

Caregiver's

HOME COMPANION

Volume 3 Issue 9 | March, 2005

H E L P I N G T H O S E W H O H E L P O T H E R S

Aging in Place

How Reverse Mortgages Help Elderly Stay in Their Home

By Donna C. Moss, Associate Editor



So you're over 62 and you love your home, but your income is only holding steady, if not dropping, and it's certainly not keeping up with inflation. Like lots of older Americans, you want to live to the end of your days in your own home. But can you afford to?

Take my 93-year-old grandmother who lives alone in her home, by choice. Even though once socially outgoing with a vibrant intellect, she can barely recall what she does from one minute to the next. Yet she prefers her "creature comforts" of home to living with "strangers" in a group setting or nursing home.

What's the answer for the millions of Americans who fit this and similar descriptions? For some, the answer is a reverse mortgage—a financing tool for the elderly to use equity built up in their home to pay their living expenses as seniors in the United States live longer and longer, often outstripping their pensions and other sources of living income.

Just how does a reverse mortgage help in this instance? By acting as a loan against the equity in the home, a reverse mortgage provides tax-free cash advances, but requires no payments during the term of the loan. Since there are no monthly payments during the life of the loan, the balance grows larger and the equity gets smaller.

The loan is not due and payable until the borrower no longer occupies the home as a principal residence; e.g., when the last surviving borrower sells, moves out permanently or passes ▶

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Subscriptions

Print: \$29.95 per year (U.S.)
Online: \$19.95 per year (U.S.)

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Caregiver's Home Companion

is published monthly by:

Pederson Publishing, Inc.

P.O. Box 693,

Southport, CT 06890-0693

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Caregiver's Home Companion is produced by caregivers and professional healthcare workers. While this publication is not intended as a substitute for professionally administered medical advice, the practical suggestions, advice and tips made in this newsletter have been tested or reviewed by an individual or organization involved in caring for elderly other loved ones. *Caregiver's Home Companion* also strives to obtain the input of educators and researchers in all branches of medical and scientific research. We welcome your comments and suggestions at editor@caregivershome.com.

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away. The borrower must be at least age 62 and own their home or condominium in order to qualify for a reverse mortgage. There are no income or credit requirements to qualify.

Reverse mortgage proceeds are available in a variety of ways: monthly payments to the elderly, as a lump sum amount, a line of credit—or a combination of these methods. The cost of getting a reverse mortgage is similar to those for a traditional mortgage. There are typically loan origination fees, appraisal and inspection fees, title policy, mortgage insurance and other common closing costs. And, like a traditional mortgage, these costs can be financed as a part of the mortgage.

Introduced in the late 1980s by the federal Government, reverse mortgages can help homeowners who are “house rich, but cash poor” remain in their homes and still meet their financial obligations. This is an especially important program not only for the elderly, but their adult children and other family members who in other situations would have to scrape from their own income and savings to care for their loved one.

Most homeowners understand traditional, or “forward,” mortgage basics. It goes like this: A mortgage company loans you money to purchase your home. As you pay your monthly interest and principal payments, the equity in your home increases and your debt decreases.

But when homeowners remain in their homes, retain the property's title, and receive tax-free funds without making monthly repayments, this is called a reverse mortgage. It may also be considered a zero-payment home loan, since no monthly mortgage repayments are required.

With a traditional mortgage, you begin with a large amount of debt and very little equity. Through the years as you make monthly payments, your debt decreases as your equity (appreciated cash value of your home) increases. As you pay your mortgage, the cash spent to pay down your mortgage—plus the increase in general home valuation—transforms into equity. However, this equity does not translate to cash until the home is sold or refinanced with a home equity loan.

But as the name implies, a reverse mortgage is just the opposite of a forward mortgage, converting homeowner equity into cash. Since the owner retains title to the home throughout the life of the reverse mortgage, they own the home, not a bank or mortgage lender. And, they will never owe more than the value of their home because the amount due can never exceed the home's value. In most markets, home value continues to rise as the elderly continue to live in the house—and live off the reverse mortgage proceeds.

