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# Working with Older Adults Living with Dementia in Clinical Practice



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# Section 1: Understanding Dementia and Major Neurocognitive Disorders

Dementia is not a single disease, nor is it an inevitable consequence of growing older. It is a clinical syndrome associated with acquired cognitive decline that becomes significant enough to affect a person's ability to function independently. For psychologists, this distinction is important because older adults may experience changes in memory, processing speed, attention, or other cognitive abilities without meeting criteria for dementia. Conversely, cognitive decline may initially appear subtle while already interfering with complex activities such as managing finances, medications, transportation, appointments, household responsibilities, or other aspects of independent living.

The clinical presentation of dementia is also considerably more diverse than the common stereotype of an older adult who becomes increasingly forgetful. Memory impairment is prominent in many cases, particularly in typical Alzheimer's disease, but neurocognitive disorders can affect executive functioning, language, attention, processing speed, visuospatial abilities, social cognition, judgment, personality, emotional regulation, and behavior. The nature of the first symptoms, the pattern of affected cognitive abilities, the course of progression, neurological findings, functional changes, and associated behavioral symptoms can provide important information when clinicians are considering possible causes of cognitive decline (Day et al., 2022).

Psychologists therefore benefit from understanding dementia as a broad clinical syndrome that can result from several underlying diseases and pathological processes. Alzheimer's disease is the most familiar cause, but vascular disease, Lewy body disease, frontotemporal degeneration, and combinations of pathological processes can also produce dementia. An individual may also have more than one condition contributing to cognitive impairment. This clinical

heterogeneity is one reason psychologists should avoid assuming that all people diagnosed with dementia will exhibit the same symptoms, progression, treatment needs, or functional limitations.

## Normal Cognitive Aging, Mild Cognitive Impairment, and Dementia

Some cognitive change occurs as part of normal aging. An older adult may require more time to retrieve a name, learn unfamiliar information, shift between complicated tasks, or process information presented rapidly. These experiences can be frustrating and may prompt concerns about dementia, but isolated cognitive inefficiencies do not establish the presence of a neurocognitive disorder.

A clinically significant decline involves more than the occasional lapse experienced by many healthy adults. The clinician considers whether there has been a meaningful change from the person's previous level of functioning, which abilities appear to have changed, whether those changes are corroborated by other information, and how cognition is affecting everyday life. Educational history, occupational demands, language, culture, sensory functioning, medical conditions, psychiatric symptoms, medications, and the individual's previous cognitive abilities can all influence this determination.

Mild cognitive impairment, commonly abbreviated MCI, occupies an important clinical position between expected cognitive aging and dementia. MCI generally refers to cognitive decline that is greater than would be expected based on normal aging but does not substantially interfere with the person's independence in everyday functioning. The person may compensate for cognitive difficulties by using reminders, calendars, organizational systems, additional time, or assistance with particularly demanding tasks. MCI can involve memory, but it can also affect

executive functioning, language, visuospatial abilities, attention, or combinations of cognitive domains (Hessen, 2025).

MCI should not be communicated as though it guarantees future dementia. Some individuals experience progression, whereas others remain relatively stable for substantial periods. The cause of MCI also matters. Neurodegenerative disease is one possible contributor, but cognitive performance can be influenced by vascular disease, psychiatric symptoms, sleep problems, medications, substance use, sensory impairment, and numerous medical conditions. This is one reason that a low score on a cognitive screening instrument should never be treated as synonymous with either MCI or dementia.

The distinction becomes increasingly important when functional independence is considered. In DSM-5-TR, dementia corresponds to major neurocognitive disorder: significant decline from a previous level of performance in one or more cognitive domains that interferes with independence in everyday activities. Mild neurocognitive disorder overlaps substantially with MCI. It involves modest decline that does not interfere with independence, although greater effort or compensatory strategies may be needed (American Psychiatric Association, 2022).

This functional component is essential. Two people can obtain similar scores on a cognitive task but experience very different effects in daily life because their previous abilities, environments, occupations, social supports, health conditions, and daily responsibilities differ.

For psychologists, assessment of cognition should therefore include attention to functioning rather than test scores alone. Questions concerning medication management, finances, shopping, cooking, transportation, communication, appointments, technology use, household safety, and decision-making may provide information that a brief cognitive measure cannot capture.

## Alzheimer's Disease

Alzheimer's disease is the most widely recognized neurodegenerative cause of dementia. Its clinical presentation varies, but the typical form is characterized by an insidious onset and progressive decline in which difficulties learning and retaining new information are often among the earliest prominent cognitive symptoms.

A person in the early symptomatic stages may repeatedly ask the same question, forget conversations, misplace objects in unusual locations, have increasing difficulty remembering recent events, or depend more heavily on written reminders. Family members may notice changes before the individual fully recognizes their significance. In other situations, the individual recognizes the changes and experiences considerable anxiety, frustration, embarrassment, or grief about them.

The memory disturbance associated with typical Alzheimer's disease extends beyond ordinary absentmindedness. Difficulty learning and retaining new information may interfere with appointments, conversations, medication routines, financial decisions, or the ability to remember recently provided instructions. As the disease progresses, additional cognitive domains are commonly affected. Language difficulties may become more apparent, executive abilities may decline, visuospatial problems can develop, and the person may experience increasing difficulty performing complex sequences of activities.

Alzheimer's disease is biologically associated with pathological processes involving amyloid beta and tau, although contemporary understanding of the disease recognizes that its clinical expression is heterogeneous. The relationship among biological pathology, cognitive symptoms, and functional impairment is complex, and neuropathological changes can precede the dementia stage by many years.

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Modern approaches increasingly distinguish the underlying disease process from the clinical syndrome that eventually becomes observable in everyday life.

This distinction is now actively debated. Some current criteria define Alzheimer's disease biologically, so a person with abnormal amyloid and tau biomarkers can be classified as having the disease before any symptoms appear (Jack et al., 2024). Other experts argue that the diagnosis should be reserved for people who have both biomarker evidence and a recognizable clinical syndrome, and that biomarker-positive people without symptoms should be described as at risk (Dubois et al., 2024). Psychologists will increasingly see patients who have biomarker results but no symptoms. A positive biomarker does not predict with certainty whether or when cognitive decline will occur.

The clinical course is progressive, but the rate and pattern of progression vary considerably among individuals. Day et al. (2022), in a systematic review and meta-analysis examining symptom onset and longitudinal course in sporadic Alzheimer's disease, frontotemporal dementia, and vascular dementia, emphasized the variability in trajectories across dementia syndromes. This variability has direct clinical implications. Psychologists should be cautious about providing families with overly precise predictions based solely on a diagnostic label.

Psychological care also requires recognition of the emotional meaning of cognitive change. A person who understands that memory is deteriorating may experience anxiety about the future, grief over anticipated losses, changes in self-confidence, or fear of becoming dependent on others. These reactions should not automatically be interpreted as symptoms of the neurodegenerative disorder itself. The psychologist must continue to view the individual as a person responding psychologically to significant changes in health, identity, relationships, and independence.

## Vascular Dementia and Vascular Cognitive Impairment

Vascular contributions to cognitive impairment represent another major area of dementia practice. The broader term vascular cognitive impairment encompasses cognitive difficulties associated with cerebrovascular disease across a range of severity, including presentations that do not yet meet the threshold for dementia.

Vascular cognitive impairment does not have one uniform cognitive profile. Its presentation depends in part on the location, extent, and type of cerebrovascular injury. Large strokes, multiple infarcts, cerebral small vessel disease, and other vascular processes can contribute to cognitive dysfunction. Vascular pathology may also coexist with neurodegenerative disease, making simple either-or distinctions between Alzheimer's disease and vascular dementia inappropriate in some patients.

Executive functioning, attention, and information-processing speed can be particularly vulnerable in cognitive impairment associated with cerebral small vessel disease. Contemporary reviews of vascular cognitive impairment have emphasized these domains, while also recognizing that memory and other cognitive abilities can be affected (Kancheva et al., 2024; Mok et al., 2024). Executive dysfunction may appear in everyday life as difficulty planning, organizing, initiating, sequencing, monitoring, or completing activities. A person may remember what needs to be done yet have increasing trouble coordinating the steps required to accomplish it. Slowed processing can make complex conversations, rapidly presented instructions, multitasking, or unfamiliar situations particularly difficult.

Some vascular presentations may appear to progress differently from the relatively gradual course commonly associated with Alzheimer's disease. Cognitive change following a stroke may have a clearer temporal relationship to the neurological event. Other vascular processes, particularly small vessel disease, can

produce more gradual decline. The traditional expectation of an obvious "stepwise" progression should therefore not be treated as a requirement for vascular cognitive impairment.

From a clinical perspective, vascular cognitive impairment also illustrates why psychologists need information extending beyond mental status testing. Medical history, stroke history, cardiovascular and cerebrovascular risk factors, neurological findings, imaging, functional changes, and the time course of symptoms may all contribute to diagnostic formulation. Psychologists should remain within their areas of competence and coordinate with medical professionals when the presentation suggests neurological or vascular disease.

## Dementia With Lewy Bodies

Dementia with Lewy bodies, or DLB, can be particularly challenging because cognitive, psychiatric, sleep-related, autonomic, and motor symptoms may occur in the same individual. The presentation may therefore initially resemble a psychiatric disorder, Alzheimer's disease, Parkinsonian illness, delirium, or another neurological condition.

Progressive cognitive decline is central to DLB, but early memory impairment may be less prominent than difficulties involving attention, executive functioning, and visuoperceptual abilities in some individuals. Clinically significant fluctuations in cognition and alertness are an important feature. A person may appear substantially more attentive and engaged at one time and markedly confused or less responsive at another.

Recurrent visual hallucinations are another characteristic clinical feature. These can be well formed and detailed, such as seeing people, children, or animals who are not present. For psychologists, the presence of hallucinations in an older adult

with cognitive impairment should encourage careful differential assessment rather than an immediate assumption of a primary psychotic disorder.

REM sleep behavior disorder is also strongly associated with Lewy body disease. During normal REM sleep, skeletal muscle activity is largely suppressed. In REM sleep behavior disorder, this normal muscle atonia is disrupted, potentially resulting in movements or vocalizations associated with dream enactment. Parkinsonian motor features can also emerge, including rigidity, slowed movement, altered gait, or other motor changes. Armstrong (2021) reviewed advances in the understanding and clinical management of DLB and highlighted the importance of recognizing its multidimensional presentation.

Severe sensitivity to antipsychotic medication is a recognized feature of DLB and has direct safety implications, because exposure can cause serious and sometimes life-threatening reactions (Armstrong, 2021). Clinicians also distinguish DLB from Parkinson's disease dementia by timing. DLB is diagnosed when dementia begins before or within one year of parkinsonism (Armstrong, 2021). Parkinson's disease dementia is diagnosed when dementia develops in the context of established Parkinson's disease.

These features have important implications for psychological practice. Fluctuating cognition can influence assessment performance and the person's ability to participate consistently in treatment. Visual hallucinations may be frightening in one person and relatively neutral in another. Motor impairment can affect independence and increase caregiver demands. Sleep disturbance may influence both the patient and the caregiver. The psychologist therefore needs to understand the broader syndrome rather than viewing each symptom in isolation.

## Frontotemporal Dementia

Frontotemporal dementia, or FTD, refers to a clinically and biologically heterogeneous group of disorders associated with degeneration affecting frontal and temporal brain systems. It differs from the stereotypical picture of dementia because early symptoms may involve substantial changes in behavior, personality, social conduct, judgment, executive abilities, or language rather than prominent episodic memory loss.

Behavioral variant frontotemporal dementia can involve early changes in inhibition, motivation, empathy, social judgment, eating behavior, or repetitive and compulsive behavior. Family members may describe the person as seeming fundamentally different. Someone who was previously tactful and socially cautious may begin making inappropriate comments. Another person may become markedly apathetic and require prompting to begin even familiar activities. Others develop rigid routines, repetitive behaviors, unusual food preferences, or diminished sensitivity to the emotional experiences of people around them.

These changes can easily be misunderstood. Apathy may be interpreted as laziness or depression. Disinhibition may be viewed as deliberate misconduct. Reduced empathy can be experienced by a spouse as evidence that the person no longer cares. Repetitive behavior may be perceived as stubbornness. The psychologist can help families understand that behavioral changes may reflect alterations in brain systems responsible for inhibition, motivation, emotional processing, and social cognition.

Language-predominant neurodegenerative syndromes also occur within the frontotemporal degeneration spectrum, particularly semantic and nonfluent or agrammatic presentations of primary progressive aphasia. The person's primary difficulty may initially involve word meaning, naming, speech production,

grammar, or other aspects of language rather than the amnestic presentation typically associated with Alzheimer's disease.

The distinction between FTD and other neurocognitive disorders is clinically important, but psychologists should also recognize the potential for overlap and diagnostic uncertainty. Because symptoms often begin in midlife and involve behavior rather than memory, behavioral variant FTD is frequently misdiagnosed as a primary psychiatric disorder, and diagnostic uncertainty is common early in the course.

The effect on families can be profound. Behavioral and personality changes may disrupt relationships long before severe global cognitive impairment develops. A spouse may struggle with behavior that appears intentional, while adult children may disagree about whether the individual is ill or simply behaving irresponsibly. These circumstances highlight why dementia education should extend beyond memory impairment.

## Cognitive Domains Affected by Dementia

Understanding cognitive domains provides psychologists with a more useful framework than asking only whether memory is "good" or "bad." Different neurocognitive disorders can produce different patterns of strengths and weaknesses, and those patterns may change as illness progresses.

Learning and memory both include the acquisition, storage, and retrieval of information. A person may have difficulty encoding new information, retaining it over time, retrieving stored information efficiently, or recognizing previously encountered material. The nature of memory difficulty can contribute to a broader neuropsychological formulation.

Executive functions include planning, organization, inhibition, cognitive flexibility, problem solving, monitoring, initiation, and the ability to coordinate goal-directed behavior. Executive impairment can have substantial consequences even when basic memory remains relatively functional. Managing finances, preparing a complicated meal, resolving an unexpected problem, or adapting to a change in routine all require executive control.

Language includes naming, word retrieval, comprehension, repetition, reading, writing, grammar, and semantic knowledge. Language impairment may begin subtly with increased word-finding pauses but can become much more consequential as a neurocognitive disorder progresses. Clinicians must also distinguish acquired language decline from longstanding linguistic differences, limited English proficiency, educational factors, hearing impairment, or normal variation in communication style.

Visuospatial and perceptual abilities allow people to understand spatial relationships, navigate environments, identify visual information, and interact effectively with objects and surroundings. Impairment can contribute to getting lost, difficulty judging spatial relationships, trouble locating objects that are visible, or problems completing tasks that depend on visual organization.

Attention and processing speed influence performance across nearly every other cognitive domain. A person who cannot sustain attention or efficiently process incoming information may appear forgetful because information was never adequately encoded. This distinction becomes especially important when psychologists later consider delirium, depression, sleep disturbance, medication effects, and other conditions that can affect cognition.

Social cognition is also relevant, particularly in disorders affecting frontal and temporal systems. The ability to recognize emotional cues, understand social expectations, appreciate another person's perspective, regulate behavior, and

respond appropriately to interpersonal situations can deteriorate. Changes in social cognition may have major consequences for relationships and decision-making even when traditional memory tests reveal relatively less impairment.

## Progression and Stages of Cognitive Decline

Dementia is progressive when it results from a progressive neurodegenerative disease, but progression should not be presented as a perfectly predictable sequence. Stage labels such as mild, moderate, and severe can be clinically useful shorthand, yet they do not capture the full range of individual differences.

During earlier stages, a person may remain independent in many basic activities while having difficulty with more cognitively demanding instrumental activities. Financial management, medication organization, complex transportation, occupational responsibilities, technology, and complicated household tasks may become less reliable. Awareness of impairment can be relatively preserved, although insight varies considerably.

As cognitive impairment becomes more extensive, greater assistance may be required. Communication difficulties may become more noticeable, familiar tasks may require prompting, and behavioral or psychological symptoms may emerge or become more disruptive. Safety concerns may increase. Caregivers often assume greater responsibility for decisions, appointments, finances, medications, transportation, and daily structure.

Advanced dementia can involve extensive dependence in everyday activities, severe communication limitations, mobility difficulties, swallowing problems, incontinence, and increased medical vulnerability. Psychological care at this stage may look very different from conventional outpatient psychotherapy. Comfort, emotional connection, environmental support, caregiver consultation, behavioral

observation, dignity, and quality of life may become increasingly important clinical goals.

