

Case Study

Sleep and Sleep Disorders in Later Life

by Robert D. Vorona, MD

Educational Objectives

1. Describe basic changes in sleep that occur as we age.
2. Review several important sleep disorders common in later life
3. Discuss treatment modalities for these sleep disorders and potential benefits of therapy.

Background

Many of us may have little understanding of sleep and the changes that occur as we age. Sleep is not a unitary process but rather subdivides into non-REM (rapid eye movement) sleep and REM or dreaming sleep. Non-REM sleep is then broken up into Stage 1, Stage 2, and Stage 3 sleep. One enters sleep through the portal of light Stage 1 sleep, which normally takes up only about 5% of the night. The next stage of light sleep is Stage 2 sleep, which generally encompasses roughly 50% of the night. Sleep spindles and K complexes on the

electroencephalogram (EEG) mark Stage 2 sleep. Particularly when young, we tend to have about 20-25% of the night comprised of Stage 3 or deep sleep. Stage 3 sleep, the final portion of non-REM sleep, is defined by the presence of low frequency and high voltage EEG waves called delta or slow waves. As we grow old, we tend to lose this deep sleep and this attenuation in deep sleep is often more marked in males than females. We tend to be least easily awakened from Stage 3 sleep.

REM sleep differs greatly from non-REM sleep and is defined by rapid eye movements, loss of chin muscle tone, and a low voltage and mixed frequency EEG. Unlike deep sleep, the percentage of REM sleep does not change much over time and generally involves 20-25% of the night. Interestingly, with the exception of our eye muscles and our diaphragm (the principal muscle of respiration), we are paralyzed during REM sleep.

In general, it takes about 15 minutes to enter Stage 2 sleep. This period from wakefulness to Stage 2 sleep is called the sleep latency to

Stage 2. It then takes about 90-110 minutes from the onset of sleep until we enter our first period of REM sleep. Thereafter, we cycle through non-REM and REM sleep through the night, generally about three to five REM periods a night for adults. Most of our deep sleep is localized to the first half of the night and most of our REM sleep occurs during the second half of the night. REM periods generally become longer during the night. A long first REM period can clue a sleep specialist to the possibility of a depression.

How long should we sleep? This question elicits some controversy and depends greatly on one's age. For example, high school students seem to require 9.25 hours of sleep a night. Adults (including the aged) tend to require less sleep than teens, with many specialists recommending about seven to eight hours of sleep a night. Studies suggest that the lowest mortality in adults is associated with approximately seven hours of sleep a night. Both significantly less sleep and greater sleep amounts are associated with reports of greater mortality, for reasons that remain unclear. However,

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restricted sleep has been associated with such important sleep disorders as hypertension, diabetes mellitus, and obesity (e.g., Vorona et al. 2005). Whether prolonging sleep duration will lower blood pressure, lower blood sugar, or help reduce weight remains to be established.

Older Adults

One consequence of aging is a reduction in deep or slow wave sleep. However, a number of other changes in sleep occur with aging. We tend to spend more time in bed awake. Sleep efficiency is defined as the proportion of time one is asleep while in the bed. In healthy sleepers, sleep efficiency is approximately 90%. However, in the elderly sleep efficiency might drop to as low as 70%. Older adults tend to “phase advance” with their internal clocks encouraging an earlier bed time and earlier wake time. Such a phase advance should not be problematic unless extreme, impairing one’s ability to live an active social life. Further, older adults tend to spend more time in lighter stages of sleep, have more arousals during sleep (mini-awakenings), and to nap more during the day than younger adults.

Several important sleep disorders afflict older adults. We will highlight obstructive sleep apnea syndrome (OSAS), Restless Legs Syndrome/Periodic limb movements of sleep (RLS/PLMS), REM sleep behavior disorder (RBD), and chronic insomnia.

OSAS is the repetitive complete or near complete occlusion of the upper airway during sleep. This syndrome is common and becomes

increasingly so, probably plateauing in prevalence after age 65 (Mehra et al, 2007). Symptoms of OSAS include snoring, nocturnal choking, gasping and pauses, as well as non-restorative sleep and daytime sleepiness. Patients might also note morning headaches, nocturia, mood disturbances, and enuresis (wetting the bed).

OSAS looks to be a common secondary cause of hypertension and has been associated with an increased risk of congestive heart failure, irregular heart rhythms, and stroke (Bradley & Floras, 2009). Moderate to severe and severe OSAS have also been linked to increases in “all-cause mortality” (Marshall et al., 2008). For two decades data have demonstrated that patients with OSAS are significantly more likely to have car crashes (Findley et al., 1988).

The diagnosis of OSAS is optimally established at an American Academy of Sleep Medicine accredited sleep disorders center or accredited sleep disordered breathing laboratory. After a history and physical examination, the patient undergoes a polysomnogram (sleep study) at the sleep center, during which the patient typically spends a full eight hours in a special bedroom. Such sleep studies measure a number of physiologic signals that include brain waves, eye movements, nasal and oral air flow, electrocardiogram, chest and abdominal wall movements, oxygen level, and leg movements. While the patient sleeps, sleep technologists or technicians monitor the signals, trouble shoot, and care for the patient’s needs. Technicians subsequently score the raw data; a sleep special-

ist then reviews their scoring and raw data, generates a report, and establishes a diagnosis. OSAS is defined by the presence of at least five partial (hypopneas) or complete pauses (apneas) in breathing per hour of sleep, described as the AHI or apnea-hypopnea index. Although far from a perfect metric, sleep specialists assume that greater number of apneas or hypopneas demonstrate more severe sleep apnea.

A number of treatment options are available for OSAS subjects. Generic treatments can include weight loss and reduction or avoidance of alcohol. One study suggests that a 10% decline in BMI leads to a 26% reduction in AHI. Patients should be instructed not to drive if sleepy and to adopt countermeasures to sleepy driving that include caffeine and napping.

Beyond these general recommendations, positive airway pressure (PAP), dental appliances, and surgery offer effective OSAS treatments. PAP applies a positive pressure to the OSAS patient’s upper airway, thus splinting open the airway and preventing the recurrent partial or complete upper airway occlusions of OSAS. PAP has been demonstrated to improve quality of life, lessen daytime sleepiness, reduce car crash rate to baseline rates, and improve mood (George, 2001; Kawahara et al., 2005). PAP may also lower blood pressure, reduce blood sugar in diabetes mellitus, improve insulin resistance, and improve ventricular dysfunction in congestive heart failure (Dorkova et al., 2008; Mansfield et al., 2004). Some early data even suggest that over the long term PAP

may reduce cardiovascular mortality. Thus, it is gratifying that an increasing database demonstrates the utility of treating OSAS.

Dental appliances for OSAS are worn over the teeth during sleep (almost akin to a football player's mouthguard) and can be effective in mild to moderate sleep apnea. Most believe that patients must have eight to 10 teeth both above and below to anchor such devices. Dental specialists should fashion these devices. A number of surgical procedures, usually performed by Ear Nose and Throat surgeons and/or Oral Maxillofacial surgeons, can treat OSAS. With older adults who may have co-morbidities, surgery should be reserved for significant OSAS that has not responded to the application of less invasive maneuvers.

