Psychologists in Long Term Care

# Psychologists in Long Term Care
# NEWSLETTER

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## Introduction to the Research Issue

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Welcome to the Research Issue of the PLTC Newsletter! This is my first year as Associate Editor for this issue of the newsletter. I hope that this newsletter serves to update the membership on the research being conducted by our professional and student members and provides opportunities for members to communicate with each other about shared research interests. By becoming an Associate Editor, I am pleased to continue my involvement with PLTC, as I recently ended a term as one of the student representatives. This transition within PLTC also mirrors a transition in my own professional life, as I recently graduated and started a postdoctoral fellowship. With this new step, I am looking forward to the opportunity to keep members updated on recent research in long term care, particularly related to work being done by our members. The articles in this issue come from both student and professional members and represent a wide range of topics related to research in long term care, along with a description of an opportunity to participate in research pertinent to our membership. Please feel free to contact me with any suggestions for future research issues (Erin_Woodhead@rush.edu) or to keep me updated on research projects for next year's issue. We hope that you enjoy this issue of the newsletter!

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## President's Column

**Joe Casciani, Ph.D.**
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Welcome to the Fall 2009 Issue of the PLTC Newsletter. I hope you find the articles and information to be helpful and of interest in your professional lives. As always, I want to extend a note of thanks to Heath Gordon, Editor, and Erin Woodhead, Associate Editor for this issue, for pulling together another quality Newsletter issue for our members.

In case you missed the announcement sent out on the listserv last month (on 9/25), the PLTC website is now set up so you can update your own member page with current contact information, work affiliation, and other items of interest to members. To do this, follow these steps: go the "Members Only" section of the website (www.pltcweb.org), enter the user ID (PLTCMember) and p/w (aging2009), and select "Create New Personal Account". Select your name from the pull down list of members, which will trigger an email to be sent to you at your email address on record. The email you receive will contain a link to a page where you can enter and update your own information. Click on the link you receive in the email and open your personal member page. You may have to log in again, using the same user ID and password as you did above. Here, you can set a new personal user ID and password, and also enter and update your listing information. Retain the ID and password in your records. If you have problem with this, contact Dave Seagraves at dave@webfeetcreations.com for assistance.

There is also a new Member Directory feature, where you can search for members by selecting the letter of their last names and review their contact information. If you click on the member's name above their contact information, you will bring up the member's entire listing. If desired, you can print a hard copy of the Member Directory.

It has taken a while to make these updates to the PLTC website, and your patience is appreciated.

I also would like to take this opportunity to tell our members about an organization established a few years ago for psychologists, dedicated to helping protect and preserve our practices. If you don't know about this organization already, The National Alliance of Professional Psychology Providers (www.nappp.org) was created by a group of highly regarded psychologists, including some former Presidents of APA, who believed that more could be done to promote psychological practice as a profession. NAPPP just held its first national practice development conference, for two days, with speakers covering a range of topics, including medical psychology, neurofeedback, forensics, and geropsychology (presented by yours truly), among others. There is a strong push to promote geropsychology practice and related professional interests within NAPPP, and I would encourage any PLTC member who is looking for an additional voice to represent our profession in the ever-changing health care arena to take a look at their website and the mission and goals of the group.

Lastly, PLTC will be having a business meeting at the upcoming convention of GSA, to be held next month in Atlanta. The PLTC meeting is scheduled for Saturday morning, 11/21, from 8 to 10am. As usual, we will have a full agenda and if you're attending GSA, I hope you will be there. Breakfast will be served.

Please feel free to contact me with any questions or comments about PLTC, at 858-272-3992, or jcasciani@cohealth.org. Thanks. Joe

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### Please Note:

**Although PLTC supports and encourages dissemination about services and products for the geropsychology community that our members may be interested in, PLTC does not endorse or recommend these services or products. Members of the organization should evaluate these services and products independently.**

## PLTC Membership News

**Amy Rosett, Ph.D.**
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Congratulations to Merla Arnold and Erlene Rosowsky for winning the APA Membership Booth raffle. They each won their PLTC Membership for 2010. The APA booth was quite successful this year. Several new Professional Members joined, including one for both 2009 and 2010, as well as 18 new student members. So how many members do we now have? 202. I'm sure many of us are pleased to know

that we have surpassed the goal of 200, which was announced at the last business meeting.

