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Mental Disorders in Older Adults, Second Edition: Fundamentals of Assessment and Treatment
By Steven H. Zarit and Judy M. Zarit. Copyright © 2007

CHAPTER 1

Introduction

CLINICAL PRACTICE WITH OLDER ADULTS

We have written this book for clinicians and clinical students interested in working with older people and their families, as well as for researchers seeking an overview of assessment and treatment of mental disorders in later life. The book provides a foundation for practice with older adults and addresses the most common problems clinicians are likely to encounter.

Colleagues of ours who do not see older adults in their practice often ask us if work with the elderly is boring. Quite the opposite! Clinical practice with older adults is intellectually challenging and rewarding. The rewards come in many ways. As with people of other ages, older adults can change and recover from problems such as depression or anxiety or can take control of their lives in ways that lead to greater personal fulfillment. In other cases, treatment can keep a bad situation from becoming worse. Assessment plays a prominent role in practice with older adults, because any particular symptom or problem may arise from several possible causes. We always feel a great sense of satisfaction when we can identify a treatable problem in someone who was considered "hopelessly senile," but even when we can only confirm bad news, we can provide the patient and family with knowledge about the problem and the opportunity to plan for future needs.

The book integrates clinical practice and research. A common complaint among practitioners is how frustrating it is to try to apply research findings that are based on standard protocols developed in university settings. In clinics and private practices, clients do not neatly conform to these standards, nor do they generally present with a single problem that meets the research requirements. At the same time, practice needs to be informed and guided by

research so that the best methods of assessment and treatment are used and so that insights into the aging process from basic research can be incorporated into our view of older people. We have backgrounds in both research and practice with older people and currently work in settings that emphasize these areas differently. One of us (SHZ) is in a primarily research and academic setting, and the other (JMZ) has 25 years of experience in private practice and as a consultant to nursing homes and retirement communities. We believe that the combination of these perspectives helps us integrate our discussions of research in a practical clinical context, while basing clinical approaches to the extent possible on a solid underpinning of empirical knowledge.

We draw heavily on our own professional training in clinical psychology, but we intend this book for all the mental health professions that work with older people. We emphasize psychosocial perspectives and expect the book to be most useful to psychologists, social workers, nurses, and gerontologists. Psychiatrists and geriatricians may also find the presentation of behavioral and neuropsychological perspectives a useful complement to their biomedical approaches.

An underlying assumption of our approach is that several professional groups can make valuable contributions to mental health care for the elderly. Clinical practice is best carried out in a context of multidisciplinary collaboration, with each field contributing its special expertise. The need for a multidisciplinary approach grows out of an understanding of mental health problems in later life. Medical, psychological, and social processes are frequently intertwined in later life, and an exclusive focus on one area to the neglect of the others can be detrimental. A major theme of this book is how to think about these interactions when conducting an assessment or treating an older person. As an example, a primarily medical approach to Alzheimer's disease (AD) can miss opportunities for behavioral or psychosocial treatment. These treatments can help patients with AD function optimally despite their disease: for example, by simplifying their environment and routines or by using behavioral management skills to control problems such as agitation or depressed mood. Conversely, an exclusively behavioral approach would overlook the potential benefits of medications in the management of disturbed behavior in dementia. Collaboration across disciplines makes it more likely that effective interventions will be identified, whether medical, psychological, social, or environmental.

One of our goals is to provide nonphysicians with information on illnesses and use of medications in later life. By understanding the effects of medical illnesses on psychological problems in later life and the uses and limits of psychoactive medications, the mental health professional can be a more effective collaborator with physicians. Nonphysicians should not, of course, give medical advice to their patients, but they can make assessments and observations that enable physicians to formulate better treatment choices. In the current health care climate, the physician's time is at a premium. By con-

trast, mental health professionals are often able to spend the time needed with patients to assess their symptoms and responses to medications, as well as to identify the best strategies for working with them. Development of collaborative relationships with physicians depends on establishing expertise in aging and mental health and in communicating findings in a succinct and jargon-free manner. Our experience shows that once physicians understand what information we can provide and how we can enhance treatment, barriers between professions fade away.

EMERGENCE OF AGING IN MENTAL HEALTH PRACTICE

For many years, geriatric practice was a backwater, a minor field viewed condescendingly by clinicians who felt that little could be done for anyone over age 50. That viewpoint was a luxury of a society that had relatively few older people. The dramatic extension of life expectancy and growth in the proportion of people over age 65 in society, coupled with empirical findings of the effectiveness of treatment for many problems of later life, provides a solid foundation for geriatric mental health practice. The number of clinicians with geriatric expertise, however, falls far short of the need.