Longitudinal research also cautions against assuming that different dementia syndromes share an identical timeline. Day et al. (2022) found meaningful differences and considerable variability when examining symptom onset and longitudinal course in the included Alzheimer's disease, frontotemporal dementia, and vascular dementia studies. Individual trajectories are influenced by etiology, comorbid disease, neurological events, cognitive reserve, environmental support, medical care, and other factors.

A sudden or dramatic deterioration should not automatically be attributed to the expected progression of dementia. Acute changes can indicate delirium, infection, medication effects, dehydration, pain, metabolic disturbance, stroke, or another medical problem.

## Mixed and Complex Presentations

Clinical practice rarely conforms perfectly to textbook categories. An older adult may have Alzheimer's disease pathology alongside significant cerebrovascular disease. Lewy body and Alzheimer-related pathological processes can coexist. Medical illness, hearing or vision impairment, depression, anxiety, sleep disturbance, medication burden, chronic pain, substance use, and environmental stress may further influence the person's cognitive and behavioral presentation.

This complexity has an important implication for psychologists: diagnosis should not become a substitute for individualized assessment. Knowing that a patient has Alzheimer's disease provides useful information, but it does not tell the psychologist exactly what the person understands, remembers, values, can accomplish independently, or needs from treatment.

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The same principle applies to assumptions about capacity. A diagnosis of dementia does not establish that a person is incapable of making every decision. An individual may have difficulty managing a complicated investment account while remaining fully capable of expressing preferences about daily routines, relationships, recreational activities, or aspects of treatment.

Similarly, the presence of severe impairment in one domain does not necessarily indicate equivalent impairment in every other domain. Preserved abilities can remain clinically meaningful. Recognizing those abilities allows psychologists and caregivers to support participation rather than unnecessarily taking control away from the individual.

## Person-Centered Understanding of Dementia

The diagnostic concepts discussed throughout this section are necessary for competent clinical practice, but they should not obscure the person experiencing the condition. Dementia changes cognition and functioning, but the individual continues to have a personal history, relationships, preferences, emotional experiences, cultural identity, values, habits, strengths, and needs. A person-centered approach asks not only, "What deficits does this individual have?" but also, "What abilities remain, what matters to this person, what circumstances increase distress, what supports functioning, and how can the person's participation be preserved?" This orientation becomes particularly important as cognitive impairment increases.

Language can reinforce or undermine this perspective. Describing someone only as "a demented patient," "an Alzheimer's patient," or "a behavior problem" reduces a complex person to a diagnosis or symptom. Person-centered terminology such as "a person living with dementia" keeps the individual conceptually separate from the illness and encourages clinicians to consider the

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experience of the person rather than focusing exclusively on disease management.

For psychologists, this perspective has practical consequences. Assessment should identify strengths as well as weaknesses. Treatment goals should reflect the person's needs and abilities. Communication should preserve adult dignity. Caregiver involvement should not unnecessarily silence the patient. Behavioral symptoms should be interpreted within context rather than automatically labeled as purposeless consequences of disease. These principles establish the foundation for the remainder of the course. Psychologists working with dementia need sufficient knowledge of neurocognitive disorders to recognize important clinical patterns, but competent practice requires more than identifying a diagnostic category. It requires understanding how cognitive changes interact with emotions, behavior, relationships, physical health, culture, environment, and everyday functioning.

## Section 2: Assessment and Diagnosis in Dementia

Accurate assessment of cognitive change is one of the most consequential responsibilities psychologists may assume when working with older adults. A conclusion that an individual has a neurocognitive disorder can influence treatment, independent living, driving, financial management, medical decision-making, family relationships, and future planning. At the same time, failing to recognize clinically significant cognitive decline can leave an older adult without needed evaluation, treatment, or support. Assessment therefore requires considerably more than administering a brief cognitive screening instrument and comparing the resulting score with a cutoff.

The central principle of dementia assessment is that cognitive test performance must be interpreted within the context of the individual. A psychologist considers

the nature and onset of the reported changes, previous functioning, cognitive and functional abilities, medical history, psychiatric symptoms, medications, sensory functioning, educational opportunities, language, cultural background, and information provided by knowledgeable collateral sources when appropriate. Brief cognitive screening can contribute useful information, but screening is not equivalent to diagnosis. This distinction is particularly important when working with culturally, linguistically, and educationally diverse older adults, for whom commonly used measures may not perform in the same manner as they do in the populations in which the instruments were originally developed or validated (Chithiramohan et al., 2024; Czerwinski-Alley et al., 2024; Nielsen, 2022).

These principles are consistent with the APA Guidelines for the Evaluation of Dementia and Age-Related Cognitive Change, which emphasize competence, informed consent, culturally appropriate measurement, and integration of multiple sources of information (American Psychological Association, 2021).

## The Purpose of Cognitive Assessment

Cognitive assessment can serve several purposes in dementia care. A psychologist may be asked whether reported cognitive changes warrant further evaluation, whether an established neurocognitive disorder appears to be progressing, whether emotional symptoms could be contributing to cognitive complaints, or whether the pattern of cognitive difficulties is consistent with a particular neurological condition. Other referrals concern functional questions, such as whether cognitive problems are interfering with medication management, finances, transportation, treatment adherence, or independent living.

These are different clinical questions and should not automatically be answered with the same assessment approach. A brief screen may be appropriate when the purpose is to identify whether additional evaluation is warranted. A more

comprehensive neuropsychological examination may be indicated when the referral requires characterization of cognitive strengths and weaknesses, differential diagnosis, treatment planning, or detailed assessment of the relationship between cognition and everyday functioning.

Assessment should begin with a clearly formulated referral question. "Test for dementia" is generally too broad to guide sophisticated clinical decision-making. More useful questions might concern whether the person has experienced objective cognitive decline, which cognitive domains are affected, whether the pattern is consistent with a neurodegenerative process, whether mood or medical conditions may be contributing, and how cognitive abilities are affecting daily functioning.

A careful history is fundamental, and the psychologist should establish what has changed, when the changes were first noticed, how they have progressed, and who first became concerned. A gradual decline occurring over several years presents a different diagnostic picture from confusion that began over two days following hospitalization. Likewise, a person whose primary early difficulty involves memory presents differently from someone whose first prominent symptoms involve language, visuospatial functioning, executive abilities, personality, or behavior.

## Cognitive Screening Tools

Cognitive screening instruments are designed to provide relatively brief estimates of cognitive functioning and identify individuals who may require more extensive evaluation. Commonly encountered instruments include the Montreal Cognitive Assessment, often referred to as the MoCA, and the Mini-Mental State Examination, commonly known as the MMSE. Other brief instruments have also been developed for particular settings and populations.

Screening measures typically sample several cognitive abilities within a limited period. Depending on the instrument, tasks may address orientation, memory, attention, language, executive functioning, visuospatial abilities, calculation, or related skills. Their efficiency makes them attractive in primary care, behavioral health, hospital, and outpatient settings.

Efficiency, however, comes with limitations. A brief instrument cannot provide the same depth of information as a comprehensive neuropsychological evaluation. A total score may indicate that further assessment is appropriate without explaining why the person performed poorly. Two individuals can receive the same total score for very different reasons. For example, one individual may lose points primarily because of difficulty learning and recalling new information. Another may perform adequately on memory items but struggle with executive and visuospatial tasks. A third may perform poorly because the test is being administered in a language in which the person is not fully proficient. A fourth may have difficulty hearing the examiner's instructions. A fifth may have limited formal education and little familiarity with the kinds of tasks contained in the instrument. Treating all five performances as equivalent because the total scores are identical would be clinically inappropriate.

The MoCA has received substantial attention as a screening instrument for MCI and dementia, but its performance is influenced by the characteristics of the population in which it is used. O'Driscoll and Shaikh's (2017) systematic review of its cross-cultural applicability identified important concerns involving education, language, and cultural adaptation. More recent reviews have continued to emphasize that translation alone does not necessarily make a cognitive instrument culturally equivalent (Czerwinski-Alley et al., 2024).

A screening score should consequently be treated as one piece of clinical evidence. It can strengthen or weaken a hypothesis, identify the need for

additional evaluation, and provide a rough indication of areas that warrant closer examination. It should not function as an automatic diagnostic verdict.

## Screening Is Not Diagnosis

One of the most important distinctions for psychologists is the difference between screening and diagnosis. Screening instruments are intended to identify possible cognitive impairment. Diagnosis requires integration of substantially more information.

A score below a recommended cutoff does not independently establish dementia. Conversely, a score above a cutoff does not guarantee that clinically meaningful cognitive decline is absent. The diagnostic accuracy of a screening instrument depends on the population, setting, threshold selected, prevalence of the condition, and characteristics of the individual being evaluated.

The psychologist should also consider measurement error. Cognitive scores are estimates rather than perfectly precise representations of ability. Fatigue, anxiety, distraction, pain, hearing difficulties, vision problems, sleep deprivation, medication effects, language mismatch, and unfamiliarity with formal testing can alter performance.

Practice effects deserve consideration when a person receives the same or similar instruments repeatedly. Improvement on a subsequent administration does not necessarily indicate neurological improvement because familiarity with the task can influence performance. Likewise, a small decline in score does not necessarily establish disease progression without consideration of measurement variability and the broader clinical picture.

A particularly problematic practice is treating a single cutoff as universally applicable. A score has meaning only in relation to the psychometric

characteristics of the instrument and the individual being assessed. Contemporary reviews of culturally fair cognitive assessment emphasize the risk of misclassification when instruments developed within one educational or cultural context are transferred uncritically to another (Chithiramohan et al., 2024).

## Neuropsychological Assessment

Neuropsychological assessment provides a more detailed examination of cognitive functioning than a brief screening instrument. Depending on the referral question, assessment may examine attention, processing speed, learning and memory, language, visuospatial functioning, executive abilities, motor abilities, and other areas. Emotional and behavioral functioning may also be assessed.

The purpose is not simply to produce more scores. Neuropsychological assessment attempts to characterize patterns of cognitive strengths and weaknesses and interpret those patterns in relation to the person's history, functioning, and clinical presentation.

This distinction is especially relevant in neurocognitive disorders because different conditions can affect cognitive systems differently. Typical Alzheimer's disease may prominently affect learning and memory early in the symptomatic course. Vascular cognitive impairment may produce substantial difficulties in executive functioning and processing speed, although presentations vary. Dementia with Lewy bodies may involve prominent attention, executive, and visuoperceptual difficulties. Frontotemporal disorders can produce substantial changes in executive functioning, language, social cognition, or behavior. These patterns are not sufficiently specific to permit diagnosis by test scores alone, but they can contribute valuable information to a multidisciplinary diagnostic formulation.

Neuropsychological assessment can also identify preserved abilities. This is clinically valuable because treatment planning should not focus exclusively on

deficits. A person with impaired episodic memory may retain meaningful language, procedural, interpersonal, or other abilities that can be incorporated into compensatory strategies and psychological interventions.

Psychologists should practice within appropriate competence boundaries. Comprehensive neuropsychological evaluation requires specialized education, training, supervised experience, and knowledge of neuropsychological interpretation. A psychologist who has not received appropriate training should not assume that general psychological assessment competence automatically establishes competence in neuropsychological diagnosis. Referral or consultation is appropriate when the clinical question extends beyond the psychologist's training.

## Establishing Change From Previous Functioning

Dementia represents acquired decline. This means that determining the person's previous level of functioning is essential. A low cognitive score does not necessarily demonstrate decline if the person's longstanding abilities are similar. Conversely, a person with high previous intellectual or occupational functioning may experience meaningful cognitive deterioration while continuing to perform within broadly average ranges on some tests.

Educational attainment provides useful information but should not be treated as a perfect proxy for educational quality. Two individuals who each completed 12 years of formal schooling may have received very different educational opportunities. Literacy, quality of schooling, occupational complexity, language history, and opportunities to use cognitive skills can all influence test performance.

The clinician therefore attempts to reconstruct a reasonable estimate of prior functioning using educational, occupational, social, and historical information.

Standardized measures may contribute to this process when appropriate. The question is not simply, "How well does this person perform compared with other older adults?" It is also, "Is there convincing evidence that this person has declined from their own previous level of functioning?"

## Collateral Information and Functional History

Individuals experiencing cognitive decline may not always provide a complete account of their difficulties. Some have limited awareness of impairment. Others recognize changes but minimize them because they fear losing independence. Still others may overestimate cognitive decline because they are anxious or depressed.

Collateral information can therefore be valuable. With appropriate consent and attention to confidentiality, a spouse, adult child, close friend, caregiver, or other knowledgeable person may provide information about changes in memory, judgment, communication, behavior, daily activities, and safety. Collateral reports should not automatically be assumed to be objective. Family relationships have histories, conflicts, expectations, and differing interpretations. One relative may underestimate impairment because acknowledging it is emotionally difficult. Another may overestimate impairment because of caregiver stress or family conflict. The psychologist integrates collateral information rather than simply accepting it as fact.

Functional change deserves particular attention because it contributes to distinctions between mild and major neurocognitive disorders. The clinician may inquire about finances, medications, shopping, cooking, household maintenance, transportation, appointments, communication, technology, and other instrumental activities of daily living.

A person's environment must also be considered. Someone living with a highly involved spouse may appear independent because the spouse has gradually

assumed responsibilities without explicitly recognizing the change. Asking only whether the individual "still lives independently" can therefore miss important functional decline.

## Recognizing Early Signs of Mild Cognitive Impairment

Mild cognitive impairment can be challenging to recognize because people with MCI frequently remain capable of many ordinary activities. The changes may first become apparent during complex or unfamiliar tasks.

Early signs can include increasing repetition, greater dependence on reminders, difficulty remembering recent conversations, declining efficiency with finances, problems keeping track of appointments, increased difficulty learning new technology, word-finding problems, reduced organizational ability, or difficulty navigating unfamiliar environments. The exact presentation depends on the cognitive domain affected.

Memory concerns are common but should not be considered the only pathway to MCI. Some individuals primarily demonstrate executive, language, attention, or visuospatial changes. Hessen (2025) emphasizes the importance of neuropsychological characterization when evaluating MCI because classification can depend heavily on how cognitive impairment is operationalized and measured.

Subjective cognitive complaints should be taken seriously but interpreted cautiously. A person's report that memory has deteriorated can reflect genuine cognitive change, but subjective complaints can also be influenced by depression, anxiety, sleep disturbance, stress, medical illness, and beliefs about aging. Similarly, absence of a complaint does not establish normal cognition. Some neurocognitive disorders can reduce awareness of impairment. Family

observations and objective assessment can therefore become especially important when self-report and observed functioning differ.

MCI also should not be communicated as though progression to dementia is certain. Clinical monitoring is important because trajectories vary. The psychologist can help patients and families tolerate this uncertainty while encouraging appropriate medical evaluation and follow-up.

## Differentiating Dementia From Delirium

Distinguishing dementia from delirium is one of the most important differential diagnostic tasks in work with older adults. Delirium is characterized by an acute disturbance in attention and awareness accompanied by cognitive change, typically developing over a relatively short period, representing a change from baseline, and fluctuating in severity (American Psychiatric Association, 2022).

Dementia caused by a progressive neurodegenerative condition generally develops over a much longer period. Family members may describe changes occurring over months or years. Delirium, in contrast, may emerge over hours or days. The time course is therefore crucial. A psychologist evaluating an older adult who became dramatically confused within two days should not simply conclude that dementia has suddenly become severe.

Changes in attention and arousal are particularly important. A person with delirium may have substantial difficulty maintaining or shifting attention. Alertness can fluctuate. The individual may appear relatively engaged during one period and profoundly confused, lethargic, or agitated later. Delirium can be hyperactive, hypoactive, or mixed. Hyperactive presentations may involve agitation, restlessness, emotional lability, or perceptual disturbance. Hypoactive delirium can involve lethargy, reduced activity, slowed responses, and diminished engagement. Hypoactive presentations are particularly important because they

may be mistaken for depression, fatigue, or advanced dementia. Delirium can occur in a person who already has dementia. Preexisting cognitive impairment increases vulnerability, which means that the clinician should not dismiss acute confusion simply because dementia is already documented.

Brief structured tools such as the Confusion Assessment Method (Inouye et al., 1990) can support recognition, but a positive screen calls for medical evaluation, not psychological diagnosis.