Restless legs syndrome (RLS) afflicts roughly 10% of the population in the United States. As defined by the International Restless Legs Syndrome Study Group (IRLSSG), four basic criteria must be satisfied to diagnose RLS: 1) The patient describes an urge to move and almost always with accompanying paresthesias (an antsy or creepy-crawly sensation); 2) The urge to move occurs at rest; 3) A clear circadian rhythm exists with symptoms being most problematic in the evening/night; and 4) Movement rapidly alleviates symptoms, although symptoms can occur with resumption of rest.

Approximately 60% of those with RLS are females and most are ages 50 or older. Patients with RLS often complain about an inability to initiate or maintain sleep and not infre-

quently manifest mood disorders. The clinician evaluating RLS must remember that, although many cases of RLS are idiopathic, a number of secondary causes can underpin RLS. For example, iron deficiency, end stage renal disease, and multiple sclerosis have all been associated with RLS (e.g., Hening et al., 2007).

Physicians and ancillary clinicians can diagnose RLS through history and physical examination. A polysomnogram is superfluous if the clinician does not suspect another sleep disorder. Some 80% of RLS patients demonstrate periodic limb movements of sleep (PLMS) on sleep studies. PLMS are repetitive and stereotypic leg jerks. RLS treatment should ensue if symptoms are frequent enough and onerous enough to prevent adequate sleep. Patients should be urged to minimize caffeine and alcohol and to avoid anti-histamines. Some will gain relief through warm baths, massage or exercise. Medications to include dopamine agonists (e.g., ropinirole and pramipexole), gabapentin, and opiates all can be effective. A recent study also suggests that intermittent pneumatic compression devices can offer relief to RLS sufferers.

REM sleep disorder. As noted above, normal REM sleep leaves the sleeper paralyzed with the exception of diaphragm and oculomotor function. REM sleep behavior disorder (RBD) is a fascinating disorder in which patients act out dreams that often are comprised of violent content. Patients can be noted by their bed partner to holler and/or punch or kick in their sleep. Patients with RBD may abruptly

leave the bed, and are apt to injure themselves and more likely to injure their bed partner. RBD most commonly afflicts older men. Evaluation should be performed by a sleep specialist who may order specialized polysomnography to include video, extra limb electromyographic leads, and more involved electroencephalographic leads (to interrogate for seizures). A paradoxical loss of REM atonia in the chin, arm and/or leg EMG leads strongly supports RBD.

Treatment of RBD should first involve making the bed area safe for both patient and the bed partner. Clonazepam effectively attenuates RBD symptoms in roughly 90% of patients (Olsen et al., 2000). Case reports suggest that caffeine can exacerbate RBD, so a reduction of intake could be worthwhile. Clinicians should be alert to the use of selective serotonin reuptake inhibitors (certain antidepressants) in patients who present with RBD. Finally, RBD not infrequently presents with or presages degenerative neurological diseases such as Parkinson's disease and Lewy Body dementia (Olsen et al., 2000). A full neurological evaluation in patients with RBD is worthwhile.

Chronic insomnia. One can define insomnia as the inability to initiate sleep or maintain sleep, the presence of early morning awakenings or the belief that sleep quality is poor. These complaints should occur in the presence of an adequate opportunity to sleep and with daytime impairment. Insomnia more commonly troubles women than men and occurs more often with increasing age. Clinicians can most effectively address insomnia

by remembering to take an organized approach that evaluates and treats the following possible cause(s): 1) Environmental issues like a noisy or hot bedroom; 2) Mood disorders, as there likely is a bidirectional relationship between depression and insomnia; 3) Medical disorders such as asthma/COPD, arthritis, reflux or prostatism; 4) Intrinsic sleep disorders such as OSAS (50% of OSAS subjects have insomnia complaints) or RLS; 5) Sleep hygiene abnormalities, e.g., chaotic bed and wake times, excessive alcohol and caffeine or using the bed to watch TV or work; 6) Circadian rhythm disorders such as Advanced Sleep Phase syndrome; and 7) Psychophysiological insomnia with hyperarousal in the bedroom and learned maladaptive behaviors

Perhaps the most contentious issue in the treatment of chronic insomnia involves the use of behavioral interventions versus sleeping pills. Most sleep specialists recommend the use of behavioral interventions such as stimulus control, sleep restriction or cognitive behavioral interventions as opposed to long term sleeping pill use. However, a small but burgeoning literature supports the long term use of sleeping pills for insomnia.

Case Study #1

Mr. S. arrived at the physician's office aghast that he struck his wife last night during his sleep. This 65 year old patient relates that his aggrieved wife awakened him immediately and that he remembered punching at an attacker in his dream. A phone call to his wife alerts the physician to the fact that

Mr. S. has a long history of modest snoring but no history of nocturnal gasping or pauses in respiration. He has been yelling and moving in his sleep for some time. He admits to no history of depression and takes only a diuretic for his hypertension. No family history of sleep disorders exists and his review of systems reveals only the recent increase in drooling.

On physical exam the physician noted a subtle shuffling of gait, as well as a resting tremor and some cogwheel rigidity. The physician, suspecting RBD, scheduled Mr. S. for a sleep evaluation and probable expanded polysomnogram. The subsequent sleep study revealed no sleep apnea (thus no pseudo-RBD) but demonstrated a marked increase in muscle tone in REM sleep. The physician instituted clonazepam with resolution of RBD symptoms, and in follow-up a neurological consultant confirmed the diagnosis of Parkinson's disease.

Case Study #2

Ms. R. reported a long history of both problems falling asleep and staying asleep. She believes that she obtains but six hours of sleep a night and finds herself increasingly irritable and unable to concentrate. She admits to a long history of depression that has been well controlled through the use of bupropion. She notes that two previous physicians have treated her insomnia with zolpidem and more recently temazepam with but modest success. She fervently denies snoring or witnessed pauses in respiration. When asked to explain specifically why she cannot sleep, she admits to an urge at rest (and at night) to

move her legs associated with a feeling that she simply cannot describe. The physician then elicits that walking quickly reduces her symptoms but only transiently. Ms. R. notes that she drinks seven to eight glasses of sweet tea daily and that her late mother had the "fidgets". The physician recommends marked reduction of caffeine and checks a serum ferritin level, which returns normal. Initiation of a dopamine agonist relieves her RLS and her insomnia.

Conclusion

Clinicians, older adults, and others should be alert to the possibility of sleep disorders in later life. Sleep disorders in older adults are common, may have substantive consequences, and often can be treated effectively.

Study Questions

1. What changes occur in sleep architecture as we age?
2. What are some of the major consequences of untreated obstructive sleep apnea syndrome?
3. Do most sleep specialists prefer the use of behavioral interventions or long term sleeping pills to treat chronic insomnia?

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report less sleep than patients with a normal body mass index. *Archives of Internal Medicine*, 165, 25-30.

