
CHAPTER 1

Introduction to Clinical Issues

STEVEN H. ZARIT AND DEE A. HAYNIE

CASE STUDY

Mrs. Frieda Baker was a 69-year-old woman who was referred because of depression to the psychological service of a vision rehabilitation program. She had multiple health problems, which resulted in her becoming socially isolated and which contributed to her depression. She had poor vision due to cataracts and glaucoma and was virtually blind in bright sunlight. In addition, she had chronic back problems that limited how far she could walk. Because she could no longer walk outside safely, she had become a virtual prisoner in her apartment, going outdoors only when a van from the senior service center took her shopping.

Fortunately, Mrs. Baker had been referred to a rehabilitation program for people with serious vision loss. As a first step, she was fitted with special wrap-around sunglasses that improved her ability to see in sunlight, and she received mobility training so that she could use her remaining vision to cross streets safely. She was still obviously depressed, and so she was referred to the psychological service for assessment and possible therapy.

Mrs. Baker described a pattern of extreme social isolation that resulted from her vision and back problems. Unable to work or even get around, she had remained in her apartment nearly all of the past two years. Her only son was an alcoholic, from whom she was estranged. A behavior treatment for depression, developed by Lewinsohn and colleagues (e.g., Lewinsohn, Muñoz, Youngren, & Zeiss, 1992), which has had good success with older adults (Zeiss & Steffen, 1996), was undertaken. Behind this approach is the idea that people who are depressed typically find themselves in a vicious cycle: feeling depressed, decreasing pleasant activities, feeling more depressed, and so on. The therapist helps to break this cycle by having clients identify and then schedule activities that they enjoy. Engaging in pleasant events improves mood, which can lead to a focus on other problems or difficulties that might have been contributing to the person's depression.

In this case, Mrs. Baker's search for pleasant events took on an almost existential quality. Her life had previously revolved around her work and the few friendships she had through her job. She could no longer work due to her disability, and, as a result, she had lost touch with most of her friends. She faced the problem of creating a life that would accommodate her pronounced disabilities. She gradually became more active, including

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coming to the rehabilitation center as a volunteer. Her mood improved as she engaged in more pleasant activities, but she felt there was still something missing, an activity that would give meaning to her life. Some possible avenues were closed to her because of her disabilities. She considered taking classes at the local community college, but getting there involved walking uphill one block from the bus stop. She could not do that because of her back problems.

Finally, Mrs. Baker decided on an activity that she had wanted to do all her life but had never gotten around to: painting. She located a painting class for senior citizens and found that she enjoyed it greatly and had a flair for it, despite her vision problems. She set up an easel in her kitchen and began spending mornings painting when the light was right. Painting invigorated her and gave her life meaning. Her depression decreased and she even won a prize for her paintings in a citywide arts contest for disabled artists.

PRINCIPLES OF GEROPSYCHOLOGY

This case example is remarkable in some ways but also typical, illustrating major features of geropsychology. The most important aspect of this case is that it demonstrates the possibility for growth and change in later life. Decline and disability are, of course, very real possibilities in old age. Most older people experience relatively benign psychological changes compared to when they were younger and can function well in their daily lives. When people develop disabilities such as Mrs. Baker's, many retain a resiliency that makes it possible for them to adapt to their losses. At one time, psychologists might have viewed a woman like Mrs. Baker as a hopeless case due to her age and depression. She might even have been confined to a mental institution or nursing home where she would aimlessly wait out the rest of her days. Instead, she was able to find meaning and fulfillment in her life when given appropriate rehabilitation services for her disabilities.

AGING FROM A LIFE SPAN PERSPECTIVE

The ability to work with older clients and to identify treatable aspects of their problems requires an understanding of the aging process, including the potential for decline and disability, as well as the possibilities for continued growth and change. We have organized the growing literature on aging into several key points that capture the dynamic interplay of growth and decline in later life. In doing so, we have drawn heavily on the life span developmental theory developed by Paul Baltes (1987, 1997).

Aging as a Multidimensional Process

Aging can best be viewed as the interaction of biological, psychological, and social processes. We typically think of aging as a biological process marked by outward signs such as gray hair and wrinkles, but aging also can occur in psychological and social realms. Psychologically, the ways people learn and

process information change, though, as we will see, not always for the worse. Likewise, people move through social roles and transitions such as having children and seeing them mature, leave home, and have children of their own. These types of psychological and social changes have a profound effect on what we think of as aging.

Consistent with this multidimensional perspective, clinical work with older people is carried out best by multidisciplinary teams that pay attention to the whole person, and not just to one symptom or system. In Mrs. Baker's case, for example, several professionals were involved in the rehabilitation effort, including mobility trainers, optometrists, low-vision technicians who trained her to use optical aids, and a psychologist.

Age or Disease?

It is important to distinguish aging from disease. The normal aging process, whether viewed at a biological, psychological, or social level, is relatively benign and does not lead to catastrophic changes. Rather, dramatic decline occurs as a result of disease. As an example, at one time, it was believed that aging eventually led to senility and that everyone would become senile if they lived long enough. We now know that the syndrome of severe, progressive memory and intellectual decline that we call senility or senile dementia results from several different diseases, such as Alzheimer's, but is not a universal part of growing older. The risk of Alzheimer's disease, like that of many other illnesses, increases with advancing age, but a majority of people at 80, 90, and even 100 do not suffer from this type of mental decline (Johansson & Zarit, 1997). Aging is associated with an increased risk of developing Alzheimer's disease and various other diseases, but the aging process is not inherently pathological.

This distinction between normal aging and disease has much practical significance. There has been a tendency to view all older people as experiencing negative changes (e.g., senility, rigidity), but that is not the case. Older people who suffer from diseases that impair their functioning should get appropriate care. The majority of older people, however, are relatively healthy and should not be construed as having diminished capacity in their ability to carry out everyday activities. In other words, we should not view all older people as having changes typical of dementia or other diseases. And as the case example illustrated, even in the face of some chronic diseases, older people may retain the resiliency to make creative adaptations.

Development as an Ongoing Process

As the term "life span development" implies, development and aging are a continuing process. Development does not stop at a particular age, but continues throughout life. Although there can be decline, there is also the possibility of continued growth. People do not lose the capacity to grow or change at a particular age, whether at 50, 60, 70, or even 80. There are certainly considerable individual differences in the degree of openness to new ideas and change. Some people at 20 or 30 are rigid and fixed in their ways, whereas others, like Mrs. Baker, can draw on their creative potential despite their advanced age.

