Alzheimer's Disease: Clinical Issues, Case Formulation, Advocacy, and Ethical Considerations

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Introduction

Alzheimer's disease (AD) is a progressive neurocognitive disorder characterized by declining memory, impaired thinking, behavioral changes, and a gradual loss of functional independence. It is the most common cause of dementia among older adults and significantly impacts not only those diagnosed but also family members, caregivers, healthcare systems, and communities. As the population continues to age, the prevalence of Alzheimer's disease is expected to increase substantially, making it one of the most significant public health concerns of the twenty-first century.

Understanding Alzheimer's disease is important because of its widespread impact on cognitive functioning, quality of life, caregiver burden, and healthcare costs. Counselors increasingly encounter clients diagnosed with Alzheimer's disease as well as family members coping with caregiving responsibilities and anticipatory grief.

Review of Literature

Alzheimer's disease is classified as a major neurocognitive disorder in the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed., text rev.; American Psychiatric Association [APA], 2022). Symptoms typically develop gradually and worsen over time. Early symptoms often include memory impairment, difficulty learning new information, and challenges with executive functioning. As the disease progresses, individuals may experience language difficulties, disorientation, impaired judgment, personality changes, behavioral disturbances, and a significant decline in daily functioning.

Alzheimer's disease affects numerous aspects of an individual's life. Individuals often experience frustration, anxiety, depression, and a loss of independence. Family members frequently assume caregiving responsibilities, which can contribute to caregiver stress, burnout, financial strain, and emotional distress (Alzheimer's Association, 2025).

Alzheimer's disease is the most common form of dementia. According to the Alzheimer's Association (2025), approximately seven million Americans age 65 and older are currently living with Alzheimer's disease. The prevalence of the disorder increases significantly with age, particularly after age 65. As life expectancy increases, projections indicate that the number of individuals diagnosed with Alzheimer's disease will continue to rise over the coming decades.

The exact cause of Alzheimer's disease remains unknown; however, researchers generally agree that biological, genetic, environmental, and lifestyle factors contribute to its development. Neuropathological changes associated with Alzheimer's disease include the accumulation of beta-amyloid plaques and tau protein tangles within the brain, leading to neuronal damage and cognitive decline (Lane et al., 2018).

Age remains the strongest risk factor. Additional risk factors include family history, genetic predisposition, cardiovascular disease, diabetes, hypertension, obesity, smoking, physical inactivity, and limited cognitive stimulation (Livingston et al., 2020). Researchers increasingly recognize that both biological vulnerabilities and psychosocial factors contribute to disease progression and overall functioning.

Currently, there is no cure for Alzheimer's disease. Treatment focuses on slowing symptom progression, improving quality of life, and supporting patients and caregivers.

Pharmacological interventions commonly include cholinesterase inhibitors and N-methyl-D-aspartate (NMDA) receptor antagonists, which may provide modest improvements in cognitive functioning for some individuals (Lane et al., 2018).

Nonpharmacological interventions are equally important. Cognitive stimulation therapy, psychoeducation, caregiver support programs, behavioral interventions, and environmental modifications have demonstrated effectiveness in improving functioning and reducing distress (Livingston et al., 2020). Integrated behavioral health approaches are particularly beneficial because they address both the medical and psychosocial aspects of the disorder (Sperry, 2013).

Case Study

Margaret is a 72-year-old White female who was referred for counseling by her primary care physician following concerns about memory loss and increased emotional distress. Margaret is a retired elementary school teacher with a bachelor's degree in education. She lives with her husband of 48 years and has two adult children who reside in different states.

Over the past two years, Margaret's family has observed increasing forgetfulness, difficulty remembering appointments, repeated questions, and occasional confusion while driving. Recently, Margaret became distressed after becoming lost while returning home from a familiar grocery store. She reports feeling frustrated, embarrassed, and increasingly anxious about her declining memory. Her husband reports that she has become socially withdrawn and frequently expresses fears about becoming a burden to her family.

Medical evaluation revealed mild to moderate Alzheimer's disease. Margaret has a history of hypertension and Type 2 diabetes, both managed with medication. She denies any previous mental health treatment but reports experiencing symptoms of anxiety and sadness since receiving her diagnosis.

