Mental Health Care for Elders with Dementia

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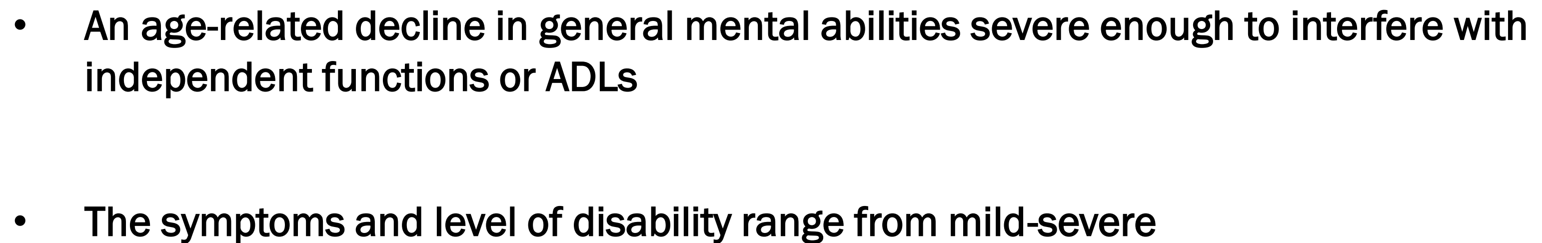
DEMENTIA: AN OVERVIEW

DEFINITION:



- An age-related decline in general mental abilities severe enough to interfere with independent functions or ADLs
- The symptoms and level of disability range from mild-severe

DEMENTIA: AN OVERVIEW

Dementia not just about *Cognition (e.g.* memory, orientation, awareness, information processing); other areas of impairment are:

- *MOOD-*

- Depression/Dysphoria
- Elation/Euphoria
- Anxiety
- Irritability

DEMENTIA: AN OVERVIEW

- THOUGHT-

  -Delusions, Hallucinations, Fear, Paranoia

  -*Possible causes*: UTI, Medical illness, Premorbid mental illness

- ACTIVITY-

  - Apathy
  - Aberrant motor behaviors
  - Involuntary Vocalizations
  - Agitation
  - Aggression

  -Wandering

DEMENTIA: AN OVERVIEW

- SLEEP DISTURBANCE-

  - *Possible causes*: Pain, Depression/Anxiety, Noise, Excessive daytime sleep, Fear of dark, Disorientation, Decreased need for sleep, Medication

- CHANGES IN APPETITE/EATING-

  - Typically anorexia
  - Difficulty swallowing/Dysphagia
  - May require assistance with feeding
  - May forget how to properly use utensils

DEMENTIA: AN OVERVIEW

- *SOCIALLY INAPPROPRIATE BEHAVIORS:

-Swearing, cursing

-Sexually-inappropriate behaviors (comments or acts)

-Disinhibition, e.g. behaviors that reflect impaired or poor judgment

-*Possible causes*: Need for intimacy, affection; poor impulse control; delirium; premorbid personality (habitual inappropriate behaviors)

*More common in males

DEMENTIA: AN OVERVIEW

- COMMUNICATION-

- Impairment in receptive and expressive language (the ability to understand and respond to verbal or written communication, or sign language)
- Inability to communicate needs
- Inability to generate language

