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Alzheimer's disease is a progressive condition that results in brain wasting and eventual death. With its increasing diagnosis rate, counselors will likely acquire clients with Alzheimer's disease or their caregivers. Important background information and several practical counseling methods are provided that may assist counselors working with this population.

Alzheimer's disease is a progressive, fatal condition that results in brain wasting and eventual death. Approximately 4.5 million Americans currently have Alzheimer's disease, and the likelihood of being diagnosed with Alzheimer's disease increases to nearly 50% by age 85 (Hodes, 2004). The annual economic cost of Alzheimer's disease on the American economy is estimated to be more than $100 billion. Furthermore, as the median age of the American population increases over the next several decades, the number of individuals diagnosed with Alzheimer's disease is projected by Hodes to increase to more than 13 million by 2050.

In the future, counselors will likely encounter clients who are diagnosed with Alzheimer's disease or who are caregivers of someone with the disease. The purpose of this article is to provide counselors with a summary of the implications of Alzheimer's disease and strategies for managing therapy with people whose lives are affected by Alzheimer's. By familiarizing themselves with information regarding the theories of etiology, behavioral effects, symptoms, diagnostic methods, current medical treatments, specific counseling considerations, and treatment interventions for those with Alzheimer's and for their caregivers, counselors can become better prepared to work with these clients.

ETIOLOGY OF ALZHEIMER'S DISEASE

A prominent manifestation of Alzheimer's is the formation of plaques and tangles of abnormal neurons in specific areas of the person's brain. The presence of plaques and tangles are characteristic of Alzheimer's disease, and the absence of one of these features means that Alzheimer's cannot be diagnosed. The plaques and neuron

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tangles found in the brain of an individual with Alzheimer's are indicative of a general wasting of the brain that leads to progressive cognitive impairment, which is characteristic of the disease. Cognitive impairment results in confusion during early stages of Alzheimer's disease. As the impairment worsens, the person with Alzheimer's disease gradually loses the ability to manage day-to-day activities such as dressing and hygiene. Eventually, those with Alzheimer's disease are unable to care for themselves and reside in a vegetative state until death.

The underlying cause of plaque formation is known to be related to harmful neurochemical processes (beta-amyloid peptides between cells and highly ordered aggregates of abnormal brain protein called *tau* within cells; Davies, 2000). Currently, experts in the field posit abnormal gene mutations as a potential basis for Alzheimer's disease (Davies, 2000). However, the three known genetic mutations related to the disease account for only about 0.5% of the cases of Alzheimer's disease, leaving the preponderance of cause still largely unknown.

Another hypothesis for Alzheimer's disease is impaired cerebromicrovascular perfusion (De La Torre, 2000). De La Torre proposed that, as part of the aging process, brain capillaries degenerate and fail to deliver adequate perfusion to brain cells to deliver glucose to neurons and remove waste products. De La Torre provided a number of factors to support his particular theory for Alzheimer's disease, including findings that the majority of individuals with Alzheimer's exhibit microvascular abnormalities and drugs that improve cerebral perfusion lower the risk of Alzheimer's disease.

Persson and Skoog (1996) indicated that psychosocial risk factors may also contribute to the development of Alzheimer's disease. They identified major life stressors such as experiencing the death of a spouse, death of a child, death of a parent before reaching age 16. Their study's participants who identified experiencing more than three stressors had an incidence of Alzheimer's disease of 20% in comparison with an incidence of 3% for participants not experiencing any of the identified stressors. Just as it has been linked to many other diseases, chronic stress combined with other health factors may be a contributor to Alzheimer's.

Regardless of whether gene mutation, brain blood circulation, stress, or some other factor is eventually found to be the underlying cause of Alzheimer's disease, diagnosis remains difficult. Additionally, the cognitive, social, and behavioral effects of the disease greatly influence the person's ability to function independently. Counselors, by the nature of their scope of practice, will focus treatment interventions on the psychosocial and behavioral aspects of the disease. The following sections describe Alzheimer's disease diagnosis and effects and the importance of counseling for those with the disease and for their caregivers.

DIAGNOSIS OF ALZHEIMER'S DISEASE

Diagnosis of Alzheimer's disease is made through evaluation of an individual's mental status and through use of other neurological tests to evaluate language,

memory, reasoning, and physical condition (Alzheimer's Association, 1997). Because one definitive test for Alzheimer's disease does not exist, practitioners use multiple modalities to rule out other possible causes of dementia. Typically, such modalities include using brain imaging to rule out strokes and medical tests to check for other contributing conditions.

