SERVICES FOR OLDER ADULTS WITH MENTAL ILLNESS

1

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2

Older Adult
Full Service Partnership Tool Kit For Cultural Relevance

- **California Institute for Mental Health**
- **2012**
- http://www.cimh.org/LinkClick.aspx?fileticket=oM--g2NzB9c%3D&tabid=864

3

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PURPOSE OF THE TOOLKIT

- To provide supervisors and team members with written guidance to support ongoing development of programs and integration of practices.

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TOOL KIT BASED ON CALIFORNIA BRIEF MULTICULTURAL COMPETENCE SCALE (CBMCS)

- Comprehensive curriculum used for training in cultural competency
- 4 Sections:
- 1. Multicultural Knowledge
- 2. Cultural barriers to care
- 3. Cultural self awareness
- 4. Socio-cultural diversities (multiple identities)

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TOOL KIT BASED ON CALIFORNIA BRIEF MULTICULTURAL COMPETENCE SCALE (CBMCS)

Includes

- Training manual & curriculum
- Set of lecture slides
- Activities
- Handouts
- References
- Pre & post tests
- Evaluations

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OUTLINE OF TOOLKIT

- Domain 1: Developing Multicultural Knowledge
- Domain 2: Overcoming cultural barriers to care
- Domain 3: Developing Cultural selfawareness
- Domain 4: Addressing socio-cultural diversities
- Domain 5: Specific evidenced based, culturally adapted, cultural specific and community defined practices

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WHAT IS CULTURE?

- Race
- Ethnicity
- Country, region of country, of origin
- Gender
- Age cohort
- Sexual Preference
- SES
- Disability status
-
- Etc.

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TERMS

- Cultural competence
- Cultural responsiveness
- Cultural relevance
- Cultural humility
- Cultural proficiency

- Respect

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CULTURAL COMPETENCE

- The "ability of systems to provide care to patients with diverse values, beliefs, and behaviors, including tailoring delivery to *meet patients' social, cultural, and linguistic needs*" ***and involves competence or abilities in three areas: 1) multicultural knowledge, 2) awareness, and 3) skills.***

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- 57% of California identifies as an ethnic minority population
- Of this group:
  - 37% are Latino
  - 13% are Asian
  - 6.2% are African American
  - 1% is Native American
  - 4.9% Multiracial
  - 0.4% native Hawaiian or Pacific Islander

  - US Census 2010

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Developing Multicultural Knowledge

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DEVELOPING MULTICULTURAL KNOWLEDGE

- What ethnic/racial/cultural groups do you work with?
- Think of 2-3 in which to target for expanding your cultural competence
- How do you gain knowledge about specific cultural attitudes and practices among these cultural groups?
- What knowledge do you particularly need?

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MULTICULTURAL KNOWLEDGE, includes, for example

- Individuals' cultural identity
- History of the culture
- Perceptions of causes of illness
- Typical help seeking behaviors
- Family patterns & modes of decision making
- Cultural views on death
- Cultural views on dementia & caregiving
- Complementary & alternative treatments
- Religious / spiritual beliefs

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CULTURAL IDENTITY

- The way in which a person (client, clinician, others) perceives his/her ethnicity, race, gender, age cohort, sexual orientation, class, and/or other possible aspects of "culture"
- A part of a person's self concept
- How do we assess a client's cultural identity?

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CULTURAL IDENTITY MODELS, eg,

- Stage 1: Initial conformity to prevailing culture
- Stage 2: Beginning questioning initial conformity through awareness of racism & stigma; taking pride in one's own culture
- Stage 3: Embracing one's own ethnic activities & norms while not conforming to dominant culture
- Stage 4: Becoming independent of one's own background & developing autonomous ethnic identity
- Stage 5: Combining own ethnicity with prevailing culture, while maintaining separate interest on behalf of own culture.

