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What Does an Independent BHRS Prescriber Do?

Dan Warner, PhD

Dr. Dan Warner

The Behavioral Health Rehabilitation Service (BHRS) program is a Medicaid-funded program in Pennsylvania that is designed to provide home- or community-based services for children with special needs. According to the BHRS model, children must be evaluated by a psychiatrist or psychologist who then participates with a treatment team and the family to craft an effective program for the child. At times the evaluating psychologist works directly for the agency that provides the services to the child (the in-house prescriber model); and at times the evaluating psychologist works independent of the agency that provides the service (the independent prescriber model). Previous research has shown that, at least in one agency, the evaluations done by in-house prescribers were better at least in terms of the amount and detail of clinically relevant information included in the reports (McAllister, Snyder, & Reed, 2010).

At a recent PPA continuing education course, Gordon Hodas, MD, challenged two "independent prescriber" psychologists in the room to write a description of their professional roles. A call to put into writing what one "does" is intimidating enough. However, the fact that Dr. Hodas was making this request made it even more daunting. Dr. Hodas quite literally wrote the book on BHRS evaluations. He is the author of the "Life-Domains" BHRS Evaluation format (now in its third edition), which is the standard all Pennsylvania child services evaluations strive towards. Thus, to have him turn around and effectively say, "tell me what you've done with my invention..." felt like both an honor and a bit of a crucible.

The following two essays (pages 5–7) are the attempts of those "independent prescriber" psychologists to rise to Dr. Hodas's challenge.

Both of the writers below spend a significant part their professional lives evaluating and prescribing services for youth with mental health problems. Both have had experiences

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Lessons Learned from Geriatric Patients

Marcy Shoemaker, PsyD

Dr. Marcy Shoemaker

I consider myself fortunate to provide therapy to geriatric patients in the age group of 65 to 102 years old. I continue to learn about relationships, economic times, and health crises from my patients, who are both my teachers and friends as we collaboratively tackle their life problems. My colleagues and I have been inspired by the patients' problem-solving skills as they conquer life's adversities. Providing therapy to geriatric patients is a journey and an ongoing education that I value as I continue to participate in many patients' senior years.

Resilience

Many senior citizens are extremely resilient individuals. They have gained strength and resilience while experiencing and surviving pivotal periods in history. Many have experienced and survived the Great Depression and have participated in World War II in active duty or as supportive family members. I recently spoke with a client who was very tearful as she reminisced about the anniversary of the death of her first love that occurred on Pearl Harbor Day. Other patients have experienced expulsions from foreign countries and losses of spouses and siblings. It has been chilling to listen to survivors of the Holocaust as they recount how they survived their ordeal and how their lives were permanently

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Helping Obese Clients Reduce Denial About Emotional Eating Habits

Daniel Materna, PsyD

Dr. Daniel Materna

Psychologists and other mental health professionals are typically used to offering suggestions to people about their life problems and possible solutions. How easy it may look to the uninitiated: "Just figure out what the person is doing wrong and tell them to do something different." As we learned early in our careers things just aren't that simple. Why does it so often seem that people are innately programmed to resist changes for the good, especially when it comes to obesity? Why do people so often struggle with eating healthfully and relying on food for nutrition instead of for comfort and pleasure? Furthermore, why are obvious solutions so easily and persistently ignored?

Most mental health professionals who work with people having co-occurring problems, such as mental health issues intertwined with obesity and the use of food for comfort, quickly realize that something more is at play here. It is obvious that food use is out of control and excessive, but surface discussions with clients may lead one to think otherwise. "Who, me?" is the common reaction when food use is questioned, even in the morbidly obese. Thus, it shouldn't take long to identify denial as the primary defense mechanism for most obese clients.

It should be obvious to people gaining weight that their clothes are getting tighter and dress sizes are growing. It is obvious to others anyway, like the clothing industry and its need to expand sizes and extra large inventories. Why do we defend ourselves against obvious facts about our weight (as well as other things)? Why do we have defense mechanisms anyway? What is so dangerous about changing, i.e., what are we trying to protect ourselves from? All of these questions are in need of consideration when working with people who are obese and/or eat for emotional reasons.