Proceeds from a reverse mortgage can be used for virtually anything:

- daily living expenses
- home repairs and home improvements
- medical bills (a main reason for personal bankruptcy in America) and prescription drugs
- pay-off existing debt
- education or travel
- long-term healthcare
- retirement and estate tax planning
- gifts to children or grandchildren

For some, this sounds too good to be true. But according to Vice President of Bank of New York Mortgage Company Joseph DeMarkey, in Westchester County, New York, it's a matter of public perception at this point. The number one fear or myth, he says, is that “people think the bank will take your house.” This is simply not true, he adds: “It's just a loan. Even Donald Trump takes loans.” When the owner dies, the loan must be repaid by surrendering the home or assets equal to the “mortgaged” amount.

When I spoke to Mr. DeMarkey, I asked why more seniors weren't doing this. Well, they are! According to DeMarkey, since 2001 the program has grown nationally by five times—from about 6,000 loans per year to about 36,000 loans per year. Still, this is a drop in the bucket of opportunity for seniors.

This also is one of the only programs in which the consumer must have a government approved free counselor (from the Department of Housing and Urban Development—HUD) before signing up. If the elderly person is unable to understand, given advanced illness or Alzheimer's disease, for example, they can have a caregiver with power of attorney handle the transaction for them.

Finally, DeMarkey says, “It's obviously not a good step if you want to leave the kids your house free and clear. However, to “Age in Place,” as the phrase implies, is not a bad thing, in the end. ■

READER RESOURCES

For more information, consult with a family legal advisor or www.aarp.org/revmort

Mortgage dictionary
www.mortgage-net.com/reference/dict/

Federal Trade Commission
www.ftc.gov/bcp/online/pubs/homes/rms.htm

Free consumer information for senior
www.seniorjobbank.org/rm/index.html

A Caregivers' Guide to Taxes

By Marney N. Emel, CPA

As if caregivers didn't already have enough on their plate, it's tax time. What can a caregiver expect from Uncle Sam in the way of tax consideration related to their elder-caregiving duties? After all, caregivers don't provide only emotional support—financial support is often a key component.

Therefore, while no one can justifiably place a monetary value on all that caregivers do, during tax time it is important to know which expenses can be deducted. Let's look at the possibilities.

Dependent Test

Before filing a tax return, caregivers should determine if the person they are caring for can be claimed as a dependent. To do so, five simple tests must be met:

Support: The caregiver must provide more than 50% of the total support. Items included in support are food, lodging, clothing, medical, dental, recreation, transportation and other necessities. If several adult children are helping to care for the person, a "multiple support agreement" (IRS Form 2120) must be filed. This allows a family to designate which of the caregivers will claim the care recipient as a dependent.

Gross Income: The elderly dependent's gross income must be less than \$3,100 for the full year. Gross income does not include tax-exempt income, such as certain Social Security benefits and municipal bond interest. However, gross income does include receipts from rental property not reduced by the repairs, taxes or other expenses of the rental property.

Citizenship: The dependent must be a resident or citizen of the United States, Canada or Mexico.

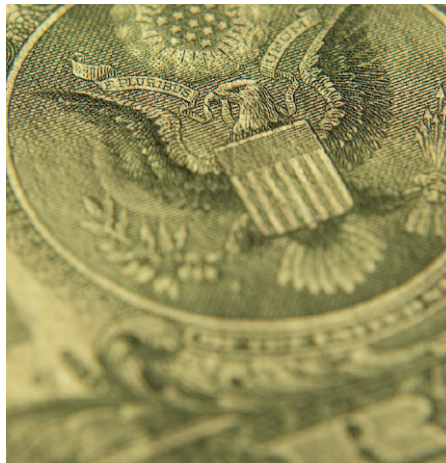
Joint Return: You cannot claim the elderly person as a dependent if they filed a joint tax return with his or her spouse.

Relationship: The senior dependent must live in the caregiver's household for the entire year or be related as a parent, grandparent, aunt, uncle or father/mother-in-law.

Even if the caregiver fails to meet any of the above five dependency tests, they still may be entitled to claim medical expenses paid on the dependent's behalf.

Deducting Medical Expenses

Caregivers who itemize their deductions may deduct medical expenses paid for a dependent, regardless of whether that person qualifies for a dependency exemption. Medical expenses for a dependent parent or relative whose annual income



exceeds \$3,100 are deductible to the extent that the expenses exceed 7.5% of the caregiver's adjusted gross income (AGI).

