Alzheimer’s/Dementia among African-Americans in the United States

Michael Olubusayo Akintayo, Adjunct Professor, Graduate of Capella University Minnesota, Metropolitan College New York, New York City Department of Health and Mental Hygiene, New York, USA

Abstract
Many clinicians believe that among all the existing diseases, dementia is the most troubling, confusing, and distressing to clients. The truth is that dementia seems to remove the totality of a client’s being, or snatch human vitality from a client. Dementia is a disease that has the potential to have negative impacts on the clients and their loved ones until death. Dementia poses a number of practical challenges; in which caretaker can no longer be sure whether the care delivered is satisfactory to the client. to achieve better treatment outcomes, as well as satisfaction with care received, This is an exploratory study that examines all existing literatures and provides challenges of dementia among African-Americans and concludes that it is necessary that clinicians and care providers take into consideration the individual with dementia’s experiences, and include this in their planning for care.

Keywords: Alzheimer/Dementia, African-American Families, Healthcare.

Introduction
Many clinicians believe that among all the existing diseases, dementia is the most troubling, confusing, and distressing to clients. The truth is that dementia seems to remove the totality of a client’s being, or snatch human vitality from a client. Dementia is a disease that has the potential to have negative impacts on the clients and their loved ones until death. Cognitive deficits in dementia occur in several different areas ranging from memory impairment, aphasia, and loss of executive functions (Kitwood, 1997b). When one has dementia/Alzheimer it leads to memory loss which is the loss of ability to communicate through verbal or written language, and an inability to, or poor recognition of familiar objects by sight, smell, touch, taste, or sound. The truth is dementia leads to physical limitations which affect clients and their caregivers, and family members (Brangman, 2006). Alzheimer’s disease and related dementia (ADRD) is a chronic neurodegenerative Disease. It is estimated that it is the sixth leading cause of death among people age 65 and above in the United States (ADA, 2009). By the year 2010, Medicare projected that expenditures for ADRD would increase by fifty-four percent to $49.3 billion dollars per year with Medicaid increased spending of about eighty percent to $33 billion dollars (Prigerson, 2003).

Incidence Rates
According to Brangman (2006), the estimated number of individuals diagnosed with Alzheimer’s Disease and Related Dementia (ADRD) worldwide is 24.3 million but likely will increase to 81.1 million by the year 2040. Alzheimer’s Disease Association, (2009). It is estimated that 5.1 million people age 65 and older will be diagnosed with ADRD in the United States. As the age 65 and older population increases in the United States, the prevalence and incidence of Alzheimer’s Disease and Related Dementia (ADRD) is expected to increase over the next 25 years even with the same increase among minority populations (Prigerson, 2003). According to the 2000 United States Census, African-Americans had 13% of the population with 2.7 million of 65 years. By 2050, it is expected to increase to 8.6 million (US Census, 2000). The incidence of ADRD is specifically higher among African-Americans in comparison to other minorities and Caucasian Americans (Dilworth-Anderson & Gibson, 1999).

Prevalence rates
According to recent statistics from the Alzheimer’s disease Association (2009), the percentage of Americans receiving long term care services with a primary diagnosis of ADRD increased from a
reported 6.8 percent in 2001 to a reported 10.1 percent in 2007. Also, in 2007, there was also increase in the burden of caring for patients in by family caregivers in their homes, or within the community. In addition, this illness places economic hardship on families caring for their relatives, so also is the long period of pain and agony for caring for their loved ones with ADRD (Prigerson, 2003). Furthermore, Teel & Carson, (2003), explain that the gradual loss of mental abilities which affect cognition and behavior, make individuals diagnosed with ADRD become dependent to supportive care by the caregivers or relatives. According to current research, the care for caring for someone with ADRD may last from 8 years after the initial ADRD diagnosis extending to 20 years after the onset of symptoms (Prigerson, 2003). The long duration of caring for a relative with ADRD predisposes families to a stress contributing to higher physiological stress symptoms and greater use of psychotropic medications by family caregivers (Parks & Novelli, 2003).

**Increased and Decreased Factors**

In a study, it is suggested that for African Americans to cope well with dementia, one needs to focus on the family and community because of various support that may come from them. Unfortunately, findings from a small 2005 study in Florida also suggest that some African American communities may accept dementia as a normal process of aging and may not use medical terms to describe the condition (Jett, 2006). This may result in delay in seeking treatment or not even seek treatment at all. Also, the role of family and community has both positive and negative implications for the person with dementia. The closely knit community provides a network of caregiving whereby everyone helps to care for the person with ADRD. Family members consider loss of memory as normal and inevitable and they come to accepting fate and reassuring person with ADRD that all will be well. As a result, the family, and community work together to provide support (Jett, 2006).

**Cultural Context**

The Alzheimer’s Association (2010) reported that understanding people’s perception of the cause of Alzheimer’s disease is very important because it influences opinions and provides recommendations on how to best prevent and treat it. The Alzheimer’s Association maintains that health-related behaviors are determined by whether individuals perceive themselves to be likely affected by a particular health problem. They may also see the Alzheimer as a serious problem; or their perception may be convincing that treatment or prevention activities are effective. This philosophy could be applied to various cultures because if a particular culture sees Alzheimer/Dementia (AD) as a normal part of the aging process, that culture’s support for seeking medical help will be lowered. However, if a culture sees AD as a medical disease that requires treatment, they will be more willing to seek medical help (Alzheimer’s Association).