Atkinson et al, 1998

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WAYS TOWARDS DEVELOPING UNDERSTANDING OF A CLIENT'S CULTURAL IDENTITY

- Ask client questions about their story, including where they come from, how they arrived, describe your family, describe your culture, discuss your upbringing, your values, etc.
- Be curious; hold an accepting attitude.
- Respect

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GAINING KNOWLEDGE OF HISTORY & CULTURE - WHAT

Historical events
Cultural values
Traditions
Beliefs
Behaviors
Religion
World views

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- Stanford Ethno Geriatric Curriculum
- http://geriatrics.stanford.edu/ethnomed
- Health and Health Care of Multi-Cultural American Older Adults
- Modules for ethnicities: African American, Alaska Native, American Indian, Asian Indian American, Chinese American, Filipino American, Hawaiian and Pacific Islander, Hispanic/Latino American, Hmong American, Japanese American, Korean American, Pakistani American, Vietnamese American

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GAINING KNOWLEDGE OF HISTORY & CULTURE - METHODS

Develop relationship with cultural guide or cultural broker

Review census data

http://www.california-demographics.com/los-angeles-county-demographics

http://www.census.gov/population/race/

Interview cultural leaders from key cultural groups you serve

Read books, search internet for information of important historical events; see movies

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CULTURAL GUIDES / CULTURAL BROKERS

Recruiting cultural brokers / cultural guides

Peer advocates
Community members
Spiritual leaders
Lay community leaders

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COMMUNITY BASED ORGANIZATIONS/INDIVIDUALS

- Churches, temples, synagogues
- Beauty salons, barbers
- Medical clinics
- Cafes, bars
- Community centers
- Parks

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- Some important historical information:

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AFRICAN AMERICANS

- History of slavery and the historical & generational impact of slavery on present
- History of migration within the United States
- History of racism and discrimination
- Tuskegee Experiment
- Use of biased psychological testing
- Ongoing racism/discrimination experiences
  -overt and subtle

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LATINO AMERICANS

- Wars for independence
- American occupation
- Immigration and corresponding policies
- Fear of deportation
- Central American wars
- Immigration stories/immigration trauma

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AMERICAN INDIANS

- Land confiscation, displacement
- Genocide
- Elimination of spiritual beliefs supplanted by missionaries' beliefs
- Coerced integration
- Forced relocation of children to boarding schools with elimination of contact with home

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ASIAN AMERICANS & PACIFIC ISLANDERS

- Economic hardship
- Taxation imposition
- Concentration camps
- Forced labor
- Exclusionary government policies
- Southeast Asian wars
- Immigration stories/traumas
- Refugee stories/traumas
- Sensitivities between immigrants from different Asian countries

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PERCEPTIONS OF CAUSES OF ILLNESS

- For example, Chinese, Mexican and Native American elders may believe their illnesses are caused by imbalances;
- African American, Native American and Latino elders may believe that spiritual causes are involved
- In some cultures, psychological problems are thought to be a result of wrongdoing, and thereby shameful
- Some elders believe their problems are caused by medical factors

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PERCEPTIONS OF CAUSES OF ILLNESS

- Consider asking your client "what do you believe caused this problem?"
- Be willing to engage in a conversation about spirits, or wrongdoings, or medical factors, etc.
- Withhold your own judgment

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EXPLANATORY MODEL OF ILLNESS

- Includes asking what the client's name for the illness is, the is the cause of the illness, and other questions by which to understand the client's viewpointof the illness
- Kleinman, A., Eisenberg, L., & Good, B. (1978). Culture, illness, and care: Clinical lessons from anthropological and cross-cultural research. *Annals of Internal Medicine, 88*:251-88.