Medical expenses can be deducted for any person for whom the caregiver paid more than half of that person's support. If the person is not a relative of the caregiver, he or she must also have lived with the caregiver for the entire year in order for the expenses to qualify.

The IRS's 31-page Publication 502 offers a complete list of qualified medical expenses. Generally speaking, deductions that can be claimed must help relieve a specific ailment and must be prescribed or advised by doctors.

The following is a general guideline for medical deductions.

- These Expenses Are Deductible:
 - Medical prescriptions.
 - Uninsured medical costs (e.g., cataract surgery, false teeth and artificial limbs).

- Special equipment installed in the caregiver's home or improvements that provide a medical benefit for the dependent.
- Doctor-recommended humidifiers, hearing aids and batteries, wheelchair expenses (or rentals), eyeglasses or eye surgery.
- Nursing care, wages, employment taxes and other amounts paid for a dependent's care. (However, the main responsibility of the person hired must be to care for the dependent, not to do other household chores or maintenance work.)
- Medical mileage, which includes travel expenses to and from medical treatments, can be deducted at 14 cents per mile.
- These Expenses Are Not Deductible:
 - Non-prescribed vitamins and herbal medicine (for example, non-prescribed supplements that help Alzheimer's patients with memory loss).
 - Improvements to the house that aid the dependent's comfort and do not serve any medical purpose (for example, adding a window to a bedroom).

Maintaining Records

It is important to maintain and keep complete records to substantiate deductions. Keep documentation of the person's medical condition, written advice from the physician about the need for capital improvements to the home and other medical expenses, as well as receipts for all claimed deductions. Remember, even if you do your homework, the IRS may still challenge your deduction.

Of course, each caregiver's tax situation is different, and this article provides only a general guideline to tax preparation. For clarification or specific questions, contact your accountant. ■

Marney N. Emel, CPA, is a tax manager for Geller, Ragans, James, Oppenheimer & Creel, an Orlando, Florida-based accounting firm. She can be reached at memel@grjoc.com.

Nutrition through a Needle or Tube

The Lifesaving Challenges of Parenteral and Enteral Nutrition

By Sharon Palmer, RD

Today when a person is unable to eat any or enough food for nourishment, there's a high tech solution waiting around the corner—parenteral and enteral nutrition, sometimes called PEN. Quite simply, without PEN, many people—especially the elderly—would die. In fact, there are thousands of people walking the streets across this country today who maintain a full, successful life with the aid of PEN.

PEN has come a long way since the days in Ancient Egypt when enemas of wine, milk, barley broth and whey were used to feed people. Parenteral nutrition (PN), or total parenteral nutrition (TPN), is a special mixture of nutrients streamed into the blood with a needle through a vein. The mixture contains all of the protein, sugars, fat, vitamins, minerals, and other nutrients needed by the body.

Enteral nutrition (EN), or tube feeding, delivers a thicker mixture of nutrients that resembles milk in appearance. It is delivered through a tube inserted into the stomach or small intestine. Current estimates place the number of people in the United States relying on EN to be 176,000 and 46,000 on PN.

There are many reasons why people may not be able to receive adequate nutrition through eating. They include Crohn's disease, motility disorder, cancer, AIDS, defects, trauma, stroke, obstructions, cystic fibrosis, ulcerative colitis, or short bowel syndrome. Sometimes PEN is a temporary solution to inadequate nutrition, while other times it becomes a life-time regimen.

Sharon Palmer is a registered dietician who has managed healthcare food and nutrition departments for 16 years. She is a member of our Board of Experts in our online Ask an Expert section and can be reached at spalmer952@earthlink.net.

The elderly are the most frequent consumers of PEN. While the medical reasons that PEN is administered may occur at any age, PEN is more common among elderly, as is malnutrition. Aging may be associated with a host of reasons that makes oral intake difficult, such as difficulty swallowing, poor appetite, poor dentition, confusion, and gastrointestinal difficulties.

The caregiver may be faced with many challenges when PEN becomes a necessity for their loved one. Unfortunately, caregiver burnout is common with PEN consumers. In a recent study reported last year in the *Journal of the American Dietetic Association*, caregivers reported providing a mean of 61.87 hours per week of caregiving tasks for older adults on home EN, and an average of 19.73 caregiving tasks per day.

