

WHAT PRACTITIONERS SHOULD KNOW ABOUT WORKING WITH OLDER ADULTS

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President, American Psychological Association

APA Working Group on the Older Adult Brochure

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— E X E C U T I V E S U M M A R Y —

This publication is designed to give psychologists and other health care providers important information to help guide their work with older adults.

Clinicians need to know more about this age group because the number and proportion of older adults in the population are increasing, and more psychologists will be called upon to deliver psychological services to them.

Older adults are defined as persons 65 years of age and older. The population of older Americans is itself getting older. The “oldest old” group, those 85 years and older, is increasing faster than any other age group. Unfortunately, there are numerous negative stereotypes about older people. The reality is that most older people live independently and maintain close relationships with family and friends. Personality remains relatively stable throughout the lifespan, and community dwelling older adults have lower rates of diagnosable depression than younger adults.

However, older adults do experience age-related changes—both physical and cognitive. Common age-related physical changes include hearing impairment, weakening vision, and the increasing probability of multiple chronic conditions such as arthritis, hypertension, heart disease, diabetes, and osteoporosis. While there is some degree of cognitive impairment, cognitive changes in older adults are highly variable from one person to another, but can include decline in information processing speed and memory problems. These changes do not typically interfere with daily living. Because a large number of older adults take several medications, drug interactions and drug side effects are more common than in younger age groups.

In assessing an older adult, the practitioner may have to modify the testing environment to assure optimal performance. Any assessment of an older adult should include the client’s current mental status, cognitive ability, social supports available to the client, the client’s medical status, and, if cognitive impairment is suspected, interviews with family members and close friends.

Research indicates that psychological interventions that historically have proven effective with younger and middle-aged adults are also effective for older adults. Specifically, cognitive-behavioral, brief psychodynamic, and Klerman and Weissman’s interpersonal psychotherapy have been shown to be effective in the treatment of one or more late-life mental disorders.

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WHY PRACTITIONERS NEED INFORMATION ABOUT WORKING WITH OLDER ADULTS

Our society is being reshaped by a rising demographic tide. Never have so many people lived into the later stages of their lives so healthy and so productively. In the United States, those born between 1946 and 1964—the “baby boomers”—are now growing older, and the first wave of this demographic phenomenon will reach age 65 in less than 15 years. At the crest of the aging of the baby boomers, 20 percent of the population of the United States will be 65 years old or older.

Who is old? Specific chronological markers for old age are arbitrary. The definition of “older adult” varies, depending on different perspectives and purposes. For example, gerontologists traditionally focus on persons aged 60 years and older. The federal government uses age 65 as a marker for full Social Security and Medicare benefits. Researchers identify subgroups of “older adults” as “younger old” (ages 65-75), “older-old” (ages 75-85), and “oldest old” (ages 85+). Age ranges vary across studies.

Subjectively, though, many older adults don’t label themselves as “old,” even at advanced ages. A survey of 2,500 seniors in a Los Angeles community revealed that as the seniors aged, they continued to grow, create, and engage in activities linked with education and travel. Some older adults are late-life career bloomers; others become active in their families or proactive in their communities, volunteer their time, or enter the political arena.

Advocates of older adults, including Nobel laureate Elie Wiesel, feel that older adults as guardians of the world’s vital memories should be appreciated and respected. Yet, they are a neglected resource. As the 1997 APA Convention keynote speaker, Wiesel said, “an old person represents wisdom and the promise of living a full life...the worst curse is to make him or her feel worthless.”

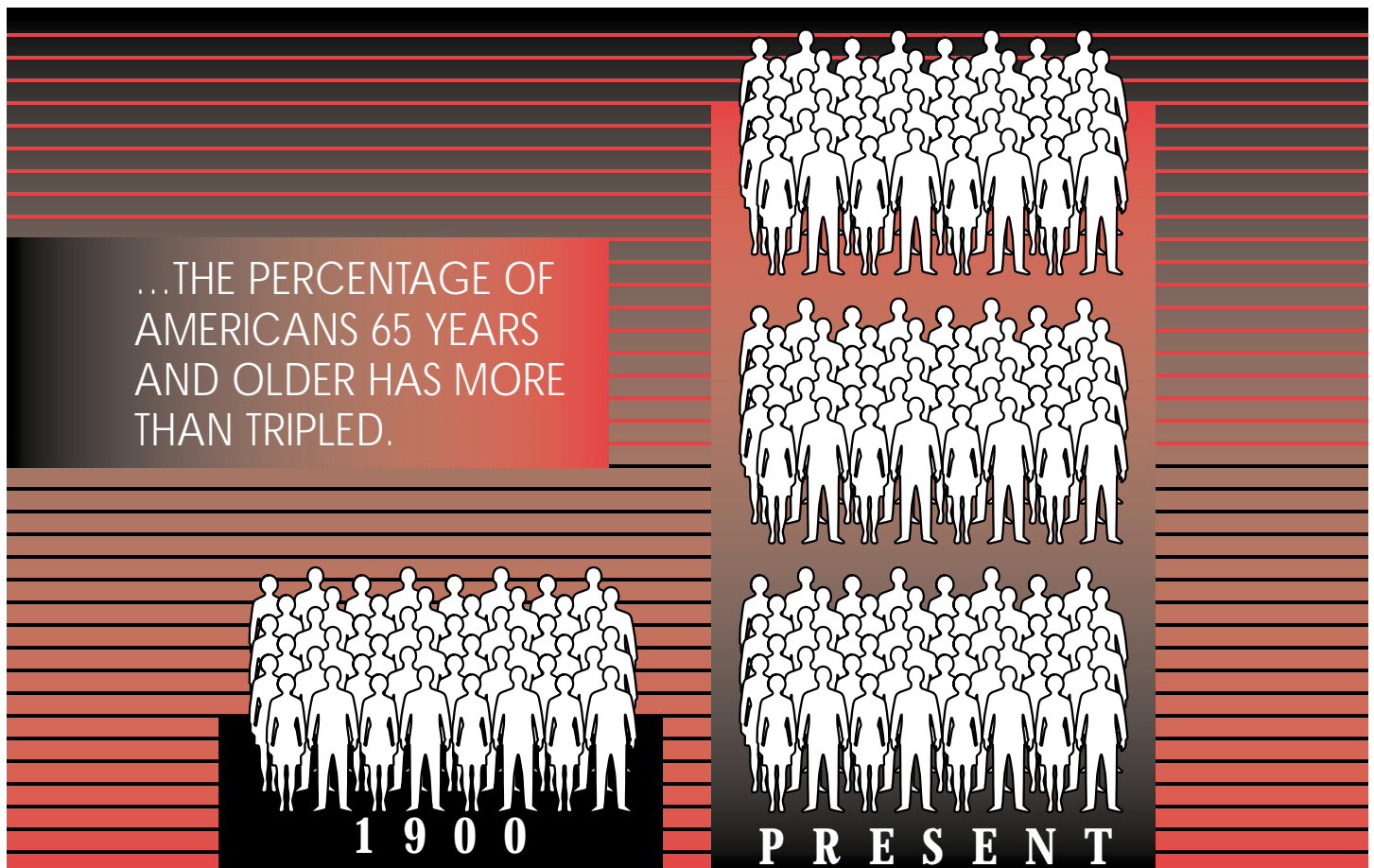
Psychologists are in a unique position to address the psychologically related issues older adults experience and enhance their intellectual, social, and emotional well-being.

In the face of the demographic changes, many psychologists who have never received formal instruction to work with older adults will choose to provide services to this growing population. Many of the skills psychologists use to aid younger adults are, for the most part, applicable to older adults. But, assessment and treatment must be informed by the impressive amount of geropsychological data now available. Armed with facts about the myths and realities of aging, knowledgeable about the problems older adults face, cognizant of how to assess and treat older persons, and familiar with broader professional issues in aging, psychologists can maximize their efforts to assist this large and diverse segment of our society.

This publication delivers information to dispel myths about older adults and raise practitioners’ awareness of facts about aging. The information is presented in seven sections. Section I, Demographic Realities of the Increasing Older Population, presents demographic information, such as gender and ethnicity, of the older population. Section II, Commonly Held Myths About Older Adults, lists facts as opposed to the myths. Section III, Realities of Aging for Older Americans, discusses productivity, economic well-being, social circumstances, and other general information about the older adult population. Section IV, Psychological Problems Some Older Adults Experience, is an alphabetical listing of common psychological problems and how they present in older adults. Section V, Assessment of Older Adults, gives information about basic principles and unique features for assessing older adults. Section VI, Appropriate Psychological Interventions for Older Adults, discusses unique problems of late life and the needed adaptation of psychological interventions. Section VII, Broad Professional Issues of Concern to Psychologists Working With Older Adults, presents practical issues in providing services, such as sources of reimbursement, ethical challenges, and unique realities of ethnic minority older adults. The publication concludes with a list of professional resources in geropsychology and a bibliography.

