

Approximately 6.5 million people age 65 and older in the United States have Alzheimer's disease, one form of dementia, and that number is projected to more than double by 2060.





# CE

## CONTINUING EDUCATION IMPROVING THE QUALITY OF LIFE FOR PATIENTS WITH DEMENTIA AND THEIR CAREGIVERS

BY TORI DEANGELIS

**T**he past several years have seen remarkable breakthroughs in the ability to detect Alzheimer's disease and other forms of dementia, as well as in drug treatments that promise to slow cognitive and functional decline.

But as impressive as these findings are, they remain of limited value in one central domain: improving the quality of life for patients with dementia and those who care for them. Brain scans, blood work, and other tests that detect biomarkers of dementia are still largely in the realm of academic medical research, while treatment medications can be exorbitantly expensive, have serious side effects, and are still mostly experimental. What is more, there is no substitute for good personal care and all the ingredients that go into it.

### CE credits: 1

**Learning objectives:** After reading this article, CE candidates will be able to:

1. Explain the trajectory of psychosocial care for patients diagnosed with dementia.
2. Describe evidence-based interventions for patients with dementia and their caregivers.
3. Discuss new developments in assessing and evaluating patients with dementia, including in the areas of multicultural assessment and behavioral assessment.

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"Even if a person has the resources to receive the best or most expensive diagnostic tests or medications for their dementia, it's uncertain how much it will actually improve their quality of life," said geropsychologist Latrice Vinson, PhD, MPH, who directs the Aging Portfolio at APA. "It is essential to understand what quality of life means to that particular individual and what's most important to the individual at the time. Psychologists are extremely well equipped to have those types of individualized conversations and help enhance quality of life for people living with dementia."

In fact, psychologists who specialize in aging—geropsychologists, neuropsychologists, and aging researchers—are essential to this high-need area. Approximately 6.5 million people age 65 and older in the United States—1 in 9—have Alzheimer's disease, and that number is projected to more than double to 13.8 million by 2060, according to research (*2022 Alzheimer's Disease Facts and Figures*, Alzheimer's Association, 2022). Other forms of dementia add to this caseload since Alzheimer's makes up only 60% to 80% of dementia cases. These psychologists are helping to address this crisis by developing assessment instruments that show how dementia affects a person's ability to function and their well-being, as well as evidence-based interventions that use behavioral and other strategies to help patients with dementia and their care providers live with greater meaning, ease, and comfort. Psychologists are also identifying ways to provide

more culturally competent care to those with dementia and their families.

That said, there remains a huge need for more psychologists to get involved in this work, including at the basic level of understanding the key indicators of dementia, said geropsychologist Ann Steffen, PhD, ABPP, a professor at the University of Missouri–St. Louis and coauthor of *Treating Later-Life Depression: A Cognitive-Behavioral Therapy Approach, Clinician Guide* (2nd ed.) (Oxford University Press, 2021), with Larry W. Thompson, PhD, ABPP, and Dolores Gallagher-Thompson, PhD, ABPP. At present, a lack of sufficient providers and provider education means that many people fail to get early assessments that could lead to better treatment, not to mention good treatment once they are properly diagnosed.

Even so, Steffen noted, "We're seeing more and more psychologists who are becoming interested in this area, either because of who they're seeing in their practice, or because of their own aging or that of a family member." Fortunately, there is a wealth of research, information, training opportunities, and resources that can help clinicians accurately spot problems among their patients and refer them to specialists as necessary: In fact, a big thrust for the APA Aging Portfolio, APA's Society of Clinical Geropsychology, and societies such as the Alzheimer's Association is to disseminate information and resources as broadly as possible, she added (see Resources).

A major contribution in the area is the *APA Guidelines for*

*the Evaluation of Dementia and Age-Related Cognitive Change*, approved by APA's Council of Representatives in February 2021. They are geared toward helping all psychologists understand the latest scientific advances and procedures in dementia assessment and deepen their empathy for people facing these conditions and their caretakers.

