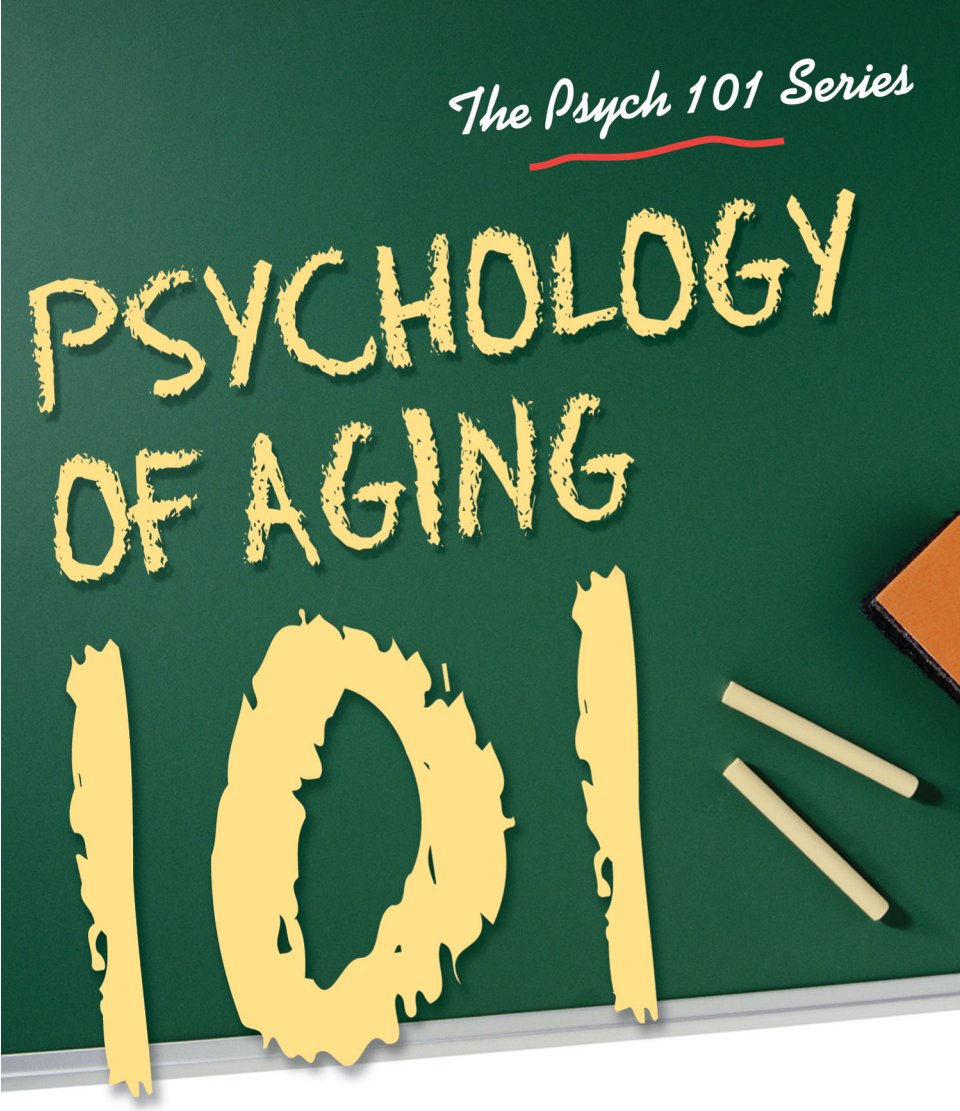


t.me/BooksandYou

Robert Youdin

SPRINGER PUBLISHING COMPANY

This is a sample from PSYCHOLOGY OF AGING 101
Visit This Book's Web Page / Buy Now / Request an Exam/Review Copy

me/BooksandYou

The Psych 101 Series

James C. Kaufman, PhD, Series Editor
Neag School of Education
University of Connecticut

©Springer Publishing Company

This is a sample from PSYCHOLOGY OF AGING 101
Visit This Book's Web Page / Buy Now / Request an Exam/Review Copy

Robert Youdin, PhD, is an independent scholar at the Princeton Research Forum. He has been a private practitioner for the past 31 years and practices in Princeton, New Jersey. For 20 years, Dr. Youdin was an adjunct associate professor at the Fordham University Graduate School of Social Service in New York City. In 2007–2008, he was a project director for a Gero Innovations Grant for the Master's Advanced Curriculum Project funded by the John A. Hartford Foundation and Council on Social Work Education. In 2005–2007, Dr. Youdin was a participant in the Curriculum Development Institute (Gero-Ed) sponsored by the John A. Hartford Foundation and Council on Social Work Education. He is a past assistant research scientist of the Biometrics Unit of the New York State Psychiatric Institute in New York City. In 1977, he was elected as member of Sigma Xi, the Scientific Research Society of North America. In addition, he has appeared on numerous public service radio programs discussing older adult substance abuse and eating disorder problems. Dr. Youdin enjoys creating an existential oasis of peace and serenity when playing jazz piano. Dr. Youdin's website can be visited at www.youdin.net.

t.me/BooksandYou

©Springer Publishing Company

This is a sample from PSYCHOLOGY OF AGING 101
Visit This Book's Web Page / Buy Now / Request an Exam/Review Copy

Psychology of Aging 101

Robert Youdin, PhD

.me/BooksandYou

SPRINGER PUBLISHING COMPANY
NEW YORK

©Springer Publishing Company

This is a sample from PSYCHOLOGY OF AGING 101
Visit This Book's Web Page / Buy Now / Request an Exam/Review Copy

Copyright © 2016 Springer Publishing Company, LLC

All rights reserved.

No part of this publication may be reproduced, stored in a retrieval system, or transmitted in any form or by any means, electronic, mechanical, photocopying, recording, or otherwise, without the prior permission of Springer Publishing Company, LLC, or authorization through payment of the appropriate fees to the Copyright Clearance Center, Inc., 222 Rosewood Drive, Danvers, MA 01923, 978-750-8400, fax 978-646-8600, info@copyright.com or on the Web at www.copyright.com.

Springer Publishing Company, LLC
11 West 42nd Street
New York, NY 10036
www.springerpub.com

t.me/BooksandYou

Acquisitions Editor: Sheri W. Sussman
Composition: S4Carlisle Publishing Services

ISBN: 978-0-8261-3012-9
e-book ISBN: 978-0-8261-3013-6

16 17 18 19 20 / 5 4 3 2 1

The author and the publisher of this Work have made every effort to use sources believed to be reliable to provide information that is accurate and compatible with the standards generally accepted at the time of publication. The author and publisher shall not be liable for any special, consequential, or exemplary damages resulting, in whole or in part, from the readers' use of, or reliance on, the information contained in this book. The publisher has no responsibility for the persistence or accuracy of URLs for external or third-party Internet websites referred to in this publication and does not guarantee that any content on such websites is, or will remain, accurate or appropriate.

Library of Congress Cataloging-in-Publication Data

Names: Youdin, Robert, author.
Title: Psychology of aging 101 / Robert Youdin.
Description: New York : Springer, [2016] | Includes bibliographical references and index.
Identifiers: LCCN 2015038173 | ISBN 9780826130129
Subjects: LCSH: Aging—Psychological aspects. | Older people—Psychology.
Classification: LCC BF724.55.A35 Y68 2016 | DDC 155.67—dc23 LC record available at http://lccn.loc.gov/2015038173

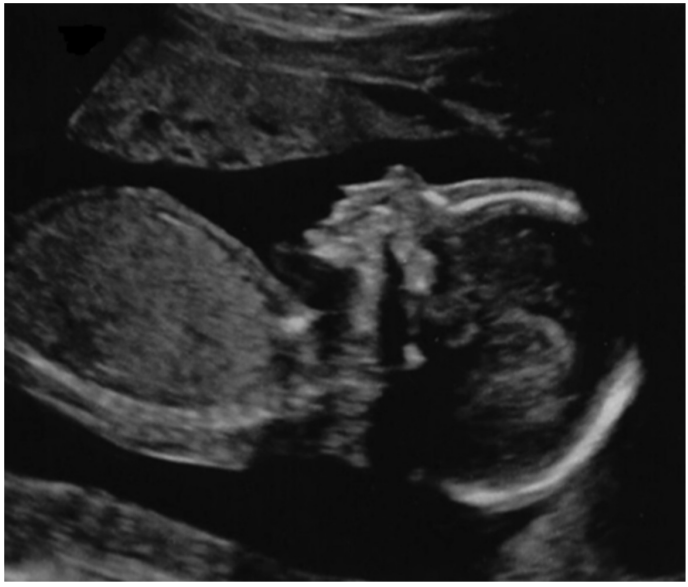
Special discounts on bulk quantities of our books are available to corporations, professional associations, pharmaceutical companies, health care organizations, and other qualifying groups. If you are interested in a custom book, including chapters from more than one of our titles, we can provide that service as well.

For details, please contact:
Special Sales Department, Springer Publishing Company, LLC
11 West 42nd Street, 15th Floor, New York, NY 10036-8002
Phone: 877-687-7476 or 212-431-4370; Fax: 212-941-7842
E-mail: sales@springerpub.com

Printed in the United States of America by Gasch Printing.

©Springer Publishing Company

This is a sample from PSYCHOLOGY OF AGING 101
Visit This Book's Web Page / Buy Now / Request an Exam/Review Copy



To my grandson Charlie, who is beginning his life journey
at the time I am beginning the end of my life journey

©Springer Publishing Company

This is a sample from PSYCHOLOGY OF AGING 101
Visit This Book's Web Page / Buy Now / Request an Exam/Review Copy

The Psych 101 Series

James C. Kaufman, PhD, Series Editor
Neag School of Education
University of Connecticut

©Springer Publishing Company

This is a sample from PSYCHOLOGY OF AGING 101
Visit This Book's Web Page / Buy Now / Request an Exam/Review Copy

Contents

Acknowledgments ix

Introduction 1

Chapter 1 Older Adults Are Not All the Same 9

Chapter 2 Ageism and Stigma 27

Chapter 3 Psychological Problems That Older Adults Experience 53

Chapter 4 Normal Cognitive Decline, Mild Cognitive Impairment, and Dementia 79

Chapter 5 Older Adults and Their Sexual Lives 109

Chapter 6 Substance Abuse/Dependence Is Not Just a Problem for Young People 129

Chapter 7 Older Adult Abuse 167

©Springer Publishing Company

This is a sample from PSYCHOLOGY OF AGING 101
Visit This Book's Web Page / Buy Now / Request an Exam/Review Copy

Chapter 8 Environmental Geropsychology 191

Chapter 9 Issues Surrounding Dying and Death 209

Chapter 10 Future Areas for Psychologists Interested in the Psychology of Aging 231

Index 237

©Springer Publishing Company

This is a sample from PSYCHOLOGY OF AGING 101
Visit This Book's Web Page / Buy Now / Request an Exam/Review Copy

Acknowledgments

I am most grateful to Sheri W. Sussman, my editor at Springer Publishing Company, who gave me the wonderful opportunity to write this book introducing the exciting field of aging to psychology students and professors. Her support and guidance, and, yes, sometimes criticism, created an environment of inspiration and humanism consistent with my experiences with the wonderful staff at Springer.

I would like to acknowledge the many psychologists and psychiatrists who were my mentors, professors, and friends, who through the years have encouraged me and supported my academic and clinical endeavors. I am forever grateful to Samuel Sutton, Arnold Mordkoff, Donald Spence, Nancy Hemmes, Benito Mustine, Milton Erickson, Sidney Rosen, Rhea Tuxen, Ted Coons, Paul Wachtel, and Bob Holt. In addition, I would like to acknowledge the many students I have had the privilege of teaching who consistently impressed me with their intellectual curiosity and highly motivated desire for learning. And, last but not least, I would like to acknowledge the many older adults I have encountered in my clinical practice who allowed me the privilege to enter their lives for brief moments and taught me the richness of their lives, shared their struggles with the trials and tribulations of late life, and taught me life lessons about being vital, interesting, and dignified while aging.

©Springer Publishing Company

This is a sample from PSYCHOLOGY OF AGING 101
Visit This Book's Web Page / Buy Now / Request an Exam/Review Copy

ACKNOWLEDGMENTS

This book would not have been possible without the extraordinary support and love from my wife, Naomi Browar. She sacrificed many hours of having my companionship without complaint, always offering encouragement and insightful advice from her clinical practice. In addition, I thank Yoni Youdin for his consistent support and companionship while I was writing this text.

©Springer Publishing Company

This is a sample from PSYCHOLOGY OF AGING 101
Visit This Book's Web Page / Buy Now / Request an Exam/Review Copy

Creativity 101
James C. Kaufman, PhD

Genius 101
Dean Keith Simonton, PhD

IQ Testing 101
Alan S. Kaufman, PhD

Leadership 101
Michael D. Mumford, PhD

Anxiety 101
Moshe Zeidner, PhD
Gerald Matthews, PhD

Psycholinguistics 101
H. Wind Cowles, PhD

Humor 101
Mitch Earleywine, PhD

Obesity 101
Lauren M. Rossen, PhD, MS
Eric A. Rossen, PhD

Emotional Intelligence 101
Gerald Matthews, PhD
Moshe Zeidner, PhD
Richard D. Roberts, PhD

Personality 101
Gorkan Ahmetoglu, PhD
Tomas Chamorro-Premuzic, PhD

Giftedness 101
Linda Kreger Silverman, PhD

Evolutionary Psychology 101
Glenn Geher, PhD

Psychology of Love 101
Karin Sternberg, PhD

Intelligence 101
Jonathan Plucker, PhD
Amber Esping, PhD

Depression 101
C. Emily Durbin, PhD

History of Psychology 101
David C. Devonis, PhD

Psychology of Trauma 101
Lesia M. Ruglass, PhD
Kathleen Kendall-Tackett, PhD, IBCLC, FAPA

Memory 101
James Michael Lampinen, PhD
Denise R. Beike, PhD

Media Psychology 101
Christopher J. Ferguson, PhD

Positive Psychology 101
Philip C. Watkins, PhD

Psychology of Aging 101
Robert Youdin, PhD

Creativity 101, Second Edition
James C. Kaufman, PhD

©Springer Publishing Company

This is a sample from PSYCHOLOGY OF AGING 101
Visit This Book's Web Page / Buy Now / Request an Exam/Review Copy

©Springer Publishing Company

This is a sample from PSYCHOLOGY OF AGING 101
Visit This Book's Web Page / Buy Now / Request an Exam/Review Copy

Ageism and Stigma

There is no need to be afraid of death. It is not the end of the physical body that should worry us. Rather, our concern must be to live while we're alive—to release our inner selves from the spiritual death that comes with living behind a façade designed to conform to external definitions of who and what we are.

Elisabeth Kübler-Ross (1975, p. 164)

A psychologist must confront many prejudices against older adults that are manifested in most people in non–older adult cohorts (see Chapter 1). Many caregivers and spouses/partners of older adults also hold these negative perceptions of older adults. Most importantly, a psychologist has a professional imperative to recognize any prejudices he or she may have toward older adults that would subsequently interfere with his or her ability to render care to older adults.

Clinical psychologists specializing in geropsychology work with individual older adults; family members of older adults, including spouses/partners, siblings, and adult children; and

©Springer Publishing Company

This is a sample from PSYCHOLOGY OF AGING 101
Visit This Book's Web Page / Buy Now / Request an Exam/Review Copy

caregivers when treating the psychological problems experienced by older adults and dealing with issues of caregiving to older adults experiencing mental illness (see Chapter 3), dementia (see Chapter 4), and/or psychological reactions to co-occurring medical illnesses.

Unlike clinical psychologists, community psychologists help older adults by developing techniques and strategies for governments, civic organizations, and vocational organizations to expand help for older adults beyond traditional psychotherapy. They do this in the capacity of policy developers, program evaluators, researchers in community organizations, professors in university settings, consultants and researchers for government organizations, and program directors.

Community psychologists engage in research with the goal of developing effective action-oriented strategies to develop programs, to facilitate the implementation of programs, and to develop means to evaluate programs for their effectiveness in fighting oppression and social inequalities that effect marginalized populations in the workplace and institutions serving older adults, and to train health care professionals, first responders, police, and other public professionals serving older adults. These programs are designed to solve social and psychological problems on a community level rather than the individual/family/group level seen in clinical psychology.

