Risk Factors in Diminished Capacity: A Primer for the Broker-Dealer Agent

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October 13 & 15, 2015

Normal Aging

- Social relationships shift
- Start to see a paring down of acquaintances, friendships
- Socio-emotional Selectivity Theory
- This is considered a normal, healthy process as the focus moves from acquiring knowledge to meaningful relationships

Retiring Well

- Retirement is a relatively new concept in American history.
- Virtually non-existent before 1890.
- Becomes more important in 1920's and is seen as a solution to unemployment and as a way to increase productivity.
- A few assumptions have persisted in the research:
  - First, retirement is an invitation to stop developing.
  - Second, retirement is a deterioration and a loss of a valuable resource.

Retiring Well cont.

- Individuals appear to cope with impending retirement by putting enormous amounts of energy into preparing financially for retirement but little thought into making sure they are psychologically prepared.
- Psychological and emotional elements are an essential aspect of retirement and have a direct impact on the individual's overall well-being as they enter this new phase of their life.
- Retirement is a process, not an event.

Phases of Retirement

- Midlife Reevaluation Phases: typically between 40's and 60's. Sense of crisis or quest. Motivated to make their life or work more gratifying.
- Liberation Phase: typically 60's to early-70's. Involves translating feeling of "if not now, when" into action.
- Summing-up Phase: shaped by desire to find larger meaning…shared through storytelling, philanthropy, community activism, and volunteerism.
- Encore Phase: shaped by desire to make long, lasting contributions on a community or personal level, to take care of unfinished business, and celebrate one's contributions.

Retirement Changes

- Retirement brings about a number of changes:
  - Career path….New, self-made path
  - Time regimentation….2500+ free hours annually
  - Daily routine….Self-determined schedule
  - Meeting deadlines….No deadline
  - Imposed schedule….Self-imposed schedule
  - Accountability….No boss
  - Rat race…Freedom of choice
  - Built in colleagues….New circle of friends

Potential Issues

- Medical issues
- Social and emotional risk factors
- Cognitive Concerns

Medical Factors

Medical Concerns

- For many reasons, medical issues can affect cognitive abilities, insight, perception, impulse control, susceptibility to influence, and both recent and remote memory.
- Conditions such as cancer, cardiovascular disease, primary endocrine and neurological disease, stroke, diabetes, organ failure, dementia, or delirium can adversely impact cognition.

Medical Concerns cont.

- Medication issues including whether or not they are even taking them; polypharmacy; and potential side effects are all potential factors. Muscle relaxants, anticholinergics, sedatives/hypnotics, and/or narcotics can all impact cognition.
- Any significant imbalance to the body's system can impact a person's functioning.

Delirium

- Characterized by an acute onset of mental status change.
  - Fluctuating course
  - Reduced clarity of awareness of environment
  - Reduced ability to focus, sustain and shift attention.
  - Disorganized thinking or an altered level of consciousness
- Change is not better explained by dementia
- Develops over a short period of time (hours to days); tends to fluctuate during the day.
- Evidence from history, physical exam, lab findings that disturbance is caused by direct physiological consequences of a general medical condition

Delirium cont.

- Evidence from history, physical exam, lab findings that disturbance is caused by direct physiological consequences of a general medical condition
- Typically resolves if the precipitating causes are removed.
- The concept of delirium as transient cognitive impairment is challenged by a study indicating that cognitive impairment resolves within three months in only 20% of people with a diagnosis of delirium.

Delirium cont.

- Causes of delirium:
  - Dehydration
  - Electrolyte imbalance
  - Medications (anticholinergic, histamine effects)
  - Pain, infection, fever
  - Myocardial infarct, arrhythmias, CHF, pulmonary emboli
  - Other medical conditions

Delirium cont.

- Who is at risk for developing delirium?
  - The very old
  - Preexisting brain damage
  - Sensory loss (e.g., hearing/visual impairment)
  - Can occur in unfamiliar surroundings and environments that cause sensory overload/deprivation

Delirium cont.

- Drugs associated with confusion in the elderly.
  - Sedatives/hypnotics (e.g., benzodiazepines, barbiturates)
  - Histamine blockers (used for GI disorders, insomnia, allergy)
  - Antidiarrheal and incontinence agents
  - Tricyclic antidepressants
  - Antipsychotics (e.g., chlorpromazine, thioridazine)
  - Antiarrhythmics (e.g., lidocaine, procainamide)
- Check out: www.icudelirium.org

SOCIAL AND EMOTIONAL RISK FACTORS

Depression

- If there is any message from my talk today, please let it be this:
  - ***DEPRESSION IS NOT A NORMAL PART OF AGING!!***

Depression

- DSM-V Criteria for MDD
  - A. Five (or more) of the following symptoms have been present during the same 2- week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.
- Note: Do not include symptoms that are clearly due to a general medical condition, or mood-incongruent delusions or hallucinations.