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General Recommended Reading or Sources:

A good source for the public:

www.sleepfoundation.org

Information about specific sleep problems: www.sleepeducation.com

General information from NIH:

www.nhlbi.nih.gov/health/public/sleep/healthy_sleep.htm

www.nhlbi.nih.gov/health/public/sleep/healthy_sleep.htm

About the Author



Robert Daniel Vorona obtained his M.D. degree from the University of Virginia, completed his internal medicine residency at the University of Michigan in Ann Arbor, and his pulmonary fellowship at the University of North Carolina at Chapel Hill. He is board certified in Internal Medicine, Pulmonary Medicine, and Sleep Disorders Medicine (American Board of Sleep Medicine). Dr. Vorona currently serves as the medical director of the Eastern Virginia Medical School/Sentara Norfolk General Hospital Sleep Disorders Center and as an Associate Professor in the Division of Sleep Medicine at EVMS. He serves as the first president of the Virginia Academy of Sleep Medicine (www.vasleepmedicine.org).

Editorials

From the Director, Virginia Center on Aging

Edward F. Ansello, Ph.D.

Blanche DuBois Geriatrics

My non-gerontological friends often say things like “your business must be booming and getting all sorts of support with the country growing older” and “people must be flocking to careers that are aging-related.” Unfortunately, in the first instance, there’s no free ride in academia or in state appropriations just because one is serving a need that is growing. As in other disciplines and concentrations, one must justify one’s costs. What seems like a priority logically is not necessarily a priority fiscally. In the second case, while the numbers of older adults are growing and the leading edge of the Baby Boom is in its 60s, aging-related education, service, and practice are far from burgeoning.

The number of students preparing for aging-related work is hardly commensurate with the growing demographics. In health care, for example, there are troubling shortages of nurses and physicians with training in geriatric care and, among those who have the most hands-on interactions with elders in need of care, i.e., nurse aides, home care workers, etc., 100% annual turnover rates among staffs are not uncommon.

New graduates of medical schools are not required to be trained in geriatrics and the overwhelming majority of freshly-minted physi-

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cians have none at all. We have been seeing a steady trend downwards among those with geriatric credentials and among those who train and teach in geriatrics. The late 1980s introduced the Certificate of Added Qualifications (CAQ) in Geriatric Medicine, under the American Boards of Family Medicine and of Internal Medicine (jointly), and in Geriatric Psychiatry, under the American Board of Psychiatry and Neurology, and, in 1991, the CAQ in Osteopathic Geriatrics in Family Medicine.

The numbers who sat for these exams, essentially but not quite a specialty board certification, peaked by 1996 and then plummeted. Re-certifications have fallen well below 50% in medicine and below 65% in psychiatry. Overall, about 14,000 physicians have been certified in geriatric medicine and psychiatry since the first certifications in 1988. As a point of reference, over this time period there were some 800,000 physicians in practice in this country. Today there are about 8,000 certified geriatricians and the number of newly-certified geriatric fellow graduates is hovering under 300 a year nationally. Similarly, the number of geriatrics educators, those physicians taking advanced training in research and teaching, has also been dropping, now down to 34-36.

Perhaps we Americans really are a do-it-yourself people. Perhaps we fully intend to rely upon self-care and self-medication as we age. Perhaps, like Blanche DuBois in *A Streetcar Named Desire*, we plan to depend upon the kindness of strangers. But, just in case we ever do need geriatrically or gerontolog-

ically trained physicians, nurses, pharmacists, therapists, recreators, social workers, and so forth, Virginia has the Geriatric Training and Education (GTE) program that we are fortunate to administer.

Owing to the foresight of former Delegate Jack Reid, the guidance of former Delegate Frank Hall, and the assistance of so many in the General Assembly and Executive branch, the GTE initiative has supported geriatric workforce development across virtually every geographic region of the Commonwealth over the past two fiscal years. Make no mistake; the GTE is a modest program that cannot possibly address the troubling shortfalls mentioned above. But the GTE does embrace the gamut of training needs from nurse aides to licensed professionals and it does respond to needs across Virginia.

The GTE program invites Virginians to submit proposals for financial support for needed training and education; these are reviewed on the basis of merit. In its two fiscal years of operation (2007-2009) we have awarded 38 projects. The 22 projects in the just-ended fiscal year included training direct service workers in the Danville-Pittsylvania region on aging and dementia among Virginians with intellectual disabilities; supporting Rappahannock's geriatric rural health physician residency program; sponsoring a training conference at UVA for physicians, nurse practitioners, and other health care providers on neuro-imaging and other research on Alzheimer's disease; training community pharmacists in three

From the Virginia Department for the Aging

Linda Nablo

Vacation time is here, gas prices are rising, the state's revenue picture is worsening; but some pretty exciting things are happening nonetheless. At the federal level, the President and Congress are attempting to move forward on Health Care Reform (although it is still unclear how Long Term Services will be included). On a separate but related front, a landmark bill has been introduced in both the House and Senate that would significantly reshape how community services are to be funded and provided to seniors. Project 2020: *Building on the Promise of Home & Community Based Services* was introduced in early June by Senators Maria Cantwell and Debbie Stabenow in the Senate (S. 1257) and in the House (H.R. 2852) by Congressmen Bruce Braley and John Sarbanes. The goal of Project 2020 is to "provide the resources to implement consumer-centered and cost-effective long-term care strategies authorized in the 2006 reauthorization of the Older Americans Act and to empower the Aging Services Network to implement these strategies through a three-pronged program." Those three elements include: 1) Person-Centered Access to Information (including support of Aging and Disability Resource Centers); 2) Evidence-Based Disease Prevention and Health Promotion programs; and 3) Enhanced Nursing Home Diversion Services.

Recognizing that demographic trends make our current strategy for

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financing long term care costs through the Medicaid and Medicare programs unsustainable, Project 2020 represents an incremental, coordinated national long-term care strategy that will generate savings in Medicaid and Medicare at the federal and state levels while enabling older adults and individuals with disabilities to get the support they need to successfully age where they want to—in their own home and community. N4A and the National Association of State Units on Aging (NASUA) are sponsoring the legislation and are seeking funding to support federal outlays of \$2.5 billion over the next five years to be administered through the Aging Services Network of State and Area Agencies on Aging.

According to initial estimates, the program has the potential to reach over 40 million Americans and will reduce federal Medicaid and Medicare costs by approximately \$2.8 billion over the first five years, resulting in a net savings to the federal government of nearly \$250 million. The program is also expected to generate significant savings for state governments as well. “Funding would be administered by AoA through disciplined, performance-based grants that will ensure that the components are implemented in ways that have been proven to work best at the community level.” The program seeks to build on and enhance, not supplant, the current system and network of SUAs and AAAs.

For consumers, this program is designed to empower individuals to make informed decisions and to better conserve and extend their own resources using lower cost evi-

dence-based programs, including consumer-directed options for care in the community. To learn more about this legislation, visit the websites of N4A www.n4a.org and NASUA www.nasua.org.

Here in Virginia, several initiatives designed to help the Commonwealth and localities prepare for the age wave are well underway. As reported in the spring issue of *Age in Action*, VDA, working with the Older Dominion Partnership, AARP, the Virginia Municipal League, the Virginia Association of Counties, V4A and others, sponsored the first *Virginia Forum on Age Wave Planning* on May 20, 2009 in Charlottesville. This forum was designed to help communities prepare for the aging of their population and was targeted to county and city chief administrative officers and community leaders. The forum provided information on how the demographic changes will impact Virginia communities, how boomers are likely to have different demands and expectations than their parents, and included “best practices” from several communities in Virginia that have already started to prepare for the impending demographic shift. Participants were also encouraged to view the coming age wave as an opportunity to transform their community to better meet the needs of citizens of all ages.