Unfortunately, despite the fact that older adults are affected by the forces of ageism and stigma, and the fact that community psychologists strive to understand and improve social inequalities and to enable empowerment of marginalized people, there is a significant dearth of research in the field of community psychology (Cheng & Heller, 2009). Cheng and Heller found that when using the publication search engine PsycINFO with the keywords *elderly*, *older adults*, and *aging*, they were only able to locate fewer than 80 articles. This search is in sharp contrast to other searches these authors performed looking for articles on *race*, *gender*, *sexism*, and *ethnic diversity*, social forces that dramatically affect other disadvantaged groups. *Race* and *gender* produced over 450 articles. The authors found that special journal

©Springer Publishing Company

This is a sample from PSYCHOLOGY OF AGING 101
Visit This Book's Web Page / Buy Now / Request an Exam/Review Copy

issues represented the topics of sexism and ethnic diversity. This lack of evidence-based research about older adults indicates that a community psychologist most likely will have a deficit of knowledge about older adult communities. Therefore, an opportunity is present for community psychologists interested in research to address this dearth of research studies.

AGEISM

The overriding theory that explains the underlying types of ageism is *terror management theory*. Terror management theory (Greenberg, Solomon, & Pyszczynski, 1997) is based on a theory first described by Becker (1973) called the *theory of generative death anxiety*. This theory indicates that the anxiety experienced by people knowing that their death is inevitable causes people to engage unconsciously in behaviors to avoid any perception of their ultimate mortality. Therefore, older adults become an obvious target (Martens, Goldenberg, & Greenberg, 2005) of these anxieties because older adults represent, to many, a life stage of dying and death (see Chapter 9).

Death anxiety is a clinical issue of importance to psychologists because death anxiety is the most chronic anxiety experienced by people across all life stages (Greenberg & Arndt, 2011). Most anxieties treated by psychologists (see Chapter 3) are experienced consciously. Conscious experience means that the person suffering from anxiety is aware that he or she is anxious and is aware of the fear and discomfort being felt. Anxiety disorders affecting older adults include panic disorder, agoraphobia, generalized anxiety disorder, adjustment disorder with anxiety, and obsessive-compulsive disorder. Death anxiety is experienced unconsciously and is considered to be an existential anxiety (Winkielman & Berridge, 2004). Existential anxiety that relates to death occurs when a person experiences a heightened awareness of his or her mortality. This is often repressed (becomes unconscious) and is displaced onto older adults who

©Springer Publishing Company

This is a sample from PSYCHOLOGY OF AGING 101
Visit This Book's Web Page / Buy Now / Request an Exam/Review Copy

represent dying and death. This displacement causes a person experiencing death anxiety to act in a biased and negative manner toward older adults.

Greenberg et al. (1990) feel that a person experiencing death anxiety develops a prejudice called *in-group bias/out-group prejudice*. In-group bias/out-group prejudice is a phenomenon whereby a person favors people in a group he or she belongs to over those who are so-called out-group members. People identifying with an in-group tend to give positive attributions to events and behaviors within the in-group and, conversely, to give negative attributions to events and behaviors within the out-group. With regard to a person experiencing death anxiety who is not an older adult, older adults are seen as an out-group that symbolically represents the end stage of life, whose finality is death. Therefore, a person experiencing death anxiety will deflect existential anxiety about his or her fear of mortality by producing negative, prejudicial attitudes toward older adults, and by acting out negative behaviors toward older adults. This deflection of anxiety is called *ageism*.

Psychologists also experience death anxiety. Psychologists may exhibit prejudice toward older adults due to their own defense against the fear of their mortality. This causes many people entering the field of psychology, and some already trained as psychologists, to be reluctant to treat older adults based on the false assumption that older adults are rigid in their ways, and consequently are unable to change (Lee, Volans, & Gregory, 2003). In addition, older psychologist cohorts may still hold the ageist view of Sigmund Freud, who felt that adults age 50 or greater are not candidates for psychoanalysis because learning stops at age 50 (Freud, 1900/1953).

Another aspect a psychologist must be vigilant about is using patronizing speech when communicating with an older adult. This type of speech is known as *elder speak* or *secondary baby talk* (Kemper, Otrhick, Gerhing, Gubarchuk, & Billington, 1998; Miller, 2009; Ruscher, 2001; Williams & Nussbaum, 2001). This speech pattern is common when a younger adult speaks to an older adult and is similar to when one speaks to an individual with disabilities (Giles & Gasiorek, 2011; Hummert & Ryan, 2001).

©Springer Publishing Company

This is a sample from PSYCHOLOGY OF AGING 101
Visit This Book's Web Page / Buy Now / Request an Exam/Review Copy

Less patronizing communication to an older adult from a younger adult is shown to have positive effects on the psychological well-being of an older adult (Giles, McCann, Ota, & Noels, 2002). This type of positive communication is called *symbiotic niceness*, whereby an older adult and a psychologist each benefit by creating a positive relationship (Li, 2004). By restructuring communication with an older adult, a psychologist creates a communication environment that leads to equality in decision making (Daveson et al., 2013; Haggstrom, Mamhidir, & Kihlgren, 2010; Hain & Sandy, 2013). This symbiotic niceness can also be taught by the psychologist to spouses/partners, caregivers, and relatives who are involved with caregiving activities to an older adult. This positive change in communication is an important intervention that helps prevent the older adult abuse (see Chapter 7) that is perpetrated on many older adults by caregivers.

Types of Ageism

There are four types of ageism: personal, institutional, intentional, and unintentional (Anti-aging Task Force, 2006). *Personal ageism* occurs when non-older people view older people as incompetent or incapable of functioning properly. This form of ageism intersects with stigmatized aspects of older adults (see the following section on stigma). *Institutional ageism* occurs when institutions create policies that discriminate against older people. An egregious example of institutional ageism occurred in Japan, where it was found that municipal governments failed to keep track of where centenarians (see Chapter 1) were residing (Ebihara, Freeman, Ebihara, & Kohzuki, 2010). This failure put these older adults at risk by not providing needed social/medical/psychological services. This institutional trend in Japan led to the term *missing centenarians*.

Institutional ageism often occurs in nursing homes. An older adult who is a resident in a nursing home is often abused by staff members when he or she complains in a hostile manner, or is experiencing dementia (Burgess, Dowdel, & Prentky, 2000; Burgess & Morgenbesser, 2005). This abuse may be verbal,

©Springer Publishing Company

This is a sample from PSYCHOLOGY OF AGING 101
Visit This Book's Web Page / Buy Now / Request an Exam/Review Copy

physical, or sexual (see Chapter 7). Many of the older adults abused in nursing homes have a history of being abused by caregivers prior to admission to a nursing home (Dong & Simon, 2013). Older adult residents in nursing homes who are cognitively free of dementia often have a higher incidence of verbal abuse that causes anxiety and depressive disorders (Begle et al., 2011; Tatara, 2001).

Another example of institutional ageism is found in social and governmental policies in the United States. In a classic policy analysis, Callahan (1987) warns of an ongoing health care system crisis that will escalate as more and more of the baby-boom generation passes 65 years of age. Callahan describes that this is caused by the increasingly high utilization of health care and psychiatric care services by older Americans. Likewise, Peterson (1999) indicates that advocates for children blame older Americans who receive government funding and benefits for subsequently causing inadequate funding for food, housing, and education for children. This trend of policy antagonisms may inspire an intergenerational war in developed countries.

For psychologists, this causes a dilemma. Due to the pressure to decrease funding for Medicare and Medicaid recipients (Kakani, 2011; Moffit & Senger, 2013), psychological services available to older adults are in serious jeopardy. This may occur because any increase in spending for Medicare and Medicaid increases the national debt. Critics of Medicare and Medicaid feel that increased spending for health care causes a decrease in spending for other domestic needs, causing an eventual economic stagnation. Campbell (2003) feels that this age bias is driven by younger policymakers who are demonizing older adults even though the policies currently supporting older adults' mental health and health care needs are successful.

Intentional ageism occurs when attitudes and rules that discriminate against older people are maintained even though they are recognized as age-biased. Examples of intentional ageism are when an older person is denied employment simply because of his or her age, and the practice in some hospitals whereby some emergency room staff members who are reluctant to treat

©Springer Publishing Company

This is a sample from PSYCHOLOGY OF AGING 101
Visit This Book's Web Page / Buy Now / Request an Exam/Review Copy

an older adult often label the older adult a *GOMER* ("get out of my emergency room"). *Unintentional ageism* occurs when there is no recognition that attitudes and rules are discriminating against older people. An example would be a planned community in which older adults reside with younger people, but elevators and ramps are lacking or nonexistent in the community. More often than not, references in broadcast and print media favor youth and are disparaging of older adults.

ADDITIONAL CLASSIC THEORIES OF AGEISM

Butler (1969) was the first to introduce the phenomenon called *ageism*. Butler described ageism as when a person has a negative attitude toward an older adult based on numerous negative stereotypes of older adults. These negative attitudes based on biased stereotypes of older adults are experienced continuously across all of a person's developmental stages. This chronic experience of negative reactions to older adults is cumulative, creating greater negativity toward older adults as people age. The majority of older adults have experienced age discrimination and stigmatization at some time after the age of 65 (Palmore, 2001). This negativity is most acutely expressed by adult men and younger people (Palmore, Branch, & Harris, 2005). Butler (Butler, 1975, 1995) indicates that according to *social identity theory*, younger people distance themselves from older adults by identifying exclusively with their own age group and reducing older adults to being other than fellow human beings. This dehumanization of older adults can be extended to a model developed for gender inequality described as *benign condescension* (Glick & Fiske, 2001). Conversely, Rupp, Vodanovich, and Crede (2005) report that as one ages, the level of ageism held by the older adult decreases. Therefore, older adults hold more positive attitudes toward older target groups than do younger adults.

©Springer Publishing Company

This is a sample from PSYCHOLOGY OF AGING 101
Visit This Book's Web Page / Buy Now / Request an Exam/Review Copy

The New Ageism

Another foundational study of ageism led to the theory described by Kalish (1979) as the *new ageism*. This theory explains how older professionals, even if they are advocates for older adults, will display age bias to the patients/clients they serve. In the case of a psychologist treating an older adult, the older psychologist may view his or her patient as less capable, less healthy, and less alert because the older adult is seeking help. When the psychologist compares the older adult to himself or herself, this prejudice is exacerbated because the psychologist is *healthy* and is treating an *unhealthy* person.

This phenomenon can happen whether the psychologist is treating psychopathologies such as depressive disorders and anxiety disorders, or giving supportive advice for life events the older adult is experiencing. These may include coping with a serious illness, having problems adjusting to a new neighborhood, being confused about managing finances, and experiencing *disenfranchised grief* (Doka, 2002). Disenfranchised grief occurs when an older adult experiences a loss that appears insignificant to others, such as the loss of a pet. The older adult becomes isolated in his or her grief and suffers emotional distress similar to what others feel when they lose a loved one. Bodner and Lazar (2009) indicate that this type of discrimination between an older adult (healthy psychologist) to an older adult (unhealthy patient/client) is an indication of prejudice toward older adults by the discriminator that has been brought forward from earlier developmental stages to his or her current life stage as an older adult. This is a form of intragenerational ageism in which older adults are biased toward fellow older adults when a group identity is labeled as *old age* (Kite & Wagner, 2002).

The Incompetence Model

Kalish (1979) extended the new ageism theory to the macro level of institutional-level ageism. In this model, institutions that advocate for older adults, and provide funding for older adults, do

©Springer Publishing Company

This is a sample from PSYCHOLOGY OF AGING 101
Visit This Book's Web Page / Buy Now / Request an Exam/Review Copy

so while ironically arguing that older adults are incompetent and therefore need the help of the respective institution. The programs created by this funding highlight the fact that older adults are incompetent in their social and psychological functioning, as evidenced by their need for help. This argument of older adult incompetence distorts the needs of a minority group of older adults who are the least independent and competent of older adults, by representing that such incompetency is typical of the whole of older adults. This facilitates and promotes the ageism that ultimately leads to biased treatment of older adults.

The Geriactivist Model

In this model, Kalish (1979) describes how older professionals who advocate for and/or treat older adults identify with younger professionals, and consequently bias treatment decisions for the older adults they are trying to help. This psychological collusion may happen when an older psychologist is treating an older adult, or participating on a treatment team treating an older adult, when the older psychologist joins with the ageist views of younger colleagues. It has been known for many years, and to this day, that the ageist views of mental health professionals often cause older adults not to be diagnosed with depression or to be misdiagnosed with dementia (Lambert & Bieliaukas, 1993). The overriding concern of the consequence of ageist views of older adults by treating psychologists is resulting inadequate treatment that further exacerbates psychological disorders (Cuddy & Fiske, 2002).

STIGMA

Stigma is a concept first described by Goffman (1963). Goffman indicates that stigma is a process that reduces vulnerable people (in this book, older adults) to a negative status of having *spoiled identities*. Spoiled identities cause a minority group

©Springer Publishing Company

This is a sample from PSYCHOLOGY OF AGING 101
Visit This Book's Web Page / Buy Now / Request an Exam/Review Copy

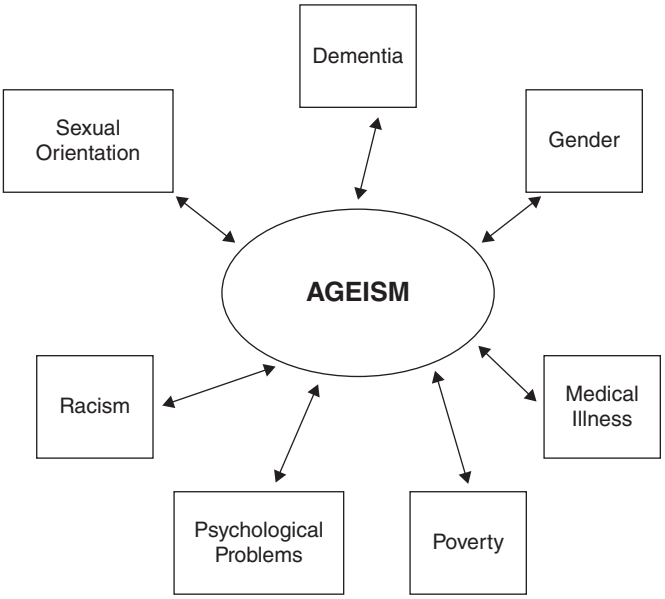


FIGURE 2.1 Intersection of stigmatized labels of older people with ageism.
Adapted from Youdin (2014).

(older adults) to aggregate together based on negative attributes (Burke, Martens, & Fauchner, 2010). This aggregation is the point of intersection (Figure 2.1) where ageism joins different stigmatized labels created by the majority against the minority (Cavelti, Kvrgic, Beck, Rusch, & Vauth, 2012).

OTHER TYPES OF STIGMA

Self-Stigma

When the non–older adult majority stigmatizes older adults, many of these older adults identify with this stigma. The identification with the stigmatized view of how others see them causes

©Springer Publishing Company

This is a sample from PSYCHOLOGY OF AGING 101
Visit This Book's Web Page / Buy Now / Request an Exam/Review Copy

many older adults to internalize the stigma directed at them. This process of internalization is called *self-stigma*. Paradoxically, this internalized process in turn becomes a validation of the stigma directed by others to older adults (Cavelti et al., 2012).

Corrigan, Watson, and Barr (2006) describe three subtypes of self-stigma: *stereotype agreement*, *self-concurrence*, and *self-esteem decrement*. Of these three subtypes, self-esteem is a key indicator of the severity of self-stigma that an older adult may experience (Schmeichel et al., 2009). If the older adult has a strong intact sense of self, the incidence of self-stigma will be attenuated as compared with an older adult who has a reduced sense of self.

Courtesy Stigma

The many labels used by the majority of non-older adults cause older adults to be devalued and marginalized. These labels exacerbate the stigma of being old by adding other stigmatized concepts, such as gender, race, poverty, sexual orientation, and medical/psychological illness. Goffman (1963) indicates that for stigmatized individuals, the stigma is not restricted to the individual (older adult). By being associated with the stigmatized older adult, spouses/partners, caregivers, adult children, siblings, other relatives, and friends become stigmatized by association. This is called *courtesy stigma*.