Potential contributors to delirium include infection, medication effects, metabolic abnormalities, dehydration, surgery, pain, acute medical illness, intoxication, withdrawal, and other physiological disturbances. Determining the medical cause is outside the scope of routine psychological diagnosis and requires appropriate medical evaluation. This creates an important safety principle. A sudden, unexplained change in cognition, attention, consciousness, or behavior in an older adult warrants prompt medical consideration rather than routine scheduling for dementia testing.

## Differentiating Dementia From Depression

Depression can produce cognitive symptoms that resemble aspects of a neurocognitive disorder. Older adults with depression may report memory problems, difficulty concentrating, slowed thinking, reduced motivation, indecisiveness, and diminished ability to complete complicated activities.

Depression and dementia are also not mutually exclusive. A person with Alzheimer's disease can develop major depression, and a person with longstanding depression can later develop a neurocognitive disorder. Longitudinal evidence indicates meaningful associations between depression and later dementia risk, although the causal pathways remain an area of continuing investigation (Livingston et al., 2024).

Differentiation requires attention to history and symptom pattern. The psychologist should examine the timing of cognitive and depressive symptoms, course of change, functional history, psychiatric history, objective cognitive performance, medical conditions, and collateral observations.

Cognitive symptoms associated with depression may include reduced concentration, slowed processing, inefficient learning, and executive difficulties. Performance can sometimes be affected by reduced motivation or effort, but clinicians should not assume that poor cognitive performance in a depressed older adult simply reflects unwillingness to try. Likewise, emotional symptoms in a person with dementia should not automatically be attributed to neurodegeneration. Older adults with cognitive impairment can experience clinically significant depression and deserve appropriate assessment and treatment.

### *Apathy Is Not Necessarily Depression*

Apathy deserves special attention because it is common in several neurocognitive disorders and can resemble depression superficially. Apathy involves diminished motivation, initiative, or goal-directed activity. A person may stop initiating hobbies, conversations, household activities, or social contact. Family members may describe the individual as sitting for long periods unless prompted.

Depression, by contrast, involves a broader affective syndrome that may include depressed mood, loss of pleasure, guilt, hopelessness, sleep or appetite changes, suicidal thinking, and other symptoms. A person can have apathy without experiencing sadness or hopelessness.

The distinction matters because family members may interpret diminished initiation as evidence that the person is "giving up." In some neurocognitive disorders, particularly those affecting frontal systems, reduced initiation may

reflect neurological dysfunction rather than a depressive belief that activities are pointless. Apathy and depression can also coexist. Assessment should therefore evaluate each construct rather than assuming that one explains the other.

## Medical and Medication Contributors to Cognitive Symptoms

Cognitive complaints in older adults should be interpreted within the broader medical context. Numerous medical conditions can affect cognition, directly or indirectly. Sleep disorders, endocrine abnormalities, neurological disease, sensory impairment, acute illness, chronic pain, and other conditions can contribute to cognitive difficulties.

Medication review is also important. Older adults are more likely to use multiple medications, and some medications can contribute to sedation, confusion, slowed processing, or other cognitive effects. The psychologist should document relevant medication information and collaborate with prescribing professionals rather than independently recommending medication changes outside the psychologist's scope of practice.

Alcohol and other substances should not be overlooked simply because the patient is older. Substance use patterns, withdrawal, interactions between alcohol and medications, and longstanding substance-related effects can contribute to cognitive presentations.

Hearing and vision also deserve explicit assessment. A patient who cannot adequately hear test instructions may appear inattentive or confused. Poor vision can compromise performance on visually mediated tasks. These problems become especially important when standardized administration depends on intact sensory functioning.

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## Cultural and Linguistic Limitations of Cognitive Screening

One of the greatest risks in dementia assessment is assuming that a cognitive test measures the same construct in the same way for every individual.

Many commonly used cognitive instruments were developed and normed within cultural, linguistic, and educational populations. Performance can be influenced by language proficiency, literacy, educational opportunity, familiarity with testing, socioeconomic conditions, acculturation, and cultural expectations surrounding the assessment situation.

O'Driscoll and Shaikh (2017) identified significant considerations affecting the cross-cultural applicability of the MoCA. More recently, Chithiramohan et al. (2024) systematically reviewed culture-fair cognitive screening tools and emphasized the ongoing need for instruments capable of reducing cultural and educational bias.

Translation does not eliminate every problem. Czerwinski-Alley et al. (2024) reviewed the effects of translation and cultural adaptation on cognitive screening instruments and found that adaptation can influence test performance and diagnostic accuracy. A word, concept, drawing, educational task, or test-taking expectation that is familiar in one cultural setting may not have an equivalent meaning in another.

Nielsen (2022) similarly addressed cognitive assessment among culturally, linguistically, and educationally diverse older adults in Europe and highlighted the limitations associated with commonly used cognitive measures in diverse populations. These findings have direct ethical implications. A low score caused partly by educational or linguistic mismatch can contribute to an erroneous diagnosis of cognitive impairment. Conversely, inappropriate norms can also lead clinicians to miss genuine decline.

The psychologist should therefore consider whether the instrument has been appropriately validated for the individual being assessed, whether suitable normative data exist, whether language proficiency affects performance, and whether interpretation requires modification or substantial caution.

### *Working With Interpreters*

Assessment through an interpreter presents additional challenges. Psychological and neuropsychological tests rely on standardized wording, timing, prompts, and scoring. Interpretation can alter these features. When possible, evaluation in the patient's strongest language by a qualified clinician is preferable. When this is not possible, the psychologist should understand how interpreter involvement may affect standardization and should document relevant limitations. Family members should generally not be treated as interchangeable with trained interpreters for formal assessment. A family member may unintentionally simplify instructions, provide hints, answer for the patient, filter information, or alter the interaction based on family dynamics.

The psychologist should also distinguish language proficiency from cognitive ability. Difficulty naming an object in English, for example, does not necessarily indicate an acquired naming impairment if English is not the individual's strongest language.

### *Education and Literacy*

Formal educational attainment can significantly affect cognitive screening performance. Years of education are commonly recorded, but the number alone may not capture literacy or quality of educational opportunity.

An older adult who has limited access to formal schooling may find tasks involving drawing, calculation, abstraction, reading, or test-taking conventions unfamiliar.

Poor performance in such circumstances can reflect a mixture of cognitive ability and educational exposure.

Educational corrections built into some screening instruments may help but should not be assumed to remove all educational bias. The systematic review by Chithiramohan et al. (2024) underscores the continuing difficulty of developing genuinely culture-fair cognitive screening approaches. The clinician should therefore resist interpreting unfamiliarity with formal testing as neurological dysfunction.

### *Race, Ethnicity, and the Risk of Misclassification*

Race and ethnicity should not be treated as biological explanations for cognitive test differences. Observed group differences can reflect unequal educational opportunities, socioeconomic conditions, discrimination, health disparities, language, acculturation, healthcare access, and numerous other contextual influences.

Normative adjustments require thoughtful use. Their purpose should be to improve the accuracy of interpretation, not to convert broad social categories into assumptions about an individual's abilities. The psychologist should ask whether the normative comparison group is appropriate for the patient and whether available norms adequately represent the person's linguistic, educational, and cultural experiences. When appropriate norms do not exist, the ethical response may be to qualify the interpretation rather than presenting uncertain conclusions with false precision.

## Integrating Assessment Findings

Good dementia assessment is an exercise in integration. The clinician considers the presenting complaint, history, cognitive test performance, functional abilities,

behavioral observations, emotional functioning, medical context, medication effects, sensory abilities, cultural and linguistic factors, collateral information, and course over time. No single component should automatically override all others.

Consider an older adult who performs poorly on a memory screening task. If the patient also has severe untreated depression, substantial hearing loss, limited proficiency in the language of assessment, and no clear evidence of functional decline, the psychologist should not treat the screening result as definitive evidence of dementia.

Now consider another individual who obtains a score just above a screening cutoff but has experienced progressive repetition, getting lost in familiar locations, medication errors, financial mistakes, and documented decline from a previously high level of functioning. A "normal" screening score should not end the evaluation. The goal is clinical understanding rather than classification by arithmetic.

## Communicating Assessment Results

The manner in which findings are communicated can significantly influence patients and families. Cognitive diagnoses can generate fear, grief, relief, anger, or uncertainty. Psychologists should explain the difference between screening results and diagnostic conclusions. If findings are uncertain, uncertainty should be communicated accurately. Statements such as "your score proves you have Alzheimer's disease" are inappropriate when the evidence supports only possible cognitive impairment. Feedback should also include strengths. A patient may hear the word "dementia" and conclude that every cognitive ability is disappearing immediately. Explaining preserved abilities can help patients and families develop more realistic expectations and identify compensatory strategies.

The psychologist should use understandable language while avoiding infantilization. Cognitive impairment does not justify speaking about the patient as though the person is absent when family members are present. When a family member accompanies the patient, the psychologist can continue addressing the patient directly to the extent possible while incorporating collateral information appropriately.

## Clinical Application

Consider a 76-year-old retired professional whose spouse reports increasing repetition and difficulty managing household finances. The patient reports that memory is "probably normal for my age" and obtains a score on a brief cognitive screen that falls only slightly below expectations.

The psychologist should not begin and end with that score. The history of progressive change, discrepancy between self-report and collateral report, decline in a previously well-practiced instrumental activity, and the patient's prior level of functioning all deserve investigation. This example illustrates why competent assessment depends on clinical reasoning rather than mechanical scoring.

## Conclusion

Assessment and diagnosis of dementia require careful integration of cognitive, functional, medical, psychiatric, cultural, linguistic, and contextual information. Brief cognitive screening instruments can be useful, but they are not substitutes for diagnosis. Their scores must be interpreted in relation to the individual and the purpose of the assessment.

Psychologists should be able to recognize early manifestations of mild cognitive impairment while understanding that MCI does not inevitably progress to

dementia. They should also distinguish the gradual course commonly associated with neurodegenerative dementia from the acute and fluctuating disturbance characteristic of delirium. Depression presents another important diagnostic challenge because depressive symptoms can impair cognition, depression can coexist with dementia, and late-life depression has a complex relationship with subsequent cognitive decline.

Culturally responsive assessment requires particular caution. Language, literacy, education, cultural experience, and familiarity with testing can affect performance on cognitive screening measures. Recent systematic reviews continue to identify limitations in the cross-cultural application, translation, and adaptation of commonly used instruments (Chithiramohan et al., 2024; Czerwinski-Alley et al., 2024; Nielsen, 2022; O'Driscoll & Shaikh, 2017).

## Section 3: Behavioral and Psychological Symptoms of Dementia

Behavioral and psychological symptoms are among the most clinically challenging aspects of dementia care. These symptoms can include agitation, aggression, apathy, anxiety, depression, psychotic symptoms, sleep disturbance, irritability, disinhibition, repetitive behaviors, wandering, resistance to care, and changes in appetite or social behavior. They are sometimes grouped under the term behavioral and psychological symptoms of dementia, or BPSD. Although the terminology is widely used, psychologists should be cautious about allowing a diagnostic label to replace individualized assessment.

Behavioral and psychological symptoms do not occur in isolation from the person's medical condition, cognitive abilities, environment, interpersonal relationships, communication needs, and emotional experience. A person who

repeatedly attempts to leave a care setting may be responding to confusion, fear, an unmet need, a longstanding routine, loneliness, or a belief that they are expected somewhere else. A patient who strikes a caregiver during bathing may be experiencing pain, embarrassment, sensory overload, fear, or difficulty understanding what is happening. Treating the behavior only as "aggression" can obscure the conditions that produced it.

Recent clinical literature emphasizes the importance of nonpharmacological and person-centered approaches to BPSD, particularly when symptoms can be understood in relation to unmet needs, environmental demands, communication difficulties, or modifiable triggers (Abraha et al., 2017; Tible et al., 2017; Warren, 2022). Psychologists can contribute substantially by helping patients, caregivers, and interdisciplinary teams develop functional formulations of behavior and identify interventions that reduce distress without unnecessarily restricting autonomy.

## Understanding Behavioral and Psychological Symptoms

BPSD are not a single syndrome with a uniform cause. The same observable behavior may arise from very different processes. Agitation may reflect pain in one individual, overstimulation in another, and fear or inability to communicate in a third. Psychosis may arise as part of a neurodegenerative disorder, but sensory impairment, delirium, medication effects, or environmental misinterpretation may also contribute.

A comprehensive assessment begins by describing the behavior as specifically as possible. Statements such as "the patient is difficult" or "she becomes aggressive" are not sufficient clinical descriptions. It is more useful to identify what actually occurs, such as shouting during dressing, pushing a caregiver away when

approached from behind, repeatedly attempting to open an exit door in the afternoon, or accusing family members of stealing misplaced belongings.

This distinction matters because interventions are more effective when they are connected to a plausible mechanism. Behavioral formulations should include antecedents, consequences, timing, environmental conditions, interpersonal context, physical discomfort, communication demands, and recent changes in routine or health.

### *Agitation*

Agitation is one of the most common and disruptive behavioral symptoms encountered in dementia care. It can include pacing, repetitive questioning, verbal outbursts, restlessness, shouting, resisting care, or other behaviors associated with heightened distress or motor activity.

A systematic review and meta-analysis by Anantapong et al. (2025) identified agitation and aggression among prominent behavioral and psychological symptoms in acute hospital settings. Clinical interpretation requires attention to context because hospitalization itself can increase confusion, sensory disruption, sleep disturbance, unfamiliarity, and loss of routine.

Psychologists should avoid assuming that agitation is simply an unavoidable consequence of dementia. Assessment should consider pain, hunger, thirst, toileting needs, infection, medication effects, sleep disruption, environmental noise, excessive stimulation, boredom, loneliness, fear, communication failure, and demands that exceed the person's current cognitive abilities. The timing of agitation can also provide useful information. A person who becomes restless late in the afternoon may be fatigued or overstimulated after a full day of demands. Another patient may become agitated primarily during personal care because the procedure is confusing or experienced as intrusive. Behavioral intervention may

therefore involve changing the timing of an activity, reducing environmental stimulation, simplifying instructions, offering choices, increasing meaningful activity, addressing physical discomfort, or changing the approach of caregivers.

### *Aggression*

Aggression can include verbal threats, shouting, hitting, kicking, pushing, biting, throwing objects, or other behavior that places the person or others at risk. These events can be frightening for caregivers and staff and may quickly lead to requests for medication or placement changes.

The psychologist's first responsibility is safety, but assessment should proceed beyond the immediate behavior. Aggressive behavior may represent defensive responding in a person who does not understand why someone is touching or restraining them. It may emerge when a caregiver attempts to complete a task too quickly or continues after the individual signals distress.

Pain is another important possibility. A person who has difficulty communicating may respond physically when a painful joint is moved during dressing or bathing. Medical causes should therefore remain under consideration, particularly when aggressive behavior is new or substantially worse than baseline.

When safety permits, caregivers can be taught to reduce confrontation, approach from the front, identify themselves, explain what is about to happen, use short statements, allow additional processing time, and stop or modify an interaction when escalating distress is evident.

### *Apathy*

Apathy is characterized by reduced motivation, diminished initiation, and decreased engagement in goal-directed activity. It is often misunderstood as laziness, depression, or unwillingness to cooperate. The distinction between

apathy and depression is clinically important. A person with apathy may not initiate activities but may enjoy them once engaged. A depressed person may experience sadness, hopelessness, guilt, loss of pleasure, or other mood symptoms that are not required for a diagnosis of apathy. Apathy can significantly affect quality of life because the individual may gradually withdraw from activities that previously provided structure, identity, and interpersonal connection. Caregivers may become frustrated when repeated encouragement produces little spontaneous initiative.

Interventions often focus on modifying the environment and reducing the amount of initiation required from the person. Activities may need to be presented concretely rather than offered as open-ended choices. A caregiver might begin an activity with the individual rather than asking, "What would you like to do today?" The goal is not to fill every moment with stimulation. Excessive demands can increase fatigue or distress. Instead, the psychologist can help caregivers identify meaningful activities matched to the person's abilities, interests, energy, and history.

### *Anxiety*

Anxiety can remain clinically significant throughout the course of dementia. In earlier stages, anxiety may arise from awareness of cognitive decline, fear of dependence, concern about the future, or embarrassment about mistakes. Later, anxiety may be expressed behaviorally when language and abstract reasoning become more impaired.

