PSYCHOTHERAPY WITH OLDER ADULTS:
The Multiple Realities of Aging

America is coming of age…*older age*, that is. By 2030, the number of Americans 65 and older is projected to double, reaching 70 million and comprising 20 percent of the population (Associated Press, 2004; Matteson, 2008; McMunn, et al, 2006). Thus, our attention as a culture is steadily becoming more focused on this phenomenon we call "aging." It is a *zeitgeist* – a spirit of the times – not because no one has ever gotten older before. Obviously. But now, we as a culture experience ourselves as "getting older" because a strong segment of the population are together going through the later years of life. Baby boomers, those born between 1946 and the early 1960s, are now reaching their 50s and 60s. The boomer generation – often described as an empowered self-focused cohort – is demanding that social attention be given to them and the issues of "aging" like never before. I place "aging" in quotations, however, because it is not a definite fixed phenomenon in and of itself. Instead, getting older is an experience filled with diversity, "a lifelong process commencing at the moment of conception" (Achenbaum, 1998, p. 1). The diverse experiences of aging reflect multiple internal and external factors – patterns of experience evident in emotional well-being, physical health, and socio-economic conditions. Recognizing these diverse and complex presentations provides a pivotal key in psychotherapy with older adults.

This paper explores various perspectives on aging and psychotherapeutic approaches toward working with older adults. It establishes a general context by discussing the individual and collective impact of ageism. The paper then provides a theoretical overview of three orientations as applied toward older adults: the Loss-Deficit model, the Contextual Cohort-Based

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Maturity/Specific Challenge model, and Process Work (also known as Process-Oriented Psychology). General adaptations for psychotherapy with older adults are considered, as well as clinical methods aimed at deepening experience regardless of age. Special attention is given to somatic methods for working with clients at various points on a continuum of consciousness.

Ageism

Entering into the discussion of "aging" is complex. Usually assumed to be merely a biological reality, aging actually reflects a psycho-social process highly dependent on multiple factors of experience, including cultural and generational values, gender, education, and socio-economics (Achenbaum, 1998; McMunn, et al, 2006; National Council on Aging, 2002). The field of gerontology is a growing specialization which addresses social, psychological, and biological aspects of aging. Such special attention to issues of aging undoubtedly expand clinical knowledge and the ability to respond to the needs of aging populations. At the same time, it is important to consider the negative stereotypes generally associated with growing older and the powerful consequences of such associations. In other words, viewing individual and life experiences through the frame of "aging" automatically raises the issue of ageism.

Ageism is a term coined by US gerontologist Robert Butler in 1969, used to describe stereotyping, prejudice, and discrimination against individuals or groups because of their age (Associated Press, 2004). Butler describes that "daily we are witness to, or even unwitting participants in, cruel imagery, jokes, language, and attitudes directed at older people" (Associated Press, p. 1). Aging – in both language and culture – has become equated with deterioration and impairment. Such negative stereotypes have social, psychological, and physiological consequences.

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When a culture worships youth and gives priority to efficiency and speed, we marginalize other aspects of our experiences – such as slowness, dependency, altered states, and anything that brings us close to death. These other experiences are then denigrated, sometimes idealized, projected onto "the old" and suppressed within ourselves (Achenbaum, 1998; Mindell, 2004). We then hold these experiences at bay, along with the people who fit the category. Ageism translates into job discrimination, how we perceive and relate to others, how we feel about ourselves, and our actual longevity. Research by the Yale School of Public Health indicates that "old people with positive perceptions of aging lived an average of 7.5 years longer than those with negative images of growing older" (Associated Press, p. 1). Recognition of the powerful impact of social and internalized ageism becomes essential for psychotherapists when approaching the conversation of "aging" and integral to process of working with clients, especially if they are perceived as and/or see themselves to be "older adults."