In the past when I evaluated patients preparing for gastric bypass surgery I used the MMPI-2 along with a standardized interview process. Typically MMPI-2 scores revealed high L scales and Conversion-V patterns (elevations on scales 1 and 3 and a relatively lower score on scale 2). Both findings indicated denial and relatively high degrees of it. So, just to be sure I had sufficient data on which to base recommendations and with respect to the findings on the testing, I would ask patients to keep a journal to help me understand what, if anything, they were in denial about and could it compromise their abilities to make changes post-surgery? I once had a patient disclose drinking "buckets" of sweetened soda pop daily, which he hadn't disclosed until journaling. It was hard for him to stop consuming it. Other types of significant life problems are often uncovered, be they of historical relevance or current issues. The initial journals, basic and simplified as they were (e.g., what are the things in your life that cause stress and how do you cope with them?) were given as homework assignments along with keeping a food and liquids consumption journal. (I learned a lesson after soda man...you never know what's being denied till you get more data and spend time with the person.) Suffice it to say there's lots of denial being used by obese patients. Nothing is meant as judgmental about it, though; denial and obesity just seem to go together like other clinical conditions having co-occurring elements. To be prudent and thorough in helping obese clients and emotional eaters, the issue of denial must be addressed and decreased. Substitute behaviors must be learned. More importantly, emotional and interpersonal problems must be resolved better to help free people from the health problems associated with obesity.

What are some common interventions and tools for decreasing denial with obese clients? The first is journaling, as stated earlier. Keeping a written record of food and liquids consumed is a common tool in weight-loss programs. Raising awareness is thought to increase the chances of change, typically. But this is not usually the case for lasting change, especially when emotional eating is the problem. It has been my experience that structured journaling is helpful but not often sufficient for people seeking lasting control over long-established eating habits. That is also why the second type of journal is required. Obese clients must also start attending to the stressors in their lives and related needs. The resistance to emotional awareness and avoidance of interpersonal problems becomes evident the first time a client returns with his or her journal. Even after detailed instruction about identifying stressors and related needs, the stress and needs journal is typically only partially completed if at all. Very superficial entries are the norm, at first anyway.

It doesn't take long to see the denial related to this particular homework task. If clients don't do as asked and as agreed to at the end of a therapy session, the clinician must not "deny" what has transpired. (Denial can be contagious.) So the fun begins uncovering why the resistance to internal and interpersonal issues is avoided – that is, if the client is willing to hang in there and continue with treatment. Decisions to abruptly stop treatment, as uncovering of psychological problems occurs, is a high risk. Pacing is critical so as not to overwhelm clients with either authority issues or too much emotional uncovering. This is where calibrated questions and ongoing

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assessment is a key. The clinician should not respond heavy-handedly to resistance, i.e., denial, for it is a much stronger force than one may realize. Denial has survival value. Instead of calling it a "defense mechanism" it might be better termed a "survival mechanism." But what is actually being "survived?" What is the intrinsic value in denial?

One way to consider the value of denial is in regard to homeostasis. People are organisms that must maintain balance and order in their universe and daily lives. Our minds are powerful tools. Children, who can't stop abusive parents from imposing harm on them, typically learn to deny their needs and related feelings early on. Parents too may model denial as a coping mechanism as they sometimes teach kids to ignore their feelings. Similarly, children may be taught that others' feelings and needs are more important and, thus, adopt denial as an unforeseen accompaniment to manage the stress in their lives. If you need to ignore your feelings for any variety of reasons and are taught to serve others at your own expense, then denial becomes an agent of achieving this task. Growing up this way requires people to minimize their feelings and needs. Denial is the tool of choice.

I was left with a lot of concern working with obese emotional eaters, after seeing how journaling was necessary but still quite limited in ability to overcome the challenges of denial. Again, written journals encompassing food and liquids consumed and delineating stressors experienced and related unmet needs only seemed to scratch the surface of a lifetime of using denial as a survival tool. I sought to develop another aid to help in the process. What follows is a description of an experimental approach I have started using recently and a little of its history. This approach has had a surprising effect on lessening denial and enhances the depth at which people attend to the deeper emotional issues of their lives related to emotional eating and obesity.