I. DEMOGRAPHIC REALITIES OF THE INCREASING OLDER POPULATION

- * Since 1900 the percentage of Americans 65 years and older has more than tripled.
- * The proportion of people 65 years and older is almost 13 percent of the U.S. population. By the year 2030, it will be 20 percent.
- * The older population itself is getting older. In 1994 the 65-74 age group was 8 times larger than in 1900. The 75-84 age group was 14 times larger. The 85 and older age group was 28 times larger.
- * The “oldest old” group (those over 85 years) is increasing faster than any other age group.
- * The ethnic racial minority population over 65 years old is growing faster than the older adults group as a whole, at a 2:3 ratio. Minority persons are projected to represent up to 25 percent of older adults by the year 2030.
- * Life expectancy for men is 73 years; for women, 80 years. After age 80, women outnumber men by almost 3 to 1.
- * In 1994 there were nearly 8.6 million veterans 65 years or older (32 percent of the total veteran population), about 4 percent of whom were women. Because of the aging of World War II veterans, the number is expected to peak by the year 2000, when there will be about 9.3 million elderly veterans (38 percent of the total veteran population). In 1996, 76 percent of civilian males aged 70-74 years were veterans, reflecting U.S. participation in World War II.



II. COMMONLY HELD MYTHS ABOUT OLDER ADULTS

MYTHS:

FACTS

Most older people are pretty much alike.

THEY ARE A VERY DIVERSE AGE GROUP.

They are generally alone and lonely.

MOST OLDER ADULTS MAINTAIN CLOSE CONTACT WITH FAMILY.

They are sick, frail, and dependent on others.

MOST OLDER PEOPLE LIVE INDEPENDENTLY.

They are often cognitively impaired.

FOR MOST OLDER ADULTS, IF THERE IS DECLINE IN SOME INTELLECTUAL ABILITIES, IT IS NOT SEVERE ENOUGH TO CAUSE PROBLEMS IN DAILY LIVING.

They are depressed.

COMMUNITY DWELLING OLDER ADULTS HAVE LOWER RATES OF DIAGNOSABLE DEPRESSION THAN YOUNGER ADULTS.

They become more difficult and rigid with advancing years.

PERSONALITY REMAINS RELATIVELY CONSISTENT THROUGHOUT THE LIFESPAN.

They barely cope with the inevitable declines associated with aging.

MOST OLDER PEOPLE SUCCESSFULLY ADJUST TO THE CHALLENGES OF AGING.

III. REALITIES OF AGING FOR OLDER AMERICANS

What is aging America really like? What are Americans' patterns of aging, education, productivity, economic well-being, social circumstances, leisure interests, cognitive abilities, physical well-being, etc.? The answers to the questions below give a broad picture.

IS THERE A "NORMAL" PATTERN OF AGING?

As with younger adults, normal performance among older adults is a range, rather than a specific value. Information is emerging on two types of "normal" aging:

- * "Optimal" or "healthy" aging of individuals who have no identified physical illnesses.
- * "Typical" aging of individuals who have one or more medical conditions that become prevalent in later life.

HOW WELL EDUCATED ARE OLDER ADULTS?

Educational attainment within the older population has increased significantly. In 1993, 34 percent of those aged 65 or older had graduated from high school, and 12 percent had a bachelor's or more advanced degree. In 2030, 83 percent of older adults will have completed high school, and 24 percent will have at least a bachelor's degree.

ARE OLDER PEOPLE PRODUCTIVE?

- * In 1993, 16 percent of older men and 8 percent of older women were labor force participants. Over half of those older adults who remain in the labor force work part time. Although today's older men are less likely to participate in the labor force than previously, older women are more likely to participate than in the past.
- * Over one-third of older adults are involved in formal or informal volunteer work.

WHAT IS THE ECONOMIC WELL-BEING OF TODAY'S OLDER ADULTS?

The overall economic picture of older adults has improved significantly since the 1970s, and, in general, they now have more assets than younger adults. In 1992, 13 percent of older adults as a group were poor (compared to nearly 15 percent of those under 65 years), although poverty rates were higher for older African Americans (33 percent), Hispanics (22 percent), and persons aged 85 or more (20 percent). The median income for older men was \$15,276, and \$8,579 for older women. Social Security benefits are the primary source of money income. Interestingly, a survey conducted by the APA Committee on Older Women found that older female psychologists were as financially secure in their later years as older male psychologists.

WHAT ARE THE SOCIAL CIRCUMSTANCES AND THE SOCIAL WELL-BEING OF OLDER PEOPLE?

Family and friends are key social supports for many older adults. The following data refer to noninstitutionalized older persons, except where noted.

- * In 1993, 64 percent of those aged 65 to 74 were married and living with a spouse. Among those aged 85 years and older, 24 percent lived with their spouse and 48 percent lived alone. Older men were nearly twice as likely as older women to be married and living with their spouse. Half the women over the age of 65 are widows. Older women are more likely to live alone than are older men.
- * Of those older adults with living children in 1984, nearly half (48 percent) had daily contact, and 86 percent had at least weekly contact with their children.
- * Many older adults provide assistance to younger family members, including giving emotional support, caring for grandchildren or disabled children, providing a place to live, or making monetary gifts or loans.
- * An older spouse is most likely to be the caregiver for an impaired older adult in the community. The majority of caregivers are women.
- * About four of five older adults report having one or more confidants. Generally, women have more interaction with friends than do men.
- * In 1990, about 1.4 percent of adults aged 65 to 74 lived in a nursing home, compared with 6 percent of adults in the 75 to 84 year old group and 24 percent in the 85 years and older group. One of every three nursing home residents is a woman aged 85 or older.
- * Salient risk factors for institutionalization include: age over 75 years, living alone, immobile, demented, and recently hospitalized.

WHAT ARE THE SOCIAL AND LEISURE INTERESTS OF OLDER ADULTS?

Although older adults vary widely in their specific interests and pastimes, there is continuity in leisure pursuits across the life course. Most leisure time is not spent in activity programs developed especially for older persons.

- * Religious affiliation is the most common form of organizational participation among older adults, with 50 percent attending religious services weekly.
- * Older adults are active in politics, with about two-thirds reporting voting in the 1992 Presidential election (compared with about half of younger adults).
- * Less than 25 percent of older adults participate in senior centers.
- * With advancing age, older adults tend to pursue more sedentary and solitary activities, such as visiting family and friends, watching television, and reading.

WHAT ARE COMMON AGE-ASSOCIATED PHYSICAL CHANGES?

Normal age-associated changes typically occur gradually over time.

- * Hearing impairment in older adults is often mild or moderate, but it is widespread. In 1990, 48 percent of men 75 years and over and 37 percent of women (noninstitutionalized) had problems with hearing.
- * Visual changes include problems with reading speed, seeing in dim light, reading scrolling or other externally paced displays, reading small print, and locating objects visually.
- * Reaction time is typically slower among older adults, particularly for more complex tasks.
- * The probability of having multiple chronic conditions increases with age. Common comorbidities include arthritis, hypertension, cataracts, heart disease, diabetes, and osteoporosis.
- * Although estimates vary, the proportion of older adults needing personal assistance with everyday activities increases with age (e.g., 9 percent of those aged 65-69 and up to 50 percent of those aged 85 or older). After age 65, a greater proportion of women than men become disabled.
- * Despite common physical difficulties, three-fourths of community dwelling people aged 65 to 74 report their health to be good, very good, or excellent compared with others their age, as do two-thirds of noninstitutionalized persons 75 years and over.
- * The top five causes of death among older adults are heart disease, cancer, cerebrovascular disease, pneumonia and influenza, and chronic obstructive pulmonary disease.



MANY OLDER ADULTS PROVIDE ASSISTANCE TO YOUNGER FAMILY MEMBERS, INCLUDING GIVING EMOTIONAL SUPPORT, CARING FOR GRANDCHILDREN OR DISABLED CHILDREN, PROVIDING A PLACE TO LIVE, OR MAKING MONETARY GIFTS OR LOANS.

WHAT ARE THE COGNITIVE CHANGES ASSOCIATED WITH NORMAL AGING?

Some cognitive abilities decline with age, some may improve, and some show little change. Such changes are highly variable from one person to another, and even vary within a given person for different aspects of cognition. For example, creativity can continue into the ninth decade of life. For those functions that do decline, the change is not severe enough to cause significant impairment in daily occupational or social functioning, as occurs with a dementing disorder such as Alzheimer's disease. Some general findings include:

- * Information processing speed declines with age, which may result in a slower learning rate and greater need for repetition of new information.
- * Divided attention between two simultaneous tasks shows age-related decline, as does ability to switch attention rapidly between multiple auditory inputs, although ability to switch attention between visual inputs does not change much with age. Overall levels of performance in sustained attention or vigilance tasks appear to reduce with age. Filtering out irrelevant information through selective attention also appears to decline with age.
- * Short-term, or primary, memory shows relatively less age-related decline.
- * Long-term, or secondary, memory shows more substantial age changes, although the decline is greater for recall than for recognition, and performance generally benefits from cueing.
- * Most aspects of language ability are well-preserved, such as the use of language sounds, meaningful combination of words, and verbal comprehension; and some aspects may continue to improve with age, such as vocabulary. However, word-finding, or naming, ability and rapid word list generation show declines with age.
- * A variety of tasks shows age-related visuospatial decline, including three-dimensional construction and drawing.
- * Abstraction and mental flexibility also show some decline with age.
- * An accumulation of practical expertise, or wisdom, may continue toward the very end of life.

