Knowledge about Alzheimer’s disease among Norwegian psychologists: The Alzheimer’s disease knowledge scale

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Professional knowledge about Alzheimer’s disease (AD) is essential in order to provide appropriate care for those suffering from this progressive and fatal condition. The optimizing of service provision to these patients and their families should also involve mental health professionals including clinical psychologists. In the present study, members of the Norwegian Psychological Association working in clinical practice were invited to participate in a web-based survey measuring knowledge about AD and related disorders. Questions regarding age, gender, accreditation as clinical specialist, age group of typical patients, and experience with patients suffering from dementia were asked in addition to the administration of the Alzheimer’s Disease Knowledge Scale (ADKS).

ADKS consists of 30 true/false items covering risk factors, assessment and diagnosis, symptoms, course, life impact, care giving, and treatment and management. A total of 956 clinical psychologists participated, yielding a response rate of 50.9%. The average mean performance score on the ADKS was 24.10 (SD = 2.5, range 15–30). Kuder-Richardson coefficient of reliability on the ADKS was 0.98. Multiple regression analysis showed that being indirectly exposed to dementia in older family members through their own patients, together with a self-reported knowledge of one’s performance on the ADKS, significantly explained high scores on the ADKS. With reservations based on study limitations, it is concluded that the knowledge of AD in Norwegian clinical psychologists is fairly good. An obvious challenge is how to strengthen this knowledge both in our professional training programs in psychology as well as among those working in applied clinical settings.

Keywords: Alzheimer’s disease; knowledge; clinical psychologists; older adults

Introduction

Despite the growing number of older people in most global populations relatively few psychologists work with older adults compared with younger age groups (Gatz, 2007; Karlin, 2006; Karlin & Humphreys, 2007; Zeiss & Karlin, 2008). Notwithstanding, as the population continues to age, mental health professionals will increasingly encounter older persons in their clinical work, either directly or indirectly through their younger adult patients (Jané-Llopis & Gabilondo, 2008). A demand for adequate mental health services to this growing age group is warranted implying a strengthened academic as well as clinical preparation for adequate assessment and treatment procedures (Hinrichsen, Zeiss, Karel, & Molinari, 2010; Qualls, Scogin, Zweig, & Whitbourne, 2010). The dissemination of scientifically based knowledge about age-related changes is fundamental for students and professionals alike in order to develop appropriate expectations for clinical work with older patients, and, not least to avoid biased images and stereotypes of mental health in old age (Jackson, Cherry, Smitherman, & Hawley, 2008).

One critical component of health in later adulthood is the distinction between normal and pathological cognitive ageing. As the proportion of older adults in the population increases, a corresponding increase in rates of dementia and age-related mental illness can be expected (Jané-Llopis & Gabilondo, 2008; Rabins et al., 2007). Early identification and screening will have a pivotal role in facilitating early access to adequate treatment and care, and allow families to adapt to the condition and its impact.

Alzheimer’s disease (AD), constitute the majority of dementia cases hence knowledge about this disease is important for clinicians. Carpenter, Balsis, Otilingam, Hanson, and Gatz (2009) recently developed the Alzheimer’s Disease Knowledge Scale in order to reflect and quantify actual clinician knowledge and bias regarding Alzheimer’s disease and related disorders. The scale is followed by the respondents’ self-rating of knowledge about AD and related disorders. The development of ADKS was based on a highly varied pool of respondents, thus reflecting an expected variation in the respondents’ knowledge of and experience with dementia. The respondents involved undergraduate students, dementia professionals, senior health care staff, dementia caregivers, and older adults, implying that groups who knew more about AD based on their experience or education should score higher than those who knew less about AD. Overall group differences generally followed the
expected directions, implying that the group of dementia professionals achieved the highest mean performance of the ADKS. Still, Carpenter, Balsis, Otulingam, Hanson, & Gatz (2009) emphasize that further research is needed specific to profession and setting, in order to confirm reliability and validity of the scale, as well as to establish norms for specific populations.