I was asked to do a talk at church last Thanksgiving on problems people have with food. Not looking forward to doing so – it seemed like such a negative role to be asked to spoil the joy of a fun holiday – I set out to make it fun. So I wrote a poem based on all my reflections and synergy of learning working with eating-disorder clients over the years. The poem was entitled, "Lollipops, Chocolate, Donuts, or Cake?" It seemed to grip several people in an obvious way; some were obviously entertained by the poem, while others were emotionally moved. Thereafter, a few positive comments along with my intrigue about why some people reacted as they did resulted in the decision to turn the poem into a short book. To further enhance its entertainment value, I asked our two teenage artists to create the drawings for the book. This gave the book a child-like appeal, which seemed to enhance its message. Five months later I started using the book with clients who were working on emotional eating/obesity concerns. The results were, and still are, quite surprising. After all of my efforts to be direct in my professional discussions with clients and patient in their development of journaling skills, this little book seemed to have a more substantial effect. The book has been able to achieve something my words alone could not instigate with obese clients: more deeply concealed and vital material within clients' lives started to present itself more readily in therapy. For some it was more obvious, e.g., when issues about childhood abuse and other offenses were starting to be talked about, in only a session or two after reading the book. I also saw people grow in awareness about hidden sources of emotional pain and needs, furthering my ability to help them. Why was this? What does this teach regarding addressing habits of denial in obese emotional eaters?

Denial has survival value. Instead of calling it a "defense mechanism" it might be better termed a "survival mechanism." But what is actually being "survived?" What is the intrinsic value in denial?

First, a child-like format seemed to help, as did humor, in describing the cognitive and emotional dynamics of obesity and other eating disorders. The book allows people to assume a non-defensive mental state, and perhaps it taps into early learning and experiences from childhood where the skill of denial was honed. The book ends in the goal of learning to get personal needs met through people and not food. Clients sometimes want to minimize this. But when I ask them how the book ends, gradually our discussion is more able to help them identify better solutions to their use of food for comfort: "Love must come from people and it is something you must pursue." Thereafter, we continue our work understanding and removing obstacles intrinsic to having healthier relationships. The overarching goal becomes that of finding comfort from people in contrast to food. People are advised to read the book nightly before journaling and to read the book if, as often happens, they can't do the journaling for one reason or another.

In conclusion, using childlike imagery, humor, visual stimuli in the form of artwork or written materials that help pinpoint "the problem" can be useful in lessening denial. The book, *Lollipops, Chocolate, Donuts, or Cake?,* helps readers start to identify and admit to the type and degree of problems they are using food to manage. Some of their problems may have origins in childhood. It is similarly useful to help clients figure out how and why they learned to be so good at denial. Unfortunately, some have had their use of denial forced upon them through adverse experiences; no wonder they persist at using it. Also, therapy becomes a less defensiveness-inducing process when creative and entertaining treatments are applied. Thus, when direct approaches to reducing denial are limited in results, consider getting creative and using interventions such as this book. Similar alternative approaches can help unlock the negative effects of chronic denial for obese clients, and support them in finding more prudent solutions to their problems.

Changes in BHRS and Implications for Evaluators

Cindy Stauffer, MS

Cindy Stauffer

The differences in how services are provided by in-house (IH) and independent prescribers (IP) are subtle, if not indistinguishable. In-house prescribers often have the benefit of working in close proximity to BHRS staff. They are privy to the day-to-day activities of the agency and may regularly receive either casual or formal updates regarding a particular child's progress. IPs tend to rely solely on information provided by the provider or parent during scheduled evaluations. Such information may vary in the extent to which it is current and comprehensive.

The distinction between types of prescribers seems to be more about the quality of the evaluator's relationship with team members, including the family, than with whether one is an IH or IP. In this article, I hope to illustrate the importance of the therapeutic relationship and how it extends beyond the impact of any structural changes imposed on BHRS programs by regulators.

In the mid 1990s, I was approached by a social worker who had learned of an innovative system for children's mental health care entitled wraparound (EPSDT) services. She was asked to develop a children's program for a large human service organization and was very excited about this new direction for children's services. "Imagine," she said, "being able to craft the services you believe could benefit the child most – a system of care that brings services to the child, treats the child as an individual, and weaves that child's strengths into his or her recovery." I was equally excited about this mission and began providing BHRS evaluations and clinical direction in a central Pennsylvania wraparound program that grew to 400 families, with more than 80 clinicians and 12 fee-for-service psychologists.

BHRS has evolved over the years to include changes in regulations brought about by managed care and closer oversight of service delivery. Most recently, the recommended authorization period has been extended from 4 months to either a 6- or 12-month period. This change has led to fewer psychological evaluations and less evaluator contact with the child. Of significant importance is the impact of extended evaluation periods on BHRS evaluators and the families with whom they work.