STIGMATIZED LABELS OF OLDER ADULTS THAT INTERSECT WITH AGEISM

There are a diverse number of stigmatized social constructs that influence how a psychologist views an older adult. Unfortunately, these concepts may bias a psychologist, consequently putting an older adult at risk for inadequate and inaccurate psychological interventions or, in some cases, no psychological services at all. As discussed, older adults may internalize the biases held by a psychologist (self-stigma), thus exacerbating the negative

©Springer Publishing Company

This is a sample from PSYCHOLOGY OF AGING 101
Visit This Book's Web Page / Buy Now / Request an Exam/Review Copy

treatment of a psychologist, or, in some cases prematurely terminating treatment. Consequently, there is a need for psychologists to engage in evidence-based studies to identify means to prevent the stigma of older adults harbored by psychologists and to explore how to develop respectful relationships with older adult clients (Satorius et al., 2010; Weiss & Ramakrishna, 2006). Results of such research will contribute to supporting ethical mandates in psychology and enhance professional competence.

Dementia

The fear of experiencing dementia (see Chapter 4) and its consequent effects on independent functioning is the greatest dread of older adults as well as adults approaching old age (Rowe & Kahn, 1998). These fears drive many older adults to be hypervigilant about their memory functioning. Such fears of memory functioning are contributory to the stigmatization of older adults experiencing dementia. In addition, when older adults verbalize these fears to others who are facilitating courtesy stigma of family members, spouses/partners, caregivers, and friends of the older adult, they in turn feel that stigma of dementia. An example of this fear of dementia is described by Lachman (2000), who found that 39% of people across the adult age spectrum of 25 to 75 years of age reported noticing a problem with their memory at least one time per week. The fear of dementia is also explained by the theory of *stereotype threat* (Eich, Murayama, Castel, & Knowlton, 2014). This theory explains that an older person is at risk for becoming, or for confirming, the negative stereotypes attributed to older adults. In this case, the stigmatization effect is that older people have memory problems and/or dementia (Barber & Mather, 2013, 2014; Hess, Hinson, & Hodges, 2009).

Gender

The issue of gender as a stigmatizing concept usually brings to mind classic issues relating to the power differential between men and women. Calasanti and Kiecolt (2007) indicate that

©Springer Publishing Company

This is a sample from PSYCHOLOGY OF AGING 101
Visit This Book's Web Page / Buy Now / Request an Exam/Review Copy

inequalities that exist in wealth, authority, and labor between men and women are supported by the patriarchal notion of men's power privilege in vocational and social settings (Dixon, Levine, Reicher, & Durrheim, 2012). This patriarchal attitude experienced by a person throughout his or her development promotes and supports ageism of older adult women. Stahl and Metzer (2012) find that college undergraduates report negative attitudes toward older adults, with males showing the most ageist behavior. Women who experience high levels of discrimination in their lives consequently have a lower sense of eudemonic well-being (Ryff, Keyes, & Hughes, 2003). This causes reduction in feelings of growth, mastery, autonomy, and self-acceptance. In addition, older women are more likely to be widowed, living alone, and financially stressed, and to have a lower level of formal education, as compared with older men (Darkwa & Mazibuko, 2002). Once widowed, women often are denied inheritance and burial rights, and face home eviction, physical abuse, loss of social status, marginalization, and poverty (DiGiacomo, Davidson, Byles, & Nolan, 2013).

Whereas the evidence just cited is characteristic of the gender dichotomy between men and women, another gender subgroup of older adults exists, and that is transgender older adults. All too often, when assessing an older adult in a clinical setting, a psychologist will label an older adult as male or female, neglecting to investigate whether the older adult is transgender.

In research, transgender older adults are often not focused on, or are equated with older gay male or lesbian adults (Davies, Greene, Macbridge-Stewart, & Sheperd, 2009). When research psychologists dichotomize gender categories to male and female, transgender older adults are relegated to a no-gender status, which in turn causes their unique problems to be underserved by psychologists (Bockting, Robinson, & Rosser, 1998; Burke, 2011; Kenagy, 2005).

Psychologists studying gender differences would benefit by extending the *intersectionality theory* (Cronin & King, 2010) to the study of gender differences between male, female, and transgender older adults. Intersectionality theory describes that in research

©Springer Publishing Company

This is a sample from PSYCHOLOGY OF AGING 101
Visit This Book's Web Page / Buy Now / Request an Exam/Review Copy

on lesbian, gay male, and bisexual (LGB) older adults, there are significant cultural, social, and psychological differences within each subcategory of LGB older adults. Curiously, this theory rightly looks at differences in sexual orientation, yet it avoids the transgender category, which has its own sexual orientation differences as well as being a third gender category (see Chapter 5). Therefore, when discussing gender influences in stigma, differences need to be identified for each of the three gender subtypes.

Medical Illness

As discussed previously, Callahan (1987) warns of a *demographic, economic, and medical avalanche* that may bankrupt health care resources for younger adults and children. This demonization of older adults serves to increase the stigma of adults experiencing medical illnesses, which in turn may cause the phenomenon of underservice of older adults by prejudiced health care providers, and as a result of older adults avoiding presenting for medical care. Putting older adults at greater risk for more acute and chronic health care problems increases the burden on the health care system and casts inappropriate blame on older adults for the crisis in the health care system (Lee, Hatzenbuehler, Phelan, & Link, 2013). This is a paradox because by discriminating against older adults who have medical problems, the situation that Callahan advocated becomes facilitated by such stigmatization (Williams & Mohammed, 2009).

Psychological Problems

Older adults experiencing psychological problems (see Chapter 3) encounter the stigma of mental illness, along with their relatives, spouses/partners, and caregivers who experience courtesy stigma (see earlier discussion) (Corrigan, 2007; Ostman & Kjellin, 2002; Shrivastava, Bureau, Rewari, & Johnston, 2013). The stigma of experiencing psychological problems exacerbates the psychological problems an older adult encounters, sabotaging the older adult's ability to return to a normal status (Shrivastava et al., 2013).

©Springer Publishing Company

This is a sample from PSYCHOLOGY OF AGING 101
Visit This Book's Web Page / Buy Now / Request an Exam/Review Copy

When compared to a more acceptable disease such as diabetes, the stigma of a mental illness is significantly worse (Lee, Lee, Chiu, & Kleinman, 2005).

A serious consequence of stigmatizing an older adult who is experiencing psychological problems is that it can exacerbate self-blame in the older adult, leading an older adult to attempt or complete suicide (Miranda et al., 2005; Pompili, Mancinelli, & Tararelli, 2003). According to the National Institute of Mental Health, older adults, who comprise 12% of the overall adult population in the United States, account for 16% of deaths by suicide (2007). Unfortunately, the stigma of an older adult experiencing psychological problems often prevents the older adult from seeking treatment with a psychologist (Bayer & Peay, 1997; Bucholz & Robins, 1987). Often an older adult will seek treatment with a primary care physician rather than with a psychologist. This phenomenon is seen at a greater frequency in rural areas as compared with urban areas because rural areas often lack mental health professionals, causing primary care physicians to provide mental health services, which usually consists of prescribing medications for psychological disorders (Komiti, Judd, & Jackson, 2006). In addition, women, rather than men, seek mental health treatment at a greater rate, causing men to be underserved by psychologists and medical professionals (Mojtabai, Olfson, & Mechanic, 2002; Narrow et al., 2000; Olfson et al., 2002).

Self-stigma is seen in an older adult experiencing a psychotic disorder when he or she engages in self-blame for delusional disorders or schizophrenia (Sadock & Sadock, 2008). Institutional stigma is seen in the United States when institutional policy constructs a temporal barrier to treatment causing, in most cases, a delay of up to 8 years for initial treatment contact for depression and a delay of up to 5 years for drug and alcohol (see Chapter 6) initial treatment contact (Wang et al., 2005). This is critical because the number of older adults affected by substance abuse is projected to increase from 2.5 million in 1999 to 5 million in 2020 (Gfoerer, Penne, Pemberton, & Folson, 2008). It is estimated that the newly arriving older adult cohort of baby boomers will show an exponential increase in prescription drug

©Springer Publishing Company

This is a sample from PSYCHOLOGY OF AGING 101
Visit This Book's Web Page / Buy Now / Request an Exam/Review Copy

abuse, from 1.2% in 1999 to 2.4% in 2020 (Menninger, 2002; Pennington, Butler, & Eagger, 2000; Rigler, 2000).

Racism/Poverty

Racism and poverty are dichotomous types of stigma that, more often than not, intersect. Many stigmatized older adults who are impoverished are Latinas and African American women and men (Ojeda & McGuire, 2006). Underservice by health and psychological professionals to Latina women and African American women and men occurs because of the lower socioeconomic status these older adults share and the consequent social value constraints caused by their impoverished state (Ojeda & McGuire, 2006). This is consistent with findings made by Gray-Little and Hafdahl (2000), who found that African Americans, as compared with Whites, have a higher incidence of psychological problems. Researchers (Mui & Shibusawa, 2008; Ortiz & Telles, 2012) find that, similar to African Americans, Mexican Americans and Asian Americans experience psychological problems that are often linked to their encounters with discrimination by the White majority.

Another barrier making it difficult for psychologists to provide mental health services to minority groups is the lack of cultural and language competence in many psychologists (Miranda et al., 2005). Historically, psychologists have been adapting therapeutic modalities developed for the White majority because minorities are less likely than are Whites to seek mental health services (Alegria et al., 2002; Husaini et al., 2002; Miranda & Cooper, 2004; Swartz et al., 1998). This phenomenon underscores a need for new psychotherapeutic modalities to be developed for minority older adults.

Sexual Orientation

There are many stereotypic forces from the majority heterosexual population that cause stigmatization of lesbian, gay male, bisexual, and transgender (LGBT) older adults. A typical example is

©Springer Publishing Company

This is a sample from PSYCHOLOGY OF AGING 101
Visit This Book's Web Page / Buy Now / Request an Exam/Review Copy

the importance of being in a partnered/marital relationship to maintain positive mental and medical health. There is a dearth of research on nonheterosexual older couples, causing psychologists to extrapolate psychological interventions for such couples from research on heterosexual couples. Fortunately, there is a beginning trend to widen researchers' lenses to develop initiatives to intervene regarding the effects of homophobia on the LGBT community (Altman et al., 2012). This is extremely important to help lessen the psychological consequences that arise from LGBT older adults avoiding a partner/marriage relationship. This is important because such partnering is an excellent means to combat the psychologically damaging effects of loneliness, lack of emotional support, and lack of opportunities for sexual intimacy (see Chapter 5).

It is highly important for psychologists to develop a research agenda for studying LGBT older adults. The *theory of intersectionality* suggests that there are significant cultural, social, and psychological differences within each subcategory of LGBT older adults (Cronin & King, 2010). This is equivalent to the significant differences within each age cohort of older adults (see Chapter 1). However, most research, as reported in Chapter 1, is limited to research on heterosexual older adults. The lack of research on LGBT older adults is thought to be a product of differences in self-identification among the LGBT cohort of older adults (Cahill, 2007; Cahill & Valadez, 2013), and the lack of institutional funding of research on older LGBT adults (Van Voorhis & Wagner, 2001).

REFERENCES

Alegria, M., Canino, G., Rios, R., Vera, M., Calderon, J., Rusch, D., & Ortega, A. N. (2002). Inequalities in use of specialty mental health services among Latinos, African Americans, and non-Latino Whites. *Psychiatric Services*, *53*(12), 1547–1555.

Altman, D., Aggleton, P., Williams, M., Kong, T., Reddy, V., Harrad, D., & Parker, R. (2012). Men who have sex with men: Stigma and discrimination. *The Lancet*, *380*(9839), 439–445.

Anti-aging Task Force. (2006). *Ageism in America*. New York, NY: International Longevity Center.

©Springer Publishing Company

This is a sample from PSYCHOLOGY OF AGING 101
Visit This Book's Web Page / Buy Now / Request an Exam/Review Copy

Barber, S. J., & Mather, M. (2013). Stereotype threat can enhance, as well as impair, older adults' memory. *Psychological Science*, *24*, 2522–2529.

Barber, S. J., & Mather, M. (2014). Stereotype threat in older adults: When and why does it occur, and who is most affected? In P. Verhaeghen & C. Hertzog (Eds.), *The Oxford handbook of emotion, social cognition, and everyday problem solving during adulthood* (pp. 302–320). Oxford, England: Oxford University Press.

Bayer, J. K., & Peay, M. Y. (1997). Predicting intentions to seek help from professional mental health services. *Australian New Zealand Journal of Psychiatry*, *31*, 504–513.

Becker, E. (1973). *The denial of death*. New York, NY: Free Press.

Begle, A. M., Strachan, M., Cisler, J. M., Arnstadter, A. B., Hernandez, M. A., & Acierno, R. (2011). Elder mistreatment and emotional symptoms among older adults in a largely rural population: The South Carolina Elder Mistreatment Study. *Journal of Interpersonal Violence*, *26*(11), 2321–2332.

Bockting, W. O., Robinson, B. E., & Rosser, B. R. S. (1998). Transgender HIV prevention: A qualitative needs assessment. *AIDS Care*, *10*(4), 505–525.

Bodner, E., & Lazar, A. (2009). On the origins of ageism among older and younger adults: A review. *International Psychogeriatrics*, *21*, 1–12.

Bucholz, K. K., & Robins, L. N. (1987). Who talks to a doctor about existing depressive illness? *Journal of Affective Disorders*, *12*, 241–250.

Burgess, A. W., Dowdel, E. B., & Prentky, R. A. (2000). Sexual abuse of nursing home residents. *Journal of Psychosocial Nursing & Mental Health Services*, *38*(6), 8–10.

Burgess, A. W., & Morgenbesser, L. I. (2005). Sexual violence and seniors. *Brief Treatment and Crisis Intervention*, *5*(2), 193.

Burke, B. L. (2011). What can motivational interviewing do for you? *Cognitive and Behavioral Practice*, *18*, 78–81.

Burke, B. L., Martens, A., & Fauchner, E. H. (2010). Two decades of terror management theory: A meta-analysis of mortality salience research. *Personality and Social Psychology Review*, *14*, 155–195.

Butler, R. N. (1969). Ageism: Another form of bigotry. *The Gerontologist*, *9*, 243–246.

Butler, R. N. (1975). *Why survive? Being old in America*. New York, NY: Harper & Row.

Butler, R. N. (1995). Ageism. In G. Maddox (Ed.), *The encyclopedia of aging* (pp. 38–39). New York, NY: Springer Publishing Company.

©Springer Publishing Company

This is a sample from PSYCHOLOGY OF AGING 101
Visit This Book's Web Page / Buy Now / Request an Exam/Review Copy

Cahill, S. (2007). The coming GLBT senior boom. *The Gay & Lesbian Review Worldwide*, *14*(1), 19–25.

Cahill, S. P., & Valadez, R. M. S. W. (2013). Growing older with HIV/AIDS: New public health challenges. *American Journal of Public Health*, *103*(3), E7–E15.

Calasanti, T., & Kiecolt, K. J. (2007). Diversity among late-life couples. *Generations*, *31*(3), 10–17.

Callahan, D. (1987). *Setting limits: Medical goals in an aging society*. New York, NY: Simon & Schuster.

Campbell, A. I. (2003). *How policies make citizens: Senior political activism and the American welfare state*. Princeton, NJ: Princeton University Press.

Cavelti, M., Kvrgic, S., Beck, E.-M., Rusch, N., & Vauth, R. (2012). Self-stigma and its relationship with insight, demoralization, and clinical outcome among people with schizophrenia spectrum disorders. *Comprehensive Psychiatry*, *53*(5), 468–479. doi:10.1016/j.comppsych.2011.08.001

Cheng, S.-T., & Heller, K. (2009). Global aging: Challenges for community psychology. *American Journal of Community Psychology*, *44*, 161–173.

Corrigan, P. W. (2007). How clinical diagnosis might exacerbate the stigma of mental illness. *Social Work*, *52*(1), 31–39.

Corrigan, P. W., Watson, A. C., & Barr, L. (2006). The self-stigma of mental illness: Implications for self-esteem and self-efficacy. *Journal of Social and Clinical Psychology*, *25*(8), 875–884.

Cronin, A., & King, A. (2010). Power, inequality and identification: Exploring diversity and intersectionality amongst older LGB adults. *Sociology*, *44*(5), 876–892.