The primary objective in the present study is to examine the knowledge base of AD using ADKS in a sample of Norwegian psychologists currently engaged in active clinical practice. We expect that clinical experience with older patients is critical to their level of AD knowledge. We thus presume that psychologists representing various clinical contexts and age segments of patients will be empirically differentiated from dementia professionals on the ADKS, favoring the latter group. In the present study, additional factors, such as age, gender, acquired clinical specialty, the presence of older patients in the respondents’ clinical practice, including dementia patients, are examined to assess their respective contribution to variation in knowledge and understanding of Alzheimer’s disease.

Method

Participants and procedure

A web-based survey questionnaire was distributed by the Norwegian Psychological Association (NPA) to members registered as currently engaged in active clinical practice at the time of the survey. Norwegian psychologists have six years of university training in psychology (graduate training according to a scientific-practitioner model) and are licensed as health personnel in pursuance to the Norwegian health legislation. Psychologists have treatment responsibilities comparable to those of medical doctors, except for the prescription of medication. All Norwegian citizens are covered by public health insurance and the majority of clinical psychologists work in public mental health services. According to the Norwegian Psychological Association there were 5075 licensed psychologists in Norway at the time of the survey (population about 4.8 million), and of whom approximately 85% were members of NPA. On approaching this register, 2031 NPA members were classified as working in public or private mental health services, comprising roughly 47% of the NPA members. Omitted from this register are clinical psychologists working in specialized areas like school and child welfare authorities, child and family protection centres, and various addiction units or clinics. Psychologists practicing clinical work will vary as regards to their respective clinical area and whether they have acquired their clinical specialty or not (a five year post licensure training program based on supervised clinical work and applied courses).

The web-based survey was preceded by a brief pre-contact e-mail letter signed by NPA’s president and the first author (from May to August 2009), in which recipients were invited to complete a survey with a particular focus on knowledge about Alzheimer’s disease. After completing the survey, the scoring key of the scale was given. Participation was anonymous, implying that the two follow-up reminders (with approximately 4-5 week intervals) were sent to the initial number of potential invited participants with a comment to ignore our reminder if they already had responded to our request. To further increase the response rate, a modest monetary incentive was used in the format of 10 gift vouchers (NOK 500/EUR 56/USD 84 each) announced in the invitation (by e-mail) letter. Those who wished to participate in the drawing of a gift voucher had to register name and e-mail address, however, without a linkage to the survey. Tailoring survey design methodology by highlighting the need for multiple contacts as well as monetary incentives, have been shown to increase response rates (e.g. Edwards et al., 2008).

Among the 2031 NPA members approached for our study, 135 persons were excluded for incomplete responding, and 18 did not work in clinical practice during the survey period (6 weeks) due to maternal leave, etc. Thus, a total of 1878 respondents were eligible, and the final overall response rate of 50.9% (N=956) incorporates completed returns from the initial and follow-up mailings to the e-mail request (and attached web-link).

Materials

The survey included a set of demographic and background questions (gender and age), as well as questions concerning relevant clinical practice defined as: acquired clinical specialty, age range of typical patient, frequency of seeing patients with dementia/symptoms concordant with dementia, frequency of indirect exposure to dementia patients in the role as family member of patient (both coded 1=never, 2=1–6 times/yr, 3=7–11 times/yr, 4=1–4 times/month, and 5=weekly or more often), and, finally, approximate percentage of patients with dementia.

The Alzheimer’s Disease Knowledge Scale (ADKS; Carpenter et al., 2009) contains 30 true/false items to assess knowledge about Alzheimer’s disease (AD) and covers the following issues: risk factors, assessment and diagnosis, symptoms, course, life impact, care giving, and treatment and management. The 30 items are followed by a rating of self-reported knowledge about AD (and related disorders), on a scale from 1 (“I know nothing at all”) to 10 (“I am very knowledgeable”). The scale takes approximately 5 to 10 minutes to complete, and is designed for use with health care professionals, students, and the general public, and has demonstrated adequate psychometric properties (Carpenter et al., 2009). A total composite score is calculated by adding together the scores for each item, yielding a total score with a range of 0 to 30 (the 30 items appear in English in Table 2; a Norwegian version of the scale is available.
from the authors). The Norwegian version was adapted from English by a standard translation-back translation procedure.