Many say that the benefits of having 6- to 12-month evaluations outweigh those of the previous 4-month requirement. Parents, for instance, are often pleased to be making only one or two trips to the evaluator, as opposed to three or four visits per year under the previous system. Some families have previously lamented about needing to "repeat" information that had been offered only a few months prior.

Highly respected evaluators have little difficulty securing employment conducting BHRS evaluations and few complain about changes in the quantity of work available. The most concerns lie with the impact of the new prescription requirements on the quality of treatment and the therapeutic relationship. These concerns and their implications are discussed in this article.

First, extended time periods between evaluations do not allow for evaluators to respond to changes that have occurred midstream. Children and families may experience many changes in their lives over the course of a year. Sometimes adjustments in educational programming, the family structure, the addition or loss of a family member, etc., can have an impact on the child's overall functioning. Likewise, treatment can also have a dramatically positive effect on the child. Six- or 12-month evaluations do not always allow for timely treatment adaptations in response to the aforementioned changes.

Also, the recently enforced policy of increasing the time between evaluations from 4 to 6 or 12 months has often resulted in the extension of services that may have been otherwise discontinued. Some providers are reluctant to end services when a prescription is in place. In other words, medical necessity for services may end, but the provider chooses to continue services rather than conflict with the existing prescription.

Evaluators now need to anticipate a child's needs a full 6 or 8 months before prescribed services are to begin.

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CHANGES IN BHRS AND IMPLICATIONS FOR EVALUATORS

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Re-evaluations often occur up to 2 months before the prescription runs out and, thus, may actually have to look at treatment needs 8 or more months forward.

Accurate predictions into the future are virtually impossible, given the multitude of factors impacting a child's life. Consequently, evaluators are often asked to complete addenda to update existing prescriptions to reflect changes in treatment needs. Evaluators frequently complete these addenda without having a broad scope of the child's functioning.

Another concern of evaluators, resulting from the extended authorization period, is further distancing from the team. The evaluator is often missing from the ISPT meetings, the time when team members convene to discuss treatment options. Most prescribers have little contact with team members between evaluations and, as a result, they often become forgotten team members. Thus, the very person who is determining the child's treatment needs (the evaluator) is only remotely involved with the team. The evaluator's absence from the treatment team meetings has obvious implications and raises significant concern for the quality of services being provided.

Evaluators can enhance their involvement in BHR services in a number of ways. They can begin by building relationships within treatment teams. One of the most practical ways is to involve themselves regularly in ISPT meetings. Encouraging providers to schedule evaluations and ISPTs on the same day will increase the likelihood of availability.

The ISPT can provide information about the child and family that otherwise is unavailable to the evaluator. The ISPT process also increases exposure to other team members and includes the evaluator in decision-making regarding treatment. Frequently, treatment recommendations include broad suggestions for effecting change, when a more helpful approach is to offer specific and detailed treatment strategies. The evaluator, an important resource to the ISPT, can provide helpful clinical direction with detailed treatment recommendations.

The evaluator relationship with the families and children served is of paramount importance. Parents take comfort in knowing that someone understands their child because they have accurate and detailed information. Families have frequently expressed appreciation for the long-term relationship I have had with them and their children. My opinion is respected more because I have been a consistent member of their team, often when others have come and gone. Parents are grateful for my excitement over positive changes in their child, and they are often eager to gain my perspective on treatment progress. When an evaluator is not a consistent, stable team member, something very valuable is compromised – the therapeutic relationship.

Simply put, the therapeutic relationship remains a vital aspect of a child's treatment. BHRS will likely continue to endure various changes that could potentially impact the quality of services. Psychologists and evaluators will make adjustments in how evaluations are completed, either as a result of structured feedback from MCOs or by more informal means. In any event, adaptation will be necessary. What is unlikely to change is the potential for advancements in treatment service through strong therapeutic relationships. Psychologists need to remain a viable part of the treatment team and cognizant of the importance of building and maintaining positive, enduring relationships.

Finally, I reiterate an important point; most families respond positively when they have an ongoing relationship with the same psychologist. Psychologists should be advocates for children and families to have consistency in regard to evaluations. Children are more likely to relate openly and honestly to familiar evaluators, and parents appreciate having the same evaluator for subsequent evaluations.