Importance of Early Diagnosis

Alzheimer's disease progresses over time, starting with minor changes in cognitive ability and ending with severe cognitive compromise and death. Because of the availability of medications that might slow the progression of this disease and the promise of more to come, researchers are trying to determine whether straightforward mechanisms for early diagnosis of Alzheimer's disease exist. A recently published paper by Amieva et al. (2005) followed nearly 1,300 older people for a period of 10 years. During that time, participants were evaluated psychologically and neurologically for dementia every 2 years. Amieva et al.'s study suggested that cognitive decline in individuals with Alzheimer's as a group can be demonstrated up to 9 years before a clinical diagnosis. In addition, the cognitive decline seemed to accelerate in the 3 years preceding a diagnosis. Whereas this research did suggest statistical significance of the mental declines within the groups, it does not show evidence that these declines are diagnostic for an individual.

Given that mental decline due to Alzheimer's disease occurs over many years, early diagnosis might offer a chance to use medications and other preventative strategies when they can do the most good (Nordberg, 2003). Early prescription of drugs might delay the advent of Alzheimer's disease symptoms or slow their progression; however, this has not been demonstrated because of the medication treating Alzheimer's symptoms rather than its cause and the difficulty in identifying the onset date of the disease.

Difficulty With Diagnosis

Early stage Alzheimer's disease is difficult to diagnose because the early, low-level confusion and memory loss do not greatly differ from what are experienced as a typical part of aging. Furthermore, many of the traits associated with Alzheimer's disease such as memory loss and anxiety also are typical of mood disorders (Goldman, 2001). Tools that are used to identify the status of those diagnosed with Alzheimer's are not specific enough to give definitive diagnosis of early stage disease. For example, the Mini-Mental State Examination (MMSE) is effective at identifying the current status of someone's mental state and is commonly used in measuring the mental status of individuals with Alzheimer's disease. However, the MMSE does not discriminate sufficiently between person-to-person mental status variability and variability due to pathology to be an accurate measure of the status of Alzheimer's disease or to diagnose Alzheimer's disease in its early state (McCarten, Rottunda, & Kuskowski, 2004). The MMSE is often used to

measure an individual's status repeatedly over several years, thereby detecting changes in mental status that could lead to diagnosis of Alzheimer's disease.

Verbal functioning is a popular neuropsychological test method for Alzheimer's disease (Forbes, Shanks, & Venneri, 2004). As Alzheimer's progresses, both spoken and written linguistic abilities decline. Instruments such as the Boston Diagnostic Aphasia Examination (Forbes et al., 2004) and the Boston Naming Test (Testa et al., 2004) assess written and spoken language and are useful in identifying cognitive deficits.

The use of neuropsychological tests to diagnose Alzheimer's is somewhat controversial from the perspective of the relative value of these tests as stand-alone tools. The ability to both remember words and construct complex sentences declines with the progression of Alzheimer's disease, so the idea to use these types of tests to diagnose early stage Alzheimer's is attractive. However, as with the MMSE, too much variability seems to exist to use these tests effectively on a stand-alone basis (Testa et al., 2004).

Neuropsychological tests can suggest the presence of underlying neurological pathology such as Alzheimer's. However, many of those tested will be placed in the category of mild cognitive impairment (MCI) in which impairment is too slight to be a basis for the diagnosis of Alzheimer's disease. Zamrini, De Santi, and Tolar (2004) suggested that 12% to 14% of those with MCI will eventually present with Alzheimer's disease. They have suggested that imaging modalities such as positron emission tomography (PET) and magnetic resonance imaging (MRI) could be used to demonstrate brain abnormalities typical of Alzheimer's disease long before neuropsychological tests could be used to make a definite diagnosis. Specific areas implicated in brain pathology are degeneration in the areas of the entorhinal cortex and hippocampus. MRI and PET can show brain atrophy clearly in those with full-blown Alzheimer's disease. Conversely, Csernansky et al. (2005) concluded that the only feature consistently predicting progression of MCI to Alzheimer's was an asymmetric feature in the hippocampus. No other studies have indicated any asymmetries in the progression of Alzheimer's disease. Therefore, the findings of Csernansky et al. indicate a need for further research before imaging techniques are relied upon for clinical diagnosis of a disease that most people view as a death sentence.