One of our member benefits is the subscription to the Clinical Gerontologist. In order to receive the first issue of the 2010 journal in a timely manner, I must submit the names and addresses of our members to the publisher by early December. Therefore, please plan to renew for next year a little sooner. In fact, right after you read this you can easily and most efficiently do this at our new and improved website: www.pltcweb.org. Both Dean Paret and I will be emailed about your renewal and PayPal payment in seconds. It is really a great system. But we are also happy to have you renew by downloading a form and sending it in with a check if that is your preference.

Finally, I want to thank Joe Casciani, all the Board members of the past two years, and the many members I have had an opportunity to know by being the Membership Coordinator. It has been a pleasure to learn from, and work with, such dedicated professionals. We have a fine organization that will continue to grow as we all let our colleagues to know about us. My term will end in December and I need to focus on another professional undertaking; I will be the President of the Los Angeles County Psychological Association next year. This has been a rewarding experience and I truly appreciate the opportunity to have served as part of the PLTC leadership.

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**PLTC Website**
**http://www.pltcweb.org**

**How to update your member information:**

1. **Go to PLTC website**
2. **"Members Only" section**
3. **Login using information in Joe's column**
4. **"Create New Personal Account"**
5. **Select your name**
6. **Respond to automated email by following link to information update page**

# The Importance of Geriatric Assessment in Clinical Outcome: A Case of Frontotemporal Dementia

**Geoffrey W. Lane, Ph.D.[1], & Wend Ratto, B.A.[1,2]**
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Case Presentation

Mrs. N., 88, resides in an assisted living facility due to declines in her ability for self-care and personal management. Over the four months prior to her evaluation, Mrs. N.'s family reported that she was significantly less verbal, stating that she was "almost mute" at times, preferred to stay in bed, refused to engage in activities, and showed a significant decrease in appetite–which the family described as a tendency, on her part, to "forget" to eat. The family also noted a lack of complaints on Mrs. N.'s part, unless someone tried to make her get out of bed.

Seven years before, at the age of 81, Mrs. N. had a CT scan and consultation with a neurologist who diagnosed her with "frontal lobe dementia due to alcohol abuse." The patient reportedly stopped drinking alcohol at that time. She was also started on Aricept, which was later stopped due to lack of perceived benefit. Four years prior to our evaluation, at the age of 84, it was reported that she was having a paranoid episode, for which she was effectively medicated for with Zyprexa. It was noted that her primary symptom of dementia was trouble forming new memories; it was also noted that the patient was sleeping "a lot".

Due to the patient's diagnosis of dementia, Mrs. N.'s current primary care physician had restarted her on Aricept approximately four months before the reported changes in her behavior. She was taking 10 milligrams daily when she was referred for evaluation. In addition, the patient's primary care physician had been suspicious of depression, and had recently started the patient on Lexapro.

Concerned about Mrs. N.'s change in behavior, the family and primary care physician initiated a geriatric assessment consult. The family requested a full assessment with the hope of generating additional treatment recommendations to address Mrs. N.'s current condition.

The patient was seen by the writer on two separate occasions for neuropsychological testing, interview, and observations. She presented as an older adult female with generally flat affect. She evidenced atonal

and generally unspontaneous and 'empty' speech, and was prone to repetitious requests to "go back to bed." The patient was administered several neuropsychological tests, including portions of the Cognitive Testing Battery (Hyer, Sohnle, Miller, & Hamer, 2003; Sohnle, Hyer, Iqbal-Hussain, & Sanchez, 2001), WMS-III, and WMS-R, as well as a modified version of the Benton right-left orientation test. She was also administered standard forms of the Mini Mental Status Exam (MMSE) and the COGNISTAT. The Stroop Color-Word test and an alternating-sequences task were given to assess executive functioning.

Discussion

What is now called frontotemporal lobar degeneration, or FTLD, was first described by Pick in 1892. He had discovered and elaborated a clinical syndrome with a clinical and histopathological profile distinct from Alzheimer's disease. For years after his findings, there was confusion about how to identify these patients, including a debate on whether the presence of Pick bodies on histopathology was required for diagnosis, which may have hamstrung research on this disease for years after (Boxer, Trojanowski, M.-Y. Lee, & Miller, 2005). Since Pick's initial discovery, the diagnostic criteria for frontotemporal dementia have evolved. Current criteria, identified by an NIH working group, specifies the core features of FTD as being both early and progressive change in personality and modulating behavior, and early and progressive change in (primarily expressive) language (McKhann et al., 2001).