Depression cont.

- Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful). Note: In children and adolescents, can be irritable mood.
- Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others).
- Significant weight loss when not dieting or weight gain (e.g., a change of more than 5 percent of body weight in a month), or decrease or increase in appetite nearly every day. Note: In children, consider failure to make expected weight gains.

Depression cont.

- Insomnia or hypersomnia nearly every day.
- Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).
- Fatigue or loss of energy nearly every day.
- Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).

Depression cont.

- Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).
- Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.
- B. The symptoms cause clinically significant distress or impairment in social, occupational or other important areas of functioning.
- C. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).

Late life depression

- Late life depression is not well captured by this system. For example, eliminating somatic symptoms can cause underestimation of depression; interpreting medical symptoms as psychiatric can lead to overdiagnosis.
- Whereas 1-3% of adults age 65 and older meet diagnostic criteria for MDD, as many as 15-25% of all older adults report depressive symptoms at a level considered clinically significant.

Late life depression cont.

- **ETIOLOGY**
- Conceptualizing late life depression requires considering the ways psychological, biological, and environmental influences on depression wax and wane – and interact – across the life span and into old age.
- Psychological vulnerability to depression is thought to decrease in late life as older adults become more adept at coping with stressors.
- Other types of biological vulnerability, however, become more frequent, including age-associated neurobiological changes that may predispose to depression.

Late life depression

- **ETIOLOGY cont.**
- Stressors are present at all ages of life, but certain stressors increase in frequency in late life, including bereavement, caregiving responsibilities, and illness-related disability.
- Interesting study by Mirowsky and Ross (1992) showed that when known risk factors for depression are statistically controlled, older adults actually have lower levels of depressive symptoms than do middle-aged adults. This suggests a role for maturity in protecting against depression.

Late life depression

- **RISK AND PROTECTIVE FACTORS**
- Older women are at greater risk than older men for depressive disorders and significant depressive symptoms but there is some evidence to show that the gap seen in midlife starts to narrow in late life.
- Socioeconomically disadvantaged and low levels of educational attainment are also related to depression in late life.

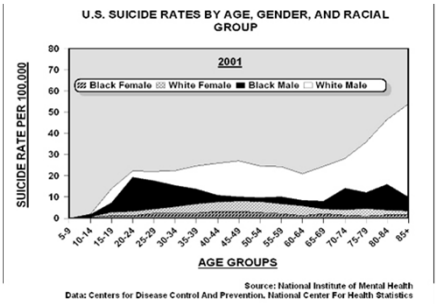
Late life depression

- **RISK AND PROTECTIVE FACTORS cont.**
- Negative life events
- Physical illness and disability
- Bereavement
- Caregiving
- Social factors
- Cognition

Depression cont.

- LESS: dysphoria, guilt, suicidal ideation
- MORE: fatigue, sleep and appetite changes, weight loss, slowed movement, vague GI complaints, somatic worries, memory and concentration problems, anxiety and/or irritability, apathy and/or withdrawal, lowered self-esteem, anhedonia, thoughts or wishes of death that are distinct from suicidal ideation, hopelessness/helplessness, memory complaints with or without signs of objective cognitive impairment, and lack of interest in personal care (ADLs or adherence to medical or dietary regimens).

Depression cont.



Depression cont.

- While older adults make up only 13% of the general population, they account for 25% of all suicides.
- 81% of elderly who commit suicide are males – in fact, the highest rate of suicide for all populations is white males over age 65.
- 20% have seen a physician within 24 hours of committing suicide and approximately 80% have seen their primary care physician in the past month.
- While assessing suicidal ideation is important, true prevention is probably better centered around more distal issues
  - Pain that limits physical function
  - Social isolation
  - Depletion of social web
- The key is to examine the person's "Social Ecology" or the fabric of their everyday life – what has changed or what could potentially change?

Anxiety

- Until the last decade, anxiety disorders in older adults have been a relatively unrecognized public health problem.
- Community prevalence rates range from 3-11% suggesting that anxiety is more prevalent than depression. As with depression, prevalence rates are higher among certain populations including homebound elders, chronically ill elders, and nursing home residents.
- Anxiety symptoms and disorders are associated with decreased physical activity and functional status, poorer self-perceptions of health, decreased life satisfaction, increased loneliness, increased physical disability, decreased quality of life, and increased service use.
- Common anxiety symptoms/disorders in older adults include generalized anxiety disorder, panic disorders, obsessive/compulsive disorder, hoarding, and mixed anxiety disorders.