More than 200 persons participated in the Forum and responses have been very enthusiastic. VDA and our partner organizations are pursuing other opportunities to continue providing information and support to local planning efforts. To view some of the presentations provided

at the forum visit www.olderdominion.org.

Two other planning efforts are also moving forward. To create the *4 Year Plan for Aging Services*, as mandated by the General Assembly, VDA has convened a work group that includes representatives of state agencies, private sector organizations, advocates, and other stakeholders. The group will continue to develop the Plan throughout the summer and fall and will provide opportunities for public input across the State before reporting the results to the Governor and the General Assembly at the end of November. Look for more information about this Plan in coming issues of *Age in Action*.

The *Virginia Alzheimer’s Disease and Related Disorders Commission* is also in the preliminary stages of planning for a state Alzheimer’s Plan. This plan will report on the impact of Alzheimer’s disease and related dementias on the Commonwealth’s population and the current programs and services that support families as they deal with this disease. The potential impact of the disease on the Commonwealth is significant: at the start of this decade, approximately 107,000 Virginians had Alzheimer’s; by the end of this decade, more than 145,000 Virginians will have the disease. The Plan will make recommendations regarding ways in which the Commonwealth can address this impact. For additional information about both the 4 Year Plan for Aging Services and the Alzheimer’s Plan, contact Bill Peterson at bill.peterson@vda.virginia.gov.

Finally, I want to take this opportu-

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nity to officially announce an exciting change at VDA. In late July, Katie Roeper will be joining the department as the Assistant Commissioner. This new position is designed to strengthen VDA's ability to work collaboratively with the broader network of aging services to increase resources, enhance services, and improve and integrate our efforts to help Virginia prepare for an aging population. Many of you already know Katie and the wonderful work she has done in developing Senior Navigator into an important partner in Virginia's aging services network. Her knowledge of the programs, people, and issues will allow her to step easily and quickly into her new role at VDA. Her experience with long-range planning, working in coalitions, securing grants and developing new resources make her a great fit for this position; and her positive attitude, energy and willingness to take on challenges will be a wonderful asset to VDA as we strive to fulfill our mission and serve older Virginians today and in the future. A transition team is already in place at Senior Navigator to provide leadership to that valuable organization until a new Executive Director is hired.

Three Receive Awards at Shepherd's Center Anniversary Program

As part of its 25th anniversary celebration on May 15th, The Shepherd's Center of Richmond recognized three persons whose work has been invaluable in the development and successful operation of the Center over the years. Receiving the first Distinguished Service Awards given by the organization were the Rev. Robert Seiler, Janyce Olson, and Nathan Bushnell, III.

"We all knew who the very first recipient should be," commented James "Buddy" Harlan, chairman of the awards committee. "**Bob Seiler** organized and led the committee which developed services and educational programs by and for the elderly in Richmond. As a result of his efforts, The Shepherd's Center of Richmond was granted a non-profit corporate charter in 1984." Seiler was the first executive director, a position he held for five years. He has continued to be a mainstay of the Center, serving on the Board of Directors and actively offering support and advice to officers and directors.

Janyce Olson served as executive director from 1993 to 2004. She was instrumental in expanding

offerings of the Open University and in increasing funding and bequests for the organization. During her tenure, she "demonstrated a remarkable ability to be on top of every aspect of the Center's operation," said Harlan. Members still remember the graciousness and tact with which she performed her duties. In her retirement, she has become a senior services volunteer for the Center.

A popular lecturer at the Open University, **Nate Bushnell**, served as president of the Shepherd's Center Board and has been re-elected many times as a Board member. Bushnell has also provided personal services to numerous senior clients. His travelogues at all the Open University sites have been entertaining and informative. "If you need a program, Nate has slides and will travel," quipped Harlan, adding that Bushnell's wisdom, experience, and enthusiasm have strengthened the Center's work in many ways.

Dr. John Rilling, current president of the Board, and Linda Frank, executive director, also recognized those hundreds of volunteers present at the luncheon who have provided services to seniors in need, manned the Center's office, worked on committees, and taught courses or lectured at lunch for the Open University.

ArtLinks

As the regional liaison for the Museum of Modern Art's Alzheimer's Project, the Virginia Museum of Fine Arts is proud to launch ArtLinks - group tours for facilities that serve individuals with dementia and Alzheimer's disease. ArtLinks offers a supportive and enriching experience by exploring works of art in a gallery setting. Tours are conducted by specially trained staff or docents and last approximately one hour.

Fee: \$4 per person, minimum of 10 and maximum of 16 per group. For more information and to schedule a tour for your facility, please call (804) 340-1419 at least three weeks in advance.

Focus on the Virginia Center on Aging

Jane Stephan, Ed.D.



Jane Stephan was born years ago, rather suddenly, in Cincinnati.

She became, successively, a student, government secretary, wife, mother, single mother, bookkeeper, administrator, a student again, project coordinator, full-time caregiver for her mother, then achieved a terminal degree in adult and community education programs, and became a program administrator. Again.

Ten years ago, she emigrated to Virginia after years in Minnesota and Ohio, but can still produce a credible Northwoods accent or an Ohio twang at the drop of a hat. At VCU, she works with our coordinators – Catherine Dodson, Jim Gray, Ellen Nash, and Barbara Wright – to provide top-rated Elderhostel programs at Richmond, Natural Bridge, Harrisonburg, and Staunton.

Jane has worked with Elderhostel programs, in one form or another, at one institution or another, since 1987, and has, mostly, enjoyed the assorted oddments of working with programs that are designed for people who love to learn and who are, now, her age. Recently, she informed her boss that she will no longer be working for “Elderhostel” come this fall.

Well, was ten years in Virginia

enough – or too much? No, she loves Virginia, has learned a great deal about this beautiful Commonwealth and all it has to offer, is truly pleased to be part of the Virginia Center on Aging at VCU, and hopes to remain here and not flit off to some other location. So, if she’s not leaving, what then is happening? Ah, it’s Elderhostel itself that is changing.

From the word go, in 1975, Elderhostel became a mecca for lifelong learning for older adults. In the first five years of its existence, Elderhostel grew from 200 to 20,000 participants, and eventually to 200,000 annually, all of whom were willing to stay in college dorms, eat in college cafeterias, and ride on yellow school buses. Well, of course, things couldn’t go on like that, and eventually Elderhostel programs moved to hotels and commercial coach service, and making participants ever thankful for the promise of a “private bathroom.” Then, thousands became millions.

That worked well for a while, until participants – and non-participants – began to scrutinize the word “elder,” and found it lacking. One does not wish to speak ill of original intentions, especially those that played out so well to describe the largest university in the world for lifelong learning, but the term “hostel” no longer applied either.

So, after almost 35 years, Elderhostel is changing its program name, and is asking for your help in the endeavor. What would you call a program for midlife and older adults who love to learn, laugh, grow and explore? Visit www.thenewelderhostel.org to view

a short video, to see current suggestions for the new name, and to submit your own ideas.