The Loss-Deficit Model

Gerontology emerged out of a field of practitioners working with the problems of frail elderly. Current perceptions of and attitudes toward aging thus reflect these historical roots, whereby the problems of a select segment of older populations are generalized to aging adults as a whole. Knight (2004) refers to this orientation as the loss-deficit model of aging, "which portrays the normative course of later life as a series of losses and the typical response as depression" (p. 5). The common beliefs and attitudes that go along with the loss-deficit model can be summarized as: aging, fragility, and illness are basically synonymous and inevitable, thus should be accepted as the norm, along with the emotional distress people experience in old age. Consequently, these beliefs and attitudes inform the approaches toward working with adults,

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viewing therapy and social services for the elderly as meant to "assist in their adjustment to the natural losses of late life and grieving for them" (p. 21).

Knight argues that such an orientation fails to recognize that loss is not unique to older adults, but rather can occur throughout life. Consequently, disease and disability should not be normalized as typical and inevitable for the aging process. As noted in the discussion on ageism above, specific problems become attributed to age itself, rather than recognizing and responding to underlying illness, psychological disorders, severe life stress, and socio-economic conditions (Knight, 2004; McMunn, et al, 2006). In addition, by focusing only on acceptance and coping, the loss-deficit model limits the possibility of optimizing functioning and improving life experience.

The Contextual, Cohort-Based, Maturity, Specific-Challenge Model

As an alternative to the loss-deficit model of aging, Knight (2004) proposes the Contextual, Cohort-Based, Maturity, Specific-Challenge (CCMSC) model. This model recognizes that multiple co-existing factors contribute to the experiences of aging. Approaching psychotherapy with older adults with this recognition in mind brings a more comprehensive understanding to life changes, and respects the diverse and specific nature of experiences influencing a client's reality. The CCMSC model acknowledges that over time the body's decreased capacity for repair can accumulate as damage and increased susceptibility to disease. However, decline is not synonymous with getting older. Knight addresses the psychological consequences of aging, yet emphasizes the positive aspects within the life development process, challenging the stereotypical frame through which older adults are commonly viewed and see

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themselves. In recognition of these potential changes, the CCMSC model also considers adaptations that may be useful for psychotherapists working with older populations.

Maturity

As people age, cognitive processes typically slow down (Knight, 2004). Perception, reaction, and attentional capacities all appear to decrease over time, as well as working memory, which specifically relates to the processing of new information. Matteson clarifies that "forgetting does not increase with age, but learning takes longer…more repetitions are necessary…and retrieval speed decreases, but accuracy doesn't" (2008, Personal Communication). Changes in recognition memory start early and shift gradually over time. However, it is interesting to note – and particularly useful for psychotherapists – that little difference in memory performance exists for older adults when the information is personally relevant and emotionally meaningful and they are motivated to learn (Knight, 2004). Knight also explains that there are "large individual differences among older adults on learning and memory abilities, and many older clients will be at least as able as younger adult clients" (p. 9).

Dementia and cognitive dysfunction due to other health problems are often misattributed to older adults in general. While the speed of processing and inferential reasoning may slow in older adults, the contents of intelligence generally remain constant until old-old age; and in some, intellectual ability improves over time (Knight, 2004). "Expert knowledge" gained through life, work, and family experiences also reflects a valuable gain through maturation. Greater complexity of thinking often seen in older adults points toward qualities of the post-formal stage of cognitive development, such as "dialectical thinking, an appreciation of the truth of ideas depending on context as viewpoint, and the ability to perceive that two opposing viewpoints may each have elements of truth in them" (p. 11).

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Considering the impact of aging on personality characteristics and emotions, personality becomes increasingly stable with age for men, whereas women tend towards marked reorganization in later years (Knight, 2004). However, both genders lean towards increasing androgyny with age, possibly signifying an organic liberatory potential from sexism and constrictive sex role stereotypes. And finally, aging appears to bring increased self-knowledge, a more complex understanding of self and others, less emotional extremes, and a greater ability to regulate emotion (Ibid).

Adaptations due to developmental changes may include the need to modify communication style by slowing down and relying less on inferential reasoning abilities. It will also benefit both psychotherapist and client to recognize the greater maturity of older adults: learn from the client's expertise based on life experience, enhanced cognitive and emotional complexity, and assist him or her to recall already existing strengths and abilities to cope.