A person may repeatedly ask when a family member is returning, follow a caregiver from room to room, resist being left alone, or become distressed during changes in routine. These behaviors may represent anxiety even when the individual cannot clearly articulate the underlying fear.

Psychologists should consider whether environmental predictability can be increased. Consistent routines, visual cues, simplified explanations, reassurance, and familiar objects may reduce uncertainty. Repeatedly correcting a confused person may be less helpful than responding to the emotional concern behind the question.

### *Psychosis*

Psychotic symptoms in dementia can include hallucinations, delusions, suspiciousness, or misidentification. Their meaning and clinical significance vary considerably.

Visual hallucinations are particularly associated with dementia with Lewy bodies, although psychotic symptoms can occur in other neurocognitive disorders. A person may see individuals, animals, or objects that are not present. Some hallucinations are frightening, while others are neutral or even comforting.

Delusions may involve beliefs that possessions have been stolen, a spouse is unfaithful, strangers are living in the home, or family members are impostors. These experiences can become especially distressing when the person acts on the belief.

Psychologists should first consider whether the experience is causing distress or creating risk. Arguing extensively about the belief may escalate conflict when the person's ability to integrate corrective information is impaired.

Environmental modification can sometimes reduce psychotic experiences or misinterpretations. Mirrors, shadows, television images, poor lighting, background noise, and unfamiliar surroundings may contribute to perceptual confusion. Improving lighting, reducing visual clutter, and removing triggering stimuli can be helpful when a clear association exists. New or rapidly worsening psychotic

symptoms should also prompt consideration of delirium, medical illness, medication effects, or sensory impairment.

## Functional Behavioral Assessment

Psychologists can apply principles of behavioral assessment to dementia care by identifying the events that occur before and after a behavior. Antecedents may include specific times of day, caregiving tasks, unfamiliar individuals, noise, transitions, requests, fatigue, or physical discomfort. Consequences may include attention, removal from an activity, access to preferred objects, or escape from a difficult task. Functional analysis does not require blaming caregivers. Caregivers often respond to difficult situations under substantial stress and with limited guidance. The goal is to identify patterns that can be modified.

For example, if aggression occurs only during bathing, the intervention should focus on the bathing routine rather than treating the person as globally aggressive. The team might consider water temperature, privacy, timing, caregiver approach, the order of tasks, sensory sensitivity, pain, and whether a full shower is necessary each time.

## Nonpharmacological Interventions

Nonpharmacological interventions represent an important component of BPSD management. Systematic reviews have evaluated approaches including caregiver training, environmental modification, behavioral strategies, structured activities, music-based interventions, sensory approaches, exercise, communication training, and person-centered care (Abraha et al., 2017; Tible et al., 2017).

The evidence is not equally strong for every intervention or every symptom. Psychologists should therefore avoid presenting nonpharmacological care as a

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single standardized treatment. The most useful approach is often individualized and hypothesis-driven.

Environmental modification can reduce unnecessary stimulation or confusion. Behavioral activation can increase meaningful engagement for individuals with apathy or reduced activity. Structured routines can reduce uncertainty. Caregiver training can improve communication and reduce interactions that unintentionally escalate distress. The guiding principle is that treatment should fit the individual rather than requiring the individual to fit the intervention.

## Communication as Behavioral Intervention

Communication is frequently central to BPSD management. A cognitively impaired person may require additional processing time, simpler sentence structure, fewer simultaneous choices, and more concrete language. Caregivers often increase verbal explanation when a patient does not understand. Unfortunately, longer explanations can increase cognitive demands. A more effective approach may be to use one instruction at a time, allow the person time to respond, supplement language with gestures or visual cues, and avoid rapidly repeating the same instruction. Tone and nonverbal behavior are also important. A hurried posture, elevated voice, abrupt touch, or visibly frustrated expression may be experienced as threatening even when the caregiver's words are neutral.

## When Behavioral Symptoms Represent Risk

Behavioral symptoms sometimes create immediate safety concerns. Aggression, wandering, self-neglect, unsafe driving, access to weapons, falls, suicidal behavior, or severe psychosis may require urgent intervention. Risk assessment should be individualized. The psychologist should document the nature, frequency, intensity, and context of the behavior; identify who may be at risk; determine whether the

risk is immediate; and coordinate with appropriate professionals. A behavioral formulation should never be used to minimize genuine danger. At the same time, restrictive interventions should not be used solely for staff convenience. Ethical practice requires balancing safety with autonomy, dignity, and the least restrictive reasonable approach.

## Collaboration With Medical Professionals

Psychologists should recognize when behavioral symptoms may indicate a medical problem. Abrupt behavioral change, new confusion, unusual sleepiness, rapidly worsening psychosis, fever, acute pain, or significant changes in mobility can warrant medical evaluation. Medication decisions are generally outside the psychologist's prescribing role unless the psychologist is appropriately credentialed in a jurisdiction permitting prescribing practice.

Psychologists should understand why nonpharmacological approaches are recommended first. Antipsychotic medications carry an FDA boxed warning for increased mortality in older adults with dementia-related psychosis. These medication risks require careful medical oversight (Tible et al., 2017). In 2023, brexpiprazole became the first medication approved by the FDA for agitation associated with Alzheimer's dementia, but it carries the same boxed warning (U.S. Food and Drug Administration, 2023). Most psychologists do not prescribe, but they can help teams and families understand these risks, document the behavioral context, and make sure nonpharmacological strategies have been tried and monitored.

Psychologists can also contribute valuable behavioral observations. They may identify the circumstances under which symptoms occur, track changes over time, document responses to nonpharmacological approaches, and communicate with medical providers.

## Supporting Caregivers

Behavioral and psychological symptoms frequently increase caregiver stress. A family member may tolerate memory impairment relatively well but feel overwhelmed by accusations, nighttime wandering, aggression, or repeated attempts to leave home. Psychoeducation can reduce personalization. Understanding that a behavior may reflect cognitive impairment, fear, pain, or environmental mismatch can change how caregivers respond. Caregivers also need permission to recognize their own limits. Supporting a person with severe behavioral symptoms can exceed what one family member can safely manage. Referral for respite, home services, adult day programs, behavioral consultation, support groups, or higher levels of care may become necessary.

## Clinical Integration

A useful clinical sequence is to describe the behavior, identify the context, investigate possible medical and environmental contributors, assess risk, develop a hypothesis about the function or meaning of the behavior, select a minimally restrictive intervention, and monitor the result.

If the intervention does not work, the psychologist revises the hypothesis rather than assuming that the person is "noncompliant." This framework reflects evidence-based practice because it combines available scientific literature, clinical expertise, patient characteristics, and contextual information. Behavioral and psychological symptoms are often dynamic. What works in one stage of dementia may become less effective later. Ongoing reassessment is therefore essential.

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### Conclusion

Behavioral and psychological symptoms of dementia require careful assessment rather than reflexive suppression. Agitation, aggression, apathy, anxiety, and psychosis can arise from neurodegenerative changes, medical conditions, environmental demands, communication difficulties, emotional distress, unmet needs, or combinations of these factors.

Psychologists are well positioned to contribute behavioral formulation, caregiver training, environmental consultation, communication strategies, risk assessment, and monitoring of intervention outcomes. Nonpharmacological approaches should be individualized, clinically justified, and adjusted as the person's abilities and circumstances change. A person-centered approach does not deny the neurological basis of dementia. Instead, it recognizes that behavior occurs within an interpersonal and environmental context and that modifying that context can sometimes reduce distress and improve quality of life.

## Section 4: Psychotherapeutic and Clinical Interventions for Older Adults Living With Dementia

Psychological treatment remains relevant after a person develops dementia, but the methods, expectations, and goals of treatment often need to change. Dementia can affect memory, executive functioning, attention, processing speed, language, insight, and the ability to transfer information from one setting to another. These changes may interfere with assumptions that underlie conventional psychotherapy, including the expectation that a patient will remember the previous session, independently complete homework, reflect on abstract cognitive patterns, and apply strategies learned several days earlier. The presence of cognitive impairment does not make psychotherapy inherently

inappropriate. Instead, it requires the psychologist to determine which abilities remain available and how treatment can be structured around those abilities.

Psychosocial interventions for people living with dementia encompass a broad range of approaches, including individually adapted psychotherapy, behavioral methods, caregiver-assisted interventions, communication training, cognitive and functional supports, reminiscence-based approaches, environmental modification, and person-centered care. The evidence supporting these methods is not uniform, and no single intervention is appropriate for every person living with dementia. Reviews of psychosocial interventions emphasize both the potential benefits and the importance of matching the intervention to the person's cognitive abilities, symptoms, environment, relationships, and stage of illness (Oyebode & Parveen, 2019). Psychologists therefore need to combine empirical evidence with clinical expertise, patient characteristics, treatment preferences, and ongoing assessment of outcomes.

## Establishing Appropriate Psychological Treatment Goals

Psychotherapy with an older adult who has dementia should begin with a clearly defined clinical question and realistic treatment goals. In the earlier stages of cognitive decline, treatment may focus on adjustment to diagnosis, anxiety, depression, interpersonal difficulties, grief, fear of dependence, changes in identity, or the emotional consequences of declining abilities. The person may still be capable of substantial reflection and participation in psychotherapy, particularly when information is presented in an accessible manner. At this stage, the psychologist should not assume that the diagnosis itself explains every emotional symptom. A person living with dementia can experience major depressive episodes, anxiety disorders, trauma-related symptoms, family conflict,

loneliness, bereavement, and other psychological difficulties that warrant assessment and treatment.

As cognitive impairment becomes more pronounced, goals may shift toward reducing distress, supporting meaningful activity, improving communication, maintaining daily routines, increasing successful participation in activities, and helping caregivers respond more effectively to behavioral or emotional symptoms. Treatment may become less dependent on abstract insight and more focused on present circumstances and observable functioning. In advanced dementia, conventional individual psychotherapy may no longer be feasible, but psychological care can continue through behavioral consultation, environmental modification, caregiver and staff education, emotional support, observation of nonverbal signs of distress, and interventions intended to preserve comfort and quality of life. Treatment should evolve with the patient rather than being discontinued merely because a previously used method is no longer effective.

An important aspect of treatment planning is distinguishing goals that are clinically meaningful from goals that are unrealistic. A psychologist should not promise restoration of lost cognitive functioning through psychotherapy. Psychological intervention can instead target distress, coping, behavioral functioning, relationships, adjustment, and quality of life. An individual may continue to experience cognitive decline while simultaneously becoming less anxious, participating in more meaningful activities, communicating more successfully with family members, or experiencing fewer distressing interactions. These outcomes represent legitimate and important treatment gains.

## Adapting Psychotherapy for Cognitive Impairment

The degree of adaptation required in psychotherapy depends on the person's cognitive profile rather than the diagnostic label alone. Two patients with the

same diagnosis may differ substantially in memory, language, attention, insight, and executive functioning. One patient may remember therapeutic conversations with minimal assistance, while another may require repeated reminders of the purpose of the session. Assessment of these abilities should guide decisions about session length, pacing, structure, homework, caregiver participation, and use of external supports.

A consistent session structure can reduce cognitive demands and improve predictability. The psychologist might begin by orienting the patient to the purpose of the meeting, briefly reviewing the previous session, identifying one or two priorities, completing the primary therapeutic work, and concluding with a concise summary. Repetition may be necessary, but it should be provided respectfully. A patient who cannot recall the previous session has not failed therapy. The treatment format needs to accommodate the memory difficulty.

Long and cognitively complex sessions may also become counterproductive. Fatigue can worsen attention and frustration, particularly in older adults with neurological illness, medical comorbidity, sleep disturbance, or slowed processing speed. The psychologist may need to reduce the number of topics addressed during a session, allow longer response times, and schedule appointments during periods when the person tends to function best. Some patients perform better earlier in the day, while others have different patterns. Individual observation is more useful than assuming that one schedule applies to all people with dementia.

External memory aids can support psychotherapy when used appropriately. These may include a written session summary, calendar, notebook, reminder card, visual cue, simplified coping plan, or caregiver-assisted reminder system. The psychologist should avoid creating elaborate organizational tools that exceed the patient's cognitive abilities. A one-sentence reminder placed in a visible location may be more useful than several pages of instructions. The success of an

intervention should be judged by whether the patient can use it in daily life, not by how comprehensive the written material appears.

## Cognitive Behavioral Therapy and Cognitive Adaptation

Cognitive behavioral approaches may be useful for selected individuals with mild cognitive impairment or dementia, particularly when anxiety, depressive symptoms, or adjustment difficulties are present. The degree to which traditional CBT can be used depends on the person's ability to recognize connections among situations, thoughts, emotions, and behavior. Standard CBT techniques such as lengthy thought records, complex cognitive restructuring exercises, and independent homework may become difficult as memory and executive functioning decline.

Adapted CBT may place greater emphasis on concrete situations, repetition, behavioral strategies, simplified coping statements, and in-session practice. Instead of asking a patient to record several automatic thoughts during the week, the psychologist might work with one recurring fear during the session and develop a short coping response. A caregiver may help reinforce the strategy between sessions when the patient agrees to that involvement, and confidentiality has been appropriately addressed.

Recent meta-analytic work has examined CBT in Alzheimer's disease and found potential effects on neuropsychiatric symptoms and quality-of-life-related outcomes, while also reflecting considerable variability across interventions and study designs (Gao et al., 2025). This literature supports cautious clinical application rather than the conclusion that a standardized CBT protocol is appropriate for every person with dementia. The psychologist should consider cognitive capacity, treatment goals, severity of impairment, and the person's ability to engage with the intervention.

Behavioral components of CBT may become especially useful as cognitive impairment progresses. Scheduling meaningful activities, reducing avoidance, establishing predictable routines, using environmental cues, and reinforcing successful participation may require less abstract reasoning than traditional cognitive restructuring. These strategies can also be easier for caregivers to support outside treatment sessions.

## Behavioral Activation and Meaningful Activity

Behavioral activation can be adapted for individuals who have become socially withdrawn, inactive, or apathetic. The goal is not simply to make the patient "busy." Activities should have meaning for the person and should be compatible with current abilities. An individual who previously enjoyed gardening may no longer be able to independently manage a large garden but may still enjoy watering plants, arranging flowers, or sitting outside while participating in a simplified gardening activity.

The psychologist should differentiate behavioral withdrawal related to depression from reduced initiation associated with apathy. A person with depression may avoid activity because of hopelessness, low mood, fatigue, or anticipated failure. A person with apathy may show little spontaneous initiation but still experience enjoyment once an activity is started. These different patterns can lead to different intervention strategies. Behavioral observation and caregiver information can help clarify whether the primary difficulty involves negative affect, motivation, cognitive initiation, environmental barriers, or a combination of factors.

Activities should also be adjusted to avoid repeated failure. Asking a former accountant with significant executive impairment to independently organize complicated financial records may be demoralizing rather than therapeutic. A better intervention may draw on aspects of the person's previous interests while

reducing cognitive complexity. Preserving meaning does not require preserving every previous level of performance.

## Supportive Psychotherapy

Supportive psychotherapy can be particularly useful when a person can benefit from emotional connection and structured conversation but has difficulty with cognitively demanding therapeutic techniques. Supportive therapy may focus on emotional expression, reassurance, validation, grief, adaptation, relationships, self-esteem, and maintenance of identity. It should not be confused with unstructured social conversation. The psychologist can establish treatment goals, assess symptoms, monitor change, and use clinical skills while reducing demands for abstract insight.

A person who has recently received a dementia diagnosis may need space to discuss fear of future dependency, concern about becoming a burden, anger about losing responsibilities, or grief about anticipated changes. The psychologist should not automatically redirect these concerns toward positive thinking. Emotional reactions to a serious diagnosis can be understandable and may need to be acknowledged before problem-solving is useful.

Supportive psychotherapy can also help patients identify areas of continuing competence. A diagnosis of dementia often shifts attention toward what the person can no longer do. Treatment can also identify relationships, activities, roles, and values that remain meaningful. This is not an attempt to minimize impairment. It is a way of constructing treatment around the person's remaining abilities and priorities rather than defining the individual entirely by losses.

As impairment advances, supportive work may become more immediate and experiential. The person may not remember the therapist's reassurance several days later, but emotional relief during the interaction can still have value. The

clinical objective may shift from retaining therapeutic insight to experiencing safety, respect, connection, and reduced distress in the present moment.