And then, watch the Elderhostel website and this space, too, where peace and harmony will be restored, we hope, by Elderhostel’s announcement this fall of its new name. Needless to say, “the-newelderhostel” will retain its excellent programs and its premier standing as the world’s largest university for lifelong learning. And Jane will remain an enthusiastic supporter of the organization.

Virginia Center on Aging Editorial, *continued*

regions on medication management for older adults; palliative care training for long term care nursing staff; four regional teleconference trainings for social workers; staff training at the Three Rivers Health District in Northern Neck on arthritis in later life; staff and volunteer training on Alzheimer’s and on early-onset support and education with the Alzheimer’s Association Chapters in the National Capital Area and Southeastern Virginia, respectively; multidisciplinary training for nurse aides in Southside, the Shenandoah Valley, and the Charlottesville region; providing three days of training at the annual conference of the Virginia Geriatrics Society for 65 non-geriatric physicians, nurses, and pharmacists; and much more.

While hoping for greater initiatives at the national level, we look forward to continuing GTE in Virginia.

2009-2010 ALZHEIMER'S RESEARCH AWARD FUND RECIPIENTS ANNOUNCED

The Alzheimer's and Related Diseases Research Award Fund (ARDRAF) was established by the Virginia General Assembly in 1982 to stimulate innovative investigations into Alzheimer's disease (AD) and related disorders along a variety of avenues, such as the causes, epidemiology, diagnosis, and treatment of the disorder; public policy and the financing of care; and the social and psychological impacts of the disease upon the individual, family, and community. The ARDRAF competition is administered by the Virginia Center on Aging at Virginia Commonwealth University. The five grant awards for 2009-2010 are as follows:

VCU Guo-Huang Fan, Ph.D. "Potential therapeutic effect of lupeol on Alzheimer's neuropathology in a transgenic mouse model"

A major histopathological hallmark of AD is the amyloid plaque, composed of β -amyloid ($A\beta$) peptides. Agents that can reduce $A\beta$ accumulation may have therapeutic potential for AD. Epidemiological studies have reported that fruit and vegetable juices may play an important role in slowing the progression of AD, suggesting that some dietary substances could be effective in reducing AD neuropathology. The investigator discovered that lupeol (a triterpene found in fruits, vegetables, and medicinal plants) potentially reduced the production of $A\beta$ in primary neuronal cultures. The mechanism of action is most likely accomplished by inhibiting the proteolysis of amyloid precursor protein, a process necessary for the generation of $A\beta$. This study aims to determine whether lupeol attenuates $A\beta$ -associated neuropathology and improves spatial memory deficits when administered to amyloid precursor protein and presenilin 1 (APP/PS1) double transgenic mice. $A\beta$ accumulation, tau hyperphosphorylation, synaptic loss, and spatial memory deficits will be assessed. The outcomes may lead to the identification of novel therapeutic agents for the treatment of AD. *(Dr. Fan may be contacted at 804/828-1674)*

**Alzheimer's Association Ellen Phipps, C.T.R.S., and Barbara Braddock, Ph.D.
Central and Western Virginia "Home-based cognitive intervention program in dementia"**

This preliminary study aims to investigate and promote 'partnered volunteering' by pairing University students with individuals who have dementia to examine the effectiveness of a home-based cognitive intervention. The intervention is designed to provide opportunities for participants to complete activities that were once meaningful in their lives using Montessori-based instruction, errorless learning, therapeutic recreational principles, and environmental modifications. The study has three goals: 1) to provide an opportunity for successful engagement in life for persons with a diagnosis; 2) to provide relief, education, and support to caregivers; and 3) to foster positive inter-generational relationships. This combination approach may translate into more constructive engagement and appropriate communication exchange for persons with dementia when delivered in the home. The findings will have implications for the development of sustainable community programs. *(Ms. Phipps may be contacted at 434/ 973-6122; Dr. Braddock may be contacted at 434/924-4000)*

UVA Karen M. Rose, Ph.D., R.N., and Ishan C. Williams, Ph.D. "Family quality of life in dementia"

Because a diagnosis of dementia has implications for the overall functioning and well-being of the family unit involved, a reliable and valid instrument to assess the impact of services and resources that are provided, or not provided, on family quality of life is needed. This study will gather input from content experts on the dementia-related dimensions that are not addressed in an existing family quality of life instrument for families of children with disabilities. A pilot instrument will be developed and group interviews will be conducted with persons who have mild to moderate stage dementia and their family members to gain insights from their unique perspectives regarding family quality of life and pilot-test the instrument. Subsequent mailings of the revised instrument will be sent to family members of persons with dementia to gather additional data

from a larger sample from across the Commonwealth of Virginia. Data from a broad-based use of the resulting instrument could result in enhanced legislation and agency policy. (*Dr. Rose may be contacted at 434/924-5627; Dr. Williams may be contacted at 434/924-0480*)

VCU H. Tonie Wright, Ph.D. “Alzheimer’s A β amyloid peptide interactions with inflammatory chaperone molecules”

The causes for the loss of mental function characteristic of Alzheimer's disease (AD) are not unambiguously identified. β -amyloid (A β) peptide exists in a number of different forms, each consisting of a different number of copies of the peptide molecule. Research suggests that certain of these aggregated states are toxic to brain cells and may also disrupt communication between neurons in the brain. If this is the case, then it is important to know which of these peptide forms are toxic and what other molecules promote their formation. The investigator hypothesizes that chaperone-like inflammatory molecules change the relative concentrations and alter the overall biological activity of the A β pool. In this way, they would regulate the pathological activity of A β and implicitly offer new pharmacological targets for the development of novel therapies and, possibly, new prevention efforts. The experiments to be conducted will provide an initial test of the hypothesis that reciprocal interactions between A β and candidate chaperone molecules modulate the activities of both molecular species and thereby make multi-synergistic contributions to the development of AD. They address important unanswered questions at the molecular and cellular level relating to the fundamental causes of AD. (*Dr. Wright may be contacted at 804/828-6139*)

UVA J. Julius Zhu, Ph.D., and Lei Zhang, Ph.D. “Mechanisms for Cdk5-mediated synaptic depression.”

Patients with Alzheimer’s disease (AD) exhibit the enhanced activity of a specific cyclin-dependent kinase 5 (Cdk5) due to the overproduction of a truncated form of the Cdk5 activator, p25 protein. The investigators’ preliminary evidence suggests that over-expression of human p25 in hippocampal neurons causes synaptic depression, a critical event that precedes defects in learning and memory in individuals with AD. Moreover, synaptic activity rapidly regulates Cdk5 signaling, which in turn induces a beta-amyloid-independent synaptic depression. The investigators will explore how Cdk5 activity regulates synaptic transmission. They will also test their central hypotheses that Cdk5 is a novel homeostatic regulator of synaptic strength and that aberrant Cdk5 activity leads to synaptic depression. The model may account for the disappointing results of recent high profile clinical trials because blocking beta-amyloid and tau should stimulate compensatory synaptic depression via Cdk5. The findings should suggest additional molecular targets and provide the scientific foundation for new drug designs and clinical trials. (*Dr. Zhu may be contacted at 434/243-9246; Dr. Zhang may be contacted at 434/243-9562*)

2009-2010 ARDRAF Awards Committee

Paul Aravich, Ph.D.

