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EDITOR'S MESSAGE

Kaaren Boothroyd, Editor

Published for over 30 years, the Journal of Aging Life Care® (formerly the Journal of Geriatric Care Management) has been an important source of information and resources for professionals working in the field of Aging Life Care.

This year begins a new era for the Journal, as it becomes a peer-reviewed publication, thereby elevating its standards for professionals and consumer seeking credible, well-researched content on topics relating to the care and concerns of the aging population.

In this issue two of our articles discuss topics directly related to the pandemic we are living through. "Stress Injury and Stress First Aid: Coping on the Front Lines of the COVID-19 Pandemic" and "Grief in the Time of COVID-19, Supporting Elders in Isolation" take in-depth looks from both the practitioner's perspective and the elders receiving care.

Two more articles highlight important subject matter for every practitioner working with the aging population. "Aging Life Care Professionals' Perceptions of Microaggressions and Verbal or Emotional Abuse Toward Aging Women" and "Medication Management: Adding Value to the Aging Life Care Manager's Practice" both inform and heighten awareness and understanding of these topics.

We are proud to have an Editorial Board and Peer Review Board made up of professionals representing a diversity of disciplines, geography, and experience. Thank you to the authors, board members, and reviewers who have contributed to this edition.

We wish everyone well and look forward to sharing the best in Aging Life Care research and writing with you in 2021.

—Kaaren Boothroyd, Editor

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Aging Life Care Professionals'® Perceptions of Microaggressions and Verbal or Emotional Abuse Toward Aging Women

Kim Kozina-Evanoski, EdD, CMC, LMSW, MPA, CDP

Keep your voice. Shine your light. Hold steadfast—you have permission.

INTRODUCTION

The demands of being a caregiver or eldercare provider are not only challenging, but can manifest in mental, emotional, physical, and financial stresses. Caregivers, who often feel void of choice when the need arises to participate in a primary caregiving role, are more likely to report negative impacts (57%) as a result of providing care. Additionally, these caregivers will continue to experience these negative effects well into the future (National Alliance for Caregiving & AARP Public Policy Institute [NAC & AARP], 2015). Caring for a seriously ill family member creates additional stressors, which are caused by a high-burdened care situation (NAC & AARP, 2015) and that pose risks, such as losing one's job (Menasce Horowitz, Parker, Graf, & Livingston, 2017). Caregiver stress and negative experiences may lead to adverse treatment of those aging adults who are receiving care. This adverse treatment is known as *elder abuse*.

Elder abuse can lead to increased psychological distress and geriatric syndromes of aging individuals, which may pose as complex health issues. Dong, Chen, Chang, and Simon (2013) found that these health issues are independently associated with premature morbidity and mortality.

The World Health Organization (WHO, 2002) adopted the most recognized definition of elder abuse, which states, "Elder abuse is a single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person" (WHO, 2002, p. 3).

Elder mistreatment can come in the form of *microaggressions*. Microaggressions are defined as subtle behaviors or verbal indignities that communicate negative messages. Microaggressions have been acknowledged as a form of abuse that is linked to psychological distress and trauma (Fleischer, 2017; Gonzales, Davidoff, DeLuca, & Yanos, 2015; Owen, Tao, & Rodolfa, 2010; Ross-Sheriff, 2012). Burnes et al. (2015) found emotional abuse to be the most prevalent of abuses, followed closely by physical abuse and neglect.

The intertwining of multiple forms of abuse is called *polyvictimization*. Microaggressions and verbal or emotional mistreatment are included as forms of polyvictimization, which significantly affects aging individuals, especially in their later years. The working definition of polyvictimization, retrieved from the Ramsey-Klawnsnik et al. (2014) national forum on later life, states:

Polyvictimization in later life occurs when a person age 60 or older is harmed through multiple co-occurring or sequential types of elder abuse by one or more perpetrators, or when an older adult experiences one type of abuse perpetrated by multiple others with whom the older adult has a personal, professional, or care recipient relationship in which there is a societal expectation of trust. Perpetrators of polyvictimization in later life include individuals with special access to older adults such as: intimate partners; other family members; fiduciaries; paid or unpaid care or service providers, resident(s) or service recipients in care settings. (p. 5)

Late-life polyvictimization trends show higher amounts of abuse, coupled with a lack of interventions (Fearing et al., 2017). A recent systematic review of community-based interventions for elder abuse and neglect indicates that intervention research is limited (Yon, Mikton, Gassoumis, & Wilber, 2017). In 2009, Ploeg, Fear, Hutchison, MacMillan, and Bolan posited that insufficient evidence existed to support any intervention relating to elder abuse targeting clients, perpetrators, or healthcare professionals. Elder mistreatment predictions reveal increasing mortality risks stemming from poorer physical and psychological health (Wong & Waite, 2017). Fearing et al. (2017) predicted that insufficient interventions for preventing elder abuse will lead to elder mistreatment potentially reaching epidemic levels. For every single case of elder abuse that becomes revealed, there are likely twenty-three additional cases that remain unexposed, hidden, and unreported (Lachs & Berman, 2011).

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When factoring in gender, elder abuse rates are higher than originally thought. As of 2017, it was estimated that sixty-eight million, or one in six, aging women experience some form of abuse worldwide (Yon et al., 2017). An aging woman is defined as being 65 years and older (Orimo, Ito, Suzuki, Araki, Hosoi, & Sawabe, 2006). At any age, women suffer higher rates of interpersonal violence, verbal abuse, and emotional abuse throughout their lifespan than their male counterparts. These forms of abuse are a consistent trend when comparing elderly women to elderly men (Hamby, Smith, Mitchell, Turner, & Smith, 2016; Mouton, Rodabough, Rovi, Hunt, Talamantes, Brzyski, & Burge, 2004; Yon et al., 2017). A report by Lachs and Berman (2011) revealed that almost two-thirds of the study participants who self-reported being victims of elder abuse were women. Abuse of these postmenopausal women did not diminish as age increased nor did the serious threat to their health or well-being (Hamby et al., 2016; Mouton et al., 2004).

Abuse varies and includes physical, verbal or psychological, emotional, sexual, and financial forms. Abuse can also mirror as intentional or unintentional neglect (Luoma et al., 2011; WHO, 2002). As demonstrated in a study across five countries in a multinational survey by Luoma et al. (2011), emotional abuse tends to be the most commonly reported form of abuse among aging women. The study revealed that 23.6% of women (or one in four women in the study) reported experiences of emotional abuse (Luoma et al., 2011).

Historically, there has been little understanding of the cause of verbal or emotional abuse toward aging women (Baker et al., 2009; Fearing et al., 2017; Lin & Giles, 2013; Mouton et al., 2004; Ross-Sheriff, 2012; Yan & Brownell, 2015; Yon et al., 2017). Women outlive their male counterparts: Statistics show that females ages 65 to 69 outnumber males by 0.7 million; females outnumber males by one million in the 75 to 79 age group; and in the age group of 85 and over, 1.9 million more females than males comprise that sector of the population (U.S. Census Bureau, 2014). Socioeconomic detriments may challenge women. Of particular concern is the vulnerability brought on by cognitive impairment, reducing aging women's financial capacity to take care of daily bills or other financial needs, hence increasing the risk of financial exploitation (Deane, 2018; Lachs & Berman, 2011). The certainty of known higher risk factors, such as poverty, lack of social support, and cognitive impairment, has led to increasing the understanding of aging women's mistreatment (Amstadter et al., 2010; Comijs, Smit, Pot, Bouter, & Cees Jonker, 1999; Lachs & Berman, 2011; Lin & Brown, 2012).

Problem Statement

Elder abuse is a global public health issue (Yan, 2019). Elder abuse is also a national public health issue, with five million Americans affected each year by elder abuse, causing injury, suffering, and exploitation (U.S. Department of Justice [USDJ], n.d.). Aging women who experience elder abuse suffer higher mortality risks due to interpersonal violence, verbal abuse, and emotional abuse throughout their lifetimes (Baker et al., 2009; Dong et al., 2013; Fearing et al., 2017; Lin & Giles, 2013; Mouton et al., 2004; Yan & Brownell, 2015; Yon et al., 2017).

The literature supports that there is an acknowledged need for further

understanding of the cause of verbal or emotional abuse toward aging women (Baker et al., 2009; Fearing et al., 2017; Lin & Giles, 2013; Mouton et al., 2004; Ross-Sheriff, 2012; Yan & Brownell, 2015; Yon et al., 2017). And while there is growing research on elder abuse toward aging women, there is little to no existing literature on the specific experiences or perceptions of the stakeholders, such as Aging Life Care Association® (ALCA) experts, who are known as trusted advocates and listeners to their clients' needs (ALCA, 2018; Horne & Ortiz, 2017; Ortiz & Horne, 2013).

This article discusses the analysis of the qualitative data gathered through interviews with seven Aging Life Care

experts. The purpose of this study was to explore the lived experience of Aging Life Care experts and the meaning that these experts assigned to their experiences with microaggressions and verbal or emotional abuse occurrence(s) toward aging women. Further, the goal was to gain insights into the phenomenon of microaggression and verbal or emotional abuse toward aging women through the perceptions of trusted stakeholders, identified for this study as Aging Life Care experts, who provide professional care services. The following research question guided this study: *How do Aging Life Care Professionals perceive the occurrence(s) of microaggressions and verbal or emotional abuse toward aging women clients?*

Methodology and Data Analysis

A homogenous sample of seven U.S. Aging Life Care experts, with shared experiences of the phenomenon of interest, participated in this study. These participants practiced in California, Florida, Georgia, Michigan, New York, Pennsylvania, and the District of Columbia at the time of the interviews (Clarke, 2009). These participants represented a culturally diverse sample that included mixed genders; diverse backgrounds in race; diverse socioeconomic status; and rural, suburban, and city settings. These participants met the prequalifying criteria for study participation and identified as engaging in the phenomenon of interest—the perceptions of an occurrence(s) of microaggressions and verbal or emotional abuse toward aging women. Interviews were conducted with each of the Aging Life Care experts through a secure online audio recording platform, and member checking was performed for study integrity.