## Caregiver Participation in Psychological Treatment

Caregivers can play an important role in extending psychological interventions beyond the therapy session. They may help remind the patient of coping strategies, facilitate activities, implement environmental changes, observe behavioral patterns, and provide information about functional changes. Communication-training interventions for caregivers have received increasing attention because caregiver communication can affect both the interaction and the experience of the person living with dementia (Perkins et al., 2022).

Caregiver involvement must nevertheless be handled ethically. The psychologist should clarify who the patient is, what information may be shared, how confidentiality will be managed, and whether the person living with dementia agrees to caregiver participation when capable of providing such agreement. Cognitive impairment should not automatically transfer control of therapy to the family.

During joint sessions, psychologists should continue directing questions toward the person living with dementia whenever feasible. Family members may have become accustomed to answering quickly because communication takes longer. Although this may be efficient, it can gradually exclude the patient from conversations about their own care. Allowing additional response time and directly inviting participation can preserve autonomy and dignity.

The psychologist should also recognize when the caregiver has separate treatment needs. A spouse experiencing significant depression, anxiety, or burnout may need their own clinician or treatment relationship. Treating the caregiver

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informally within the patient's psychotherapy can create role confusion and confidentiality problems.

## Behavioral Approaches to Daily Functioning

Behavioral approaches can be especially useful when treatment goals involve everyday functioning. Rather than focusing solely on internal symptoms, the psychologist may examine how environmental cues, routines, task complexity, reinforcement, and caregiver responses influence successful participation.

A patient who frequently forgets medication instructions may not benefit from repeated education alone. The treatment plan may instead involve coordination with appropriate medical and caregiving professionals to develop a structured routine, visual cue, supervised system, or environmental prompt. The psychologist's role is not to independently manage medication but to recognize how cognitive limitations affect adherence and to support behavioral strategies within appropriate professional boundaries.

Tasks can also be broken into smaller steps. Someone who can no longer prepare a full meal independently may still participate successfully if ingredients are organized, unnecessary choices are reduced, and each step is cued. Functional intervention should aim to preserve participation where feasible rather than converting every difficulty into total dependence.

This approach is consistent with person-centered dementia care, which emphasizes the individual's abilities, preferences, relationships, and environment. The evidence base is heterogeneous, and the needs of the person living with dementia should guide adaptation of clinical strategies. Research on psychosocial caregiver interventions also highlights the importance of attending to the mental health and support needs of informal caregivers (Wiegelmann et al., 2021).

## Quality of Life as a Central Clinical Outcome

Quality of life deserves explicit attention in dementia treatment. If intervention is evaluated only by whether cognition improves, many clinically meaningful outcomes will be overlooked. Quality of life can include comfort, emotional well-being, meaningful activity, social connection, autonomy, dignity, familiarity, enjoyment, and the ability to participate in everyday decisions.

A patient may continue to forget recent conversations while experiencing less anxiety and greater enjoyment of daily activities. Another may require substantial assistance but continue to experience meaningful connections with family. A third may show no measurable improvement on cognitive testing while having fewer distressing behavioral episodes after environmental changes are introduced. These changes can represent important therapeutic outcomes.

Psychologists should therefore ask patients and caregivers what a good day looks like, which activities matter most, what situations produce distress, and which abilities the person most wants to preserve. Treatment goals can then be linked to those priorities whenever possible. Quality of life should not be defined exclusively by observers. Family members and clinicians may underestimate or overestimate a person's subjective well-being. When the individual can communicate preferences and experiences, those reports should remain central to treatment planning.

## Treatment of Anxiety

Anxiety can arise at multiple stages of dementia. In earlier stages, patients may worry about diagnostic uncertainty, future decline, dependency, loss of driving privileges, finances, or the effect of illness on family members. Treatment can include adapted CBT, relaxation methods, behavioral activation, problem-solving, supportive therapy, and environmental strategies.

As cognition declines, anxiety may be expressed more behaviorally. Repetitive questioning, following a caregiver closely, resistance to separation, pacing, or distress during transitions may reflect underlying fear or uncertainty. Extensive verbal explanation may become less useful if the person cannot retain it.

Predictability can become therapeutic. Consistent routines, familiar staff or caregivers, simplified choices, advance warning of transitions, and calm reassurance can reduce uncertainty. The psychologist should consider whether the environment repeatedly places the person in situations that require more memory or cognitive flexibility than they currently possess.

## Treatment of Depression

Depression should be assessed rather than assumed to be a normal consequence of dementia. Cognitive impairment can complicate diagnosis because symptoms such as reduced activity, concentration problems, sleep disturbance, and apathy can overlap with depression or neurodegenerative disease. The psychologist should therefore examine affective symptoms, behavioral changes, history, collateral information, suicidal thinking, and the relationship between mood symptoms and cognitive decline.

Psychological intervention may include behavioral activation, adapted CBT, supportive psychotherapy, social engagement, problem-solving, and interventions addressing loss, identity, and relationships. Treatment selection depends on cognitive ability and severity of depression.

Suicidal ideation should be assessed when clinically indicated. A diagnosis of dementia does not eliminate suicide risk. Research suggests risk may be highest in the months shortly after diagnosis, particularly for people diagnosed at younger ages (Alothman et al., 2022). Earlier stages may be particularly difficult for some patients because awareness of diagnosis and anticipated decline can produce

substantial distress. Risk assessment should follow appropriate professional and legal standards and should not be omitted merely because cognitive impairment is present.

## Cultural Responsiveness in Psychotherapy

Cultural context influences how dementia, psychological treatment, independence, caregiving, aging, and emotional expression are understood. Psychologists should not assume that Western ideals of individual independence or direct emotional disclosure are universally preferred.

Some families may understand cognitive decline primarily as a medical condition, while others may interpret it in spiritual, familial, or social terms. Certain cultures place strong emphasis on family-centered decision-making, while others prioritize individual privacy and independence. These differences should be explored rather than judged.

Communication strategies must also account for language. A person who was previously highly proficient in more than one language may show changing language abilities as dementia progresses. Conducting psychotherapy in a less familiar language can impose additional cognitive demands. Whenever feasible, treatment should occur in the language in which the person can communicate most effectively, with appropriate professional language support when needed.

Cultural responsiveness also means recognizing the patient's life history. Experiences of racism, migration, poverty, war, religious community, family obligation, gender expectations, or discrimination may shape treatment goals and relationships with healthcare professionals. Person-centered care is incomplete if it recognizes individual preferences while ignoring the cultural and social context in which those preferences developed.

## Professional Competence and Scope of Practice

Psychologists working with dementia should recognize the limits of their competence. Specialized neuropsychological assessment, complex neurological diagnosis, medical management, swallowing problems, medication decisions, and certain legal capacity questions may require consultation or referral.

Psychological intervention frequently occurs within an interdisciplinary system. Neurologists, geriatricians, primary care clinicians, psychiatrists, nurses, social workers, occupational therapists, speech-language pathologists, physical therapists, palliative care professionals, and other specialists may contribute information that changes psychological treatment planning.

Interdisciplinary collaboration should involve clear communication about roles. A psychologist can identify behavioral patterns or medication-related concerns without independently changing medication. Similarly, a psychologist can identify functional risk without assuming competence in every specialized capacity or forensic evaluation.

Professional competence also requires continuing education. Dementia care is evolving rapidly, and psychologists should remain current regarding diagnostic approaches, psychosocial intervention, communication, caregiver support, cultural assessment, and ethical practice.

## Monitoring Treatment Outcomes

Evidence-based psychological practice requires monitoring whether an intervention is helping. With dementia, outcome measurement may need to extend beyond conventional symptom scales.

The psychologist can monitor anxiety, depressive symptoms, frequency of distressing behaviors, participation in activities, quality of communication,

caregiver observations, functional success, and individualized quality-of-life indicators. When self-report becomes less reliable, collateral reports and behavioral observation may become increasingly important, but they should not automatically replace the patient's perspective when the patient remains able to communicate it.

Treatment plans should be revised when outcomes do not improve. A strategy that previously worked may lose effectiveness as cognition changes. Conversely, an intervention that was initially too difficult may become useful after the environment or caregiver support is modified. The psychologist should document both benefit and burden. An intervention that produces minimal improvement while causing substantial frustration may not be appropriate simply because it is theoretically evidence-based.

## Interdisciplinary Coordination

Dementia care frequently involves clinical issues that cross professional boundaries. A patient receiving psychotherapy for anxiety may also have untreated hearing loss, sleep disturbance, pain, medication effects, or mobility limitations that contribute to distress. Addressing only the psychological symptoms may therefore produce limited improvement.

Speech-language pathologists can assess communication and cognitive-communication difficulties. Occupational therapists can evaluate daily functioning and environmental adaptations. Physicians can investigate medical contributors to behavioral change and manage medications. Social workers can address caregiving resources, community services, placement concerns, and financial or systems barriers.

Psychologists contribute assessment of emotional functioning, behavioral formulation, psychotherapy, caregiver consultation, communication strategies,

treatment adaptation, and ethical reasoning. Collaboration allows each professional to contribute within their area of competence.

## Clinical Application: Early-Stage Dementia

Consider a 72-year-old patient with early Alzheimer's disease who has stopped attending a weekly social group because she is afraid that other members will notice her memory problems. She reports anxiety and embarrassment but continues to understand the diagnosis and participate actively in treatment.

An adapted intervention might include identifying the feared consequences of making a mistake, developing a brief coping statement, rehearsing how to respond if she forgets a name, scheduling a gradual return to the group, and arranging a simple reminder system. The psychologist might provide a brief written summary rather than a complex worksheet.

The goal would not be to eliminate the memory impairment. It would be to reduce avoidance and support continued participation in a valued activity. Progress could be assessed by anxiety, attendance, enjoyment, and the patient's sense of confidence.

## Integrating Psychotherapeutic and Clinical Care

Psychological intervention in dementia is most effective when clinicians move beyond the question of whether a person "can do therapy." A more useful question is what form of psychological care is appropriate given the person's current abilities, goals, emotional needs, relationships, environment, and stage of illness.

Some patients can participate in adapted CBT or supportive psychotherapy. Others benefit more from behavioral approaches, communication modification,

reminiscence, caregiver-supported strategies, or environmental intervention. These approaches are not mutually exclusive. Treatment often combines several elements and changes over time.

Evidence-based practice also requires humility about what the literature can establish. Psychosocial dementia studies differ substantially in intervention type, dementia severity, setting, duration, outcomes, and methodological quality. Reviews have identified promising benefits for several psychosocial and person-centered approaches while also emphasizing heterogeneity and limitations in the evidence base (Oyebode & Parveen, 2019; Wiegelmann et al., 2021). Psychologists should therefore avoid presenting one technique as universally validated for all people with dementia.

The strongest clinical approach combines scientific evidence with individualized assessment. The psychologist considers what the literature supports, what the patient can realistically use, what the person values, what the caregiving environment can sustain, and whether the intervention produces measurable benefit.

## Conclusion

Psychotherapeutic and clinical interventions for people living with dementia require adaptation rather than abandonment of psychological care. Cognitive impairment can alter memory, language, attention, executive functioning, and the ability to generalize treatment strategies, but patients may continue to experience emotional distress, relationships, preferences, values, and a need for meaningful psychological support.

Psychologists should remain attentive to cultural context, caregiver relationships, ethical boundaries, professional competence, and the changing nature of dementia. As abilities decline, the form of psychological treatment may shift from

individual psychotherapy toward behavioral consultation, environmental intervention, caregiver support, and interdisciplinary care. The underlying purpose remains consistent: to use psychological knowledge to reduce avoidable distress, preserve meaningful participation, support remaining abilities, and protect the dignity and quality of life of the person living with dementia.

## Section 5: Ethical, Legal, and Capacity Considerations in Dementia Care

Ethical practice with older adults living with dementia requires psychologists to balance several principles that may become increasingly difficult to reconcile as cognitive impairment progresses. Respect for autonomy remains important, but so do beneficence, nonmaleficence, dignity, privacy, protection from exploitation, and attention to safety. Dementia complicates these responsibilities because cognitive abilities may change over time, fluctuate with medical or environmental conditions, and affect some decisions more than others. These responsibilities are grounded in the APA Ethical Principles of Psychologists and Code of Conduct, particularly the standards addressing competence, informed consent, privacy and confidentiality, and assessment (American Psychological Association, 2017).

Psychologists should approach ethical decision-making in dementia through an individualized and functional framework. The central questions are not simply whether the person has dementia or whether a cognitive test score falls below a cutoff. More clinically useful questions concern the specific decision being considered, what the person understands about that decision, whether the individual appreciates its consequences, how consistently preferences are expressed, what supports could improve participation, and whether temporary factors are interfering with decision-making. Shared and supported decision-making approaches are particularly important because people living with

dementia can often remain involved in meaningful decisions even when they require assistance to understand information or communicate preferences (Daly et al., 2018).

Ethical practice should also be distinguished from legal determination. Laws governing guardianship, healthcare proxies, capacity, involuntary intervention, abuse reporting, driving, duty to protect, and surrogate decision-making vary by jurisdiction. Psychologists should understand the laws applicable to their practice setting, but they should avoid presenting general ethical principles as though they were universal legal rules. Consultation with qualified legal counsel, risk management resources, ethics committees, supervisors, or other knowledgeable professionals may be appropriate when legal consequences are significant or uncertain.

## Informed Consent in the Context of Cognitive Impairment

Informed consent is not merely the completion of a form. It is an ongoing process through which the patient receives information about the nature and purpose of psychological services, reasonably foreseeable risks and benefits, alternatives when applicable, confidentiality and its limits, fees or administrative requirements, and other information necessary for meaningful participation. Cognitive impairment can affect this process, but it does not eliminate the psychologist's responsibility to communicate directly with the patient.

When dementia is present, informed consent may require modification of the way information is presented. The psychologist may need to use shorter explanations, avoid unnecessary jargon, divide information into smaller portions, repeat essential points, provide written or visual supports, and allow additional time for questions. The purpose of these accommodations is not to lower ethical standards. It is to make informed participation more accessible.

A person may understand simple treatment decisions but struggle with highly complex ones. For example, an individual may be capable of deciding whether to participate in supportive psychotherapy while being unable to understand a complicated financial contract. Capacity is therefore generally considered decision-specific rather than all-or-none. Lühnen et al. (2019) emphasized the importance of supporting informed decision-making for people with dementia and the individuals acting on their behalf, particularly as decisional abilities change over the course of illness.

The psychologist should also distinguish inability to recall information later from inability to understand it at the time of consent. Memory impairment can complicate informed consent, but the relevant clinical question includes whether the person can comprehend the information sufficiently to make the decision. When important information is easily forgotten, consent discussions may need to be revisited periodically rather than relying on a single conversation conducted months earlier.

## Decision-Making Capacity

Decision-making capacity refers broadly to the abilities required to make a particular decision. In clinical contexts, commonly considered abilities include understanding relevant information, appreciating how that information applies to one's own situation, reasoning about available options, and communicating a choice. The specific requirements vary according to the decision and legal context, so psychologists should be cautious about applying a single capacity framework without attention to jurisdiction and referral purpose.

A dementia diagnosis alone does not establish incapacity. Many individuals with mild dementia continue to participate effectively in medical, psychological, financial, and personal decisions. Even in more advanced disease, some

preferences and choices may remain clear and consistent. Ethical practice therefore favors preserving the person's participation rather than transferring decision-making authority prematurely.

Assessment should focus on functional abilities rather than diagnostic labels. The psychologist may ask the person to explain the decision in their own words, describe perceived benefits and risks, compare alternatives, and indicate what matters most to them. Performance should be interpreted in the context of language, education, sensory ability, fatigue, psychiatric symptoms, and medical status. The seriousness of the decision may also affect the level of scrutiny required. A patient's difficulty making one highly complex decision should not automatically be generalized to every area of life.

### *Fluctuating Capacity*

Capacity can fluctuate. Dementia with Lewy bodies may involve variation in cognition and alertness, while delirium, infection, medication effects, fatigue, pain, sleep deprivation, metabolic disturbance, dehydration, and acute illness can temporarily worsen cognition in people with many forms of dementia.

This variability has important ethical consequences. A patient who appears unable to understand a decision during an episode of delirium may regain meaningful decisional abilities after the acute condition resolves. When circumstances permit, high-stakes decisions should be addressed when the patient is functioning near their best baseline rather than during a period of temporary impairment.