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Continuities in Development

As we observe people over time, we find evidence for both continuity and change in psychological functioning. How people function in the present is usually consistent with how they performed in the past. People do not take on a different persona or different qualities when they get old. There is no single or universal pattern of mental decline, nor do people enter a stage of life in which their behavior can be explained by a simple precept or formula. Rather, as people grow older, there is continuity with their previous life. An older person who is demanding and angry is likely to have been so when younger. Likewise, someone who is vitally involved in everyday life in all likelihood was like that earlier in life. In fact, personality characteristics are “age blind”; that is, they remain relatively stable throughout adulthood (Costa & McCrae, 1988). People continue to be recognizable as themselves, despite outward physical changes.

These findings of continuity have practical importance for people who work with older adults. Understanding an older person means finding out about that person’s past, including experiences, preferences, values, beliefs, hopes, and fears. Even when working with someone with severe disabilities such as Alzheimer’s disease, finding out about the person’s past is key to developing a good relationship and providing good care.

Patterns of Change with Aging

There can also be change throughout the life span. The changes that occur with aging can be viewed in two ways: as *interindividual* differences and as *intra-individual* differences. Interindividual differences refer to the ways that people differ from one another. There are many sources of interindividual differences, including aging. People may also differ from one another on some ability due to their education, cultural background or ethnicity, prior experience or other factors. The rate at which abilities change can also vary from one person to the next. Intra-individual changes refer to the changes an individual experiences over time. People experience age-related changes at different rates for different abilities. As an example, someone may experience a decline in cardiovascular fitness, which leads to limited mobility, but can still perform well at intellectual tasks. In other words, changes in abilities are often specific rather than global.

Compensation for Decline

One of the most important facets of aging is the ability to compensate for decline by utilizing functions that have not declined. Baltes (1987) calls this process “selective optimization with compensation.” The best example of this type of compensation comes from Salthouse’s (1984) classic study of older typists. One of the earliest and most predictable changes with aging is a decline in reaction time, which typically begins around age 20. Although there are considerable interindividual differences in the rate of change in reaction time, older people consistently perform worse on speeded tasks than younger people. Salthouse observed that older expert typists were still able to maintain a high rate of typing speed compared to younger typists. He found that they were able to maintain their productivity despite declines in reaction time by anticipating the upcoming text better than younger typists. In other words,

older typists were able to draw on their experience to offset an age-related decline in reaction time.

We see evidence of compensation in many different realms. An older tennis player who has slowed down a step and lost some power may compensate by using better strategies, such as placing a bewildering array of spins on the ball that keep a younger player off balance. Older people maintain expert performance in a variety of areas, ranging from chess to law, suggesting that selective optimization with compensation is a common process (Salthouse, 1990).

Improving with Age: Plasticity and Training

Another important consideration is that change does not always involve decline. People can improve their performance on particular abilities through experience and training. It was once thought that intellectual abilities peaked in the 20s and then gradually declined. Longitudinal studies that have followed people through their adult years have demonstrated that many intellectual abilities, especially verbal abilities that benefit from experience, increase into the 40s and 50s and do not decline until the 60s or even later (Schaie, 1996).

A portion of the decline that we ascribe to aging may be due to a lack of practice or fitness. Regarding physical parameters such as endurance and strength, a sedentary lifestyle may result in some of the changes we call aging, and these changes can be reversed with appropriate training (Evans, 1996; Evans & Cyr-Campbell, 1997). It is widely believed that improved physical fitness has made it possible for people to live longer and healthier lives. Similarly, it has been hypothesized that at least some portion of intellectual decline may be the result of a lack of practice or of exercising these intellectual abilities. A variety of cognitive training studies have demonstrated that older people can make improvements in their intellectual functioning (e.g., Baltes & Kliegl, 1992; Floyd & Scogin, 1996; Hill, Sheikh, & Yesavage, 1988).

Training can be used to overcome decline due to inactivity or lack of practice. It can also be used to demonstrate plasticity, that is, the capacity for new growth (Staudinger, Marsiske, & Baltes, 1995). Plasticity was long regarded as a quality of the young. A young person who suffers a brain injury, for example, will have more recovery of function than an older person, as the brain is able to form more new connections to overcome the effects of the injury. But there remains some potential for plasticity with aging. As an example, animals placed in enriched laboratory environments where there is ample stimulation show development of more neural connections than animals living in standard, unstimulating environments (Diamond, Johnson, Protti, Ott, & Kajisa, 1985; Rosenzweig & Bennett, 1996).

A similar capacity for growth has been demonstrated in humans. In an interesting series of training studies with older people, Willis and colleagues (Willis, Blieszner, & Baltes, 1981; Willis & Nesselroade, 1990) found clear evidence of plasticity in cognitive abilities. People were trained in skills that would help their performance on either a fluid intelligence task, which is generally affected more by aging, or a crystallized intelligence task, which tends to be stable with age. The average age of people in the sample was 70 years. Following training, people showed improvement on the test related to the skills

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they learned, though not on the other test. These results demonstrated that training in underlying skills could improve intellectual performance, even on a fluid intelligence task that typically declines with aging. More impressively, a follow-up seven years later indicated that the benefits of training were largely maintained (Raykov, 1997; Willis & Nesselroade, 1990).

The possibility for plasticity and its limits can be demonstrated by testing the limits, that is, pushing people to high levels of performance until they cannot respond further (Baltes, 1987). In testing the limits, we can see both the possibilities for development and the boundaries created by aging. As an example, if we observe a younger and an older person walk a certain distance, we are not likely to find much difference (Baltes, 1987). If we look at marathon runners, however, we find clear differences. Some older people can run marathons, which demonstrates the possibility of maintaining a high level of functioning in later life. At the same time, the best older runner will run a marathon in a slower time than good younger runners. Of course, an older person who can run a marathon is in better shape than many younger people who lead largely sedentary lives, but there is a limit imposed by aging.

Baltes and colleagues (Baltes & Kliegl, 1992; Kliegl, Smith, & Baltes, 1989) have examined the effects of testing the limits for cognitive performance. Older and younger people participated in an experiment in which they learned a strategy for remembering long lists of items, called the method of loci. This method involves associating something you want to remember with a particular place or location, such as a room in your house or a familiar place in the city where you live. Older people were able to learn and use this memory technique. When tested on word lists, older people learned more slowly and could only manage shorter lists than younger people (15 words compared to 30), but they were still able to increase the number of words recalled on average from 6 prior to training to 15 after training. In testing the limits, then, we can see how much potential there is for growth, as well as the limits to plasticity imposed by the aging process.