The methodology used for this study was Interpretive Phenomenological Analysis (IPA), which aims for a detailed exploration of how participants make sense of their personal and social world (Smith & Osborn, 2007). IPA allowed the researcher to gather first-person, detailed, and reflective reasoning from the research participants, so the IPA study captures and reflects upon the essential beliefs and concerns of the research participants

(Larkin & Thompson, 2012). The two components, giving voice and making sense, take a substantial amount of time and effort by the researcher (Larkin & Thompson, 2012), because it is a dynamic process in which the researcher plays an active role (Smith & Osborn, 2007). The researcher's objective is to make sense of the participants' worlds through interpretive activity and to develop an inside perspective (Conrad, 1987).

In this study, the theory of CAD (cumulative advantage/disadvantage) served as the theoretical framework for understanding Aging Life Care experts' assigned meaning to their experience with microaggressions and verbal or emotional abuse. The theory helps conceptualize the research findings as theorist Dannefer (2003) addresses aging women suffering from a life course of inequality and poverty by how society is structured.

The data analysis process, using the lens of IPA methodology and the CAD theory, focused on both the details of each participant's experience of the phenomenon and on the shared experiences of the phenomenon by each of the study participants.

Findings

Five themes emerged through the researcher's analysis, which interpreted

the study participants' responses and identified patterns: (a) *insidious transactions*, in which microaggressions are negative interactions against aging women; (b) *definition interpretation*, in which microaggressions and verbal or emotional abuse are intertwined; (c) *trauma*, in which higher vulnerabilities in aging women lead to a higher amount of microaggression and verbal or emotional abuse that traumatizes; (d) *dignity*, in which recurring microaggressions and verbal or emotional abuse violate aging women's human dignity and human rights; and (e) *advocacy*, in which support is an essential tool to use against microaggressions and verbal or emotional abuse toward aging women.

A varied definition of microaggression and verbal or emotional abuse terminology emerged from the study participants that provided a foundation for how each participant understood the research question: *How do Aging Life Care Professionals perceive the occurrence(s) of microaggressions and verbal or emotional abuse toward aging women clients?* For the purpose of this study, a *microaggression* was defined as verbal indignities that communicate negative messages; this is a more recently acknowledged form of abuse linked to psychological distress and trauma. For the purpose of this study, *verbal or emotional abuse* was

defined as uncontrolled anger, hollering, mocking or name-calling, ignoring, threatening, bullying, and fear-induced language.

The examination of the findings began with each participant's definition of microaggressions and verbal or emotional abuse. The study participants defined microaggressions and verbal or emotional abuse in many ways. These definitions were essential to understand, as each participant specifically defined microaggressions and verbal or emotional abuse through client stories, personal observations, interactions, and transactions.

During the interviews, the participants shared their particular definition of microaggressions and verbal or emotional abuse by their perceptions of their aging women clients' experiences. The meaning that the participants assigned to their experiences was influenced by these particular definitions of microaggressions and verbal or emotional abuse. As summarized in Table 1, this was an unanticipated finding around the definitions, as each study participant's definition of microaggressions and verbal or emotional abuse varied. There were some similarities in the definitions provided by the participants, but there was no singular definition of microaggressions and verbal or emotional abuse that emerged from the study.

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TABLE 1
Summary of Participant Definition for Microaggressions and Verbal or Emotional Abuse

PARTICIPANT	DEFINITION	WORD USE FOR MICROAGGRESSIONS AND VERBAL OR EMOTIONAL ABUSE
Participant 1	serious and impactful	Verbal confrontations; hollering; timed, forced interactions/reactions; interpersonal violence; emotional pain; trauma
Participant 2	exclusionary conversations	Elder abuse; financial and verbal exploitation; being a pronoun; cultural differences; trauma
Participant 3	emotional upset	Harassment; pressure causing emotional pain; threatening; aggression; interpersonal violence; trauma
Participant 4	human dismissal	Dismissive; latent trauma; overt ignoring; lack of sensitivity; lying; warehoused; invisible; emotional pain
Participant 5	cultural misunderstanding	Infantilization; fear of retribution; being a pronoun; trauma; cultural differences
Participant 6	abilities insensitivity	Risky transactions; ignoring; withholding care; timed, forced interactions/reactions; cultural differences; trauma
Participant 7	verbal indignity	Cringing; harassment; distress; no voice; fear-induced language; bullying; interpersonal violence; trauma; verbal indignities

(continued from page 5)

Understanding each participant's definition of microaggressions and verbal or emotional abuse set the foundation for understanding the meaning that each participant assigned to their experience with microaggressions and verbal or emotional abuse. All seven study participants self-identified as observing or experiencing microaggressions and verbal or emotional abuse toward aging women and experiencing the phenomenon through their perceptions of aging female clients' experiences.

Furthermore, all the study participants stated the end results of the microaggressions and verbal or emotional abuse toward their aging female clients produced some form of trauma (being upset, showing pain or a type of suffering, noticeably becoming disturbed, shocked, or agitated) for those clients. Although this was the study participants' perceptions of their aging female clients' experiences, the study participants felt personally upset for their clients when describing their clients' emotional pain and the interpersonal violence they endured.

Further, the definition and word use related to how the study participants described the aging women being treated as a nonentity, such as *being a pronoun* (using forms of "she" or "her" in place of the person's name), and of their aging female clients' reacting to harassment (pestering, persecuting, agitating). Many of the study participants expressed the distress they experienced when watching timed, forced interactions/reactions (e.g., saying to an aging woman, "You can put an X here, don't worry about writing your name," thus making the aged woman into a nonentity). Such interactions reduce an aging woman's dignity and sense of identity, giving further meaning to microaggressions and verbal or emotional abuse that emerged from the study.

Understanding each participant's definition of microaggressions and verbal or emotional abuse provided the context for examining the five themes that emerged from the study. The five themes outlined and discussed represent the unique meanings that the

participants assigned to microaggressions and verbal or emotional abuse as well as the shared experiences across the study participants.

**Insidious transactions:
Microaggressions are negative interactions against aging women.**

All the study participants indicated that verbal indignities, or the existence of microaggressions, were real. All seven Aging Life Care experts observed microaggressions as an ongoing problem. There were many types of microaggressions witnessed. These participants gave meaning to the types of microaggressions that Sue et al. (2007) described in their research, such as *micro assault* (name calling or other forms of conscious and deliberate discriminatory actions), *micro invalidation* (communication that excludes, negates, or nullifies feelings), *micro insult* (rudeness or insensitivity or subtle snubs), and *micro invisibility* (disregarded presence).

**Definition interpretation:
Microaggressions and verbal abuse were intertwined and interchanged by the study participants.**

There was an intertwined, interdependent relationship between microaggressions and verbal or emotional abuse when the study participants shared their stories or discussed how they perceived their aging female clients' experiences with microaggressions and verbal or emotional abuse. As seen in Table 1, terms used by the study participants – such as "verbal indignities," "exploitation," "verbal confrontation," "avoiding care," "bullying," "ignoring," "manipulation," and "withholding care" – were used as both microaggressions and as verbal or emotional abuse, and sometimes these acts moved to polyvictimization. The study participants moved through their stories, sometimes defining microaggressions as verbal or emotional abuse; at other times, the study participants defined verbal or emotional abuse as a microaggression.

Trauma: Higher vulnerabilities in aging women lead to higher incidence of microaggressions and verbal or emotional abuse that traumatize.

The study participants described how higher vulnerabilities in aging

women lead to a higher incidence of microaggressions and verbal or emotional abuse. These participants realized vulnerable aging women with such issues as memory loss, physical/health needs, interpersonal violence, or emotional pain, were being subjected to microaggressions and verbal or emotional abuse, which would cause them emotional distress and trauma. Past or repeated unresolved trauma placed further emotional distress on these vulnerable aging women.

Dignity: Recurrences violate human dignity and human rights.

Study participants recognized that recurring microaggressions and verbal or emotional abuse violate aging women's human dignity. Financial exploitation, facility-centered care, infantilization, memory loss vulnerability, physical alteration, and unmet physical and health needs—many of these abuse types are also human rights violations. These Aging Life Care experts spoke of recurring dignity violations happening to their clients.

Advocacy: Advocacy is an essential tool.

The study participants, in their discussion and narratives of the advocacy theme, further believed that advocacy must be used as an essential tool to use against microaggressions and verbal or emotional abuse toward aging women. They acknowledged their vital role as client advocates in assisting aging women. In particular, the participants in this study noted that coaching, modeling, and educating were an essential part of their role as advocate, especially in building awareness of microaggressions and verbal or emotional abuse toward aging women or in empowering aging female clients.

