

a rule, people prefer to be in a position of giving help more frequently than they are in a position of needing to ask for or receive aid. This results in people building up a measure of 'support credits' that can then be exchanged if they are in need of assistance. However, later in life people may try to prevent older persons from reciprocating if a favour is done for them. The older person is being told, in effect, that they can no longer participate in the social exchange on an equal footing, which the older person may experience as demeaning.

One source of unconditional and non-judgmental support for older adults comes from their pets or companion animals (Hafen, Rush, Reisbig, McDaniel, & White, 2007; Pachana, Massavelli, & Robleda-Gomez, 2011). In their review, Pachana and colleagues (2011) outline how, throughout the lifespan, animals play an important role in maintaining physical and emotional wellbeing, influence recovery from illness and have an impact on reactions to loss or grief. Longitudinal research in Australia has found that people who continuously own pets are the healthiest group, compared with those who no longer have pets or have never had one (Headey & Grabka, 2007). With older adults specifically, it has been shown that the ability to perform activities of daily living is higher in pet owners than non-pet owners (Raina, Waltner-Toews, Bonnett, Woodward, & Abernathy, 1999). Moreover, Raina and colleagues (1999) suggest that pet ownership may buffer the harmful effects of lack of social support on psychological wellbeing. Therefore, it is important to consider companion animals as potential sources of emotional support for older adults.

## Psychological disorders in later life: the dementias

## LO 11.2

### THE DEFINITION OF DEMENTIA AND RECENT *DSM-5* CHANGES

Many people mistakenly believe that disorders such as dementia are to be expected as one grows old. In reality, there is a substantial difference between the memory lapses associated with normal ageing and the significant memory impairments seen in dementias such as Alzheimer's disease. Moreover, dementia does not affect all adults or even a majority of older adults. There are many forms of dementia, with distinct aetiologies and symptom profiles. However, in all cases dementia is not a part of normal or primary ageing but represents a neurological disease process (secondary ageing) characterised by distinct changes in the brain.

Dementia has been regarded as a term for a broad class of neurological disorders associated with cognitive, personality and behavioural changes in later life. However, in the recently released edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)* (American Psychiatric Association [APA], 2013), the term dementia has been eliminated and replaced with major or mild neurocognitive disorder. Major neurocognitive disorders include diagnoses such as dementia from the previous edition of the DSM (*DSM-IV-TR*) (APA, 2000), which constitute a substantial level of cognitive decline (two or more standard deviations) from previous functioning and interfere with the person's independence (Siberski, 2012). In contrast, mild neurocognitive disorder describes a level of cognitive decline that goes beyond declines associated with normal ageing changes but is not yet at the level of a major neurocognitive disorder. The mild neurocognitive disorder diagnosis requires that the person is experiencing cognitive changes that negatively affect functioning; that are observable by the individual, others or on objective cognitive testing; and that require the affected individual to engage in compensatory strategies to help maintain independence and perform the activities of daily living. However, critics have pointed out that while early identification of a

person with such a decline may improve access to assistance and potential early interventions, it may not be straightforward to ascertain such changes accurately (Morris, 2012). After a clinician determines whether the neurocognitive disorder is major or minor, then a subtype is listed (e.g., ‘major neurocognitive disorder due to Alzheimer’s disease’).

Since the *DSM-5* change replacing the term dementia with the term neurocognitive disorder is very recent, most of the existing literature still refers to dementia. The use of the term neurocognitive disorder rather than dementia may assist with alleviating negative stereotypes around the use of the term dementia. However, in this transitional period there will be much overlap in the usage of both terms, which may result in confusion in the short term. In this chapter, the term dementia is used for the most part, as reference is being made to research and conceptualisation of the disorder prior to the formal introduction of the mild and major neurocognitive disorder categories. For example, the recent US National Institute on Aging–Alzheimer’s Association (NIA–AA) research criteria and guidelines for diagnosing dementia due to Alzheimer’s disease (McKhann et al., 2011) still refer to dementia, and some clinicians and researchers will continue to do so. But an important concept underpinning these changes, welcomed by both clinicians and researchers alike, is the idea that impaired memory might not be the first sign or symptom of neurocognitive decline indicating possible dementia and that it is important to try to identify cognitive changes that adversely affect the individual as early as possible (i.e., even while still of a mild nature).

The prevalence of dementia in Australia is similar to that of other industrialised countries. Meta-analyses of survey data suggest that the prevalence of dementia in Australia in 2003 among Australians aged 65 years or older was between 136 000 and 193 000 (5.3 per cent to 7.6 per cent) (Australian Institute of Health and Welfare, 2006). Some estimates suggest that approximately 24 per cent of those over 85 years have some form of dementia (Henderson & Jorm, 1998). A 1987 **meta-analysis** demonstrated that despite variability in data across studies, the prevalence rate for dementia doubles with approximately every additional five years of age in older adults (Jorm, Korten, & Henderson, 1987).