IMPLICATIONS OF A LIFE SPAN PERSPECTIVE FOR PSYCHOPATHOLOGY IN LATER LIFE

These perspectives on the normal aging process contribute to a better understanding of psychopathology in later life in several ways. First, aging is not by itself a pathological process. Although aging or age-related issues such as the death of a spouse may play a role in the development of a psychological problem, age is not the sole cause, nor does it preclude the possibility for recovery.

Second, there is considerable variability among older people. The many different pathways and experiences people have had during their lives contribute to these individual differences. Further, age-related changes occur at different times and in varying degrees from one person to the next, increasing individual differences further. Finally, the social and ethnic backgrounds of older people are another source of variability.

Assessment Issues with Older Adults

There are similarities but also some important differences in clinical practice with older adults (Zarit & Zarit, 1998). Assessment takes a more central place in clinical work with older people than it does with younger people. In particular, three assessment issues are of paramount importance when working with an older client.

First, many referrals for assessment have either an explicit or implicit request to determine if a person is suffering from dementia. Although most older people do not have dementia, the association of dementia and old age in the minds of family members, physicians, and even older clients themselves makes it important to establish if the person may be suffering from this type of progressive decline.

Second, assessment of an older person more often has to deal with the issue of the comorbidity of health problems; that is, the person is suffering both from mental health and medical problems. The example of Mrs. Baker illustrated a typical pattern of comorbidity of depression and medical problems, in her case, vision loss and back problems.

Psychiatric symptoms can be both a primary and a secondary consequence of medical problems. Some illnesses have a direct or primary effect on neurobiological systems that make psychiatric symptoms more likely. An example is Parkinson's disease, which is associated with a loss of the neurotransmitter dopamine. Dopamine is also implicated in depression, and, as a result, depression is a common correlate of Parkinson's disease. Of course, the pain, threat, and/or disability associated with an illness can lead to anxiety, depression, or other problems.

An important part of assessment is to identify when an illness might be implicated in the etiology of psychopathology. In those cases, treatment of the medical problem can lead to a reduction of psychiatric symptoms. Conversely, it is often necessary to treat a psychiatric problem so that a person can more fully comply with medical or rehabilitation efforts. Rather than assuming that disability inevitably causes people to feel depressed, it is important to identify ways that the person might be able to compensate better through physical or psychological means. People who have disabilities due to illness or disease can often learn new techniques to help them recover the ability to perform some tasks. In Mrs. Baker's case, she was taught how to get around safely outdoors and also how to use visual aids such as high-powered magnifiers that helped her read and carry out other visual tasks. Depression, however, can often get in the way of learning these types of strategies. A coordinated program that emphasizes multifaceted and multidisciplinary efforts to restore function, such as the one Mrs. Baker participated in, is more likely to be successful in sorting out the comorbidity of chronic illness and emotional distress.

Not only are the illnesses of older people a possible source of psychiatric symptoms, so are the medications they take for those illnesses. Medication-related problems are very common among older people. One reason is that rates of prescription drug use are very high. Most older people are taking one or more prescription medications, and it is not uncommon to find people on 10 or more medications. At the same time, older individuals are more susceptible to adverse

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effects from medications. As we grow older, the ways our bodies process medications change. In particular, older people absorb, metabolize, and excrete medications more slowly (Beizer, 1994). This means that it takes longer for a medication to reach a therapeutic dosage, but then the medication may remain in the body longer, causing it to build up to toxic levels. A related problem is when a person takes multiple medications, because there can be harmful interactions between two or more of them. It is also very common for prescription drugs to have harmful interactions with alcohol as well as with nonprescription drugs or with foods (Adams, 1997). Of course, the more medications one takes, the more possibilities for harmful interactions among them. Thus, the potential that medications might cause adverse reactions and lead to an increase in psychiatric symptoms is much stronger among older people than among younger people. Assessment of medications needs to be an important focus when evaluating symptoms in an older adult.

A common comorbidity problem is that many illnesses, as well as the medications used to treat them, can lead to a loss of memory and other cognitive problems that resemble dementia (see Zarit & Zarit, 1998, for a review). For that reason, it is strongly urged that people suspected of suffering from Alzheimer's disease or other dementing illnesses receive a thorough physical examination to rule out potentially treatable causes due to other illnesses and/or medications.

The third assessment issue concerns the family of the older person. Family members are more likely to be involved in bringing the older person in for an assessment. When an older person is experiencing serious memory problems that make it impossible to get a complete picture of the history, it can be very helpful to enlist the assistance of a spouse, child, or other relative who knows the person well and who can fill in the missing information. When a family member accompanies the designated patient, the clinician conducting the assessment must ask the question, "Who *is* the patient?" In some cases, the older person neither wants nor will benefit from help. The family member, however, is struggling with the stresses involved in caring for a frail or difficult older person and may respond to treatment to help him or her cope more effectively with the situation (Zarit & Zarit, 1998). When involving other people, the clinician should respect the confidentiality of the client and not seek out other information or divulge material told in confidence by that client without explicit consent (Zarit & Zarit, 1998).

Implications for Treatment of Older People

There are several challenges in planning and implementing treatment for older people. A major consideration is to identify treatable aspects of the problem. As we have stressed, older people retain the capacity to change even in the face of significant illnesses. Yet, because of prevailing stereotypes about aging, older people are often regarded as undesirable clients who cannot respond to treatment. Sometimes, the gains will be limited but important. It may not be possible to restore someone to a prior level of functioning, but treatment can nonetheless make the situation significantly better. For people suffering from dementia, it is currently not possible to do much to reverse the underlying illness, but we can

make changes in psychological and social aspects of the problem. Family caregivers can learn more effective strategies for managing behavior problems associated with dementia or identify more support and assistance so that the care demands falling on them become more manageable (Zarit & Zarit, 1998). The person with dementia may benefit indirectly from these types of interventions or more directly from treatments such as support groups, which have been reported to be very helpful to people in the early stages of their illness (Yale, 1999).

Another issue in the treatment of older adults is the more complex use of medications for psychiatric problems. Changes in how older people process medications in their body result in a more unpredictable response to psychotropic medications (Beizer, 1994). It can be difficult to find a dosage that is neither too low nor too high. In addition, there may be medical reasons why an older person may not be able to take a particular medication.

Finally, just as family members can play a role in assessment, they may also be a valuable part of treatment. Many older people have concerns about their family that can be addressed more directly by bringing in the people involved. This can be done in a couple of sessions and does not require longer-term family therapy (Zarit & Zarit, 1998).