Summary of the Implications of the Findings

These study Aging Life Care experts were engaged in finding the meaning of microaggressions and verbal or emotional abuse toward aging women and were focused on acknowledging microaggressions as being real in aging women's lives. All the study participants observed microaggressions and verbal or emotional abuse as an ongoing societal problem and were grappling

with the concept of microaggressions and verbal or emotional abuse being intertwined. This study's participants recognized there was a significant complexity with microaggression and verbal or emotional abuse toward aging women. These Aging Life Care experts realized that, for vulnerable aging women with memory loss, physical/health needs, interpersonal violence, or emotional pain, microaggressions and verbal or emotional abuse cause additional emotional distress and trauma. This study's participants validated and acknowledged that aging women with higher vulnerabilities experience higher microaggressions and verbal or emotional abuse that traumatize, and that the many forms of microaggressions and verbal or emotional abuse violate aging women's dignity and human rights. Further, these Aging Life Care experts acknowledged their role as advocates in assisting aging women who experience microaggressions and verbal or emotional abuse.

The meaning that these study participants assigned to their perceptions of aging women's experiences with microaggressions and verbal or emotional abuse were personal, exploratory for some participants, and profound for other participants. Identifying the existence of verbal abuse and the complexity and intertwined nature of microaggressions and verbal or emotional abuse was challenging to these participants, who were trying to gain a greater understanding of the complexity of the phenomenon. Throughout the meaning of microaggressions and verbal or emotional abuse, as defined by these study participants, are found the elements of control, fear, outside influences, and participants' own biases and attitude toward their experiences with microaggressions and verbal or emotional abuse toward aging women. Insights gained from this study's Aging Life Care experts regarding their shared experiences may be useful to other Aging Life Care experts and care providers who acknowledge the importance of understanding microaggressions and verbal or emotional abuse toward aging women but who have yet to deal with the behavior with their clients.

Recommendations for Improved Practice

The findings of this study suggest that Aging Life Care experts, care management personnel with aging professionals and leaders, ALCA Board of Directors, policymakers, researchers, and key stakeholders should develop *a shared understanding* of microaggressions and verbal or emotional abuse toward aging women. Language by experts and leaders can assist in developing text and context (Schegloff, 1997) when there is a need for shared understanding. The unanticipated findings around the study participants' definitions of microaggressions and verbal or emotional abuse suggests that Aging Life Care experts can effect a positive and important cultural change regarding how aging women are viewed and treated.

Recommendations for Policy and Legislative Initiatives

ALCA, care management and aging leadership can advocate for funding to build educational programs for professionals, families, and aging women that deliver advocacy skills and evidence-based practices that empower and protect aging women against microaggressions and verbal or emotional abuse. Legislatively, Medicare could fund programs as well as make policy changes by implementing trauma-informed care protocols addressing microaggressions and verbal or emotional abuse impact toward aging women. Practitioners such as Aging Life Care experts, who physically go across systems of care, have the knowledge base to provide insight, training, and mentorship. Aging Life Care experts could reach other practitioners through a grassroots effort, building a capacity to change practitioners' knowledge and treatment of aging women who are burdened with microaggressions and verbal or emotional abuse.

Limitations

The sample was not geographically representative of ALCA because of time constraints placed on the researcher. In addition, participants interested in volunteering for this study needed to meet

certain professional criteria to participate, thus further limiting a more diverse geographic representation. Five of the participants were from the east coast, one from the Midwest, and one from west coast. A more representative sample of ALCA members based on chapters may have provided further and differing perceptions.

Recommendations for Future Research

The research methodology employed in this study could easily be replicated by other researchers to achieve dependability. A mixed-methods study could examine a larger number of study participants in the United States who could give data about the validity of this study's themes—including more exploration of the experiences with microaggressions and verbal or emotional abuse toward aging women.

Kim Kozina-Evanoski, EdD, CMC, LMSW, MPA, CDP is the owner and CEO of Care Manage For All, LLC, an innovative care management service covering fourteen counties in Upstate New York. Dr. Kozina-Evanoski is nationally certified as a Care Manager through the National Academy of Certified Care Managers (NACCM) and is an Advanced Professional member of the Aging Life Care Association. She completed the New York University's Silver Social Work Leadership Fellowship in Palliative and End-of-Life Care, becoming nationally recognized as a Social Work Leader for improving palliative care. She is a cofounder of The Memory Maker Project, an innovative cultural arts access program. She teaches at Keuka College and Binghamton University, and has created a national Care Management Fellowship. Dr. Kozina-Evanoski's current research focus is on professional perceptions of microaggressions and verbal or emotional abuse toward aging women and EM-DR-Flash protocols for vulnerable aging populations.

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Stress Injury and Stress First Aid: Coping on the Front Lines of the COVID-19 Pandemic

Traditional models of self-care are not enough for front-line workers and Aging Life Care Professionals® during the pandemic.

Barbara Ganzel, PhD, LMSW, Kim Kozina-Evanoski, EdD, CMC, LMSW, MPA, CDP, Pamela Newland, PhD, RN, CMSRN, Lisa Richards, and Patricia Watson, PhD

Care Management in the COVID-19 Pandemic: Interaction in the first person

The third time I enter the hospital is the last time for my patient, who is dying today. The first two times were through the emergency room. The sequence:

.... Severe heart attack.

.... Fluid in the lungs and labored breathing.

.... Severe chronic disease.

... then COVID-19... positive, negative, positive, positive tests.

Coming in to see my long-time client, to be present for the family. Acknowledgement that she is in imminent status. Her family hasn't seen her since last year because of the COVID-19 restrictions. In the specialized COVID Unit's closet-like "transition room," I suit up exactly as instructed. I suit up over my N95 respirator mask. We add double gloves, specialized gown, boot covers, hair covering, face shield over my glasses, and the most important item for the family — a plastic-covered iPad with Zoom communication loaded to start at a moment's notice, so they could tell her how much they love her.

Nurse: "You get 30 minutes, then it becomes too dangerous, ok?"

I say, "OK, Thank you."

I walk down the hall hearing my own breathing. The heavy gowns make swishing sounds. The hallway is long, with many closed doors. Dark blue doors in a completely empty hallway. "Turn here," says the nurse. I enter her room.

Somehow, the family finds closure

with tears, laughter, a favorite song, and "I love you" passed around many times. I think she really hears us. I think she knows that I am with her, despite this unforgiving suited barrier. I know she hears the kids. I promise her I will take care of everything else, hopefully giving her release. "All is ok. Let go when you are ready."

Back in the "transition room," careful orders are given by two nurses. "I will tell you exactly what to do, follow my directions carefully." Sweat pours down my back. My hands swim in my double gloves. I then realize my hyper-vigilance. I am stressed and anxious to be properly released from the COVID area. "Carefully take this off, like this...." "You are going to fold in your body like this and take the gown off like this...." Carefully. "Sanitize your gloves." "Take off this shield now." Careful. "Sanitize your gloves." "I will clean this for you..." Be careful. "Sanitize your gloves." All of the sudden, I feel like the room drops ten degrees. I am keenly aware that all of the equipment is off my body and I can breathe more naturally in just one respirator mask.

Out of the "transition room," I am instructed now to take my gloves off and wash my hands at a special sink. Carefully placing the contaminated gloves in a special disposal. I wash three times. Taking my time. Do it carefully and methodically, I say to myself. Did I do everything correctly?

I felt I understood "blind faith," because I can't see if I carried COVID out with me or not. As I am escorted through the hospital to leave, I thank the young nurse for keeping me safe.

She smiles. I thank her for doing her best in taking care of these COVID-19 patients. She acknowledges my appreciation. I talk to this young nurse about how serious all this has become; she agrees. We talk about how someday COVID-19 will end. This young nurse looks me straight in the eye, then says, "Even when they say COVID ends and they close the unit, I am still going to burn my shoes. Yes, burn them. I never want to see anything related to this pandemic again."

I never want to see COVID like this again either. I could never wear that N95 respirator mask again. I disposed of it in a very over-cautious way. I symbolically burned what has been taken away from me and others by this pandemic.

As a trauma-informed professional, I know the symptoms of trauma avoidance. Her shoes. My mask. I see the symptoms in us.

ALCPs, Self-Care, and COVID-19

Aging Life Care Professionals (ALCPs) assist clients in attaining their maximum functional potential (ALCA, 2020) through all stages and circumstances in clients' lives. Many ALCPs help their clients during more difficult health stages of palliative care and end-of-life. These life stages can be stressful and challenging to ALCPs, but especially during COVID-19.

Resilience has been discussed with ALCPs (e.g., Davis-Laack, 2015), although self-care and resilience strategies have never been addressed in the ALCA Business Practice. Resilience in
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patient care is a critical perspective in trauma work and in being trauma-informed. However, ALCPs' exposure to their clients' traumas through COVID-19 has not been discussed. COVID-19 exposes professionals to potential trauma and stress injury in a very different and serious way than previously.

Traditional Models of Self-Care

Aging Life Care Managers (ALCMs) who are nurses, social workers, and other professionals play an important role in the care of clients during the COVID-19 pandemic. During this time of fighting the virus and protecting clients, many ALCMs and healthcare professionals place the needs of others before their own. The exercise of self-care is soon forgotten or abandoned as impossible. This is illustrated using two very different professional models of self-care.

Nursing. Often times, nurses are not taught during their nursing education to consider their own health, and even do not know how to begin self-care practices. Attention has grown recently related to resilience and self-care for nurses and other healthcare professionals during this time of COVID-19. How little nurses care for themselves has been brought to the forefront. Even research on the concept of nurse self-care has been sparse, especially with respect to nurses exerting agency over their own self-care.

This is illustrated by the concept of self-care as defined by well-known nursing theorist Dorothea Orem (Orem, 1991), who included "activities that individuals personally initiate and perform on their own behalf in maintaining life, health, and well-being" (p. 365). According to Orem (1991), essential criteria for self-care agency includes the patient having knowledge and skills required for health care needs, being motivated to carry out self-care practices, valuing health, and believing that new health behaviors will reduce vulnerability to developing illness.