The aging of the population is one of the most profound and far-reaching changes affecting contemporary society. The number and proportion of older people in the population has grown dramatically in most developed countries and, more recently, in many developing nations. Among all the changes that occurred in the 20th century, one of the most profound and far-reaching was the dramatic increase in life expectancy. Throughout human history, only a very small part of the population enjoyed long life. Most people died young as a result of acute illness, injury, the effects of contaminated food or water, or, for women, from complications of childbirth. Improvements made at the beginning of the 20th century in public health and control of infectious diseases had a dramatic effect on the prospect of living to old age. Between 1900 and 2000, average life expectancy in the United States rose from 46 to 74 years for men and from 49 to 80 years for women (U.S. Census Bureau, 2003). The combined influence of greater life expectancy and smaller family size has led to growth in the proportion of people 65 and older in the population. As seen in Figure 1.1, only 4% of the population of the United States was 65 years of age or older in 1900. That figure rose to 12.3% in 2000 and is projected to increase to 20% by the year 2030 (Treas, 1995; U.S. Department of Health and Human Services, 2003). Canada and many of the European countries have experienced similar patterns of growth in their older populations (Kinsella & Velkoff, 2001). With so much of the population over age 65, mental health professionals with the expertise to assess and treat the problems of later life are sorely needed.

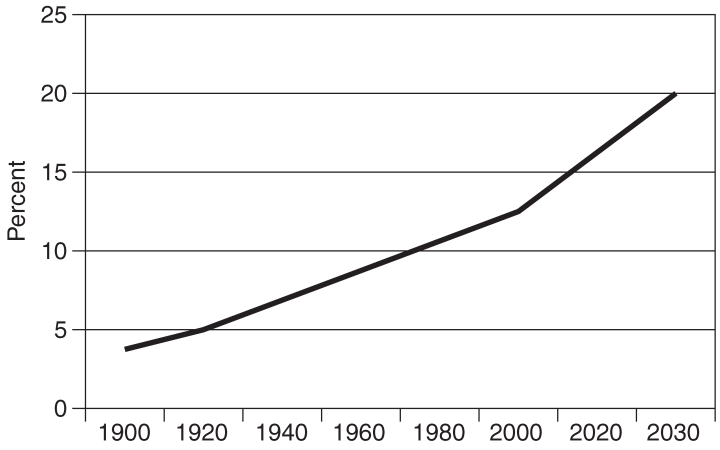

FIGURE 1.1. Proportion of the U.S. population ages 65 and older: 1900–2030. Data from U.S. Census Bureau (2003).

These demographic and social changes mean that an increasing number of older people are in need of psychological services. The mental health field, however, has been slow to respond with adequate numbers of trained professionals who have specialized training in geriatrics. Estimates from the United States indicate that in every mental health field—psychiatry, psychology, nursing, and social work—too few people currently have geriatrics training (Halpain, Harris, McClure, & Jeste, 1999; Shea, 2003). Shea (2003), for example, estimates the current need as an additional 2,400 psychiatrists, 2,800 psychologists, and 3,750 nurses with geriatrics training, as well as an indeterminate number of social workers. The failure to develop enough programs that provide specialized training in psychology, nursing, and social work will exacerbate the shortfall just as the baby-boom generation increases the number of older people dramatically.

The need for trained professionals comes at a time when steadily growing knowledge about the aging process and clinical problems of aging make research and practice with older people exciting and challenging. Studies of normal psychological and social processes of aging have challenged many negative stereotypes. In contrast to the image of older people as decrepit and depressed, studies repeatedly have demonstrated that older people are often competent and enjoy their lives (Carstensen, Pasupathi, Mayr, & Nesselroade, 2000; Rowe & Kahn, 1987, 1997). The aging process is characterized by the possibility of growth, as well as decline (e.g., Baltes, 1987, 1997). Many abilities once thought to undergo significant decline during the adult years, such as memory and intelligence, now appear to be stable on average or even to improve in some individuals until the 60s or 70s (Schaie, 1995). Dementia,

depression, and other serious disorders typically identified with later life affect only a minority of the population and are not intrinsic or universal aspects of the aging process.

This optimistic picture of aging is reflected in the daily lives of older people. People are not just living longer; they are living *better* longer than ever before in human history. The prospect for successful aging, that is, for older people to lead healthy, active, and fulfilling lives, has become a real possibility (Rowe & Kahn, 1987, 1997). Improvements in disease prevention and health promotion, the widespread availability of public and private pensions and other financial benefits, and increased educational opportunities for each successive generation have dramatically improved the lives of today's older population. The next generation of older people will have had better education and have taken better care of their health across the lifespan, so their prospects for successful old age are even greater.