WHAT ABOUT THE MENTAL HEALTH OF OLDER ADULTS?

- * Older people evidence fewer diagnosable psychiatric disorders than younger persons, excluding cognitive impairments. A major population-based survey found that the overall prevalence of mental disorders for older adults was lower than for any other age group. Only cognitive impairment shows a definite age-associated increase in incidence.
- * General life satisfaction among older adults is as good as, if not better than, any other age group. Life satisfaction is associated with good health, an adequate income, adequate social relationships, and a sense of control over one's life.
- * Older adults often have a positive outlook and seek challenges and activities that maintain their well-being. They may take classes, participate in elder hostels, exercise, study new subjects, travel, and have satisfying sexual relationships.

HOW IS PERSONALITY AFFECTED BY AGE?

- * A variety of studies shows considerable stability of key personality traits, such as neuroticism, extraversion, and locus of control, over time.
- * Stability across the second half of the adult lifespan may be stronger than across the first half.

HOW DO OLDER ADULTS COPE WITH NORMAL AGE-ASSOCIATED CHANGES?

Despite physical or cognitive declines, many older adults develop effective coping mechanisms, either spontaneously or through outside instruction:

- * “Use it or lose it”—Practicing memory and other cognitive strategies by doing crossword puzzles, playing bridge, engaging in other challenging mental activities.
- * Making lists, notes.
- * Training in mnemonic skills such as semantic associations, interactive imagery.
- * Participating in mood and memory workshops.
- * Modifying tasks or modifying the environment to accommodate physical changes.
- * Drawing strength from personal spirituality and cultivating creativity, optimism, and hope.
- * Seeking support from family, friends, neighbors, other peer groups.

IV. PSYCHOLOGICAL PROBLEMS SOME OLDER ADULTS EXPERIENCE

Older adults may evidence a broad array of psychological issues and disorders, including almost all the problems that affect younger adults. Older adults may suffer recurrences of psychological disorders they experienced when younger, or they may have new problems due either to the developmental stresses of late life or neuropathology. Older adults often have multiple problems. For example, an individual may have a mental disorder such as major depression and a substance abuse or personality disorder. Medical problems are more common in older adults, and psychological symptoms and syndromes are often comorbid with physical illness. In addition, the classic presentation of disease is sometimes not evident, but rather the symptoms present in a nonspecific manner (e.g., refusal to eat, falling). Further, older adults often receive one or more medications for medical problems, and difficulties may arise due to drug-drug interactions or side effects of medications. Understanding comorbidity of mental and medical disorders is a central task in assessing and treating psychological problems in older adults. The psychological disorders listed are in alphabetical order.

ANXIETY DISORDERS

- * Population-based surveys have found that about 6 percent of older people have anxiety disorders. Because anxiety disorders often coexist with affective disorders, medical disorders, and dementia, this rate may actually be higher.

- * The most common anxiety diagnosis among older adults is generalized anxiety disorder.
- * A number of medical conditions are often mistaken for generalized anxiety disorder because anxiety and shortness of breath may be prominent early symptoms.
- * Obsessive-compulsive symptoms wax and wane throughout the life course and can present as a primary problem or secondary to depression.
- * Panic disorder rarely has a later-life onset, and, among those who developed it earlier, the symptoms usually recede by late adulthood. Some older adults report episodes of panic, but these are usually less severe and may coexist with physical illness or symptoms of depression.
- * Phobic disorders affect some older adults but are more common earlier in life.
- * Posttraumatic stress disorder can occur at any age and is a common symptom among older combat veterans and former prisoners of war.



THE MOST COMMON ANXIETY DIAGNOSIS AMONG OLDER ADULTS IS GENERALIZED ANXIETY DISORDER.

CHRONIC PAIN

- * By far the most common painful condition found among older adults is osteoarthritis.
- * Assessment and diagnosis of pain are typically more complicated in older adults than in younger adults. However, it is important that the condition be evaluated thoroughly, as pain complaints may mask a major depressive disorder.
- * Depression is often associated with chronic pain. This is especially true among older adults in which the two may coexist and interact. In addition, boredom, loneliness, and bereavement can influence the perception and report of pain.
- * Pain behavior may be reinforced inadvertently by well-meaning family members and others who pay more attention to the individual when he or she is complaining of pain than when there are no physical complaints.

DELIRIUM (ACUTE CONFUSIONAL STATE)

- * Rapid-onset, fluctuating mental status changes may represent a delirium or acute confusional state. Delirium-related confusion and agitation are usually accentuated later in the day (so-called “sundowning”).
- * Predisposing factors to delirium include older age, metabolic disturbances, polypharmacy, infections, anesthesia, hip fracture, unfamiliar surroundings with loss of daily routine, sensory understimulation or overstimulation, disruption of sleep-wake cycle, a history of dementia or brain injury, and a number of other physical and psychological stressors.
- * Delirium generally remits when the precipitating factor is treated or removed.

DEMENTIA

- * Population-based research has found that the prevalence of dementia increases dramatically with age, with estimates that 5 to 7 percent of those over age 65 and nearly 30 percent of those over age 85 suffer some form of this disorder. Up to 20 percent of patients have a partially or completely reversible form of dementia.
- * The most common types of age-associated dementia are those caused by Alzheimer's disease and cerebrovascular pathology (most notably vascular dementia—formerly called multi-infarct dementia). Some older adults may have both Alzheimer's disease and vascular dementia.
- * Unlike milder forms of cognitive decline associated with normal aging, the cognitive deficits associated with dementia cause significant impairment in social and occupational functioning.
- * People with progressive dementias often evidence coexistent psychological symptoms, which may include depression, anxiety, paranoia, and behavioral disturbances.
- * Along with the older adult's need for individual attention, families and caregivers often need help in understanding and coping with the cognitive factors and behavioral problems that accompany dementia.
- * Dementia is a risk factor for delirium, and the two often coexist.
- * Depression may also be associated with memory complaints and cognitive impairment. Older adults with a major depressive disorder may perform more poorly on some measures of cognitive function than nondepressed older adults. This reversible cognitive impairment has sometimes been called pseudodementia.

MOOD DISORDERS

- * Major depressive disorder affects about 1 percent of older adults, and dysthymia, about 2 percent. Major depressive disorder is the most common late onset psychological problem.
- * Mania in late life does occur in the absence of acute medical precipitants. However, not enough is known about bipolar disorder in older adults, and it may be that it is underdiagnosed in adults over the age of 60.
- * Mood disorders may present differently in older than in younger adults. For example, compared to younger adults, depressed older adults are more likely to have anxiety, agitation, memory problems, and bodily complaints. They are less likely to complain of depression or feeling sad. Feeling hopeless is often an important indicator of depression among the elderly.
- * About 20 percent of older individuals living in the community report clinically significant depressive symptoms that do not reach criteria for a diagnosis of mood disorder. They fall into the diagnostic categories of dysthymic disorder or adjustment disorder with depressive features. Certain high-risk groups of older adults have a higher prevalence of depressive symptoms and syndromes, including medical outpatients, inpatients, and those in long-term care settings.
- * The highest suicide rate of any age group is found in older adults, primarily older Caucasian men who live alone, for whom suicide increases dramatically from age 65 to 85 and older.

PSYCHOTIC DISORDERS

- * Schizophrenia rarely occurs for the first time in older age. Only 10 percent of people suffering from schizophrenia experience the onset of the disorder after age 40. Consequently, older adults with schizophrenia often have a history of chronic psychotropic use and institutionalization. Older age appears to be related to reduction in frequency and severity of positive symptoms of the disorder, such as hallucinations and delusions. However, because of other aspects of schizophrenia, such as apathy and withdrawal, older people with schizophrenia are at high risk for social isolation and neglect by the mental health system.
- * The most common form of psychosis in later years is paranoia. Hearing loss may be one important risk factor for developing late-life paranoia. Other risk factors are social isolation, a long-standing personality disorder, dementia, and delirium. Paranoia in older adults tends to be characterized by beliefs that are less bizarre than those reported by younger adults. People may be able to function adequately and demonstrate normal cognitive functioning. Unfortunately, because older adults with paranoia often have delusions related to relatives, friends, and caregivers, the disorder is especially likely to result in increased social isolation.

SEXUAL DYSFUNCTION

Normal age-related changes in sexual functioning can be described as a generally slowed and slightly decreased response to stimulation at every stage of the sexual arousal cycle. However, these changes do not prevent arousal, sexual activities, or orgasm.

- * The incidence of sexual dysfunction increases with age for both men and women, mostly because of an increase in chronic health problems and increased medication use.
- * Medication can adversely affect sexual functioning. This is particularly the case with antihypertensive, antipsychotic, anxiolytic, antidepressant, and cardiac medications.
- * Health problems may also affect sexual functioning. Up to 50 percent of men with diabetes report erectile difficulties, and diabetic women often experience sexual dysfunctions as well. Older men often undergo a surgical procedure to reduce enlarged prostate, known as the transurethral resection of the prostate (TURP). Older age is associated with a higher risk of sexual difficulties after this procedure.
- * Neurological disorders are sometimes tied to a decline in sexual functioning, including Parkinson's disease, Alzheimer's disease, multiple sclerosis, and stroke.