Cuddy, A. J. C., & Fiske, S. T. (2002). Doddering, but clear: Process, content, and function in stereotyping of older persons. In T. D. Nelson (Ed.), *Stereotyping and prejudice against older persons* (pp. 3–26). Cambridge, MA: MIT Press.

Darkwa, O. K., & Mazibuko, F. N. M. (2002). Population aging and its impact on elderly welfare in Africa. *International Journal of Aging and Human Development*, *54*, 107–123.

Daveson, B. A., Bausewein, C., Murtagh, F. E. M., Calanzani, N., Higginson, I. J., Harding, R., . . . Gomes, B. (2013). To be involved or not to be involved: A survey of public preferences for self-involvement in decision-making involving mental capacity (competency) within Europe. *Palliative Medicine*, *27*(5), 418–427. doi:10.1177/0269216312471883

©Springer Publishing Company

This is a sample from PSYCHOLOGY OF AGING 101
Visit This Book's Web Page / Buy Now / Request an Exam/Review Copy

Davies, A. S., Greene, G., Macbridge-Stewart, S., & Sheperd, M. (2009). The health, social care and housing needs of lesbian, gay, bisexual, and transgender older people: A review of the literature. *Health Social Care Community*, *17*(6), 647–658.

DiGiacomo, M., Davidson, P. M., Byles, J., & Nolan, M. (2013). An integrative and social-cultural perspective of health, wealth, and adjustment to widowhood. *Health Care for Women International*, *34*(12), 1067–1083.

Dixon, J., Levine, M., Reicher, S., & Durrheim, K. (2012). Beyond prejudice: Are negative evaluations the problem and is getting us to like one another more the solution? *Behavioral and Brain Sciences*, *35*(6), 411–425. doi:10.1017/S0140525X11002214

Doka, K. J. (2002). *Disenfranchised grief: New directions, challenges, and strategies for practice*. Champaign, IL: Research Press.

Dong, X., & Simon, M. (2013). Association between reported elder abuse and rates of admission to skilled nursing facilities: Findings from a longitudinal population-based cohort study. *Gerontology*, *59*(5), 464–472.

Ebihara, S., Freeman, S., Ebihara, T., & Kohzuki, M. (2010). Missing centenarians in Japan: A new ageism. *The Lancet*, *376*(9754), 1739.

Eich, T. S., Murayama, K., Castel, A. D., & Knowlton, B. J. (2014). The dynamic effects of age-related stereotype threat on explicit and implicit memory performance in older adults. *Social Cognition*, *32*(6), 559–570. doi:101521soco2014326559

Freud, S. (1953). On psychotherapy. In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 6, pp. 249–263). London, England: Hogarth Press. (Original work published 1900)

Gfoerer, J. C., Penne, M. A., Pemberton, M. R., & Folson, J. R. E. (2008). The aging baby boom cohort and future prevalence of substance abuse. In S. P. Korper & C. L. Council (Eds.), *Substance use by older adults: Estimates of future impact on the treatment system* (DHHS Publication No. SMA 03-3763, OAS Analytic Series A-21; pp. 71–94). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Giles, H., & Gasiorek, J. (2011). Intergenerational communication practices. In K. W. Schaie & S. L. Willis (Eds.), *Handbook of the psychology of aging* (7th ed., pp. 233–247). San Diego, CA: Elsevier.

Giles, H., McCann, R. M., Ota, H., & Noels, K. A. (2002). Challenging intergenerational stereotypes: Across Eastern and Western cultures. In M. S. Kaplan, N. Z. Henkin, & A. T. Kusano (Eds.), *Linking lifetimes:*

©Springer Publishing Company

This is a sample from PSYCHOLOGY OF AGING 101
Visit This Book's Web Page / Buy Now / Request an Exam/Review Copy

A global view of intergenerational exchange (pp. 13–28). Honolulu, HI: University Press of America.

Glick, P., & Fiske, S. T. (2001). An ambivalent alliance: Hostile and benevolent sexism as complementary justifications for gender inequality. *American Psychologist*, *56*, 109–118.

Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity*. Garden City, NY: Prentice Hall.

Gray-Little, B., & Hafdahl, A. R. (2000). Factors influencing racial comparisons of self-esteem: A quantitative review. *Psychological Bulletin*, *126*, 26–54.

Greenberg, J., & Arndt, J. (2011). Terror management theory. In P. Kruglanski, A. M. Van Lange, & E. T. Higgins (Eds.), *Handbook of theories of social psychology* (Vol. 1, pp. 339–415). New York, NY: Sage.

Greenberg, J., Pyszczynski, T., Solomon, S., Rosenblatt, A., Veeder, M., Kirkland, S., & Lyon, D. (1990). Evidence for terror management theory II: The effects of mortality salience on reactions to those who threaten or bolster the cultural worldview. *Journal of Personality and Social Psychology*, *58*, 308–318.

Greenberg, J., Solomon, S., & Pyszczynski, T. (1997). Terror management theory of self-esteem and cultural worldviews: Empirical assessments and conceptual refinements. In M. P. Zanna (Ed.), *Advances in experimental social psychology* (Vol. 29, pp. 61–139). San Diego, CA: Academic Press.

Haggstrom, E., Mamhidir, A. G., & Kihlgren, A. (2010). Caregivers' strong commitment to their relationship with older people. *International Journal of Nursing Practice*, *16*(2), 99–105.

Hain, D. J., & Sandy, D. (2013). Partners in care: Patient empowerment through shared decision-making. *Nephrology Nursing Journal*, *40*(2), 153–157.

Hess, T. M., Hinson, J. T., & Hodges, E. A. (2009). Moderators of and mechanisms underlying stereotype threat effects on older adults' memory performance. *Experimental Aging Research*, *35*, 153–177.

Hummert, M. L., & Ryan, E. B. (2001). Patronizing. In W. P. Robinson & H. Giles (Eds.), *The new handbook of language and social psychology* (pp. 253–269). Chichester, England: Wiley.

Husaini, B. A., Sherkat, D. E., Levine, R., Bragg, R., Holzer, C., Anderson, K., . . . Moten, C. (2002). Race, gender, and health care service utilization and costs among Medicare elderly with psychiatric diagnoses. *Journal of Aging and Health*, *14*(1), 79–95.

©Springer Publishing Company

This is a sample from PSYCHOLOGY OF AGING 101
Visit This Book's Web Page / Buy Now / Request an Exam/Review Copy

Kakani, P. (2011). *Runaway Medicare and Medicaid spending*. Retrieved from http://harvardpolitics.com/arusa/runaway-medicare-and-medicaid-spending/

Kalish, R. (1979). The new ageism and the failure models: A polemic. *The Gerontologist*, *19*, 398–402.

Kemper, S., Otrhick, M., Gerhing, H., Gubarchuk, J., & Billington, C. (1998). The effects of practicing speech accommodations to older adults. *Applied Psycholinguistics*, *19*, 175–192.

Kenagy, G. P. (2005). Transgender health: Findings from two needs assessment studies in Philadelphia. *Health & Social Work*, *30*(1), 19–26.

Kite, M. E., & Wagner, L. S. (2002). Attitudes toward older adults. In T. D. Nelson (Ed.), *Ageism: Stereotyping and prejudice against older persons* (pp. 129–161). Cambridge, MA: MIT Press.

Komiti, A., Judd, F., & Jackson, H. (2006). The influence of stigma and attitudes on seeking help from a GP for mental health problems. *Social Psychiatry and Psychiatric Epidemiology*, *41*(9), 738–745.

Kübler-Ross, E. (1975). *Death: The final stage of growth*. New York, NY: Simon & Schuster.

Lachman, M. E. (2000). Promoting a sense of control over memory aging. In L. Backman, R. D. Hill, & A. Stigsdotter-Neely (Eds.), *Cognitive rehabilitation in old age* (pp. 106–120). New York, NY: Oxford University Press.

Lambert, G. J., & Bieliaukas, L. A. (1993). Distinguishing between depression and dementia in the elderly: A review of neuropsychological findings. *Archives of Clinical Neurology*, *8*, 149–170.

Lee, B., Hatzenbuehler, M. L., Phelan, J. C., & Link, B. G. (2013). The role of stigma in health disparities. *American Journal of Public Health*, *103*(8), E4–E5.

Lee, K. M., Volans, P. J., & Gregory, N. (2003). Attitudes towards psychotherapy with older adults among trainee clinical psychologists. *Aging & Mental Health*, *7*, 133–141.

Lee, S., Lee, M. T., Chiu, M. Y., & Kleinman, A. (2005). Experience of social stigma by people with schizophrenia in Hong Kong. *British Journal of Psychiatry*, *186*, 153–157.

Li, S. (2004). "Symbiotic niceness": Constructing a therapeutic relationship in psychosocial palliative care. *Social Science & Medicine*, *58*, 2571–2583.

Martens, A., Goldenberg, J. L., & Greenberg, J. (2005). A terror management perspective on ageism. *Journal of Social Issues*, *61*, 223–239.

©Springer Publishing Company

This is a sample from PSYCHOLOGY OF AGING 101
Visit This Book's Web Page / Buy Now / Request an Exam/Review Copy

Menninger, J. A. (2002). Assessment and treatment of alcoholism and substance-related disorders in the elderly. *Bulletin of the Menninger Clinic*, *66*, 166–184.

Miller, C. A. (2009). *Nursing for wellness in older adults*. Philadelphia, PA: Lippincott Williams & Wilkins.

Miranda, J., Bernal, G., Lau, A., Kohn, L., Hwang, W. C., & LaFromboise, T. (2005). State of the science on psychosocial interventions for ethnic minorities. *Annual Review of Psychology*, *1*, 113–142.

Miranda, J., & Cooper, L. A. (2004). Disparities in care for depression among primary care patients. *Journal of General Internal Medicine*, *19*, 120–126.

Moffit, R. E., & Senger, A. (2013). *Medicare's rising costs—and the urgent need for reform*. Retrieved from http://www.heritage.org/research/reports/2013/03/medicares-rising-costsand-the-urgent-need-for-reform

Mojtabai, R., Olfson, M., & Mechanic, D. (2002). Perceived need and help-seeking in adults with mood, anxiety, or substance use disorders. *Archives of General Psychiatry*, *59*, 77–84.

Mui, A. C., & Shibusawa, T. (2008). *Asian American elders in the 21st century: Key indicators of psychological well-being*. New York, NY: Columbia University Press.

Narrow, W. E., Regier, D. A., Norquist, G., Rae, D. S., Kennedy, C., & Arons, B. (2000). Mental health service use by Americans with severe mental illness. *Social Psychiatry and Psychiatric Epidemiology*, *35*, 147–155.

National Institute of Mental Health. (2007). *Older adults: Depression and suicide facts*. Retrieved from http://www.nimh.nih.gov/health/publications/older-adults-depression-and-suicide-facts-fact-sheet/index.shtml

Ojeda, V. D., & McGuire, T. G. (2006). Gender and racial/ethnic differences in use of outpatient mental health and substance use services by depressed adults. *Psychiatric Quarterly*, *77*(3), 211–222.

Olfson, M., Marcus, S. C., Druss, B. G., Elinson, L., Tanielian, T., & Pincus, H. A. (2002). National trends in the outpatient treatment of depression. *JAMA*, *287*(2), 203–209.

Ortiz, V., & Telles, E. (2012). Racial identity and racial treatment of Mexican Americans. *Race and Social Problems*, *4*(1), 41–56.

Ostman, M., & Kjellin, L. (2002). Stigma by association: Psychological factors in relatives of people with mental illness. *British Journal of Psychiatry*, *181*, 494–498.

©Springer Publishing Company

This is a sample from PSYCHOLOGY OF AGING 101
Visit This Book's Web Page / Buy Now / Request an Exam/Review Copy

Palmore, E. B. (2001). The ageism survey: First findings. *The Gerontologist*, *41*, 572–575.

Palmore, E. B., Branch, L., & Harris, D. (Eds.). (2005). *Encyclopedia of ageism*. Binghamton, NY: Haworth Press.

Pennington, H., Butler, R., & Eagger, S. (2000). The assessment of patients with alcohol disorders by an old age psychiatric service. *Aging & Mental Health*, *4*, 182–185.

Peterson, P. G. (1999). *Gray dawn: How the coming age wave will transform America and the world*. New York, NY: Times Books.

Pompili, M., Mancinelli, I., & Tararelli, R. (2003). Stigma as a cause of suicide. *British Journal of Psychiatry*, *183*, 173–174.

Rigler, S. K. (2000). Alcoholism in the elderly. *American Family Physician*, *61*, 1710–1716.

Rowe, J. W., & Kahn, R. L. (1998). *Successful aging*. New York, NY: Dell.

Rupp, D., Vodanovich, S., & Crede, M. (2005). The multidimensional nature of ageism: Construct validity and group differences. *Journal of Social Psychology*, *145*, 335–362.

Ruscher, J. B. (2001). *Prejudiced communication: A social psychological perspective*. New York, NY: Guilford Press.

Ryff, C. D., Keyes, C. L. M., & Hughes, D. L. (2003). Status inequalities, perceived discrimination, and eudaimonic well-being: Do the challenges of minority life hone purpose and growth? *Journal of Health and Social Behavior*, *44*(3), 275.

Sadock, B. J., & Sadock, V. A. (2008). *Kaplan & Sadock's concise textbook of clinical psychiatry* (3rd ed.). Philadelphia, PA: Wolters Kluwer/Lippincott Williams & Wilkins.

Satorius, N., Gaebel, W., Cleveland, H. R., Stuart, H., Akiyama, T., Arboleda-Florez, J., . . . Tasman, A. (2010). WPA guidance on how to combat stigmatization of psychiatry and psychiatrists. *World Psychiatry*, *9*, 131–144.

Schmeichel, B. J., Gailliot, M. T., Filardo, E., McGregor, I., Gitter, S., & Baumeister, R. F. (2009). Terror management theory and self-esteem revisited: The roles of implicit and explicit self-esteem in mortality salience effects. *Journal of Personality and Social Psychology*, *96*, 1077–1087.

Shrivastava, A., Bureau, Y., Rewari, N., & Johnston, M. (2013). Clinical risk of stigma and discrimination of mental illnesses: Need for objective assessment and quantification. *Indian Journal of Psychiatry*, *55*(2), 178–182. doi:10.4103/0019-5545.111459

©Springer Publishing Company

This is a sample from PSYCHOLOGY OF AGING 101
Visit This Book's Web Page / Buy Now / Request an Exam/Review Copy

Stahl, S., & Metzger, A. (2012). College students' ageist behavior: The role of aging knowledge and perceived vulnerability to disease. *Gerontology & Geriatrics*, *2*, 175–180.

Swartz, M. S., Wagner, H. R., Swanson, J. W., Burns, L. K., George, L. K., & Padgett, D. K. (1998). Comparing use of public and private mental health services: The enduring barriers of race and age. *Community Mental Health Journal*, *34*(2), 133–144.

Tatara, T. (2001). Characteristics of victims and perpetrators. In T. Tatara (Ed.), *Elder abuse*. Tokyo, Japan: Chuohoki Shuppan.

Van Voorhis, R., & Wagner, M. (2001). Coverage of gay and lesbian subject matter in social work journals. *Journal of Social Work Education*, *37*, 147–159.

Wang, P. S., Berglund, P., Olfson, M., Pincus, H. A., Wells, K. B., & Kessler, R. C. (2005). Failure and delay in initial treatment contact after first onset of mental disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry*, *62*, 603–613.

Weiss, M. G., & Ramakrishna, J. (2006). Stigma interventions and research for international health. *The Lancet*, *367*, 536–538.

Williams, A., & Nussbaum, J. F. (2001). *Intergenerational communication across the lifespan*. Mahwah, NJ: Lawrence Erlbaum.

Williams, D. R., & Mohammed, S. A. (2009). Discrimination and racial disparities in health: Evidence and needed research. *Journal of Behavioral Medicine*, *32*, 20–47.

Winkielman, P., & Berridge, K. C. (2004). Unconscious emotion. *Current Directions in Psychological Science*, *13*, 120–123.

Youdin, R. (2014). *Clinical gerontological social work practice*. New York, NY: Springer Publishing Company.