Cohort Differences

Older adults are not all the same. This may seem obvious. However, as discussed above, stereotypical ideas of what it means to be "old" are often generalized and attributed to all who have grey hair and wrinkles, or are above a certain age. Depending on one's own age, "old" actually becomes incredibly relative. A psychotherapist's understanding of older adults' experiences becomes diluted without considering the *generational sub-culture* in which they were born. Individuals differ based on cohort membership. As Knight (2004) describes,

> Cohort differences are explained by membership in a birth-year-defined group that is socialized into certain abilities, beliefs, attitudes, and personality dimensions that will stay stable as the group ages and that distinguishes that cohort from those born earlier and later (p. 15).

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These differences appear as generational tendencies according to the particular values, common knowledge, and cultural trends of the time. For example, cohort differences can be seen in: intellectual skills (verbal fluency of older cohorts vs reasoning ability younger cohorts); personality (increased extroversion since World War II and greater threat reactivity since the beginning of 20th century); and worldview (note changing awareness regarding racism, sexism, and sexual orientation since the 1960s and 70s, as well as positive and negative aspects of technological advancement). Therapists can sensitize and prepare themselves for working with older adults by being aware of when a client was born, significant historical events, and collaborating with the client to explore what it was like to grow up during another time.

Social Context

Not only do cohort differences influence the unique experiences of older adults, but their environmental realities must also be considered. Whether a person lives at home alone, with family or friends, in a nursing care or assisted living facility, a retirement community, or government subsidized apartments for older adults, these different social contexts present diverse sub-cultures with their own environmental dynamics, rules and regulations. Where people socialize, as well as the network of aging services and their accordant rules and regulations, also influence the realities of older adults.

Aligned with learning theory approaches which understand human behavior in relation to environment, Knight explains that "the problems of older people often result from, and are almost always influenced by, the context in which they live their lives" (2004, p. 18). As a psychotherapist, it is important to familiarize oneself to these environments and learn about the various services and systems set up for aging populations. This helps build rapport with clients, facilitates care coordination with other significant caregivers in their lives, and assists in

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identifying the extent to which the source of the problems lie in the environment itself. Understanding these settings and building a level of comfort and expertise within various social contexts becomes critical in determining appropriate interventions, both for the individual and within the system at large. While much of psychotherapeutic training provides global sensitivity and skills that are useful in working with any population, direct knowledge of social contexts and the rules and regulations incumbent to the daily reality of older adults provides essential practical information for effective therapy.

Specificity of Challenges

Whereas the loss-deficit model conceptualizes aging as a continual escalating experience of loss, the CCSMC suggests that it can be helpful for both practitioner and client to recognize the specific nature of change, rather than equating aging with illness, disability, and loss in a global manner. Older adults in psychotherapy may present issues related to chronic physical illness, recent or increasing disability, loss of loved ones due to death, as well as ongoing caregiving for family members. These issues are not specific to aging, but are usually more prevalent in the latter third of life. Other issues relate to challenges faced throughout life, such as fights with family members, socio-economic problems, love and disappointments. People who have experienced depression, anxiety, drug and alcohol addiction, and psychosis throughout their lives may continue to experience these struggles, often with the interconnected complications of physical illness and other life challenges. Recognizing the specific nature of problems differentiates the issue from aging itself and brings more accurate understanding and responsiveness to clients' needs. Reconceptualizing losses as challenges to be worked through in psychotherapy assists the client in optimizing functioning, whether this addresses chronic illness

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and disability, grief counseling, the stress of caregiving, the need for social services, or a combination of all of these areas.

Working with older adults expands the traditional boundaries of a psychotherapist's role. As Knight explains,

> The increased proportion of chronic illness and disability with each decade of life and the increased correlation of the physical and the psychological in later life make it impossible to function without the ability to discuss physical problems and to understand when a problem may have physical causes (2004, p. 21).

Such interconnected issues require a working knowledge of neuropsychology, psycho-pharmacology, and health psychology. In addition, psychotherapists need to work as a team and coordinate client care with physicians, social workers, family members, and other caregivers. Such a multi-disciplinary approach enhances the effectiveness of psychotherapy and the integral relationship between psychology, physical health, and social well-being.