SLEEP DISORDERS

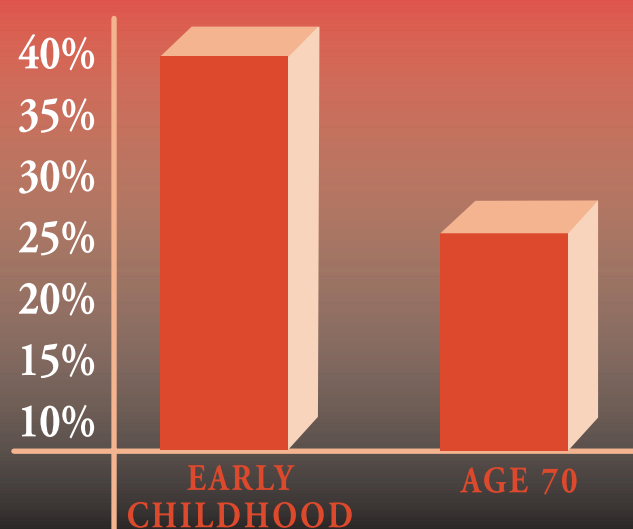
- * Several normal age-related changes in sleep patterns exist. The relative amount of dream sleep declines from 40 percent of sleep time in early childhood to about 25 percent by age 70. Slow wave, or stage 4 sleep, also decreases. There are more frequent arousals from sleep in later adulthood, and older adults tend to be awake longer during these arousals. Older adults also take about 5 minutes longer to fall asleep at night, compared to younger adults. Snoring increases in frequency with age, and, in general, older adults report that they do not feel as refreshed in the morning, compared to younger adults.

- * Sleep problems increase with age, and about half of people over age 80 complain of a sleep difficulty. Insomnia is a common complaint among older adults, but hypersomnia is uncommon. Hypersomnia is characterized by excessive daytime sleepiness or prolonged periods of sleep. It does not refer to the naps that older adults often take.
- * Because older people may not need to adhere to a daily schedule, they are more likely to experience sleep-wake schedule problems. These disorders involve a lack of synchrony between the actual times the individual is asleep and awake, and the body's natural circadian rhythm.
- * Sleep apnea, episodes during which breathing stops briefly during sleep, increases with age and is a common problem among older adults. Severe apnea may be particularly dangerous because it can trigger rhythm problems of the heart, lead to increased blood pressure, and result in decreased cognitive functioning.
- * Periodic leg movements may also cause sleep disturbances in later adulthood. This twitching of the legs during sleep usually occurs earlier in the night and lasts from a few minutes to a few hours, often causing the individual to get out of bed repeatedly to relieve the discomfort.

SOMATOFORM DISORDERS

- * Hypochondriasis is the somatoform disorder most likely to be found in later adulthood. From 10 to 15 percent of older adults exhibit a marked concern about their health and overestimate their level of physical impairment. Hypochondriasis may exist alone or coexist with a number of other disorders, such as depression, anxiety, and dementia.
- * Older adults with somatoform disorders are at risk for lack of appropriate attention from health care professionals who may minimize symptoms of real physical disorders. Those with somatoform disorders are also more likely to take unnecessary medications and to undergo unnecessary medical procedures, both of which are especially risky for them and may contribute to actual morbidity.

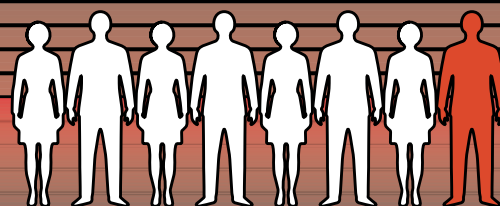
...DREAM SLEEP DECLINES FROM 40 PERCENT OF SLEEP TIME IN EARLY CHILDHOOD TO ABOUT 25 PERCENT BY AGE 70.



SUBSTANCE USE/ABUSE DISORDERS

- * The prevalence of alcohol abuse and dependence in adults 65 years of age and older ranges from 2–5 percent for men and about 1 percent for women. There is a decline in substance abuse for adults over age 60 years.
- * Risk factors for alcohol abuse among all adults include genetic predisposition, being male, limited education, low income, and a history of psychiatric disorders, especially depression.
- * Stressors are more important contributors to late onset alcohol and drug abuse than to early onset abuse. Common stressors that contribute to alcohol and drug abuse in later adulthood include retirement, relocation, death of a spouse or close relative, conflict within the family, financial concerns, and physical health problems.
- * Older widowers have the highest prevalence rates of alcohol abuse among older adults.
- * Regular alcohol consumption may lead to other medical problems for older adults because of the physiological changes that accompany aging. A major problem for older adults who consume excess alcohol is malnutrition, because they may fail to eat a balanced diet.
- * Excess alcohol consumption may lead to cirrhosis of the liver, one of the eight leading causes of death in older adults.
- * Another alcohol-related problem is osteomalacia, or thinning of the bones.
- * Excess alcohol intake is also related to a decrease in the ability of the stomach to absorb food.
- * The most frequent and serious problem with chronic alcohol use in older adulthood is a decline in cognitive functioning. Chronic alcohol abuse may lead to major declines in memory and information processing.
- * Over many years of alcohol abuse, the effects of these physical and cognitive changes lead to significant impairment in most persons who survive past middle age. The same is true for those who begin to drink heavily in later life.

EXCESS ALCOHOL CONSUMPTION MAY LEAD TO CIRRHOSIS OF THE LIVER, ONE OF THE EIGHT LEADING CAUSES OF DEATH IN OLDER ADULTS.



- * The abuse of drugs by older adults typically takes the form of abuse of prescription medications, tranquilizers, and sedatives. One-fourth of medications used in this country are taken by adults over 65 years of age, including prescription drugs and over-the-counter medications. Some of the most commonly used drugs among older adults are tranquilizers and sleeping pills.
- * Because of physiological changes associated with aging, drug toxicity is more likely in later than in younger adulthood.
- * Combining alcohol and drugs, especially tranquilizers and sleeping pills, is especially dangerous, as there may be a cumulative depressant effect on the central nervous system.

OTHER PROBLEMS THAT MAY AFFECT OLDER ADULTS

- * **Adjustment Disorder.** The most common stressor that leads to adjustment disorder in later life is physical illness. Other stressors which often precipitate adjustment disorders among older adults are those associated with late-life losses, e.g., relocation, retirement, financial problems, family problems, and lengthy hospitalization.
- * **Personality Disorders (PDs).** Most PDs, particularly those in Cluster B (i.e., Borderline, Narcissistic, Histrionic, and Antisocial) decline in frequency and intensity with age. However, PD presentation may take a modified form, and these “geriatric variants” are associated with difficulties in medical management and psychotherapeutic treatment. For example, the antisocial behavior of older adults may not be manifested in ways that lead to incarceration as with some younger persons with sociopathy, but may be exhibited as selfish, impulsive behavior towards community caregivers, resulting in abandonment of the older adults.
- * **Bereavement.** Most older adults experience the loss of loved ones including spouses, other family members, and friends. While bereavement is a normal reaction to loss, pathological grief may develop. Symptoms of pathological grief among older adults are essentially the same as those for younger adults and include extensive guilt and preoccupation with death, a pervasive sense of worthlessness, marked psychomotor retardation, and functional impairment. The length of time spent in grieving is culturally determined and is also a function of resources of the individual and the circumstances of the death. In the United States, grief usually requires about 2 years for completion, with a great deal of variation around this average.
- * **Elder Abuse.** Some older adults are vulnerable to mistreatment by spouses, adult children, grandchildren, and caregivers. Elder abuse is much more likely to occur when the older person is experiencing physical, emotional, or cognitive problems. In a recent study, about 3 percent of community residing older adults reported being abused, including physical abuse, neglect, and chronic verbal aggression. This figure probably underestimates the problem because older adults are less likely to report domestic abuse. Sexual abuse is the most underreported form of abuse among older adults.

Because medical practitioners may overlook signs of physical abuse (e.g., bruises or other injuries) or assume they are because of falls, it is important for the mental health professional to question the cause of physical injuries. Most reports involve abuse committed by one spouse against another, sometimes in retaliation for lifelong patterns of abuse. This type of abuse is followed in frequency by an adult child abusing a parent. In

comparison to younger individuals, older husbands are abused twice as often as older wives, and the abusers usually are dependent on the person they abuse. Patients with Alzheimer's Disease and other dementing disorders are at greater risk for elder abuse. Late onset spousal abuse is related to substance abuse and psychopathology of both the abused and the abuser. Elder abuse occurs at all economic levels and among all age groups in later adulthood. When abuse occurs in the home, reporting is mandatory in many states by health care, social service, or other professionals who become aware of it. All states require reporting when abuse occurs in an institution. Psychologists working with older adults should be knowledgeable about applicable state laws on reporting elder abuse.