Dementia is a debilitating disorder affecting a large number of people worldwide. Alzheimer’s disease is the most prevalent type of dementia, and an estimated 4 million Americans are affected by it. Equally important is the notion that the number will continue to grow and by 2050, where 1 in 45 Americans may develop Alzheimer’s disease unless a cure is found (Klein & Kowall, 1998).

**Clinical Data**

Dementia is a generic term that refers to a group of symptoms that reflects the loss of intellectual capabilities or memory loss which interferes with daily functioning (Loring, 1996). According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR; American Psychiatric Association (APA), 2000), dementia is defined as “The development of multiple cognitive deficits manifested by memory impairment as well as one or more of the following: aphasia, apraxia, agnosia, and disturbance in executive functioning” (p. 88). Clarinette et al. (2001) found that clients suffering psychosis have severe memory difficulties ranging from black-outs to amnesia similar to Alzheimer. Hanninen et al. (1994) conducted a study on somatic complaints and found that clients with severe somatic problems often have memory complaints like dementia symptoms. In another study conducted by Comijs et al. (2002) found that low self-esteem often restricts a client’s ability to maintain or have good memory. In the same sense, a study by Hanninen et al. (1994) found that neuroticism personality
factors significantly lead to poor memory results. Jorm et al. (1994) completed a study as well that indicated that low self-esteem neurotic personality significantly decreased one’s memory capabilities as well as performance on memory tests. These findings suggest the need to control these factors based on research concerning dementia and other related factors which can significantly cause poor memory results.

Physical Findings
Alzheimer or dementia is a personal experience in which the client struggles to establish meaning of their lifetime experiences. The description of dementia in the literature lists the general syndrome as impairments in cognitive functioning, short-term memory loss, and a reduction in verbal fluency. This explains that dementia is defined in terms of intellectual, linguistic, and cognitive functioning developing from neurological impairments. This means that dementia is a disease of the brain, which affect activities of specific parts of the brain (Brooks, Kraemer, Tanke, & Yesavage, 1993). Dementia poses a number of practical challenges; in which caretaker can no longer be sure whether the care delivered is satisfactory to the client. The way in which dementia undermines personality is through an attack on the individual’s identity. For example, dementia has been identified with a loss of individual identity, due to the deterioration of memory and the increasing difficulty of communication (McGowin, 1993). Many persons suffering from advanced Alzheimer/dementia experience great distress and pain as they feel their sense of identity is slipping away. Persons with dementia describe this loss of identity in poignantly articulate terms (McGowin, 1993), and family members and other loved ones experience their own unique painful reactions.

Laboratory Data
Howieson, et al. (2003) performed an analysis of cognitive decline in healthy community-dwelling among elderly adults for 13 years and found that the old people are at risk for dementia by virtue of their extreme age. Results indicated that 51% of participants developed or experience cognitive decline, with an averaged 90 years of age. Currently, both the American Psychiatric Association and the American Psychological Association agree with these deficits as diagnostic and have applied the term “Age-Related Cognitive Impairment” (ARCI) (American Psychiatric Association [DSM-IV-TR], 2000).

Pathophysiology of Risks Factors
The literature (Maslow, Selstad, & Denman, 2002; Prigerson, 2003) indicates that age is one of the risk factors. It is recommended that between fifty and sixty percent of people greater than age 75 meet the classification criteria for dementia disorders. Currently, there are no specific diagnostic tests available to substantiate a diagnosis of ADRD. Unfortunately, for those diagnosed with ADRD, there is no cure. However, upon establishing an early accurate diagnosis; early pharmacological intercession to increase the neurotransmitter acetylcholine and reduce stimulation of glutamate receptors; treating any co-existing diseases; providing referrals for appropriate services, treatment of behavioral and psychiatric symptoms and pharmacological interventions; and outlining caregiver needs by treatment center will provide a manageable condition for person with ADRD (Desai & Grossberg, 2005). Additionally, positive values of resilient individuals in African-American families include a high regard for the elderly and the provision of social and economic support among African-Americans, a high respect for parents, high status of the elderly, as well as strong emphasis on mutual support or reciprocity including obligation to assist one another will assist person with ADRD to live an improved life (Hill, 1998).

Nursing Prevention and Intervention
Based on research, people with dementia search for meaning as most people do about their lives and environments, as well their struggles to understand and ascribe meaning to loss of functioning. The experience of frustration, fear, loss of control, and anger are common to all people. Interestingly, although loss of cognitive functioning may occur, experiential and emotional feelings are always the
same. It is important to remember that individuals with dementia are still people, and that their experience of any decline in their functioning and quality of life often will lead to emotional reactions much like anyone else (Teel, & Carson, 2003).

**Conclusion**

To achieve better treatment outcomes, as well as satisfaction with care received, it is necessary that clinicians and care providers take into consideration the individual with dementia’s experiences, and include this in their planning for care. Tom Kitwood’s (1997) suggest that fuller attention to emotional and total well-being is paramount when considering just how the individual will fair with treatment. To achieve better informed treatment of care it is necessary to consider the individual’s experiences, which can lead to a better idea of how to approach their condition.

**References**