Process Work

Process Work views life as made up of multiple levels of reality, and specializes in working with heightened awareness to unfold the patterns of experience within individual and collective processes. Process Work (also referred to as Process-Oriented Psychology) is an inter-disciplinary approach to working with individual and collective conflict and change, developed by Arnold and Amy Mindell and their international community of students and colleagues. Process Work recognizes that conflict manifests in various ways, including internal distress, body symptoms or illness, addictions, relationship and organizational problems, altered and extreme states, or social unrest. Applied to individuals, couples, families, organizations, and

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multi-cultural large groups, Process Work methods help to unfold the deeper experiences within these various manifestations of conflict in order to discover the potential meaning and creative insights within the challenges people face.

The discussion below provides an overview of Process Work theory and methods, and its applications to aging experiences. Process Work recognizes that multiple levels of reality, or realms of perception, contribute to our experiences of life, including Consensus Reality, Dreamland, and Essence or Sentient experience (Diamond & Jones, 2004; Mindell, 2004; S&S, 2008). *Consensus reality* refers to those things commonly agreed upon as true and normal. This level defines the status quo and relies on objective measurements. For example, if I were to point to a tree and ask a group what it was, most everyone would agree to call it "tree." We could measure this tree, look up its genus and species, and estimate its age.

At the same time, however, reality is also influenced by *Dreamland*. This level connects with individual experience and is usually farther away from everyday consciousness. Dreamlike experiences include subjective feelings that cannot easily be measured, and differ based on personal history, fantasies, and associations. So if I asked the group instead to imagine a tree and describe it, the results will probably vary drastically. Someone may imagine a full green Oak on a lush hillside, while another might describe a forest of tall ancient Redwoods gathered in the mist of early dawn, or someone else might see a lonely old tree stripped bare in the midst of Winter. This diversity and the subjective feelings that go along with such images reflect the co-existing reality of Dreamland.

And finally, the *Essence* level speaks to the unitary depths from which all experience arises. Essence reflects experience without judgment, the subtle (often pre-verbal) tendencies we sense within ourselves and the world around us. By going all the way down to this fundamental

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level of reality, the Essence of the Oak may connect us with an experience of lush, ever-evolving life; the Redwoods may reflect steady, enduring community; and the barren tree may transform into simple, crisp, raw experience.

Paying attention to and valuing all of these simultaneously co-existing realities can assist with the complex issues of aging and working with older adults. Applying these different levels to older adults, consensus reality refers to body deterioration and natural effects of aging; such as skin losing thickness and elasticity, decreased capacity for memorization and learning, and slower response ability (Knight, 2004; Mindell, 2004; Matteson, 2008). While these aging phenomenon are generally true, can be measured, and are often the focus of research, focusing solely on this level of experience equates aging with deterioration and feeds stereotypes and depression by marginalizing the rich subjective reality beneath the surface. Ageism and the loss-deficit model exemplify the problems of restricting perception to consensus reality only.

The dreamland of aging connects us to the deeper experiences contained within consensus reality labels. Dreamland refers not only to nighttime dreams, but the ways in which we are "dreaming" all the time, through our body experiences, visions, voices we hear, and emotions. Through his clinical research with older clients, Mindell (2004) has found psychological tendencies that often accompany physiological changes and point toward the dreamland experiences of aging. For example, the dreaming process behind changes in the skin may connect with changes in one's sense of self and boundaries. The deeper message behind changes in memory may be to forget the moment in order to detach from self and history. While consensus reality merely views the senses getting dulled as nerve cells die and circulation decreases, the dreaming process may be an invitation to stop looking at and listening to oneself and others, and instead connect with infinity.

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Finally, when considering the experience of aging at the Essence level of reality, Mindell suggests that "aging is but one facet of the force of silence" (2004, p. 168). Explored in various spiritual traditions, the force of silence refers to the intangible subtle force which moves all of life. Particularly useful with aging processes, or any experience which confronts us with the reality of death, Mindell describes that

> The force of silence is both a subtle body sensation and the driving force behind our dreams, subtly trying to move you along a given path, giving life specific meanings. These meanings become clear only after looking back over your life or by getting in touch with that force in a given moment (p. 8).