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TYPICAL HELP SEEKING BEHAVIORS

- Ask client family how they & their culture would expect this problem to get solved
- Ask client who else they have consulted to gain help with their problem
- Consider incorporating consultation and collaboration with persons and practices from the client's culture in the treatment, including, for example, shamans, curanderos, religious leaders

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ACCULTURATION

- The importance of understanding the degree to which, and the impact of, a client's adjustment to the prevailing culture, and his/her connection to his culture of origin
  - DY and his expectations that their teenage children would stay home
  - IY and her expectations that their teenage children would adapt to US culture

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HELPING STAFF TO INTEGRATE CULTURAL AWARENESS INTO M.H. SERVICES

- Help staff to feel more comfortable talking about sensitive subjects; practice
- Help staff to become aware of their own biases
- Encourage staff to learn about history, values, stories, family patterns, views of illness and mental illness, etc. of a few of the specific cultures they serve which differ from their own.
- Train supervisors to initiate talking about cultural issues in supervision and treatment teams

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HELPING STAFF TO INTEGRATE CULTURAL AWARENESS INTO SERVICES

- Model for staff persons respectful ways to talk about sensitive subjects such as race, religion, age, sexual orientation by addressing cultural issues in supervision
- Arrange for cultural discussion at staff retreat, meal; consider a culturally oriented pot luck and ask staff to share something from an aspect of their culture.
- Consider discussing in staff meetings, ways in which culture may have impacted/impeded staff to staff communication

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USING CULTURAL KNOWLEDGE WITHOUT STEREOTYPING

- "I have gathered from my experiences & readings that_____'s may think _____- Is true so for you?" e.g.,
- "I have learned that Asians may find it especially shameful to divulge personal information to a stranger – Is that so for you?"

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WORKING WITH FAMILY MEMBERS AMONG DIVERSE CULTURES

- You have a Latina client. She has been deteriorating in her cognitive abilities. After she asked you what is going on, you arrange for her to receive a cognitive screening. You see that she meets criteria for dementia. You ask her to have a family meeting. Just before the meeting, her son takes you aside and asks you what did you find out, and will you please not tell her if you found that she has "Alzheimer's."
- What would you do?

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WORKING WITH FAMILY MEMBERS AMONG DIFFERENT CULTURES

- Remember that some cultures (e.g., Latino, Asian, Middle Eastern, African-American) **may** value the family collective above the individual.
- Ask local culture broker about typical family values with regard to telling older adults about medical/mental health diagnoses.
- Ask older adult whom he/she prefers to have involved in treatment and decisions.
- Ask older adult if he/she were to have a serious medical illness, would she/he want to be given the information?

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WORKING WITH FAMILY MEMBERS AMONG DIFFERENT CULTURES

- Allow the client to determine who to include in treatment, who should make decisions about treatment, who should be considered a family member, etc.
- May need to ask client in private

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QUESTION

- Clinician Sally, a Asian American 30 year old female, is seeing a 79 year old Caucasian female client, Anna. Anna has a diagnosis of Major Depressive Disorder with psychotic features. She lives alone and has significant medical impairments. She has had trouble keeping steady IHSS workers; she frequently fires them for not meeting her standards for completing tasks she wants done. She currently has a caregiver, a 50 year old African American woman, who is particularly patient with her and is helping Anna remain living in her own apartment. Anna states that she hates being taken care of by a "colored" person.
- Discuss how you would respond in this situation.

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CULTURAL VIEWS ON DYING & DEATH

- Different cultural groups have different views on what is and is not appropriate to talk about.
- In some cultures, talking about dying or death is considered to be wishing it, or bringing it on (e.g., Asian)
- Cultures may vary as to what aspects of dying are frightening (e.g., pain; loss of control (e.g., Caucasian); dying along (e.g., Latino); what occurs after death, etc.

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CULTURAL VIEWS ON COGNITIVE IMPAIRMENT / CAREGIVING

- Hispanic and Chinese caregivers tend to think Alz. Disease is a normal part of aging, and may delay seeking help.
- Native Americans may view caregiving as sacred, and to be undertaken with forbearance
- African American & other non-White families may be more likely to provide care within the family than Anglo families, and may consider institutional care more stigmatizing.
- African American caregivers are less likely to report stress with caregiving than Caucasian caregivers.