Treatment

Although there are no treatments that alter the progression of FTD, there are guidelines for treatment. For FTD patients with significant behavioral problems (e.g., problems with eating, impulsivity, or personality changes), SSRIs may be helpful (Robert, Benoit, & Caci, 2007). For patients with treatment-refractory agitation, mood stabilizers are recommended in favor of traditional antipsychotics, due to increased risk of side effects in FTD patients. Most importantly, caregiver support is integral in improving quality of life for caregivers and FTD patients. Treating caregiver depression and offering behavioral and environmental strategies to manage behavioral problems is a necessary part of any treatment strategy for FTD patients (McKhann et al., 2001).

Outcome

Testing indicated significant cognitive impairment. Attention, judgment, repetition, and naming performance were mildly impaired. Language functioning was impaired, with severe deficits found in semantic fluency and expressive language (e.g., animal naming). Moderate deficits were noted on tests of receptive language. Motor systems evidenced moderate to severe apraxia; gross motor movements were largely unimpaired, while performance of movements requiring praxis, sequencing, and fine finger movement showed deficits. Severe memory impairment was found to encompass both verbal and nonverbal material, as well as immediate, short-term, and even long-term (biographical) time frames.

Note that unlike classic Alzheimer's Dementia, the patient's memory problems extended to her remote personal (biographical) memory, which is striking given her relative retention of function in other areas (e.g., confrontation naming, judgment, insight). The patient's memory problems seemed to be driven by her executive functioning deficits. This was viewed as consistent with FTD, particularly in light of the patient's sharp decline coincident with introduction of Aricept.

The writer recommend a fairly standard set of recommendations in this case, including caregiver support for Mrs. N.'s family, continued residence at the assisted living facility, and continued involvement in intellectually and socially stimulating activities. We also recommended a re-evaluation of the patient's medication regimen with the probable FTD diagnosis in mind.

Several weeks after the report was delivered, the writer received several urgent-sounding phone calls from her physician. After finally reaching the physician by phone, he explained to the writer that he had discontinued Mrs. N.'s Aricept and Namenda prescription and switched her antidepressant treatment from Lexapro to Effexor, with profound results—she was now spending much more time out of bed, her flat presentation was considerably decreased and she was much more animated, verbal, and her "old self." The physician made it clear he was very appreciative of the writer's assessment.

Although no formal outcome measures were administered to follow up with this patient, it was clear to the writer that Mrs. N.'s condition had improved markedly as a result of the treatment changes borne of her new diagnosis of FTD. This case report demonstrates that correct identification of dementia syndromes by trained geriatric assessment

specialists can have a profound impact on clinical outcomes.

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# Experiential Learning and Aging Attitudes: A Pilot Study

**Stacy A. Ogbeide, M.S.[1], Kristen H. Sorocco, Ph.D.[2], & Christopher A. Neumann, Ph.D.[1]**

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For the past two decades, researchers have attempted to determine how to best interest clinical psychology graduate students in geropsychology (Hinrichsen & McMeniman, 2002). Several sources of disinterest have been noted: negative stereotypes about older adults, graduate programs being slow to adopt gerontology and geropsychology courses into their curricula, and few clinical geropsychologists available to serve as supervisors and models during clinical psychology practica (Hinrichsen & McMeniman, 2002). In an attempt to understand the barriers to working with older adults, the current study examined attitudes of clinical psychology and marriage and family therapy graduate students toward personal aging before and after an aging course guided by the principles of experiential learning. Assessing personal attitudes toward aging will provide information for students and graduate programs who desire to expand geropsychology training.

In experiential learning, the instructor plays an important role in the learning process. The instructor helps the learner form a connection between the learner's experiences and the course material. It is in this process that the learner is able to develop new ideas or alter old perceptions. Studies using the experiential learning approach with undergraduate populations have found an increase in positive aging attitudes after exposure to this approach (Haman, Coll, & Koch, 1993; Wood, 2002). There is a lack of studies evaluating the impact of an experiential learning approach on attitudes of clinical psychology students, particularly related to working with older adults.

Seven clinical psychology/marriage and family therapy students volunteered for the study. The mean age of the sample was 27.71 years ($SD$ = 4.57) with a gender distribution of five females and two males. All of the volunteers were enrolled in the course titled "MFT/PSY: Aging and Adult Development" offered by The School of Professional Psychology at Forest Institute in Springfield, Missouri. The following topics were covered during the 16-week course: key theories and paradigms in development; family life cycle and clinical implications; family normality and dysfunction; implications for family therapy practice; early adulthood: emotional and social development, personal identity and belonging; intimacy and differentiation; sexuality and social development; single hood; families; family development; adoptive families; risk and resilience after divorce; single parent and blended families; alternative family forms and lifestyles; middle adulthood: parenthood and relationships at midlife; career development and transitions; late adulthood and end of life; physical, social, and cognitive development; end of life issues; retirement and mental health issues in the elderly; elder care and abuse; culture and spirituality; developmental perspectives on family functioning; and right to die issues.