Orem defined self-care as "... the

complex acquired ability to meet one's continuing requirements for care that regulates life processes, maintains or promotes integrity of human structure and functioning and human development, and promotes well-being" (Orem, 1991, p. 145). In this model, self-care agency refers to capabilities that a *patient* acquires to care for themselves, as supported by the nurse. Likewise, self-agency is the power that impacts the abilities of the *patient* to carry out self-care practices (Denyes, Orem, Bekel, & SozWiss, 2001). The power components develop in relation to performed operations - decisions are made, purposes formulated, and productive actions generated. Notably, Orem's theory of self-care specifies the nurse as providing the nursing agency to foster the patient's self-care, not as the individual whose self-care agency or self-care needs are addressed (Orem, 2003).

Social work. Social workers, on the other hand, are vigorously encouraged to practice self-care on their own behalf. According to Lee and Miller (2018), self-care is critical to social work practice in preventing secondary traumatic stress, burnout, and high staff turnover. The National Association of Social Workers (NASW) encourages self-care during the COVID-19 pandemic in order to avoid burnout and overwork (NASW, 2020). The NASW website offers a truly vast array of self-care strategies -- exercise, setting boundaries (e.g., taking time off), getting out in nature, getting good sleep, practicing mindfulness, reflective journaling, staying connected with supportive others, using cognitive reappraisal to prevent catastrophizing, leaning on your faith, practicing gratitude, being of service to others, protecting yourself from over-consumption of negative news (a.k.a. "doomscrolling"), to name a selection (e.g., NASW, 2020; Webster, 2020; Wright, 2020).

Despite the robust attention to self-care in social work, there has been relatively little practical or empirical guidance in how to implement self-care (Lee & Miller, 2013). This leaves social workers with a very wide field of self-care options, but little structure or direction for selecting strategies to try or what to do if they don't help.

Moreover, there is little guidance on what to do when the social worker cannot take time off, and when that social worker simply has no time/energy left to exercise, journal, meditate, eat well, or take a hike.

The COVID-19 pandemic has radically shifted the context and need for self-care. Aging Life Care Managers, whether they are nurses, social workers, or other professionals, may find themselves working 10-hour days for weeks or months (all hope not years) on end. Their vacations may be canceled for the duration and personal safety in doubt, in situations where their clients are dying and care-as-usual is not possible, all with no end in sight. The pandemic has placed these providers in situations so far outside the range of normal professional experience that they verge on mass trauma. During this pandemic, none of the usual self-care models are, by themselves, sufficient. Aging Life Care Managers need new models of stress resilience designed for front-line stress. It is for this reason that Stress First Aid is introduced here.

Stress First Aid for Healthcare

As of the writing of this article, the United States is now the epicenter of the global COVID-19 pandemic. As the coronavirus entrenches itself, there has been a dramatic increase in the fatigue, grief/loss, ethical challenges, and outright danger associated with providing health care (e.g., Hoffman, 2020). As outlined above, the standard models of self-care in health care are failing in this context. The COVID-19 pandemic is testing everyone's self-care skills, and no group more so than those who are providing health care.

This crisis is unprecedented, as is the potential for stress injury for care managers and healthcare providers who are holding the front lines of the pandemic. Front-line stress deserves and requires specialized training. The Ithaca College Gerontology Institute has joined forces with Patricia Watson, PhD, of the National Center for Posttraumatic Stress Disorder (NCPTSD) to adapt the Stress First Aid model for this use. Stress First Aid is a self-care and peer support toolset originally developed for "operational stress control" in the U.S. Navy

and Marine Corps (Nash, Westphal, Watson, & Litz, 2009). It has since been adapted for civilian fire, rescue, and law enforcement (e.g., Watson et al., 2013) – and now for front-line healthcare workers and long-term care providers during the COVID-19 pandemic (Watson & Ganzel, 2020; Watson, 2020).

The Stress First Aid model can help identify and address stress reactions early and in an ongoing way. It is about stress management in the moment. The model is based on research on the most effective interventions to reduce the immediate and mid-term effects of mass trauma (Hobfoll et al., 2007). Stress First Aid includes seven actions that provide a flexible framework for identifying and reducing stress reactions, and for preventing stress injuries from becoming embedded. It is also a guide for supporting workers who are experiencing significant distress or problems in functioning.

The Stress Continuum

The stress continuum model forms the foundation of the Stress First Aid actions. The key point here is that stress responses lie along a spectrum of type and severity. Figure 1 provides a visual tool for assessing stress responses as they occur in yourself or

others. This stress continuum is usually presented as a color scale that ranges from Ready (green) through Reacting (yellow) and Injured (orange) to Ill (red).

Response to stress generally depends on how prepared someone is to handle it and how they interpret the stressful event. *Everyone will respond to stress*: the key is to move to and stay within the Green and Yellow zones of the stress response continuum as much as possible.

Stress reactions in the Yellow zone are, in fact, common and even healthy. They are a normal part of reacting to challenge in the world. Figuring out how to transition from Green to Yellow and back again is part of developing competence and confidence. Even larger reactions – into Orange and Red – can be normal responses to abnormally challenging situations. During the course of a stress reaction response, a person can transition through all of the zones, from Green to Red and back again, depending on the circumstances. Stress injuries (Orange zone) and stress illnesses (Red zone) result from more intense effects of stress on the brain and body. These can result in feeling out of control or being impaired in work or personal roles.

In environments where it is less acceptable to acknowledge feeling

stressed, people may try to hide their stress reactions from each other, their supervisors, even themselves (“I’m fine”). A workplace that shares and uses the stress continuum model is taking an important step in recognizing that *everyone* experiences stress, and *everyone* reacts to it. People may react to stress somewhat differently (e.g., anger vs. depression vs. guilt and shame), but everyone cycles through these same zones, and everyone needs support when spending too much time in the Orange and Red zones. Recognizing the signs of Orange and Red zone stress in self or others is key to taking steps to lessen its severity by practicing self-care or helping a colleague connect with support.

Interestingly, there is benefit in identifying and naming one’s emotional state or state of stress. Neuroscience research shows that activation in the brain areas associated with stress can be reduced simply by labeling or evaluating the negative emotion or state (Hariri, Bookheimer, & Mazziotta, 2000; Hariri et al., 2003). This supports the practice of using a tool like the Stress Continuum to assess and monitor one’s own stress level in an ongoing way.

Stress Injuries

The Orange zone on the stress continuum (see Figure 1) indicates the point at which stress exposure creates actual injury to the brain and body (Nash et al., 2010). The Red zone indicates the point at which these injuries have been aggravated to the point that they generate diagnosable stress-related illnesses, such as major depression or posttraumatic stress disorder (PTSD).

Stress injuries have their origin in the normal physiological adjustments that help us meet everyday environmental challenge (Yellow zone stress). If those challenges are very intense or become chronic, the associated physiological adjustments can create physical injuries to the brain and body (Ganzel, Morris, & Wethington, 2010). These injuries are dynamic and can deepen over time. This makes it

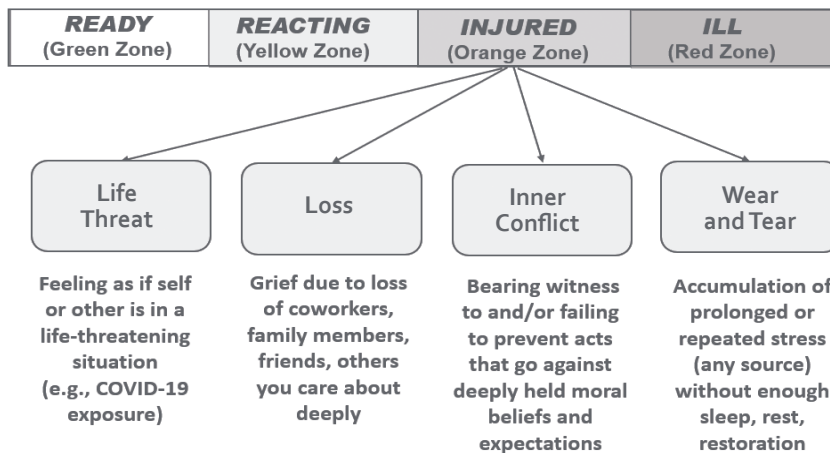
(continued on page 12)

FIGURE 1. The Stress Continuum Model

(reprinted with permission from Nash et al., 2009)

READY (Green Zone)	REACTING (Yellow Zone)	INJURED (Orange Zone)	ILL (Red Zone)
<ul style="list-style-type: none"> • Optimal functioning • Adaptive growth • Wellness <p>Features</p> <ul style="list-style-type: none"> • At your best • Well-trained and prepared • In control • Physically, mentally, and spiritually fit • Mission-focused • Motivated • Calm and steady • Behaving ethically • Having fun 	<ul style="list-style-type: none"> • Mild, temporary distress or loss of functioning • Always goes away • Loss risk for illness <p>Causes</p> <ul style="list-style-type: none"> • Any stressor <p>Features</p> <ul style="list-style-type: none"> • Feeling irritable, anxious, or down • Loss of motivation • Loss of focus • Trouble sleeping • Muscle tension or other physical changes • Not having fun 	<ul style="list-style-type: none"> • More severe and persistent distress or loss of function • Leaves a “scar” • Higher risk for illness <p>Causes</p> <ul style="list-style-type: none"> • Life Threat; Loss, Inner Conflict; Wear-and-Tear <p>Features</p> <ul style="list-style-type: none"> • Loss of control • Panic, rage, depressed mood • Substance abuse • Guilt, shame, blame • Diminished sense of purpose, meaning, hope for future 	<ul style="list-style-type: none"> • Unhealed stress injury causing life impairment • Clinical mental disorder <p>Types</p> <ul style="list-style-type: none"> • PTSD • Depression • Anxiety • Substance Dependence <p>Features</p> <ul style="list-style-type: none"> • Symptoms persist, worsen over time • Severe distress; social or work impairment

FIGURE 2. Four Types of Stress Most Likely to Result in Stress Injury



(continued from page 11)

important to identify them as soon as possible, so they can be treated, and the possibility of further injury can be reduced. The earlier a stress injury is mitigated, the better the prognosis.