There are many issues involved in home administration of PEN. The first is learning how to administer the nutrition. Many caregivers wake up to reality when they realize that a nurse won't be stopping by each day to handle the feedings. Typically one to three home nursing visits are required during the first week of home EN, at which point education of the caregiver and patient is usually completed and the patient will be discharged from services.

For home PN consumers, caregivers are usually taught by homecare nurses how to administer the therapy over a period of two to three days. Afterwards, the homecare nurse usually visits once per week for site care and lab work.

As if the added tasks of home administration of PEN were not strenuous enough, plenty of people need to be concerned about the cost of the therapy. EN is less expensive than PN, but it is still more costly than food. People with private



insurance may not have full coverage for all of the equipment and supplies needed for EN, while most state Medicaid programs tend to cover them with appropriate paperwork.

Medicare covers EN only if specific criteria are met. Enteral formulas are available through local meal delivery programs, cancer societies, mail order, discount pharmacies, and buying clubs. Specialized enteral formulas are available for various health conditions, which are usually more costly than traditional for-

FINDING SUPPORT FOR HOME PEN CAREGIVERS

The Oley Foundation was established with private funding in 1983 to address the unique needs of patients, professionals, and caregivers faced with home PEN. The foundation was established with goals for outreach, education, and research. They aim to enrich the quality of life for those on home PEN.

The foundation provides a bi-monthly newsletter, annual conferences, regional gatherings, a toll-free hotline, information clearinghouse, complication charts, video library, online articles, and a national network with volunteers providing support, telephone consultation, networking, and outreach activities. A recent study outlined the positive impact Oley services may have on the overall well-being of those dependant upon home nutrition support.

If you are a caregiver seeking support to face the challenges of home PEN, log onto the website and read some of the amazing stories of Oley members who have survived insurmountable obstacles thanks to home PEN and Oley. Visit www.oley.org or call 800-776-6539.

mulas. Private insurance and Medicaid criteria for home PN vary based on individual policies, but they usually cover it if it is medically indicated and all the necessary forms are completed. Overall, caregivers will find times when coverage may be only 80–90%, leaving a substantial portion for the patient when TPN costs upwards of \$200 a day. Medicare part B covers 80% of approved costs for PN with specific criteria.

The care and monitoring of PEN may become exhausting. While most home EN consumers prefer to cycle the formula during the day, many home PN patients cycle the infusion at night over 8–14 hours. Devices are available to help secure tube feedings in place. Tube feedings also tend to get clogged, typically because of administering medications through the tube without adequate flushing. Gastrostomy tubes may leak at the point they meet the skin.

Ongoing nutrition assessment and monitoring for nutritional adequacy, hydration, and tolerance of the home PEN consumer is very important. A certain amount of visual acuity, physical strength

and manual dexterity is needed to administer PN solutions, operate the PN pump, and care for the catheter. A safe, clean home environment for PN consumers is essential to avoid infection and other complications.

On top of all of these tasks, caregivers must be aware of the social and emotional impact of having a PEN consumer around the house. Eating brings with it much more than a collection of nutrients. For example, you may suddenly find one less plate at the dinner table, which presents a multitude of difficult emotions.

When you come home from the hospital with your new PEN plan in place for your loved one, don't go it alone. Choose a homecare company provider with a clinical staff specially trained to oversee the care of the PEN patient and not only a staff of clerks and delivery personnel who check on your supply needs. Some provide nutrition oversight that tracks formula tolerance, weight and progress. Make sure you select a PEN plan that is the easiest on you as caregiver and the best for your loved one. And make sure you get support from organizations like

the Oley Foundation (see sidebar page 4). PEN isn't a death sentence; for many it brings a new chance for life. ■

COMING UP IN APRIL

- The doctor suggests a new drug to help your loved one. But is it safe? With the recent consumer wake-up calls over harmful drugs, **how can a caregiver assess value and risk of new medications for their elderly?**
- **When our parents die**—can we really be prepared for the role of “orphaned adult?”
- **Whether caregiver or elderly, a regular exercise routine can extend your life.** Learn the importance of fitting this lifesaver into your crowded routine.
- **Caregiver journaling**—a liberating and positive way to deal with stress and avoid burnout while recording feelings and experiences, privately or to share with others.

