



## AskTheInternetTherapist.com Newsletter February 2005



*Happy Valentine's Day!*

### Featured Article

## Elderly in America - What Does the Future Hold? by Barbara Averre, MHPCS, M.A

Elderly citizens sixty-five and over constitute over thirteen percent of the United States' population. In thirty-five years the number of elderly will increase to twenty two percent. This dramatic shift has a number of implications; first and foremost of which is that the elderly will demand the attention of the population as a whole. This shift in awareness indicates a wider spectrum of change already underway in American culture: changes in the perception of aging, the role of medicine for the elderly, the practice of elder care, and the overall quality of life for the elderly. These changes are significant for the individuals now finding themselves past the sixty-five year mark as well as for the rest of society. The key to making change a positive one will be to recognize these shifts that have taken place, interpret them to foretell future trends, and implement appropriate adaptations. The elderly of 1950, 1990, and 2030 may fit the same chronological age bracket, but they possess widely differing needs, values, and lifestyles.

In the field of medicine, the changing needs of the elderly are an especially important issue on which to keep current. In the medical community, rapid developments seem to unfold daily, thereby necessitating an extra effort to keep up with the changing needs of the field itself. In particular, the progressive work on nutrition and preventative health measures offer much in the way of healthier living and increased longevity both for those who may feel their elder years are too distant to be concerned with and for those whose elder years are rapidly approaching. By understanding the aging process better, medicine has been more adequately prepared to approach the elderly with age-appropriate provisions.

Up through the 1940's aging was seen as a process of complete deterioration. Dementia and delirium were thought to be normal to the aging process; illness was accepted as inevitable. Since this time, much research has added to our understanding of what the "normal aging process" should look like. Most of the disability experienced by the elderly results from disease, not from the aging process itself. The well-documented decline in mental performance between old and young is now thought to derive significantly from a slowing of motor functions, not a weakening of the brain. It is reported that at the beginning of this century people began declining into frailty at age fifty-five, and almost no one lived past the age of seventy. Due to improved medical practices and better standards of living most adults now live well into their eighties and may not even show signs of decline until after seventy-five. Life expectancy has soared from a meager forty-seven years to an incredible seventy-six years.

Aging may have been delayed, but in many regards the actual process still looks much the same as in earlier times. What can younger people expect for their later years? As people age, most experience weight gain, a decrease in height, wrinkles in the skin, a (minimal) decrease in sensory perceptions, and weakening of bones, kidneys, and the immune system. In opposition to popular belief, people do not necessarily experience any weakening of the heart, brain (or measurable intelligence), liver, or sexual functioning. All of these can be protected by healthy precautions taken in the younger years: a varied diet rich in nutrients, moderate exercise, and abstinence from toxins such as nicotine. Already we have seen noteworthy improvements in dietary fat consumption, calcium intake, use of nutrition label information, incidence of coronary and stroke mortalities, and blood pressure and cholesterol levels.

These changes, which mirror similar trends in the general population, have created a generation of individuals who no longer face immediate health-related threats such as malnutrition. However, cardiovascular problems still remain the number one cause of morbidity and mortality among the elderly, and this has not decreased over time. Despite this ominous trend, the percentage of deaths which are reported as "due to natural causes" has steadily risen in accordance to the decrease in deaths resulting from preventable causes. As a coinciding factor of this shift is the dramatic increase of elderly living with disease, living with dementia, and simultaneously planning for their futures. Some ten percent of all elderly now suffer from some form of dementia, and this number is expected to triple by the year 2030, due mostly to increased survival rates.

With this remarkable shift in human health must come a comparable shift in human health care. Most notably, the medical community must begin to reform its strategies for a long-term approach. People over sixty-five, even those with disabling illnesses, may live another thirty years, unarguably a significant portion of their lifespans. During these years, maintaining quality of life matters just as much as it does in earlier life. In the past, the main medical objective for treatment of the elderly was to alleviate pain and uncomfortable symptoms. But, allaying symptoms without treating the underlying illness is not sound medical practice, especially since the increasing likelihood is that the illness may be harbored for years. And even though a cure may not always be available, the discomfort or disability produced by many chronic conditions may be substantially affected. There is cause for optimism that the elderly of tomorrow will enjoy greater benefits from science and medicine than those of today who, in turn, enjoy more benefits than the elderly who preceded them.