### PROMOTING BRAIN HEALTH

Because cognitive concerns are difficult to discuss and people are at varying levels of education and resources to address them, there are various ways and stages at which patients first start to discuss these problems. For some, the first person they will talk to is a psychologist or geropsychologist, whether in traditional office settings, clinics, or integrated care settings. For others, it may be with their primary-care provider, for example, in the context of the Medicare Annual Wellness Visit, where physicians are trained to look for signs of dementia and gather input from family members, friends, and caregivers, following up if necessary.

Psychologists, and geropsychologists in particular, are natural guides in this area because of their extensive training in the human mind and emotions. In fact, psychologists have an important preventive role to play in educating the public and their patients in general about dementia and normal age-related cognitive decline, Steffen noted. Because worry about age-related cognitive problems is more the rule than the exception, such education can help to reduce fear and stigma and promote healthier

### KEY POINTS

**1**  
Despite breakthroughs in dementia detection, psychological knowledge and intervention continue to play a central role in dementia care.

**2**  
Psychologists can use their training to help destigmatize dementia and age-related cognitive decline and promote brain health.

**3**  
Powerful interventions include behavioral treatments that harness the relationship between the person with dementia and their caregivers, and environmental interventions that modify environments for the safety and comfort of the person with dementia.

**4**  
Newer interventions are beginning to incorporate socioeconomic and multicultural factors into dementia care.

conversations around this common human concern, she said.

To this end, she talks with patients—including those who are middle-age and otherwise not necessarily at risk for dementia—in ways that help allay their anxieties and guide them to consider these topics through the lens of brain health. This is the notion that the brain is an organ just like the heart and other organs and can be protected through preventive measures such as exercise, healthy diet, and lowered stress—a growing area of research (Jia, R., et al., *BMC Geriatrics*, Vol. 19, No. 1, 2019).

Steffen also educates patients and psychologists who seek training in the area about potential causes of cognitive difficulties that are unrelated to dementia and treatable, such as clinical depression and problems with sleep, medications, blood sugar, and heart disease. Evidence-based treatment of depression in older adults is often an important first step, she added, as cognitive concerns in this population may be primarily related to depression.

If she or her patients have strong reasons to be concerned about memory or other cognitive problems, Steffen does a short cognitive assessment and then helps them to take the next steps. For example, she may help them prepare for an upcoming physician visit by determining questions to ask, drafting emails to send, or calling the physician's office together to explain the patient's concerns and what they want to discuss. She recommends what in medical parlance is called a "warm handoff"—not leaving



the patient to do everything themselves, particularly when addressing anxiety-provoking health concerns.

"Much of this is about having gentle conversations on these issues, about creating a sense of comfort and using 'we' language—because this education is true for all of us," she said.

### FORMAL DIAGNOSTIC TESTING

If the patient's physician or geropsychologist believes that more investigation is needed, the person may then be referred to a neuropsychologist for testing.



This process can last from 2 to 6 hours depending on the referral question or the complexity of the case, said clinical neuropsychologist Christopher M. Nguyen, PhD, faculty director of the Office of Geriatrics and Gerontology at The Ohio State University College of Medicine in Columbus, Ohio. The first step is conducting a clinical interview with the patient and their family to get a sense of current issues and concerns—to assess changes in their thinking and behavior, when the changes began, and how they are handling activities of daily living such as driving and managing their own

medications and finances.

The next step is comprehensive neuropsychological testing, which uses paper-and-pencil testing to examine the patient's cognitive and emotional functioning. The tests are scored and compared with normative data from people of similar demographics, and if they differ, there is likely a problem, said Nguyen. Results from the testing, the clinical interview, and a review of the person's medical records determine if the patient's cognitive changes are likely due to mild neurocognitive disorder—the current term in the *Diagnostic*

**Psychologists can help educate patients about protecting their brain health through preventive measures such as lowering their stress.**

and Statistical Manual of Mental Disorders (Fifth Edition) for mild cognitive impairment, meaning cognitive changes that are noticeable but do not impact daily functioning—or to major neurocognitive disorder, the current *DSM-5* term for dementia, meaning cognitive impairments that have progressed to the point that the person can no longer independently complete activities of daily living. People do not get diagnosed with dementia per se—that is an umbrella term for a variety of conditions—but rather with a specific form or forms of dementia, he added. The most common forms are Alzheimer's disease and forms of dementia that are due to vascular disease, Parkinson's disease, frontotemporal damage, Lewy bodies, traumatic brain injury, or substance use and alcohol use disorders.