Connecting with this force penetrates all levels of reality, helping to bring deeper understanding, organic shifts, and creative guidance for change.

Recognizing common trends among older clients provides useful insight. However, not everyone has the same *experience* within those symptoms. Each person is drawn to and/or repelled by different things. This diversity is significant. When applying Process Work methods to older clients, attending to all three levels of reality is important. However, the specificity of one's experience points toward that which needs attention. Knight (2004) emphasizes this importance by outlining different areas which influence older adults' worlds, including cohort affiliation, social context, maturation, and unique challenges. Process Work excels in working with the unique challenges clients face – regardless of age – while simultaneously integrating historical, social, and developmental awareness.

In the case of individual clients, Process Work assesses patterns of experience revealed through the client's process structure. The structure of a process is organized by: that which is closer to one's identity; that which is farther away or disavowed; and the boundaries between the

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two. By attending to language, para-language, and somatic signals, Process Work identifies these three aspects of self (identity, disavowed parts, and edges), as well as the specific channel of information present in the moment. Channels refer to modes of communication, including verbal, visual, auditory, kinesthetic, proprioceptive, relational, and world. By working within the specific channels of information, Process Work speaks the language of the process as it presents itself in the moment. In this way, Process Work methods provide powerful tools for accessing direct experience. This enables clients to more deeply attune to their somatic, emotional, and cognitive states, and unfold the core meaning and potential messages carried within those experiences. In order to illustrate these concepts further, the final section applies Process Work theory and methods to clients with dementia.

Process Work & Dementia

From a medical viewpoint, dementia is defined as progressive cognitive decline, characterized by memory impairment and various cognitive disturbances, including aphasia, apraxia, agnosia, and executive dysfunction (American Psychiatric Association, 2000). One of the diseases commonly associated with dementia is Alzheimer's. The neurophysiology of Alzheimer's disease shows up as plaques and tangles within the brain. These protein deposits clog the spaces in between brain cells and prevent neurons from sending information, ultimately resulting in cell death (Shabahangi & Szymkiewicz, 2008; Dunkel, 2006). However, Dunkel clarifies that "it's uncertain whether plaque debris and tangles are a cause or an effect of Alzheimer's" (p. 3). Research indicates that intellectual and social engagement, as well as corollary experiences of creativity and optimism, serve as protective factors against Alzheimer's (Dunkel, 2006; Baker, 2007). As Knight explains, "Differences between current younger and older adults in memory performance are not large when the material is meaningful and relevant

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to the older adult and the older adult is motivated to learn" (2004, p. 9). *Meaningful* and *relevant* become critical and pivotal differentiations in our perception of older adults and methods for working with them.

Much of intellectual and social activity is defined according to culturally-determined parameters of "important" information and "normal" or "appropriate" behavior. How can we work with individuals whose experiences fall outside of these parameters? Methods emphasizing consensus reality include reality orientation, memory training, and medications, in order to help people remember their identity and significant relationships (Shabahangi & Szymkiewicz, 2008). However, as discussed above, Process Work recognizes that altered states have meaning and value unto themselves. The key word in the preventative factors of "intellectual and social engagement" is *engagement* – meaning *engagement with one's experience*.

Process Work assists people to more deeply engage with their experiences by addressing the three levels of reality, attending to process structure, and communicating in the relevant channels of experience. Based on their gerontological research, Shabahangi and Szymkiewicz (2008) provide clinical recommendations for engaging clients in various states of consciousness. For example, someone with mild dementia might be disturbed by her changes in memory, feel bad about losing things and getting confused. She is attached to her usual identity and consensus reality standards, yet her state is altered as she is pulled by dreamland and essence experiences. It may be helpful to explore her associations to the things she is losing, as well as those new experiences that are pulling her. Assisting her to "loosen" her identity will address the fear and anxiety connected with forgetfulness.