Timing can therefore be an ethical intervention. Scheduling a consent discussion at a time of day when the person is typically more alert, ensuring hearing aids or glasses are available, treating pain, minimizing environmental distractions, and simplifying communication may meaningfully improve participation. The clinician should document the circumstances under which capacity-related observations

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were made. A statement that "the patient lacks capacity" is less clinically useful than documentation describing the decision at issue, information presented, responses observed, supports provided, and factors that may have affected performance.

### *Supported Decision-Making*

Supported decision-making seeks to preserve the person's agency by providing assistance that enables participation rather than immediately replacing the person's decision with someone else's. Support can include simplified information, repetition, visual materials, additional time, communication assistance, trusted family members, or structured comparison of options.

Shared decision-making literature in dementia suggests that people with cognitive impairment can remain involved in everyday and healthcare decisions when communication and environmental supports are appropriately adapted (Daly et al., 2018). The degree of participation will vary, but the ethical goal is to preserve involvement to the greatest extent reasonably possible.

Supported decision-making is especially relevant in psychological practice because clinicians regularly make decisions about treatment goals, session structure, family involvement, confidentiality, scheduling, and behavioral interventions. These decisions should not automatically be redirected to family members simply because dementia has been diagnosed.

The psychologist should also avoid confusing agreement with capacity. A patient is not necessarily competent because they agree with the clinician, nor incompetent because they refuse. Capacity concerns the quality of the decision-making process rather than whether the final choice is convenient or consistent with professional recommendations.

### *Surrogate Decision-Making*

When a person is unable to make a particular decision, an authorized surrogate may become involved. The identity and authority of that person depend on applicable law, advance directives, healthcare proxy documents, guardianship arrangements, and institutional policies.

Surrogate decision-making should remain connected as closely as possible to the patient's known values and preferences. When prior wishes are known, substituted judgment may guide decisions by asking what the person would likely have chosen. When preferences are unknown or cannot reasonably be inferred, decision-makers may be required to consider the person's best interests.

Family members can experience considerable emotional burden when asked to make decisions for someone with dementia. Decisions about hospitalization, feeding, long-term care placement, life-sustaining treatment, or transitions to comfort-focused care may produce guilt, uncertainty, disagreement, and fear of making the wrong choice. Psychologists can help families clarify values, identify emotional conflicts, improve communication, and distinguish their own preferences from the patient's previously expressed wishes.

Lühnen et al. (2019) developed an educational program addressing informed decision-making for legal representatives of people with dementia, reflecting the complexity of surrogate participation and the need for structured support. The psychologist's role may include helping surrogates understand that their responsibility is not simply to choose what they personally prefer.

## Family Involvement and Confidentiality

Family members often possess clinically valuable information, but family involvement does not eliminate confidentiality. The psychologist should clarify the

patient's preferences regarding who may participate in sessions, what information may be shared, and how communication will occur as cognition changes. A family member may provide collateral information even when the psychologist cannot disclose confidential information in return. The clinician should understand applicable law and professional standards concerning receiving versus releasing information. When the patient retains decision-making ability, family members should not automatically be given access to psychotherapy content simply because they provide transportation or caregiving. At the same time, rigid exclusion of caregivers can undermine treatment when memory impairment makes their participation necessary for implementing interventions. Ethical practice requires a thoughtful balance rather than a universal rule. The psychologist should establish these boundaries early whenever possible. As dementia progresses, conversations about future family involvement may be easier to conduct before significant decisional impairment develops.

## Risk Assessment in Dementia

Risk assessment with dementia may involve suicidality, self-neglect, exploitation, abuse, aggression, wandering, unsafe driving, medication errors, financial vulnerability, falls, access to weapons, or inability to respond appropriately to emergencies. The psychologist should assess the nature of the risk, its immediacy, frequency, context, likely consequences, and available protective factors. Cognitive impairment may affect the reliability of self-report, so collateral information and behavioral observations may become particularly important.

A patient who repeatedly wanders outside at night presents a different level of concern from one who enjoys supervised daytime walking. Similarly, occasional medication reminders differ from repeated serious dosing errors. The goal is not

to generate a list of possible dangers but to determine which risks are clinically meaningful and what intervention is proportionate.

### *Abuse, Neglect, and Exploitation*

People living with dementia can be vulnerable to physical abuse, emotional abuse, neglect, financial exploitation, and coercion. Cognitive impairment may make it difficult to recognize exploitation, report it consistently, or provide detailed accounts. Psychologists should take concerns seriously even when memory is impaired. Inconsistency does not automatically mean an allegation is false.

Financial exploitation deserves particular attention because impaired judgment and increased dependence can create opportunities for misuse of money or property. Sudden financial changes, unexplained transfers, new individuals exerting control, fearfulness around a caregiver, or unexplained deprivation may warrant further inquiry. Mandatory reporting requirements differ across jurisdictions. Psychologists should know the relevant adult protective services laws and professional obligations in the locations where they practice.

### *Driving and Firearms*

Driving is one of the most emotionally charged safety issues in dementia care because it is closely tied to independence and identity. A dementia diagnosis alone does not mean a person must stop driving, but risk increases as the disease progresses. Warning signs include family concern about driving safety, recent crashes or traffic citations, getting lost on familiar routes, and the person reducing or avoiding driving on their own (Iverson et al., 2010). A cognitive screening score alone does not predict driving safety, and a formal on-road evaluation is often the most informative next step. Reporting requirements for unsafe drivers vary by state. Firearm access also deserves routine, direct questions, because impaired judgment, paranoia, depression, and misidentification of family members can

create serious risk. Psychologists can help families plan safe storage or removal of firearms early, ideally while the person can still take part in the decision.

### *Duty to Protect and Threat Assessment*

Dementia can occasionally involve threats, aggression, paranoia, or impaired judgment that raises concern about harm to others. The psychologist should assess such threats in context rather than assuming they are either meaningless because of dementia or automatically predictive of violence. Threat assessment should consider intent, planning, access to means, history of aggression, psychosis, environmental triggers, cognitive ability to carry out the threat, caregiver vulnerability, and the immediacy of danger. Legal duties to warn or protect vary by jurisdiction. Psychologists should therefore apply the law and professional standards relevant to their practice setting rather than relying on a universal rule. Consultation and documentation are especially important when a clinician is uncertain whether a threat triggers legal obligations.

## End-of-Life Care and Advanced Dementia

Advanced dementia raises complex ethical issues involving comfort, hospitalization, artificial nutrition and hydration, infection treatment, symptom management, resuscitation, and other medical decisions. Psychologists generally do not make these medical decisions, but they frequently work with patients, caregivers, and interdisciplinary teams affected by them.

Communication about nutrition and hydration can become particularly difficult in severe dementia. Anantapong et al. (2022) described the challenges multidisciplinary teams and families face when discussing nutrition and hydration in acute hospital care. These conversations can involve strong emotional and cultural meanings surrounding feeding, caregiving, hope, suffering, and

responsibility. Psychologists can help families process grief, guilt, conflict, and anticipatory loss while supporting communication with medical professionals. The psychologist should not present personal values as clinical recommendations.

### *Dignity in Advanced Dementia*

Advanced dementia may substantially reduce language, mobility, and independence, but it does not eliminate dignity. Ethical care continues to require respect for privacy, comfort, personal history, preferences, cultural identity, and relational needs. Care practices can unintentionally undermine dignity when clinicians speak about the person in their presence, expose the body unnecessarily, use infantilizing language, or assume that limited verbal communication means the individual has no preferences. Behavioral responses may continue to communicate comfort or distress. Facial expression, vocalization, body movement, withdrawal, and resistance can therefore provide clinically relevant information. The psychologist can help caregivers and staff interpret these behaviors without assuming they are meaningless symptoms.

## Ethical Consultation and Professional Competence

Dementia cases can involve conflicts among autonomy, safety, family wishes, institutional policies, and legal requirements. Psychologists should recognize when a case exceeds their competence or when multiple ethically defensible options exist.

Consultation with colleagues, neuropsychologists, physicians, ethics committees, attorneys, risk management professionals, or other specialists can strengthen decision-making. Seeking consultation is not evidence of professional weakness. In complex dementia cases, consultation can be an important expression of competence. Documentation should describe the clinical facts, ethical concerns,

consultation obtained, alternatives considered, patient preferences, family involvement, and rationale for decisions.

### Conclusion

Ethical care for people living with dementia requires psychologists to preserve autonomy and dignity while responding appropriately to cognitive impairment, risk, and changing decisional abilities. Dementia should never be treated as automatic evidence of global incapacity.

Informed consent should be adapted to cognitive needs and revisited when circumstances change. Capacity should be considered in relation to the specific decision. Supported decision-making should be used whenever it can preserve meaningful participation. Surrogates may become necessary when decisional abilities are insufficient, but the patient's values and previously expressed wishes should remain central.

Risk assessment, family involvement, confidentiality, driving, exploitation, duty to protect, advance care planning, and end-of-life decisions require careful clinical reasoning and awareness of jurisdiction-specific law. Ethical practice in dementia is therefore not a matter of choosing autonomy over safety or safety over autonomy. It requires proportional, individualized, well-documented decisions that respect the person while addressing clinically meaningful risk.

## Section 6: Caregiver Support and Systems of Dementia Care

Dementia affects not only the person who receives the diagnosis but also the family members, friends, and professionals who provide care. As cognitive and functional abilities decline, caregivers may assume increasing responsibility for

transportation, appointments, medication routines, finances, household tasks, supervision, behavioral management, communication with healthcare professionals, and eventually personal care. These changes can develop gradually, which means that families may adapt to increasing responsibilities without recognizing how extensive the caregiving role has become. Psychologists working with older adults living with dementia should therefore evaluate the caregiving system as part of the broader clinical picture rather than focusing exclusively on the diagnosed individual.

Caregiving can include meaningful experiences such as closeness, reciprocity, fulfillment, family responsibility, and a sense of purpose. At the same time, prolonged caregiving can place substantial emotional, physical, social, occupational, and financial demands on the caregiver. Contemporary reviews of dementia caregiving interventions indicate that caregiver outcomes can improve through appropriately targeted psychosocial interventions, although effects vary depending on intervention type, caregiver characteristics, dementia severity, and the outcomes being measured (Wiegelmann et al., 2021). For psychologists, the practical implication is that caregiver support should be individualized rather than reduced to a recommendation that the caregiver simply "take better care of themselves."

## Understanding the Caregiving Role

Caregiving responsibilities can differ considerably depending on the stage and type of dementia. In earlier stages, a spouse or adult child may provide reminders, transportation, assistance with appointments, or oversight of finances. As cognitive impairment progresses, the caregiver may assume responsibility for medications, meals, safety monitoring, hygiene, mobility, and supervision. Behavioral and psychological symptoms can further increase demands because

the caregiver may need to respond to agitation, repetitive questioning, wandering, sleep disruption, suspiciousness, hallucinations, aggression, or resistance to care.

The relationship between dementia severity and caregiver distress is not always straightforward. Some caregivers experience substantial distress during early stages because the diagnosis creates uncertainty and anticipatory grief. Others experience greater strain later, when physical care demands and behavioral symptoms intensify. Relationship history, health status, financial resources, family support, cultural expectations, caregiver coping style, availability of services, and the living arrangement all influence the caregiving experience. A comprehensive psychological assessment should therefore explore the actual demands being placed on the caregiver rather than estimating burden solely from the patient's diagnosis.

It is also important to distinguish caregiving tasks from the psychological meaning attached to them. A spouse may be physically capable of helping but experience profound grief over the loss of mutual decision-making. An adult child may manage appointments effectively while struggling with guilt about balancing caregiving with employment and parenting responsibilities. Another caregiver may experience resentment because other relatives provide little assistance. These emotional responses do not necessarily indicate poor commitment. They may reflect the complexity of prolonged caregiving under changing circumstances.

## Caregiver Burden

Caregiver burden is a multidimensional construct that can include emotional distress, physical fatigue, financial strain, reduced social activity, disruption of employment, conflict with family members, sleep disturbance, and a perceived loss of personal freedom. Reviews of psychosocial interventions for dementia

caregivers consistently identify burden, depression, anxiety, and quality of life as important caregiver outcomes (Wiegelmann et al., 2021). The experience of burden is subjective, which means that two caregivers facing similar practical demands may perceive those demands very differently.

Psychologists should assess specific components of burden rather than relying on a single general question. One caregiver may be primarily exhausted by nighttime supervision, while another is distressed by verbal aggression. A third may experience little emotional distress but severe financial pressure because paid care is unaffordable. Understanding the primary source of burden helps the psychologist identify interventions that are more likely to be useful.

Caregiver burden can also affect the person living with dementia. A chronically exhausted caregiver may have less patience, may communicate more abruptly, or may unintentionally increase environmental tension. This does not mean the caregiver should be blamed for behavioral symptoms. Rather, caregiver stress and patient behavior can become part of a reciprocal cycle. Supporting the caregiver may therefore improve the caregiving environment as well as the caregiver's own well-being.

## Caregiver Burnout

Caregiver burnout may develop when caregiving demands consistently exceed the caregiver's available emotional, physical, social, or financial resources. Burnout can involve exhaustion, irritability, emotional detachment, hopelessness, resentment, reduced empathy, and a sense that the caregiving situation has become impossible to sustain. These reactions warrant attention because they can affect both caregiver health and patient safety.

A psychologist should not frame burnout as evidence that the caregiver has failed. Instead, burnout can be understood as an indication that the current care

arrangement needs to be reassessed. The person providing care may have developed medical problems of their own, may have reduced mobility, may be working full-time, or may simply have reached the limits of what one person can manage. A care plan that depends on unlimited caregiver availability is not sustainable.

Assessment should include practical questions about how many hours of care are being provided, whether the caregiver receives uninterrupted sleep, whether other people assist, whether the caregiver has time away from caregiving, and whether caregiving is affecting employment or medical care. These questions can reveal risks that may not emerge from a general discussion of stress.

## Depression, Anxiety, and Other Mental Health Concerns

Caregiving stress does not automatically constitute a mental disorder, but caregivers can develop clinically significant depression, anxiety, trauma-related symptoms, or other conditions. Reviews of psychosocial interventions indicate that cognitive behavioral and other structured psychological approaches can improve some mental health outcomes among informal dementia caregivers, although effectiveness varies across studies (Wiegelmann et al., 2021). Psychologists should therefore assess caregivers for clinically significant symptoms when appropriate rather than assuming that distress is merely an unavoidable consequence of caregiving.

Persistent hopelessness, loss of interest, severe sleep disturbance, panic, marked functional impairment, or suicidal ideation warrant direct assessment. A caregiver who reports being "at the end of my rope" may be using an idiom of exhaustion, but the psychologist should clarify whether this statement reflects frustration, depression, suicidal thinking, or fear of harming the care recipient.

Role clarity becomes important when the psychologist is primarily treating the person with dementia. Brief caregiver education or consultation may be clinically appropriate within the patient's treatment, but extensive psychotherapy for the caregiver can create confusion regarding who the patient is and whose treatment goals are primary. When a caregiver has substantial independent treatment needs, a separate treatment relationship or referral may be appropriate.

## Psychoeducation for Caregivers

Psychoeducation is a central component of caregiver support, but effective psychoeducation involves more than handing families a brochure. Caregivers need information that is relevant to the challenges they are currently facing and presented in a form they can understand and use. Reviews of psychoeducational interventions have identified potential benefits for caregiver knowledge, burden, mood, and coping, while also showing that engagement and intervention design influence outcomes (Wiegelmann et al., 2021).

Early psychoeducation may include information about the nature of dementia, expected cognitive changes, differences between dementia and delirium, communication strategies, safety, and the possibility of behavioral symptoms. Later education may focus on personal care, environmental modification, wandering, agitation, advanced care planning, or transitions to higher levels of care.

Information should be paced carefully. Families who have just received a diagnosis may become overwhelmed if clinicians immediately describe every possible complication of advanced dementia. Education is often more useful when it anticipates the next likely set of decisions without forcing families to absorb the entire course of illness at once.

## Skills Training and Behavioral Consultation

Caregiver education becomes more clinically useful when it includes behavioral skills training. A caregiver may understand that arguing with a confused person is ineffective but still struggle to respond differently during a stressful interaction. Psychologists can teach caregivers to identify antecedents, modify environmental triggers, simplify instructions, increase predictability, reinforce successful participation, and respond to emotional meaning rather than repeatedly correcting factual errors.