CLASSIFYING LATE LIFE DISORDERS: THE *DSM-IV*

The fourth edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV, 1994)* evolved primarily to provide a guide for reliable diagnosis in clinical practice (*DSM-IV, American Psychiatric Association, 1994*). Other objectives included facilitating research through the use of operational criteria for diagnosis that could be replicated from one study to the next and improving communication between clinicians and researchers by adopting a common terminology (*DSM-IV, 1994*). Age-related characteristics, however, have only partly been incorporated into diagnostic criteria, and so an ongoing concern is whether at least some diagnostic approaches need to be modified for older adults.

The *DSM-IV* (1994) classification system has five axes, each of which refers to a different domain of information that may help the clinician plan treatment and predict outcome. The axes provide information about various mental disorders and general medical conditions, psychosocial and environmental problems, and level of functioning.

The first axis consists of clinical disorders and usually can be thought of as the reason the person is seeking help (reason for the visit). A person can have more than one Axis I disorder, and all should be reported. The first diagnosis listed is then considered to be the principal diagnosis or reason for the visit.

The second axis, or Axis II, is where personality disorders and mental retardation are reported. A personality disorder (there are 10 specific disorders) is an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the person's culture, is pervasive and inflexible, has an onset

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in adolescence or early adulthood, is stable over time, and leads to distress or impairment (*DSM-IV*, 1994). Mental retardation involves subaverage intellectual functioning accompanied by significant limitations in adaptive functioning, and onset must occur before the age of 18 years.

Axis III is for reporting current general medical conditions that might reveal how the person's mental disorder is being affected by his or her physical health. General medical disorders can be related to mental disorders in a number of ways. For instance, the general medical condition may be the direct cause of the development or worsening of mental symptoms and so the mechanism for this effect is physiological (*DSM-IV*, 1994). In this case, when the mental disorder is a consequence of a general medical condition, a "mental disorder due to a general medical condition" should be diagnosed on Axis I, and the general medical condition should be recorded on both Axis I and Axis III. An Axis I mental disorder may also be present as a reaction to a medical condition (e.g., depression as a reaction to a diagnosis of cancer). Some general medical conditions may not be directly related to the mental disorder but nevertheless be important when decisions about treatment and prognosis are being made.

Psychosocial and environmental problems are reported on Axis IV. Usually, the psychosocial and environmental problems occurring within a year of the current assessment are listed. Examples include life events, a lack of social support or personal resources, interpersonal difficulties, or other problems associated with a person's current difficulties. In some instances, a psychosocial and environmental problem may be the primary focus of clinical attention. In this situation, the psychosocial or environmental problem should also be recorded on Axis I, coded "other conditions that may be a focus of clinical attention."

Overall level of functioning is reported on Axis V and is useful in treatment planning and predicting the efficacy of treatment. Overall functioning is assessed using the Global Assessment of Functioning (GAF) scale. This scale is used to rate only psychological, social, and occupational functioning, not physical or environmental limitations. The ratings of overall psychological functioning are on a scale of 100 to 0, with 100 indicating superior functioning with no symptoms and 10 or lower indicating persistent danger of severely hurting self or others.

In the *DSM-IV*, V Codes are sometimes used to indicate other conditions that may be a focus of clinical attention. An example of a V Code is a situation in which there is not enough information to know whether a presenting problem is attributable to a mental disorder (e.g., V62.82, Bereavement). A V Code may also be used to indicate that there is no diagnosis or condition on Axis I or no diagnosis on Axis II (V71.09).

The *DSM-IV* was produced by 13 work groups comprised of experts in their respective fields. In turn, the work groups reported to the Task Force on *DSM-IV*, which consisted of 27 members, many of whom were chairs of their work groups (*DSM-IV*, 1994). An attempt was made to ensure that diverse clinical and research disciplines and settings were represented. Many of the participants were international experts and people with different ethnic backgrounds in the United States, which allowed cultural diversity issues to be addressed. The Task Force on *DSM-IV* communicated openly with many components of the American

Psychiatric Association and with more than 60 organizations, including the American Psychological Association (*DSM-IV*, 1994).

A major strength of the *DSM-IV* lies in the consideration of extensive empirical evidence in defining disorders and their characteristics. In the past, psychiatric diagnosis was characterized by vague definitions of disorders that led to unreliable diagnosis. The *DSM-IV* is built on empirical studies that identify which symptoms and characteristics typically are present in a disorder. The authors of the *DSM-IV* also stressed constructing clear and precise definitions of disorders and symptoms so that clinicians will interpret the definitions in similar ways and make more accurate diagnoses.

For diagnosis of psychopathology in older adults, the *DSM-IV* has strengths and weaknesses. The main strength is improvement of those categories that mainly include older people, namely, dementia and delirium. The *DSM-IV* also added two new categories specifically for older adults, age-related cognitive decline and mild neurocognitive disorder. The main weakness is that the *DSM-IV* largely does not address the issue of criteria for diagnosis of older people with other disorders. Should the criteria for depression, for example, be the same or different for an older person compared to a younger person? In fairness, there is little research available to guide questions like this. The larger issue, however, is that we do not know to what extent many common disorders look different in later life than earlier in life. This question is important, because accurate diagnostic criteria for older people will lead to better diagnosis and improved access to treatment.

In the sections that follow, we first look at the diagnoses specific to later life and then turn to other categories of disorders that are commonly found among older people.

DISORDERS OF LATER LIFE

DELIRIUM

Delirium is a particularly troubling category, because it is frequently overlooked or misdiagnosed, with sometimes severe consequences. Previous editions, the *DSM-III* (1980) and *DSM-III-R* (1987), replaced an older category of acute brain syndrome with delirium and developed diagnostic criteria for it. These criteria were based on the clinical experience of expert psychiatrists and represented an improvement over the previous classification scheme. However, they were not based on systemic empirical data and were not adequately field-tested (Liptzin & Levkoff, 1994). These problems are largely corrected in the *DSM-IV*.

In the *DSM-IV* (1994), delirium is characterized by a disturbance of consciousness and a change in cognition that develop over a short period of time, usually hours to days. There should be evidence that the delirium is a direct physiological consequence of a general medical condition, substance intoxication or withdrawal, use of a medication, toxin exposure, or a combination of these factors. The disorders that make up the delirium section are distinguished by etiology, for instance, delirium due to a general medical condition or

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substance-induced delirium (including medication side effects). According to *DSM-IV*, associated features (common symptoms but not part of the actual criteria) may include a disturbance in the sleep-wake cycle, disturbed psychomotor behavior, and emotional disturbances, or no diagnosis on Axis II (V71.09).