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being both in-house evaluators (in which they work directly for the organization that provides the BHRS), and independent prescribers (in which private consultants evaluate and prescribe services). From this perspective, they are uniquely qualified to speak about how the roles are similar and different. Both psychologists strongly believe that neither the in-house evaluator nor the independent prescriber is necessarily superior to the other, depending on the context and available community resources.[1] In fact, as one of the writers, I continue to play both roles in my career. Instead, each operates differently, and fits into the mental health system in a unique way that contributes to the system's whole vitality. Reflecting on the differences helps us all clarify the work we do in the system and the role psychological evaluations have in providing expert services. Of course, other psychologists working in other areas of the state may have had different experiences with these models. Please feel free to share your experiences with the authors, Dan Warner (dwarner@nulton.com) and Cynthia Stauffer (cstauffer@aol.com).

The evaluation is a key moment in the children's Medicaid system, where the expertise of a licensed psychologist is brought to bear on a child who will otherwise be seen mostly by unlicensed people (save the occasional psychiatric appointment, which is dominated by 15-minute "med-checks.") This moment has been much understudied and discussed, though it is both a key moment in the client's care (or at least should be), as well as a significant part of the career of many professional psychologists. We hope these essays help spark reflection and dialogue among all those doing Medicaid evaluations in Pennsylvania's child-serving system as to what we are doing and for what purpose.

[1]Two years ago PPA had responded in writing to one Medicaid managed care company which (inaccurately we believe) claimed that in-house prescribing was inherently unethical and that independent prescribing was always superior.

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Lack of Licensed Clinicians Makes the Independent Prescriber a Necessity

Dan Warner, PhD

In the in-house prescriber vision, community-based services are only recommended once a licensed outpatient psychotherapist feels that her outpatient treatment is failing. That licensed clinician then does a thorough biopsychosocial assessment and recommends a unique community-based treatment, which the licensed clinician supervises directly, on a regular basis, several times a month. I like this vision, and have, in fact, pursued it in my professional work. There are still several times a year where I go to a client's home or community to conduct my own functional behavioral analyses, and then work directly with vast treatment teams consisting of everything from special education directors to bachelor's-level therapeutic staff support in crafting comprehensive treatment plans. This work is rewarding, but economically untenable, as well as inefficient in a variety of ways. In fact, there are times that I even feel clients are at risk of not getting timely appropriate care because of it, and that is why I have come to better understand the role of independent prescribing in the Pennsylvania community mental health system.

First, I must be clear that I am speaking as a clinician who primarily works in rural areas (e.g. Cambria, Somerset, Bedford, & Blair Counties) and thus have to deal with rural realities. Mental health services of any kind are a rarity in rural areas. Outpatient facilities are often too expensive to maintain in small rural communities, and BHRS has emerged as the ***de facto*** first-line mental health service once natural supports fail for children and families. BHRS is reimbursed at a low rate, and rural providers often set up in low-rent areas such as strip malls to keep their overhead low. They then reach far and wide and try to find as many appropriate clients as they can. Typically this is just a handful, but these are kids who do, in fact, need mental and behavioral health services, and they would receive nothing if there were not an agency working to bring services to them. For these firms, in-house prescribers are not a realistic option, because there simply is not enough business to keep a psychologist busy. Instead, it is much more efficient to contract with a psychologist who will come by a couple of days a month and provide consultation and evaluation services. As such, independent prescribing allows an optimization of expertise and resources, especially in the neediest areas.

> *I want to discuss the expertise that they don't teach you about in graduate school, and which is essential for being a community mental health evaluator.*

Scarcity also runs the other direction. As a licensed psychologist in a rural area, I can tell you that access to adequately trained and qualified TSS, MTs and BSCs is hard to come by, especially when one runs a tiny practice, and thus cannot guarantee steady work to anyone. Licensed psychologists find that they are spending most of their time just trying to find someone to fill hours if they are only using BHRS for a few specialty cases that they then expect to carefully oversee. And even after the facility finds quality workers it risks losing them if they cannot find a sufficient number of clients to justify their employment.