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Overcoming Cultural Barriers

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OUTREACH

- Network with cultural ambassadors – community persons who are members of culture of the clients served; have them educate staff about cultural issues
- Have cultural ambassadors outreach into community
- Build relationships with community based organizations, to help identify older adults in need of services, and build bridge to mental health services

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CROSS CULTURAL CLINICAL RELATIONSHIPS

- How do you feel about talking about race? Ethnicity? Sexual orientation? Age?
- How do you feel talking about these topics with others who are similar to you?
- Different from you?

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CROSS CULTURAL CLINICAL RELATIONSHIPS

- Making race, for example, more comfortable to address in clinical encounter
- Consider cultural differences with humility
- Address cultural differences directly & sensitively
- "I notice that you and I appear to come from different cultures, e.g., gender, age, ethnicity, race. How do you imagine this might affect our work together?"

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CROSS CULTURAL CLINICAL RELATIONSHIPS

With African American clients

- Consider demonstrating awareness of possible experiences of discrimination
- Consider showing personal openness with some self disclosure &/or discussing some non therapy topics.

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CROSS CULTURAL CLINICAL RELATIONSHIPS

With Latino clients

- Demonstrate personalismo (informal personal attention) simpatia (affiliative verbalizations), familismo (i.e. understanding a possible preference for closeness with family), platicando (chatting) confianza (trust)
- Possibly try to learn and use a few phrases in Spanish
- Consider learning and using some "dichos" – sayings or proverbs in Spanish

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CROSS CULTURAL CLINICAL RELATIONSHIPS

With Asian American clients

- Incorporate "gift giving" such as producing an immediate treatment benefit (e.g., relaxation techniques on a CD; a self help manual; referrals for tangible services; problem solving approaches)
- Possibly try to learn a few phrases in in the client's language of origin

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CROSS CULTURAL CLINICAL RELATIONSHIPS

With Native Americans clients

- It may be appropriate to avoid eyecontact
- It may be helpful to begin with informal chatting, and / or establishing a link between clinician and client with a pre-existing social relationship, or subject of common interest.

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WHITE PRIVILEGE

- White Americans benefit from more unearned freedoms and privileges than non-White groups.
  - E.g., higher salaries, schools with smaller class sizes, less severe criminal justice system sentences
- Helms (1990) describes a process by which whites can recognize and give up their privilege
- Be aware of power differentials

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DSM IV TR CULTURAL FORMULATION: KRISTEL NAZZAL, M.A.

- Formulation supplement to multi-axial diagnostic assessment
- Formulation helpful when issues arise with applying DSM-IV criteria to culturally diverse environment
  - Example: Intake with Eritrean male
- Overall intention of formulation→ expand understanding of mental illness outside Western/United States lens

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DSM IV TR CULTURAL FORMULATION: 5 COMPONENTS

Formulation narrative form; addresses 5 areas:

1. Client's cultural Identity
2. Client's cultural explanation of illness
3. Cultural factors related to psychosocial environment & functioning
4. Cultural elements of relationship between client and clinician
5. Overall assessment for diagnosis & care

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DSM IV TR CULTURAL FORMULATION: CLIENT'S ID (1)

- Client's cultural identity
  - Ethnic or cultural reference group/groups
  - Level of involvement with home and host cultures for immigrants/ethnic minorities
  - Language(s) spoken and preferred
- Additional considerations
  - Cultural ID more comprehensive: gender, age cohort, sexual orientation, class, religion, profession, etc.
  - Cultural developmental factors: personality characteristics better understood if environmental factors considered i.e. family and gender roles
  - Sources of minority stress and privilege

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DSM IV TR CULTURAL FORMULATION: CLIENT'S EXPLANATION (2)