Once he synthesizes these findings, Nguyen then integrates them into a report that he sends to the patient and their medical provider, who may refer the patient to a neurologist for additional diagnostic testing. This may include laboratory tests to rule out reversible causes of cognitive decline, such as vitamin deficiencies or infections, and brain scans to help solidify a diagnosis based on the pattern of brain changes specific to certain forms of dementia.

In some cases, this testing may reveal a mixed form of dementia—for example, probable Alzheimer's disease and vascular dementia—added Wake Forest University School of Medicine neuropsychologist Bonnie C. Sachs, PhD, ABPP.



## NEW EVALUATION GUIDELINES FOR DEMENTIA

**U**pdated APA guidelines are now available to help psychologists evaluate patients with dementia and their caregivers with accuracy and sensitivity and learn about the latest developments in dementia science and practice.

APA *Guidelines for the Evaluation of Dementia and Age-Related Cognitive Change* was released in 2021 and reflects updates in the field since the last set of guidelines, released in 2011, said geropsychologist and University of Louisville professor Benjamin T. Mast, PhD, ABPP, who chaired the task force that produced the guidelines.

“These guidelines aspire to help psychologists gain not only a high level of technical expertise in understanding the latest science and procedures for evaluating dementia,” he said, “but also have a high level of sensitivity and empathy for those undergoing a life change that can be quite challenging.”

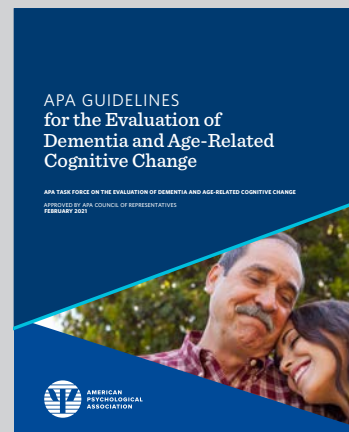
Major updates since 2011 include:

■ **Discussion of new DSM terminology.** The new guidelines discuss changes in dementia diagnosis and diagnostic criteria reflected in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders* (Fifth Edition). In particular, the *DSM-5* changed the term “dementia” to “major neurocognitive disorder,” and “mild cognitive impairment” to “minor neurocognitive disorder.” As was true with earlier nomenclature, providers and others amend these terms depending on the cause or causes of the disorder, for example, “major neurocognitive disorder due to traumatic brain injury.” That said, the terms “dementia” and “mild cognitive impairment” are still widely used in medicine and mental health care.

■ **Discussion of new research guidelines.** The new guidelines also discuss research advances in the field, in particular the use of biomarkers to detect various forms of dementia. Examples are the use of amyloid imaging—PET scans with a radio tracer that selectively binds to amyloid plaques—and analysis of amyloid and tau in cerebrospinal fluid.

While these techniques are still mainly used in major academic medical centers, it is important for clinicians to know about them because they may eventually be used in clinical practice, said Bonnie Sachs, PhD, ABPP, an associate professor and neuropsychologist at Wake Forest University School of Medicine. “These developments change the way we think about things like Alzheimer’s disease, because they show there is a long pre-clinical asymptomatic phase before people start to show memory problems,” she said.

■ **An expanded guideline on assessing multicultural issues.** As more people of diverse racial and ethnic backgrounds are referred for neuropsychology assessments for dementia, it is increasingly important to expand assessment instruments to account for how sociocultural, genetic, and health-related diversity factors may contribute to the development of dementia, according to Guideline 5. “As practice and referrals in this area become more diverse, our ways of doing things need to adjust as well,” Mast said.