Asking Experts for Caregiving Advice

(Editor's Note: Caregiving often presents thorny questions or issues that are not easily answered for caregivers. To help caregivers navigate their challenging role, our Board of Experts, respected professionals representing many caregiving disciplines, address these issues for readers who submit their questions in the Ask an Expert section of our website at www.caregivershome.com. Here is a sampling of issues and answers.)

Mother-in-Law Wants to Go Home

Q. My 72-year-old mother-in-law has been staying with us for over a month until my husband and his siblings decide on the next move for her care. She has always suffered from chemical depression and social anxiety, and now she is suffering from dementia making it impossible for her to continue to live by herself safely.

It has been very hard having her with us because she is constantly crying about wanting to go home, and in her mind she is capable of taking care of herself. She does not understand that she forgets what she is talking about mid-sentence or that she would never change her clothes or

bathe if we were not helping her, not to mention eat properly and take her meds.

What is the best way to deal with this? Is it appropriate to tell her straight up that she has dementia and needs to be taken care of?

Liza F., Los Angeles

A. I always believe aging in place is the best approach. If she is functional and has the resources for a companion to stay with her at home, she should do that as it would be the best environment for her well-being. Transitions are very difficult for the elderly, and living in your house is not only a transition, but also a conscious reminder of dependency with the possibility of never returning home.

I don't think telling her she has dementia will help her understand her behavior any better. You never mentioned any medical intervention that she has had, but I always suggest a work-up by a gerontologist (physician specializing in the care of the elderly) because the treatment plan from that level of expertise could raise her quality of life.

This answer has been provided by Dr. Tara A. Cortes, the Senior Vice President for Patient Care Operations and Chief Nursing Officer at Bridgeport Hospital in Bridgeport, Connecticut, and Clinical Professor at Yale University in the School of Nursing doctoral program. She can be reached at atcort@bpthosp.org.

continues on back cover



A Caregiver's Dilemma: Answering Life's Hardest Questions

By Dr. Kenneth J. Doka

Thomas was in a persistent vegetative state for months before the nursing home approached his wife, Elena, about removing the feeding tube. She struggled with her decision. Could—should—she remove the feeding tube that sustained her husband?

Meanwhile, Joe faced a similar issue. His wife has severe dementia. A few days earlier she suffered a hard fall and then a stroke. Connected to a nasogastric tube through her nostrils used to provide nutrition, she now has to be physically constrained so she will not yank out the apparatus. Joe has approached the hospital ethics committee about removing the tube.

Decisions such as these—to withdraw and withhold artificial nutrition or hydration—are daily dilemmas faced by caregivers. Food and water seem, after all, to be so basic. Is it ethical to withdraw such services? Is that not letting someone starve to death? The questions themselves carry a heavy weight; the answers are equally heavy.

In many ways, such decisions are a result of the increasing technological achievements of medical care. Years ago, this dilemma would not be an issue. If the person were not able to feed himself or herself, or at least be able to be fed, there were few options. The ethical issue would never be raised.

As Elena and Joe struggle with these decisions, they may wish to consider a few things. First, they may wish to question the benefit. We often think of food and water as sources of basic, compassionate care. However, when bodily systems are shutting down, the body may not be capable of effectively dealing with this increased stress. Artificial nutrition and hydration, then, may not be palliative, or they may make the patient less rather than more comfortable. One has to be careful not to equate the experiences of a dying person ebbing into death with that of a healthy person who is hungry or thirsty.

Moreover, Elena and Joe may need to know exactly what is involved. Artificial hydration is not simply a nurse or nurse's aide sitting by the bedside, gently spooning food and sips of water into a near comatose patient. Food is administered through a nasogastric tube that enters the nose and is fed into the stomach. This invasive procedure—and the possibility that physical restraints are required to insert and maintain such technologies—may carry their own risks and increase pain and discomfort. This was a surprise to Joe when he was first asked to approve such a procedure. Assessing the benefit of such treatment is a critical first step in deciding on a course of action. What will this action accomplish? What is the goal? Will it truly extend life or merely prolong dying?