Thus, it is no surprise that independent prescribers emerged as a model before it became a policy of certain managed care companies. The resource pressures are so significant that in my area of the state, I know of only a handful of psychologists who actually practice in the format of the classical in-house "vision" I presented above. Instead, even most in-house prescribers are not truly meeting with their clinical teams regularly, or personally devising the behavioral intervention plans for their clients. Most in-house psychologist evaluators I know work as a sort of "intake" department for the BHRS division of the agency. They do their assessment, they follow up with the case regularly, but are mostly independent of the day-to-day work with the client. This day-to-day work is covered by the BSC, MT, or TSS, who utilize the psychologist for occasional consultations. Ironically, this is exactly the same way that most independent prescribers I know work, which leads me to the important point that *just because one is not directly in charge of treatment does not mean that he or she is isolated from treatment*. More often than not, IPs contract with firms for extended periods of time and provide the regular re-evaluations for the clients. They are available for consultation throughout the treatment period and regularly get involved when their expertise is called upon. As such, IPs have the ability to integrate into the treatment arc as much as any in-house prescriber, as long as such communication is valued by the prescriber and the provider agency. To my experience, this happens as regularly for IPs, as it does for in-house clinicians.

Understanding that there is a process at work that is naturally pushing the prescriber to increased independence from the case (either as an employee of the providing agency or not), the question that emerges for me is: what kind of expertise and responsibility should we expect from the evaluator-prescriber today, either in-house or independent? If the idea that the person who writes an evaluation recommending hours is not going to be fully involved in delivering those services, then what comprises "excellence" for that professional?

Here I offer a preliminary answer to this question, based on "surprising" expertise I have picked up in my work. I say

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"surprising" because this is not the expertise that we are trained towards in graduate school: namely the ability to diagnose mental health problems, identify structural and behavioral changes that could bring symptom amelioration, track symptoms and treatment outcomes, and then to write all of this into a report that helps clinicians (and care managers) do their work. This is expertise we should expect from both in-house and independent prescribers. Instead, I want to discuss the expertise that they don't teach you about in graduate school, and which is essential for being a community mental health evaluator.

First, there is learning about the system of available services in any given location where one provides evaluations. In some counties, there are slews of services of various quality, and psychologists need to learn to refer appropriately. In other areas, BHRS is often the only game in town. There are also important differences in non-mental health systems that are important to understand, and which differ by jurisdiction. For instance, in some counties there is no patience for truancy, while in other areas, families can be in and out of jail for various reasons, and this doesn't necessarily signal a need for community attention. This is all to point out the "cultural" nature of mental health work, and the fact that it takes a while to learn indigenous customs, and to begin to work effectively within them for the betterment of one's clients.

The evaluator also develops an expertise in speaking various languages: the languages of different firms, different parts of the child welfare system, and different MCO and state regulations. Helping a client to navigate through the ever-changing matrix of the community mental health system is a big chunk of the job. Especially in our state's commonwealth structure, where each county has significant jurisdiction on the nature of their mental health services, learning how to optimize client care in each of these environments is an important task.

In short, this is expertise on "the system." Both IPs and in-house evaluators benefit from this knowledge. It is about the knowledge outside of any one provider or group. Standardizing this knowledge, and expecting evaluators of all kinds to refer to it in making treatment decisions, would be a valuable advancement for the children's mental health field.

LESSONS LEARNED ...

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affected. The survival skills acquired by many seniors is applied in today's world when dealing with economic crises and chronic health problems. While speaking with one geriatric patient about today's economic crisis, he felt that our country and citizens will survive since in his opinion we have faced more difficult times during the Great Depression and similar financial crises. He felt that positive changes will take time and eloquently stated that American citizens must be more patient and reflect on the past as they face the future.

Staying active

Many seniors advise me that the secret to their healthy lives is participation in activities, especially those that involve learning. Seniors are often disillusioned by individuals who feel that they are too old to learn new skills. Many seniors embrace technology and utilize computers to stay in contact with their grandchildren via e-mail and programs including Skype and webcams. Others enjoy researching areas of interest, playing card games, buying presents online, and using other programs to chat and stay in touch with friends. Another area of interest is staying involved in exercise programs. Many forms of exercise do not exclude individuals who are wheelchair-bound, experience chronic pain, or have limited ambulation (Westcott & Simons, 2006). Involvement in word games is often a popular way for seniors to strengthen vocabulary skills, and many researchers believe that cognitive skill can be maintained (Fillit, Butler, O'Connell & Birren, 2002). Discussion groups where seniors can review books and discuss current events are also popular activities. Staying active is a critical part of maintaining a positive outlook in the lives of many seniors.