For healthcare providers in the COVID-19 pandemic, the four types of stress injury in Figure 2 can arise in expected and unexpected ways. For instance, an ALCM going into clients' homes may feel a constant threat of catching the coronavirus and/or carrying infection to a vulnerable loved one at home. Multiple client deaths might have occurred in a short period. An ALCM whose organization lacks personal protective equipment (PPE) may experience the moral distress of not being able to practice proper infection protocols, while knowing, as a professional, how important they are. Or, the ALCM may be working 10- to 12-hour days under intense stress with no breaks and no vacation, with children at home because the schools are all closed due to the pandemic. Nearly everyone will have stress reactions under these circumstances, which makes new stress resilience skills imperative.

The Seven Actions of Stress First Aid to Mitigate Mass Trauma

During development of the original Stress First Aid model, a panel of twenty experts reviewed the research on the critical factors that support stress resilience in the face of mass

disaster and violence (Hobfoll et al., 2007). The question: *What genuinely helps to mitigate mass trauma?* The panel identified five intervention principles that had empirical support. These principles included (1) fostering a sense of safety, (2) calm, (3) a feeling of connection with others, (4) a sense of efficacy and ability to create positive change, and (5) hope (e.g., for a better future). These became the basis for the core actions of Stress First Aid.

In creating the Stress First Aid model, two more actions were added as precursors to help identify when

one or more of these five core actions should be implemented. These precursor actions are Check (to observe and assess) and Coordinate (get help or refer, if needed). Together, these seven core actions were translated into the "Seven Cs" (a play on words referencing the seven seas in honor of the U.S. Navy and Marines, for whom the model was developed). In keeping with this military context, safety was translated as Cover, and efficacy was translated as Confidence (confidence in oneself and one's team to manage the stressful situation and one's own stress reactions). Thus, the "Seven Cs" became **Check, Coordinate, Cover (to make safe), Calm, Connect, Competence, Confidence (hope)**. See Figure 3.

Stress First Aid can be used to improve provider responses and functioning in stressful, adverse circumstances. The first two of these actions, Check and Coordinate, should be performed on a day-to-day basis and incorporated into regular duties in a natural, seamless way. The other five core actions are implemented as needed.

To be performed continuously:

1. Check: Watch for indicators of stress response in self and coworkers, determine how other members of the team are being affected, and decide what can be done next to manage the stress in a healthy way.

FIGURE 3. The Seven Core Actions of Stress First Aid: The "Seven Cs" (reprinted with permission from Nash et al., 2009)



Seven Cs of Stress First Aid:

- 1. CHECK**
Assess: observe and listen
- 2. COORDINATE**
Get help, refer as needed
- 3. COVER**
Get to safety ASAP
- 4. CALM**
Relax, slow down, refocus
- 5. CONNECT**
Get support from others
- 6. COMPETENCE**
Restore effectiveness
- 7. CONFIDENCE**
Restore self-esteem and hope

11/16/2020
image used with permission of Patricia Watson, PhD; National Center for PTSD

2. Coordinate: Be aware of situations that require intervention for the sake of provider and client wellbeing and safety. Those situations may demand quick action. If needed, work with a supervisor to resolve those confidentially and expeditiously.

To be implemented as needed (together or separately):

3. Cover: Remain available to provide cover to coworkers who need assistance and help them feel safe. Restore a sense of safety.

4. Calm: Slow down physically and mentally to refocus, rest, or sleep. If supporting a coworker, help them refocus on something less stressful or simply be present and listen.

5. Connect: Support coworkers under stress or, in turn, seek support from coworkers when needed. This includes listening, mentoring, empathizing, and/or involving others in groups and activities.

6. Competence: Restoring or developing skills – social, occupational, and coping – is essential to reestablishing and maintaining adequate function in all aspects of life.

7. Confidence: Fostering healthy self-esteem, hope, trust, pride, and commitment to one's values takes time and work, but it also has the greatest potential to improve wellbeing.

Ultimately, the flexibility of this framework makes it easier for those working in care management or health-care settings to build stress resilience actions into their daily work and interactions with colleagues. These tools are especially helpful now but can also be adopted as an ongoing self-care practice following the pandemic.

Applying Stress First Aid During the COVID-19 Pandemic

During the COVID-19 pandemic, front-line Aging Life Care Managers and healthcare workers may be experiencing any or all of the four types of potential stress injury described in Figure 2. As illustrated in the narrative at the beginning of this paper, COVID-19 poses a direct threat to the lives of ALCMs, their healthcare colleagues and clients, and possibly their loved ones at home. As the narrator describes, use of personal

protective equipment (PPE) is an act of “blind faith” because the virus is invisible. It is impossible to see if PPE has been 100% effective in preventing infection, so there is always uncertainty and potential danger.

In this narrative, one also hears the narrator's unspoken moral conflict and grief about not being able to meet her own standards of providing good care because of COVID-19 restrictions. Her client lies dying behind a closed door, seeing only masked figures swathed in PPE who she can barely hear. Her client is allowed no visitors until her death is unmistakably imminent and even then, she can't have her dying wish, which is to be with her loved ones.

There is also the wear-and-tear of having this epidemic drag on with no end in sight. This stress injury is not overtly addressed in the narrative but is evident in the natural history of the pandemic. This narrative is being re-enacted in different forms, but more often, as the second and third waves of the pandemic progress through the United States.

How might Stress First Aid be applied here?

First, the narrator does the **Check** action. She assesses her own stress reactions, today and in past days or weeks – she asks, “Where am I on the Stress Continuum” (Figure 1)? She has already noted her own symptoms of avoidance and anxiety. This is a cue to check herself for other stress reactions – sleep disruption, muscle tension, irritability/anger, sadness, guilt/shame/blame, or perhaps a growing reliance on that extra glass of wine or beer at night to unwind. Then she asks herself, “Are these stress reactions transient (Yellow zone) or have they become persistent (Orange zone) or even severe, so that they are impairing my ability to do my job or are causing a high level of distress in me or the people around me (Red zone)?”

The narrator decides she is more often in the Orange zone these days and uses that information to evaluate what she most needs. Her first impulse is to handle this on her own using **Cover** and **Calm** actions, at which she is very skilled.

Cover – The narrator mentally reviews the PPE precautions she used

at the hospital. She is reassured that her actions were supported and carefully monitored by the nurses on the COVID unit. She vigorously sterilizes the N95 mask she used during that visit (and cleans the interior of her car again).

Calm – To calm her mind and body, she turns to her physical exercise and mindfulness skills, with a little journaling and “online retail therapy.” This helps. However, she recognizes that she just doesn't have the energy or time to put into them to make a significant difference in how she feels. She decides to add **Connection** and some further **Coordination** to the core Stress First Aid actions she will draw upon.

Connect – The narrator connects with two trusted colleagues who are also ALCMs to talk about her experience on the COVID unit, which she realized (afterward) was very difficult. This provides her with space to speak her truth and feel heard. She feels personal and professional validation. They “get it.” At the same time, she reaches a sense of compassion for herself in the context of that experience.

Coordination – The Coordinate action involves knowing who to contact if further help is needed. The narrator reaches out to her therapist of choice to address what she sees as escalating symptoms of stress injury. She prefers eye movement desensitization and reprocessing (EMDR), one of three evidence-based therapies to reduce symptoms of stress injury that are endorsed by the U.S. Veteran's Administration (the other two are exposure therapy and cognitive processing therapy (U.S. Department of Veterans Affairs and Department of Defense, 2017).

Together, these core actions help the narrator return to the Yellow zone. Narrator follow-up:

My truth is that my work is now dangerous. I am still doing it, and I am making the best decisions I can. I examine what I have done, decide what I can do better, and make informed decisions about how I can manage it now and in the future. Yes, I can do my work, although I know it is more dangerous than it used to be.

Heading back out to work in the

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field, the narrator feels secure in her skills in providing safety for her clients and herself. She has recognized her stress reactions and worked to reduce them to be mostly in the Yellow zone. She feels confident in her ability to do so in the future. She is also hopeful about managing her difficult yet very meaningful work in the context of the COVID-19 pandemic. Thus, in this scenario, she doesn't need to intentionally address the core actions of **Competence** and **Confidence**, as they automatically and naturally reassert themselves once she addresses her needs for **Cover**, **Calm**, and **Connection**, and also reaches out to known resources to **Coordinate** the help she needs. This illustrates that, while **Check** and **Coordinate** are used continuously, the other five core actions are only employed when needed.

Summary

Aging Life Care Managers and healthcare professionals have, in large, been unprepared to practice in disaster situations like the current COVID-19 pandemic that have the potential to produce mass trauma. Self-care is essential, but many of the traditional models of self-care in healthcare are not sufficient to this emergency. The adoption of Stress First Aid is proposed as a self-care and peer support toolset for stress resilience by all professional organizations whose members are on the front lines of the COVID-19 pandemic.