- * **Age-Related Cognitive Decline.** DSM-IV now lists this category (coded 780.9) under "Other Conditions That May Be a Focus of Clinical Attention." It refers to an objectively identified decline in cognitive functioning consequent to the aging process that is within normal limits given the person's age, and it is not attributable to a specific mental disorder or neurological condition.

V. ASSESSMENT OF OLDER ADULTS

WHAT ARE BASIC PRINCIPLES IN THE ASSESSMENT OF OLDER ADULTS?

In view of the physical, cognitive, and sensory changes often accompanying aging, the testing environment should be modified to assure optimal performance. The psychologist must be flexible in the testing process and in the interpretation of results. Qualitative indices are, at times, of more importance than quantitative indices. The following accommodations may be necessary according to the unique characteristics of the older individual being tested.

- * Familiarize the older adult with the purpose and procedures of testing. Older adults, especially those with little formal education, are often less familiar with testing than younger adults and may be more cautious in responding. The psychologist should pay particular attention to achieving fully informed consent from the older adult or significant other.
- * Ensure optimal performance. Older adults should be prepared in advance for testing. They should be given prior notice to bring all assistive devices (e.g., hearing aids, eyeglasses).
- * If English is not the primary language or is not well understood, the validity of the testing may be in doubt. If the tester is not bilingual, use an interpreter, preferably one whose expertise reflects both the specific language need and psychological training. The psychologist should be aware of how language problems can adversely affect test results.
- * Create a well-lighted and quiet environment. Glare should be minimized. Arrange the space to accommodate a wheelchair or other device for those with physical limitations.
- * Preferably use tests that have been constructed specifically for older adults. Most commonly used psychological tests have not been developed for use with older people, although some have age-related norms.

- * Ensure that the older adult understands the test instructions. Speak in clear, simple language but do not shout. Query and repeat if necessary. If needed, use large print materials.
- * Determine if the older adult patient is experiencing pain or discomfort and attempt to reduce it when possible. Find out what medication(s) the patient is taking and assess effect on performance.
- * Adjust the testing time to suit the optimal functioning of the older adult. Older adults tire more easily than younger adults. Plan for frequent rest and bathroom breaks. If fatigue sets in, resume testing at another time.
- * Use encouragement and verbal reinforcement liberally when testing.
- * Utilize multiple testing sessions to gauge how the older adult performs at varied times of the day.

WHAT ARE THE UNIQUE FEATURES OF A DIAGNOSTIC INTERVIEW WITH AN OLDER ADULT?

- * The diagnostic interview is a primary psychological assessment approach. Prior to a formal interview, the client or the client's legally designated guardian must give informed consent. The client or the client's guardian must understand the rationale for the testing, as well as how the findings may be utilized. Even with the consent of a legally designated guardian, obtaining the client's consent is essential to obtaining reliable and valid findings.
- * Current mental status, the event precipitating the request for an evaluation, prior psychiatric history, and likely psychiatric diagnosis should be elicited. Current psychological difficulties should be placed in the context of the older client's values, beliefs, stage-of-life issues, education, culture, and ethnicity.
- * Social aspects of the client's problems should also be assessed. The presence of recent losses, adverse living conditions, financial stressors, pending legal matters, and family/interpersonal difficulties should be evaluated.
- * Information on the older client's medical status is critical, because some psychiatric symptoms may be secondary to medical problems. Specifically, the following should be documented: current medical problems; past major medical problems; prescriptions and over-the-counter medications; current and past use of alcohol, tobacco, and nonprescribed drugs.
- * Noncompliance with prescribed treatment regimens should be ascertained. Acute psychological changes possibly related to initiation or discontinuation of medical treatments should be noted.
- * If cognitive impairment is suspected, diagnostic interviews with older clients should be supplemented, if at all possible, by interviews with family members or friends to determine convergence and discrepancies between information sources.

WHEN IS COGNITIVE/NEUROPSYCHOLOGICAL TESTING APPROPRIATE?

Because a significant number of clients in geropsychiatric inpatient and outpatient settings are cognitively impaired, psychologists are often called upon to perform cognitive testing. Five of the major reasons for such assessment are: 1) To evaluate cognitive ability, 2) to detect and monitor cognitive changes, 3) to evaluate dementia, 4) to assist with the differential diagnosis of dementia versus depression, 5) to help determine competency.

ASSESSMENT OF DEMENTIA SHOULD INCLUDE TESTS OF:

- * Attention/concentration
- * Short- and long-term memory and delayed recall
- * Reasoning ability
- * Language
- * Executive functions
- * Visual-motor skills

BRIEF ASSESSMENT OF COGNITIVE ABILITY

Because people are at increased risk for cognitive impairment as they age, a brief screening instrument should be part of all psychological evaluations.

- * One widely used brief screening measure specifically developed for the older age group is the Mini-Mental State Examination (MMSE). It is easy to administer and includes verbal and nonverbal items. The MMSE and other brief cognitive screening tools are not diagnostic, and they should not be used as stand-alone diagnostic tests.
- * A major problem with most screening tests is that more subtle cognitive problems may not be detected. In addition, a poor score on a screening test does not indicate which of a large number of potential causes is responsible for the impairment. If screening or other history suggests cognitive impairment, then further evaluation including differential diagnosis may be necessary.

ASSESSMENT OF ACUTE AND REVERSIBLE CHANGES

Sometimes persons present with a rapid change in mental abilities as evidenced in a delirium (acute confusional state). A wide variety of factors may affect cognitive abilities in older adults. Family members or residential staff are often important sources of information regarding premorbid and current cognitive functioning.

- * A review of the medical record and drug regime (prescribed, nonprescribed) and consultation with a physician or other primary health care provider is usually a first step in evaluating acute cognitive changes.
- * Repeat testing in the acute phases may be necessary to help monitor improvement or deterioration in cognitive functioning.

ASSESSMENT OF DEMENTIA

- * Dementia is a global and often progressive loss of mental ability. Assessment of dementia should include tests of attention/concentration, short- and long-term memory and delayed recall, reasoning ability, language, executive functions (e.g., planning, organizing, sequencing, abstracting), and visual-motor skills. Determination of the degree of impairment in these areas can be crucial for disposition planning.

- * No single accepted battery of tests exists. The Mattis Dementia Rating Scale and CogniStat (formerly known as Neurobehavioral Cognitive Status Examination; both tests are listed in the *Geropsychology Assessment Resource Guide*) are easily administered, well-validated tests of general cognitive functioning that can be useful in the assessment of dementia. Findings of cognitive deficits may need to be followed up with referral to neuropsychology/neurology colleagues to determine etiology and appropriate treatment.

ASSESSMENT OF DEPRESSION VERSUS DEMENTIA

Psychologists are often called upon to assist in the evaluation of the psychological status of patients with overlapping symptoms of depression and dementia (which can coexist). Depressed individuals are more likely to have an abrupt onset of symptoms, a history of psychiatric problems, decreased motivation, variability in mental status, and conspicuous complaints about their memory problems. Testing can be useful in identifying to what degree the cognitive deterioration is secondary to depression.

COMPETENCY

Competency is a legal determination. Therefore, the psychologist must be knowledgeable of state laws governing determination of competency. Psychological assessment provides useful information in making this determination.

- * The examiners must be clear which competencies they are being asked to assess. Typical referral questions include competency to drive an automobile or to make medical, legal, or financial decisions.
- * Competency is a match between an individual's abilities and environmental demands. Therefore, traditional neuropsychological tests of specific cognitive abilities must be supplemented by ecologically valid functional capacity measures (e.g., Lawton's Instrumental Activities of Daily Living Scale).
- * Awareness of cognitive deficits is often an important factor in determining competency and can be gauged by the use of specific interview questions, prior behavior, and observations of current behavior.

HOW IS A BEHAVIORAL ASSESSMENT CONDUCTED?

Behavior disorders are frequent precipitants for admission to a psychogeriatric inpatient unit and may cause significant difficulties for family members or staff in acute medical units and nursing homes. Behavior disorders can take the form of physical aggression, motor overactivity (e.g., wandering), and disruptive vocalizations. Common causes of behavior disorders are delirium, dementia, depression, psychosis, and premorbid personality traits. Interpersonal and environmental factors may be antecedent to behavioral episodes, and an assessment of these is central to developing a treatment plan. While outwardly expressed behavioral problems are easily identifiable, behavior deficits (e.g., social withdrawal) can be more easily overlooked.

- * Agitation may be the result of an underlying physical condition, and referral for a medical workup may be needed.
- * Agitation in older adults is often attributable to chronic cognitive impairment and/or overstimulation in the environment. Changes in the milieu and in the response of staff, family, or other caregivers may reduce disruptive behavior.

- * Treatment plans that are supported by detailed behavioral analyses may increase staff receptivity to necessary systemic change. For example, careful observation may determine that the wandering problem of a nursing home resident can be reduced if the administrator of the institution designates a safe place for ambulation.
- * In institutions or residences, agitation may only occur at certain times of the day or evening, or only with particular caregivers, or only during specific activities (e.g., feeding, bathing). In such cases, the possibility of modifying existing caregiver behavior or routines should be assessed.
- * Family members may more closely attend to the older adult when he or she becomes agitated. Evaluation of family members' ability or motivation to change their own behavior should be conducted.
- * Positive reinforcement of appropriate behavior in the agitated individual may increase its occurrence and reduce disruptive behavior.