Psychotic Disorders

- Psychosis may manifest as bizarre or disorganized behavior, inappropriate affect, delusions, and/or hallucinations.
- Late-onset schizophrenia (after age 45) is associated with persecutory delusions, olfactory hallucinations, and tactile hallucinations (early-onset schizophrenia has a low association with these symptoms).
- Late-onset schizophrenia is 5x more common in women than in men.
- Often multiple physical complaints.

Substance Abuse

- Cognitive loss – reducing their ability to resist or detect coercion or fraud. Heavy drinking may result in dementia-type symptoms (global cognitive loss) or a Korsakoff syndrome (primarily memory impairment)
- Additionally, heavy alcohol use is thought to be a contributing factor in approximately 21-24% of all dementia.
- Physical disabilities – rendering them more dependent on others for assistance or care.

Substance Abuse cont.

- Wernicke-Korsakoff's Syndrome
  - Consequence of long-term chronic alcoholism caused by deficiency of thiamin.
  - Can be treated with abstinence and vitamin replacement if caught in the early stages.
  - Characterized by extreme memory problems along with confabulation to fill in memory losses.
  - Memory loss may extend back to when the person began heavy drinking and new memory information is almost nonexistent.

Cognitive Concerns

Dementia

- Dementia does not refer to one particular disease but rather to a family of diseases characterized by cognitive and behavioral deficits involving some form of permanent damage to the brain.
  - Dementia has many presentations as well as causes.
  - Dementia can be stable or progressive.
  - It can afflict the young or the old.
  - It is associated with a wide range of mental and behavioral disturbances, many of which are reminiscent of other psychiatric disorders.
  - Dementia involves functional impairments that derive from the impairments in cognition but can also result from behavioral disturbances.
  - Dementia renders individuals more vulnerable to the effects of coexisting medical conditions and medications.
  - Dementia occurs in a family and social context, affecting the lives of many others.

Dementia cont.

- Definition of dementia:
  - Decline, or deterioration, in the cognitive or thinking capacities (memory, language, judgment, etc.) – remember, it is a decline from a previous level of functioning.
  - Multiple areas of cognition are impaired. It is more global. Almost every disease that causes dementia affects memory; the other cognitive impairments in judgment, perception, language, abstraction, etc. depend on the specific disease and the stage of the illness.
  - Please note that even though dementia requires multiple impairments, not all cognitive functions are necessarily affected.
  - Normal level of consciousness. This distinguishes dementia from delirium.

Vascular Dementia

- Caused by cerebrovascular accidents (strokes), which result from a disruption of the blood flow (infarct) caused by a blockage or hemorrhage.
- While many individual strokes produce cognitive decline that is specific, vascular dementia has a more global presentation.
- The individual has a series of small strokes producing a global pattern resulting in vascular dementia.
- Vascular dementia typically has a more sudden onset and its progression is stepwise or stuttering. Its symptom pattern is highly variable.
- The stepwise progression can look like delirium.

Vascular dementia cont.

- The general course of the illness is approximately 2-4 until death.
- The symptoms of vascular dementia are very similar to other dementias and it is important to know that various forms of vascular dementia can occur in the person at the same time or in conjunction with other dementias.
- Specific symptoms can include confusions and problems with recent memory, wandering or getting lost in familiar places, moving with rapid/shuffling steps, laughing or crying inappropriately, difficulty following instructions.
- Can diagnose with use of MRI or CT scan to look at blood flow patterns.

Parkinson's Dementia

- Approximately 14-40% of people with Parkinson's disease will develop dementia. (Dementia is usually only seen in advanced cases)
- The symptoms of Parkinson's disease are well recognized and are primarily known for its characteristic cluster of motor problems such as very slow walking, stiffness, difficulty getting in and out of chairs, tremors.
- It is controversial whether PD dementia is due to (1) the subcortical neurodegenerative changes, (2) superimposed Alzheimer's disease, or (3) a combination of these and assorted neurochemical changes.
- When cognitive symptoms do develop, they appear more diffuse, with impairment of memory and executive functions most prominent.