Role-play can help translate information into behavior. For example, the psychologist might rehearse how to respond when the person repeatedly asks to go home, refuses to bathe, or becomes suspicious about missing belongings. Caregivers can practice shorter language, validation, redirection, or offering limited choices. The therapist can then refine the approach based on what feels realistic for the caregiver. Behavioral plans should also be evaluated over time. A strategy that reduces distress for several months may become less effective as cognition changes. Caregiver consultation should therefore include follow-up and revision rather than presenting recommendations as permanent solutions.

## Cognitive Behavioral Approaches for Caregivers

Cognitive behavioral approaches can be helpful when caregiver distress is intensified by rigid beliefs, guilt, catastrophizing, or unhelpful expectations. A caregiver may believe, "If I ask for help, I am failing," "No one else can care for him correctly," or "A good daughter should never consider residential care." These beliefs can increase distress and prevent the caregiver from using needed resources.

Intervention should not dismiss family or cultural values. Instead, the psychologist can examine whether the belief is helping the caregiver act consistently with

those values or creating an unsustainable standard. For example, accepting outside help may allow a caregiver to remain emotionally available rather than becoming completely exhausted. Evidence syntheses of dementia caregiver interventions suggest that psychotherapeutic components can improve caregiver outcomes, including burden and depressive symptoms, although effect sizes and intervention formats vary (Wiegelmann et al., 2021). Psychologists should present these interventions as evidence-informed options rather than guaranteed solutions.

## Social Support and Support Groups

Caregiver isolation is common because increasing supervision needs can make it difficult to maintain friendships, hobbies, employment, or community involvement. Social withdrawal can occur gradually as the caregiver declines invitations because leaving the person with dementia becomes too complicated.

Support groups can provide validation, practical ideas, and connection with others facing similar challenges. Some caregivers benefit from diagnosis-specific or relationship-specific groups, such as programs for spouses or adult children. Others prefer individual counseling or informal community support. The usefulness of groups varies. A caregiver in the early stages of adjustment may find descriptions of advanced dementia overwhelming, while another may value the opportunity to prepare. Psychologists should therefore discuss group fit rather than assuming all caregivers will benefit equally.

## Care Coordination and Transitions

Care transitions are periods of particular vulnerability. A person with dementia may move from home to hospital, hospital to rehabilitation, rehabilitation back home, or home to long-term care. Each transition creates opportunities for

information loss, medication confusion, behavioral destabilization, and caregiver stress.

Care transitions for people living with dementia may require coordination among clinicians, families, and community services. Communication across care settings can reduce avoidable confusion and clarify follow-up responsibilities.

### *Home Health and Home-Based Services*

Many people with dementia prefer to remain at home for as long as feasible. Home health and community-based services can support this goal by providing nursing care, rehabilitation, personal assistance, and other services depending on eligibility and local availability.

Home-based care also allows clinicians to observe the interaction between cognition and environment. A patient who appears highly impaired in a clinic may function more effectively in a familiar home setting. Conversely, home observation may reveal hazards that were not apparent in the office, such as unsecured medications, fall risks, poor lighting, or confusing routines. Psychologists should understand the general role of home services but avoid promising services for which the patient may not qualify. Eligibility depends on healthcare systems, insurance, geography, and local resources.

### *Adult Day Programs and Community Resources*

Adult day programs can provide supervision, structured activities, social interaction, meals, and respite for caregivers. Community programs may also include memory cafés, caregiver education, transportation, meals, exercise, legal resources, benefits counseling, and social activities.

A referral should be evaluated for practical fit. Transportation may be unavailable, fees may be prohibitive, the program may not offer services in the person's

language, or the schedule may conflict with caregiver employment. A recommendation is only useful when the family can realistically use it. Psychologists can improve follow-through by asking whether the caregiver was able to contact the program, whether the patient attended, and whether the service was acceptable. This follow-up helps distinguish a theoretically appropriate resource from one that is accessible.

### *Long-Term Care, Assisted Living, and Memory Care*

As dementia progresses, families may consider assisted living, memory care, or skilled nursing care. These decisions can be emotionally difficult because residential placement may be associated with guilt, grief, stigma, financial concerns, or fear that the person will feel abandoned.

Psychologists should avoid framing placement as either a failure or an inevitable outcome. The relevant question is whether the current environment can safely and sustainably meet the person's needs. Factors may include wandering, falls, nighttime supervision, personal care needs, caregiver health, aggression, medical complexity, and the availability of community support.

The transition can be particularly difficult when family members disagree. A psychologist can help clarify the patient's previously expressed preferences, the caregiver's capacity, and the realistic demands of remaining at home. Placement does not end caregiving. Family members often continue to visit, advocate, participate in decisions, accompany the person to appointments, and provide emotional connection. The caregiving role changes rather than disappearing.

### *Palliative Care and Hospice*

As dementia becomes advanced, palliative approaches may become increasingly relevant. Palliative care focuses on comfort, symptoms, communication, quality of

life, psychosocial support, and goals of care. Hospice care may become appropriate when eligibility criteria are met, although specific criteria vary across healthcare systems.

Psychologists can support caregivers through anticipatory grief, family conflict, guilt, uncertainty, and changing treatment goals. They can also help families communicate values and concerns to medical teams. A shift toward comfort-focused care should not be interpreted as abandonment. It represents a change in goals when burdensome interventions may no longer be consistent with the patient's values or clinical situation.

## Cultural and Systemic Considerations in Caregiving

Caregiving expectations are influenced by culture, family structure, religion, gender roles, socioeconomic circumstances, and community norms. In some families, caring for an older relative at home is viewed as a central moral responsibility, and residential placement may carry significant stigma. In others, professional care may be viewed as the safest and most appropriate option.

Psychologists should explore these beliefs without stereotyping. A caregiver may deeply value family responsibility and simultaneously recognize that the current arrangement is unsafe. Culturally responsive practice allows both realities to be discussed.

Systemic barriers can further shape caregiving options. Families with limited financial resources may have fewer choices about respite, home care, transportation, or residential placement. Rural families may have little access to specialty services. Language differences can restrict access to caregiver education and support groups. A treatment plan that ignores these structural constraints can unintentionally blame families for failing to use services they cannot realistically obtain.

## Caregiver Safety and Risk of Harm

Severe caregiver stress can increase the risk of neglect, harsh interactions, or abuse, particularly when caregivers are isolated, sleep deprived, and attempting to manage difficult behavioral symptoms without support. This does not mean that stressed caregivers are inherently abusive. It does mean that clinicians should assess risk when warning signs are present.

A caregiver who reports feeling afraid that they may "snap" should be taken seriously and responded to without judgment. The psychologist should assess immediate safety, access to respite, family support, crisis resources, and whether the current care setting remains appropriate. The safety of the caregiver also matters. A caregiver who is being struck, pushed, or threatened by a person with dementia may require immediate support and changes to the care plan. Family loyalty should not be used to justify unsafe conditions.

## Conclusion

Caregiver support is an essential component of competent dementia practice because the functioning of the caregiver and the person living with dementia are closely interconnected. Caregivers may experience burden, chronic vigilance, sleep disruption, depression, anxiety, grief, family conflict, occupational strain, and financial pressure. At the same time, caregiving may also contain meaning, connection, and a sense of purpose. Psychologists should assess the full caregiving experience rather than assuming that burden is either universal or absent.

Evidence-based caregiver interventions include psychoeducation, behavioral skills training, cognitive behavioral approaches, social support, and respite. Reviews indicate that such interventions can improve outcomes for some caregivers, but effects vary, which reinforces the need for individualized treatment planning (Wiegelmann et al., 2021).

Competent dementia care also requires coordination across systems. Home health, adult day programs, community agencies, long-term care facilities, rehabilitation professionals, social services, and medical teams may all become relevant at different stages. Psychologists should understand these systems sufficiently to coordinate care and make appropriate referrals while remaining within professional competence boundaries.

## Section 7: Cultural and Systemic Considerations in Dementia Care

Clinical practice with older adults living with dementia occurs within cultural, social, historical, and healthcare contexts. Dementia is a neurological condition, but the ways in which cognitive changes are recognized, interpreted, discussed, assessed, and treated are influenced by culture, family beliefs, language, socioeconomic circumstances, experiences with healthcare systems, and access to services. Psychologists who work with older adults should therefore understand cultural responsiveness as part of competent dementia practice rather than as an additional consideration that applies only when a patient belongs to a particular racial or ethnic group.

Culturally responsive dementia care does not mean assuming that every person from a particular community holds the same beliefs. Such an approach can replace one form of bias with another. Instead, psychologists should consider the individual patient's cultural identities, language, educational experiences, family structure, immigration history when relevant, socioeconomic circumstances, religious or spiritual beliefs, experiences of discrimination, community relationships, and personal understanding of cognitive decline. These factors may influence whether symptoms are reported, when help is sought, how assessment

results are interpreted, who participates in healthcare decisions, and which interventions are acceptable or accessible.

Cultural and systemic factors also intersect. Differences in dementia outcomes across racial and ethnic groups should not automatically be attributed to biological differences between groups. Social determinants of health, educational opportunities, neighborhood conditions, cardiovascular risk, healthcare access, discrimination, socioeconomic inequality, environmental exposures, and other structural factors can contribute to disparities in cognitive aging and dementia (Livingston et al., 2024). Psychologists should therefore avoid explanations that treat race or ethnicity as a simple biological cause when interpreting disparities.

## Cultural Understandings of Cognitive Decline

The meaning assigned to memory loss and cognitive decline varies among individuals, families, and communities. Some people recognize cognitive changes primarily through a medical framework and seek evaluation soon after symptoms become noticeable. Others may interpret forgetfulness as a normal part of aging and may not view it as a reason to consult a healthcare professional. Cognitive changes may also be understood through spiritual, familial, psychological, or social frameworks depending on the person's beliefs and community context.

These interpretations can affect the timing of dementia assessment. If a family believes significant memory decline is an inevitable part of aging, symptoms may need to become severe before professional evaluation is considered. In other situations, stigma associated with dementia may lead the patient or family to conceal symptoms. A family may worry that the person will be treated differently, lose independence, become socially excluded, or be viewed as incapable if the diagnosis becomes known. Stigma and help-seeking are closely connected in dementia care.

The psychologist should explore the patient's explanatory model rather than immediately correcting it. Questions about what the patient believes is happening, what the family calls the problem, why they think the changes have occurred, and what they expect from treatment can reveal clinically important information. Understanding the person's interpretation does not require the psychologist to agree with inaccurate medical explanations. It allows scientific information to be communicated in a manner that addresses the patient's actual concerns.

For example, a family that understands cognitive decline primarily as normal aging may need clear education about the difference between ordinary age-related changes and clinically significant impairment. A family concerned about stigma may need information about confidentiality, treatment options, and the value of earlier assessment. A patient who interprets illness partly through a spiritual framework may still accept medical evaluation when clinicians respectfully recognize that spiritual and medical understandings can coexist.

## Culture, Family, and Decision-Making

Cultural values can also influence expectations regarding independence and family participation. Psychological and medical practice in the United States frequently emphasizes individual autonomy, but not every patient understands autonomy as making decisions without family involvement. Some older adults prefer collective decision-making and expect spouses, adult children, extended relatives, or religious leaders to participate in important discussions.

Culturally responsive practice does not require abandoning respect for the individual patient. Instead, psychologists can ask how the person prefers decisions to be made. A patient may explicitly want an adult child present for discussions or may prefer that certain information be shared with the entire family. Another

patient from the same cultural community may strongly prefer privacy and individual decision-making. The patient's preference, rather than the clinician's stereotype about the group, should guide the approach whenever decisional capacity permits.

Family caregiving expectations can similarly differ. In some families, placing an older relative in residential care may be understood as inconsistent with family responsibility. Other families may view professional care as an appropriate way to ensure safety and specialized treatment. These beliefs can affect caregiver guilt, willingness to use respite, and decisions about long-term care. Psychologists can help families explore these values while also considering caregiver capacity and patient safety.

## Education and Cognitive Test Performance

Educational experience can influence cognitive test performance in ways that are clinically relevant. Years of education alone do not fully describe educational quality, literacy, educational opportunity, or familiarity with formal testing. Two people who both completed eight years of schooling may have had very different educational experiences.

Some cognitive screening tasks assume familiarity with test-taking procedures, drawing, abstraction, reading, or particular forms of problem-solving. An individual with limited formal education may find these tasks unfamiliar even in the absence of dementia. Conversely, a highly educated person may perform within a broadly normal range during early cognitive decline because previous abilities provide substantial cognitive reserve. The psychologist should therefore interpret screening results within the patient's educational and occupational history. Test performance should be integrated with functional change, collateral

information, medical history, behavioral observations, and other assessment data rather than treated as a stand-alone diagnosis.

## Acculturation and Assessment

Acculturation and language experience can affect performance on cognitive measures, making culturally and linguistically appropriate interpretation essential (American Psychological Association, 2021).

Acculturation should not be reduced to how many years a person has lived in the United States. Language use, educational setting, immigration history, community participation, occupational experience, family practices, and exposure to the dominant culture can vary substantially among people with similar lengths of residence.

Psychologists should also avoid treating acculturation as a measure of how well a patient has adopted a supposedly preferred culture. It is a contextual variable that may help explain experiences relevant to assessment and healthcare. The clinical goal is improved validity, not evaluation of cultural conformity.

## Racial and Ethnic Disparities in Dementia

Dementia does not affect all populations in the United States equally. Large epidemiological studies have identified differences in dementia incidence and prevalence across racial and ethnic groups. Kornblith et al. (2022), using a large national cohort of older veterans, reported differences in dementia incidence across racial and ethnic groups. Manly et al. (2022) likewise provided national estimates of dementia and mild cognitive impairment in the United States and documented important variation across demographic groups.

These differences should be interpreted carefully. Racial categories are social classifications that correlate with differences in exposure to social, economic, environmental, and healthcare conditions. They should not be used as shorthand explanations for biological destiny. Differences in dementia risk may reflect cumulative experiences across the life span, including educational inequities, cardiovascular risk, neighborhood disadvantage, discrimination, occupational exposures, healthcare access, and other social determinants. Dementia risk and clinical outcomes reflect interacting medical, social, and environmental determinants (Livingston et al., 2024).

## Social Determinants of Cognitive Health

Social determinants of health include the conditions in which people are born, grow, learn, work, live, and age. These conditions influence exposure to health risks and access to protective resources throughout the life course. The 2024 Lancet Commission on dementia (Livingston et al., 2024) likewise highlighted the importance of socioeconomic, environmental, educational, and social conditions.

Educational opportunity is one example. Access to high-quality education has historically been unequal across racial and socioeconomic groups. Because educational experiences affect cognitive test performance and may influence cognitive reserve, these inequities can have implications decades later.

Neighborhood conditions also matter. Access to safe physical activity, nutritious food, healthcare, social opportunities, clean environments, and stable housing varies across communities. Cardiovascular risk factors associated with dementia are also shaped by healthcare access and broader structural conditions. Psychologists do not need to become public health specialists to recognize these influences. They do need to avoid interpreting cognitive outcomes as though patients developed within identical environments.

## Disparities in Diagnosis

Equity in dementia care involves more than determining whether dementia prevalence differs across groups. Clinicians should also consider who receives a diagnosis, when diagnosis occurs, and what happens after diagnosis.

Barriers to diagnosis may include limited access to primary care, lack of specialty services, transportation difficulties, language barriers, financial limitations, stigma, mistrust of healthcare institutions, and lack of culturally appropriate assessment tools. These barriers may be particularly pronounced for people from ethnic minority and lower socioeconomic groups.

Some patients may present later because cognitive changes were interpreted as normal aging. Others may have raised concerns previously but encountered healthcare professionals who minimized symptoms. Still others may be reluctant to seek assessment because they fear loss of independence or believe that diagnosis offers no benefit. Psychologists can reduce some barriers by explaining the purpose and limitations of assessment, using appropriate language services, considering cultural and educational factors, and communicating results in an understandable manner.

## Mistrust and Historical Context

Mistrust of healthcare and research institutions should not automatically be interpreted as irrational resistance. Some communities have experienced historical and ongoing discrimination within healthcare, research, education, and other institutions. Individual patients may also have personal experiences of being dismissed, misdiagnosed, treated disrespectfully, or denied adequate care.