HOW IS PSYCHOPATHOLOGY ASSESSED IN OLDER ADULTS?

- * Since geriatric and subclinical variants of some of the major psychological disorders exist, comparing the individual's particular scores on a continuum with the relative performance of the older age group (e.g., dimensional analysis) is preferable to the use of strict cutoffs (e.g., categorical analysis).
- * No widely used self-report measures of anxiety have been specifically developed for older adults. The Beck Anxiety Scale is brief and easily administered, but results should be viewed with caution in the assessment of frail and less educated older adults.
- * A variety of good screening measures exists for depression (e.g., Hamilton Depression Rating Scale, Beck Depression Inventory). The Geriatric Depression Scale (GDS) was specifically developed for older adults. The GDS is useful because it (1) has age-related norms; (2) can be administered in oral and written form, thus allowing for more accurate assessment of persons with mild cognitive impairment; and (3) omits somatic items that can elevate depression scores for clients who may be manifesting somatic symptoms associated with medical problems and not depression.
- * The CAGE and Michigan Alcoholism Screening Test-Geriatric Version are instruments that have demonstrated potential as alcohol screening tools with older adults.
- * Broad-based measures of psychopathology that have been normed on older people are available. The MMPI-2 is a widely used self-report instrument that was normed on persons up to 84 years of age. However, in view of its length and required reading level, it may not be practical for very old, less educated, or visually or cognitively impaired adults. The Brief Psychiatric Rating Scale is a clinician-rated scale encompassing primary domains of psychopathology and has been found to be useful with older adults.
- * Assessment of personality features can be important in planning treatment strategies. Unfortunately, there are no measures of personality disorder (PD) specifically developed for use with older adults. Current structured PD scales are lengthy, and their routine use with older adults is impractical.
- * The Rorschach Inkblot Test should only be used with caution in assessing the personality or disordered thinking of older adults. Age-related norms have not been established for the widely used Exner system,

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and psychopathology can easily be overdiagnosed by inexperienced examiners testing older adults who are not comfortable with unstructured tasks.

- * The Thematic Apperception Test has been used extensively with older adults in research studies and clinical settings. It yields geriatric themes with the same frequency as the Senior Apperception Test and Gerontological Apperception Test. Information from these measures is sometimes useful in identifying life issues that need to be addressed in psychotherapeutic interventions.

WHAT ARE THE ESSENTIALS OF A GOOD PSYCHOLOGICAL TESTING REPORT ON AN OLDER ADULT?

- * The psychologist should integrate psychological findings with relevant social and medical variables. The report should document both weaknesses and strengths.
- * The report should include the aging/cohort/cultural variables that may have affected test scores, including language barriers, low educational attainment, sensory/physical limitations, and the client's values.
- * Recommendations should be geared to enhance or maintain the older client's cognitive and psychological well-being and independence.
- * Referrals should be made to other professionals as needed, for example, to neuropsychologists for specialized cognitive testing; to mental health professionals for individual/family/group psychotherapeutic interventions; to psychiatrists for consultation on psychotropic medication; to medical internists, geriatricians, or other health care providers for assessment of physical health problems; and to social service workers for assistance with financial and community resources.
- * Re-testing may be recommended for older adults, particularly if there is variability in test scores or when an acute medical condition is suspected of affecting test results.
- * The assessment of psychological problems of older adults requires attention to a variety of complex biopsychosocial factors. Clear and timely communication of test findings and recommendations to all treatment team members, family caregivers, and especially to the older person is essential.

VI. APPROPRIATE PSYCHOLOGICAL INTERVENTIONS FOR OLDER ADULTS

Research indicates that psychological interventions that historically have been provided to younger and middle-aged adults are also effective for older adults. Many psychologists, therefore, possess therapeutic skills that could be beneficial to older adults with psychological difficulties. However, knowledge of the unique problems of late life and of the needed adaptation of psychological interventions for older adults will maximize the effectiveness of those therapeutic skills in this age group. Below are discussed general principles for conducting psychological interventions, the more common and appropriate interventions, and other useful interventions.

WHAT ARE GENERAL PRINCIPLES FOR CONDUCTING PSYCHOLOGICAL INTERVENTIONS WITH OLDER ADULTS?

- * Many older adults are referred for psychological services at the behest of a third party, most typically a spouse, adult child, or service provider. The psychologist needs to ascertain older adults' understanding of why they are meeting with the psychologist, their possible expectations for treatment, and motivation for treatment.
- * This cohort or generation of older adults' perceptions of mental health care have been shaped by historical experiences in which mental illness was much more stigmatized than today. Embarrassment or shame about receiving mental health services or concerns about psychiatric institutionalization need to be addressed more frequently among older than younger adults.
- * Older adults may require more education with regard to the rationale, structure, and goals of psychological interventions than younger persons for whom there may be greater familiarity with psychotherapy.
- * The psychologist needs to be attuned to sensory deficits, particularly hearing and vision loss, that may make communication more difficult. Attention to the environment in which services are provided, such as privacy, adequate lighting, temperature, ambient noise, and ease of access for persons with physical limitations, is required.
- * Because older adults referred for psychological treatment often have concurrent physical or social problems, coordination with other service providers is essential. It is particularly critical to ascertain whether psychological symptoms (e.g., depression, anxiety) are caused or exacerbated by underlying medical problems or medications. When needed, psychologists should obtain permission from older adults or their legal guardians to contact other service providers.
- * Although recent evidence indicates that psychologists are interested in providing psychological services to older adults, many psychologists need to be attentive to their own negative biases or stereotypes about older people, including their suitability for psychological treatment.

WHAT PSYCHOLOGICAL INTERVENTIONS ARE APPROPRIATE FOR OLDER ADULTS?

- * No single psychological intervention is preferred for older adults. The treatment of choice is guided by the nature of the problem, therapeutic goals, preferences of the older adult, and practical considerations.

Although older people share similar generational experiences, there is considerable diversity among them. As with younger individuals, differences in race, culture, gender, sexual orientation, and social class need to be taken into account in understanding problems of older adults and in making interventions.

- * Both individual and group psychotherapy appear to be effective in the treatment of older adults' psychological problems.
- * Existing psychological interventions are likely beneficial to adults regardless of age. Cognitive-behavioral, brief psychodynamic, and Klerman and Weissman's interpersonal psychotherapy have been shown to be effective in the treatment of one or more late-life mental disorders. These include depression, anxiety, sleep disturbance, and other psychological difficulties.
- * Although few studies have formally examined its efficacy in older adults, couples therapy may be an effective treatment for late-life marital or partner problems. Issues of concern raised by older adults include long-standing interpersonal differences or difficulties that arise in the context of late-life stress (e.g., one partner's physical decline and increasing dependency).
- * Since family members often play an instrumental role in bringing older adults for psychological treatment in many settings, coordination with them is important. Although most theories or research studies of family therapy do not address the late-life family, family intervention may be indicated. Because of practical problems in assembling several geographically dispersed family members with competing role responsibilities (typically children), family therapy with the elderly is often dyadic (e.g., an adult child and older adult).
- * Psychoeducational approaches developed particularly for family members caring for older adults with cognitive loss may be useful in helping them more successfully care for the impaired relative. Education about the nature of cognitive loss, problem-solving practical problems, and the provision of emotional support are key components of such psychoeducation. A similar psychoeducational approach may be useful for relatives caring for older adults with depressive or anxiety disorders.
- * For older adults experiencing significant cognitive loss, cognitive training techniques, behavior modification, and changes in the social or physical environment may lead to improved emotional health and functioning.
- * Since many people experience a diminishing of select mental abilities as they age (also called age-consistent memory decline), older adults may benefit from interventions to enhance mental performance.

WHAT OTHER INTERVENTIONS MAY BE USEFUL FOR OLDER ADULTS?

Other psychologically informed approaches exist to treat late-life problems or to enhance the quality of later life.

- * Some have observed that older people may find it beneficial to engage in reminiscence or "life review," in which past problems and successes are the focus of reflection. The goal of such an effort is to help the older person to reckon more fully with the many threads of a person's own course of adult development, with the desired result of greater psychological integration and emotional resiliency.
- * Mutual aid support groups exist for persons facing a variety of life difficulties. For older people receiving psychological treatments, they may be a useful adjunct. For example, in many regions of the country,

support groups exist for family members caring for persons with Alzheimer's Disease and for persons contending with the major medical illnesses evident in late life (e.g., Parkinson's Disease, cardiac problems, arthritis, cancer).

- * Focused efforts to facilitate grief or bereavement may be especially helpful for older adults experiencing issues of unresolved loss or contending with multiple losses.
- * Mood and memory workshops may improve functioning and are effective for properly trained psychologists to use. In addition, regular mood and memory checkups for older adults can be encouraged, just as we now encourage physical health checkups. Although age-consistent memory changes and mild depressive symptoms may be common and not severe, the discomfort they can cause should not be overlooked or downplayed. These problems may be appropriate targets for psychological intervention, much as hearing and vision loss in older adults, while common and not necessarily severe, are routinely treated with assistive devices or other interventions.