©Springer Publishing Company

This is a sample from PSYCHOLOGY OF AGING 101
Visit This Book's Web Page / Buy Now / Request an Exam/Review Copy

©Springer Publishing Company

This is a sample from PSYCHOLOGY OF AGING 101
Visit This Book's Web Page / Buy Now / Request an Exam/Review Copy

4

Normal Cognitive Decline, Mild Cognitive Impairment, and Dementia

Imagine a foreign country assaulting our nation and killing 500,000 Americans. We would commit hundreds of billions of dollars to vanquish the enemy. Yet 500,000 Americans die of Alzheimer's annually, and we continue to allocate only 1.5 percent of the budget of the National Institutes of Health to Alzheimer's research.

Stanley B. Prusiner, MD (2014, p. 255)

©Springer Publishing Company

This is a sample from PSYCHOLOGY OF AGING 101
Visit This Book's Web Page / Buy Now / Request an Exam/Review Copy

CHAPTER 4

THE PSYCHOLOGIST'S ROLE IN TREATING AN OLDER ADULT WITH DEMENTIA

A psychologist's first task when assessing an older adult for dementia is to discriminate between *normal cognitive decline*, *mild cognitive impairment*, and *dementia*. Normal cognitive decline occurs when one ages, but is significantly different from mild cognitive impairment and the dementias described later in this chapter. Normal cognitive decline is evidenced in many cognitive domains (McGuire, Ford, & Ajani, 2006). These include executive functioning, language difficulty, memory (Lachman, 2000), psychomotor ability (difficulty with movements), language, and speed of processing. These are normal changes in cognitive functioning that have minor effects on instrumental activities of daily living (IADLs). Examples of IADLs include an older adult's ability to drive safely, manage his or her finances, manage multiple medication schedules, or remember important appointments with health care providers. Even though these mild impairments are distressing to the older adult, they do not cause significant loss of autonomy, or require the need for supervision in the home environment (Frank et al., 2006).

If a psychologist finds during an assessment that an older adult is experiencing normal cognitive decline, the older adult must in addition be assessed for any increased level of distress that he or she may be experiencing (Vignette 4.1). This distress can be an indication that the older adult is fearing that he or she may be experiencing the beginning stages of a dementia, especially *Alzheimer's disease* (Lachman, 2000). The anxiety reaction the older adult may experience is evidenced by symptoms of disturbance in interpersonal functioning, sleep disturbance, or exacerbation of a preexisting anxiety disorder (see Chapter 3). Consequently, this fear of dementia may be heightened by the stereotype that often stigmatizes older adults (see Chapter 2) with mild memory lapses, falsely implying that they are demented (Barber & Mather, 2013; Hess, Hinson, & Hodges, 2009). Many older adults who focus on changes in their memory (between 25% and 75%, depending

©Springer Publishing Company

This is a sample from PSYCHOLOGY OF AGING 101
Visit This Book's Web Page / Buy Now / Request an Exam/Review Copy

on the study) report that their memory has worsened as compared with when they were younger (Hanninen, Hallikinen, & Tuomainen, 2002; Jonker, Geerlings, & Schmand, 2000). Of these, 8% do progress to developing dementia (Lindsay, Sykes, McDowell, Verreault, & Laurin, 2004).

VIGNETTE 4.1 The Case of Bertha

(*Note:* Names and other identifying information have been changed to preserve confidentiality.)

Bertha is a 91-year-old widow living in a residential care facility in Los Angeles, California. Bertha has been a widow for the past 21 years. In the years immediately after her husband died, Bertha maintained an active social life and was able to continue working as an accountant for a national property development company. At age 80, Bertha retired and moved to a residential care community, one of the properties owned by her former employer. Bertha decided to move to this facility because, as she did with everything else in life, she always made plans that were conservative and with anticipation of future events. The facility she moved to seemed ideal to Bertha. She would live in her own apartment, and if necessary, she would stay in the same community and move to the company's assisted living facility, which was an extension to the building her apartment was located in. And if the worst happened, the company had a separate facility that specialized in care for Alzheimer's disease patients.

Approximately 2 years ago, Bertha's son came to visit her and noticed something out of the ordinary. On the dining room table, Bertha had stacks and stacks of bills neatly piled. Her son looked through the bills and noticed that some were 4 or 5 months old. He asked Bertha why she had all these bills piled on the dining room table. Bertha told him that the bills were very overwhelming and that she had a friend help her organize them. Her son asked if they were all paid, and Bertha said that she had not gotten to them yet. Her son became concerned, because Bertha, being an accountant, always exerted due diligence with financial matters and always paid her bills on time, never letting any bills accrue interest or penalties.

(continued)

©Springer Publishing Company

This is a sample from PSYCHOLOGY OF AGING 101
Visit This Book's Web Page / Buy Now / Request an Exam/Review Copy

VIGNETTE 4.1 (*continued*)

Her son asked her if she would mind if he took over paying bills for her so that she would not be so troubled by all the bills piled on the table. Bertha replied that his help would not be necessary and that she would attend to them that week.

Her son returned to Bertha's apartment 1 month later and was shocked to see that the stack of bills was piled higher and that several collection notices were also in evidence. Her son called his brother and told him what he discovered at their mother's apartment. They arranged to meet with each other the next day.

At the meeting, they discussed having Bertha evaluated for any sign of dementia. They knew nothing about dementia, but because of her age, the obvious stereotype of dementia in older people concerned them. They called Bertha's family physician to express their concerns and ask for her advice. Bertha's physician said that she would be delighted to meet with Bertha and do an initial screening to see if there was truly something to worry about.

At the appointment with the family physician, Bertha was asked several questions, and at the end of the meeting, the physician indicated that Bertha appeared to have some cognitive problems. Her short-term memory had some disturbance, she appeared confused about her financial affairs, and, at times, she seemed to be unaware and nonparticipatory in the subsequent conversation between the physician, Bertha, and her sons. Her family physician recommended that her sons take her to a neuropsychologist for testing to determine the extent and type of her cognitive difficulties. In addition, she made a referral to a neurologist who would assess Bertha for any pathology that may be occurring in her brain that would be another reason for her symptoms. The physician indicated that the neuropsychologist and neurologist often work together to complete a comprehensive and accurate assessment when an older adult begins to show cognitive disturbances.

If an older adult is diagnosed with mild cognitive impairment or one of the many dementias (both described later in this chapter), a psychologist must take into consideration when formulating a treatment plan that a spouse/partner, relative, and/or

©Springer Publishing Company

This is a sample from PSYCHOLOGY OF AGING 101
Visit This Book's Web Page / Buy Now / Request an Exam/Review Copy

caregiver are necessary adjuncts to the proposed treatment plan. A spouse/partner, relative, and/or caregiver may be in need of psychoeducation about mild cognitive impairment or dementia, and more often than not may be experiencing anxiety or a depressive reaction to the distress of caring for an older adult with dementia. The anxiety may be an exacerbation of a preexisting anxiety disorder, or may be *dementia anxiety*. Dementia anxiety is an anxiety most often experienced by a first-degree relative, in which this relative dreads and feels anxious about developing dementia, especially Alzheimer's disease, at some time in his or her lifetime (Roberts & Connell, 2000). A first-degree relative may also be experiencing a depressive disorder from the distress of caring for a relative with dementia, especially if the older adult is suffering from Alzheimer's disease (Mahoney, Regan, Katona, & Livingston, 2005; see Chapter 3).

NEUROPSYCHOLOGICAL CONCEPTS FOR UNDERSTANDING COGNITIVE DEFICITS IN MILD COGNITIVE IMPAIRMENT AND DEMENTIA

It must be understood by a psychologist that an older adult diagnosed with mild cognitive impairment may progress to a diagnosis of Alzheimer's disease. Similar to an older adult with mild cognitive impairment, an older adult diagnosed with any of the dementias will experience a progressive decline in functioning, which is incurable and most often fatal unless the older adult dies from another co-occurring disease or normal causes. Therefore, a good part of a psychologist's role in treating an older adult with mild cognitive impairment or a dementia is that of psychoeducation. The diagnosed older adult and his or her spouse/partner, relative, and/or caregiver are in need of understanding the pathological process the older adult is experiencing. This increase in understanding facilitates the

©Springer Publishing Company

This is a sample from PSYCHOLOGY OF AGING 101
Visit This Book's Web Page / Buy Now / Request an Exam/Review Copy

treatment of the older adult with dementia and a reduction of consequent anxiety or depressive reactions in all participants in the treatment plan. Therefore, a psychologist must increase his or her understanding of the following neuropsychological aspects that underlie mild cognitive impairment and the various dementias.

Neuroplasticity

Neuroplasticity is a phenomenon whereby the brain has the capacity to change as a product of interpersonal (Badenoch, 2008; Siegal, 2006) interaction, in response to novel stimuli and activities (Fields, 2009), or as a result of high levels of education (Barnes & Yaffe, 2011). This is commonly known as the *use-it-or-lose-it phenomenon* (Ball, Vance, Edwards, & Wadley, 2004), or in more scientific terms, *positive neuroplasticity* and *negative neuroplasticity*. Positive neuroplasticity occurs when interneuronal connections are established. This interconnectivity between neurons creates more complex cognitive pathways that give an older adult an increased cognitive reserve. An older adult can increase his or her cognitive reserve by introducing novel stimuli such as brain-teaser puzzles, learning a new foreign language, or engaging in a task using a nondominant hand (e.g., combing one's hair with the other hand). In addition, this phenomenon of increasing cognitive reserves may occur in older adults experiencing early stages of Alzheimer's disease (see following discussion) or mild cognitive impairment (see following discussion) when the older adult engages in a challenging educational activity (Roe et al., 2008; Ye et al., 2013) or cognitive training (Belleville, 2008). Teaching an older adult how to increase positive neuroplasticity is a useful intervention that will improve functioning in an older adult experiencing mild cognitive impairment, and will delay the progression of cognitive deterioration in an older adult experiencing dementia.

Conversely, negative neuroplasticity occurs when there is a disruption in the connectivity between neurons, causing

©Springer Publishing Company

This is a sample from PSYCHOLOGY OF AGING 101
Visit This Book's Web Page / Buy Now / Request an Exam/Review Copy

a diminishment of cognitive reserve in an older adult. This breakdown in connectivity occurs when the older adult is in a nonstimulating and/or non-novel environment, or when a biological process is causing atrophy in the brain. Such biological processes can result from stroke, tumors, plaque formation, and prions (proteins associated with brain damage causing dementia; Prusiner, 2014). When the environment is less complex, or biological disease is present, a consequential diminishment of neuroplasticity will occur, significantly lessening the cognitive reserve available to the older adult. This results in mild cognitive impairment, or any of the dementias described later in the chapter. Therefore, it is important for a psychologist to begin psychoeducation immediately after diagnosing an older adult with mild cognitive impairment, or dementia, in order to reverse as much as possible the progression of negative neuroplasticity by introducing techniques to augment and enhance positive neuroplasticity.

A dramatic example of the difference between positive neuroplasticity and negative neuroplasticity is found in a study of London taxi and bus drivers (Maguire, Woollett, & Spiers, 2006). In this study, the authors compared the imaging of the brains of taxi drivers who were given the task of driving to novel destinations with the brain imaging of bus drivers who routinely spent their time driving to fixed destinations (non-novel) in London. The taxi drivers, who were trained to memorize destinations throughout London over a 4-year period, consequently drove passengers to destinations at the passengers' request, making each trip a novel experience. After examining MRI scans of the brains of London taxi drivers and bus drivers, these researchers found that novel stimuli enhanced the cognitive reserves of London taxi drivers. The taxi drivers showed an increased volume of neurons in the hippocampus of their midbrains as compared with the bus drivers, who drove routine, predictable (non-novel) routes and did not show a corresponding increase in the hippocampus of their midbrains. The hippocampus (Figure 4.1) is the site in the midbrain in which memory is formed and consolidated.

©Springer Publishing Company

This is a sample from PSYCHOLOGY OF AGING 101
Visit This Book's Web Page / Buy Now / Request an Exam/Review Copy

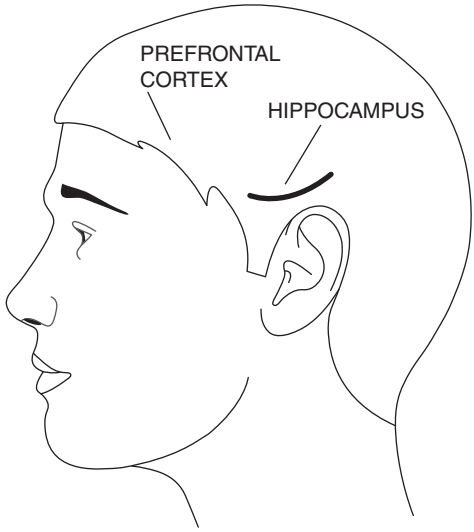


FIGURE 4.1 The location of the hippocampus in the midbrain. Adapted from Youdin (2014).

Memory and Memory Impairments

In order to understand what type of memory is impaired, a psychologist must discriminate between *crystallized intelligence* and *fluid intelligence* (Kay, 2005). Crystallized intelligence is the representation of knowledge accumulated and stored as memory. These memories include past interpersonal relationships and associated feelings, information accrued from education, and various life experiences such as hobbies, extravocational activities, travels and vacations, and so forth. Older adults have a large storage of crystallized memories due to their longevity.

Fluid intelligence is a dynamic intelligence that indicates one's level of cognitive functioning rather than what has been learned and experienced in the past and subsequently stored. Dysfunction in any aspect of fluid intelligence may be the first indication of a dementia process (Elias & Saucier, 2006; Kay, 2005), or may be a normal occurrence in the normal aging process (Park,

©Springer Publishing Company

This is a sample from PSYCHOLOGY OF AGING 101
Visit This Book's Web Page / Buy Now / Request an Exam/Review Copy

O'Connell, & Thomson, 2003). Deficits in fluid intelligence are a red flag signaling further assessment by the treating psychologist.

Fluid intelligence includes *executive functioning*, *language*, *memory*, *psychomotor ability*, and *speed of processing*. Executive functioning (Elias & Saucier, 2006) refers to the ability of an older adult to plan and organize, rational reasoning, and the ability to problem solve. Language encompasses visual and auditory processing and the relationship of such processing to fluid as well as crystallized intelligences (Abrams, Farrell, & Margolin, 2010; Vance, Robertson, McGuinness, & Fazeli, 2010). In addition, language includes vocabulary and the ability to detect misspellings (Abrams et al., 2010). In memory, aspects of fluid intelligence are reflected in an older adult's ability to recall previously learned information and/or personal experiences (Fleischman, Wilson, Gabrieli, Bienias, & Bennett, 2004). Psychomotor ability refers to an older adult's ability to maintain his or her gait (ability to walk correctly, and speed of walking), perform gross motor movements (moving arms and legs and positioning them properly), and perform fine motor movements, as measured in reaction time and mirror tracing tests (Elias & Saucier, 2006). Speed of processing is the older adult's ability to automatically perform overlearned cognitive tasks, or easy novel tasks, with relative ease (Inzitari et al., 2007; Rodrigue, Kennedy, & Raz, 2005). This type of processing requires an older adult to process information with great speed devoid of intentional thinking and consideration. Therefore, the assessment of fluid memory is a multidimensional assessment process performed by a psychologist, usually in conjunction with a treating neurologist.

Deficits in Olfactory Functioning

Assessment of deficits in olfactory functioning are potentially useful for a psychologist who is attempting to differentiate between cognitive disturbances of normal aging and mild cognitive impairment that may progress to Alzheimer's disease. Most older adults with olfactory deficits have little or no awareness of such deficits (Djordjevic, Jones-Gotsman, De Sousa, & Cherkow,

©Springer Publishing Company

This is a sample from PSYCHOLOGY OF AGING 101
Visit This Book's Web Page / Buy Now / Request an Exam/Review Copy

2007). However, because the olfactory sensory system (sense of smell) is intimately connected to the gustatory sensory system (sense of taste), older adults with olfactory deficits may complain that their foods do not taste right or the same as they are used to, or may start using excessive amounts of salt or spices to enhance the taste of their foods. Such complaints may alert the treating psychologist, spouse/partner, relative, and/or caregiver that olfactory functioning is impaired in the older adult.