■ **A new guideline on assessing behavioral and mood aspects of dementia.** Guideline 12, which is new, underlines the importance of evaluating behavioral and psychological symptoms of dementia such as agitation, wandering, depression, delusions, and paranoia. Without good interventions, these behaviors contribute to lower quality of life, higher caregiver burden, and negative outcomes such as early nursing home placement, the guidelines state.

■ **A new guideline on assessing family caregivers.** Guideline 13, also new, recognizes the importance of evaluating the health and well-being of caregivers, including their needs, resources, and mental health. “We know from literature that addressing caregiver health and well-being is something that’s good for the caregiver but also good for their ability to provide care for a person living with dementia,” Mast said.

A three-part APA continuing-education webinar series on this topic is available at <https://apa.content.online/catalog/main.xhtml>.

"We used to view these conditions as relatively distinct in nature," she said, "but postmortem brain studies and advances in imaging have shown that mixed pathology may actually be the norm rather than the exception." This will undoubtedly be an important focus of research and treatment in years ahead, she noted.

### AFTER A DIAGNOSIS

Once a formal diagnosis is made, there is much that psychological practitioners can do to help patients and their families cope, adjust, and have a good quality of life. An underlying principle is person-centered care: considering the stage of a person's diagnosis, their personal and financial resources, and personality and cultural factors, for example.

"It's really about removing barriers and empowering people to live well despite a diagnosis of dementia," said Claire Williams, a Virginia Commonwealth University counseling psychology doctoral student with a concentration in geropsychology and an

intern with APA's Aging Portfolio.

In keeping with the movement toward destigmatization, being transparent with information is key, Williams added. "It's empowering to have a name for and an idea of what's happening to you regardless of the stage of your condition or how you're experiencing symptoms in the moment," she said. "It's important for the caregiver to know what's going on, of course, but at the end of the day, it is really important for the patient to also have that knowledge."

Depending on the stage of illness at which someone is diagnosed, geropsychologists may also perform capacity evaluations, which help people and their families think through whether and how a person with dementia can live independently, carry out activities of daily living, deal with their finances, designate health care proxies and financial assistants, and other life essentials. University of Alabama geropsychologist Rebecca S. Allen, PhD, ABPP, who conducts

### RESOURCES

#### **Alzheimer's Association**

Comprehensive information, including the fact sheet *10 early signs and symptoms of Alzheimer's*  
[www.alz.org](http://www.alz.org)

#### **APA Aging Portfolio**

<https://www.apa.org/pi/aging>

#### **APA Caregiver Briefcase**

<https://www.apa.org/pi/about/publications/caregivers>

#### **E4 Center of Excellence for Behavioral Health Disparities in Aging**

Post-licensure training and resources  
<https://e4center.org>

#### **Gerontological Society of America KAER Toolkit**

How to initiate conversations about brain health and detect and diagnose dementia  
[www.geron.org/publications/kaer-toolkit](http://www.geron.org/publications/kaer-toolkit)

#### **Society of Clinical Geropsychology (APA Div. 12, Section II)**

<https://geropsychology.org>

#### **World-Wide FINGERS**

Global dementia prevention network  
<https://wwfingers.com/>

these types of evaluations, also helps families determine ways to create supports that help patients live in the least restrictive environment possible. For example, older adults with dementia may be able to continue living in their own homes if they receive adequate in-home care, such as help from area agencies on aging and programs like Meals on Wheels, as well as environmental changes that facilitate safety and comfort. An example is implementing universal design in bathrooms such as grab bars, high-seat toilets, and roll-in showers with seating.

Allen is also trained in contextual issues related to aging that may influence how patients with dementia fare and cope. For example, she assesses many older adults in rural areas in the southern United States who may have experienced racial segregation and medical and educational inequalities that affected their performance on standardized tests. Incorporating knowledge of that background is crucial to accurate diagnosis and treatment, she said: For example, it may be more important to foster their adaptive functioning than to assess their cognitive test performance. Allen also works to build and maintain trust with community partners who can help in assisting these individuals.