REGULAR MOOD AND MEMORY CHECKUPS FOR OLDER ADULTS CAN BE ENCOURAGED...

- * There are psychologically beneficial aspects of exercise for older adults.
- * Social and educational programs such as classes, travel, elder hostels, and volunteer work can promote socialization and social support among older people.

WHAT ADAPTATIONS OF PSYCHOLOGICAL INTERVENTIONS ARE REQUIRED FOR OLDER ADULTS?

In addition to the general principles of working with older adults outlined earlier, several adaptations of existing psychological interventions may be helpful.

- * The processes of problem-solving, learning, and behavior change may evolve more slowly for older adults.
- * Written materials that are typically part of cognitive-behavioral interventions need to be presented in a manner that is understandable to most older people and printed in type large enough so that adults with visual impairment can read them.
- * Cognitive impairment in an older client is not necessarily a contraindication to receiving psychological treatment. Although older clients must have the capacity to interact with the psychologist, understand what is discussed in therapeutic sessions, and retain the basic issues and themes of the psychotherapy, older people with mild and even moderate cognitive loss may benefit from psychotherapy. In the case of cognitively impaired older adults, interpersonal support and environmental/behavioral modification may play a greater role than with other older people.
- * Many late-life mental disorders are recurrent or chronic. The psychologist needs to be flexible about setting therapeutic goals. Goals may emphasize managing symptoms, preventing relapse, and enhancing functional capacity rather than completely ameliorating presenting problems.

HOW DOES DELIVERY OF PSYCHOLOGICAL SERVICES TO OLDER PEOPLE DIFFER ACCORDING TO THE SETTING WHERE THE OLDER PERSON RECEIVES THEM?

Psychological services may be provided to older adults in a wide range of locations including in their own homes; outpatient and inpatient medical, rehabilitative, or psychiatric settings; adult homes (also referred to as board-and-care facilities); senior centers; day care centers; and nursing homes. For some settings, specific issues must be addressed when delivering services.

- * Psychologists who see older clients within an independent practice or outpatient mental health settings need to be flexible about missed or rescheduled appointments. This is required because of acute medical crises, responsibility for care of infirm relatives, or the understandable reluctance of many older people to travel during inclement weather.
- * Close and timely coordination with other professionals is particularly important when providing psychological treatment to older people in inpatient medical, rehabilitation, or psychiatric settings where increasingly there are abbreviated lengths of stay.
- * There has been a significant increase in the delivery of mental health services by psychologists in nursing homes. Nursing home clients perhaps present the greatest challenges for psychologists of all older adults seeking psychological services.
- * Usually nursing home clients are physically frail and have cognitive deficits. This requires the psychologist to be especially flexible and creative about adapting psychological interventions so that they are most useful to the client.
- * Because psychologists sometimes work for nursing homes or depend on the cooperation of their administrators to deliver services there, sometimes they are pressured to act in ways that may not always be in the older client's best interests (e.g., silence an angry and complaining older client who may have legitimate concerns about the quality of care that is being received). Maintaining clarity that the client's interests are foremost is consistent with ethical principles.
- * Privacy of psychotherapeutic sessions may require considerable effort, because older residents often have roommates, and finding a quiet, separate place to talk may be difficult. The psychologist must make certain that the client consents to sharing the contents of any psychotherapeutic session with other staff.
- * Since the nursing home is indeed the older client's home, environmental and interpersonal issues may have an important influence on the client's emotional well-being. Interventions made on behalf of the client are sometimes necessarily those that seek to change institutional routines, reduce environmental stresses, and decrease maladaptive behavior on the part of staff toward the patient. In view of these issues, collaboration and coordination with nursing home staff are critical. (See *Standards for Psychological Services in Long-Term Care Facilities* for a more detailed account of these issues.)

WHAT OTHER ROLES CAN PSYCHOLOGISTS PLAY TO IMPROVE THE PSYCHOLOGICAL WELL-BEING OF OLDER ADULTS?

Although providing direct services to older adults is the chief focus of professional psychologists, there are other activities that may enhance the well-being of older people.

Consultation Particularly in institutional settings (e.g., nursing homes, inpatient rehabilitative, medical, psychiatric services) psychologists may consult on cases in which there are complex behavioral problems or maladaptive interpersonal behavior on the part of the older adult.

Supervision Not only do psychologists supervise psychology trainees, but they will be increasingly called upon to supervise the activities of paraprofessionals who provide a wide range of health-related services to older adults.

Prevention Psychologists may engage in activities that target the special problems or issues of particular communities of older adults with the goal of preventing the onset of mental disorders or ameliorating them at early stages. Efforts to educate older adults about mental health issues, conduct outreach to settings where older adults congregate (e.g., senior centers, education centers, senior citizen housing, special group homes for adults with mental illness, houses of worship) or conduct outreach through mobile geriatric units may be part of prevention activities. Use of psychoeducational approaches may delay the onset of illness or reduce excess disability.

VII. BROAD PROFESSIONAL ISSUES OF CONCERN TO PSYCHOLOGISTS WORKING WITH OLDER ADULTS

A number of issues crosscut the specific topics that have been previously discussed. They encompass practical topics, including sources of reimbursement for psychological services, the need for interdisciplinary collaboration in providing services to older people, and awareness of the realities of older adults from racial or ethnic minority groups and other special populations. There are also specific ethical challenges in working with this age group. Finally, psychologists can play a role in educating the larger community about mental health/behavioral health care and aging, supervising and collaborating with colleagues and other professionals, and participating in the shaping of public policy in this area.

HOW ARE MENTAL HEALTH SERVICES TO OLDER ADULTS REIMBURSED?

- * Directly or indirectly, most mental health services to older adults are reimbursed through one or more sources of public funding, notably Medicare, Medicaid, and the U.S. Department of Veterans Affairs. Local, county, and state initiatives exist in some parts of the country to enhance the scope or quality of mental health services to older people. Some older people purchase additional private insurance, typically to supplement Medicare reimbursement, and others are dually eligible for Medicare, Medicaid, or veterans' benefits.

- * In 1987 psychologists (as well as social workers) were designated as Medicare providers, which has enabled psychologists to provide fee-for-service assessment and treatment to older adults. Under this arrangement most services are reimbursed at 50 percent of fees established by Medicare.
- * Since the designation of psychologists as Medicare providers, there has been considerable expansion of mental health services into nursing homes and other residential facilities. While provision of psychological services to this population is a welcome development, reimbursement of these services has recently come under sharp scrutiny by Medicare, which has raised questions about the appropriateness of some of the services that have been delivered.
- * Increasing numbers of older people are entering managed care delivery systems, including health maintenance organizations (HMOs). HMOs provide the potential for better integrated systems of care than exist in many sectors, yet there is ongoing concern about the level of mental health services that are available within them, especially to those older persons with chronic and persistent mental illness.

WHY IS MULTIDISCIPLINARY/INTERDISCIPLINARY COLLABORATION SO IMPORTANT IN WORKING WITH OLDER ADULTS?

- * As previously noted, many older adults seeking psychological services have concurrent medical problems. Some have more than one mental disorder or coexisting social problems. Initial and ongoing collaboration with other health care professionals and family members is critical for the accurate assessment and treatment of older adults. The most tightly integrated form of collaboration is an interdisciplinary treatment team which sets team goals, develops joint treatment plans, and addresses team process and content issues.
- * In outpatient settings, collaboration with the client's primary health care provider may be critical to understanding whether initial psychological symptoms and acute changes in the client's mental status have a medical component. For older clients in need of psychotropic medication, a good working relationship with a psychiatrist may increase the likelihood that psychological symptoms improve and that medication side effects are addressed. Social workers can play a vital role in assuring that the older client and family are knowledgeable of financial entitlements and community resources that may improve the quality of life.
- * In nursing homes or in adult homes/board and care facilities, collaboration with resident staff and those who provide onsite health care services will expand the psychologist's understanding of the older client's day-to-day functioning, as well as provide opportunities to address environmental issues that may adversely affect the mental and social well-being of the older resident.

WHAT ARE ISSUES OF CONCERN IN DELIVERING SERVICES TO MINORITY OLDER ADULTS AND OTHER SPECIAL POPULATIONS?

When working with older adults, it is important to keep in mind the singular experiences of special populations, including racial and ethnic minorities and older gay men and lesbians. In addition to the unique historical experiences that have affected the lives of the larger cohort of older adults, life histories of ethnic and racial minority older people have been further shaped by their prior and current status in the society. As an example, Blacks in this older adult age group spent much of their lives receiving separate, but not always equal,

segregated health services. These experiences will often influence health-related attitudes and behaviors in the present.

WHAT ARE SOME BASIC FACTS ABOUT ETHNIC AND MINORITY AGING?