Reviewing alternative classification schemes such as the tenth edition of the *International Classification of Diseases (ICD-10)* as well as empirical studies of delirium, Liptzin and Levkoff (1994) recommended criteria that focus on the core symptoms of impairment of consciousness/attention along with a change in cognition. The symptoms of sleep and psychomotor disturbances were felt to be associated features, and it was recommended that these be included in the text rather than the criteria. Subtypes of delirium such as hyperactive, hypoactive, or mixed states were considered to be interesting but premature and requiring further research. Liptzin and Levkoff determined that the category of dementia with delirium was not viable because there was not anything unique about delirium with or without dementia. These two conditions should be diagnosed independently.

DEMENTIA

The dementia section of the *DSM-IV* (1994) is made up of disorders that are characterized by the development of multiple cognitive deficits (including memory impairment) that are due to the direct physiological effects of a general medical condition, to the persisting effects of a substance, or to multiple etiologies (e.g., the combined effects of cerebrovascular disease and Alzheimer's disease). Criteria for the diagnosis of dementia include demonstrable impairment of short-term and long-term memory and at least one of the following: impaired abstract thinking, impaired judgment, disturbance of higher cortical functions (e.g., aphasia, agnosia, apraxia), or personality change. These impairments must not occur exclusively during the course of delirium and must significantly interfere with work or usual social activities or relationships. To meet the criteria for dementia, a person needs to be evaluated through a neurological examination, neuropsychological testing, and an assessment of functioning in activities of daily living (Salmon, Butters, Thal, & Jeste, 1994).

The *DSM-IV* criteria represent some modifications from previous editions that bring the classification of dementia in line with current empirical evidence. There is more attention to subtypes of dementia: dementia of the Alzheimer's type (DAT), vascular dementia, dementia due to other general medical conditions, dementia due to multiple etiologies, and dementia not otherwise specified.

The findings of the study by Salmon et al. (1994) are an example of how the criteria in the *DSM-IV* are derived from research. For instance, progressive decline in multiple cognitive areas (particularly memory) and in functional abilities are warranted for a diagnosis of dementia. Personality change was not seen as an effective criterion, and neurological signs play an important supporting role in the diagnosis of DAT but are not effective on their own.

AGE-RELATED COGNITIVE DECLINE AND MILD NEUROCOGNITIVE DISORDER

Rediess and Caine (1997) discuss the addition of two new designations in the *DSM-IV* (1994) of age-related cognitive decline (ARCD) and mild neurocognitive disorder. ARCD is a V Code indicating that although it may not be indicative of a disease diagnosis, it is a condition that may be a focus of clinical attention. Mild neurocognitive disorder is proposed as a research diagnosis in need of further study and appears in Appendix B of the *DSM-IV*. Rediess and Caine state that these two terms together reflect a trend toward representing age-associated cognitive changes across a continuum from normal functioning to dementia.

These new categories were developed based on clinical observations that patients often exhibit neurocognitive symptoms (mild cognitive impairment) that do not meet the criteria for dementia but that nonetheless affect daily functioning. The main feature of the new diagnostic guidelines is decline in cognitive performance that can include memory impairment and learning or concentration difficulties. The main difference between the two categories is that ARCD is not associated with any specific medical disorder, whereas mild neurocognitive disorder can be the beginning of a progressive decline toward dementia.

The category mild neurocognitive disorder is particularly interesting because it reflects that cognitive changes can be caused by many different factors. The criteria were developed from three sources: the literature on alcohol and substance abuse and dependence, the literature on neurological disorders, and the literature on medical disorders with central nervous system complications (Gutierrez, Atkinson, & Grant, 1994). Persons with alcoholism could experience neuropsychological problems such as disturbances in learning recall, abstracting ability, and complex conceptual motor skills that exist in the context of relatively preserved IQ (Gutierrez et al., 1994). Mild neurocognitive problems can also occur in people involved in polysubstance abuse (Gutierrez et al., 1994). There is abundant evidence that certain medical conditions such as chronic obstructive pulmonary disease and autoimmune diseases produce mild neurobehavioral disturbances (Gutierrez et al., 1994). The treatment of these diseases with medication can reverse the neurocognitive disorder in some cases or prevent further deterioration. Both these new V Code categories may also include people in the early stages of progressive dementing disorders such as Alzheimer's disease and Parkinson's disease, where there can be a prolonged period of mild neurocognitive impairment that is clinically significant but fails to meet the *DSM-IV* (1994) criteria for dementia.

DIAGNOSES NOT SPECIFIC TO LATER LIFE

We now consider categories of disorders that are not specific to later life. We have been selective, because virtually any problem that occurs earlier in life can persist or reoccur in late life, and have highlighted some key categories that are particularly important for later life. In each case, the main issue is to

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what extent current definitions reflect an understanding of how a particular disorder is manifested in later life, and if diagnostic criteria should be similar or different for older people.

Substance-Related Disorders

The *DSM-IV* (1994) category of substance-related disorders includes abuse of specific substances such as alcohol and 10 other classes of drugs, the side effects of medications, and the exposure to toxins. The substance-related category is further broken down into substance use disorders (substance use and dependence) and substance-induced disorders (including disorders resulting from misuse of medications). According to Allen and Landis (1997), the available literature suggests that substance use disorders decrease with increasing age and that the prevalence is higher in men than in women. Certain groups of older adults have higher rates of substance use disorders, such as hospitalized patients (alcohol abuse) and older people living in the community who abuse prescription drugs, especially sedative-hypnotics, antianxiety agents, and analgesics (Allen & Landis, 1997).

As in many of the *DSM-IV* categories, the diagnostic criteria for substance abuse were not developed with older adults in mind and are not adequately validated with older people, which could lead to an underestimation of these disorders. There are two main concerns about the present criteria. First, they do not reflect a greater susceptibility to medications among older adults. An older individual who is dependent on alcohol may drink less yet continue to become intoxicated because of physiological changes in the way alcohol is absorbed, metabolized, and excreted. Older people are also more likely to be taking prescription medications, which can increase the effects of alcohol and other substances or lead to toxic interactions with these substances. Second, one part of the diagnostic criteria of substance abuse is poor work performance (i.e., an adverse consequence of drinking), which may not be applicable for the older person (Allen & Landis, 1997). The effects of substance abuse may be less obvious, such as when an older person with a drinking problem rarely ventures outside the house. This invisibility of the problem may lead to underdiagnosis. Further research and clinical data in regard to substance-related disorders and aging are needed to substantiate and improve *DSM* diagnostic criteria.

Mood Disorders

The *DSM-IV* (1994) can be viewed as a categorical approach to the diagnosis of depression and other affective disorders in late life. As Blazer and Koenig (1996) point out, older people often suffer from depressive symptoms that do not meet diagnostic criteria for major depression, yet these symptoms adversely affect their quality of life. In contrast to the *DSM-IV*, the *ICD-10* allows for diagnosis of mild, moderate, or severe depression. This type of approach would encompass many older people who are omitted by the main *DSM-IV* criteria but who could benefit from treatment.