Deficits in olfactory functioning in an older adult are thought to herald the onset of mild cognitive impairment, and are a possible predictor of Alzheimer's disease (Djordjevic et al., 2007; Eibenstein et al., 2005; Luzzi et al., 2007). Because olfactory deficits limit an older adult from detecting odors, an older adult may be at risk due to not recognizing a gas leak in his or her home, eating spoiled food, or not being able to smell smoke from a fire in the house.

MILD COGNITIVE IMPAIRMENT AND THE MOST COMMON DEMENTIAS TREATED BY A PSYCHOLOGIST

Mild cognitive impairment and the most common dementias seen by a psychologist are described here. All of these diagnoses are complicated to make and have multidimensional symptoms. As noted earlier, the dementias are incurable and in most cases are the primary cause of death for older adults who suffer from dementia. The psychologist's role in treating an older adult is also multidimensional. He or she needs to provide psychoeducation, interventions to enhance positive neuroplasticity, treatment for secondary anxiety or depressive problems, and psychotherapeutic care for the spouse/partner, relative, and/or caregiver of an older adult experiencing mild cognitive impairment or dementia. In addition, a psychologist may be called upon to provide care to survivors of an older adult who dies after being treated for mild cognitive impairment or dementia (see Chapter 9).

©Springer Publishing Company

This is a sample from PSYCHOLOGY OF AGING 101
Visit This Book's Web Page / Buy Now / Request an Exam/Review Copy

Mild Cognitive Impairment

Historically, *mild cognitive impairment* (MCI; Krahn et al., 2006) is considered a *bridge diagnosis* that occurs between the functioning of a normal older adult and an older adult experiencing one of the dementia diagnoses (Petersen et al., 1999; Tröster, 2008). The diagnosis of MCI (Krahn et al., 2006) is a dichotomous diagnosis made in two distinctly different cognitive domains—*single-domain* and *multiple-domain MCI* (Petersen, 2004). Single-domain MCI is indicated when an older adult's memory is impaired without impairment in the other aspects of fluid intelligence—executive functioning, language, psychomotor ability, and speed of processing. Multiple-domain MCI is indicated when one or more of the aspects of fluid intelligence are dysfunctional along with a dysfunction in memory (Saunders & Summers, 2010, 2011). MCI is considered to be a *preclinical stage* of dementia (Lyketsos et al., 2002; Mega et al., 2000).

Single- and multiple-domain MCIs are further classified into four subtypes by other authors (Albert et al., 2011; Winbald et al., 2004) as follows: *single-domain amnestic MCI* (a-MCI), in which there is a presence of memory disturbance; *multiple-domain amnestic MCI* (a-MCI+), in which there is a presence of memory disturbance along with a disturbance in executive functioning, language, memory, psychomotor ability, and/or speed of processing; *single-domain nonamnestic MCI* (na-MCI); in which there is dysfunction in one domain but not in memory; and *multiple-domain nonamnestic-MCI* (na-MCI+), in which there are multiple-domain dysfunctions but no dysfunction in memory.

In addition to determining whether an older adult is presenting with single- or multiple-domain MCI subtypes, a psychologist must also ascertain whether the older adult has a co-occurring depressive disorder, anxiety, and/or apathy (Apostolova & Cummings, 2008; Geda et al., 2008; Lyketsos et al., 2002; see Chapter 3). Any of these diagnoses often precedes a diagnosis of a single- or multiple-domain MCI subtype. Conversely, a psychologist assessing an older adult with any of these psychological diagnoses must ascertain whether the older adult is experiencing

©Springer Publishing Company

This is a sample from PSYCHOLOGY OF AGING 101
Visit This Book's Web Page / Buy Now / Request an Exam/Review Copy

any dysfunction in executive functioning, language, memory, psychomotor ability, and speed of processing (Spira, Rebok, Stone, Kramer, & Yaffe, 2012; Tung, Chen, & Takahashi, 2013) in order to diagnose a co-occurring MCI, whether of the single- or multiple-domain subtype. These co-occurring diagnoses are also considered risk factors for progression from MCI to Alzheimer's disease (Mondrego & Ferrandez, 2004; Teng, Lu, & Cummings, 2007). Ramakers et al. (2013) dispute this finding and feel that these co-occurring psychological diagnoses are not predictors for progression to Alzheimer's disease (see following discussion of Alzheimer's disease). Jungwirth, Zehetmayer, Hinterberger, Tragl, and Fischer (2012) feel that MCI may predispose an older adult to *vascular dementia* (see following discussion of vascular dementia). Further research is needed to clarify whether MCI is truly a bridge diagnosis to the dementias.

Vascular Dementia

Vascular dementia (VaD) is the second-most-common type of dementia throughout the world (Bandyopadhyay et al., 2014). VaD can result from multiple strokes or any injury to the small or large vessels in the brain. VaD may occur suddenly and progress over time, or may subside periodically during an older adult's lifetime. VaD is often preceded by a-MCI (Petersen et al., 2001; Winbald et al., 2004) or na-MCI (Petersen, 2004). VaD may predispose an older adult to Alzheimer's disease (Jagust, 2001; see following discussion of Alzheimer's disease).

When an older adult suffers multiple small strokes (*punctate strokes*) with no behavioral or psychological symptoms, VaD is diagnostically considered as *vascular cognitive impairment* (VCI). VCI causes cognitive dysfunction in executive functioning, language, memory, psychomotor ability, and speed of processing, the same symptomatology as seen in MCI (described earlier). In addition, VaD can cause psychological symptoms, which are categorized as *behavioral and psychological symptoms of dementia* (BPSDs; Gupta et al., 2013). BPSDs in VaD include agitation, aggression, apathy, and depressive symptoms.

©Springer Publishing Company

This is a sample from PSYCHOLOGY OF AGING 101
Visit This Book's Web Page / Buy Now / Request an Exam/Review Copy

Risk factors for VaD include *atrial fibrillation* (an abnormal heart rhythm that causes the heart to beat rapidly, with irregular beats) and *metabolic syndrome* (Raffaitin et al., 2009). Metabolic syndrome comprises five symptoms: hypertension, abdominal obesity, high triglycerides, low levels of high-density-lipoprotein (HDL) cholesterol, and elevated fasting glycemia (diabetes). In addition, another risk factor for VaD is elevated blood cholesterol levels.

Frontotemporal Dementia (Pick's Disease/ Complex)

Frontotemporal dementia (FTD) was previously termed *Pick's disease* or *Pick's complex* (Hodges, 2001; Kertesz, 2003). FTD is often preceded by na-MCI (Petersen, 2004). Older adults with this disorder have an abnormal amount of *Pick bodies* and *Pick cells* inside of the nerve cells in the frontal and temporal lobes of the brain (Figure 4.2). These cells contain an abnormal amount of a protein called *tau*. This is thought to be the cause of FTD. When studied at autopsy, FTD has a prevalence rate of 3% to 10% in patients previously diagnosed with dementia (Kertesz, 2005). FTD is often confused with Alzheimer's disease (see following discussion of Alzheimer's disease) by clinicians (Snowden et al., 2001). Despite this confusion, clinical reports indicate an FTD prevalence of approximately 20% of older adults diagnosed with dementia (Varma et al., 1999).

FTD has combined behavioral (Boxer & Miller, 2005; Chan et al., 2009; Hodges, 2001; Thompson, Patterson, & Hodges, 2003) and cognitive symptoms (Hodges, Martinos, Woollams, Patterson, & Adlam, 2008; Hodges & Patterson, 2007; Knibb & Hodges, 2005; Snowden, Thompson, & Neary, 2004). They include *apathy* (lack of feeling, emotions, or interest; Kumfor & Piguet, 2012), *loss of insight*, *perseveration* (repetition of a word, phrase, or gesture), *personal neglect*, *logopenia* (difficulty understanding complex instructions, frequent pauses when speaking, inability to repeat sentences or string of words), *anomia* (inability to name objects), and *semantic aphasia* (difficulty generating or recognizing

©Springer Publishing Company

This is a sample from PSYCHOLOGY OF AGING 101
Visit This Book's Web Page / Buy Now / Request an Exam/Review Copy

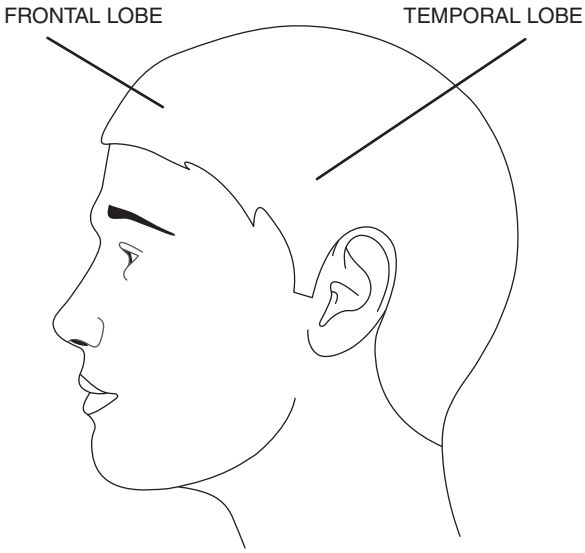


FIGURE 4.2 The frontal and temporal lobes of the brain.
Adapted from Youdin (2014).

familiar words). Other researchers consider FTD to be a heterogeneous diagnosis with two sub diagnoses (Valverde, Jimenez-Escrig, Gobernado, & Barón, 2009). FTD has a behavior variant (bv-FTD) with symptoms of *loss of insight*, *personality changes*, and *disturbances in social cognition* (lack of concern about social norms, impaired emotional judgment, and gluttony), and a language variant called *primary progressive aphasia* (McKeith et al., 2005), with symptoms of *logopenia*, *anomia*, and *semantic aphasia*.

Dementia With Lewy Bodies

Dementia with Lewy bodies (DLB) was originally described as *Lewy body disease* in 1980 (Kosaka, Matsushita, Oyanagi, & Mehraein, 1980). Lewy bodies are spherical structures that are found in neurons in the brain and were first described in 1912 by F. H. Lewy (Lewy, 1912). DLB and VaD are the second most common dementias aside from Alzheimer's disease,

©Springer Publishing Company

This is a sample from PSYCHOLOGY OF AGING 101
Visit This Book's Web Page / Buy Now / Request an Exam/Review Copy

and DLB is often preceded by na-MCI or a-MCI (Chiba et al., 2012; Molano et al., 2010; Petersen, 2004; Winbald et al., 2004). In addition, older adults with DLB often experience *prodromal symptoms* (symptoms preceding a diagnosis) of *REM sleep behavior disorder*, *constipation*, *orthostatic hypotension* (dizziness on standing), *visual hallucinations*, and *sensory motor dysfunction* (movement problems). DLB is seen as a spectrum disorder with *Alzheimer's disease* and *Parkinson's disease dementia*.

Three prominent psychopathological symptoms (Ballard et al., 2001) differentiate DLB from Alzheimer's disease. Visual hallucinations are more frequent with DLB, occurring in more than 50% of cases, and delusions in DLB are more evident than in Alzheimer's disease, found in up to 75% of cases. In addition, unlike in Alzheimer's disease, delusions in DLB are not as persistent. In some older adults with DLB the visual hallucinations may be coupled with a belief by the older adult that he or she has been replaced by an identical imposter (Josephs, 2007; Thaipisuttikul, Lobach, Zweig, Gurnani, & Galvin, 2013). This phenomenon is called *Capgras syndrome*. Unlike in Alzheimer's disease, the use of antipsychotic medications for delusions and visual hallucinations is contraindicated for DLB because this would produce profound *extrapyramidal symptoms*, such as continuous spasms and muscle contractions, motor restlessness, muscle rigidity, tremor, and irregular jerky movements (Ballard et al., 2001). Conversely, when an older adult is diagnosed with Alzheimer's disease, antipsychotic medications are administered. Finally, depression is more frequent in DLB (approximately 30% of cases) but, as with delusions, is not as persistent in DLB as it is in Alzheimer's disease.

Lewy Body Dementia and Parkinson's Disease Dementia

When dementia occurs with *Parkinson's disease* (PD), dementia symptoms that occur simultaneously with the onset of PD or within 1 year of the diagnosis of PD are attributed to DLB. About 70% of older adults suffering from DLB have PD (Graeber & Müller, 2003). Dementia symptoms that occur after 1 year of the onset of PD are considered *Parkinson's disease dementia* (PDD;

©Springer Publishing Company

This is a sample from PSYCHOLOGY OF AGING 101
Visit This Book's Web Page / Buy Now / Request an Exam/Review Copy

Emre et al., 2007). A psychologist often makes diagnostic errors as to the type of dementia occurring with PD because in many cases it is difficult to pinpoint the onset of PD. DLB is differentiated from PDD (McKeith et al., 2005) by *visual hallucinations* and *cognitive symptoms* that are more predominant in DLB. There are greater disturbances in executive functioning in DLB than in PDD, whereas in PDD there are greater auditory attention deficits (Aarsland, Londos, & Ballard, 2009; Singleton & Gwinn-Hardy, 2004).

Alzheimer's Disease

In 1911, Alois Alzheimer presented a clinical case at a medical conference in Tübingen, Germany, of an older adult experiencing memory problems, behavioral dysfunctions, and neuropathological findings of *plaques* and *neurological tangles* that today is diagnosed as *Alzheimer's disease*. After the Alzheimer's case presentation, noted psychiatrist Emil Kraepelin, who was a pioneer in attributing mental dysfunction to a biological basis, named the syndrome described by Alois Alzheimer as Alzheimer's disease (Möller & Graeber, 1998). It is estimated that by the year 2040 there will be approximately 81 million older adults suffering from Alzheimer's disease due to the increased longevity older adults are now experiencing, increasing the opportunity for chronic debilitating Alzheimer's disease to manifest in older adults worldwide (Ferri et al., 2005). Alzheimer's disease ranks third in causes of death in the United States, and the threat of being diagnosed with Alzheimer's disease is an anticipatory anxiety (Laditka et al., 2011) experienced by many older adults (Clark & Karlawish, 2003).

Alzheimer's disease is a chronic, debilitating disease process that begins with inclusions of abnormal proteins (*tau* and *amyloid plaques*) in neurons in the brain, although this stage of the illness does not demonstrate any cognitive impairment in the older adult. This is followed by subtle changes in cognition and memory (see earlier discussion of MCI), and then more obvious cognitive decline and memory impairment that leads to significant dementia and death in end-stage Alzheimer's disease

©Springer Publishing Company

This is a sample from PSYCHOLOGY OF AGING 101
Visit This Book's Web Page / Buy Now / Request an Exam/Review Copy

(Albert et al., 2011; Dubois et al., 2010; Jack et al., 2011; Petersen et al., 2001; Winbald et al., 2004).

The progression just described can be broken down into seven stages of Alzheimer's disease (Beers, Porter, Jones, Kaplan, & Berkwits, 2011; Youdin, 2014). This description of the seven stages of Alzheimer's disease is useful for a psychologist to know when assessing an older adult for dementia, and/or counseling an older adult's spouse/partner, relative, or caregiver who is seeking information and advice on the care of an older adult experiencing Alzheimer's disease. These stages (adapted from Youdin, 2014) are as follows:

Stage 1: The older adult at this stage does not show any discernable memory problem on assessment. However, on a neuronal level, structural changes may occur as early as 20 years prior to recognition by a psychologist, which usually occurs in Stage 3. In addition, mild disturbances in executive functioning, language, psychomotor ability, and speed of processing may occur.

Stage 2: During this stage, an older adult may begin experiencing forgetfulness with names of acquaintances, and may lose or misplace personal objects such as car or house keys, a wallet, eyeglasses, or other items regularly used by the older adult. This type of forgetfulness is recognized by the older adult, but is not obvious to others who are in frequent contact with the older adult or the older adult's psychologist.

Stage 3: In contrast to Stage 2, people who are in frequent contact with the older adult in Stage 3 might notice problems in the older adult's memory that occur in a home setting or workplace. Errors in naming people close to the older adult become obvious. The struggle of the older adult to remember new names of acquaintances or fellow workers becomes more frequent and obvious to others. This stage shows a more obvious deterioration in executive functioning, language, memory, psychomotor ability, and speed of processing, in addition to memory problems.