Fronto-Temporal Dementia

- Affects the frontal and temporal lobes of the brain
- Pathologic features include loss of nerve cells, no amyloid plaques, tau tangles seen in certain FTDs
- Types of FTD include Pick's Disease, corticobasal degeneration, familial FTDP-17, progressive supranuclear palsy, amyotrophic lateral sclerosis/parkinsonism-dementia complex of Guam, and motor neuron disease.

FTD cont.

- Clinical features include:
  - Uninhibited and socially inappropriate behavior
  - Inappropriate sexual behavior
  - Loss of awareness or concern about changes in behavior
  - Loss of concern about personal appearance or hygiene
  - Increase in appetite that leads to constant eating and weight gain
  - Apathy, loss of drive, social withdrawal, lack of concern/empathy for others
  - Loss of speech and language (many become completely mute by middle to late stage)
  - Compulsive or repetitive behavior such as pacing, collecting things, handwashing
  - Oral fixation
  - Memory loss – although not one of the first symptoms and is less severe relative to other symptoms
  - May have motor difficulties like those seen in Parkinson's (rigidity, lack of balance, and stiffness of movement but not he trembling arms and legs)

Lewy Body Dementia

- Caused by the development of Lewy bodies in the cortex. Neuropathologically, it looks like Parkinson's disease but the distribution looks like Alzheimer's disease (in other words, the Lewy bodies are spread around the brain, not just in one particular part).
- Characterized by fluctuating cognitive impairment (memory deficits and confusion followed by lucid intervals).
- Parkinsonian symptoms (rigidity, slowed movements, and poor balance) often with unexplained falls.
- Also characterized by visual hallucinations, auditory hallucinations, paranoid delusions, and behavioral difficulties.
- Highly sensitive to neuroleptic medications.

Alzheimer's Disease

- AD is the most common dementia and is estimated to account for 60 to 80 percent of cases.
- The global prevalence of AD is estimated to be as high as 24 million and is predicted to double every 20 years through to 2040.
- In the United States, an estimated 5.4 million people have AD.
- 5.2 million of these individuals are age 65 and older.
- Approximately 1 in 8 people aged 65 and older has AD.
- Nearly half of all people aged 85 and older have AD.

Epidemiological risk factors

- Cerebrovascular disease – hemorrhagic infarcts, cortical infarcts, vasculopathologies, and white matter changes.
- Blood pressure – especially in midlife
- Type 2 diabetes
- Body weight – research seems to show a U-shaped relationship with regards to AD. Too low or too high on the BMI seems to put people at greater risk. Again, this is especially true for people in midlife.
- Plasma lipid levels
- Smoking
- Depressive symptoms
- Psychological stress
- Traumatic brain injury

Protective factors

- Diet
- Physical activity
- Intellectual activity – possible theories include cognitive reserve and/or better access to care, etc.

Looking forward

- Looking forward it is estimated that by 2030 approximately 7.7 million Americans over age 65 will have AD (a 50% increase). By 2050 it is estimated that this same population will increase to 11 to 16 million.
- The financial impact of these changes in population are immense. Current studies show unpaid caregiving valued in the hundreds of billions (btw, that is estimated at an $11.93 per hour rate).
- By 2050, the estimated costs for care of people with AD is estimated to be about $1.1 trillion (it's close to about $200 billion right now). The cumulative cost to Medicare and Medicaid programs between 2010 and 2050 is projected to be $20 trillion, measured in today's dollars.

Looking forward cont.

- I think the National Strategic Plan put together by the Alzheimer's Study Group in 2009 said it best --

"The prospect of an overwhelming hurricane never became real enough to prompt the strengthening of New Orleans' levies; the result was $82.2 billion in damage and almost 2000 lives lost. Concerns about subprime lending never became urgent enough to prompt corrective regulatory actions; we're still tallying the cost of this crisis as job losses and bank failures mount and stock values plummet. If we fail to address the Alzheimer's crisis now, we face the prospect of losing lives and dollars on a much larger scale."

New Diagnostic Recommendations

- In April 2011, the National Institute on Aging and the Alzheimer's Association published several papers related to diagnostic guidelines for Alzheimer's disease. These papers looked at updating the criteria established in 1984 by the National Institute of Neurological and Communicative Disorders and Stroke (NINCDS) and the Alzheimer's Disease and Related Disorders Association (ADRDA).
- The key changes are related to the use of biomarkers and in acknowledging that memory decline is not always the central issue.
- The new criteria essentially look at three different stages – Preclinical, Mild Cognitive Impairment (MCI), and Alzheimer's disease.