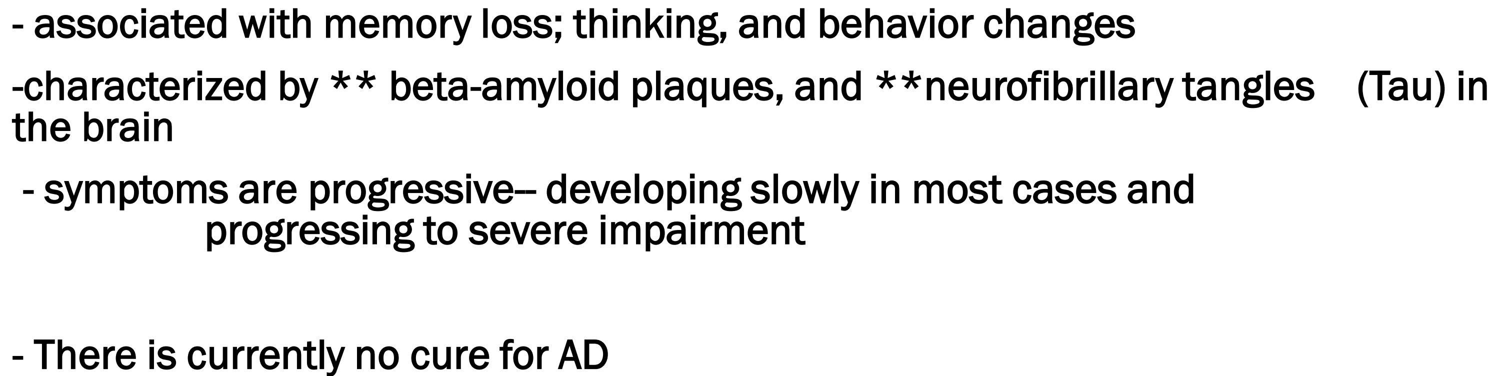
Possible causes: Effects of CVA, UTI, Metabolic encephalopathy, Cell death

TYPES OF DEMENTIA

1. Alzheimer’s disease
2. Vascular dementia
3. Lewy body disease
4. Parkinson’s disease
5. Creutzfelt-Jacob disease
6. Huntington’s disease
7. Fronto-Temporal dementia
8. CTE (associated with sports like football)

TYPES OF DEMENTIA

1. Alzheimer's (AD)- most common type (60-80% of cases)



- associated with memory loss; thinking, and behavior changes

-characterized by ** beta-amyloid plaques, and **neurofibrillary tangles (Tau) in the brain

- symptoms are progressive-- developing slowly in most cases and progressing to severe impairment

- There is currently no cure for AD

ALZHEIMER'S DISEASE

What the Numbers Tell Us:

- 1 in 9 people >65y.o. have Alzheimer's
- 1/3 of people >85y.o. have Alzheimer's
- More women than men are diagnosed with the disease
  - at age 65, women have a 1 in 6 chance of developing AD
  - for men there is a 1 in 11 chance of having the disease
  - of the roughly 5 million people living with AD, 3.2 million are women
  - women in their 60s are twice as likely to develop AD than breast cancer

ALZHEIMER'S

- Of those with the disease-

- 82% > 75y.o.
- Someone develops Alzheimer's every 67 seconds
- 2000 411,000 new cases
- 2010 454,000 new cases up 10%
- 2030 615,000 new cases up 50%

ALZHEIMER'S

Why More Women than Men with AD?

- Longevity
- ApoE-4 gene variant- possible interaction with Estrogen
- Heart health (cholesterol, diabetes, obesity)
- Chronic lack of exercise (cardiovascular fitness reduces cerebral atrophy)
- No definitive answers