The prevalence of dementia in Australia is expected to triple by 2050 (AIHW, 2012). Over 165 000 Australians are affected by Alzheimer’s disease alone. By 2040, it is expected that 500 000 people will be diagnosed with dementia in Australia. The financial costs of caring for persons with dementia is staggering—direct health costs total \$3.2 billion, of which \$2.9 billion is spent on residential care costs. By 2050, dementia costs to the federal government may exceed 3 per cent of gross domestic product (GDP), up from the nearly 1 per cent of GDP spent today (Alzheimer’s Australia, 2003).

## ALZHEIMER’S DISEASE

There are many distinct types of dementia. Alzheimer’s disease is the most common form of dementia and represents approximately 50–70 per cent of all cases of dementia diagnosed. The average age of onset for the disease is 65, with a course lasting between 8 and 10 years before death. Women are somewhat more at risk of developing Alzheimer’s disease than men, even after women’s longer lifespans are taken into account.

Alzheimer’s disease was initially described by Alois Alzheimer, who was born in Germany in 1864. In 1903 he became a research assistant to Emil Kraepelin at the Munich medical school where he created a new laboratory for brain research. Having published many papers on diseases of the brain, in 1906 Alzheimer gave the lecture that made him famous, identifying an ‘unusual disease of the cerebral cortex’ affecting a female patient, Auguste D., that caused memory loss, disorientation, hallucinations and ultimately her death aged only 55. The autopsy revealed various abnormalities of the brain previously only encountered in much older individuals. Kraepelin named the disease after Alzheimer. Today, the pathological signs used in the diagnosis of Alzheimer’s disease are still generally the same as in Alzheimer’s day, although many other advances in neuroscience have allowed greater understanding of the underlying biological processes.

**meta-analysis**  
Statistical  
technique for  
summarising results  
across several  
studies.

## BEREAVEMENT

A number of studies have indicated that while bereavement is common among older adults, it does not necessarily result in **clinically significant** psychological distress (Fisher, Zeiss, & Carstensen, 2001). In fact, some research has indicated that younger widows and widowers may experience more symptoms of depression and physical health problems than older persons who are bereaved (Nolen-Hoeksema & Larson, 1999). This may be partly due to the fact that older adults tend to have a support network more able to help them with such an event than younger adults whose friends may find this unexpected situation difficult to deal with. Moreover, the experience of the death of a spouse at an older age is more expected than the death of a spouse at a younger age and unexpected losses (as opposed to anticipated losses) may result in poorer mood among older adults (Pachana, 1999). Expected losses generally result in lesser degrees of dysfunction than unexpected losses, particularly if the unexpected loss involves suicide. Increased coping with bereavement among older populations may also reflect the fact that this group may have more experience in coping with death due to a lifetime of personal losses. This explanation is also congruent with research that demonstrates that those who have had greater exposure to grief tend to have less severe reactions following a death (Fisher et al., 2001).

The finding that older adults often fare better than their younger counterparts in responding to grief is not to minimise the distress that loss occasions in older individuals. Older adults experience the loss of a spouse from a variety of life circumstances. For instance, they will vary in their level of closeness with their spouse, their financial and social situation, and their perspective on the circumstances of the loss. Generally, though, studies have found that older adults, particularly older males, report the loss of a long-term spouse as devastating (Turvey, Carney, Arndt, Wallace, & Herzog, 1999).

Normal grief reactions may include some of the symptoms that occur in depression, such as sadness and changes in appetite or sleep. Other symptoms, however, suggest that the person's bereavement has precipitated a full-blown depressive episode. Distinguishing normal grief reactions from depression is difficult, but the latter usually includes feelings of worthlessness and pervasive guilt or hopelessness (Gallagher, Breckenridge, Dessonville, Thompson, & Amaral, 1982). This is especially true if such reactions persist for more than six months after the loss. In a controversial decision, the *DSM-5* has removed their previous 'bereavement exclusion' clause, which meant that a grieving person could not be diagnosed with depression or an adjustment disorder. This change has been made in order to provide treatment for the 10–15 per cent of mourners with severe and crippling reactions to the loss of a loved one. However, opponents to this change argue that it may result in pharmaceutical companies pathologising and medicalising even normal reactions to loss (Doka, 2013).

It is often assumed that the opportunity to grieve prior to a loss, sometimes referred to as anticipatory grief, may ease adverse reactions to the loss when it actually occurs. However, this may not necessarily be the case. For example, Hill, Thompson, and Gallagher (1988) found that older women who had rehearsed their loss by discussing financial issues or funeral arrangements with others were more poorly adjusted following their loss, reported significantly greater numbers of health concerns, and tended to show greater

### clinical

### significance

Degree to which the effect size of a research finding is large enough to indicate the finding will be useful in predicting or treating a disorder.



TBC