It is, however, not the only step. Both Joe and Elena have to examine their values and beliefs. Religious faith and spiritual beliefs vary in how each tradition understands such choices. Each person has their own personal ethical stances framed by their experience and beliefs. These, too, need to be honored. For some individuals there is no moral difference between the technologies used in artificial feeding and hydration and other end-of-life technologies. Patients and their surrogates have the right to refuse such treatment, to withdraw and withhold such treatments under certain conditions.

Others might disagree. These individuals may believe offering food and water, by whatever means, constitutes basic human care. They would not be comfortable with the idea that a patient “starved” to death. Others may fear that such actions are a slippery slope that allows even more active steps to end a life.

These conflicting perspectives are not easily reconciled. While withdrawing or withholding hydration and artificial nutrition has been upheld by the courts and is consistent with many professional codes of ethics, it still generates debate.

Whatever the decision, caregivers may wish to really review the effects of the choice not only on the patient but on themselves and others. Will certain decisions cause family conflict? What might be the effect of different actions on one's own grief or the grief of others?

The point is that caregivers have to be comfortable in their decisions—reaching them in their own personal way and time, perhaps incorporating the perspectives and beliefs of other family members. Sometimes the decision can be not to decide—to wait a specified time and to reconsider based on the realities of that moment.

Caregivers may wish to consider the beliefs, values and wishes of the patient. Does the patient have the capacity to contribute to the discussion? Do advance directives offer a guide to the wishes of the person? Did he or she ever offer opinions? Such discussions may not only serve to illuminate the desires of the patient; these conversations also may assist in developing a family consensus on the most appropriate actions.

Others may offer support, information and opportunities to explore and discuss these ethical dilemmas. Medical professionals can offer another gift beyond information, support and opportunities to discuss options. They can offer time. It is important to allow caregivers the time to decide—to weigh all alternatives and discuss possible courses of action—perhaps even the time to reach a consensus with the patient's family or intimate network. One should not rush this process. For in the end, it is the caregiver who has to be personally comfortable—and at peace—with the course of action selected. ■

Dr. Kenneth J. Doka is a professor of gerontology at the Graduate School of the College of New Rochelle in New York and a senior consultant to the Hospice Foundation of America. He has edited 17 books, including the Foundation's Living with Grief series. Dr. Doka can be reached at kndok@aol.com.

Recognizing and Avoiding Caregiver Depression

By Jacqueline Marcell

When I had to give up my life to care for my elderly parents, both of whom were developing dementia, I was so surprised to learn that caregivers are more often depressed than those they care for, and that they have a 63% higher death rate than their peers. A year later, without a single day off, I was surprised the statistic was so low.

Researchers have found that a person who cares for someone with dementia is twice as likely to suffer from depression as a person providing care for someone without it. Since more than 4.5 million people in the United States are afflicted with Alzheimer's (just one form of dementia), and 7 out of 10 are being cared for at home by family and friends who provide nearly 80% of their care, millions of family caregivers are coping with depression or are at great risk of developing it.

Depression often occurs when caregivers become overwhelmed managing numerous responsibilities for an ailing family member or friend. The resulting feelings of sadness, loss, isolation, anxiety, exhaustion, anger and – finally — the guilt for having those feelings, can exact a heavy toll. Oftentimes caregivers are so inundated with responsibilities they sacrifice their own careers along with their own physical and emotional needs (even ignoring their own medical checkups), resulting in their own ailments going undiagnosed and treated.

Therefore, it's critical for caregivers to recognize that they are at great risk of developing depression and/or a serious ailment, and that they need to seek consistent and dependable support as soon as they begin their caregiving journey.

This point simply cannot be over-emphasized; it is bedrock to successful caregiving and caregiver well-being.

However, family members often don't even think of themselves as "caregivers." They feel they just need to toughen-up. And even though the stigma of seeing a doctor for depression is lessening, many feel it is a sign of weakness. They feel they will eventually snap out of it on their own. A National Mental Health Association survey found that 41% of the women surveyed cited embarrassment or shame as the reasons they avoided seeking treatment.

Caregivers who regularly attend support groups typically report lower levels of depression and anger. Creative solutions and coping strategies start to present themselves during brainstorming sessions with other caregivers who are going through similar experiences.