Among the elderly of today there has developed what can be called a "compression of morbidity;" their functioning remains sufficiently intact until shortly before the time of death.

Due to this consolidation of disability toward the very end of life, the handling of one patient to another must vary by the individual, just as it does among the young. In the same way that a sixty-five year old and a ninety-five year old, both suffering from cancer, offer entirely different case scenarios, so do they deserve and require different case treatment. The elderly have special medical concerns, such as atypical presentation of illness and a decreased tolerance for medication. Illnesses ranging from a urinary tract infection to hypoglycemia may present with confusion, irritability, or depression; and, often these signs get misinterpreted as precursors of dementia while the real problem goes untreated.

As for the treatment they receive, medication dosages must be lowered to an appropriate level for geriatric use. Because the aging process results in an increase in fat storage and a decrease in lean muscle mass, the rates of absorption and excretion of possibly toxic substances is markedly different than in younger bodies. The problem also exists of physicians practicing general medicine with insufficient training in gerontology. Their often mistaking the normal signs of aging as disease results in overmedicating and overtreating patients, which leads to poor outcomes.

In response to this, attention to the care of chronic illnesses in the elderly is on the upswing. More attention is being paid to what kind of care is most effective and suitable for the healthy elderly as well. This is most readily seen in the changes being made in residential treatment facilities. These placements were originally intended for temporary use, such as an invalid might need while convalescing. This arrangement relieved burden from caregivers at home who would welcome the patient back home when their condition had improved and they were better able to care for themselves without assistance.

Over time, this practice shifted, primarily due to the aging of the convalescing population. Patients would grow older, and even after recovery had been made from an acute injury or illness, they found their needs had changed. An elderly patient's decreasing efforts of self-care, such as getting adequate nutrition or sleep, usually serves as the main indicator of the need for assistance. Home care was the original answer to this. People who were able to return to their homes but still needed a little more assistance than could be provided by well meaning friends and relatives could have a visiting nurse provide for them. While this situation sounds ideal, it is far from widespread. Only five percent of people sixty-five and older are in nursing homes. Eighty percent of elder care is still given by family members. Why? The cost of these services has also changed with time, and not for the better. It is more and more becoming the norm for individuals to be priced out of the very services they need most.

What can be expected for the future of elder care? The typical caregivers of the elderly are daughters, daughters in law, and spouses (more often wives than husbands). However, there are a number of very interesting new trends which indicate a possibility of bearing fruit. Senior companion programs, primarily funded by federal dollars and volunteers, offer a dual benefit of pairing up the younger elderly with the older elderly. This system is especially effective for seniors who shun those in the helping professions for reasons of pride, habit, or mistrust. Simply the word "client" can create feelings of imbalance. A companion allows more of a mutual working and helping relationship, and self-image is preserved in a voluntary relationship.

Also appearing in various communities are hospice services, both within institutional settings and in a patient's own home. This service is generally used when a patient needs twenty-four

hour assistance, often in the final stages of a terminal illness. If the patient requests specific mental health or spiritual needs be met, hospice workers can fill this gap as well. Family members are encouraged to participate in the care of patients with the health team members if they are willing and able. In fact, overburdened family members can benefit from being included in a process involving outside help. This can alleviate guilt, soothe resentment, and guide a relationship back onto healthy ground. Family members, while dedicated, are oftentimes not professional caregivers by nature. Simply learning some specific methods of caring for an elderly patient can be useful in easing strain. Programs inviting family members of patients to join in the therapeutic process are becoming increasingly common.

Within these new programs, new methods are also being tried in order to impact elderly patients non-pharmacologically. One such method, reality orientation, has shown mixed results. Some patients' conditions improve if they learn permanent ways to relate and interact within their current living environments. Others seem to be reachable only through their own lenses of reality, regardless of what behavioral-modification techniques are employed to bring them back into the reality of their current situations and surroundings. In addition, pet therapy, music, play, exercise, touch, and relaxation have been added to pre-existing programs with varying degrees of success. Any kind of physically oriented activity that gets a patient to employ muscles, dexterity, and hand-eye coordination helps them function in all other areas of their lives. Instead of focusing on what these individuals cannot do, physical activities explore what an individual can do. By working from this foundation individuals expand their area of the possible, thereby eclipsing what they thought they could not do.