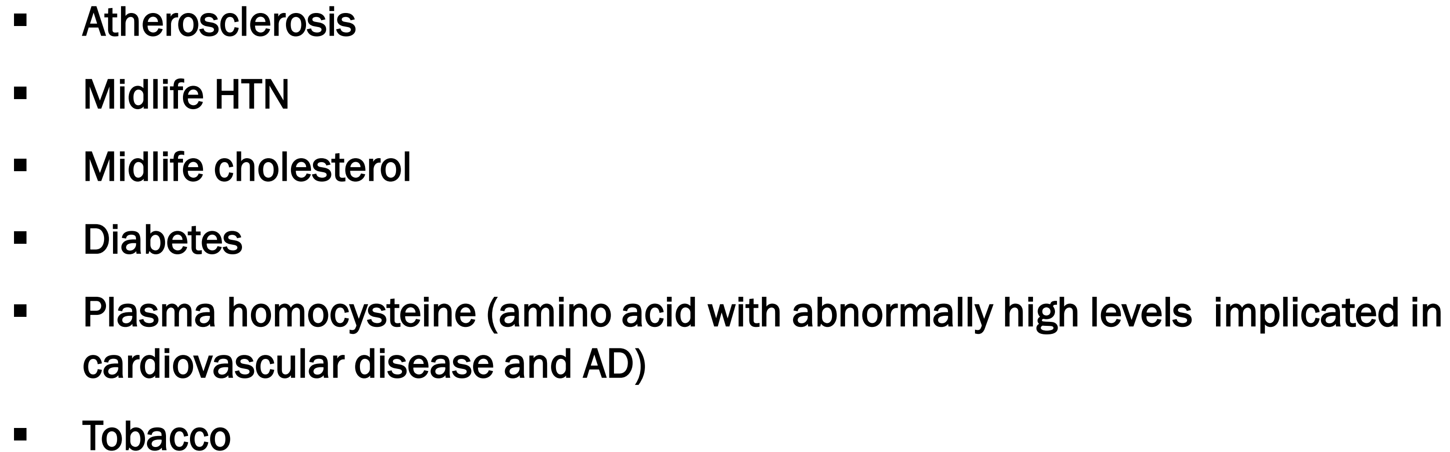
TYPES OF DEMENTIA

2. Vascular type- second most prevalent

-typically associated with multiple strokes.

- Diagnosis requires onset of cognitive deficits contemporaneous with occurrence of stroke (CVA) or other vascular event
- Or, clear relationship of cognitive impairment to *diffuse* sub-cortical cerebrovascular disease pathology

VASCULAR DEMENTIA



Major Risk Factors-

- Atherosclerosis
- Midlife HTN
- Midlife cholesterol
- Diabetes
- Plasma homocysteine (amino acid with abnormally high levels implicated in cardiovascular disease and AD)
- Tobacco

VASCULAR DEMENTIA

ALSO-

- Small vessel lesions

  -Micro bleeds

  -Micro infarcts

  -Small vessel disease

  -Atherosclerosis

  - Cerebral Amyloid Angiopathy (amyloid deposits form in the walls of the blood vessels of the CNS)

TYPES OF DEMENTIA

3. Parkinson's & Lewy Body- share some clinical similarities

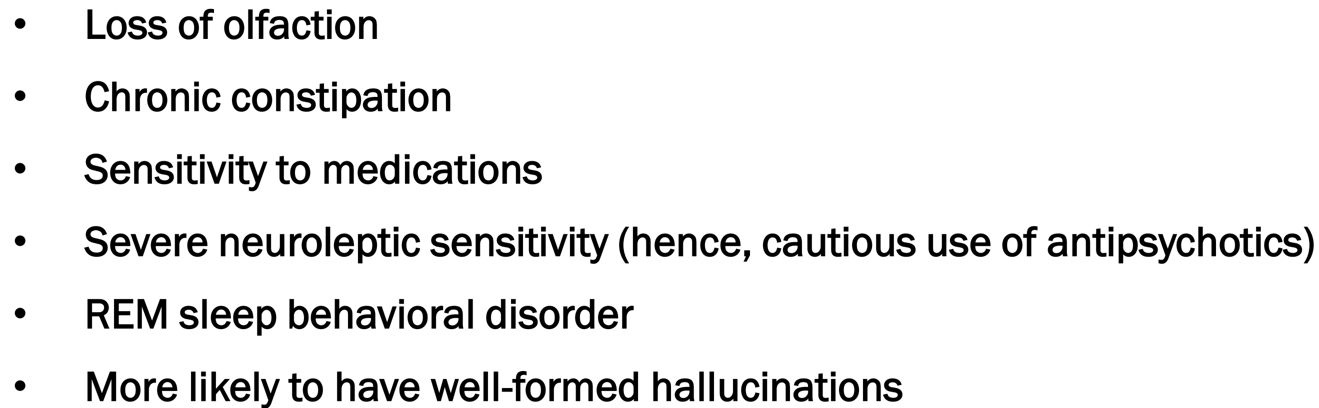
- Alpha-synuclein protein are the major protein clumps (i.e. 'Lewy Bodies') found in Parkinson's disease
- Cognitive deficits: Attention, executive functions, memory, language
- Behavioral symptoms:

  -*Parkinson's*: Hallucinations, delusions, apathy, depression, anxiety

  -*Lewy Body*: Visual hallucinations (well-formed, detailed); fluctuations in attention/alertness; Parkinsonism (muscle rigidity); progressive cognitive decline

TYPES OF DEMENTIA

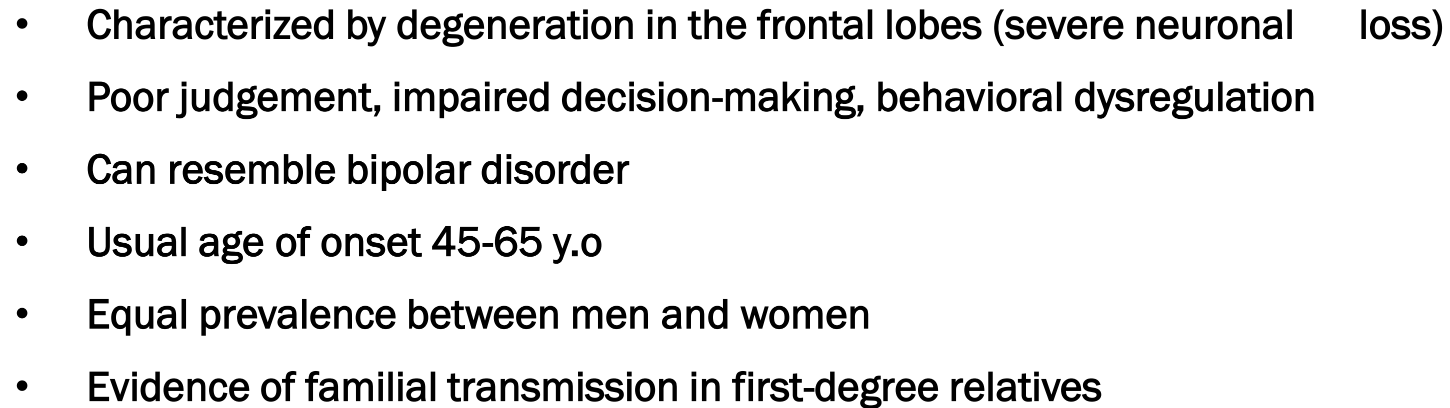
More on Lewy Body Dementia-



- Loss of olfaction
- Chronic constipation
- Sensitivity to medications
- Severe neuroleptic sensitivity (hence, cautious use of antipsychotics)
- REM sleep behavioral disorder
- More likely to have well-formed hallucinations

TYPES OF DEMENTIA

4. Fronto-temporal dementia-



- Characterized by degeneration in the frontal lobes (severe neuronal loss)
- Poor judgement, impaired decision-making, behavioral dysregulation
- Can resemble bipolar disorder
- Usual age of onset 45-65 y.o
- Equal prevalence between men and women
- Evidence of familial transmission in first-degree relatives

TYPES OF DEMENTIA

5. Chronic Traumatic Encephalopathy (CTE)-

- *Not Alzheimer's Disease*
- CTE: "Dementia Pugilistica" – a type of CTE associated with rough sports such as boxing, football, hockey, Military veterans

  - characterized by multiple concussions/impacts to the head
  - commonly manifests as dementia due to memory loss, or
  - declining mental abilities, e.g. confusion
  - Parkinsonism prevalent (lack of coordination)
  - aggressive/violent behaviors, depression, suicidality
  - onset of symptoms typically delayed by up to 20 years

CTE

- Brain pathology-
  - aggregation of abnormal proteins
  - neuronal inflammation
  - dysarthria, ataxia
  - Parkinsonism

OTHER SOURCES OF DEMENTIA

- Alcoholism: Wernicke-Korsakoff Encephalopathy (Thiamine deficiency, ataxia, confusion, confabulation, frontal lobe dysfunction, et al)