Research into the utility of an earlier diagnosis of Alzheimer's has yet to demonstrate that early diagnosis allows doctors to alter the course of the disease significantly. However, demonstrations of early detection of brain pathology are necessary to facilitate future research into drugs that may arrest this pathology before it causes clinical impairment (Zamrini et al., 2004).

PSYCHOSOCIAL AND BEHAVIORAL EFFECTS OF ALZHEIMER'S

The gradual loss of memory and reasoning capabilities result in high levels of stress for those diagnosed with Alzheimer's disease and for their caregivers. People with Alzheimer's gradually become less and less able to function in

society. Routine tasks such as paying bills, going to the store, taking scheduled medications, or even getting dressed require too much mental processing and planning to complete for people with Alzheimer's disease. This loss of ability to function creates tremendous stress for those with Alzheimer's. They experience the immediate stress of not being able to function and complete tasks necessary to live independently. Many individuals experience shame associated with their inability to live up to their own expectations of how they should live their life. Eventually, as cognitive abilities decline further, people with Alzheimer's also experience a loss of the ability to comprehend many instructions or to understand what is happening around them, which results in confusion and fear.

Continuum of Disease Progression

Alzheimer's is a chronic disease in which the early symptoms may be apparent more than 12 years prior to the eventual death of the individual (McMahon & Lacy, 2005). As with many chronic illnesses, individuals with Alzheimer's will commonly follow a predictable progressive course of increasing disability.

In the early stages of the disease, the symptoms may be relatively mild. Symptoms may manifest as forgetfulness; however, people with early stage Alzheimer's often remain employed. They may live alone or at home with a companion. Those with mild Alzheimer's may still be able to perform calculations necessary for balancing their checkbooks and paying their bills.

At middle and later stages of the disease, usually within 5 years of death, individuals may lose the ability to dress unaided. Disease progression continues with loss of the ability to toilet and shower unaided, and loss of bowel and urine control perhaps 2 to 3 years prior to death. Speaking ability declines until individuals with Alzheimer's have command of only five or six words. Eventually, they lose all ability to speak, sit up, or even smile. Clinicians must understand and plan treatment interventions that are relevant to the stage (early, middle, late) of the disease their clients are experiencing.

Common Behaviors

Behaviors often exhibited by individuals with Alzheimer's disease include anger and agitation; hallucinations and paranoia; repetitive actions; screaming and verbal noises; incontinence; problems with bathing, dressing, eating, and sleeping; wandering; and wanting to go home when they cannot (Robinson, Spencer, & White, 1989). Contributing factors to these behaviors include physiological and medical causes, environmental causes, and specific triggers from their caregivers or others. Understanding the possible causes of these behaviors is important because those with Alzheimer's disease often are unable to communicate the sources of their problems. Careful and diligent observation is necessary to determine what may be causing individuals with Alzheimer's to behave inappropriately and to select appropriate courses of action to address their needs.

Psychosocial Distress

Individuals with Alzheimer's disease experience many events and emotions that can result in psychological distress. They experience loss of control over their environments and even their own behaviors. They may experience extreme fatigue as the quality of their sleep declines. They may experience physical discomforts that they are unable to communicate to their caregivers. They may experience side effects from medications that they are taking. Such experiences contribute to feelings of being out of control, which commonly results in depression in many individuals with Alzheimer's disease (Robinson et al., 1989). While nursing staff or other medical caregivers generally manage many of these behaviors, counselors working with individuals with Alzheimer's or their caregivers would benefit from gaining a good understanding of the interactions between causes of behaviors and coping strategies.

PROVIDING COUNSELING FOR INDIVIDUALS WITH ALZHEIMER'S

Currently, a paucity of research literature exists regarding individual counseling for those with Alzheimer's disease. A search of the PsycINFO database from 1967 to the present for the terms "Alzheimer's AND individual AND counseling" yields only 26 citations of which nearly all refer to counseling for the Alzheimer's caregiver. Several reasons may account for this lack of counseling literature. One reason may be a perception on the part of counselors of the difficulty in treating individuals whose verbal and cognitive skills are declining. A second reason is the healthcare system's tendency to manage the behaviors of people with Alzheimer's through nursing staff rather than specialized behavioral clinicians such as counselors. A third reason is that the easy availability and perceived cost effectiveness of medications to address symptoms of depression and anxiety promotes chemical management rather than behavioral management of the symptoms of people with Alzheimer's.