Newly diagnosed patients and their families may also seek additional psychotherapy or other brief psychological interventions to discuss their fears and concerns, engage in more specific planning work, and explore how to maximize their remaining time, Steffen added.

"For many people, a diagnosis

**Comprehensive neuropsychological testing for dementia is often followed by a thorough review of a patient's medical history with their physician.**



becomes an opportunity to focus on what's important to them, to say, "What am I interested in? What are my values? How can I do more of the things that matter to me?" she said. These questions are especially meaningful for people who have been diagnosed early and have a fair amount of time before the condition worsens—a situation that is likely to become more common as detection methods continue to improve, she said.

Specific interventions that can be helpful at this stage include anticipatory grief work, which helps people diagnosed with dementia and their family members begin to process feelings of loss; acceptance and commitment therapy, or ACT, which helps people radically accept their emotions and circumstances and continue to move forward; and cognitive behavioral interventions for depression, said Vinson.

### LATER INTERVENTIONS

As patients progress in the illness, it becomes increasingly important to educate family caregivers, skilled nursing facility staff, and others caring for the person with dementia on what to expect and how to intervene. One vital though somewhat neglected form of evaluation—the focus of one of the new 2021 APA evaluation guidelines—are behavioral assessments, which involve asking caregivers about behavioral and emotional problems they observe in their loved ones and guiding them in managing those behaviors. These may include disruptive behaviors and emotions such as wandering or agitation but also depression,



**Patients with dementia are often calmed by tasks that offer predictable stimulation, such as folding laundry.**

rated as a top stressor by family caregivers because it is painful seeing one's loved one suffer in this way, said University of South Florida geropsychologist William E. Haley, PhD, who studies caregiver stress.

"As psychologists, we have to be careful that we don't pay too much attention to cognitive decline and not enough to the behavioral issues that are key to managing these problems," he said.

In fact, understanding and addressing environmental factors can go a long way toward easing difficult behaviors, Haley

emphasized. In essence, patients with dementia can not handle overly complex environments, a situation that worsens as the disease progresses. Depending on the stage of illness, too much complexity can be as simple as having the TV on while people in the same room are talking, or giving the person too many instructions at once, like asking the person to get undressed and prepare to take a bath while you get the water running.

On the other hand, environments that provide no stimulation can also lead to problems, he

said. Families can help by figuring out what the person likes to do and helping to facilitate that. Haley recalled a family whose mother with dementia still enjoyed folding towels. The family kept a large laundry basket full of towels just for that purpose. The mom “folded them slowly but carefully and felt that she was doing something important, and that helped to calm her,” he said. Once the job was done, the family could bring out the laundry basket an hour later and the woman could perform the enjoyable task another time.

Psychologists should also be aware that patients with dementia have difficulty adjusting to unfamiliar environments, Haley noted. Being hospitalized or sent to another living space, such as the home of a sibling who wants to share caregiving duties, can cause behavioral disruptions if the new surroundings are not set up carefully. To that end, if the person is moving to a care facility, Haley advises choosing one specifically designed for patients with dementia that is easy to navigate and provides opportunities for sensory enjoyment. “Simple environmental design features can make a tremendous difference in helping a person to prosper,” he said.

Other promising interventions for patients with more advanced stages of dementia include music therapy, animal therapy—visits from specially trained pets, including animatronic ones—and interventions delivered via technology (Moreno-Morales, C., et al., *Frontiers in Medicine*, Vol. 7, 2020; Koh, W. Q., et al., *JMIR Rehabilitation and Assistive*

*Technologies*, Vol. 8, No. 1, 2021). For example, the Department of Veterans Affairs (VA) uses a care model called INSIGHT (Individualized Non-Pharmacological Services Integrating Geriatric Health and Technology), which delivers traditional psychotherapy interventions such as reminiscence therapy, behavioral activation, and relaxation exercises to veterans with dementia on an iPad or tablet. Studies show that the interventions help to reduce agitated behaviors and the use of psychotropic medications. (Mazzone, J. A., et al., *Alzheimer’s & Dementia*, Vol. 15, 2019).