Eastern Virginia Medical School

John W. Bigbee, Ph.D.

Virginia Commonwealth University

Jorge Cortina, M.D.

Hampton VA Medical Center

Jeffrey L. Dupree, Ph.D.

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Jodi Teitelman, Ph.D.

Virginia Commonwealth University

Patricia A. Trimmer, Ph.D.

University of Virginia Health System

E. Ayn Welleford, Ph.D.

Virginia Commonwealth University

Aging in Place Prolongs Life: But One Has to Use Resources to Stay Put

by Sung C. Hong, PhD

A recent survey in Ireland found that the survival rate of residents in nursing homes is substantially lower than that of their counterparts living in the community. *The Irish Times* reports that older patients discharged from hospitals to long-term care in nursing homes live 30.3 months on average. These patients had an average age of 82 and two thirds were female. The survival length of these frail, elderly residents is just half that of a corresponding community-dwelling group, at age 82; their survival is 67 months for a man and 85 months for a woman. The analysis was based on the detailed study of a random sample of 210 subjects from 1,552 patients discharged from Irish hospitals during the period of 1997-2003 (*Gerontology News*, February, 2009).

Although there is no comparable study in the U.S., there are some parallels. The average length of stay in a nursing home in the U.S. is 28.8 months, according to a Met Life survey in 2004. Of course, even in the Irish study there are difficulties in finding truly comparable groups inside and outside of long-term care institutions. Nonetheless, fairly or unfairly, there are numerous negative anecdotal descriptions of life in nursing homes which cite impersonal care and resulting guilt borne by close relatives. These and other depictions, as well as high

costs, have led many gerontologists to embrace the concept and practice of aging-in-place. Indeed, the broad aging network of assistance embodied in the Older Americans Act aims primarily to help older adults to live in their homes as long as possible. Particular attention is given to low-income minority individuals to maintain their independence with dignity. However, even today many elders are unaware of beneficial resources created for meeting their specific needs.

According to the City of Richmond Survey of Older Adults, 2008, which the city conducted and Dr. Coogle and I analyzed on behalf of the Virginia Center on Aging, the three most common concerns expressed by respondents (n=283, age 50+) who answered open-ended questions were found to be housing (20%), homecare (14%), and transportation (10%), all essential for aging in place. However, fewer than 20% of survey participants had ever visited a senior center and barely 10% of them had utilized services provided by an adult day-care center. Under-use of existing services appears to be widespread and to stem from confusion among frail elders or their caregivers as to where to turn to for help. Less than one quarter of those surveyed (22%) had contacted Senior Connections, The Capital Area Agency on Aging, a one-stop aging-related information center; only 10% of respondents had used the City of Richmond's Senior Hot Line.

Clearly, the aging network should promote existing information centers more vigorously in order to increase awareness of resources. The *No Wrong Door* initiative is a

good step in that direction. Some elders and their caregivers lack the wherewithal or the inclination for computer-based accessing. Richmond City and area agencies on aging have what might be called "guidance centers" where a case manager provides a packaged, comprehensive shopping list, including referrals suiting each individual's needs and care. According to the City of Richmond survey, more than one third of respondents (38%) indicated that they get information through television, about a quarter (23%) use printed resource guides. Whatever the means of outreach, we all must work to help elders to age in place.

A full report of The City of Richmond 2008 Survey of Older Adults, both results and recommendations, is available through the Virginia Center on Aging home page (www.vcu.edu/vcoa/index/richcity_survey08.pdf)

NIA Exercise Guide

For the past few years, the International Council on Active Aging has been part of a National Institute on Aging (NIA) team of experts charged with redeveloping the NIA exercise guide.

Now available online and in print, the 2009 version (**Exercise and Physical Activity: Your Everyday Guide** from the National Institute on Aging) is a valuable educational tool for your clients and staff. To order this free publication or to view/download it, please visit: www.nia.nih.gov/exercise.

Memory Walks across Virginia

The Alzheimer's Association will host Memory Walks in Fredericksburg on September 12th (www.memorywalkfredericksburg.kintera.org), Gloucester on September 12th (www.memorywalkgloucester.kintera.org), and Richmond on October 3rd (www.memorywalkrichmond.kintera.org). The Richmond event will celebrate its 20th anniversary.

"This is our biggest fundraising event of the year. I hope everyone who has a friend or loved one with Alzheimer's will join us in this walk," said Sherry Peterson, CEO of the association's Greater Richmond chapter.

Peterson suggested four ways that people can participate in Memory Walk: form a team of walkers; become a sponsor (opportunities ranging from \$500-\$10,000.); become a Memory Walk volunteer; and donate a service or product to help support the event.

Some 600 Memory Walks will take place across the country this fall. Americans who have participated in these walks in the past have raised more than \$200 million for programs and services to support individuals with Alzheimer's disease.

Richmond-based Genworth Financial Corp. is a presenting national sponsor of Memory Walk.

For more information and to register, call (800) 272-3900 or visit www.alz.org/grva.

ARDRAF Awards Committee Hard at Work

The 2009-2010 ARDRAF Awards Committee met in June to review all proposals and select this year's awardees. Each proposal receives peer, committee, and external reviews. Applicants suggest peers with relevant research experience; Dr. Coogles assigns each proposal to a committee member whose area of expertise aligns with the proposal; in addition, she identifies external reviewers who agree to offer incisive reviews. For this round, reviewers from universities across the U.S., plus Milan, Toronto, Madrid, and Muenster, contributed essential commentary that helped maintain ARDRAF's standing as the finest state-supported dementia research program in this country.



Commonwealth Council on Aging Best Practices Award

The Commonwealth Council on Aging is pleased to announce the winners of the 2009 Best Practices Award Program. As organizations and agencies struggle to meet the challenges of serving a rapidly aging population during a time of budget cuts and growing demand, the Commonwealth needs to share best practices and applaud our successes. The Council's Best Practices Award program attempts to do both.

The Council wishes to recognize and encourage model aging programs throughout the Commonwealth. These programs may be sponsored by local governments, municipalities, community organizations, aging services providers, universities, faith organizations, and public private partnerships. Programs are judged for their innovation, cost-effectiveness, ease of replication, and their impact on the quality of life of older Virginians, their families, and their caregivers. The Council works to disseminate information about these programs throughout the Commonwealth.

For more information about the 2009 Best Practices Awards program, go to the Department for the Aging's website at www.vda.virginia.gov or contact Bill Peterson at (804) 662-9325 or via bill.peterson@vda.virginia.gov.

The 2009 Award winners are:

Community Partnership Category

The Shenandoah Valley Compassionate Pharmacy Program
Winchester. Contact Mary Ann Kirkpatrick, RPh, PhD, Shenandoah University, at (540) 665-1281 or mkirkpat@sua.edu.

Education Category

TechWorld (Students/ Alzheimer's Caregivers Technology Project)
Mountain Empire Older Citizens, Inc, Big Stone Gap. Contact Marilyn Maxwell, Director, Mountain Empire Older Citizens at (276) 523-4202 or mmaxwell@meoc.org.