In addition, depression may present in some unusual ways in later life (Blazer & Koenig, 1996). For many of today's older adults, it is more acceptable to have a medical than a mental health problem. As a result, depression

may be manifested by somatic complaints or apathy but with no overt complaints about feeling sad or blue. A variation on this pattern is pseudodementia, in which the person complains of excessive memory loss but has little or no objective memory impairment and improves with treatment for depression.

Bereavement is a V Code in the *DSM-IV* that becomes the focus of clinical attention when there are symptoms of depression during the first two months after the loss of a loved one. Symptoms that are not considered part of a "normal" grief reaction include extreme feelings of worthlessness and active suicidal ideation. Any person fulfilling the criteria for major depression at or beyond two months from the death should be recognized as having a major depressive episode (Blazer & Koenig, 1996).

Anxiety Disorders

Anxiety disorders are another category where diagnostic criteria may not reflect important differences in older people. Older people may express anxiety in terms of physiologic arousal (panic attacks, motor tension or restlessness, autonomic hyperactivity, or sleep disturbance) or overt behavioral responses (compulsive behaviors or exaggerated startle response) (Palmer, Jeste, & Sheikh, 1997). In fact, it has been suggested that older adults are more likely than younger adults to exhibit a mixture of anxiety and depression. The diagnosis of mixed anxiety-depressive disorder is included in the *DSM-IV* appendix to guide further study.

Palmer et al. (1997) raise the question of whether physical and psychosocial changes associated with aging change the way anxiety symptoms cluster for older people when compared to younger patients. An example of such a change is a decrease in physical abilities such as vision, which might result in an older person's being hesitant to go out at night. Palmer et al. point out the importance of making the distinction of whether or not this behavior is a phobic response or an adaptive one.

Anxiety states and many medical conditions have often been found to be associated in younger and older adults (Palmer et al., 1997). A number of factors may be attributed to the high comorbidity of anxiety and medical problems. Anxiety as well as depression can be a psychological response to the onset of a medical problem and/or a side effect of prescribed or over-the-counter medications used to treat the medical problem. In turn, some medications, such as beta blockers, used in the treatment of hypertension may have anxiolytic effects, which may mask the existence of an anxiety disorder. Physical illnesses such as hyperthyroidism and cardiac arrhythmia may present clinically as anxiety. The opposite may also be true: symptoms of anxiety such as palpitations, sweating, and dizziness may be expressed by the older adult as physical symptoms. In considering the *DSM-IV* diagnostic criteria for an anxiety disorder, it is necessary to rule out any direct physiological effects of a general medical condition. Due to the high comorbidity of anxiety and medical problems in older adults, this differentiation can be especially complex. Palmer et al. conclude that research is needed to determine the diagnostic accuracy for specific anxiety disorders as outlined in the *DSM-IV* and whether revision or reclustered of symptoms is necessary to describe better the anxiety syndrome in older adults.

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Personality Disorders

Personality disorders, which by their definition have an onset in late adolescence or early adulthood, often persist into old age. There is little information, however, on how these syndromes change as people age or if the same or different criteria should be used for their diagnosis in later life (Camus, Augusto de Mendonça Lima, Gaillard, Simeone, & Wertheimer, 1997).

The comorbidity of personality disorders and problems such as depression and anxiety may be fairly common in later life (Camus et al., 1997). Treatment of a person with depression and a long-standing personality disorder will be more difficult, and may result in only partial alleviation of symptoms. Failure to recognize this comorbidity may cause the clinician to become extremely frustrated over the lack of response to usual treatment. As we have stressed, this lack of response is often due more to the type of disorder than to the age of the person.

CASE DIAGNOSIS

In concluding this section on classifying late life disorders, we illustrate how the case of Mrs. Baker can be conceptualized using the *DSM-IV* as a framework. Using the multiaxial format, a *DSM-IV* evaluation of Mrs. Baker when she first sought help is presented in Table 1.1.

Axis I designates the clinical disorder that was the reason Mrs. Baker was referred for psychological services (reason for the visit). It was determined that Mrs. Baker was experiencing a major depressive disorder (first 3 digits are 296). The clinician would gather additional background information to ascertain whether Mrs. Baker had any previous history of depressive illnesses. This is indicated in the fourth digit of the diagnostic code, either 2 (if there is only a single major depressive episode) or 3 (if there are recurrent major depressive episodes). The fifth digit in the diagnostic code for major depressive disorder indicates the current state of the disturbance. In Mrs. Baker's case, her depression was quite severe.

There was nothing in Mrs. Baker's background information that warranted a diagnosis on Axis II indicating a personality disorder (mental retardation is also reported here). A V Code was used to indicate that there is no diagnosis

Table 1.1 Example of *DSM-IV* evaluation.

Axis I	296.23	Major depressive disorder, single episode, severe without psychotic features.
Axis II	V71.09	No diagnosis.
Axis III	366.9	Cataract.
	365.9	Glaucoma.
	369.9	Visual loss.
		Back pain.
Axis IV		Extreme social isolation, estranged from only son.
Axis V	GAF = 50	(prior to treatment.)

(V71.09). On Axis III, several medical conditions were noted. Mrs. Baker's poor vision was due to cataracts and glaucoma, and she had chronic back problems. The listing of these medical conditions allows the clinician to understand better how Mrs. Baker's mental condition was being affected by her physical health. From the scenario presented in this chapter, it is very likely that Mrs. Baker's psychological distress was a reaction to her physical disabilities.

Psychosocial and environmental problems for Mrs. Baker, which are reported on Axis IV, consisted of her being socially isolated and estranged from her only son. Her overall level of functioning (GAF = 50) was assessed on Axis V. Mrs. Baker was exhibiting serious symptoms as evidenced by her extreme social isolation.

Although one might be inclined to argue that Mrs. Baker's distress was a result of her physical limitations, a principle of geropsychology was confirmed: her case demonstrated the possibility for growth and change in later life. With a behavioral therapeutic intervention, Mrs. Baker's mood improved significantly. She became more socially engaged and found an activity that made her life meaningful despite her physical limitations. It should be noted that when using the *DSM-IV* multi-axial evaluation, the strengths of the individual, such as useful coping skills, are not at the forefront. This is a clinical issue regardless of the person's age.