Concentration difficulties occur, which begin to impair social and/or occupational functioning. Disorganization in

©Springer Publishing Company

This is a sample from PSYCHOLOGY OF AGING 101
Visit This Book's Web Page / Buy Now / Request an Exam/Review Copy

the older adult increases, as evidenced by a greater frequency of losing objects, and problems in the older adult's ability to organize daily activities at home and/or in a vocational setting. Concentration difficulties begin to be evidenced in an older adult's ability to read, and the individual often has difficulty in following a story or passage because of an increasing inability to retain information from passages read.

Stage 4: In this stage, an older adult has increasing difficulty in remembering recent events or recently learned information. A mental status exam reveals a marked inability to perform calculations or remember digital spans. An older adult will have difficulty in abstract thinking, which is manifested as having difficulties in managing finances, forgetting to pay bills, having difficulty planning social events with others, and displaying marked impairment in vocational settings. On examination, an older adult will have difficulty remembering aspects of his or her personal history. These reduced cognitive abilities often cause an older adult to socially withdraw, which is often misdiagnosed as depression or social anxiety.

Stage 5: At this stage, a continued deterioration in executive functioning, language, memory, psychomotor ability, and speed of processing occurs. Memory impairment is marked, evidenced by severe deficits in daily functioning. Family members are often needed to assist in the activities of daily living (ADLs) of the older adult, or to retain outside help for this assistance. Assistance with ADLs includes dressing (choosing proper combinations of clothing), housecleaning, meal preparation, and financial organization. On assessment, the older adult will often be disoriented in regard to person, time, or place. The older adult will make errors or be unable to respond to questions of general knowledge. Greater deficits are seen in performing calculations, remembering three objects, and recalling digital spans. Impairment in knowledge of personal details becomes more extensive, generalizing from recalling his or her name to errors and omissions of personal historical events.

©Springer Publishing Company

This is a sample from PSYCHOLOGY OF AGING 101
Visit This Book's Web Page / Buy Now / Request an Exam/Review Copy

Stage 6: Most, if not all, recent events are difficult for the individual at this stage to remember. However, distant events may still be recalled, because crystallized memory is relatively intact. Help with ADLs is needed. These include eating, bathing, and bathroom activities. In many older adults at this stage, delusional thinking is evidenced along with paranoid thought processes. These pathological thought processes might lead to violent behavior. In addition, it is not uncommon for the older adult to be disoriented in two or more spheres (person, place, or time).

Stage 7: This final stage finds the older adult bedridden, unable to feed himself or herself, and incontinent. In addition, the older adult is unable to communicate except in very primitive ways, such as hand signaling or verbal grunts, rather than clear verbal commands.

SECONDARY CONSEQUENCES OF THE DEMENTIAS

Driving Retirement

A psychologist is often called upon by a spouse/partner, relative, or caregiver to determine if and when driving must be prevented with an older adult who has dementia (Breen, Breen, Moore, Breen, & O'Neil, 2007). Unfortunately, there is no definite marker that would indicate driver retirement (Eby & Molnar, 2012). Having a diagnosis of dementia does not automatically mean retirement from driving. However, some of the symptomatology of the dementias become risk factors for dangerous driving and require vigilance by a spouse/partner, relative, or caregiver to provide feedback to the psychologist, who may then determine the threshold where driving by the older adult with dementia must stop. Symptoms of concern include cognitive decline, dysfunction in fluid memory, problems with visuospatial and sensory motor awareness, attention difficulties, and problems with

©Springer Publishing Company

This is a sample from PSYCHOLOGY OF AGING 101
Visit This Book's Web Page / Buy Now / Request an Exam/Review Copy

executive functioning (Aksan et al., 2012). At some point during the first 3 years after the diagnosis of dementia, the decision of driving cessation usually occurs (Aksan et al., 2012).

Inappropriate Sexual Behaviors

Psychologists who work in continuing care residential settings or nursing homes, or with spouses/partners, relatives, or caregivers of an older adult experiencing dementia, often have to deal with the inappropriate sexual behaviors (ISBs) exhibited by an older adult experiencing a dementia. ISBs are defined as sexual behaviors that interfere with functioning and occur at inappropriate times with nonconsenting people (Alkhalil, Tanvir, Alkhalil, & Lowenthal, 2004). ISBs include inappropriate unwanted fondling, exposure of the genitals, public masturbation, removal of one's clothes in a public place, delusions of marital infidelity, and the display of pornographic material in public (Alagiakrishnan et al., 2005; Tsatali, Tsolaki, Christodoulou, & Papaliagkas, 2011; Youdin, 2014). Older adults in nursing homes or continuing care residential settings may exhibit ISBs by entering the bed of a fellow resident without being invited or making unwanted sexual advances to staff members, residents, or visitors (Higgins, Barker, & Begley, 2005). ISBs are more common in men and older adults in the moderate to severe stages of dementia (Alagiakrishnan et al., 2005).

Dementia in Imprisoned Older Adults

Forensic geropsychology, a subfield of geropsychology, offers opportunities for psychologists who are interested in working in correctional settings. Imprisoned adults over the age of 50 constitute the fastest-growing cohort of the prisoner population, which corresponds to the overall increase in the population of older adults outside of prison in the United States (Beckett, Peternelj-Taylor, &

©Springer Publishing Company

This is a sample from PSYCHOLOGY OF AGING 101
Visit This Book's Web Page / Buy Now / Request an Exam/Review Copy

Johnson, 2003; Reimer, 2008). This creates an opportunity for psychologists interested in a career in forensic geropsychology to study the needs of this population of older adults.

For those older adults experiencing dementia, Fazel, McMillan, and O'Donnell (2002) indicate that incarceration of these older adults is inappropriate because the prison facilities are not equipped to handle the needs of older adults suffering from dementia. There are limited resources available to these older adults because prisons are designed for a younger and more violent population (Crawley & Sparks, 2005; Crawley, Wallace, Loeffelholz, & Sales, 2005). Older adults have difficulty walking long distances for meals, recreation, or vocational activity. Correction officers are trained to maintain order and are not trained to assist older adults with ADLs (see Chapter 1). Older adult prisoners suffering from dementia are more likely to be abused by younger prisoners and older prisoners who are not suffering from dementia (Kerbs & Jolley, 2007).

From a policy and humanistic standpoint, older adult prisoners suffering from dementia need not be in prison. These older adults are no longer a threat to society and would be better served in a nursing home setting with the required security, or, better still, through the initiation of a compassionate release for older adult prisoners suffering from dementia (Williams, Sudore, Greifinger, & Morrison, 2011). This would enable them to have their medical and psychological needs met, and in the case of release from prison, they may return to spouses/partners and relatives who could provide the care they require (Binswanger, Krueger, & Steiner, 2009). Removing an older adult with dementia from prison is an advocacy opportunity for psychologists to facilitate proper treatment of these older adults suffering from dementia.

REFERENCES

Aarsland, D., Londos, E., & Ballard, C. (2009). Parkinson's disease dementia and dementia with Lewy bodies: Different aspects of one entity. *International Psychogeriatrics*, *21*(2), 216–219. doi:10.1017/S1041610208008612

©Springer Publishing Company

This is a sample from PSYCHOLOGY OF AGING 101
Visit This Book's Web Page / Buy Now / Request an Exam/Review Copy

Abrams, L., Farrell, M. T., & Margolin, S. J. (2010). Older adults' detection of misspellings during reading. *Journals of Gerontology. Series B, Psychological Sciences and Social Sciences*, *65*, 680–683.

Aksan, N., Anderson, S. W., Dawson, J. D., Johnson, A. M., Uc, E. Y., & Rizzo, M. (2012). Cognitive functioning predicts driver safety on road tests 1 and 2 years later. *Journal of the American Geriatrics Society*, *60*, 99–105.

Alagiakrishnan, K., Lim, D., Brahim, A., Wong, A., Wood, A., Senthilselvan, A., . . . Kagan, L. (2005). Sexually inappropriate behaviour in demented elderly people. *Postgraduate Medical Journal*, *81*, 463–466.

Albert, M. S., DeKosky, S., Dickson, D., Dubois, B., Feldman, H. H., Fox, N. C., . . . Phelps, C. H. (2011). The diagnosis of mild cognitive impairment due to Alzheimer's disease: Recommendations from the National Institute on Aging–Alzheimer's Association workgroups on diagnostic guidelines for Alzheimer's disease. *Alzheimer's & Dementia*, *7*(3), 270–279.

Alkhalil, C., Tanvir, F., Alkhalil, B., & Lowenthal, D. T. (2004). Treatment of sexual disinhibition in dementia: Case reports and review of the literature. *American Journal of Therapeutics*, *11*, 231–235.

Apostolova, L. G., & Cummings, J. L. (2008). Neuropsychiatric manifestations in mild cognitive impairment: A systematic review of the literature. *Dementia and Geriatric Cognitive Disorders*, *25*, 115–126.

Badenoch, B. (2008). *Being a brain-wise therapist: A practical guide to interpersonal neurobiology*. New York, NY: W. W. Norton.

Ball, K. K., Vance, D. E., Edwards, J. D., & Wadley, V. G. (2004). Aging and the brain. In M. Rizzo & P. J. Eslinger (Eds.), *Principles and practice of behavioral neurology and neuropsychology* (pp. 795–809). Philadelphia, PA: Saunders.

Ballard, C., O'Brien, J. T., Swann, A. G., Thompson, P., Neill, D., & McKeith, I. G. (2001). The natural history of psychosis and depression in dementia with Lewy bodies and Alzheimer's disease: Persistence and new cases over 1 year of follow-up. *Journal of Clinical Psychiatry*, *62*, 46–49.

Bandyopadhyay, T., Biswas, A., Roy, A., Guin, D., Gangopadhyay, G., Sarkhel, S., . . . Senapati, A. (2014). Neuropsychiatric profiles in patients with Alzheimer's disease and vascular dementia. *Annals of Indian Academy of Neurology*, *17*(3), 325–330. doi:10.4103/0972-2327.138520

Barber, S. J., & Mather, M. (2013). Stereotype threat can enhance, as well as impair, older adults' memory. *Psychological Science*, *24*, 2522–2529.

©Springer Publishing Company

This is a sample from PSYCHOLOGY OF AGING 101
Visit This Book's Web Page / Buy Now / Request an Exam/Review Copy

Barnes, D. E., & Yaffe, K. (2011). The projected effect of risk factor reduction on Alzheimer's disease prevalence. *The Lancet Neurology*, *10*, 819–828.

Beckett, J., Peternelj-Taylor, C., & Johnson, R. L. (2003). Growing old in the correctional system. *Journal of Psychosocial Nursing & Mental Health Services*, *41*(9), 12–18.

Beers, M., Porter, R. S., Jones, T. V., Kaplan, J. L., & Berkwits, M. (Eds.). (2011). *Merck manual of diagnosis and therapy* (18th ed.). Whitehouse Station, NJ: Merck Research Laboratories.

Belleville, S. (2008). Cognitive training for persons with mild cognitive impairment. *International Psychogeriatrics*, *20*(1), 57–66.

Binswanger, I. A., Krueger, P. M., & Steiner, J. F. (2009). Prevalence of chronic medical conditions among jail and prison inmates in the USA compared with the general population. *Journal of Epidemiology and Community Health*, *63*(1), 912–919.

Boxer, A. L., & Miller, B. L. (2005). Clinical features of frontotemporal dementia. *Alzheimer Disease and Associated Disorders*, *19*, S3–S6.

Breen, D. A., Breen, D. P., Moore, J. W., Breen, P. A., & O'Neil, D. (2007). Driving and dementia. *British Medical Journal*, *334*, 1365–1369.

Chan, D., Anderson, V., Pijenburg, Y., Whitwell, J., Barnes, J., Scahill, R., . . . Fox, N. C. (2009). The clinical profile of right temporal lobe atrophy. *Brain*, *132*, 1287–1298.

Chiba, Y., Fujishiro, H., Iseki, E., Ota, K., Kasanuki, K., Hirayasu, Y., & Satoa, K. (2012). Retrospective survey of prodromal symptoms in dementia with Lewy bodies: Comparison with Alzheimer's disease. *Dementia and Geriatric Cognitive Disorders*, *33*, 273–281.

Clark, C. M., & Karlawish, J. H. T. (2003). Alzheimer disease: Current concepts and emerging diagnostic and therapeutic strategies. *Annals of Internal Medicine*, *138*(5), 400–410.

Crawley, E., & Sparks, R. (2005). Hidden injuries? Researching the experiences of older men in English prisons. *Howard Journal of Criminal Justice*, *44*, 345–356.

Crawley, E., Wallace, R. B., Loeffelholz, P. L., & Sales, M. (2005). Institutional thoughtlessness in prisons and its impacts on the day-to-day prison lives of elderly men. *Journal of Contemporary Criminal Justice*, *21*, 350–363.

Djordjevic, J., Jones-Gotsman, M., De Sousa, K., & Cherkow, H. (2007). Olfaction in patients with mild cognitive impairment and Alzheimer's disease. *Neurobiology of Aging*, *29*, 693–706.

Dubois, B., Feldman, H. H., Jacova, C., Cummings, J. L., DeKosky, S., Barberger-Gateau, P., . . . Scheltens, P. (2010). Revising the definition

©Springer Publishing Company

This is a sample from PSYCHOLOGY OF AGING 101
Visit This Book's Web Page / Buy Now / Request an Exam/Review Copy

of Alzheimer's disease: A new lexicon. *The Lancet Neurology*, *9*(11), 1118–1127.

Eby, D. W., & Molnar, L. J. (2012). Cognitive impairment and driving safety. *Accident Analysis & Prevention*, *49*, 261–262.

Eibenstein, A., Fioretti, A. B., Simaskou, M. N., Sucapane, P., Mearelli, S., Mina, C., . . . Fusetti, M. (2005). Olfactory screening test in mild cognitive impairment. *Neurological Sciences*, *26*, 156–160.

Elias, L. J., & Saucier, D. M. (2006). *Neuropsychology: Clinical and experimental foundations*. Boston, MA: Pearson.

Emre, M., Aarsland, D., Brown, R., Burn, D. J., Duyckaerts, C., Mizuno, Y., . . . Dubois, B. (2007). Clinical diagnostic criteria for dementia associated with Parkinson's disease. *Movement Disorders*, *22*(12), 1689–1707.

Fazel, S., McMillan, J., & O' Donnell, I. (2002). Dementia in prison: Ethical and legal implications. *Journal of Medical Ethics*, *28*(3), 156–159.

Ferri, C. P., Prince, M., Brayne, C., Brodaty, H., Fratiglioni, L., Ganguli, M., . . . Scazufca, M. (2005). Global prevalence of dementia: A Delphi consensus study. *The Lancet*, *366*, 2112–2117.

Fields, R. D. (2009). *The other brain: From dementia to schizophrenia, how new discoveries about the brain are revolutionizing medicine and science*. New York, NY: Simon & Schuster.

Fleischman, D. A., Wilson, R. S., Gabrieli, J. D. E., Bienias, J. L., & Bennett, D. A. (2004). A longitudinal study of implicit and explicit memory in old persons. *Psychology and Aging*, *19*, 617–625.

Frank, L., Lloyd, A., Flynn, J. A., Kleinman, L., Matza, L. S., Margolis, M. K., . . . Bullock, R. (2006). Impact of cognitive impairment on mild dementia patients and mild cognitive impairment patients and their informants. *International Psychogeriatrics*, *18*, 151–162.

Geda, Y. E., Roberts, R. O., Knopman, D. S., Petersen, R. C., Christianson, T. J., Pankratz, V. S., . . . Rocca, W. A. (2008). Prevalence of neuropsychiatric symptoms in mild cognitive impairment and normal cognitive aging. *Archives of General Psychiatry*, *65*, 1193–1198.

Graeber, M. B., & Müller, U. (2003). Dementia with Lewy bodies: Disease concept and genetics. *Neurogenetics*, *4*(4), 157–162. doi:10.1007/s10048-003-0155-y

Gupta, M., Dasgupta, A., Khwaja, G., Chowdhury, D., Patidar, Y., & Batra, A. (2013). The profile of behavioral and psychological symptoms in vascular cognitive impairment with and without dementia. *Annals of Indian Academy of Neurology*, *16*(4), 599–602. doi:10.4103/0972-2327.120488

©Springer Publishing Company

This is a sample from PSYCHOLOGY OF AGING 101
Visit This Book's Web Page / Buy Now / Request an Exam/Review Copy

Hanninen, T., Hallikinen, M., & Tuomainen, S. (2002). Prevalence of mild cognitive impairment: A population-based study in elderly subjects. *Acta Neurologica Scandinavica*, *106*, 148–154.