Statistics

SPSS for Windows version 17 (SPSS, Chicago, III) was used for the statistical analysis. Mean and standard deviation of the total score on the ADKS were calculated, followed by calculation of difficulty indexes and discrimination indexes, respectively for each item of the ADKS. A total score of the ADKS was calculated by summing the number of correct responses. We calculated a difficulty index \( (p) \) for each item, which represents the percentage of respondents who answered the item correctly. In concert with the item difficulty index (to indicate the extent to which the scale items discriminate between individuals with high or low scores), a discrimination index \( (DI) \) was estimated (ideally between 0.3 and 0.7). DI was calculated by estimating the number of correctly answered items among the high scorers (top 27%) subtracted from the number of correctly answered items among the low scorers (bottom 27%) divided by the number of respondents comprising 27% of the sample (Kelley, 1939). Internal consistency of the ADKS was calculated using Kuder-Richardson’s formula for dichotomously scored items.

Independent sample t-tests were used to compare mean performance in the current sample with mean performance in the scale’s validation study. The tests were calculated manually based on the means, standard deviations and sample sizes reported in the validations study.

Finally, a multiple linear regression analysis was conducted, in which the number of correct answers on the ADKS constituted the criterion variable. Predictor variables were: sex, age, clinical speciality, and to what degree the psychologist works with older adults, directly or indirectly. We also checked for normality in the variables included in the regression models. However, as the sample in the current study was large \((N=956)\), no further steps were taken to overcome this, as the risk of problems associated with both skewness and kurtosis are reduced with large samples \((200+)\), and will, according to Tabachnick and Fidell (1996), not make a substantive difference in the analyses.

Results

Sample characteristics

The sample \((N=956)\) comprised 68.9% females, had an average age of 42.9 years \((SD=11.7)\), with a significant gender difference of mean 41.6 \((SD=11.3)\) for women and mean 45.9 \((SD=12.2)\) for men. As displayed in Table 1 about one half \((50.8\%)\) of the respondents had acquired a clinical speciality, and the majority of the respondents \((56.3\%)\) were in the age range of 30 to 49 years. Not surprisingly, only a small percentage, 3.2%, had adults 60 years and above as their typical patient, and seldom met with patients – neither directly nor indirectly – suffering from dementia. In terms of generalizability, there were no statistical differences between responders and non-responders in terms of age, gender or clinical speciality.

Predictors of ADKS

Table 3 displays the results of the multiple regression analysis. Neither age nor gender significantly explained variance in ADKS performance. After entry of clinical characteristics these variables explained an additional 6.4% of the ADKS performance, \(F(5,567)=7.821, p<0.001\). When self-rated knowledge was entered, an additional 1.7% of the variance in ADKS performance was explained.
Table 1. Sample characteristics: demography and clinical experience (%, \( n \), \( p \)-value).