Someone with moderate dementia may live between worlds, confuse past and present, display strong emotions, wander, and have increasing difficulty using spoken language

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(Shabahangi & Szymkiewicz, 2008). At this stage, it may be helpful to enter into these other worlds of experience, imagine the creative expression connected to each emotion and its symbolic meaning, and draw upon non-verbal forms of communication, such as movement, sound, and touch. Finally, when someone enters into the late stage of Alzheimer's, she lives primarily in another reality, so everyday places, people, and objects lose significance. Her attention may be focused inward, spending a lot of time sleeping and daydreaming. At this point, it is important to respect the dignity of the body and personal care needs. Although she may not talk and seem far away, she is emotionally and spiritually present. Paying attention to subtle somatic experiences, such as breath, gaze, and slight movements, can assist practitioners in attuning to these worlds at a feeling level. The key at this realm of experience is joining the altered states, dreaming into their meaning, and following the non-verbal feedback of the client.

Conclusion

As psychotherapists, it is important to not only attend to what others define as appropriate and important, but value and assist people to connect with and further actual subjective experiences, even when they differ with social norms, everyday reality, and one's known identity. This respect for both diversity and specificity of experience becomes all the more relevant in working with older adults. The loss-deficit model emphasizes the common perception that aging means inevitable decline and illness. In contrast, the Contextual, Cohort-Based, Maturity, Challenge-Specific model brings greater understanding to the multiple factors contributing to older adults' worlds. Process Work provides experiential methods to access the deeper meaning contained within somatic, cognitive, and relational disturbances. Doing so

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stimulates the intellect and supports relating in ways that are congruent with the altered states which often accompany such disturbances. Knight reminds us that

> therapy with older adults should not become so specialized that techniques and concepts developed for other clients are not readily generalized to older adults, and that techniques and concepts developed in gerontological counseling are not tried with younger adults as appropriate (2004, p. 23)

Engaging with subjective experience confronts internalized messages from personal history and socialization which create internal and external conflicts and limit one's identity and expression. Working through these conflicts can be liberating – at any age – and allow for more access to one's whole self, inspiring an organic experience of creativity stemming from a connection to the deeper forces moving all of life.

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References

Achenbaum, W. (1998). *Perceptions of aging in America.* Retrieved March 5, 2008 from http://findarticles.com/p/articles/mi_qa3651/is_199804/ai_n8805478/print

American Psychiatric Association. (2000). *DSM-IV TR: Diagnostic and statistical manual of mental disorders* (4th Ed., Text Revision). Washington, DC: American Psychiatric Association.

Associated Press. (2004). *Ageism in America becomes hot topic.* Retrieved March 5, 2008 from http://www.msnbc.msn.com/id/5868712/print/1/displaymode/1098/

Baker, B. (2007). *The ethics of aging.* Washington Ethical Society: May 6, 2007. Retrieved on May 24, 2008 from http://www.users.rcn.com/bethbaker/EthicsOfAging.pdf

Diamond, J. & Jones, L. (2005). *A path made by walking: Process Work in practice.* Portland, OR: Lao Tse Press.

Dunkel, T. (2006). *Offering an education in aging: Nuns who spent their careers teaching give lessons through Alzheimer's study.* Retrieved March 5, 2008 from http://www.baltimoresun.com/news/health/bal-te.to.nuns18jun18,0,4588782.story?coll=bal-home-outerrail

Knight, B. G. (2004). *Psychotherapy with older adults*. Thousand Oaks: Sage Publications.

Matteson, W. (2008). *Understanding older minds: Issues in geriatric health care.* Personal communication: May 15, 2008.

McMunn, A., Breeze, E., Goodman, A., Nazroo, J. & Oldfield, Z. (2006). Social determinants of health in older age. In Marmot, M. & Wilkinson, R. (Eds.), *Social Determinants of Health*, (2nd Ed.) New York: Oxford University Press, pp. 267-296.

Mindell, A. (2004). *The quantum mind and healing: How to listen and respond to your body's symptoms*. Charlottesville, VA: Hampton Roads Publishing Co.

National Council on Aging. (2002). *American perceptions of aging in the 21st century*. Retrieved March 5, 2008 from http://www.ncoa.org/Downloads/study_aging.pdf.pdf

Shabahangi, N. & Szymkiewicz, B. (2008). *Deeper into the soul: Beyond dementia and Alzheimer's toward forgetfulness care.* San Francisco, CA: Elders Academy Press.