Resources

Ithaca College Gerontology Institute – Stress First Aid COVID-19 Toolkit (download)

- Stress First Aid for long-term care staff: For the COVID-19 pandemic response
<https://www.ithaca.edu/file-download/download/public/16484>

National Center for PTSD Coronavirus Websites

- <https://www.ptsd.va.gov/covid/index.asp> (for everyone)
- https://www.ptsd.va.gov/covid/list_healthcare_responders.asp (for healthcare workers)
- https://www.ptsd.va.gov/covid/list_employers_leaders.asp (for employers, leaders)

- Main page <https://www.ptsd.va.gov/>

Schwartz Center Compassion in Action Archive (webinars)

- *Caring with compassion: Supporting patients and families in a crisis*
<https://www.theschwartzcenter.org/webinar/caring-with-compassion-supporting-patients-and-families-in-a-crisis>
- *Leading with compassion: Supporting healthcare workers in a crisis*
<https://www.theschwartzcenter.org/webinar/leading-with-compassion-supporting-healthcare-workers-in-a-crisis>
- *Caring for yourself and others during the COVID-19 pandemic: Managing healthcare workers' stress*
<https://www.theschwartzcenter.org/webinar/caring-for-yourself-others-during-the-covid-19-pandemic-managing-healthcare-workers-stress>

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- Co-authoring versions of Stress First Aid self-care/coworker support models for military, law enforcement, forest firefighters, nurses, probation officers, and rail workers, as well as public-facing versions for patients, clients, and families.
- Co-editing three books on disaster behavioral health interventions, and numerous publications and courses on disaster mental health, combat and operational stress, military culture, early intervention, and resilience.

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Grief in the Time of COVID-19: Supporting Elders in Isolation

Rachel G. Risler, LCSW

INTRODUCTION The year 2020 has been a challenging experience for everyone. As the COVID-19 pandemic continues, healthcare professionals must adapt their work to serve the needs of clients in this unusual time. One area that presents a special challenge is grief support. Typically, when there is a loss, families rally around grieving elders, support groups are offered, and activities encouraged. But today, many elders must grieve alone while they are isolated in their private homes or within a senior community that does not allow visitors. Healthcare professionals may be the only people allowed to visit them in some senior communities. How can professional helpers support them at an especially difficult time? The first step is to be familiar with the grieving process in general and the effects of isolation on older adults.

The Grieving Process

Eldercare professionals may already have a general awareness of the grief process. Grief takes many forms, and every person's path is unique. Over the past century, many studies and books have been written on the subject. However, there are a few well-known models that most grieving individuals follow, albeit in their own way.

The Five Stages of Grief model, as developed by Elizabeth Kübler-Ross, is perhaps the most well-known (Kübler-Ross and Kessler 2005). These stages are Denial, Anger, Bargaining, Depression, and Acceptance. Originally developed to describe the process a person with terminal illness goes through, it was expanded to include those who grieve a loved one. When her work first was published, it was believed that the stages happen linearly, but more recently it is understood that one can move from stage to stage and back again, sometimes skipping a stage. What do the five stages look like?

Denial: Denial can be obvious, such as saying the person is not gone. This can occur when there is no body to see, such as in an accident or a military death. For older people, especially if

there is some confusion, being unable to see their loved one prior to death may result in a period of denial. One may also be in the denial stage if one does not fully accept the reality of the death despite acknowledging the fact of it. Initially, denial can be healthy, because it reduces the psychological impact of the death, particularly if the death was traumatic.

Anger: This can be anger directed at themselves, the deceased, healthcare providers, and/or God. Anger is a necessary stage to pass through in order to fully process the death and resulting grief. Rather than suppressing it, safe expression of anger should be encouraged.

Bargaining: A grieving person who is bargaining may ask God to let them switch places with the deceased. It may also be expressed as guilt and "what if..." statements about the past. They may ruminate on past decisions as a caregiver, or on things they wish they had addressed while the person lived. This stage is where the person seeks to regain control in their life, by examining what could have been different or what they wish they could change now.

Depression: This is what many people consider grief. While not

everyone experiences what would be described as clinical depression, mourners will usually experience periods of sadness and hopelessness regarding life without the deceased. A period of depression could last only a few days here and there, or it could be persistent, lasting for months.

Acceptance: In this model, acceptance is considered the final stage. While the loved one will always be missed and there will be times of sadness, overall, the survivor learns to find new meaning in life without the deceased.

Another model is presented by William Worden. His Four Tasks of Mourning focus on adjusting to a loss and finding new meaning in life without the deceased (Worden 2009). The tasks occur in no particular order, and a survivor will likely jump from one to the other. The grieving person eventually finds a way to connect to the deceased while embarking on a new way of life without them. The tasks are defined as:

Task One: Accept the reality of the loss. Similar to the stage of Denial above, this is when the mourner learns to fully come to terms with the death and how their own life will be forever changed. Feelings of guilt or regret

surrounding the death are resolved.

Task Two: Process the pain of grief. Pain can be both physical and emotional after a death. Healthy expression of pain, anger, and sadness helps the person move forward to other tasks and avoid increased risk of complications in the future, such as physical illness and clinical depression.

Task Three: Adjust to a world without the deceased. Death affects a survivor's world in three ways that require adjustment: Externally, this involves taking over tasks from the deceased, such as bill paying and cooking. Internally, the person learns how their own sense of self is affected, such as identifying as a spouse vs. a widow. Finally, spiritual adjustment means coming to terms with beliefs about how the world operates or how it should be. A death challenges one's assumptions about the world and may alter their perceptions about what is "fair" or "right."

Task Four: Find an enduring connection with the deceased while embarking on a new life. According to Worden, this task is "to find a place for the deceased that will enable the mourner to be connected with the deceased but in a way that will not preclude him or her from going on with life" (Worden, p. 50). The person is able to honor their loved one while finding satisfaction in a life without them. Examples include having time set aside to visit a grave, light a candle, or write a letter to the deceased.

Complicated Grief

When isolated, people are at increased risk of complicated grief. According to the Columbia Center for Complicated Grief, it is defined as "a persistent form of intense grief in which maladaptive thoughts and dysfunctional behaviors are present along with continued yearning, longing and sadness and/or preoccupation with thoughts and memories of the person who died" (Columbia Center, homepage). In the *Diagnostic and Statistical Manual of Mental Health Disorders*, 5th Edition (DSM-V), this form of grief is called persistent complex bereavement disorder. Symptoms must be

present more than six months after the death. If a person has this diagnosis, treatment by a mental health professional would be covered by Medicare and most private insurance.

Besides isolation, other risk factors for complicated grief include an ambiguous relationship with the deceased, history of abuse in the relationship, history of substance abuse, and history of mental health disorders. It is important to note, however, that people with loving, secure relationships can also experience complicated grief. Understanding the signs of complicated grief can help professionals get help for those who need it. If a client has incapacitating grief, with intense yearning, maladaptive thoughts, and/or dysfunctional behaviors, particularly several months after the death, then a referral to a mental health professional for assessment is indicated.

Effects of Isolation on the Elderly

While there are not yet studies examining the isolation specifically caused by COVID-19, there are earlier studies on isolation among the elderly. A 2020 report from the National Academy of Science, Engineering and Medicine (NASEM) states that one quarter of adults over the age of 65 are socially isolated (www.cdc.gov). Social isolation is often a problem for those who live alone, have a chronic illness (being less mobile), or have sensory impairments. As adults age, they experience a gradual loss of their peers, resulting in a shrinking social circle.

Isolated adults are at increased risk of premature death, heart disease, and stroke. In addition, the risk of developing dementia is 50% higher than for those with strong social support. Most significant to the grieving process is that isolated people have higher rates of depression, anxiety, and suicide compared to the general population (www.cdc.gov). This makes proper support for those who are grieving during the pandemic even more important.

Grief in Isolation

The isolating effects of COVID-19 can adversely affect the grieving pro-

cess and increase the risk of complicated grief. Isolation may affect the ability to accept the death. Dying patients in hospitals and nursing homes are unable to have loved ones at bedside to say goodbye. This can result in a sense of unreality, especially in older people with confusion, who may insist the person is still alive. An isolated elder who lacks the in-person support of loved ones and is less active than before, has more time to think and ruminate, stalling the process of grief. For many people, there is also underlying anxiety about an uncertain future due to COVID-19, and the grieving process may exacerbate this anxiety (Spendelov 2020).

COVID-19 isolation also means that families have not been able to hold funerals, sometimes postponing them but often having no ritual at all. Rituals after death are important in the grieving process, providing an opportunity for families to come together and formally say farewell to the deceased. This is important to the tasks of acceptance and processing the pain of grief. If there is a service, it is by necessity small, often only with immediate family. Historically, funeral rituals have been an important part of grieving. Funeral rituals are found in all human cultures and are an important way for the living to process their grief: funerals are actually for the living, not for the dead. In Western culture, funerals are often the only "socially acceptable" time to lament the death of a loved one. Outside of these events, mourners feel pressure to repress their emotions and behave as though everything is fine. But often, it's not. Therefore, when a family cannot have this ritual, it is important to acknowledge the need for such rituals and offer safe alternatives.

It should also be noted that not all elders will need special support after a loss. As with the general population, elders respond to grief differently, and some have greater resilience than others. For example, someone who has lived through the Depression and World War II may have strong coping skills on which to rely. Someone else, who has experienced significant emotional trauma in the past, may need more support.