The Independent Living Project

Fairfax. Contact Catherine Cole, Fairfax Area Agency on aging, at (703) 324-5377 or Catherine.cole@fairfaxcounty.gov.

Healthy Aging Category

The Sunnyside Wellness Center's "Escape to Paris" Motivational Challenge
Harrisonburg. Contact Annie Shaffer at (540) 568-8289 or ashaffer@sunnyside.cc.

Housing Category

Chesterbrook Residences, Inc.
Harrisonburg. Contact Marjorie Lohre, President of the Resident Council, at (703) 534-4103.

Long-Term Care Category

The Southside Geropsychiatric Services
Virginia Beach. Contact Kathleen O'Connor at (757) 385-4202 or koconnor@vb.gov.

Seniors as Volunteers/Resources Category

The Protective Money Management Program

Culpeper. Contact Sallie Morgan, Project Director, Rappahannock-Rapidan Community Services Board/Area Agency on Aging, at (540) 825-3100, Ext 3437 or smorgan@rrcsb.org.

Senior Safety Category

Project Lifesaver International

Chesapeake. Contact Amber Whittaker, Project Lifesaver International, at (757) 328-8973 or awhittaker@projectlifesaver.org.

Jay Speer Receives VERC Award

The Virginia Elder Rights Coalition (VERC) presented its 2009 Award to Jay Speer, Executive Director of the Virginia Poverty Law Center, recognizing his advocating for the rights of low-income people for over 20 years. Jay has counseled individual clients, offered technical assistance and training to legal aid attorneys and other advocates, and sought legislative solutions through the General Assembly. Jay was instrumental in developing the Virginia Partnership to Encourage Responsible Lending and in recruiting diverse groups to join this collaborative effort. Jay worked as a staff attorney at Central Virginia Legal Aid for 13 years and was a charter member of the VERC.

Nominations Sought for Governor's Caregiver Recognition Awards

The Council on the Status of Women is happy to announce the third annual *Governor's Caregiver Recognition Awards*. This award program symbolically honors the thousands of caregivers who lovingly take care of family and friends. Although the award is given to only a few caregivers, it serves to heighten public awareness of the contributions of all caregivers.

Winners will be honored at a ceremony on November 17, 2009, at the Science Museum of Virginia in Richmond.

The nomination form can be downloaded at: www.dss.virginia.gov/community/council_women/caregiver.html. A request to have the form mailed can be made by calling (804) 726-7017 or emailing council.women@dss.virginia.gov.

Completed nomination forms can be submitted as follows:
Council on the Status of Women
7 N. 8th Street
Richmond, VA 23219
FAX (804) 726-7015
council.women@dss.virginia.gov

The deadline for nominations is July 31, 2009.

Serve America Act Will Help with Midlife Career Transitions

John Gomperts reported in McClatchy-Tribune Information Services on the landmark Edward M. Kennedy Serve America Act, which President Barack Obama signed in April. Gomperts considers it "the most inclusive and comprehensive national service legislation in our history," one which will, "for the first time, make national service accessible and inviting for millions who have finished their midlife careers." The following are excerpts from his report.

This quiet revolution starts with a simple reality: People in their 50s, 60s and 70s will need to, and often want to, work longer than their parents did. Half of them, according to a recent national survey, want encore careers that combine income, meaning, and work that matters. The Serve America Act recognizes how tough that midlife career transition is by creating a dazzling policy innovation, something akin to internships for boomers. These "encore fellowships" will provide people 55 and older access to one-year management or leadership positions that will prepare them for jobs in the public and nonprofit sectors. Encore fellowships recognize that people in this stage of life need bridges and pathways to get from one stage to the next. These fellowships may inspire other institutions, such as universities, community colleges, training facilities, to build a thriving marketplace for midlife retooling.

The Serve America Act makes it much easier for those finishing midlife careers to make the transition from work to continued education by tripling the number of AmeriCorps positions and reserving 10 percent of them for organizations that engage people age 55 and older. Moreover, the Serve America Act provides two big, new incentives for individuals over 55 and for organizations that can use their experience to find each other.

First, midlifers who participate in AmeriCorps programs for a full year and earn an education award will now be able to use that money for their own continued education or, for the first time, to transfer that money, more than \$5,000 in tuition, to their children or grandchildren. Second, people over 55 who provide a minimum of 350 hours of service to any accredited community organization will earn Silver Scholarships, which provide them with a \$1,000 education award that can be used for encore career training — or transferred to their children or grandchildren. Perhaps most important, the Serve America Act will stimulate nonprofit organizations to create higher-impact work and service opportunities for those 55 and up, support programs that do enroll older adults, prompt national service programs to recruit more experienced people and encourage the design of programs that take advantage of their talents.

John S. Gomperts is president of Civic Ventures, former chief of staff at the Corporation for National and Community Service (home of AmeriCorps) and former CEO of Experience Corps.

A Reflection on Spirituality and Life Review

by Alexander Tartaglia, D. Min.

There exists an increasing interest in the concept of *spirituality* among medical and health-related professionals. Though numerous definitions of spirituality exist, it can be understood as that which relates to those aspects of life and human experience involving an individual's sense of *meaning and purpose*. Spirituality is fundamentally an existential phenomenon that involves expressions of *ultimate concern*. It seeks to address the questions of life that focus on that which *really matters*. Defined in those terms, spirituality is distinct from *beliefs*, assumptions of truth, or religion, the collective expression of a system of beliefs.

Recent survey data suggest that organized and collective religious practice is on the decline. The new common assumption, however, is that all persons are spiritual although not necessarily religious. If this is the case, learning to identify and discuss spiritual matters becomes an increasingly significant core competency among health care practitioners, as well as other providers of care to older adults.

One of the common interventions of persons who work with older adults as well as the terminally ill is life review. Life review is grounded in both methodological and theological concepts that explore the spiritual in a person's life.

A key methodological concept in

life review is *storytelling*. Used throughout the ages, storytelling is a primary tool of individuals, faith communities, and cultures. Storytelling is at once an individual and a collective enterprise. It is a way of making connections among individuals and between generations. Storytelling connects one's own story to the stories of one's family, one's community, and one's culture. Whether personal or communal, storytelling addresses what is fundamental about human existence:

- *Is the world a safe place? How do I experience the world? How do I respond to life events?*
- *Who am I? From where did I come? Where do I belong? How am I connected to those around me or to humankind?*
- *Am I OK? Do I have the capacity to offer and receive love?*
- *Why am I here? What is my calling? What gives my life meaning and purpose?*
- *What are my values? How am I to live?*

For those experienced in working with older adults, *reminiscence* is well known as a special type of storytelling. Reminiscence is a type of life review typically brought about by the realization of that one's life is at a turning point and that some form of taking inventory is demanded. It may involve recognition of an approaching dissolution, in most cases associated with loss or even death.

Reminiscence may be characterized by the progressive return to awareness of past experience, particularly the revisiting of those aspects of life that remain unresolved. One purpose of reminiscence is to exam-

ine life's regrets and move toward resolution to find new meaning. For some, this may involve reinterpreting life events in a new light. A second dimension of reminiscence is a mental recollection and valuing of one's life. In telling one's story, one can weave together a fabric of how one's life intertwines with LIFE. It makes an historical connection to one's past and allows one to embrace an uncertain future.