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Women ( 68.9% (n = 659) )</th>
<th>Men ( 31.1% (n = 297) )</th>
<th>All</th>
<th>( p )-value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20–29</td>
<td>16.6 (90)</td>
<td>10.9 (27)</td>
<td>14.8 (117)</td>
<td>(&lt; 0.001)</td>
</tr>
<tr>
<td>30–39</td>
<td>38.5 (209)</td>
<td>30.4 (75)</td>
<td>35.9 (284)</td>
<td></td>
</tr>
<tr>
<td>40–49</td>
<td>21.4 (116)</td>
<td>18.2 (45)</td>
<td>20.4 (161)</td>
<td></td>
</tr>
<tr>
<td>50–59</td>
<td>16.0 (87)</td>
<td>27.9 (69)</td>
<td>19.7 (156)</td>
<td></td>
</tr>
<tr>
<td>( &gt; 60 )</td>
<td>7.6 (300)</td>
<td>12.6 (31)</td>
<td>9.1 (72)</td>
<td></td>
</tr>
<tr>
<td>Certified clinical specialist (Yes)</td>
<td>45.5 (300)</td>
<td>62.5 (185)</td>
<td>50.8 (485)</td>
<td>(&lt; 0.001)</td>
</tr>
<tr>
<td><strong>Age range of typical patient</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0–6 yrs</td>
<td>2.6 (17)</td>
<td>1.4 (4)</td>
<td>2.2 (21)</td>
<td>(&lt; 0.001)</td>
</tr>
<tr>
<td>7–18 yrs</td>
<td>31.2 (205)</td>
<td>18.5 (54)</td>
<td>27.3 (259)</td>
<td></td>
</tr>
<tr>
<td>17–59 yrs</td>
<td>62.6 (410)</td>
<td>77.7 (227)</td>
<td>67.3 (637)</td>
<td></td>
</tr>
<tr>
<td>( &gt; 60 )</td>
<td>3.5 (23)</td>
<td>2.4 (7)</td>
<td>3.2 (30)</td>
<td></td>
</tr>
<tr>
<td>Frequency of seeing patients with dementia/symptoms concordant with dementia</td>
<td></td>
<td></td>
<td></td>
<td>(&lt; 0.001)</td>
</tr>
<tr>
<td>Never</td>
<td>60.6 (392)</td>
<td>47.8 (139)</td>
<td>56.6 (531)</td>
<td></td>
</tr>
<tr>
<td>1–6 times/yr</td>
<td>32.0 (207)</td>
<td>36.8 (107)</td>
<td>33.5 (314)</td>
<td></td>
</tr>
<tr>
<td>7–11 times/yr</td>
<td>2.5 (16)</td>
<td>6.5 (19)</td>
<td>3.7 (35)</td>
<td></td>
</tr>
<tr>
<td>1–4 times/month</td>
<td>1.5 (10)</td>
<td>5.8 (17)</td>
<td>2.9 (27)</td>
<td></td>
</tr>
<tr>
<td>Weekly or more often</td>
<td>3.4 (22)</td>
<td>3.1 (9)</td>
<td>3.3 (31)</td>
<td></td>
</tr>
<tr>
<td>Frequency of indirect exposure to dementia through patients in the role of family member</td>
<td></td>
<td></td>
<td></td>
<td>(&lt; 0.001)</td>
</tr>
<tr>
<td>Never</td>
<td>44.2 (288)</td>
<td>35.5 (105)</td>
<td>41.5 (393)</td>
<td></td>
</tr>
<tr>
<td>1–6 times/yr</td>
<td>45.5 (295)</td>
<td>47.3 (140)</td>
<td>45.9 (435)</td>
<td></td>
</tr>
<tr>
<td>7–11 times/yr</td>
<td>4.9 (32)</td>
<td>11.1 (33)</td>
<td>6.9 (65)</td>
<td></td>
</tr>
<tr>
<td>1–4 times/month</td>
<td>2.3 (15)</td>
<td>3.7 (11)</td>
<td>2.7 (26)</td>
<td></td>
</tr>
<tr>
<td>Weekly or more often</td>
<td>3.4 (22)</td>
<td>2.4 (7)</td>
<td>3.1 (29)</td>
<td></td>
</tr>
<tr>
<td>Approximate percentage of patients with dementia/symptoms concordant with dementia</td>
<td>2.0 (10.4)</td>
<td>3.6 (11.2)</td>
<td>2.5 (10.6)</td>
<td>0.066</td>
</tr>
</tbody>
</table>

Table 2. Item characteristics: the Alzheimer’s Disease Knowledge Scale (ADKS).