### CARE FOR THE CAREGIVER

Another new APA evaluation guideline focuses on the assessment of family caregivers or care providers, who are an obvious focus of dementia treatment and research. There are numerous interventions geared toward helping them provide good care to their significant others and to themselves. A helpful way to frame this issue is via a coping model developed by Haley and colleagues, which shows a teeter-totter with stressors on one side and resources on the other. If stressors are too high and resources too low, caring for a person with dementia can be hard to sustain. “But having sufficient resources—getting family members to provide more help, hiring paid services, and practicing self-care strategies, for example—can help a great deal,” he said.

As an example of this, NYU Grossman School of Medicine public health practitioner Mary Mittelman, DrPH, along with

### FURTHER READING

#### Caregiver family therapy: Empowering families to meet the challenges of aging

Qualls, S. H., & Williams, A. A.  
APA, 2013

#### Ethical practice in geropsychology

Bush, S. S., et al.  
APA, 2017

#### Ethnicity and the dementias (3rd ed.)

Yeo, G., et al. (eds.)  
Routledge, 2019

#### Feedback that sticks: The art of effectively communicating neuropsychological assessment results (1st ed.)

Postal, K., & Armstrong, K.  
Oxford University Press, 2013

#### Skills for brain health: Healthy cognitive aging

In Steffen, A. M., et al.  
*Treating later-life depression: A cognitive-behavioral therapy approach* (2nd ed.)  
Oxford University Press, 2022

Haley and other colleagues, created and studied a caregiver intervention that includes six sessions of individual and family counseling, participation in support groups, and individualized phone consultations for each caregiver. Compared with caregivers who did not receive the treatment, those who received it had less depression 3 years later and were able to delay nursing home placement of their family member by an average of 1.5 years. And even though behavior problems in all the patients with dementia worsened over time, caregivers who received the intervention rated their stressors as lower over time, while controls rated them as higher.

Another set of evidence-based caregiver interventions was developed by geropsychology researcher and University of Washington (UW) professor Linda Teri, PhD, who has taken a unique approach to dementia care. Rather than treating patients and caregivers separately—the modus operandi when she began this work more than 30 years ago—she pioneered the methodology of working with them together, as dyads, families, or communities, depending on the case. Her system and its related interventions, collectively called the Seattle Protocols, have been adapted nationally and internationally and by groups and organizations including nursing homes, the LGBTQ+ community, the VA, and more.

A core feature of her approach is a behavioral analysis called the ABCs (activators, behaviors, and consequences), which helps caregivers understand how their actions or communications might



trigger difficult reactions in the person with dementia. “My job is to help [caregivers] understand that there is always a chain, there is always something that triggers the reaction whether you understand it or see it or not,” she said. Another aspect of the model is having patients with dementia identify activities that are pleasurable for them and that their caregivers deem are accessible, affordable, and easy to implement. If a person living with dementia fondly recalls spending time in Hawaii, for instance, bringing out old photographs and stories from those times can be a way to encourage and share those pleasant memories, Teri explained.

Over time, Teri observed something else: Caregivers were more likely to engage in an item on the patient’s list if they enjoyed doing it themselves. She also showed that when the event was something they both liked to do, both of their moods improved. “A lot of times it’s really about figuring out what is happening in the interaction now, what are the good pieces of it, and then taking those good pieces and figuring out how to maximize them and make them easier,” she said. (Teri, L., & Uomoto, J. M., *Clinical Gerontologist*, Vol. 10, No. 4, 1991).

All these insights have been woven into a framework that is being used in several different contexts. An example is the RDAD (Reducing Disabilities in Alzheimer’s Disease) program, which uses a combination of exercise and “pleasant events” individualized to patient preferences—for example, simple crossword puzzles for a patient

who loved tackling tough puzzles, or easy sewing projects for a former seamstress—to help reduce physical disability in Alzheimer’s patients. This is a key intervention because falls and other injuries can be devastating to these patients: If they end up in a hospital or rehab setting, the stress of trying to adjust to an unfamiliar environment can exacerbate their condition, as can the frustration of trying to follow rehab instructions (see Teri, L., et al., *Journal of the American Medical Association*, Vol. 290, No. 15, 2003).