Focus groups and support groups are another new method used to attempt a connection with failing elderly patients. These have proved fruitful for encouraging communication and expression of feelings among normally withdrawn patients. Founders of these groups, which are often open-ended meetings where members can share their problems with each other, frequently run up against opposition from the same elderly clients they were intended to reach. This hesitation may be due to habits the elderly keep: not "airing dirty laundry," keeping things "within the family," and viewing the use of services for themselves as selfish when they feel they should instead be contributing to others.

Techniques that have long been used in the past are often still used today if they have shown a good success rate at improving patients' conditions. Decreasing background noise and distractions is helpful if a patient presents as especially confused or disoriented. Establishing a consistent and structured environment gives patients a stable foundation from which to work. Maintaining eye contact as well as physical contact draws the patient's attention to their immediate surroundings, and has been a useful tool for bringing them back to the present if their mind begins to wander. Teaching them specific techniques they can use on their own, such as external memory aids like lists, not only solves the problem of forgetting but also provides a sense of self-confidence. Purposeful distractions have been used to get activities done that patients resist, such as taking a bath or de-escalating when under stress. In situations like these, a caretaker draws the patient into conversation, offers them food, or otherwise takes their mind away from the troublesome stimulus in order to accomplish desired results.

Sometimes the problems are not so severe, and therefore may go unnoticed for some time. The neighborhood an elderly individual has lived in for fifty years may decline over time; crime sets in, kids overrun the streets, familiar stores move to better areas and are replaced by

unfamiliar merchants selling unfamiliar goods. Often a patient may have been retired for some time and has no new sources of income, status, and socialization available to them, and therefore feels an unwillingness to relocate. All this is reason enough for an elderly individual to seek outside assistance. Programs like "Meals on Wheels" provides food so a person does not have to go out to the store by themselves and carry heavy groceries home with them. Laundry services can pick up and deliver goods. And caretakers, whether from the family or from an agency, can assist with day to day details.

So what quality of life does this provide? A relatively satisfactory one it turns out. If an individual takes care of themselves throughout their younger years, there is no reason to believe they cannot maintain their usual quality of life throughout old age, barring individual predispositions for various risk factors. Few of the often touted pitfalls of growing old offer legitimate reason to fear. Cognitive impairment exists in only fifteen percent of the elderly, and a proportion of this is treatable, such as those cases caused by excess medication or minor illnesses. Over eighty percent of the elderly have relatives either caring for them directly or able to if the need arises. There is no discernible difference in incidences of anxiety between the elderly and the young. While there is a larger incidence of clinical depression among the elderly (likely caused by life events such as the death of loved ones) there is a notable decrease in subjectively experienced depression, as well as in anger and hostility.

As for physical concerns, the one that takes precedence is preventing falls. While these are immediate and serious threats to the safety of elderly people, they are preventable. An orderly living arrangement with little under foot, such as pets or small children, allows maximum benefit to be gained from a measure of extra caution. The major ailments of old age derive mostly from earlier lifestyle habits like smoking, drinking, sunbathing, and inadequate diet. Researchers cannot always agree on where the line should be drawn between unavoidable or naturally occurring diseases and those caused by unhealthy lifestyles, such as with certain cancers, but we are all well advised to err on the side of caution.

Living with chronic diseases is becoming more common as medical treatments prolong survival and reduce suffering among the ill. While this offers obvious benefits to individuals, the drawbacks include questions of financing an extended life after medical expenses, and learning to live with disability, either on one's own or with a caregiver. These are serious concerns for those who have lived long lives as healthy and independent adults. For all this to change with the onset of an illness can be a catastrophic change for the less flexible.

What there will be to look forward to is increased awareness in the general population of the presence and needs of the elderly. This will be due in part to the rising number of elderly surviving ever longer as well as to the improved health and abilities of those elderly which will enable them to remain active members of society for a longer period of time. There may also be more older people, particularly women, in major positions of political and business leadership. Institutions such as nursing facilities are becoming more attuned to the needs of the elderly, offering programs that seek to improve and assist the daily functioning and enjoyment experienced by the elderly residing within them. Nursing homes are no longer a last resort, a place to house the elderly until they die; they are helpful and sociable settings where elderly who need their services may live comfortable among their peers. And to finance these moves, some benefits of Medicare that are rarely utilized may begin to be brought to the attention of more of its members, thereby increasing their options, improving the standard of care they receive, and allowing them the dignity of having a choice for their futures.