A psychologist who interprets mistrust as evidence that the patient is "difficult" may further damage the therapeutic relationship. A more useful approach is to

ask what concerns the patient or family has about evaluation and what previous healthcare experiences have been like. Trust is built through transparency, consistency, respect, and meaningful choice. The clinician should explain what assessment can and cannot determine, how information will be used, who will receive results, and what options the patient has. Cultural responsiveness therefore involves more than knowledge about cultural traditions. It also requires awareness of power, healthcare history, and the ways institutional experiences influence current behavior.

## Socioeconomic Barriers

Financial circumstances can strongly influence dementia care. Families with substantial resources may be able to purchase home care, transportation, private neuropsychological assessment, legal consultation, home modification, and residential memory care. Families with fewer resources may depend on limited public services or unpaid caregiving.

These differences can influence when families seek help and whether recommended interventions are implemented. A caregiver who does not follow a recommendation for weekly respite may not be resistant. The family may simply be unable to afford the service. Psychologists should ask about feasibility before concluding that a patient or caregiver is nonadherent. Recommendations should account for insurance coverage, transportation, employment schedules, caregiver availability, and community resources. When financial or systems barriers are significant, collaboration with social workers, case managers, community agencies, or benefits specialists may be necessary.

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## Rural Dementia Care

Rural residence can introduce distinctive challenges. Specialty services may be concentrated in urban centers, requiring patients and caregivers to travel long distances. Public transportation may be limited, and smaller communities may offer fewer adult day programs, support groups, or memory care facilities.

At the same time, rural communities may have strengths that should not be overlooked, including strong informal networks, longstanding relationships with primary care clinicians, faith communities, and community organizations. Culturally responsive practice includes identifying these assets rather than focusing exclusively on service deficits.

Telehealth can extend psychological consultation and caregiver support into rural settings when technology permits. Psychologists should nevertheless evaluate whether the patient can use the platform effectively and whether cognitive, hearing, visual, or technological limitations interfere with participation.

## Dementia-Related Stigma

Stigma can affect people living with dementia and their families at multiple levels. Public stigma involves negative beliefs and attitudes within the broader community. Internalized stigma can occur when a person adopts negative beliefs about dementia and applies them to themselves. Family members may experience stigma by association, particularly in communities where dementia is poorly understood or associated with shame. Stigma can influence whether patients disclose a diagnosis, participate in activities, seek support, or discuss symptoms. Some individuals may withdraw socially because they fear embarrassment. Friends may stop visiting because they do not know how to communicate with the person. Families may conceal the diagnosis to avoid judgment. Psychologists can address stigma through psychoeducation, person-

centered language, support for disclosure decisions, and interventions that maintain social participation where possible.

## Ageism in Dementia Care

Ageism involves stereotypes, prejudice, or discrimination based on age. In dementia care, ageism can intersect with stigma associated with cognitive impairment. Older adults may be assumed to be confused simply because they are old, while treatable symptoms may be dismissed as normal aging.

Ageism can also contribute to therapeutic nihilism. Clinicians may assume that psychotherapy is not useful for older adults with cognitive impairment, that depression is an inevitable consequence of aging, or that maintaining autonomy is unimportant because the person is already dependent in some areas. Langmann and Weßel (2023) discussed the intersection of ageism and ableism within concepts of successful aging. Their analysis is relevant to dementia because expectations about independence and cognitive ability can shape how society values older adults who develop disability. Psychologists should examine whether treatment decisions would be different if the patient were younger. Age alone should not determine whether emotional symptoms are assessed, whether treatment is offered, or whether the person's preferences are taken seriously.

## LGBTQ+ Older Adults Living With Dementia

LGBTQ+ older adults may encounter specific concerns in dementia care. Some have lived through periods when their identities were criminalized, pathologized, or heavily stigmatized. Entering a healthcare or residential care system can therefore raise concerns about discrimination, disclosure, partner recognition, and whether chosen family will be respected.

Dementia can create additional vulnerability if the individual becomes less able to advocate for preferred names, relationships, gender expression, or personal history. Care plans should therefore document important identity information and relationship preferences when the patient wants this information included. Clinicians should not assume heterosexuality or conventional family structure. Questions about important relationships and sources of support are often more useful than assuming that legal or biological relatives are the patient's only meaningful caregivers.

## Cultural Considerations in Caregiver Support

Caregiver interventions should also reflect cultural context. Expectations about filial responsibility, gender roles, privacy, use of formal services, and residential placement can influence caregiver burden and help-seeking. A caregiver who refuses outside help may fear community judgment or believe accepting assistance violates a family obligation. Simply explaining that respite is available may not address the actual barrier.

The psychologist can explore how the caregiver understands responsibility and whether support can be framed in a manner consistent with those values. For example, accepting help may allow the caregiver to sustain home care longer rather than representing withdrawal from responsibility. Culturally responsive caregiver work respects values while also recognizing that severe exhaustion can endanger both the caregiver and the person with dementia.

## Improving Access to Dementia Services

Psychologists can contribute to improved access at several levels. At the individual level, they can provide clear referrals, communicate in accessible language, use professional interpreters, and identify financial or transportation barriers. At the

organizational level, clinicians can advocate for accessible scheduling, telehealth when appropriate, translated materials, and referral networks that include culturally responsive services.

Community partnerships may also improve engagement. Faith organizations, senior centers, cultural associations, primary care clinics, and community health workers may be trusted sources of information in communities where specialty mental health or memory services are less familiar. The goal of outreach should not be to persuade communities to accept professional assumptions without question. Effective engagement involves listening to community concerns and identifying why existing services may not be accessible or trusted.

## Integrating Cultural Humility Into Dementia Practice

Cultural competence should not be understood as memorizing characteristics of different racial or ethnic groups. No clinician can master every cultural context, and group-level information cannot determine an individual patient's beliefs.

Cultural humility involves ongoing self-reflection, curiosity, willingness to recognize limitations, and openness to correction. The psychologist can ask rather than assume. When specialized knowledge is needed, consultation can be sought. This approach is particularly important in dementia care because clinicians may become increasingly dependent on family members for information as cognition declines. The psychologist should remain attentive to whose interpretation is being heard and whether the patient continues to have opportunities to express preferences.

## Professional Competence and Continuing Education

Culturally responsive dementia practice is part of professional competence. Psychologists should remain current regarding cross-cultural neuropsychological assessment, interpreter use, disparities in dementia care, culturally responsive psychotherapy, caregiver systems, and social determinants of health relevant to cognitive aging.

Competence also requires recognizing limits. A psychologist who does not have appropriate training to evaluate a patient across significant linguistic or cultural differences may need consultation or referral. Referral should not be used reflexively whenever a patient differs culturally from the clinician. Such a practice could itself reduce access. Instead, psychologists should determine whether they can provide competent care with reasonable consultation, language support, or other accommodations.

## Conclusion

Cultural and systemic considerations are central to competent psychological practice with older adults living with dementia. Culture can influence how cognitive decline is understood, when families seek help, how patients participate in decisions, and which treatments are considered acceptable. Language, educational experience, acculturation, and test familiarity can affect cognitive assessment and should be considered when interpreting screening and neuropsychological data.

Dementia disparities also reflect broader social conditions. Differences in incidence, diagnosis, and treatment across racial and ethnic groups cannot be adequately understood without considering social determinants of health, structural inequality, healthcare access, and cumulative life experiences.

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Psychologists should avoid treating racial categories as simple biological explanations for complex population differences.

Access barriers may include geography, transportation, finances, workforce shortages, language differences, limited culturally appropriate services, and mistrust based on historical or personal healthcare experiences. Psychologists should consider whether their recommendations are realistically accessible and collaborate with interdisciplinary and community resources when necessary.

Culturally responsive dementia practice ultimately requires more than knowledge about demographic differences. It requires individualized assessment, cultural humility, attention to systemic barriers, careful interpretation of psychological data, awareness of bias, and willingness to adapt care while preserving scientific and professional standards. These practices support the broader goals of evidence-based psychological care by integrating the best available evidence with clinical expertise and the cultural, personal, and contextual characteristics of each patient.

## Section 8: Future Directions in Dementia Clinical Practice

The field of dementia care is changing rapidly. Advances in biomarkers, disease-modifying therapies, digital technologies, risk-reduction strategies, and models of interdisciplinary care are altering how clinicians conceptualize the detection and management of neurocognitive disorders. For psychologists, these developments create opportunities as well as new ethical and professional responsibilities. Future dementia practice will require psychologists to remain current with scientific developments while continuing to emphasize the psychological, functional, cultural, relational, and ethical dimensions of care.

Although technological and medical advances are important, the future of dementia care should not be understood solely as a search for a cure. People who are currently living with dementia continue to need competent psychological assessment, behavioral intervention, psychotherapy, caregiver support, capacity evaluation, and assistance maintaining quality of life. Future-oriented clinical practice therefore requires a balance between emerging biological approaches and person-centered psychological care.

## Earlier Detection and the Expanding Role of Biomarkers

One of the most significant changes in Alzheimer's disease care involves the increasing use of biomarkers. Historically, dementia diagnoses were based heavily on clinical symptoms, cognitive assessment, functional decline, medical history, and exclusion of alternative causes. Contemporary Alzheimer's disease practice increasingly incorporates biological evidence obtained through cerebrospinal fluid analysis, positron emission tomography, and emerging blood-based biomarkers.

Blood-based biomarkers are particularly important because they may eventually make biological assessment of Alzheimer's disease more accessible than procedures such as lumbar puncture or specialized imaging. Recent literature describes continued progress in translating fluid, imaging, and digital biomarkers into clinical practice (Livingston et al., 2024). These developments may change referral pathways and may allow biological evidence of Alzheimer's disease pathology to be obtained earlier in the disease process.

These changes are already reaching practice. In 2025, the FDA cleared a blood test to aid in evaluating Alzheimer's disease pathology in symptomatic adults (U.S. Food and Drug Administration, 2025). Anti-amyloid therapies, including lecanemab and donanemab, have demonstrated statistically significant slowing of decline in selected people with early symptomatic Alzheimer's disease, but their

benefits must be weighed against amyloid-related imaging abnormalities, infusion burden, and MRI monitoring requirements (Sims et al., 2023; van Dyck et al., 2023). Trial results should not be generalized to all people living with dementia. Psychologists may help patients and families understand uncertainty, clarify values, support shared decision-making, and cope with ineligibility or changes in treatment plans.

For psychologists, biomarkers do not eliminate the need for careful clinical assessment. Biological evidence and functional assessment answer different questions. A biomarker may provide information about underlying disease pathology, while psychological and neuropsychological assessment can help determine how cognitive changes affect memory, executive functioning, language, emotional functioning, daily activities, and decision-making. Psychologists may increasingly participate in counseling surrounding disclosure, adjustment, uncertainty, treatment decision-making, and family communication.

## Precision and Personalized Dementia Care

Future dementia treatment is likely to become increasingly individualized. Dementia is not a single disease, and even patients with the same diagnosis can differ substantially in pathology, cognitive presentation, comorbid medical conditions, behavioral symptoms, social circumstances, culture, and treatment goals. Precision approaches seek to use these differences to guide assessment and intervention.

Personalization should extend beyond biological markers. A comprehensive model of individualized dementia care includes the patient's cognitive strengths and weaknesses, functional abilities, psychiatric symptoms, medical conditions, relationships, living environment, cultural background, financial resources, caregiver system, and personal priorities.

Psychologists are well positioned to contribute to this broader form of precision care. Neuropsychological and psychological assessment can identify patterns of functioning that may not be apparent from biomarkers alone. Behavioral analysis can identify environmental contributors to distress, while psychotherapy and caregiver consultation can be adapted to cognitive ability and individual circumstances.

## Digital Technologies and Artificial Intelligence

Digital technologies are likely to assume a larger role in dementia assessment and care. Smartphone applications, wearable devices, remote cognitive assessment, passive monitoring systems, telehealth platforms, and artificial intelligence may provide clinicians with new forms of information about functioning outside the traditional clinic.

These technologies could help identify changes in movement, sleep, medication routines, communication, navigation, or everyday activity. Digital approaches may also expand access to caregiver education, psychological consultation, and behavioral support for patients who live far from specialty centers. However, technological innovation should not be confused with established clinical validity. New tools require evidence demonstrating reliability, validity, clinical usefulness, and appropriate application across diverse populations. Psychologists should be cautious about incorporating artificial intelligence or digital assessment tools simply because they are available.

Digital systems also raise ethical concerns involving privacy, informed consent, surveillance, data security, and autonomy. A monitoring system that improves safety may simultaneously reduce privacy. These tensions become particularly important when a person with dementia cannot fully understand or consent to

continuous monitoring. Psychologists can contribute to discussions about proportionality, autonomy, safety, and the least restrictive approach to care.

## Dementia Prevention and Risk Reduction

Another important future direction involves increased attention to dementia risk reduction across the life span. The 2024 Lancet Commission concluded that a substantial proportion of dementia may potentially be prevented or delayed by addressing modifiable risk factors. The Commission identified 14 potentially modifiable factors, including less education, hearing loss, hypertension, smoking, obesity, depression, physical inactivity, diabetes, excessive alcohol consumption, traumatic brain injury, air pollution, social isolation, untreated vision loss, and high LDL cholesterol (Livingston et al., 2024).

These findings have important implications, but clinicians should communicate them carefully. Risk reduction does not mean that every case of dementia can be prevented, nor does developing dementia mean that an individual failed to live correctly. Dementia develops through complex interactions among age, genetics, neurological disease, medical conditions, environment, and life-course exposures.

Psychologists can contribute to prevention through interventions addressing depression, social isolation, health behavior change, treatment adherence, sleep, substance use, and engagement in meaningful physical, cognitive, and social activities. Prevention messages should emphasize realistic opportunities for health promotion without creating blame or false guarantees.

## Increasing Attention to Diversity and Equity

Future dementia research and clinical practice will also need to address longstanding inequities in representation, assessment, diagnosis, and treatment.

As discussed in Section 7, culturally and linguistically diverse populations have not always been adequately represented in dementia research. New diagnostic technologies will not automatically eliminate disparities. In fact, expensive treatments and specialized biomarker testing could widen existing inequalities if access is concentrated among patients with greater financial or geographic resources.

Equitable implementation should therefore accompany scientific innovation. Researchers and clinicians will need to determine whether biomarkers, cognitive measures, algorithms, and treatment protocols perform appropriately across populations. Greater diversity in clinical trials and longitudinal studies will be essential for determining whether findings generalize beyond historically overrepresented groups. Psychologists should remain alert to the possibility that technological progress can coexist with unequal access. An intervention cannot improve population health equitably if large groups of patients cannot obtain it.

## Evolving Roles for Psychologists

The psychologist's role in dementia care is likely to continue expanding. Psychologists may increasingly participate in early identification, differential diagnosis, neuropsychological characterization, adjustment to biomarker findings, treatment decision-making, caregiver interventions, behavioral consultation, capacity assessment, interdisciplinary care, and advance care planning.

As diagnostic technologies become more sophisticated, psychologists will need to explain what psychological assessment contributes that laboratory and imaging findings cannot. Cognitive test scores should likewise not be interpreted in isolation from biological, functional, medical, and contextual information.

Continuing education will be particularly important because standards of dementia assessment and treatment are changing rapidly. Psychologists should

periodically update their knowledge regarding diagnostic criteria, biomarkers, treatments, assessment technologies, cultural considerations, ethics, and evidence-based psychosocial interventions. Competence in dementia care should be viewed as an ongoing professional responsibility rather than expertise achieved permanently through a single training experience.

## Conclusion

The future of dementia clinical practice will likely involve earlier and more biologically informed diagnosis, increasingly personalized treatment, expanding use of digital technologies, continued development of disease-modifying therapies, and greater emphasis on dementia prevention and risk reduction. These advances have the potential to improve care, but they also create questions involving informed consent, access, privacy, equity, treatment expectations, and professional competence.

For psychologists, the central clinical task will remain broader than identifying cognitive impairment. Psychological practice contributes an understanding of the whole person, including cognition, emotion, behavior, relationships, culture, functioning, values, and environment. These dimensions will remain essential even as biological technologies become more sophisticated.

Future dementia care should therefore combine scientific innovation with person-centered practice. Progress should be measured not only by advances in biomarkers and treatment but also by whether people living with dementia and their families receive accessible, ethical, culturally responsive, evidence-based, and dignified care.

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