<table>
<thead>
<tr>
<th>Item #</th>
<th>Item</th>
<th>Content</th>
<th>Discrimination index</th>
<th>Difficulty index</th>
<th>Alpha if item dropped</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>People with Alzheimer’s disease are particularly prone to depression.</td>
<td>Life impact</td>
<td>0.30</td>
<td>0.96</td>
<td>0.97</td>
</tr>
<tr>
<td>2</td>
<td>It has been scientifically proven that mental exercise can prevent a person from getting Alzheimer’s disease.</td>
<td>Risk factors</td>
<td>0.43</td>
<td>0.77</td>
<td>0.97</td>
</tr>
<tr>
<td>3</td>
<td>After symptoms of Alzheimer’s disease appear, the average life expectancy is 6 to 12 years.</td>
<td>Course</td>
<td>0.48</td>
<td>0.54</td>
<td>0.97</td>
</tr>
<tr>
<td>4</td>
<td>When a person with Alzheimer’s disease becomes agitated, a medical examination might reveal other health problems that caused the agitation.</td>
<td>Assessment and diagnosis</td>
<td>0.47</td>
<td>0.86</td>
<td>0.98</td>
</tr>
<tr>
<td>5</td>
<td>People with Alzheimer’s disease do best with simple instructions giving one step at a time.</td>
<td>Care giving</td>
<td>0.25</td>
<td>0.97</td>
<td>0.97</td>
</tr>
<tr>
<td>6</td>
<td>When people with Alzheimer’s disease begin to have difficulty taking care of themselves, caregivers should take over right away.</td>
<td>Care giving</td>
<td>0.44</td>
<td>0.83</td>
<td>0.97</td>
</tr>
<tr>
<td>7</td>
<td>If a person with Alzheimer’s disease becomes alert and agitated at night, a good strategy is to try to make sure that the person gets plenty of physical activity during the day.</td>
<td>Care giving</td>
<td>0.51</td>
<td>0.63</td>
<td>0.98</td>
</tr>
<tr>
<td>8</td>
<td>In rare cases, people have recovered from Alzheimer’s disease.</td>
<td>Course</td>
<td>0.31</td>
<td>0.92</td>
<td>0.97</td>
</tr>
<tr>
<td>9</td>
<td>People whose Alzheimer’s disease is not yet severe can benefit from psychotherapy for depression and anxiety.</td>
<td>Treatment and management</td>
<td>0.34</td>
<td>0.86</td>
<td>0.97</td>
</tr>
</tbody>
</table>

(continued)
When looking at the final step in the regression analysis indirect exposure to dementia through primary patients recorded the highest beta value (Std. beta = 0.27, p < 0.001) followed by self-reported ADKS performance (Std. beta = 0.15, p < 0.001).

Thus, the results described above demonstrate that Norwegian clinical psychologists have adequate knowledge of Alzheimer’s disease according to the ADKS criteria. This study also provided some evidence that indirect exposure to dementia in older adults may give a certain boost to ADKS performance.
together with a positive self-rating of knowledge about AD and related disorders. However, as indicated above, the predictors explained only a small amount of the variation in ADKS performance.

**Discussion**

The average score among Norwegian clinical psychologists on ADKS was 24.01. By way of comparison, Carpenter et al. (2009) found that dementia professionals demonstrated an average ADKS score of 27.40 whereas undergraduate students had an average score of 20.19. Thus, our expectation that these groups would be differentiated by the ADKS was supported. Considering that daily clinical work with older adults in general, and with patients suffering from dementia in particular is sparse in our sample, we regard the results as satisfactory. We do not know however, how this knowledge translates into practical problem solving when faced with an actual dementia patient. It should be noted that during the development and psychometric testing of the scale it was emphasized that ADKS is not an assessment tool, but rather reflects a general knowledge base which should be supplemented by additional modules in order to differentiate between professional groups (Carpenter et al., 2009). For this reason, the current scale may show ceiling effects in certain expert groups, including clinical psychologists. It should also be emphasized that Norwegian professional programs in psychology are founded on a generalist model in which cognitive impairment throughout the lifespan is the topic of required course reading material, if not necessarily a part of the internship practice for the majority of our graduate students. Additionally, we should not rule out a certain influence on knowledge from topics debated in health care contexts as well as in the public health care discourse.

The discrimination index as it appeared in the present sample was relatively low on most items, indicating that the items seem suitable for the purpose of discriminating at a high level of general professional knowledge. In terms of concurrent validity, scores on the ADKS should be different across groups with different levels of knowledge about Alzheimer’s disease. We would argue that clinical psychologists working with adults in general, should be familiar with clinical characteristics of dementia, which would enable them to refer the patient for appropriate dementia assessment when indicated. In line with the Carpenter et al. (2009), the correlation between the performance on the ADKS and ratings of self-reported knowledge about AD suggests an adequate predictive validity (0.52, p < 0.001).

