Psychiatric aspect of Dementia

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Dementia

- A syndrome due to disease of the brain, usually of a chronic or progressive nature.
- There is disturbance of multiple higher cortical functions, including memory, thinking, orientation, comprehension, calculation, learning capacity, language, and judgement.
- Consciousness is not clouded.
- The impairments of cognitive function are commonly accompanied, and occasionally preceded, by deterioration in emotional control, social behaviour, or motivation.

Psychiatric aspect

- Affective – depression, anxiety, emotionality
- Psychotic – delusions, hallucinations
- Behavioural – agitation, aggression, vocalisation, wandering, disinhibition, apathy, sleep disturbance

General principles

- Non-judgmental approach
- Dignity and respect

- Mental capacity for decision-making
- Valid informed consent
- Patient's best interest

- Impaired communication
- Poor attention and concentration
- Sensory impairment

Affective symptoms 1

- Depression
  - Very common comorbidity (30-50%)
  - Check if past psychiatric history + consult the specialists
  - Symptoms may present differently/ less typical
    - Depressed mood/tearfulness
    - Social withdrawal/ agitation
    - Lack of motivation/ interest/ energy/ apathy
    - Change in diet and sleep pattern

Affective symptoms 2

- Anxiety
  - Inability to settle/relax
  - Seeking reassurance all the time
  - Restlessness/ clinging
  - Poor sleep
- Emotionality
  - Outbursts/ inability to control emotions

Affective symptoms 3

- Find out and remove/reduce the triggers

- For depression, **Avoid TCAs!**
- SSRIs: Citalopram (max 20 mg OD), Sertraline
- Others: Venlafaxine, Mirtazapine

- For anxiety, **Avoid Benzodiazepines!**
- Antidepressants can be used esp if A+D

- Non-pharmacological treatment – relaxation, massage, aromatherapy, music, walking, etc.

Psychotic symptoms 1

- Delusions
  - More common than hallucinations
  - Theft, burglary, misidentification (imposters), infidelity
  - Risk assessment
  - Treat if high risk, distressing or affecting the care

Psychotic symptoms 2

- Hallucinations
  - Less common than delusions
  - Visual hallucinations in DLB (Dementia with Lewy Bodies) – early, vivid, intrusive
  - In other dementias – mid/late stages
  - Is treatment necessary?
    - Risk
    - Distress
    - Disturbance

Psychotic symptoms 3

- Antipsychotic medication
  - **NOT to be used routinely!**
  - **Do NOT use if DLB is suspected!**
  - Associated with increased risk of CVA
  - Accelerates the decline of dementia
  - Risk of falls, sedation, immobility, death
  - Start very low and stay on the minimum effective dose!
  - Eg. Risperidone 0.25 mg BD

Behavioural symptoms 1

- Agitation (“sun-downing”) – 80%
- Aggression (hitting, kicking, biting, scratching, spitting, grabbing)
- Wandering (within and outside home)
- Disinhibition (urinating in inappropriate places, sexual comments and behaviour)
- Abnormal vocalisation (shouting, calling out, screaming)
- Apathy
- Disruptive sleep pattern

Behavioural symptoms 2

- Greater functional impairment
- Accelerated cognitive decline
- Increased mortality
- Increased stress in the care-giver
- Increased care cost
- Breakdown of care at home
- Moving into residential care early

Behavioural symptoms 3

- Environment: ? noisy, busy, crowded, too hot/ too cold
- Change: ? loss of routine/ familiar faces/ surrounding
- Physical health: ? pain, infection, constipation, any source of discomfort or cause for delirium
- Sensory impairment: ? Poor sight/ hearing/ misinterpretation
- Mental health: ? new or pre-existing depression/anxiety/ bipolar
- Medicines: ? interactions in polypharmacy, anticholinergic drugs
- Disease progression: ?frontal lobe involvement
- Personal history and backgrounds: ? likes and dislikes

Psychoeducation

- Acknowledge the carer's effort and their stress.
- Explore the carer's understanding and experience.
- Explain that behavioural symptoms are a manifestation of an illness of the brain. The patient is not putting it on.
- Management is not all about medication.
- Always try to understand from the perspective of the patient.
- Carer to get help and support for their own wellbeing.
- Carers are our partners in successful management/ care for the patient.

Environmental modification

- Keep a routine.
- Maintain eye contact at the same level.
- Speak in a slow, calm voice and tone.
- Do NOT disagree – respect and validate their concerns/distress an d offer reassurance.
- Redirect to the activity or food that they like.
- Keep them away from what seems to be the source of their upset.
- Give them time before approaching them again – eg for bathing/ changing.

Sleep hygiene

- Keep regular bedtime and wake up time
- Avoid daytime naps
- Keep the bedroom at the right temperature and not too bright
- Keep the noise level down in the house/environment
- No caffeine-containing drinks (tea, coffee, cola etc)
- Warm bath and a cup of warm milk before bed time

Pharmacological

- Review of polypharmacy
  - **Review** anticholinergic medication
  - **Avoid** Chlorpheniramine
  - Consider interactions/ paradoxical effects/ SEs
- Antibiotics for infection
- Analgesics for pain - Paracetamol
- Antidepressants for depression/anxiety
- Antidementia drugs (ChEIs)
- Antipsychotics – **Risks*****

Risks 1

- Risk of not treating
  - Falls and injuries
  - Wandering and getting lost
  - Vulnerability to exploitation/abuse – physical/emotional/financial/sexual
  - Self neglect
  - Aggression: verbal/physical
  - Breakdown of care

Risks 2

- Risks of treating
  - Increased CVA and death with antipsychotics
  - Accelerated cognitive decline with antipsychotics
  - Sedation, falls, immobility and consequences
- Assess
  - intensity
  - frequency
  - **urgency**

Mental Capacity, QoL & Best Interest

- Ability to understand, retain, weigh up the relevant information and communicate the decision
- Whose QoL are we considering? How accurate is our assumption?
- Best Interest: views of all who know the patient well

Summary

- Affective – depression, anxiety, apathy, emotionality
- Psychotic – delusions, hallucinations
- Behavioural – agitation, aggression, vocalisation, wandering, disinhibition, sleep disturbance

- Pharmacological and non-pharmacological treatments

- Risks of not treating and treating

- Carers are our partners in successful management/ care.

Reference

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