Diagnostic Formulation

Margaret meets criteria for Major Neurocognitive Disorder Due to Alzheimer's Disease (APA, 2022). Evidence supporting this diagnosis includes progressive memory impairment, decline in executive functioning, impaired navigation abilities, and increasing difficulty completing previously familiar tasks. Her symptoms have gradually worsened and interfere with daily functioning. In addition, Margaret presents with symptoms of anxiety related to fears about cognitive decline and future dependency.

Clinical Formulation

Using Sperry and Sperry's (2020) framework, Margaret's difficulties can be understood through the interaction of biological, psychological, and environmental factors. Biologically, she demonstrates progressive neurodegenerative changes associated with Alzheimer's disease. Her age, hypertension, and diabetes may further contribute to cognitive decline.

Psychologically, Margaret interprets her memory difficulties as evidence that she is losing control and becoming a burden to her family. These thoughts contribute to anxiety, sadness, hopelessness, and social withdrawal. From a CBT perspective, automatic thoughts such as "I am

useless now," "My family would be better off without me," and "Things will only get worse" intensify emotional distress and reinforce avoidance behaviors.

Behaviorally, Margaret has begun withdrawing from social activities, limiting opportunities for positive experiences and support. Her withdrawal contributes to reduced engagement, increased isolation, and worsening depressive symptoms. This cycle reinforces her negative beliefs and emotional distress.

Predispositions

Biological risk factors include advanced age, hypertension, and Type 2 diabetes (Livingston et al., 2020). Psychologically, Margaret strongly values independence and competence, making it difficult to accept cognitive decline. Socioculturally, her identity as a caregiver and educator contributes to feelings of inadequacy as her functioning decreases.

Perpetuants

Margaret's distress is maintained by negative thoughts such as "I am a burden" and "I am losing who I am." These beliefs contribute to anxiety, depression, and social withdrawal, which further reinforce feelings of isolation and helplessness.

Protective Factors

Protective factors include a supportive husband and children, willingness to participate in treatment, a history of successful coping, and access to healthcare and community resources.

Treatment Goals

Short-term goals include reducing anxiety and depressive symptoms, increasing understanding of Alzheimer's disease, and maintaining social engagement. Long-term goals focus on improving quality of life, strengthening family support, and promoting adjustment to cognitive decline.

Treatment Focus

Treatment will focus on reducing emotional distress, challenging maladaptive beliefs, and increasing adaptive coping and social engagement.

Treatment Strategy

Using a CBT framework, treatment will combine cognitive restructuring, behavioral activation, psychoeducation, caregiver support, and collaboration with medical providers (Sperry & Sperry, 2020).

Treatment Interventions

Interventions include identifying and challenging negative thoughts, encouraging participation in meaningful activities, teaching coping skills for memory difficulties, providing family education, and referring to support groups and community resources.

Treatment Obstacles and Challenges

Potential challenges include the progressive nature of Alzheimer's disease, resistance to accepting help, memory-related difficulties applying skills, and emotional reactions such as grief, fear, and frustration.

Treatment-Cultural

Treatment should respect Margaret's beliefs about independence, aging, and family roles. Family involvement should be encouraged while maintaining her dignity and autonomy (Sperry & Sperry, 2020).

Treatment Prognosis

Margaret's prognosis is fair. Although cognitive decline is expected to continue, counseling can improve emotional adjustment, strengthen family support, and enhance overall quality of life (Livingston et al., 2020).

Advocacy and Legal/Ethical Considerations

Counselors play an important advocacy role when working with individuals diagnosed with Alzheimer’s disease and their families. Advocacy efforts may include connecting clients with community resources, caregiver support groups, respite services, transportation assistance, and educational programs. Counselors may also advocate for policies that improve access to healthcare services, dementia screening, caregiver support, and integrated behavioral health programs.

Several legal and ethical issues arise when working with clients experiencing cognitive impairment. One major concern involves assessing decision-making capacity and informed consent. As cognitive functioning declines, counselors must continuously evaluate the client’s ability to understand treatment information and participate in decision-making. Issues involving guardianship, power of attorney, advanced directives, and financial exploitation may also emerge.

Confidentiality can become more complex when family members are heavily involved in care. Counselors must balance client autonomy with family collaboration while adhering to ethical standards. Additionally, counselors have an ethical responsibility to monitor for elder abuse, neglect, and exploitation. Maintaining respect for the client's dignity, autonomy, and cultural values remains essential throughout the counseling process.

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