After completing the informed consent, the students completed the Reactions to Ageing Questionnaire (RAQ) before and after the 16-week course. The purpose of the RAQ is to measure personal reactions towards aging, which have been

strongly correlated with attitudes toward older adults (Mandy, Lucas, & Hodgson, 2007). The questionnaire contains 27 items using a 6-point Likert scale (1 = disagree very much to 6 = agree very much) with scores ranging from 27 to 162. Higher scores are associated with more positive attitudes. The RAQ has 3 attitude types: gerophobe (negative attitude towards aging; 27-79), neutral (80-119), and gerophile (positive attitudes towards aging; 120+). This scale has been established as a reliable and valid index of personal reactions towards aging (Gething, 1994; Gething et al., 2004; Mandy, Lucas, & Hodgson, 2007).

At the start and the end of the course, all of the students were in the neutral range, which indicates neither a positive or negative attitude toward aging. There were no statistically significant differences between the pre-test ($M$ = 116.86, $SD$ = 11.39) and post-test ($M$ = 115.00, $SD$ = 9.78) scores on the RAQ.

Can a course in aging influence the career interests of graduate students in psychology? Research indicates that graduate psychology students hold negative attitudes about aging which relates to a reluctance to work with this population. Although this study did not find a difference in attitudes after exposure to an aging course, the results highlight the importance of gerontological education in graduate programs in order to promote positive views toward aging (Draper, Gething, Fethney, & Winfield, 1999).

Experiential learning as a teaching method has been shown to be an effective medium for students to acquire the appropriate interpersonal skills and adequate levels of self-awareness in order to be successful in the mental health field (Green, 1995). The purpose of experiential learning is to help the student uncover the "…understanding of a phenomenon as experienced by the particular individual" (p. 421). By having the students conceptualize their personal experiences and relate it to the topics of the course, students give meaning to their own learning. By incorporating an experiential approach with an interpersonal component, students have a better understanding of the factors that are related to the older adult population.

Although the current study did not find that attitudes toward aging changed as a result of an experiential learning course, future studies might examine student attitudes from different learning approaches in order to determine if there is an association between learning approach and change in attitudes toward aging.

The information presented in this study suggests that clinical psychology students do not hold positive or negative beliefs towards aging. Because the students in this sample were in the neutral range, continual exposure to aging issues could instill positive views toward the aging population over time. In addition, there may be a benefit of clinical exposure to working with older adults, as Hinrichsen and McMeniman (2002) found that when graduate psychology students had practicum experiences in geropsychology, it had an influence in their future career interests. It is recommended students receive practicum experiences in geropsychology in addition to aging courses in order to prepare future practitioners to work with this rapidly growing population.

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## *PLTC Members … Your Opinion Counts!!!*

*Feeling stressed and burned out? Does your practice have you down? If so, effective coping skills, creativity, and proactive self-care strategies may help significantly in both personal and professional domains.*

With this in mind, participate in the ***"Survival Skills for Self-Preservation" Survey*** to help us identify optimal coping strategies used by psychologists working in long term care. Results of the survey will be included in the Winter issue of the PLTC newsletter and will be used to create a ***"Survival Skills Tool Kit"*** from survey responses. Take a few minutes to complete the survey and share your best tips with PLTC colleagues! To participate, simply click on the following link, or copy and paste it into your browser:

**http://www.surveymonkey.com/s.aspx?sm=_2fFk5otdPk7RipXWt5_2fEgFA_3d_3d**

## Leadership Opportunities

**There are multiple opportunities to become involved in PLTC leadership in the coming year, and we hope you will consider assuming an active role in one of these positions:**

1. **Website Support Person (ASAP)**
2. **Newsletter Editor**
3. **Membership Coordinator**
4. **Student Representative**

If you would like more information, please feel free to contact me, heath_gordon@bellsouth.net.

## PLTC Members at APA in Toronto

**From Left to Right:**
**Joe Casciani, Barry Edelstein, Victor Molinari, Margie Norris, Erlene Rosowsky, and Amy Rosett**