'Future' and 'choice' are two of the key words emerging for the elderly of today, and even more so for the elderly of tomorrow. In large part, due to the recent advances in medicine, today's elderly face a longer and healthier future. They have the benefit of new drugs, new treatment programs, and new services, such as home nursing that were not available fifty years ago. In addition to similar benefits, the elderly of tomorrow will have the added bonus of having engaged in healthier practices from an earlier age, due to the much publicized recent developments in nutrition as well as newer health agendas aiming for long-term benefits. These changes have already created a dramatic rise in the average life expectancy of both women and men in this country. The implications of this shift include a larger percentage of elderly in the general population, a larger percentage of disabled individuals surviving longer, and medical approaches that aim for long-term treatment plans rather than immediate or temporary relief.

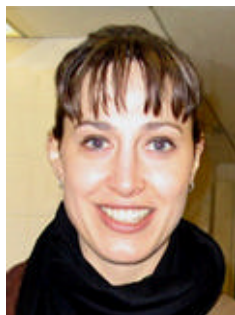
The elderly today are also experiencing a marked change in the services provided to them. Nursing homes have become reasonable options to home care. Senior meetings and senior companion programs encourage socialization, communication, and motility. Family members also have the new option of joining their efforts with outside help instead of choosing between the options of being sole caretakers or abandoning all caregiving entirely. Overall, the new services available to the elderly offer a wide variety of lifestyle choices. The elderly are living longer and enjoying these additional years more. Despite a number of problems that have arisen alongside these shifts, such as extended financial burdens, the quality of life for the elderly seems to have improved over the last one hundred years. And with continued vigilance, we can expect further improvements for the elderly in years to come.

Barbara Averre, MHPCS, MA

## Featured Therapist

**Barbara Averre, MHPCS, M.A.**

**Relationships, Identity, and Well-Being Online Counselor**



As a writer, a psychologist, and now an online counselor, I appreciate the value of the written word, especially when it comes to matters of the heart and soul. And for some of us, the face to face show down of a one on one office visit can be more inhibiting than helpful. You trek out to the therapist's office, you wait in the waiting room, greet awkwardly, take a seat, feel the studied gaze of the therapist's judgmental eye, and are asked, "so, where would you like to begin today?" to immediately draw a blank. As an online counselor, I obviously don't believe this is how real soul work is best done. Real soul work happens in accordance with real life – while conflict is in progress, when questions come up, when feelings are present – and oftentimes within the confines of our own minds. How nice it

would be to dive into such a pursuit in one's own time, in one's own company, at one's own pace – like this – with your online counselor available on just the other side of your modem.

I offer my services as an online counselor for others who function best in this medium. Some people are verbal, some are more expressive with the written word. I think there should be a space for both. I love that the world is made up of every different sort of person, introverts, extraverts, talkers and listeners, the shy, the bold, the creative, the rebellious, the curious, and we're all changing. How you change, whether you change is all up to you and the choices you make and remake every day. Choosing an online counselor or counseling at all is one of those choices to decide for yourself.

I chose to become an online counselor and psychotherapist. I began working with teenagers, the biggest, toughest, leanest, meanest, seen-it-all teenagers you've ever met. And they turned out to be some of the most wonderful people and teachers I've had. Inspired by their guidance I became a psychologist and a diagnostician and now an online counselor. I trained with the best of the best at Columbia University, Johns Hopkins University, and The Albert Einstein College of Medicine, earning my Masters degree in 1996. I became a researcher, studying individuals with severe psychopathologies. I traveled the country, and even beyond its borders, following patients, interviewing them, taking their histories, and learning their life stories. I thought asking the same questions over and over would become tiresome after awhile, but each individual life was such a unique prism of all the elements that had come together in their experience, I couldn't help but be fascinated over and over again. The hard part was knowing the benefits of the research were meant to be long-term and not to immediately help any single participant, and I couldn't stay and work with any of the people who had opened up and let me into their lives.

So I left research and returned to working directly with people, and enable them to help themselves. I worked closely with men and women in shelters and prisons. I gained training and experience in substance abuse issues. I led HIV awareness interventions teaching individuals how to protect themselves and their loved ones. I worked with families who had children with developmental disorders and learning disabilities. I worked with mothers on welfare, and workers on Wall Street. Money, family – these are issues we all struggle with. I worked closely with our respected elders, facing issues of death and dying, bereavement and loss. Depression, anxiety, a family history of mental illness – as labels they sound like little to worry over, but as elements to wake up to every day they are as pressing as any life and death issue.