Counselor Self-Awareness and Preparedness

Counseling older people also presents specific challenges for counselors. Counselors need to be aware of their own biases toward older people. Such biases can hamper counselors' abilities to listen to their clients objectively and to manage the situations being encountered (Newton & Jacobowitz, 1999). Older clients often do not have the energy, means, or opportunity to demonstrate many positive aspects of therapy that the counselor may have come to expect from younger clients. Attitudes that stereotype older people as frail or needing protection can prevent the therapist from realistically assessing the situation and offering the best level of treatment.

Although individuals with Alzheimer's and their caregivers experience similar stages of psychological adjustment as the disease progresses, the therapist must recognize the individual problems that each person is encountering. Therapists

who can recognize their own countertransference reactions and respond to their clients in a manner appropriate to their levels of functioning can offer much support in relieving stress associated with Alzheimer's disease.

Counseling for people with Alzheimer's disease can be conceptualized as occurring in three general categories: strategies for helping the individual cope with decreased cognitive abilities and symptoms of the disease, strategies for addressing emotional upset that comes from having a serious illness, and strategies aimed at improving cognitive function and performance. Because individuals with Alzheimer's may spend years in the early to moderate stages of the disease during which they remain able to communicate and respond to others, counselors need therapies that address people's need to live their life with reduced cognitive abilities. In addition to these general strategies, the literature has identified some specific approaches for working with people with Alzheimer's disease, such as structuring the environment; attending to nonverbals; providing education, advocacy, and support; gaining knowledge of pharmacological therapies; and offering validation and redirection.

Structure the Environment

Many aspects of helping individuals with Alzheimer's involve structuring their environment to provide cues that help them to live effectively. Counselors typically are not involved directly with addressing these needs; however, knowledge in this area can be helpful because counselors may be called on to provide educational services to caregivers.

Individuals with Alzheimer's have difficulty focusing and planning; therefore, structuring their environment becomes very important (Robinson et al., 1989). People with dementia sometimes find the physical spaces in which they live too confusing. Keeping living spaces relatively small to restrict the amount of detail individuals must assimilate is helpful. Smaller living spaces also tend to limit social interaction to small groups, which also helps to reduce confusion.

Excessive stimulation also contributes to confusion for individuals with dementia (Robinson et al., 1989). Reducing clutter in their environment can be helpful. Decrease stimulation by removing extraneous materials from shelves and tabletops, eliminating unused furniture, and generally simplifying their living spaces. Stimulation also comes from music playing during conversations, too many people participating in conversations, and other extraneous noise.

People with Alzheimer's have difficulty with "ordinary" aspects of their environment such as finding the way to the bathroom or simply walking across the floor (Robinson et al., 1989). Strategies to address this problem include labeling locations with signs, for those who can still recognize text, or using colored awnings above doors to help identify specific rooms. Those with Alzheimer's do not see as well, so lighting and floor surfaces become important. Patterned flooring may be confusing because people with Alzheimer's have

difficulty determining whether the surface is flat, ramped, or involves stairs. Glare from lighting may also contribute to confusion about the solidity of floors and fear of falling on steps.

Increased Importance of Nonverbal Cues

Some attempts have been made to involve individuals with Alzheimer's disease in group work. Their living environments in adult day care or nursing homes make gathering people relatively easy, and the group work can be structured as one of their daily activities. Junn-Krebs (2003) described the development of groups for those with Alzheimer's and the group leader's role. In these groups, the leader must assume a much more active role to draw individuals toward participation in the group. Attention to nonverbal cues such as facial expression becomes critical because some participants may be capable of providing only that form of feedback. The group leader needs to acknowledge nonverbal cues and work to build cohesiveness based upon them.

LaBarge, Rosenman, Leavitt, and Cristiani (1988) conducted a study in which they divided participants with mild dementia into groups that received counseling and control groups that did not receive counseling. The participants indicated that they enjoyed participating in the groups; however, no pre- or postparticipation statistical difference existed between treatment and control groups in measures from the State-Trait Personality Inventory or the Self-Concept scale. LaBarge et al. noted that their study excluded those with identified depression who might have shown more marked improvement through therapy.

Counselors need to recognize that many behaviors of those with organic brain disease are beyond control of the individual and that the individual may or may not be aware of what he or she is doing (Vickers, 1994). This realization needs to be incorporated into the counselor or caregiver's reactions to the individual because, somewhat paradoxically, many people with Alzheimer's develop heightened awareness of body language. Therefore, any irritation or aversion present in the motions or bearing of the caregiver will influence the individual and that influence may be more significant than the influence of verbal directions.