- * In the future, the older population will be much more racially and ethnically diverse. The current older population is predominantly White. However, by the middle of the next century, the number of older Black persons will more than triple, increasing their proportion of the total older adult population from 8 to 10 percent. More dramatically, the Hispanic population will increase nearly 11 fold, rising from less than 4 percent of today's older adults to nearly 16 percent.
- * Achieving a healthier America depends on significant improvements in the health of those who are at highest risk of premature death, disease, and disability, which include many minority older people. Poor income and low literacy, which are associated with minority status, are important risk factors for the major chronic illnesses. For example, the risk of death from heart disease is more than 25 percent higher for low income people than it is for the overall population. People in families with incomes of less than \$13,000 a year are twice as likely as the total population to be limited in major activities of daily living because of health. Activity of daily living limitations are 4 times more common among people with 8 or fewer years of education than among those with 16 years or more.
- * There is a robust correlation between lower educational attainment and low income. The fastest growing group of older Americans are the poor and the octogenarians (ages 85+ years). These groups use a higher percentage of the overall health budget and have longer hospital stays and more physician visits.
- * Each minority group of older adults has a unique history which, in many cases, has been influenced by discrimination. There are, of course, many differences among individuals within each group.

WHAT HEALTH-RELATED INFORMATION IS IMPORTANT TO KNOW IN DELIVERING SERVICES TO OLDER MINORITY GROUP INDIVIDUALS?

- * The onset of chronic illness is usually earlier than in White older adults.
- * There are frequent delays in seeking health-related treatments.
- * Problems are underreported to health care providers or only conveyed to them in generalities until trust is established.
- * Mental health services are underutilized.
- * There are high rates of noncompliance with medical regimens and treatment dropout.
- * There is evidence of increased tolerance to illness/disorder/discomfort to which individuals have adapted.
- * Although longevity for Black older men is shorter than for White older adults, after age 75 Blacks live longer than Whites ("racial crossover").
- * There is a higher incidence of obesity and late onset diabetes.
- * A sizable number of minority older adults do not qualify for Medicaid in some states.

- * Minority older adults frequently have been excluded from drug research.
- * Factors contributing to poor mental health include: poverty, segregated and disorganized communities, poor quality of education, few role responsibilities, sporadic and chronic unemployment, stereotyping, discrimination, and poor health care.
- * Access to mental health care is problematic for many minority older persons because up to 40 percent of psychiatrists will not accept Medicaid patients.
- * As with the majority of older adults, chief providers of mental health services are more likely to be primary health care physicians (nonpsychiatrists).
- * There is frequent misdiagnosis. For example, an older Black man may act suspiciously toward White mental health care staff who might interpret this as paranoia, without taking into consideration past adverse experiences with health care providers.
- * There is overrepresentation in state mental hospitals.
- * Some minority older adults use dual systems of care in which other approaches to health care augment Western approaches. Knowledge of dual systems of health care is important because minority older people may not readily accept traditional western formulations of their problems. They may be wary of interventions that do not make sense within their belief system.

WHAT ARE SOME ISSUES IN THE ASSESSMENT OF MINORITY OLDER ADULTS?

- * Few assessment instruments have been normed on minority older adults, which raises caution about interpretation of test findings in these groups.
- * Assessment of minority older adults should take into account literacy and fluency in speaking and understanding English.
- * Notably, instruments have been developed, for example, to assess mental status, depression, dementia, and pain in ethnic minority individuals.

WHAT ARE SPECIAL ETHICAL ISSUES IN DELIVERING PSYCHOLOGICAL SERVICES TO OLDER ADULTS?

Working with older adults may present special challenges to the psychologist. This is because older adults receive care from overlapping and not always well-integrated health systems. For some adults with chronic illness, both family members and paid caregivers are involved. In some settings (e.g., nursing homes, adult homes, board and care facilities), older adults both live and receive care in the same facility. With late life also comes increasing risk of severe physical debilitation and death. Because of these factors, there are particular ethical issues pertaining to confidentiality and end-of-life decisionmaking for professionals working with older adults.

- * APA's Ethical Principles of Psychologists and Code of Conduct provides a framework for understanding central issues on the ethical treatment of older and younger clients. With older adults, however, issues arise that require careful evaluation and application of those principles.

- * It is important to note that unless declared incompetent, the older adult has a right to make decisions to initiate, withdraw, or terminate treatment. They have the right to personal autonomy and to refuse medications, surgery, and research participation.
- * In community settings adults, children, spouses, and other caregivers are frequently in contact with mental health professionals. To assure confidentiality, written permission should be obtained from older persons to communicate information regarding their status to relatives or to health care professionals.
- * For older persons with dementia, or other forms of significant cognitive impairment, confidentiality issues can become complex because questions may arise about the cognitively impaired older person's ability to give truly informed consent to release information. Competency is a legal judgment, rules for which vary from state to state. However, if the older person is legally judged incompetent, then the appointed guardian is responsible for release of information. Some cognitively compromised persons have signed a document that grants permission to another individual, usually a spouse or adult child, to manage their affairs, in which case this is the person responsible for consent. In some cases the as yet legally competent older client may be willing to sign a consent form, yet the psychologist may have serious doubt about their ability to understand what is being requested. In this case, the psychologist must use best judgment guided by the principle that what is done is in the client's best interest.
- * In nursing homes and assisted care facilities, some older clients whom the psychologist sees may be distressed over problems with the facility or staff. Some staff may request information from the psychologist to clarify the nature of the older client's concerns and seek solutions to problems. Authorization to disclose information must be provided by the older client or guardian. Even if permission is granted, the psychologist must communicate only that information that is pertinent to the specific issue at hand.
- * The Patient Self-Determination Act of 1990 requires Medicaid and Medicare provider organizations to request at patient admission advanced directives from the client regarding termination of care. Another form of directive is the living will. The psychologist working with a severely ill older person may be part of a decisionmaking process that also includes family and medical personnel regarding end of life issues (e.g., whether or not to make extraordinary efforts to prolong the patient's life). In these circumstances, the psychologist's central task is to help patient and family better understand issues and options and help them to make value laden decisions without imposing the psychologist's own views.

WHAT ARE LARGER ROLES THAT THE PSYCHOLOGIST WITH A PROFESSIONAL INTEREST IN OLDER ADULTS CAN PLAY?

- * **Education.** Psychologists can educate other professionals about the facts regarding normal aging, problems that some older adults encounter, and psychological interventions to address those problems. Educational efforts take place in a range of settings including the traditional classroom, institutional settings, continuing education offerings, professional meetings, media appearances, and during consultations or informal discussions with individual colleagues. There are also many opportunities for the education of family members, who provide 80 percent of all long-term care.

- * **Advocacy.** Psychologists may engage in a wide variety of advocacy efforts on behalf of older adults, especially those in need of mental health services. The focus of these activities may be directed at public policy on the local, state, or national level or in concert with the activities of professional organizations concerned with the social and emotional well-being of older people. The psychologist should respond to notices of proposed changes in mental health laws and rule making.
- * **Research.** Providing psychological services to older adults may present unique opportunities to initiate research studies or collaborate with those for whom research is their primary professional focus.

CONCLUSION

As the number of older adults increases in the 21st Century, psychologists are in a position to enjoy the challenges and rewards of working with those adults as they address their developmental and psychologically related issues and enhance their intellectual, social, and emotional well-being. Armed with facts about the myths and realities of aging, knowledgeable about the problems older adults face, cognizant of how to assess and treat older persons, and familiar with broader professional issues in aging, psychologists can maximize their efforts to assist this large and diverse segment of our society.

— PROFESSIONAL RESOURCES IN GEROPSYCHOLOGY —

APA Affiliated Groups/Divisions

Division 12, Section II (Clinical Geropsychology)

Lynn G. Peterson, Administrative Officer
P.O. Box 1082
Niwot, CO 80544
PHONE: (303) 652-3126
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Division 20 (Adult Development and Aging)

APA Division Services
PHONE: (202) 336-6013

APA Committee on Aging

Public Interest Directorate
American Psychological Association
750 First Street, NE
Washington, DC 20002-4242
PHONE: (202) 336-6050
FAX: (202) 336-6040
EMAIL: publicinterest@apa.org

Other Societies/Organizations

American Society on Aging

Mental Health and Aging Network
833 Market Street, Ste. 511
San Francisco, CA 94103-1824
PHONE: (415) 974-9600

Gerontological Society of America

Mental Health Practice and Aging Interest Group
1030 15th Street, NW, Ste. 250
Washington, DC 20005-1503
PHONE: (202) 842-1275
FAX: (202) 842-1150
EMAIL: geron@geron.org
HTTP://www.geron.org

Psychologists in Long-Term Care

Peter Lichtenberg, PhD
261 Mack Blvd.
Detroit, MI 48201
PHONE: (313) 745-9763
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State Psychological Associations With Divisions or Interest Groups on Aging

New York Psychological Association

Division of Adult Development and Aging
Diane B. Kermani, Executive Director
Six Executive Park Drive
Albany, NY 12203
PHONE: (518) 437-1040

North Carolina Psychological Association

Public Advocacy Committee
Sally Cameron, Executive Director
1004 Dresser Court, Ste. 106
Raleigh, NC 27609-7353
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Ohio Psychological Association

Kathy French, Executive Director
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Columbus, OH 43215-1599
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