Maintaining a positive outlook

It is often helpful to ask senior citizens their secrets to a happy life. One gentleman recently told me that the second that he wakes up each day he feels blessed that he can participate in another day. He often shares positive quotations with other seniors who are feeling blue. He clearly told me that I shouldn't assume that his life has been easy but that he has been able to deal with life's adversities including the loss of his wife, living through the Great Depression, and the lack of children in his life. Some seniors credit their optimism to a role model in their lives, their participation with younger people, a predisposition to happiness, or an active choice to become a positive individual. Involvement in spiritual and/or religious practices is often stated by many seniors as a way of maintaining a positive outlook in their life. Some seniors were always spiritual or religious individuals while others have embraced their faith during their senior years. Involvement in relaxation exercises is one component of a positive life embraced by many seniors. Others feel that it is crucial to engage in socialization, which may include watching their favorite sports with others, talking on the phone with friends and family, and not eating alone (Bial, 2005). Luxury activities also include getting manicures, hair styling, watching movies, and eating favorite foods. Recently an elderly patient told me that her senior years are dedicated to caring for herself. She felt that she has spent the majority of her life caring for others.

Senior citizens are a vibrant and growing group in our society. As psychologists, we can learn a great deal from our senior clients. We cannot assume that we possess all of the answers when providing therapy to this important segment of our population. A collaborative approach to therapy will prove beneficial to both the professional and the senior client.

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The Silent Heroes

Marcy Shoemaker, PsyD

Caretakers come in all sizes, shapes, races, and both sexes. They are usually not prepared for their new roles because their job responsibilities often arrive unexpectedly. They do not have time in their schedules to reduce their work hours, juggle their personal lives, budget their finances or emotionally prepare for their challenging and often time-consuming role. It is a responsibility that often arrives without warning and often has negative consequences, including the loss of friends, family assistance, free time, and feelings of alienation. Caretakers are silent heroes due to their devotion, timeless commitment, self-sacrifice, and lonely lives that are accompanied only by the sound of silence.

There are few guarantees in the life of the caretaker. One certainty is that one family member usually assumes the role of caretaker where others rarely participate. The commitment of time is endless where feelings of guilt pervade the caretaker's world. Many caretakers jeopardize their occupations and personal lives since it is simply too difficult to balance the additional responsibility of caretaking. "There has been much research on marriage and much research on disability, but little research that has combined these two issues" (Gordon & Perrone, 2004). The research on chronic illness rarely considers the effect on a marriage and usually ignores romantic aspects. In a survey, *How Love and Marriage Is Affected by Caregiving,* conducted by caring.com, it was found that 80% of respondents said that caregiving put a strain on their relationship or marriage. Three factors contributed to a caregiver's highest risk for marital strain: holding down a job on top of caregiving duties, providing financial assistance to an aging relative, and caring for an aging relative in the home. Caregiving of chronically ill children also contributes to increased stress and potential damage to a family's established relationship (http://www.caring.com). "Research shows that regarding the severity of the child's diagnosis, parents experience disequilibrium during certain times of treatment and care" (Meleski, 2002).

Quality resources involving the use of caretakers, long-term care institutions, assisted living facilities, and day care centers are difficult to find, and the decision-making process is usually overwhelming. This leaves the caretaker with increased fear and anxiety on a daily basis. At the same time, the caretaker may also be responsible for scheduling diagnostic tests and treatments and coordinating financial and domestic responsibilities, which were previously handled by the family member. The caretaker usually feels very isolated, and it is not uncommon to experience both emotional and physical symptoms. It can be difficult to adapt to a family member's chronic illness. Sometimes the condition calls for changes to life plans for the future and changes to everyday life. They or their spouse may no longer be able to work outside the home or participate in household chores or social plans, and they may need to monitor medications and treatment regimes including doctor visits. It is not unusual for the caretaking spouse to experience fear, anger, and alienation. The illness often becomes the third party in a relationship or the elephant in the room (Fekete, Stephens, Mickelson, & Druley, 2007).

Is there a solution to the plight of the caretaker? This complex problem does not have a simple solution, and answers are different for each caretaker. It is helpful to contemplate the need for long-term care in the form of savings or long-term care insurance and by asking a loved one what her wishes would be if the need arises for care. When caring for children, this is not a responsibility that a parent usually would ever imagine occurring in their lives. It is extremely critical to realize that the caretaking responsibility should not be undertaken alone.