Diagnostic Guideline References

- Clifford R. Jack Jr., et al. (2011). Introduction to the recommendations from the National Institute on Aging-Alzheimer's Association workgroups on diagnostic guidelines for Alzheimer's disease. *Alzheimer's & Dementia: The Journal of the Alzheimer's Association*, 7(3):257 – 262.
- Guy M. McKhann and David S. Knopman, et al. (2011). The diagnosis of dementia due to Alzheimer's disease: Recommendations from the National Institute on Aging and the Alzheimer's Association Workgroup. *Alzheimer's & Dementia: The Journal of the Alzheimer's Association*, 7(3):263 – 269.
- Marilyn S. Albert, et al. (2011). The diagnosis of mild cognitive impairment due to Alzheimer's disease: Recommendations from the National Institute on Aging and Alzheimer's Association Workgroup. *Alzheimer's & Dementia: The Journal of the Alzheimer's Association*, 7(3):270 – 279.
- Reisa A. Sperling, et al. (2011). Toward defining the preclinical stages of Alzheimer's disease: Recommendations from the National Institute on Aging and the Alzheimer's Association Workgroup. *Alzheimer's & Dementia: The Journal of the Alzheimer's Association*, 7(3):280 – 292.

Preclinical

- The preclinical stage, for which the guidelines only apply in a research setting, describes a phase in which brain changes, including amyloid buildup and other early nerve cell changes, may already be in process.
- At this point, significant clinical symptoms are not yet evident. In some people, amyloid buildup can be detected with positron emission tomography (PET) scans and cerebrospinal fluid (CSF) analysis, but it is unknown what the risk for progression to Alzheimer's dementia is for these individuals. However, use of these imaging and biomarker tests at this stage are recommended only for research.

Subjective Cognitive Impairment

- Subjective cognitive impairment/subjective cognitive decline/subjective memory complaints are generally used interchangeably.
- Subjective – self-perception of cognitive performance. Independent of performance on cognitive tests.
- Cognitive – refers to any cognitive domain, not just memory (other domains include executive function, attention, language, visuospatial function)
- Decline – subjectively experienced worsening of cognitive capacities.

ARCD v. SCI v. MCI (from nuance to evidence)

- Age-related cognitive decline – subtle…may include episodic memory, attention, and time needed to complete tasks. Degree of decline is small. Not all older adults experience ARCD.
- SCI – less subtle. Do not show evidence of impairment on neuropsychological tests (note MMSE) and cognitive problems do not cause functional decline.
- MCI – mild cognitive impairment. Similar to SCI in that may not impair functional abilities but dissimilar in that MCI demonstrates impaired performance on objective cognitive tests.

Key Points on SCI/SCD in Preclinical AD

- There is evidence that SCI occurs at the preclinical stage of AD and may serve as a symptomatic indicator of preclinical AD because
  - Longitudinal data support SCI as a risk factor for future cognitive decline
  - There is cross-sectional biomarker evidence for an increased prevalence of preclinical AD in those with SCI
  - Individuals with SCI and biomarker evidence for AD are at increased risk of future cognitive decline and progression to MCI and AD dementia

Key points cont.

- Current knowledge is insufficient to comprehensively define the specific features of SCI in preclinical AD. The characteristics of SCI in preclinical AD are probably variable and are expressed heterogeneously.
- Preclinical AD is, by definition, a biomarker diagnosis, and SCI is neither required for the diagnosis of preclinical AD nor is it necessarily present in all cases of preclinical AD. SCI by itself may never be sufficient to diagnose preclinical AD.

Key points cont.

- Numerous causes of SCI other than preclinical AD exist. These include, but are not limited to, SCI in MCI due to AD/prodromal AD, dementia, normal aging, psychiatric and neurologic disorders other than AD, or related to effects of medication and substance use.

Mild Cognitive Impairment (MCI)

- The MCI stage is marked by symptoms of memory problems and/or other cognitive domains, enough to be noticed and measured, but not compromising a person's independence. Person must also not be demented.
- Does the person have increased difficulty with any of the following activities?
  - *Learning and retaining new information:*
  - *Handling complex tasks:*
  - *Reasoning ability:*
  - *Spatial ability and orientation:*
  - *Language:*
  - *Behavior:*

MCI cont.

- Cognitive testing is strongly recommended at this stage. 1-1.5 SD below mean (on average)
- People with MCI may or may not progress to Alzheimer's dementia. This is where the biomarkers and other history (genetic factors, medical, etc.) are important. The paper seeks to separate MCI with MCI due to AD.
- Researchers will particularly focus on standardizing biomarkers for amyloid and for other possible signs of injury to the brain. Currently, biomarkers include elevated levels of tau or decreased levels of beta-amyloid in the CSF, reduced glucose uptake in the brain as determined by PET, and atrophy of certain areas of the brain as seen with structural magnetic resonance imaging (MRI).