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Cultural Considerations

Cultural competency is essential for healthcare professionals. If a client's culture or religion is different than the healthcare professionals, it is important to take the time to research how they mark death and ask questions of the client or their family regarding how to best support them. In some cultures, it may be taboo to talk about the deceased or to discuss grief.

For some faiths it is important to have the body washed and prepared with the family's involvement. An important question during a pandemic would be how this ritual is affected, and if family cannot take part, it may add to their pain and suffering while mourning. Other rituals, such as the Jewish tradition of sitting shiva, may also be impacted by the pandemic. The website www.shiva.com has information on Jewish mourning during the pandemic.

For LGBTQ clients, particularly older people, disenfranchised grief must be a consideration. Disenfranchised grief is unacknowledged by social norms. In this case, a personal relationship may not have been acceptable, or even known, to the couple's families, which affects the support available to the survivor. In addition, LGBTQ elders are more at risk for social isolation and depression (Seegert 2018).

Interventions

Healthcare professionals are integral to identifying at-risk individuals in order to provide resources and support. It is recommended that routine physical exams include questions about isolation and loneliness. Examples include the Berkman-Syme Social Network Index and the UCLA Loneliness Scale (www.cdc.gov).

When a funeral cannot occur, time can be spent planning a celebration of life for a later date. Loved ones can also write letters to the deceased and make donations in their honor. Some families have "gone virtual," with an online celebration of life. If culturally appropriate, encourage clients to talk

about their loved one and how they are feeling.

While visitors may be restricted in many senior living communities, healthcare workers often are still allowed. Consider hiring a companion or caregiver several hours per week to provide socialization and a listening ear. They can be a valuable support, someone who listens without judgment, and may be easier to talk to than a family member who is also grieving. Peer-to-peer support is also valuable, either through direct relationships or a support group, allowing more resilient individuals to offer support to others.

To lower the risk of clinical depression, encourage movement and exercise, maintaining a daily routine despite any lockdowns, and provide healthy meals. A Mediterranean way of eating, for example, has been shown to reduce symptoms of depression (Bakalar 2019). In addition, animal companionship, either through a pet or therapy dog visits, may be beneficial in lowering depression and loneliness (Gee et al, 2017).

If these interventions do not help the client process and move through the stages of grief, and symptoms of depression persist, then a referral to a mental health professional would be recommended. Many therapists now offer telehealth and in-home counseling appointments. Even those with mild cognitive impairment may benefit from counseling. Grief counseling is helpful for people who are experiencing the usual trajectory of grief as outlined earlier but want some extra support. Grief therapy is more specialized and is for those who fit the diagnostic criteria for persistent complex bereavement disorder, as defined in the DSM-V.

Conclusion

As 2020 comes to a close, uncertainty remains regarding the pandemic and how long it will last. The final effect of visit restrictions and social distancing on elders is not known. At this moment, many residents of long-term care have not seen a family member in almost six months. Some people may question whether restric-

tions meant to protect physical health are worth the cost to mental health, including grief. There are no easy answers to this dilemma.

What is known is that isolation and loneliness have significant effects on health, both mental and physical. Prior to the pandemic, this was already a growing concern as people live longer and are less likely to cohabitate with family. Hence, there is a growing population of people aging alone and requiring more effort from people in their lives to keep them socially engaged. When a loss occurs, a support system is not suddenly created. It is the people who have already been a part of the survivor's life who can offer the best support. As a result of the extended isolation during the pandemic, these relationships may grow more distant or be lost altogether. Therefore, it is important to address loneliness and isolation proactively when possible, rather than wait until the support is urgently needed.

Eldercare professionals are uniquely placed to both identify a need for support and also provide that support to grieving elders. A care manager, for example, can help a person be well supported before and after a loss by seeing early signs of the negative effects of isolation, as well as by being a familiar person the survivor can trust after a loss. A professional familiar with complicated grief, disenfranchised grief, and cultural differences who is involved in someone's care is an invaluable resource. They can also provide education to family members regarding what to expect and how to support the grief process from afar.

Finally, when this pandemic has passed, perhaps it will have called greater attention to isolation and loneliness among the grieving elderly even in normal times, and future clients will benefit from the experience and learning gained during this challenging time. Another benefit will be the new research into grief during the pandemic, particularly among a more diverse cohort of elders. There is much to be learned so that people of various ages, ethnicities, and cultures may be better prepared and supported in the future should a similar event occur.

Case Studies

Below are a few examples of older adults experiencing grief during the pandemic and how interventions have helped them.

CASE STUDY #1

Mary is an 85-year-old woman living in a CCRC with symptoms of dementia. She has been isolated from her family throughout the pandemic but forgets why they do not visit her. Her husband passed away during the pandemic. Her family was allowed to see her a few times around his death to offer support, though she does not remember this. Family also brought her his cremains to keep in her apartment until they can have a proper burial ceremony. Due to her forgetfulness, however, she holds anger at her family for “abandoning” her and remembers only that her daughter “just brought the ashes and dumped them here.” In addition to her loss, she has moved to a smaller apartment and feels the loss of many of her belongings. These compound losses, combined with pandemic-related isolation, have resulted in complicated grief for Mary. She benefits from routine visits from a counselor who validates her experience while also providing repeated education about the reasons behind her isolation. She also has a part-time companion hired by her family. Being able to talk about her husband and their life together has helped her process his death and resolve her anger.

CASE STUDY #2

Betty, 78, lost her husband one year ago and lives alone in a senior living community. The time around his death was upsetting for her, and she remains angry at his hospice team for how he died. In addition, she regrets some decisions she made regarding his care. Currently, she breaks into

uncontrollable crying whenever she talks about him. Prior to the pandemic, she had stopped going out with friends or attending events in the community. She has one adult child who is not comfortable talking about her late husband or grieving with her. A healthcare professional referred her to a counselor who provided grief therapy. After some time in therapy, she has begun reaching out to friends more via cards and phone calls. In addition, she is seeking out ways to become active in the community – virtually for now and in person when it is safe. She can now talk about her husband and his death at times without crying.

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Medication Management: Adding Value to the Aging Life Care Manager's® Practice

Anne Rich, MSN, RN

SUMMARY: Many older adults take multiple medications for a variety of chronic conditions and diseases. They are at risk for problems related to their medications because of factors including age, cognition, or polypharmacy, leading to an increase in complications such as falls and visits to the emergency room or hospital. Aging Life Care Managers® can add extra value to their practices by good medication monitoring. Understanding the risk factors for adverse drug events, the role of the Beers Criteria® in prescribing, and polypharmacy can reduce health care costs, prevent unnecessary hospitalizations, and improve a client's quality of life.

Medication Management: Adding Value to the Aging Life Care Manager's Practice

Aging Life Care Managers® (AL-CMs) understand the importance of monitoring medications taken by older adult clients. Most older adults suffer from more than one chronic medical condition and take multiple medications. They usually see more than one prescriber and may use both local and mail order pharmacies, making it difficult for pharmacists to track medications and spot contraindications or adverse drug reactions. Age affects the way drugs are metabolized and excreted in the body by the liver and kidneys, so dosages may need to be adjusted. This puts older adults more at risk for drug-related problems and complications. These unique care needs require a thoughtful approach to medication management.

Risk Factors for Adverse Drug Reactions

There are numerous issues that can increase the older adult's risk of an adverse drug reaction. Twice as many adults over the age of 65 are hospitalized for problems related to medications than younger adults (Lavan et al., 2016). Cognitive impairment can greatly influence the ability

of the older adult client to manage their own medications. Caregivers and families may notice medications are being forgotten, skipped, or taken at irregular intervals, or that prescriptions are not being refilled when they should. Often age is not taken into consideration when medications are prescribed and dosages are not adjusted, resulting in dangerous side effects. Many prescribers have no training in gerontology and may not appropriately prescribe or manage the client's medications. Older adults who are considered frail, as well as residents of long-term care facilities, are more at risk for adverse drug reactions.

Polypharmacy and Its Consequences

Polypharmacy has become a serious problem, especially in older adults. Polypharmacy is generally defined as the regular use of five or more medications. Older adults over 65 take many more medications on average than younger adults, including over the counter (OTC) drugs and supplements. More than half (54%) of adults age 65 and older report taking four or more prescription drugs compared to one-third of adults 50-64 years old (Kirzinger et al., 2019). Most clients do not realize that even OTC

drugs and supplements are considered medications. A recent article in American Family Physician notes that up to 91% of residents in long-term care take at least five medications every day (Halli-Tearney et al., 2019). Older adults who take more than four medications are at higher risk of falls with injuries, often resulting in a trip to the emergency room or hospitalization, and the risk increases with each additional medication. With multiple medications there is a greater chance of an adverse drug reaction (ADR), resulting in hospitalization. Studies estimate that ADRs are responsible for 10-30% of all hospital admissions of older adults (Nair et al., 2016). Hospitalization is costly, affects the client's quality of life, and puts them at risk for hospital-acquired infections or complications. It is estimated that almost 50% of these hospitalizations are preventable with the help of responsible patient care practices and proper medication management.