Successful aging is only part of the picture of later life. The increase in life expectancy means that people are more likely to live until their 70s, 80s, or even 90s, ages at which a variety of chronic illnesses and disabilities become common. Along with unprecedented numbers of vital and active old people, we have seen a dramatic increase in elders with significant mental and physical problems (e.g., Zarit, Johansson, & Malmberg, 1995). Their complex problems are costly for society and often overwhelming for their families. The dual existence of unprecedented numbers of successful agers and those with significant need is a key point for understanding old age.

Fortunately, timely and well-conceived clinical interventions can make a difference. Many older people retain resiliency and can respond positively to mental health interventions. A growing body of research documents the effectiveness of psychotherapy with older people and their families (Gatz et al., 1998). For disorders such as depression, response to treatment may be as good for older as for younger people (Scogin & McElreath, 1994). Even when confronted with the most devastating problems in later life, such as AD, clinicians can make interventions that dramatically improve the situation (e.g., Mittelman et al., 1995; Whitlatch, Zarit, & von Eye, 1991). Opportunities are emerging to design prevention programs for disorders such as depression and anxiety and to develop strategies for promoting health, as well as intellectual and functional competency, thus helping to make old age a productive and fulfilling period of life.

Older people themselves are increasingly turning to mental health professionals for help with their problems. In the past, clinicians often remarked that older people were not interested in psychotherapy. Indeed, when we first began our practices, we found that some older clients were reluctant or embarrassed to visit a psychologist. Increasingly, however, our older clients view psychotherapy positively. Some have been in treatment earlier in their lives and do not feel the stigma associated with seeing a therapist that typified previous generations. This trend is likely to increase with future generations.

The cohort of people currently in their 40s and 50s who are now consulting us about their parents will have even fewer inhibitions about seeking out appropriate mental health treatment for themselves when they are older.

One other major factor in the growth of clinical practice with older people in the United States is the inclusion of outpatient mental health treatment in Medicare. When Medicare was first implemented in 1965, it paid only for inpatient psychiatric treatment. Beginning in the late 1980s, however, coverage was extended to mental health services in outpatient settings and in nursing homes and other institutional settings. Although Medicare currently reimburses differently for outpatient mental health care than for other medical problems (50% of usual costs are covered, compared with 80% for most other treatments), a major financial obstacle to seeking treatment has been reduced. Increasingly, older people and their families are taking advantage of the options for mental health treatment available to them.

PURPOSE AND PLAN FOR THIS BOOK

We have written this book for the student who is exploring geriatric mental health for the first time, for the experienced professional who wants to learn the specialized knowledge and skills that are needed for meeting the growing needs of an aging population, and for the researcher wanting a broad foundation in clinical concepts and approaches. With knowledge in geriatric mental health rapidly expanding, we have chosen to emphasize some topics and not others.

Our decisions were guided by three considerations. First, we wanted to write a concise introduction that provides clinicians and students with the basic knowledge and framework necessary to begin practice with older adults. The book covers the topics recommended in guidelines for practice with older adults developed by the American Psychological Association (2004). We could have gone into greater depth on many topics, but instead we have chosen to present a foundation for each area while providing references for readers wishing to pursue an issue in greater depth. By organizing the book in this way, we believe we have created a practical introduction to clinical work with older adults. Second, we have been guided by the fact that clinical practice with older people is both similar to and different from practice with other adults. To be successful in assessing and treating older adults, clinicians need a combination of basic clinical skills that they might use with any adult client, combined with specialized knowledge about what is different about disorders in later life and when and how clinicians need to use different strategies in their clinical work with an older adult. In this book, we emphasize the issues and topics that are different in geriatric practice, topics that are usually not covered in clinical training. Third, we integrate research findings with our clinical experience. This will be most evident in discussions of treatment, in

which we present findings about empirically validated treatment but also discuss approaches developed by JMZ through clinical experience. These examples illustrate different ways of implementing validated approaches, as well as treatment of problems on which there is as yet little empirical evidence. Each therapist will develop a unique style, and so these approaches are meant to be illustrative rather than a definitive blueprint for treatment.

Throughout, we use clinical examples to illustrate key points. These are drawn mainly from JMZ's clinical practice, with names and details changed to ensure confidentiality. As a stylistic note, because the clinical work was done by one person, we use the first-person pronouns "I" and "me" in all the examples.