Alzheimer's dementia

- The NIA states that "these criteria apply to the final stage of the disease" which is an important statement in and of itself – they are implicitly stating that AD has been going on for quite some time, even before official diagnosis.
- They outline ways clinicians should approach evaluating causes and progression of cognitive decline. The guidelines also expand the concept of Alzheimer's dementia beyond memory loss as its most central characteristic. A decline in other aspects of cognition, such as word-finding, vision/spatial issues, and impaired reasoning or judgment may be the first symptom to be noticed.

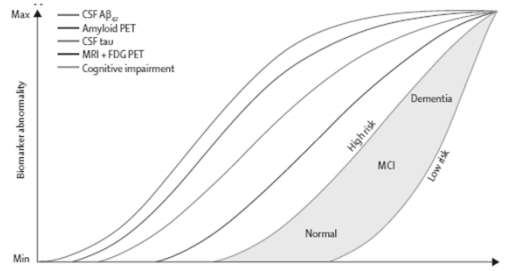
Alzheimer's dementia cont.

- The guidelines for diagnosing AD start with meeting the criteria for dementia, which are:
- Dementia is diagnosed when there are cognitive or neuropsychiatric symptoms that:
- Interfere with the ability to function at work or at usual activities, and
- Represent a decline from previous levels of functioning and performing, and
- Are not explained by delirium or major psychiatric disorder:
- Cognitive impairment is detected and diagnosed through a combination of (1) history-taking from person and a knowledgeable informant and (2) an objective cognitive assessment ("bedside" mental status or neuropsychological eval).
- Impairment involves a minimum of two of the following domains:
  - Impaired ability to acquire and remember new information
  - Impaired reasoning and handling of complex tasks, poor judgment
  - Impaired visuospatial abilities
  - Impaired language functions (speaking, reading, writing)
  - Changes in personality, behavior, or comportment

Alzheimer's dementia cont.

- And, in addition, have the following characteristics:
- Insidious onset and clear-cut history of worsening of cognition by report or observation;
- Initial and most prominent cognitive deficits are evident on history and examination in one of the following categories.
- **Amnestic presentation**: Most common syndromic presentation of AD. Deficits include impairment in learning and recall of recently learned information. Also evidence of cognitive dysfunction in at least one other cognitive domain.
- **Nonamnestic presentation**:
- Language presentation: word finding deficits are most common, other deficits possible.
- Visuospatial presentation: deficits in spatial cognition, face recognition, etc.
- Executive dysfunction: most prominent deficits are impaired reasoning, judgment, and problem solving.
- And deficits in at least one other cognitive domain.

Underlying Biology Begins 10+ Years Before Symptoms



Elder Abuse

- In it's common usage, elder abuse is an all-inclusive term representing all types of mistreatment or abusive behavior toward older adults.
- This mistreatment can be an act of commission (abuse) or omission (neglect), intentional or unintentional, and of one or more types: physical, psychological (or emotional), or financial abuse and neglect that result in unnecessary suffering, injury, pain, loss or violation of human rights, and decreased quality of life.
- Whether a behavior is labeled as abusive, neglectful, or exploitative may depend on its frequency, duration, intensity, severity, consequences, and cultural context (Wolf, 2000).

Elder Abuse cont.

- Physical abuse: physical force that results in bodily injury, pain, or impairment. It includes assault, battery, and inappropriate restraint/confinement.
- Neglect: the failure of a caregiver to fulfill his or her care giving responsibilities, which are necessary to maintain physical or mental health.

Elder Abuse cont.

- Psychological abuse: the willful infliction of mental or emotional anguish by threat, humiliation, unreasonable confinement or punishment, or other verbal or nonverbal conduct.
- Financial abuse: the illegal or improper use of an older person's funds, property, or resources with or without informed consent of the older adult that results in monetary, personal or other benefit, gain, or profit for the perpetrator, or monetary or personal loss for the older adult.

Elder abuse cont.

- There is a need to make sure that we do not shift blame for elder abuse from perpetrator to victim. In every case of elder abuse, the perpetrator is responsible for his or her acts, and must be held accountable.
- It is also important to note, however, that elder abuse (other than self-neglect or self-abuse) happens within social interactions that at the very least involve a victim-perpetrator dyad.