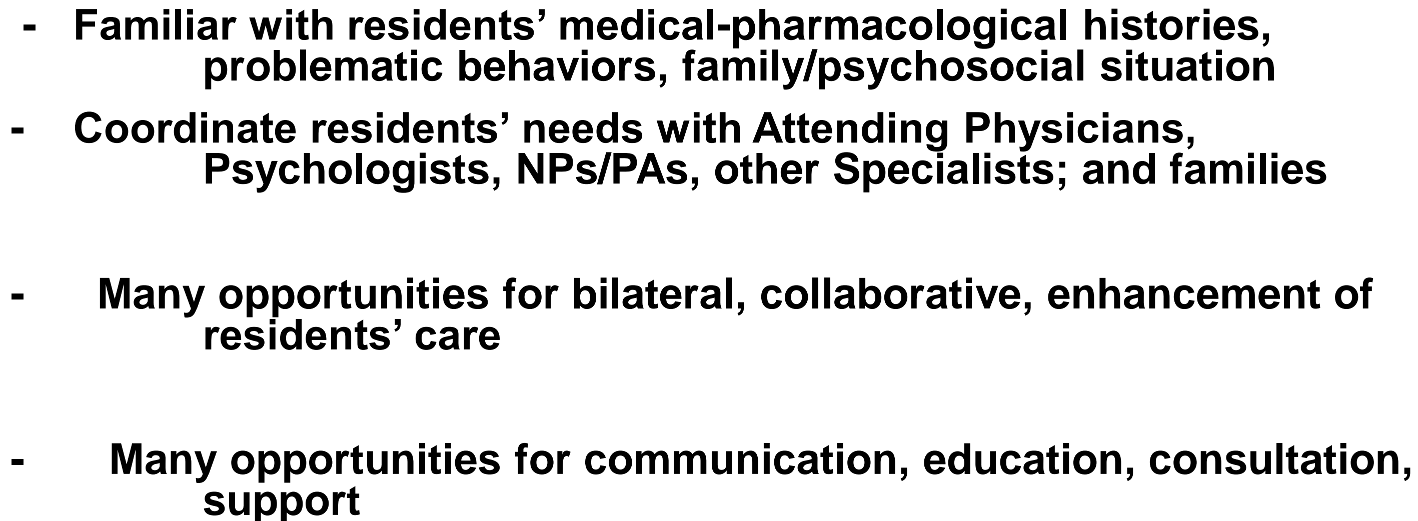
MENTAL HEALTH ASSESSMENT & COLLABORATIVE TREATMENT APPROACHES

A. PSYCHOLOGICAL ASSESSMENT

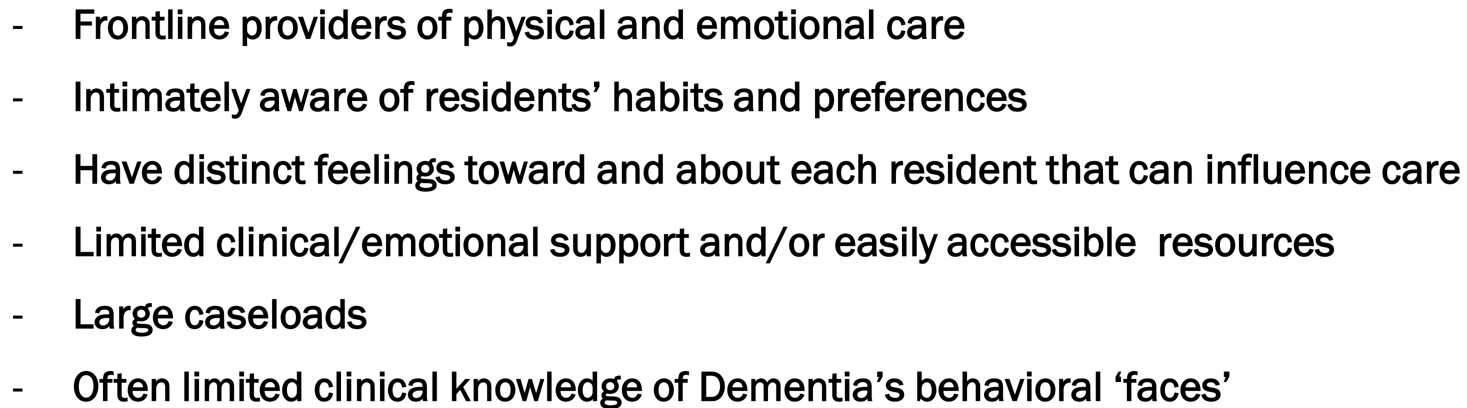
- Mental Status Examination (alertness, orientation, memory, receptive/expressive speech)
- Review of Medical History (*Red flags*: vascular conditions, UTI, other infections, Pain)
- Assessment of
  - Mood
  - Sleep/ Appetite
  - Motivation
  - Acceptance