Preventing Adverse Drug Events: Understanding the Beers Criteria®

In 1991, Dr. Mark Beers and others developed a list of medications that should be avoided or used with caution in patients over the age of 65. Over the years these criteria and lists

have been expanded by the American Geriatrics Society, and updated every three years, most recently in 2019. The list now includes over fifty-three medications or medication classes. These lists include the following categories:

- Medications that should be avoided in adults over age 65
- Medications that should be avoided in older adults with certain medical conditions
- Medications to be used with caution in older adults
- Potential drug-drug interactions that can occur in the older adult

An example of some inappropriate medications listed in the Beers Criteria® includes anticholinergics, anti-parkinsonian drugs, antispasmodics, and some antihistamines. What are known as first-generation antihistamines, such as Benadryl, are commonly found in OTC allergy, cold, and sleep medications. These medications can cause dizziness, drowsiness, as well as nausea, blurred vision, even urinary retention. There is mounting evidence that anticholinergics may be linked to the development of dementia and could cause permanent cognitive decline. The Beers Criteria has historically been available online, and the 2019 update can be found at https://qioprogram.org/sites/default/files/2019BeersCriteria_JAGS.pdf

Organizations such as the Pharmacy Quality Alliance, National Committee for Quality Assurance, and Centers for Medicare and Medicaid have designated the Beers Criteria® as an important quality measure. Individual medications can be searched online to determine if they have been placed on the Beers list.

Medication Management Techniques

Part of an initial client assessment process includes compiling a complete list of all medications, including OTC drugs and supplements. An elder care professional who is not a licensed health care practitioner may want to consider teaming up with a Registered Pharmacist, Registered Nurse, Nurse Practitioner, or Physician Assistant to review and discuss a client's medica-

tion list. Part of the scope of practice of a Registered Nurse, for example, includes educating the client, caregivers, and family about the medications, why they are taking them, and any possible side effects. It is a good idea to check the Beers Criteria® to see if a client is taking any medications that might be contraindicated. The client's pharmacist and prescriber can help determine the reason a medication on the Beers Criteria® list is being prescribed and if it is appropriate. The Beers Criteria® is not mandatory, but rather is a guideline, giving clinicians the freedom to prescribe a medication if they feel the benefits outweigh the risks.

If the medication is questionable or on the Beers list, the prescriber may be able to discontinue the medication or find a safer or less expensive alternative. The trend now is toward "de-prescribing" to prevent polypharmacy, which can help the client realize cost savings on prescription drugs. For clients still living at home, an elder care professional can prepare a list of medications, including dosage, how often they are taken, and the names and numbers of their pharmacies and prescribing physicians. The list can be put in a clear vinyl sheet protector and placed on the refrigerator or other convenient location. It can then be taken to doctor appointments, or by EMS workers in case the client goes to the emergency room or hospital. Aging Life Care Managers (ALCMs) should ensure that the client's medication list is reviewed by their primary care provider after every hospitalization or every six months. All OTC medications and supplements, even if they are not taken every day, should be included, and the list should be updated regularly as part of the plan of care.

Advanced medication management can be offered as an added benefit to the client or included as part of the fee-for-service. Standard good care management practice includes keeping all medication records up-to-date and communicating with the primary care provider or prescriber to advocate for the client as needed. The elder care professional – with the team's Registered

Pharmacist, Registered Nurse, Nurse Practitioner, or Physician Assistant, if necessary – can provide, as an additional service offering, a comprehensive list of all medications, including the reason for taking, dose, and any side effects or contraindications. If the list includes a medication in the Beers Criteria®, the ALCM can call the prescriber and ask for a consultation to determine the reason and appropriateness of the medication. This is especially important if the family, caregivers, or ALCM have noticed any adverse reactions, or if there has been a change in the client's status, such as an increase in falls. Caregivers and family are educated on how to store and administer medications and to report any reactions or side effects to the ALCM. Qualified professionals can also come to the home and prefill medication cassettes or dispensers, usually on a weekly or monthly basis. This is helpful if the client lives alone or does not have a regular caregiver or family member who is willing or able to handle medications. ALCMs should not offer this service unless it is within their scope of practice, however, because taking medications from their original bottles for any reason might be considered dispensing medication. It may be necessary to add a Registered Nurse or other licensed professional to the care team to provide this service, or to teach family or caregivers to do this. The use of cassettes, electronic devices, reminders, or automatic medication dispensers can improve compliance and reduce medication errors, and are generally easy to use, providing peace of mind for the client, family, and caregivers. An assessment to determine the level of assistance a client needs with medication will help determine what recommendations to make regarding use of cassettes or dispensers.

ALCMs might want to consider compiling a list of resources and companies that provide various forms of medication cassettes and automatic medication dispensers. Most automatic dispensers are not too expensive, and some can be leased; they come in various sizes which can be manually, digitally, or electroni-

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cally programmed. Many pharmacies offer home delivery of medications in weekly or monthly blister packs or individual packaging that help clients and families keep track of prescriptions and when refills are needed. The use of medication dispensers or medication management systems of any kind can help the care manager quickly address any errors or inconsistencies and improve home medication safety. These systems can save an average of \$3,000 per year over using human care providers to administer medications ("Medication", 2020). The ALCM can ask the client, family, or caregiver to report as soon as possible any changes in medications, pharmacies, or prescribers, so the medication list and records can be kept up to date.

Improving compliance with medications is crucially important to the well-being of clients. A group of researchers (Marcum, et al., 2017) recommended a series of interventions to improve medication adherence and health outcomes in older adults. These strategies included a comprehensive geriatric assessment, use of medication aids and reminders, patient and caregiver education, adherence assessment, and advocacy to optimize treatment. All of these strategies can be provided or facilitated by an ALCM.

ALCMs can add value to their practice by offering enhanced medication management. During the initial interview or assessment with a new or potential client, it is a good idea to emphasize how this service can provide true cost savings. This can be achieved by recognizing polypharmacy and understanding the role of the Beers Criteria® in managing medications in the older adult. The ALCM can collaborate with prescribers and others on the client's health care team to reduce or eliminate unnecessary medications, decrease drug costs, prevent adverse drug reactions and side effects, and lessen the incidence of falls, emergency room visits, and hospitalizations. This will result in greater family and caregiver satisfaction, better outcomes, and improved quality of life for the older adult client.

See Table on back cover.

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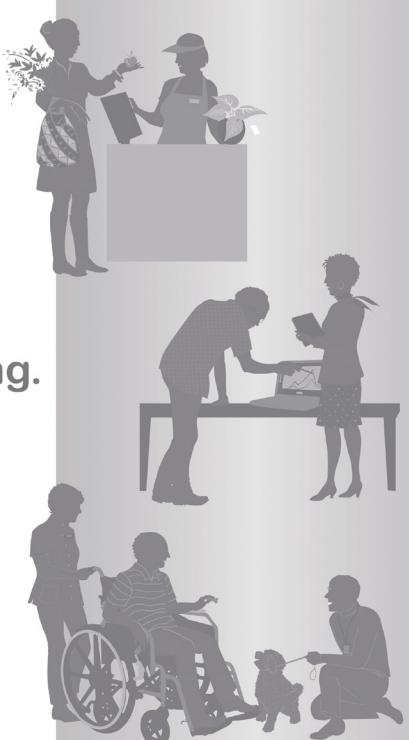
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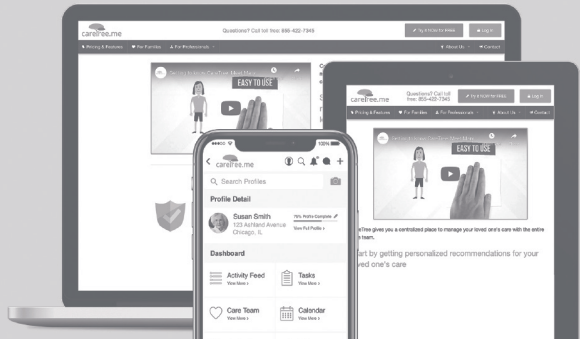
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Best Practice	Rationale	CM Action & Advocacy	Benefit/Outcome
Create comprehensive list of ALL medications, including supplements, vitamins, OTC medications	<p>Knowledge of what client takes, how, and when they take the medication</p> <p>Knowledge of what medications, supplements, or OTC medications are supportive or obstructive to care</p> <p>Information on potential diagnoses that clients do not disclose or understand</p>	<p>Review medications with physician and/or pharmacist</p> <p>Educate client on medication management, diagnoses, and treatment plan</p> <p>Develop and engage client in a supportive medication management system</p>	<p>Ensures care team and health care providers are fully informed what medications are taken and how they are taken</p> <p>Eliminates potential barriers to plan-of-care</p> <p>Encourages better understanding of medications</p> <p>Improves medication adherence and compliance</p> <p>Identifies potential medication errors</p>
Review medications against Beers Criteria	<p>Identifies medications that should be avoided in adults over 65</p> <p>Identifies medications that should be avoided in older adults with certain medical conditions</p> <p>Identifies medications that should be used with caution in older adults</p> <p>Identifies potential drug-drug interactions</p>	<p>Review medications with physician or primary care provider</p> <p>Request medication assessment on risks vs. benefits</p> <p>Discuss possible deprescribing of medications, safer alternatives, if appropriate</p>	<p>Deprescribing medications that may be detrimental to client safety</p> <p>Provides cost savings by eliminating unnecessary or duplicate medications</p> <p>Enhances client quality-of-life by minimizing medication side effects and interactions</p>
Partnership with health care provider	<p>Collaboration with licensed practitioner best equipped to review medications</p> <p>Alternative option to reviewing medications for safety, other uses and feasibility of deprescribing</p>	<p>Use information to discuss medication needs, risks vs. benefits, and deprescribing with physician</p> <p>Use information learned to educate client on medication management, diagnoses and treatment plan</p> <p>Use information learned to develop and engage client in supportive medication management system</p>	<p>Enhanced client-care manager relationship since client gains improvement from interventions (reduced medication costs, decreased risk of injury or hospitalization due to drug side effects or interactions)</p> <p>Improved client health care literacy, medication compliance, and adherence to treatment plan</p>