RESEARCH ISSUES IN THE PSYCHOPATHOLOGY OF LATER LIFE

Research on issues of aging is complex because it involves devising strategies to estimate changes that have occurred over relatively long periods of time and to differentiate effects due specifically to aging from change resulting from other influences on people's lives. As an example, people may grow older in different ways in societies that venerate and respect elders compared to those that place a higher value on youth. The influence of the social position of older people in a particular society is important, but should not be mistaken for a universal pattern of aging.

The research issues involved in studying psychopathology in later life are similar to research on normal processes of aging. (Schaie & Willis, 1996 provide a comprehensive introduction to research methods for studying aging.) We examine some of the key issues as well as the implications for understanding psychopathology in old age.

RESEARCH DESIGN: CROSS-SECTIONAL, LONGITUDINAL, AND SEQUENTIAL STUDIES

Most research on aging is conducted by comparing old and young people. This type of research is called *cross-sectional*. According to Schaie and Willis (1996), cross-sectional research reveals age differences, that is, how old and young people differ on a particular characteristic at a particular point in time. These

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findings, however, do not indicate whether these differences are due to aging or to other influences. In particular, cohort or generational differences can contribute to differences between old and young. Young and old people may differ on a particular characteristic not because the older group has changed, but because each generation started out with different levels of that characteristic. For example, older people may hold certain beliefs that differ from the young because they have always held those beliefs, not because they have become more rigid or conservative with age. There is evidence of generation differences on a number of characteristics, such as intelligence (Schaie, 1996), personality (Whitbourne, Zuschlag, Elliot, & Waterman, 1992), and even rates of depressive symptoms (Roberts, Lee, & Roberts, 1991).

Specific historical events can also contribute to age differences. The passage of Medicare in 1965, which provides comprehensive health insurance for everyone 65 and older, has probably been one of the major factors associated with improved health among subsequent cohorts of people turning 65. It is no accident that today's older people are healthier and have better functioning than previous generations.

An alternative to cross-sectional studies is *longitudinal* research. In a longitudinal study, the researcher follows the same people over time. This type of design makes it possible to observe how people change. Often, these changes reflect at least in part the effects of aging, but they can also be related to other factors. A particular cohort, such as baby boomers, may age in a unique way. Likewise, a specific historical event can lead to changes in the cohort being followed but not other cohorts in the population.

To overcome these problems, Schaie (1996; Schaie & Willis, 1996) has proposed conducting different types of *sequential* studies. In a cohort sequential study, for example, several cohorts of people are followed over time. This design makes it possible to examine whether the changes occurring in one cohort are specific to that generation or are replicated in the next cohort. Likewise, it is possible to consider whether changes in one time period are related to events that occurred during that era or if a similar pattern of change is observed in successive cohorts at the same time in their lives.

Using this design, Schaie (1996) has found that age differences in intelligence are due more to cohort differences than to aging. Younger cohorts have had successively higher initial levels of intelligence on many abilities compared to older cohorts. Furthermore, most dimensions of intelligence continue to rise during the adult years, with decline occurring only by the decade of the 60s or 70s. Even then, some people remain stable over time in most or all dimensions of intelligence, or even increase. These findings contrast sharply with cross-sectional research on intelligence, which has emphasized age differences between young and old. Those age differences, however, were due mainly to cohort effects.

There is a place for each type of research design in studying aging. Cross-sectional research is quicker and less expensive to conduct than longitudinal research and can provide useful information on how old and young people may differ. This can be important for planning programs and policies, as long as cross-sectional differences are not interpreted as indicating age changes.

Longitudinal research provides a better estimate of the changes that may be occurring with aging, but it can take a long time to conduct. Researchers must also address problems of sample attrition due to dropping out or death. Sequential studies also suffer from the same drawbacks as longitudinal research, although Schaie (1996) uses the strategy of adding new subjects over time to estimate for the specific effects of attrition.

PROBLEMS IN EVALUATING OLDER PEOPLE

Another important research issue is that it is more difficult to assess functioning and performance among older compared to younger people (Zarit & Zarit, 1998). Older people may tire more quickly and need frequent breaks to perform at their maximum ability. As a result, it may be necessary to space out testing or assessment sessions across multiple days to avoid confounding the test results with the effects of fatigue. The pace of testing also needs to be slower; the tester needs to read instructions to present material at a slower pace. It is simply not possible to test an older person at the same quick pace as with a younger person. Failure to take this slowing of response into account may produce test results that indicate a decrement in performance for the older person that is attributable to the pace of the tester rather than the person's ability.

Older people also may have hearing and vision problems that make assessment more difficult. It is important when assessing older people to make sure they have brought along eyeglasses, hearing aids, or other sensory aids. Assessments need to be conducted in settings in which there is good lighting and acoustics. Background noise and other distractions will interfere with test performance.

IMPLICATIONS OF RESEARCH ISSUES FOR STUDYING PSYCHOPATHOLOGY IN LATER LIFE

These research issues have three important implications for the study of psychopathology in later life. First, it cannot be assumed that the psychological problems an older person experiences are associated with aging. These problems may have originated in later life, or they may be part of a long-standing pattern. In other words, we need to distinguish between the age of the person and the age of his or her problem. Just as we need longitudinal or sequential research to uncover the effects of aging, we need to take a longitudinal perspective when viewing psychopathology.

It is generally useful to take this type of developmental perspective on psychopathology, that is, determining at what age a disorder typically has its onset and how it changes over time. With schizophrenia, for example, most forms have their onset in adolescence and young adulthood. Following people over time, we find that some have a complete remission of symptoms, some have partial remission or suffer from intermittent episodes, and some have an

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apparently unwavering course (Ciompi, 1987). There is much that can be learned by studying these different developmental trajectories. By contrast, if we study schizophrenia and aging by obtaining a sample of older people who currently meet the criteria for a schizophrenic disorder, we need to be careful not to draw incorrect inferences about either schizophrenia or aging. A group of older schizophrenics may contain people who had more severe or treatment-resistant forms of the disorder to start with, so that their symptoms have persisted to late life. Aging may play some role in worsening or alleviating some types of symptoms, as well as introducing new stresses. An older person with schizophrenia may have fewer social supports and suffer more from the deaths of parents and other family members than someone with a better social network. On the other hand, a lessening of social demands in later life may lead to better functioning for some people with chronic mental disorders. Overall, the key to understanding the etiology of schizophrenia and other chronic mental illnesses lies in the period of life when the disorder has its onset and in the factors that influence the subsequent course of symptoms. Aging does not lead to these chronic and immutable conditions, though aging issues may play some role in an individual's current problems and concerns.