- Client's cultural explanation of illness
  - Identify predominate *idioms of distress*: culturally salient markers of distress; alternative psychosocial expressions of distress; manifestations and understanding of distress
  - Compare meaning/severity of individual's symptoms to norms of cultural reference group
  - Learn about culture-bound syndromes- local illness category used by community
    - DSM-IV: Glossary of Culture-Bound Syndromes
      - Zar/jiin
      - Ghost sickness
  - Causes/explanatory model to explain illness
  - Past experiences/current preferences with care

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DSM IV TR CULTURAL FORMULATION: CLIENT'S EXPLANATION (2)

- Additional considerations
  - Traditional healingpractices
  - Cultural perception of mental illness
  - Community barriers to seeking psychological services i.e. language, stigma
  - Expectations of treatment

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DSM IV TR CULTURAL FORMULATION: PSYCHOSOCIAL ENVIRONMENT & FUNCTIONING (3)

- Cultural factors related to psychosocial environment & functioning
  - Culturally sanctioned understanding of social stressors
  - Accessible support-system
  - Levels of functioning and disability
- Additional considerations
  - Where community gathers

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DSM IV TR CULTURAL FORMULATION: RELATIONSHIP BETWEEN CLIENT AND CLINICIAN (4)

- Relationship between client and clinician
  - Understand differences in culture and social status between clinician and client
  - Identify/consider prospective issues that may arise in diagnosis and treatment as result of differences
- Additional considerations
  - Being honest about your biases, skills/abilities; being open with client and knowing if/when to refer out

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DSM IV TR CULTURAL FORMULATION: DIAGNOSIS AND CARE (5)

- Overall assessment for diagnosis & care
  - Putting it all together: Comprehensive discussion about how four cultural considerations impact diagnosis and care
  - Lewis-Fernández R; Díaz, N. (2002). The cultural formulation: a method for assessing cultural factors affecting the clinical encounter. *The Psychiatric Quarterly*, *73*(4), 271-295.

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CASE PRESENTATION – JENNIFER PORTER

- Salient Identities
- Cultural explanation of illness
- Explanatory or causal model
- Meaning of Illness
- Psychosocial environment
- Clinician-client relationship

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DSM CULTURE BOUND SYNDROMES

- Amok
- Ataque de nervios
- Bilis & colera
- Boufee delirante
- Brain fag
- Dhat
- Falling-out or blacking out
- Ghost sickness
- Hwabyung
- Koro
- Latah
- Locura
- Mal de ojo
- Nervios
- Pibloktoq
- Qi-gong psychotic reaction
- Rootwork
- Sangue dormido
- Shenjing shuairuo
- Shen-k'uei or shenkui

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DSM CULTURE BOUND SYNDROMES

- Shin-byung
- Spell
- Susto
- Taijin kyofusho
- zar

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EXERCISE

- Split into pairs; one plays Caucasian clinician; one plays older adult client of Color
- Introduce the topic of wanting to understand your partner better, particularly his/her cultural/ethnic identity.
- Perhaps state that while you have some understanding from classes, books, friends, etc., about people from other backgrounds, you want to understand him/her, him/herself, better.
- Ask your partner what he/she considers to be his ethnicity.
- Ask your partner what does he/she considers as factors which are important to his/her identity as a person of this background.

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EXERCISE

- Consider asking your partner what were some of the ethnic traditions he participated in in his family growing up; what are some ethnic traditions he participates in now?
- Consider asking what values from his ethnicity he appreciates?

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ADDRESSING SYSTEM BARRIERS

- Agency policies and practices
- Assessment of agency's cultural competence
  - Value of diversity
  - Performance of cultural self assessment
  - Managing the dynamics of difference
  - Institutionalizing cultural knowledge
  - Adapting to diversity polices, values, structure and services
- Addressing weaknesses

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EXERCISE

- 1. What is your earliest memory of becoming aware of ethnic/racial differences between you and another person?
- What messages were implied or stated to you from your significant others about ethnic differences?

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