People check themselves saying there is someone out there worse off than themselves, and someone better off as well. But it has been said there is no great or small suffering, as suffering expands to the space allowed. In order to grow, we need not measure “against” but measure “within.” Just as we all need our regular physical checkups, just as our cars need regularly scheduled maintenance, so do our minds and souls. And this is what I do. If you'd like to talk with me, I'm available around the clock. Drop me an email or let me know if you'd like to have an online chat. I look forward to your possibilities.

## February Contest Winner



Congratulations to Teresa D. She is our February 2005 winner and she picked the Sleep Forest Tape. Enjoy Teresa.

## Featured Product Personal Transformation CD by Dr. Doug Gilbert

This is a self-hypnosis CD that combines a powerful script with binaural beats to assist your body in moving into a deep, suggestible state. This binaural beat technology allows the suggestions to work at a very deep level so that you can remain calm, and feel whole, in a world where stress prevails and many things pull at your energy.

The Personal Transformation CD guides you through a process of helping you integrate all the parts of your subconscious mind that have been fragmented due to emotional traumas in your past, and the chaos possibly existing in your present life. It allows you to start recognizing your true feelings in a safe and gentle way rather than keeping them buried. After working on

reintegration, it then guides you through the process of convincing your mind to have your body work in a healthier and more efficient way.

All speech on this CD is audible, nothing is hidden so you will know exactly what is being said at all times.

Dr. Doug has taken hundreds of hours of post graduate classes dealing with the physiology of emotions and has done years of personal research into the creation and use of self-hypnosis CD's to remove blocks to health and success. Some of the classes Dr. Doug has taken and uses material from are; Applied Kinesiology, Neuro Emotional Technique, Total Body Modification, Reiki, The Reconnection, Touch For Health and Landmark Forum.

You can find Dr. Doug's CDs at:

[http://www.asktheinternettherapist.com/hypnosis\\_hypnotic\\_audiotapes.asp](http://www.asktheinternettherapist.com/hypnosis_hypnotic_audiotapes.asp)

## Special Announcements

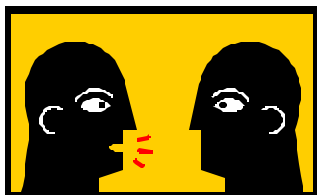
We are now offering another way that you can order Educational Mental Health Videos and Hypnosis Tapes and CDs. You can fax or mail your order using or downloadable order form at [http://www.asktheinternettherapist.com/Order\\_Form\\_ATIT.pdf](http://www.asktheinternettherapist.com/Order_Form_ATIT.pdf). Just fill it up and send it to us via mail or fax. Fax: 480-998-1058 or mail to:

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As you have already seen, all of our videos are digitally re-mastered and are available on VHS and DVD. Although we still have some of the old videos, which we are selling for \$25.00 each to make room for more of the new, digitally re-mastered ones. They are available at the price above only by calling 1-800-881-7693 and placing an order over the phone. ***We have just a few left!! Hurry before this offer expires 12/31/04*** (This offer is available only for the Love Addiction, Communication Assertiveness, Post Traumatic Stress Disorder, Chemical Dependence, Co-dependence, and Dysfunctional Families videos).



Be sure to utilize our **free** discussion boards. These forums are formatted by the following special topics- Hypnosis, Chemical Dependence, Co-Dependence, Parenting, Post-Traumatic-Stress-Disorder, Medical Issues, Dysfunctional Families, Attention Deficit Disorder, Relationships, Veterinary Concerns, and Depression. You might find useful information in the various topics. These forums are usually monitored by our clinicians in a weekly basis.

As you are probably aware asktheinternettherapist offers online individual paid appointment times for in depth assistance with any of our professionals. Our discussion groups however are visited from time to time by our staff and their comments to discussions or questions are provided free of charge. This is an added benefit in addition to client self-help that makes up the bulk of the discussion group traffic. Visit soon.

PLEASE REMEMBER:  
*This is a pay for session site, so  
please email the therapist you  
selected only if after you have paid  
for a session.*

## Remove

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***We believe better health  
begins with better Mental Health.  
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