This developmental perspective on psychopathology suggests the importance of taking a careful history of an individual suffering from psychological symptoms. When symptoms have occurred previously in the person's life, we can identify which treatments had been effective before. If a particular treatment was helpful once, it is likely to be helpful again. We can also determine if there are some specific effects of aging that may be contributing to the current episode. Often, social losses, such as the death of a close relative or friend, or financial problems can trigger a new episode of a disorder such as depression. Rather than ascribing these problems solely to aging, and then feeling hopeless because the effects of aging cannot be reversed, we can uncover evidence of which treatments had previously been effective.

Some disorders have their first onset in later life, and so aging can be presumed to have a more central role. These processes may be biological, such as the onset of a major illness, but they can also be psychological and social. Depression and anxiety disorders typically have an onset earlier in life, but symptoms can occur for the first time in later life. There is also a disorder considered to be a late-onset schizophrenia, which is usually characterized by paranoid symptoms (Zarit & Zarit, 1998). The most common problem that has a late-life onset is dementia, which occurs only rarely before age 60 and is quite common after age 75. Treatment of late-onset disorders involves identifying sources of resiliency from earlier in the person's life and helping the person reestablish these more effective patterns of coping. Taking a careful history of the person, then, is also important both in recurrent disorders and in those that have a first onset in old age. Even in cases of people suffering from dementia, there may be resources used earlier in life that can be drawn on, including the person's social network, that may partly alleviate the effects of the disorder.

A second implication of research methods for studying psychopathology in later life is the importance of cohort or generational differences. People's

behavior and beliefs have been shaped to a large extent by their background and past experiences. Today's older people who grew up during the Great Depression of the 1930s, for example, have a different attitude about money than do more recent cohorts who have lived through a period of unprecedented prosperity. As a result, a young therapist may have a difficult time understanding why a relatively wealthy older person is unwilling to spend money on something that would make his or her life easier. This reluctance is not a sign of pathology; it is a strongly ingrained habit. We can better understand how problems develop and can be treated in later life by becoming familiar with the generational influences that shaped this cohort of older people.

The third issue is the considerable diversity in aging. This diversity is due to many sources. Older people do not all change at the same rate or at the same chronological age. Some people experience decline in an ability relatively early in life, whereas others continue to show improvements in that same ability until relatively late in life. There is no single universal pattern of aging, nor is there a single organizing psychological principle. Older people are very different from each other because of the variety of their life experiences as well as the varying rates of aging.

An important source of diversity in aging is ethnicity and social class. People in disadvantaged racial and ethnic groups have been described as experiencing double jeopardy; that is, they are faced with negative stereotypes about their ethnic group and about aging. Perhaps the most dramatic evidence of these negative effects is on life expectancy. African American men have a life expectancy seven years lower than that of White men, and the difference for women is over four years (Hayward & Heron, 1999). Likewise, the difference for Hispanics is almost six years for men and three years for women.

These negative effects may be partly offset by social resources within minority communities. For many African Americans, for example, their families are a source of support and strength in later life, and older people are treated with respect and care. Many continue to play important roles in their families, for example, taking an active part in raising grandchildren. How we grow older is influenced by social conditions, so factors such as race, ethnicity, and social class need to be taken into account.

Another major source of diversity in aging is gender. Women and men have different life experiences, which influence how they grow older. Today's generation of older people was raised during a period when there was great differentiation of roles and responsibilities between men and women. The changing roles of men and women in society may be a source of bewilderment and resentment to some older people or lead to regrets about lost opportunities among others.

Gender is also important for its strong relation to life expectancy. Women live longer than men in virtually every country (Kinsella & Taeuber, 1993). In the United States, the average difference in life expectancy is seven years: women can expect to live 79 years; men's life expectancy is 72 years (Treas, 1995).

These differences in life expectancy have important social implications for the lives of older people. First, it means that communities of older people are

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predominantly women. Among people aged 65, women outnumber men by a ratio of 3 to 2. By very late life, the proportion of women is even greater: at age 80, there are only 43 men for every 100 women (U.S. Bureau of the Census, 1992).

Second, these differences in life expectancy affect marriage rates in later life. Older men are more likely to be married and older women more likely to be widows. Among people 65 and older, 77% of men but only 42% of women are married (U.S. Bureau of the Census, 1992). Several factors account for these marriage rates. Men tend to marry women younger than themselves, and so their wives outlive them. If a man outlives his wife, there will be many single women he might remarry who are his age or younger. For a woman whose husband dies, the odds are different: there will be relatively fewer men her age or older, because men have a shorter life expectancy, and fewer still will be single. Because of social traditions, it is relatively rare for a woman to marry a man who is younger than she.

CONCLUSION

This chapter provided a comprehensive overview of how clinical work with an older person might be conceptualized and implemented. The objective was to walk through a clinical case coupled with clinical and empirical considerations as a heuristic method of working with older adults. Presentation of various principles of geropsychology allows the clinician to begin assimilating a theoretical basis for understanding emotion and behavior in later life. Classifying late life disorders using the *DSM-IV* introduced how this version of the manual was refined using empirically derived findings and some of the limitations imposed when considering the gerontological literature. The disorders presented in this chapter, although not exhaustive, were attempts to acquaint the reader with the more common disorders that a clinician might encounter in a therapeutic setting.

Because one of the primary goals of the *DSM-IV* is to facilitate research, the section concerning research issues in the psychopathology of later life questioned the assumption that psychological problems an older person may be experiencing are associated with aging. The importance of considering cohort or generational differences and the considerable diversity in aging were pointed out. By linking clinical practice and research findings, better diagnostic criteria can be developed as well as better guidelines for therapeutic interventions.

STUDY QUESTIONS

1. In what ways does the clinical vignette about Mrs. Baker illustrate major features of geropsychology?
2. Give a brief description and example of the process Baltes (1987) calls "selective optimization with compensation."

3. Willis and her colleagues (Willis, Blieszner, & Baltes, 1981; Willis & Nesselroade, 1990) found evidence of plasticity or the capacity for growth in cognitive abilities. Describe what these authors found.
4. Give an example of a limitation to plasticity imposed by the aging process.
5. In what ways can the normal aging process contribute to a better understanding of psychopathology in later life?
6. When working with an older client there are several assessment issues that need to be taken into account. Describe two of these assessment issues.
7. Describe briefly the two new designations specific to late life that were included in the *DSM-IV*.
8. Discuss a major limitation of the *DSM-IV* diagnostic criteria when considering its use with elderly people.
9. Cross-sectional research provides what kind of information? What is a potential problem with using this kind of research?
10. What is an alternative to cross-sectional research? What are the advantages? Disadvantages?
11. Illustrate an important source of diversity in aging.

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