Caregiver Risk Factors

- It is very important to remember that caregiving is not the primary cause of elder abuse – in fact, it's not a "cause." Rather, it is a context for interaction in which abuse can occur.
- Some authors have suggested a sort of "typology" for elder abuse perpetrators. There are five of them: the overwhelmed, the impaired, the narcissistic, the domineering or bullying, and the sadistic.

Caregiver Risk Factors cont.

- Overwhelmed: generally well intentioned…abuse takes place when the amount of care expected exceeds that which they can comfortably provide.
- Impaired: have problems that render them unqualified to provide adequate care to dependent people (ex: advanced age, physical/mental illness, developmental disabilities)
- Narcissistic: motivated by personal gain and meeting their own needs. Those under their care are a means to an end.
- Domineering or bullying: feel justified in blaming or attacking others, especially those over whom they perceive themselves as having power and authority.
- Sadistic: derive feelings of power and importance by humiliating, terrifying, and harming others.

Red Flags

- Sudden reluctance to discuss financial matters
- Sudden, atypical, or unexplained withdrawals or changes in financial situation
- Abrupt changes in wills, trusts, or POA
- Changes in beneficiaries on insurance policies or IRAs
- Increasing lack of contact with and interest in outside world
- Admission of financial or material exploitation or suspected exploitation

Red Flags cont.

- Concern or confusion about missing funds in his/her account
- Unusual or first-time wire transfers, especially to foreign countries
- Fear of eviction or nursing home placement if money is not given to a caretaker
- Appearance of insufficient care despite having money

CAPACITY/COMPETENCY

- The term "capacity" is multifaceted. There are many different types of capacity. For example there is testamentary capacity, donative capacity, contractual capacity, capacity to convey real property, capacity to execute a durable power of attorney, capacity to consent to medical care, capacity to execute a health care advance directive, capacity to consent to sexual relations, capacity to drive, capacity to mediate, and others (capacity to marry, to stand trial, to sue, to be sued, to vote, etc.)

Capacity/Competency cont.

- In Kansas, an adult with an impairment in need of a guardian, conservator, or both, means a person 18 years of age or older (or a minor based on statute) whose ability to receive and evaluate relevant information, or to effectively communicate decisions, or both, even with the use of assistive technologies or other supports, is impaired such that the person lacks the capacity to manage such person's estate, or to meet essential needs for physical health, safety or welfare, and who is in need of a guardian or a conservator, or both.

Cross-sectional/Longitudinal

- Cross-sectional and longitudinal refers to types of observational studies used in research design.
- Cross-Sectional: this is a moment in time. It is essentially a "snapshot" of a particular behavior or ability.
- Longitudinal: this is across time. It is observation of the same items over a period of time.
- Potential concern with capacity issues is that the professional is sometimes looking at two different things. In other words, it is possible that the legal standard for some capacity issues (e.g., testamentary) is more cross-sectional or situation/task specific whereas other capacity issues (e.g., guardianship/conservatorship) is more longitudinal in nature.

Financial Capacity

- The capacity to manage money and financial assets in ways that meet a person's needs and which are consistent with his/her values and self-interest
- Includes but not limited to:
  - Identifying and counting money
  - Understanding debt and loans
  - Conducting cash transactions
  - Paying bills
  - Maintaining judgment to act prudently and avoid financial exploitation.

10 Commandments of Mental Capacity

I. Thou shalt presume capacity
II. Thou shalt talk to the client alone
III. Thou shalt take steps to maximize capacity
IV. Thou shalt not worship any one standard for capacity
V. Thou shalt not covet the mini-mental status exam
VI. Thou shalt not end any query with only the word "capacity." Yea, the proper query shall be, "Capacity to do What?"

10 Commandments cont.

VII. Thou shalt seek the big picture, with all its variability, intermittency, and nuance.
VIII. Thou shalt honor thy client's own considered or habitual standards of behavior and values, not standards and values held by you or others.
IX. Thou shalt honor thy client's confidentiality and autonomy even in the face of incapacity.
X. Thou shalt plan ahead for incapacity to ensure that one's wishes are respected.

-C. Sabatino, Georgetown University Law Center

- Burden is on the securities industry professionals to identify and recognize "warning signs" of impairment and then take the appropriate steps.
- Goal is to balance two basic principles:
  - Autonomy (self-determination)
  - Beneficence (protection)

Potential Cognitive Concerns

- Dementia: Multiple types of dementia, each with its own progression and symptoms. It is a decline from previous levels of functioning.
  - Alzheimer's Disease
  - Vascular Dementia
  - Fronto-temporal Dementia
  - Lewy Body Dementia
  - Parkinson's Dementia

Cognitive Domains

- Executive Functioning: ability to organize, plan, sequence, and abstract reasoning.
- Working Memory: ability to attend to information, hold and process that information in memory, and to formulate a response based on that information.
- Language: expressive and receptive aphasia
- Attention/Concentration: ability to attend to relevant tasks.
- Visuospatial: ability to pick out relevant issues in the environment, spatial relationships.