COLLABORATIVE TREATMENT APPROACHES

Collaboration with Key Providers-



COLLABORATIVE TREATMENT APPROACHES



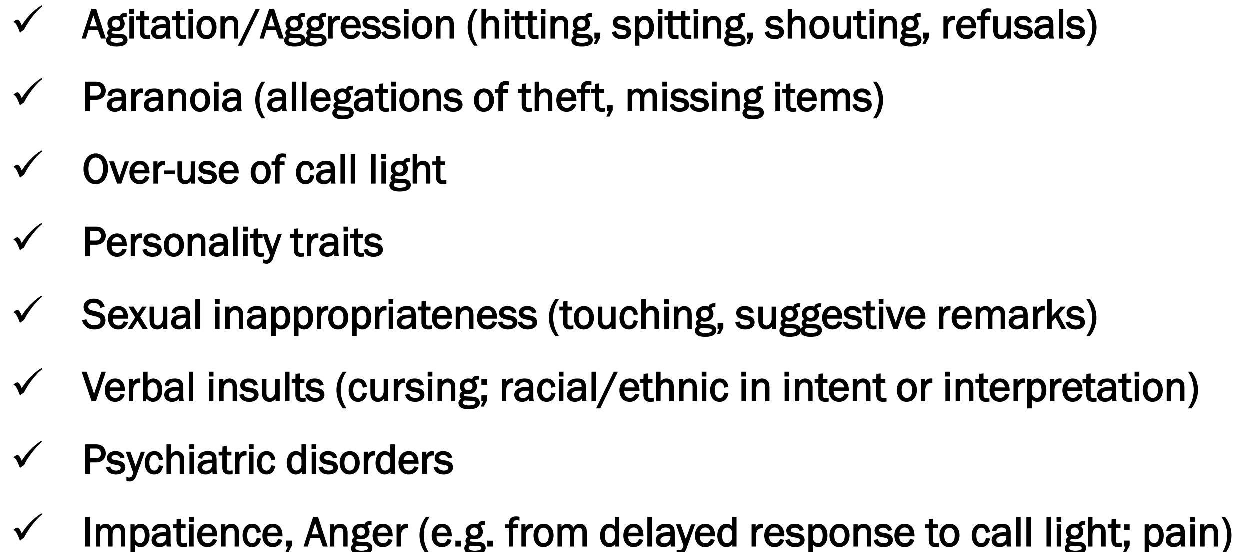
❖ CENAs/MAs

- Frontline providers of physical and emotional care
- Intimately aware of residents' habits and preferences
- Have distinct feelings toward and about each resident that can influence care
- Limited clinical/emotional support and/or easily accessible resources
- Large caseloads
- Often limited clinical knowledge of Dementia's behavioral 'faces'

COLLABORATIVE TREATMENT APPROACHES

- SOCIAL WORKERS
- Familiar with residents' histories, family dynamics, and psychosocial needs.
- Collaborate with Nurses, Psychologists, Psychiatrists, NPs/PAs

BEHAVIORAL INTERVENTIONS IN DEMENTIA



BEHAVIORAL INTERVENTION IN DEMENTIA

- ❖ Some General Principles for Behavioral Interventions

A. Be Proactive: e.g. Training of CNAs/MAs

B. Be Proactive: Know the Person

C. Develop a virtual ‘toolkit’ of responses that minimize

- Personalization
- Retribution
    - Neglect
    - Avoidance

BEHAVIORAL INTERVENTIONS IN DEMENTIA

Examples of Meaning of Agitation and other Behavioral Disturbance

Imbalance in interaction of lifelong habits and personality; physical and mental states; and less than optimal environmental conditions