Providing Education, Advocacy, and Support

Providing education about Alzheimer's disease to clients who may have significant fears following their initial diagnosis is a very valuable role for the counselor. In addition to general disease education, information about coping strategies, community resources, and assistance in developing "disease management plans" are resources that counselors can provide. Furthermore, advocating for clients with health care providers, providing emotional support, and helping clients to martial their social support systems are important therapeutic services that a counselor can provide to the Alzheimer's client.

Knowledge of Pharmacological Therapies

Counselors working with clients should familiarize themselves with the therapeutic benefits and side effects of any medications their clients are taking. Counselors, while not prescribing medications, have an important role in educating clients and caregivers about medications, encouraging compliance, and advocating for clients with physicians concerning medication adjustments. As with most individuals diagnosed with chronic diseases, those with Alzheimer's are commonly prescribed medications to help with cognitive decline and behavioral symptoms. Several drugs recently approved for treating cognitive decline are specifically indicated for Alzheimer's disease. Most of these are in a class of drugs called *cholinesterase inhibitors* (Alzheimer's Association, n.d.). Cholinesterase inhibitors have the effect of increasing the level of the neurotransmitter acetylcholine, which in turn improves cognition and memory. Drugs in this class include donepezil (marketed as Aricept), galantamine (marketed as Reminyl and renamed Razadyne), and rivastigmine (marketed as Exelon).

Cholinesterase inhibitors have relatively minor side effects, which can include nausea, vomiting, and loss of appetite. The Alzheimer's Association provides a useful handout on its Web site that explains the effect of these drugs and is suitable for individuals with Alzheimer's and their caregivers (http://www.alz.org/documents/national/FS_cholinesteraseinhibtors.pdf).

Memantine (marketed as Namenda) is a newer drug that works on different chemical pathways than do the cholinesterase medications. This drug reduces excess glutamate present in the brain, which influences calcium flow into the nerve cells. Memantine has been clinically demonstrated to produce improved memory and function in individuals with Alzheimer's. The Alzheimer's Association also provides a useful memantine handout on its Web site (http://www.alz.org/documents/national/FSmemantine.pdf).

Medications are frequently used by physicians in treating behavioral symptoms in Alzheimer's disease. Medications in the antidepressant class known as *selective serotonin reuptake inhibitors* (SSRIs) are prescribed for low mood and irritability or depression that often accompany Alzheimer's disease (Alzheimer's Association, 2007). These drugs, such as citalopram (marketed as Celexa), fluoxetine (marketed as Prozac), paroxetine (marketed as Paxil), and sertraline (marketed as Zoloft), are generally well tolerated with minor side effects.

Atypical antipsychotic drugs are also prescribed to treat symptoms such as hallucinations, delusions, aggression, and uncooperativeness (Alzheimer's Association, 2007). These drugs, which were developed to address schizophrenia, affect a variety of neurotransmitters in the brain and are generally well tolerated. However, the U.S. Food and Drug Administration (FDA) has issued a product alert that these medications can increase the incidence of death in older people (FDA, 2005). A small number of people experienced symptoms such as neuroleptic malignant syndrome, tardive dyskinesia, high blood sugar and diabetes, and strokes. The FDA has not stated that these drugs should not be used but that physicians should be aware of and monitor for these potential complications.

Antianxiety or Anxiolytic drugs, such as lorazepam (marketed as Ativan) or oxazepam (marketed as Serax), are often prescribed for individuals with Alzheimer's disease to address anxiety, restlessness, or verbally disruptive behavior (FDA, 2005). These medications are in a class of drugs called *benzodiazepines* and are sedative drugs (Sadock & Sadock, 2003). Because sedation can contribute to dizziness, falls, and confusion, these drugs are to be used sparingly.

Validation and Redirection

One of the more important techniques that is effective with difficult behaviors is validation and redirection (Gordeau & Hillier, 2005). When individuals with Alzheimer's become upset by something, such as thinking that someone has stolen something from their room, counselors can intervene to help address the situation. First, counselors validate feelings by acknowledging that they understand the individuals' belief of being wronged and confirming that they will help find the perpetrators of the wrong. Then, counselors redirect by asking the individuals to do something that interests them or at which they are good. The validation helps to calm individuals and the redirection shifts their focus to new, positive activities.