By inspection of the specific items, only 6 items had a difficulty index (p) below 0.70. The two items with the lowest percentage of correct answers (0.36 and 0.32, respectively) were related to medical risk factors, that is, high levels of cholesterol (item 18) and high blood pressure (item 26). These two items, representing outliers in our sample, may be the ones most clearly falling as a consequence of AD (item 14, p = 0.49) together with the average life expectancy issue (item 3, p = 0.54), both items falling within the area of broader medical issues. We would argue, however, that working with older adults in general and with dementia...
patients in particular involves the need for a bare minimum knowledge concerning medically related symptoms as well as pharmacological treatment options for AD. Hence, these issues should be better addressed in our professional psychology training programs. Reversely, issues related to co-morbidity with mental health issues such as in dementia, is obviously a well recognized topic in our sample (item 1, programs. Reversely, issues related to co-morbidity addressed in our professional psychology training programs. As for top performances in the present study, one third of the items had a $p = 0.90$ or above, a finding that once again indicates the risk of a certain ceiling effect for the scale.

The regression analysis demonstrated that two of the predictors in sum explained 8.1% of the variance of ADKS performance, these being indirect exposure to patients suffering from dementia (Std. beta = 0.27, $p < 0.001$) and self-rated ADKS performance (Std. beta = 0.15, $p < 0.001$). The total explained variance is relatively low, indicating that we might favourably have included a larger number of potentially relevant predictors in our data collection. We would argue, however, that exposure to dementia in clinical practice deservedly appears in the top spot as a plausible predictor of AD knowledge. The significant positive relationship between knowledge and indirect contact with the AD patient, points at a potential cross-learning between family care givers and professionals. Our sample has demonstrated the sparsity among psychologists of clinical work with older adults in general and patients with dementia in particular. Unfortunately, our study also highlighted that little appears to have changed since various surveys which showed that only between 1–4% of psychologists considered specializing in working with older adults or considered older patients as their primary professional target (e.g. Gatz, Karel, & Wolkenstein 1991; Qualls, Segal, Norman, Niederehe, & Gallagher-Thompson, 2002; Wells, 2004). Of particular interest, however, is the fact that indirect exposure to dementia also has an impact on AD performance. Although at a small-scale level, this reminds us of the extensive area of application for which AD knowledge is relevant and in which it may develop. As a consequence, we should more explicitly endorse an attitude that knowledge about abnormal ageing is not just a matter for those specializing in working professionally with older adults. Accurate knowledge of the physical, cognitive and psychological changes that may occur with age is imperative within an integrated model of general adult health care (Jackson, Cherry, Smitherman, & Hawley, 2008). It goes without saying, that the boosting of psychology students’ exposure to older adults through mandatory placements in age care settings within professional clinical programs and curricular content focused on geropsychology would have a great impact on preparing future psychologists to work with older patients (e.g. Pachana, Helmes, & Koder, 2006).

Meanwhile, we find the ADKS as a potentially helpful tool to assess current basic knowledge about Alzheimer’s disease and related disorders.

In closing, limitations of this study deserve mention. Our sample may not be representative of the Norwegian clinical psychologist population. Still, given that more than 50% of Norway’s NPA licensed clinical psychologists participated in the study, substantial deviations from our findings do not seem particularly likely. Additional international studies would be required, however, before attempting any broad generalizations about AD knowledge in psychologists. As indicated by Carpenter et al. (2009), the ADKS is not a complete assessment tool, but rather contains representative items indicating the level of general knowledge about AD. The risk of ceiling effects in certain expert groups, psychologists included, should consequently not be underestimated. In order to strengthen the utility of this scale, we believe that supplementary modules adapted to specific professional groups would provide added value, making it more appropriate for use in professional training programs and subsequent evaluation of teaching efforts. On a broader note, our findings underscore the fact that psychologists without formal geropsychology training may find that that they are providing clinical services to older adults, either directly or as part of support given to relatives of older persons suffering from dementia. In addition to strengthening models of graduate clinical geropsychology training, continuing post licensure education appears crucial in preparing psychologists to provide clinical services to older adults and their families. The ADKS may usefully serve as part of a monitoring tool in the effort to increase professional awareness among psychologists working with older patients.

References