Most caretakers don't care for themselves. A caretaker is not being selfish if other professionals are utilized to reduce their burden. Caretakers rarely seek the help of mental health professionals or homecare aides nor simply allot free time for themselves. They are usually wonderful at caring and sacrificing for others but don't realize that they may eventually be unable to care for their loved one if they become ill. I recall one caretaker asking me if it was okay if he visited his wife, who was afflicted with dementia, three times a week. When he was told that there was no correct answer to the question but that his allotted time would be okay, he appeared relieved. When asked what he would do during his free time, he simply stated that it wouldn't be correct to engage in any activities. A husband took food from his wife's plate at a facility since he didn't know how to cook and felt too exhausted upon returning home to order take-out food. Another caretaker asked if it was okay if she left a facility to get a cup of coffee. She appeared guilt-ridden and crying when she returned with the coffee 30 minutes later. A caretaker of a young child with a terminal illness felt overwhelmed when her husband applied for active duty and quickly was sent to Iraq. When he received permission for a short trip home, he only criticized her parenting style. Another caretaker's spouse relocated to a job in Washington, while the sibling of her chronically ill child felt abandoned and became severely depressed. Holidays are usually sacrificed, doctors' appointments for the caretaker are delayed, and simple pleasures like exercising are sacrificed including spending time with friends.

Three factors contributed to a caregiver's highest risk for marital strain: holding down a job on top of caregiving duties, providing financial assistance to an aging relative, and caring for an aging relative in the home.

How does a caretaker handle these overwhelming pressures and burdens

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THE SILENT HEROES

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without becoming physically or emotionally ill? The Internet can be helpful in finding needed resources including companions, homecare companies, long-term care facilities, rehabilitation resources, support groups, activities for caretakers and their loved ones, and day care centers. It is always helpful to speak with friends and relatives. Word of mouth is one of the best resources, including help from relatives and friends. Caretakers should have an active presence with outside caretakers and/or institutions until they gain trust in their care techniques. Self-help or support groups may help caretakers unburden some of their feelings of guilt and learn from other caretakers. Remember, it is essential for caretakers to give themselves permission to relax, enjoy, and not be a caretaker for designated periods of time during the week. They may want to actually schedule time on their calendar for personal time. They or their loved one may think that no one can provide the same level or quality of care. It is important for the family member to realize that he or she can survive without the caretaker. This also fosters a level of independence and empowerment for the family member. It is important for caretakers to discuss other topics besides the chronic illness (Kershaw et al., 2008). Remember that caretakers' emotions and needs are still valid – and that caretakers also need care!

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Member News

Dr. John Lemoncelli has written *Healing from Childhood Abuse: Understanding the Effects, Taking Control to Recover,* published by Praeger books. Dr. Lemoncelli teaches at Marywood University in Scranton.

Dr. Dan Materna has written *Lollipops, Chocolate, Donuts, or Cake?* Dr. Materna is in independent practice in Hermitage, PA, where he helps patients address weight issues.

Dr. Sadie Strick has recently published a book, *Troubling Dreams: Unlocking the Door to Self-Awareness,* published by New Horizon Press. Dr. Strick is in private practice in Pittsburgh, specializing in psychodynamic psychotherapy.

Carlow University awarded its first Doctor of Psychology degrees in December 2011 to eight students. Carlow's Counseling Psychology Program was recently accredited by the American Psychological Association.

Classifieds

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Workshop on Violence Prevention

The American Psychological Association Public Interest Directorate/Violence Prevention Office will offer a 7-CE workshop (#108) at the APA Convention on August 2 from 8:00 a.m. to 3:50 p.m. The workshop, entitled "Increasing the Effectiveness of Providers for Child Victims of Violence and Trauma," gives a detailed overview of five evidence-based treatments and six assessment measures to help psychologists make informed decisions to adopt those models that best fit child and adolescent victims of violence and trauma under their care.

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Gettysburg, PA
Marti Evans (717) 232-3817

November 1 and 2, 2012
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For CE programs sponsored by one of the Regional Psychological Associations in Pennsylvania, visit http://www.PaPsy.org/index.php/collaboration-communication/.

Registration materials and further conference information will be mailed to all members.

If you have additional questions, please contact Marti Evans at the PPA office.

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