Possible Cognitive Signs of Incapacity

- Short-term memory loss: repeats questions frequently; forgets what is discussed within 15-30 min.; cannot remember events of past few days.
- Communication problems: difficulty finding words frequently; vague language; trouble staying on topic; disorganized; bizarre statements or reasoning.
- Comprehension problems: difficulty repeating simple concepts; repeated questioning.

Possible cognitive signs cont.

- Lack of mental flexibility: difficulty comparing alternatives; difficulty adjusting to change.
- Calculation problems: addition or subtraction that previously would have been easy for the client; bill paying difficulty.
- Disorientation: trouble navigating office; gets lost coming to office; confused about day/time/year/season.

Potential Psychiatric Concerns

- Psychiatric Concerns:
  - Mood dysfunction: depression, anxiety, and bipolar disorder may produce cognitive distortions, compromise judgment, and cause irritability or impulsiveness.
  - Delusions: paranoid delusions may be secondary to a number of clinical syndromes, including schizophrenia, delusional disorders, dementia, delirium, acquired brain injury, and other brain lesions.
  - Alcohol/Drug Abuse: both acute and chronic effects on cognition, judgment, and behavior. Even small amounts may affect perception, judgment, and impulsiveness.
  - Suicidality: important to note that highest rate of suicide is white males over age 65.

Possible Emotional Signs of Incapacity

- Significant emotional distress: anxious; tearful/distressed; excited/pressured/manic; depression/lack of joy.
- Emotional lability/Inappropriateness: moves quickly between laughter and tears; feelings inconsistent with topic.

Possible Behavioral Signs of Incapacity

- Delusions: feels others out "to get" him/her, spying or organized against him/her; fearful, feels unsafe.
- Hallucinations: appears to hear or talk to things not there; appears to see things not there; misperceives things.
- Poor grooming/Hygiene: unusually unclean/unkempt in appearance; inappropriately dressed.

Potential Medical Concerns

- Medical Concerns:
  - For many reasons, medical issues can affect cognitive abilities, insight, perception, impulse control, susceptibility to influence, and both recent and remote memory.
  - Conditions such as cancer, cardiovascular disease, primary endocrine and neurological disease, stroke, diabetes, organ failure, dementia, or delirium can adversely impact cognition.
  - Medication issues including whether or not they are even taking them; polypharmacy; and potential side effects are all potential factors. Muscle relaxants, anticholinergics, sedatives/hypnotics, and/or narcotics can all impact cognition.

Mitigating Factors in Assessing Capacity

- Stress; Grief; Depression; Recurrent Stressful Events
  - Address by asking about recent events, losses; allow some time; possible referral to mental health professional.
- Reversible Medical Factors
  - Ask about nutrition, changes in eating/weight, medications, hydration; possible referral to physician.
- Normal Fluctuations in Mental Ability in Older Adults
  - Time of day variability may be present and appointment times may need to be adjusted.

Mitigating Factors cont.

- Hearing and Vision Loss
  - Assess ability to read/repeat simple information; adjust seating/lighting; use visual and hearing aids; possible referral for hearing and vision evaluation.
- Individual Differences and Variability Considerations
  - Educational/Cultural/Ethnic Barriers – be aware of race and ethnicity, education, and long-held values and traditions.

Task-Specific Factors

- The more serious the concerns about the following factors…
  - Is decision consistent with client's known long-term values or commitments?
  - Is the decision objectively fair? Will anyone be hurt by the decision?
  - Is the decision reversible?

Task-Specific Factors cont.

- The higher the function needed in the following abilities…
  - Can client articulate reasoning leading to this decision?
  - Is client's decision consistent over time? Are primary values client articulates consistent over time?
  - Can client appreciate consequences of his/her decision?

Summary: Autonomy v. Beneficence

- Are there observational signs of diminished capacity?
- Are there any mitigating factors that explain observational signs?
- Consider legal analysis of capacity for transaction and categorize:
  - Intact – proceed with transaction
  - Mild problems – proceed and/or consider referral
  - Greater than mild – proceed and refer
  - Severe problems – do not proceed

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