Hess, T. M., Hinson, J. T., & Hodges, E. A. (2009). Moderators of and mechanisms underlying stereotype threat effects on older adults' memory performance. *Experimental Aging Research*, *35*, 153–177.

Higgins, A., Barker, P., & Begley, C. (2005). Hypersexuality and dementia: Dealing with inappropriate sexual expression. *British Journal of Nursing*, *13*, 1130–1134.

Hodges, J. R. (2001). Frontotemporal dementia (Pick's disease): Clinical features and assessment. *Neurology*, *56*, S6–S10.

Hodges, J. R., Martinos, M., Woollams, A. M., Patterson, K., & Adlam, A. L. (2008). Repeat and point: Differentiating semantic dementia from progressive non-fluent aphasia. *Cortex*, *44*, 1265–1270.

Hodges, J. R., & Patterson, K. (2007). Semantic dementia: A unique clinicopathological syndrome. *The Lancet Neurology*, *6*, 1004–1014.

Inzitari, M., Newman, A. B., Yaffe, K., Boudreau, R., de Rekeneire, N., Shorr, R., . . . Rosano, C. (2007). Gait speed predicts decline in attention and psychomotor speed in older adults: The Health, Aging and Body Composition Study. *Neuroepidemiology*, *29*, 156–162.

Jack, C. J., Albert, M. S., Knopman, D. S., McKhann, G. M., Sperling, R. A., Carriool, M. C., . . . Phelps, C. H. (2011). Introduction to the recommendations from the National Institute on Aging–Alzheimer's Association workgroups on diagnostic guidelines for Alzheimer's disease. *Alzheimer's & Dementia*, *7*(3), 257–262.

Jagust, W. (2001). Untangling vascular dementia. *The Lancet*, *358*(9299), 2097–2098.

Jonker, C., Geerlings, M. I., & Schmand, B. (2000). Are memory complaints predictive for dementia? A review of clinical and population-based studies. *International Journal of Geriatric Psychiatry*, *15*, 983–991.

Josephs, K. A. (2007). Capgras syndrome and its relationship to neurodegenerative disease. *Archives of Neurology*, *64*, 1762–1766.

Jungwirth, S., Zehetmayer, S., Hinterberger, M., Tragl, K. H., & Fischer, P. (2012). The validity of amnestic MCI and non-amnestic MCI at age 75 in the prediction of Alzheimer's dementia and vascular dementia. *International Psychogeriatrics*, *24*(6), 959–966. doi:10.1017/S1041610211002870

©Springer Publishing Company

This is a sample from PSYCHOLOGY OF AGING 101
Visit This Book's Web Page / Buy Now / Request an Exam/Review Copy

Kay, J. (2005). Crystallized intelligence versus fluid intelligence. *Psychiatry*, *68*, 9–13.

Kerbs, J. J., & Jolley, J. M. (2007). Inmate-on-inmate victimization among older male prisoners. *Crime and Delinquency*, *53*, 187–218.

Kertesz, A. (2003). Pick Complex: An integrative approach to frontotemporal dementia: Primary progressive aphasia, corticobasal degeneration, and progressive supranuclear palsy. *Neurologist*, *9*, 311–317.

Kertesz, A. (2005). Frontotemporal dementia: One disease, or many? Probably one, possibly two. *Alzheimer Disease and Associated Disorders*, *19*(Suppl. 1), S19–S24.

Knibb, J. A., & Hodges, J. R. (2005). Semantic dementia and primary progressive aphasia: A problem of categorization? *Alzheimer Disease and Associated Disorders*, *19*(Suppl. 1), S7–S14.

Kosaka, K., Matsushita, M., Oyanagi, S., & Mehraein, P. (1980). A cliniconeuropathological study of the "Lewy body disease." *Seishin Shinkeigaku Zasshi*, *82*, 292–311.

Krahn, D. D., Bartels, S. J., Coakley, E., Oslin, D. W., Chen, H., McIntyre, J., . . . Levkoff, S. E. (2006). PRISM-E: Comparison of integrated care and enhanced specialty referral models in depression outcomes. *Psychiatric Services*, *57*(7), 946–953.

Kumfor, F., & Piguet, O. (2012). Disturbance of emotion processing in frontotemporal dementia: A synthesis of cognitive and neuroimaging findings. *Neuropsychology Review*, *22*(3), 280–297. doi:10.1007/s11065-012-9201-6

Lachman, M. E. (2000). Promoting a sense of control over memory aging. In L. Backman, R. D. Hill, & A. Stigsdotter-Neely (Eds.), *Cognitive rehabilitation in old age* (pp. 106–120). New York, NY: Oxford University Press.

Laditka, J. N., Laditka, S. B., Liu, R. U. I., Price, A. E., Wu, B. E. I., Friedman, D. B., . . . Logsdon, R. G. (2011). Older adults' concerns about cognitive health: Commonalities and differences among six United States ethnic groups. *Ageing and Society*, *31*(7), 1202–1228. doi:10.1017/S0144686X10001273

Lewy, F. E. (1912). Paralysis agitans I. Pathologische Anatomie (von F. H. Lewy). In M. Lewandowsky & G. Abelsdorff (Eds.), *Handbuch der Neurologie III*. Berlin, Germany: J. Springer.

Lindsay, J., Sykes, E., McDowell, I., Verreault, R., & Laurin, D. (2004). More than the epidemiology of Alzheimer's disease: Contributions of the Canadian Study of Health and Aging. *Canadian Journal of Psychiatry*, *49*(2), 83–91.

©Springer Publishing Company

This is a sample from PSYCHOLOGY OF AGING 101
Visit This Book's Web Page / Buy Now / Request an Exam/Review Copy

Luzzi, S., Snowden, S. S., Neary, D., Coccia, M., Provinciali, L., & Lambon Ralph, A. M. (2007). Distinct patterns of olfactory impairment in Alzheimer's disease, semantic dementia, frontotemporal dementia and corticobasal degeneration. *Neuropsychologia*, *45*, 1823–1831.

Lyketsos, C. G., Lopez, O., Jones, B., Fitzpatrick, A. L., Breitner, J., & DeKosky, S. (2002). Prevalence of neuropsychiatric symptoms in dementia and mild cognitive impairment: Results from the Cardiovascular Health Study. *JAMA*, *288*, 1475–1483.

Maguire, E. A., Woollett, K., & Spiers, H. J. (2006). London taxi drivers and bus drivers: A structural MRI and neurophysiological analysis. *Hippocampus*, *16*, 1091–1101.

Mahoney, R., Regan, C., Katona, C., & Livingston, G. (2005). Anxiety and depression in family caregivers of people with Alzheimer's disease: The LASER-AD study. *American Journal of Geriatric Psychiatry*, *13*, 795–801.

McGuire, L. C., Ford, E. S., & Ajani, U. A. (2006). Cognitive functioning as a predictor of functional disability in later life. *American Journal of Geriatric Psychiatry*, *14*, 36–42.

McKeith, I. G., Dickson, D., Lowe, J., Emre, M., O'Brien, J. T., Feldman, H. H., . . . Yamada, M. (2005). Diagnosis and management of dementia with Lewy bodies: Third report of the DLB Consortium. *Neurology*, *65*(12), 1863–1872.

Mega, M. S., Lee, I., Dinov, I. D., Mishkin, F., Toga, A. W., & Cummings, J. L. (2000). Cerebral correlates of psychotic symptoms in Alzheimer's disease. *Journal of Neurology, Neurosurgery and Psychiatry*, *69*, 167–171.

Molano, J., Boeve, B. F., Ferman, T., Smith, G. E., Parisi, J., Dickson, D., . . . Petersen, R. C. (2010). Mild cognitive impairment associated with limbic and neocortical Lewy body disease: A clinicopathological study. *Brain*, *133*, 540–556.

Möller, H. J., & Graeber, M. B. (1998). The case described by Alois Alzheimer in 1911. Historical and conceptual perspectives based on the clinical record and neurohistological sections. *European Archives of Psychiatry and Clinical Neuroscience*, *248*, 111–122.

Mondrego, P. J., & Ferrandez, J. (2004). Depression in patients with mild cognitive impairment increases the risk of developing dementia of the Alzheimer type: A prospective cohort study. *Archives of Neurology*, *61*, 1290–1293.

Park, H. L., O'Connell, J. E., & Thomson, R. G. (2003). A systematic review of cognitive decline in the general elderly population. *International Journal of Geriatric Psychiatry*, *18*, 1121–1134.

©Springer Publishing Company

This is a sample from PSYCHOLOGY OF AGING 101
Visit This Book's Web Page / Buy Now / Request an Exam/Review Copy

Petersen, R. C. (2004). Mild cognitive impairment as a diagnostic entity. *Journal of Internal Medicine*, *256*, 183–194.

Petersen, R. C., Doody, R., Kurz, A., Mohs, R. C., Morris, J. C., Rabins, P. V., . . . Winbald, B. (2001). Current concepts in mild cognitive impairment. *Archives of Neurology*, *58*, 1985–1992.

Petersen, R. C., Smith, G. E., Waring, S. C., Ivnik, R. J., Tangalos, E. G., & Kokmen, E. (1999). Mild cognitive impairment: Clinical characterization and outcome. *Archives of Neurology*, *56*, 303–308.

Prusiner, S. B. (2014). *Madness and memory*. New Haven, CT: Yale University Press.

Raffaitin, C., Gin, H., Empana, J.-P., Helmer, C., Berr, C., Tzourio, C., . . . Barberger-Gateau, P. (2009). Metabolic syndrome and risk for incident Alzheimer's disease or vascular dementia: The Three-City Study. *Diabetes Care*, *32*(1), 169–174.

Ramakers, I. H. G. B., Verhey, F. R. J., Scheltens, P., Hampel, H., Soininen, H., Aalten, P., . . . Visser, P. J. (2013). Anxiety is related to Alzheimer cerebrospinal fluid markers in subjects with mild cognitive impairment. *Psychological Medicine*, *43*(5), 911–920. doi:10.1017/S0033291712001870

Reimer, G. (2008). The graying of the U.S. prisoner population. *Journal of Correctional Health Care*, *14*, 202–208.

Roberts, J. S., & Connell, C. M. (2000). Illness representations among first-degree relatives of people with Alzheimer's disease. *Alzheimer Disease and Associated Disorders*, *14*, 129–136.

Rodrigue, K. M., Kennedy, K. M., & Raz, N. (2005). Aging and longitudinal change in perceptual-motor skill acquisition in healthy adults. *Journals of Gerontology. Series B, Psychological Sciences and Social Sciences*, *60*, P174–P181.

Roe, C. M., Mintun, M. A., D'Angelo, G., Xiong, C., Grant, E. A., & Morris, J. C. (2008). Alzheimer's disease and cognitive reserve: Variation of education effect with carbon 11-labeled Pittsburgh compound B uptake. *Archives of Neurology*, *64*, 1467–1471.

Saunders, N. L. J., & Summers, M. J. (2010). Attention and working memory deficits in mild cognitive impairment. *Journal of Clinical and Experimental Neuropsychology*, *32*, 350–357.

Saunders, N. L. J., & Summers, M. J. (2011). Longitudinal deficits to attention, executive and working memory in subtypes of mild cognitive impairment. *Neuropsychology*, *25*, 237–248.

Siegal, D. J. (2006). An interpersonal neurobiology approach to psychotherapy: Awareness, mirror neurons, and neuroplasticity

©Springer Publishing Company

This is a sample from PSYCHOLOGY OF AGING 101
Visit This Book's Web Page / Buy Now / Request an Exam/Review Copy

in the development of well-being. *Psychiatric Annals*, *36*(4), 247–258.

Singleton, A., & Gwinn-Hardy, K. (2004). Parkinson's disease and dementia with Lewy bodies: A difference in dose? *The Lancet*, *364*(9440), 1105–1107.

Snowden, J. S., Bathgate, D., Varma, B., Blackshaw, A., Gibbons, Z. C., & Neary, D. (2001). Distinct behavioral profiles in frontotemporal dementia and semantic dementia. *Journal of Neurology, Neurosurgery and Psychiatry*, *70*, 323–332.

Snowden, J. S., Thompson, J. C., & Neary, D. (2004). Knowledge of famous faces and names in semantic dementia. *Brain*, *127*, 860–872.

Spira, A. P. P., Rebok, G. W. P., Stone, K. L. P., Kramer, J. H. P., & Yaffe, K. (2012). Depressive symptoms in oldest-old women: Risk of mild cognitive impairment and dementia. *American Journal of Geriatric Psychiatry*, *20*(12), 1006–1015.

Teng, E., Lu, P. H., & Cummings, J. L. (2007). Neuropsychiatric symptoms are associated with progression from mild cognitive impairment to Alzheimer's disease. *Dementia and Geriatric Cognitive Disorders*, *24*, 253–259.

Thaipisuttikul, P., Lobach, I., Zweig, Y., Gurnani, A., & Galvin, J. E. (2013). Capgras syndrome in dementia with Lewy bodies. *International Psychogeriatrics*, *25*(5), 843–849. doi:10.1017/S1041610212002189

Thompson, S. A., Patterson, K., & Hodges, J. R. (2003). Left/right asymmetry of atrophy in semantic dementia: Behavioral-cognitive implications. *Neurology*, *61*, 1196–1203.

Tröster, A. I. (2008). Neuropsychological characteristics of dementia with Lewy bodies and Parkinson's disease with dementia: Differentiation, early detection, and implications for "mild cognitive impairment" and biomarkers. *Neuropsychology Review*, *18*(1), 103–119. doi:10.1007/s11065-008-9055-0

Tsatali, M. S., Tsolaki, M. N., Christodoulou, T. P., & Papaliagkas, V. T. (2011). The complex nature of inappropriate sexual behaviors in patients with dementia: Can we put it into a frame? *Sexuality and Disability*, *29*(2), 143–156. doi:10.1007/s11195-010-9187-z

Tung, E. E., Chen, C. Y. Y., & Takahashi, P. Y. (2013). Common curbsides and conundrums in geriatric medicine. *Mayo Clinic Proceedings*, *88*(6), 630–635.

Valverde, A. H., Jimenez-Escrig, A., Gobernado, J., & Barón, M. (2009). A short neuropsychologic and cognitive evaluation of frontotemporal

©Springer Publishing Company

This is a sample from PSYCHOLOGY OF AGING 101
Visit This Book's Web Page / Buy Now / Request an Exam/Review Copy

dementia. *Clinical Neurology and Neurosurgery*, *111*(3), 251–255. doi:10.1016/j.clineuro.2008.10.012

Vance, D. E., Robertson, A. J., McGuinness, T., & Fazeli, P. L. (2010). How neuroplasticity and cognitive reserve protect cognitive functioning. *Journal of Psychosocial Nursing & Mental Health Services*, *48*(4), 23–30.

Varma, A. R., Snowden, J. S., Lloyd, J. J., Talbot, P., Mann, D., & Neary, D. (1999). Evaluation of the NINCDS-ADRDA criteria in the differentiation of Alzheimer's disease and frontotemporal dementia. *Journal of Neurology, Neurosurgery and Psychiatry*, *66*(2), 184–188.

Williams, B. A., Sudore, R. I., Greifinger, R. B., & Morrison, R. S. (2011). Balancing punishment and compassion for seriously ill prisoners. *Annals of Internal Medicine*, *155*(2), 122–126.

Winbald, B., Palmer, K., Kivipelto, M., Jelic, V., Fratiglioni, L., Wahlund, L.-O., . . . Petersen, R. C. (2004). Mild cognitive impairment—beyond controversies, towards a consensus: Report of the International Working Group on Mild Cognitive Impairment. *Journal of Internal Medicine*, *256*, 240–246.

Ye, B. S., Seo, S. W., Cho, H., Kim, S. Y., Lee, J.-S., Kim, E.-J., . . . Na, D. L. (2013). Effects of education on the progression of early- versus late-stage mild cognitive impairment. *International Psychogeriatrics*, *25*(4), 597–606. doi:10.1017/S1041610212002001

Youdin, R. (2014). *Clinical gerontological social work practice*. New York, NY: Springer Publishing Company.

©Springer Publishing Company