- Expression of frustration
- Depression, anxiety
- Unmet needs (e.g. chronic pain)
- Loneliness
- Soliciting help, engagement

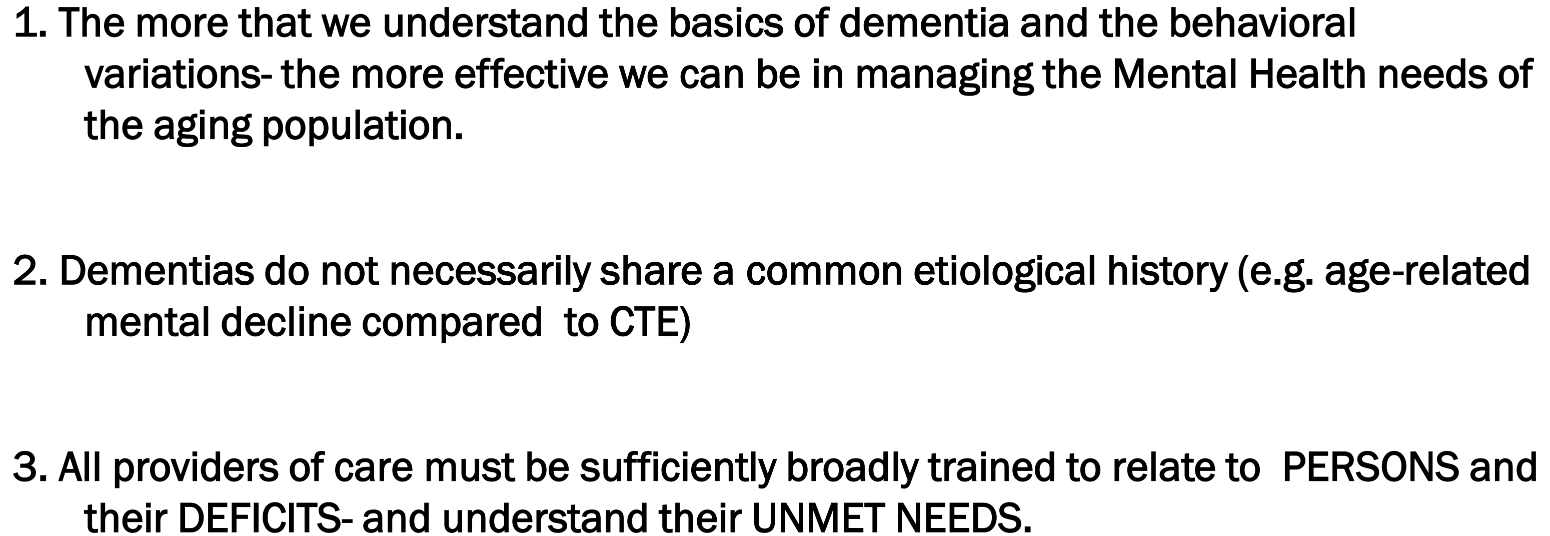
BEHAVIORAL INTERVENTIONS IN DEMENTIA

WHAT TO DO IN THE SETTING-

KNOW THAT NEEDS ARE PRESENT BUT THEIR COMMUNICATION IS DISRUPTED BY DEMENTIA

1. Identify the unmet need (s): Ability to communicate unmet needs re pain, dependence/helplessness, discomfort, loneliness, fear of death, etc.
2. Try to understand the situation from the resident' s perspective
3. Optimize occupational/spiritual/pleasurable resources
4. Seek peer/supervisor support

SUMMARY



1. The more that we understand the basics of dementia and the behavioral variations- the more effective we can be in managing the Mental Health needs of the aging population.

2. Dementias do not necessarily share a common etiological history (e.g. age-related mental decline compared to CTE)

3. All providers of care must be sufficiently broadly trained to relate to PERSONS and their DEFICITS- and understand their UNMET NEEDS.

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