Also, the use of adult day healthcare for loved ones provides specific hours of respite for an overwhelmed caregiver and is often the very best thing for the patient. Their day is filled with social interaction and fun activities with professionals who are trained to work with them. Additionally, by the end of the day, the activities usually tire the patient, turning around "sun-downing," where elderly people sleep all day but are up all night. Once the patient sleeps regularly through the night, the family caregiver will finally be able to sleep as well.

By becoming aware of the risk of depression and giving attention to the earliest symptoms, caregivers may be able to lessen the severity and duration of an episode. Regular exercise, a healthy diet, a caregiver support group, positive self-encouragement, focusing on the

present rather than the decline of a loved one, and the help of a supportive mental health professional are ways to reduce depression or avoid it entirely. ■

Jacqueline Marcell is an author, publisher, radio host, national speaker, and advocate for eldercare awareness and reform. Her writing includes Elder Rage, or Take My Father...Please! How to Survive Caring For Aging Parents. For more information, see www.ElderRage.com.

SIGNS OF CAREGIVER DEPRESSION

Look for these warning signs of your own depression while caring for your loved one. If you see yourself in any of these, seek professional attention quickly.

- Feeling tired most of the time, lethargic, uninspired
- A change in eating habits resulting in unwanted weight gain or loss
- A change in sleep patterns—too much or not enough
- A loss of interest in people and activities that had been pleasurable
- Becoming easily agitated, anxious, angered, frustrated, overwhelmed
- Feeling that nothing you do is good enough
- Persistent "what's the use" thinking
- Thoughts of death or suicide
- Ongoing physical symptoms that don't respond to treatment, such as headaches, digestive disorders and chronic pain



Asking Experts for Caregiving Advice continued from page 5

Clearing Away Mom's Clutter

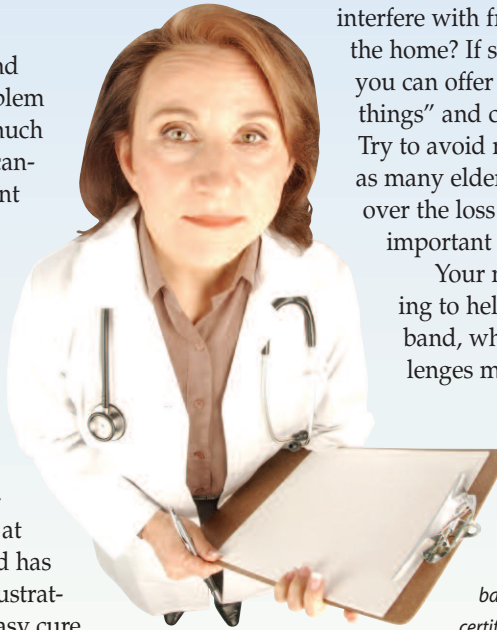
Q. My 80-year-old mother lost her husband last August. She has always had a problem with collecting everything. Now it is much worse without my father there to temper it. She cannot throw out anything and has gotten to the point where the house has seating only for her. The kitchen table has an area clear just for meals.

It is a sensitive problem, and we need advice. How do we go about clearing the house of unneeded debris she thinks she needs to save? Does she need counseling?

Penny L., North Barrington, Illinois

A. What you describe is a relatively common problem for many elderly people. Lifelong patterns tend to crystallize at this time of life, and the recent loss of her husband has strengthened this habit. Although this is a very frustrating thing for the family to deal with, there is no easy cure.

Safety factors must be considered. Does the clutter



interfere with free and safe movement about the home? If so, action must be taken. Perhaps you can offer your assistance in “going through things” and clearing away unnecessary items. Try to avoid making any big or sudden changes, as many elderly individuals will actually grieve over the loss of what they consider to be important possessions.

Your mother might benefit from counseling to help her deal with the loss of her husband, which would enable her to face challenges more effectively. I doubt, however, that the counseling would have much impact on her habit of accumulating things. ■

This answer is provided by Paula P. Tchirkov, MSW, LSW, ACSW, president of Pittsburgh-based Allegheny Geriatric Consultants and a certified and licensed geriatric care manager. She can be reached at Paula@caregivingadvice.com.

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