Teri and colleagues have also developed successful programs under variants of the acronym STAR (Staff Training in Assisted Living Residences) that use this methodology to train nursing home staff, home-based caregivers, and VA staff who work with veterans who have dementia. An online version of the STAR protocol is now being tested in a clinical trial funded by the National Institute on Aging, with preliminary results showing it helps to reduce caregiver burden (Lindauer, A., et al., *Journal of Medical Internet Research*, Vol. 23, No. 2, 2019).

Other groups are adapting these programs as well. For instance, Karen I. Fredriksen Goldsen, PhD, a professor in the University of Washington School of Social Work, is tailoring specific components of RDAD for the aging LGBTQ+ population, taking into account that their family structures are often nontraditional and that dementia adds one more area of perceived “difference” or “weakness” in a community that is already marginalized and stigmatized. Meanwhile, community

programs in the United States, Europe, and Asia are also adopting versions of these programs, and they have been translated into Spanish, Italian, Chinese, and Japanese.

Caregivers may also benefit from mindfulness interventions, shown to reduce caregiver depression and enhance subjective well-being, according to a meta-analysis of 131 randomized controlled trials of caregiver interventions. The analysis also found that caregivers benefited from educational programs with psychotherapeutic components, from psychotherapy, and from multicomponent therapy such as Teri’s interventions (Cheng, S., et al., *Psychology and Aging*, Vol. 35, No. 1, 2020).

## DIVERSITY CONSIDERATIONS

Psychologists who specialize in aging issues are also working to amplify the knowledge base on effective multicultural treatment for patients with dementia.

For example, APA greatly expanded Guideline 5, which focuses on cultural diversity and multicultural competence. “Our goal was to recognize the growing diversity in our society, the growing diversity of referrals for neuropsychological testing and dementia evaluation, and to reflect the developing science and practice in this area,” said University of Louisville geropsychologist Benjamin T. Mast, PhD, ABPP, author of *Whole Person Dementia Assessment* (Health Professions Press, 2011) and chair of the guidelines revision task force.

The updated diversity guideline notes that practitioners can

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expand their cultural competence with patients with dementia by becoming aware of their personal biases, committing to increasing their cultural competence and cultural humility, and evaluating tests and norms in terms of racial and ethnic background as well as language, said Mast. For example, different cultures may express psychological symptoms differently, be reluctant to disclose information, or have different levels of health care literacy, he noted.

Also important is to better understand how health disparities may influence a patient's cognitive health and treatment, Vinson added. Studies show that Black Americans and people with lower education are at higher risk for dementia than White Americans, the result of factors

**Psychologists who specialize in aging are working to expand research on effective multicultural treatment for patients with dementia.**

that include a dearth of sufficient educational, health, and resource opportunities (Manly, J. J., et al., *JAMA Neurology*, Vol. 79, No. 12, 2022). "Many risk factors for dementia are preventable," such as hypertension, diabetes, obesity, unhealthy diet, and substance use, Vinson said. "But we know that people of color are less likely to have access to particular resources that would help them in their prevention efforts."

Other psychologists are working to improve cultural competence in dementia care. As incoming president of the Asian Neuropsychological Association (ANA), Nguyen plans to advocate for a more streamlined referral process that enables neuropsychologists nationwide to access, consult with, and refer to

colleagues who speak the same language as the patient. The ANA is also working to establish a clinical consultation corner that is open to members and other neuropsychologists to discuss cases and questions related to cross-cultural clinical work.

Working with patients with dementia and their caregivers is gratifying—bringing out psychology's ability to help people maximize their life potential, regardless of their diagnosis, Allen added. "What can we do from here to help people lead as full of a life as possible?" she said. "It's the interventions and scaffolds that we can put in place to create the least restrictive environment so that people can be where they want to be for as long as possible." ■