IMPORTANCE OF PROVIDING COUNSELING FOR CAREGIVERS

Providing counseling to individuals with Alzheimer's may be essentially triadic in nature, given that almost all of these people will have some type of caregiver. Counselors must realize that the quality of life of individuals with Alzheimer's is often directly related to the mental and physical health of their caregivers. Counselors, therefore, should include supportive therapy for the caregivers of individuals with Alzheimer's disease.

Caregiver Stress

Caregivers for individuals with Alzheimer's experience high levels of stress. That stress can result in depression or even premature death of the caregiver. Schulz and Beach (1999) found that older caregivers of spouses with a disability who reported experiencing strain had a 63% higher mortality rate than older people whose spouses did not have a disability. Studies have suggested a number of factors that may contribute to increased mortality, including caregivers being less likely to address their own health issues while giving care, having decreased immune function, experiencing cardiovascular changes, and healing from wounds more slowly.

Counseling for family members caring for individuals with Alzheimer's needs to address the stress encountered by the caregivers. Therapy for caregivers can include combinations of individual therapy, group and family therapy, or informal support groups (Frazer, 1999). Stress for caregivers can directly result from the burden of care required by individuals with Alzheimer's but also from disagreements with relatives (particularly siblings) regarding care decisions. Stress commonly results in depression and anxiety for the primary

caregiver. Treatment can involve a combination of information, stress management techniques, social support establishment, and education to help the caregiver address problems encountered.

Caregiver Depression

In one study of 790 caregivers, the prevalence of major depressive disorder meeting diagnostic criteria was more than 22% (Cuijpers, 2005). This rate was noted as being higher than the typical rate of depression in older people, which was stated as being around 10%. Depression may be a contributing factor to caregiver mortality as noted in Schulz and Beach (1999).

Awareness of depression in caregivers is critical because many caregivers spend all their energy tending to the needs of their wards and neglect their own health (Lu & Austrom, 2005). Caregivers with more severe depression tended to have more psychological distress and more physical symptoms that limited their ability to give care to their loved ones. In addition, those with more severe depression tended to be less likely to seek professional help (Lu & Austrom, 2005). These findings highlight the need for counselors working with older populations to perform outreach in an attempt to address the needs of this population.

Importance of Education for Caregivers

Just as educating individuals with Alzheimer's is a very valuable aspect of counseling, so too is educating their caregivers. Counselors working with caregivers can produce considerable relief through education on effective strategies for providing care.

Education is important to help caregivers understand how to effectively deal with needs of the individual with Alzheimer's. Reference books such as *Understanding Difficult Behaviors: Some Practical Suggestions for Coping With Alzheimer's Disease and Related Illnesses* (Robinson et al., 1989) and *Alzheimer's Essentials: Practical Skills for Caregivers* (Gordeau & Hillier, 2005) can provide a framework for understanding the changing needs of individuals with Alzheimer's and help caregivers take less personally the behaviors of these individuals that result from the disease.

Education can also reduce caregiver stress through knowledge of what resources to apply to care for the individual with Alzheimer's. Being able to anticipate the stages of Alzheimer's and being equipped to manage the ongoing disease progression are enhanced through education. Better care through education will result in less distress for the individual with Alzheimer's. Kaufer, Borson, Kershaw, and Sadik (2005) found that effective treatment of the individual with Alzheimer's through pharmaceuticals benefited both the individual and the caregiver. Effective pharmacological treatment of the individual with Alzheimer's resulted in measurable decreases in caregiver distress and reduced time spent by the caregiver in managing distress in the individual with Alzheimer's. Therefore, an overall benefit to caregivers is produced when education helps in the delivery of effective, efficient care.

Helping Caregivers Engage Social Supports

Counselors should consider referring caregivers to the local chapters of the Alzheimer's Association. The Alzheimer's Association offers numerous resources to the caregiver including education, support, respite care, information about medical treatments, information about doctors and legal issues. Counselors should also aid caregivers in forming support systems. In addition to individual counseling, many sources of support groups for caregivers exist. Such groups are often offered through local chapters of the Alzheimer's Association and nursing homes.

SUMMARY

Alzheimer's has significant mental health implications for the people diagnosed with this disease and for those who care for them. Counselors can help ameliorate severity of mental health issues by providing education and support to individuals with Alzheimer's and to their caregivers. Counseling efforts need to be focused on addressing day-to-day issues. Furthermore, because depression and anxiety often are present in individuals with Alzheimer's and in their caregivers, counselors should be alert for symptoms and prepared with treatment interventions. Counselors, through their attentiveness, can help prevent the already difficult process of negotiating a debilitating chronic illness from becoming even more unbearable.

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