What constitutes the basic knowledge needed for practice with older adults? We believe the starting point is being able to recognize when a client is suffering from one of the common disorders of aging. Assessment is important when working with people of any age, but it takes on an even more prominent role in practice with older adults. Given the negative stereotypes of and expectations for older people, the tendency exists to mislabel potentially treatable problems as irreversible aspects of age or disease. Geriatric mental health specialists must be able to make sophisticated assessments of symptoms, which, in conjunction with medical assessments, help differentiate between mild, everyday problems and the more pathological processes due to disorders such as AD.

Three main components contribute to assessment: (1) an understanding of the normal changes that occur with aging, (2) knowledge of the characteristics of the most common disorders in later life, and (3) familiarity with assessment approaches. In Chapter 2, we present an overview of the normal psychological processes of aging and summarize the usual and expected changes in intellectual functioning, memory, personality, and other areas. Knowing what is usual and expected is helpful for setting goals in treatment and for comparing findings from a clinical assessment to determine whether an individual has a problem that needs to be treated.

The next three chapters address the problems and disorders of later life. Chapter 3 focuses on disorders that impair cognition—dementia and delirium—and reviews their symptoms, prevalence, and etiology. Chapter 4 addresses the affective disorders—specifically, depression and anxiety. These are the most common psychiatric disorders in later life and also the ones for which the most treatment options exist. In Chapter 5, we look at the most disabling of the psychiatric diagnoses: personality and psychotic disorders. Although most cases of these disorders have their onset in earlier periods of life, they often continue to exert a major influence on older people and their support networks.

Building on this foundation, we move to methods for assessing older people, emphasizing approaches for differentiating dementia from other disorders. This is the most common assessment question that is raised and one that

must be clearly answered before developing a treatment plan. Chapter 6 describes how to conduct a clinical interview, including the goals and process of the interview, topics to address, and brief testing. Chapter 7 focuses on psychological testing. We include examples of the tests used and how the results of testing contribute to determining diagnosis and competency.

Chapters 8 through 14 address treatment, with an emphasis on issues in treatment that are different or unique in practice with older people. Treatment of older people with mental health problems requires a multifaceted approach. Clinicians need to draw on basic skills of psychotherapy, to coordinate psychological with psychiatric and other medical treatment, and to intervene at different levels—that is, with patients, with patients' families, with community agencies that provide supportive services, and with nursing homes and other residential settings.

We begin the discussion of treatment in Chapter 8 by exploring basic concepts and approaches that underlie successful treatment of older people and by examining differences and similarities in treatment of older clients. Chapter 9 applies this framework to treatment of depressive disorders, and Chapter 10 takes a similar approach with anxiety disorders.

Chapter 11 turns to the problem of paranoid disorders in later life, when treatment is typically different from that for younger patients. Chapter 12 focuses on the treatment of people with dementia, including new medications and psychosocial interventions that help people function as well as possible despite their illness. In Chapter 13, we broaden the focus on treatment to include caregivers—the families of people with dementia and other serious disabilities. We examine the burden experienced by family caregivers and present treatments that alleviate stress.

Chapter 14 discusses the nursing home as a system and presents approaches for successful intervention. Nursing homes and other special housing are very important settings for mental health interventions. Many residents in nursing homes have mental health problems that often go undetected and untreated (e.g., Burns et al., 1993; German, Shapiro, & Kramer, 1986; Shea, Streit, & Smyer, 1994). Increasingly, mental health professionals are being called on to consult in nursing homes and other institutional settings. Clinicians working in these settings need to call on their knowledge of assessment and treatment approaches for older adults, as well as understand how to solve problems within a complex system.

We conclude in Chapter 15 with a discussion of ethical issues. Familiar ethical issues, such as maintaining confidentiality, take on a new twist when working with older adults, particularly when family members are involved or when the person lives in an institution. Some issues are more complicated in later life, such as how to assess consent for treatment when someone is cognitively impaired and making end-of-life decisions.

Working with older people is intellectually challenging and personally rewarding. Older clients often pose complex and varied assessment questions,

which need to be addressed by integrating medical, psychological, social, and sometimes legal information. Treating an older person is sometimes like opening a window to the past. Our clients have lived through major historical events and have personally met many great figures of the past century. Unlike young adults, who often have limited experience and may lack basic practical skills for managing everyday life, our older clients can draw on a lifetime of adaptation, bringing it to bear on their current situation. In the end, we have always found that we can make a difference in the lives of older people and their families, and that is gratifying.

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72 Spring Street
New York, NY 10012
212-431-9800
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