The key to reintegration of one's story, of successful reminiscence if you will, is the ability to tie content to feeling and feeling to meaning. Reminiscence begins with events as we remember them (content). It originates as an exercise to recapture the past. One's story generates power as one identifies the affective components that constellate around the content (feelings). The artful processing of one's feelings includes identifying and evaluating the thought process that sparked one's feelings (cognitive reframing). The evaluative process around content and feeling emerges as one seeks to make sense out of the experience (new meaning and self-understanding). The ability to reminisce successfully is indicative of one's capacity for growth and resilience in the midst of life's critical moments.

In the end, *life review* may be understood as a spiritual exercise that focuses on the three Rs of: Reconstruction, Resolution, and Reintegration. Successful completion of life review includes the task of recovery and re-translation through a form of ordered reflection. It brings understanding to the words of Danish philosopher Soren Kierkegaard that life must always

be lived forward, but can only be understood backwards.

Finally, it comes as no surprise to the successful practitioner that successful storytelling is a partnership. It calls for the capacity to “actively listen.” The effective listener hears the content, and then validates not only the feelings and re-interpreted meaning, but, most importantly, the storyteller.

Related reading: Clements, W.M. (1979). *Care and counseling of the aging*. Philadelphia: Fortress Press.

Alexander (Lex) Tartaglia is Associate Dean, School of Allied Health Professions, Virginia Commonwealth University

Women Be Healthy: A Curriculum for Women with Intellectual and Developmental Disabilities

August 27, 2009

9:00 a.m. until 4:00 p.m.

Henrico Training Center
Richmond, Virginia

Would you like to support women with intellectual and developmental disabilities to achieve better health and participate more actively in their health care? If so, this free workshop is for you. This training is designed for women participants.

For more information, contact Monica Uhl at (804) 828-8587 or muhl@vcu.edu.

Family Abuse Protective Orders

Unfortunately, mistreatment does not end as we age. Older Virginians may be abused or threatened by others, even by family members. A protective order is a document issued by a court to help protect us, our children, and other family or household members from someone who is abusing us. A protective order can help to set clear limits with an abuser and send a clear message that abuse is wrong. Protective orders are designed to prevent future abuse and to protect a victim of family violence.

A protective order can only be enforced if the order has been served to the respondent, meaning that the abuser has received a copy of the order and knows it has been issued against him or her. Once a protective order has been served, it is entered into a law enforcement data base called Virginia Criminal Information Network (VCIN), which is available statewide to law enforcement. An entry into the VCIN also means that the abuser is legally prohibited from purchasing a firearm when a background check occurs.

In Virginia, there are three different types of family abuse protective orders that are available when domestic or family violence occurs. To be eligible for these orders, the abuser must be a current or former spouse, someone with whom the victim has had a child, a current or recent (within the past year) boyfriend or girlfriend, or another family member.

Emergency Protective Order.

This is usually requested by a law enforcement officer if an arrest has been made or if the officer believes there is probability of future abuse. Only a Magistrate can issue this order, and it usually lasts a short time, such as 72 hours. A victim of abuse can also make an emergency request for this order at the Magistrate's office.

Preliminary Protective Order.

This order is issued only by a judge when danger exists for further abuse, but there is not enough time for a full hearing with both parties. It usually lasts only 15 days, but can be extended if the abuser/respondent cannot be served.

“Permanent” Protective Order.

This order is issued if there is sufficient evidence of family abuse and both parties are present to discuss the abuse before the court. This order can be issued for up to two years.

All of these family abuse protective orders can prohibit contact by the abuser, prohibit further abuse, and exclude possession of the home by the abuser. Preliminary Orders can also require the abuser to maintain utilities service to the home, grant temporary possession of a jointly owned vehicle to the victim, and provide other relief necessary to protect the victim and other family or household members.

To find a domestic violence advocate in your area or learn more about family abuse protective orders, call the Virginia Family Violence & Sexual Assault Hotline at 800-838-8238 anytime.

Calendar of Events

July 27-31, 2009

Generations United 15th International Conference: Because We're Stronger Together. Washington, D.C. For more information, contact lbradley@gu.org or (202) 289-3979.

August 13, 2009

Sexual Violence in Later Life: Meeting the Complex Needs of Elderly Victims. Richmond. For more information, visit www.vsdvalliance.org.

August 27, 2009

Chronic Disease Self-Management. Presented by the Chesterfield Council on Aging. 9:00 a.m. - 10:00 a.m. Lucy Corr Village, Chesterfield. This presentation is designed to promote healthy lifestyle behaviors and assist people living with chronic diseases to become better self-managers of their own illness. Call (804) 768-7878 to register.

September 24, 2009

The Hidden Epidemic: Alcohol, Medication and the Older Adult. Presented by the Chesterfield Council on Aging. 9:00 a.m. - 10:00 a.m. Lucy Corr Village, Chesterfield. This presentation discusses the "ABC's" of alcohol and its effect on older adults, i.e., the changes in the aging body that increase the effects of alcohol in older adults. The goal of the presentation is to teach risk reduction management and encourage responsible consumption. To register, call (804) 768-7878.

October 22-25, 2009

34th Annual Meeting and Conference of the National Consumer Voice for Quality Long-Term Care. Hamilton Crowne Plaza Hotel, Washington, DC. For more information, visit www.nccnhr.org.

November 6, 2009

Best Practices in Dementia Care. Alzheimer's Association Central and Western Virginia Chapter's 8th Annual Alzheimer's Education Conference. Featuring Marilyn Albert, Director, Division of Cognitive Neuroscience, Johns Hopkins University. Salem Civic Center. 9:00 a.m.- 5:00 p.m.. To register or for more information, call (434) 973-6122 or visit www.alz.org/cwva.

November 15-17, 2009

Changing Times, Changing Strategies: Working Together to Strengthen the Safety Net. Virginia Association of Free Clinics & Virginia Rural Health Association Joint Annual Conference. The Homestead, Hot Springs, VA. For more information, visit www.VRHA.org.



SGS to Meet in Richmond

The Southern Gerontological Society (SGS) will hold its 31st Annual meeting at The Jefferson Hotel, Wednesday, April 7th to Saturday, April 10th, in 2010. The meeting theme is *Applied Gerontology as Community Engagement*.

SGS's annual meeting attracts academics, policy makers, providers in health care, social services, and other direct services, and others committed to the quality of later life. The Society aims to bridge and interconnect researchers, educators, and practitioners, with the annual meeting being a focal point for interactions. SGS will issue a Call for Presentations shortly. For more information about The Jefferson, visit www.jeffersonhotel.com.

Age in Action

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Edward F. Ansello, Ph.D.
Director, VCoA

Linda Nablo
Commissioner, VDA

Kimberly S. Ivey, M.S.
Editor

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**Fall 2009 Issue Deadline:
September 15, 2009**

Virginia Center on Aging

at Virginia Commonwealth University, Richmond, Virginia

www.vcu.edu/vcoa

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