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The 3D's: DELIRIUM DEPRESSION DEMENTIA

The Facts...

- ⇒ Psychiatric illness has been reported to affect more than 90% of residents of Nursing Homes (NH).
- ⇒ The number of Nursing Home residents is expected to triple by the year 2020.
- ⇒ Psychiatric illnesses are often undetected.
- ⇒ The most common chronic psychiatric illness in all nursing homes is dementia; the most common acute psychiatric illness is delirium.

DELIRIUM *disturbance of awareness*

- Causes abrupt changes in behavior or mental status
- Most frequently caused by underlying infection, medication toxicity or other medical illness

DEPRESSION *disturbance of mood*

Symptoms necessary for diagnosis of major depressive disorder are a depressed (sad) mood/loss of interest for at least two weeks, and at least 5 of the following:

- Tearful or sad feelings
- Weight change, (usually decreased)
- Trouble sleeping
- Psychomotor agitation or retardation
- Fatigue or loss of energy
- Feelings of worthlessness or guilt
- Loss of ability to concentrate
- Indecisiveness

DEMENTIA *disturbance of memory*

The most common type of dementia is Alzheimer's Disease, but cerebrovascular disease (strokes) may also contribute to dementia.

Symptoms for diagnosis of dementia must include:

- **Impaired memory** - an inability to learn new information or recall learned information.

With one additional problem in thinking such as:

- **Aphasia**—language impairment affecting the production or comprehension of speech.
- **Apraxia**—loss of ability to carry out movements such as writing, gait, and complex tasks.
- **Agnosia**—loss of ability to recognize objects or persons.
- **“Executive function” Loss**—loss of ability to plan ahead, foresee consequences, etc.

DELIRIUM

To recognize delirium, look for:

- reduced awareness of the environment
- inability to focus, sustain, or shift attention
- disorientation
- perceptual problems (hallucinations)
- fluctuating course
- abrupt onset

Did you know:

- The most common cause of delirium in the nursing home is urinary tract infection.
- Other common causes of delirium are respiratory infections, electrolyte imbalance, congestive heart failure, and medication interactions.
- Approximately 40% of delirious patients present as apathetic and quiet.
- Persons with dementia and depression are vulnerable to delirium.

First Course of Action:

- Identify source of underlying physical problem through a physical exam, laboratory or other assessment.
- Treat underlying problem immediately.
- Look for possibility of overmedication.

Medical Treatment:

First course of medical action is to reduce or stop a potential offending medication. If symptoms of agitation are problematic, consider a low dose antipsychotic drug such as haloperidol or risperidone to maintain safety until delirium resolves. Avoid physical restraints if possible.

DEPRESSION

Symptoms of depression may be hard to distinguish from symptoms of dementia, but feelings of worthlessness, guilt, sleeplessness and weight loss are indicators of depression. A history of depression in young adulthood is a risk factor for late life depression.

Individuals are at higher risk of depression if they have:

- Cerebrovascular disease—History of stroke
- Parkinson's disease
- Losses/grieving
- Loss of independence
- Social isolation
- Impending dementia
- Multiple medical problems
- Chronic Pain

First Course of Action:

- Work with the environment: Provide social support, minimize isolation, involve in community and family, encourage physical activity.
- Examine potential overuse of benzodiazepines (lorazepam, alprazolam) and other sedatives, or over-the-counter agents that may be contributing to loss of function.
- Investigate possible underlying dementia.
- Consider referral for supportive counseling through clergy, psychologist or therapist.

Approximately 20% of persons over 65 suffer from depression.
Treatments for depression are available, safe and effective.

Intervene

with Medications when:

- the environment has been optimized, and medical problems have been ruled out.
- there is severe distress and tearfulness.
- severe symptoms such as substantial weight loss, suicidality/death wish, ongoing sleeplessness, or depressive symptoms are present.

Medical Treatment:

For Major Depressive Disorder, Selective Serotonin Reuptake Inhibitors (SSRIs) are often the first line of treatment. For example: citalopram, sertraline, paroxetine, and fluoxetine.

Some alternative medications include venlafaxine, bupropion and mirtazapine.

Did you know:

Pseudodementia is an older term used to describe cognitive impairment that resolves with successful treatment of depression. Unfortunately, even patients with complete recovery appear to be at high risk for irreversible dementia.

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DEMENTIA

Behavioral signs in **early dementia** include apathy (loss of interest), social withdrawal, and anticipatory anxiousness.

Behavioral signs in **advancing dementia** include suspicious beliefs—such as belongings are being stolen, a spouse is being unfaithful, food is being poisoned or caregivers are imposters.

Common symptoms of visual misperceptions are:

- Somatic delusions (conviction of having cancer or other fatal illness)
- Perceiving people in the room
- Wandering (aimless pacing, entering other's rooms)
- Agitation (physical threats, verbal outbursts)
- Night-time confusion—also called 'Sundowning'
- Uncooperativeness and resistance with bathing/feeding

First Course of Action:

To best manage and minimize problems that may lead to agitation, aggression, hostility and falls:

- Maintain adequate lighting and avoid clutter and loud stimuli.
- Use 'guides' to help orient the resident (e.g. signs that identify their rooms).
- Provide reassurance that the individual is in a safe place.
- Recognize delusions are symptoms of dementia; do not confront or try to 'teach' the individual that their beliefs are incorrect.
- Use reassurance instead of confrontation.
- Recognize that hostility is a common symptom often related to misperceptions; avoid "taking it personally".

When Caring for Persons with Dementia:

- Keep decision-making at a level that fits the person's ability to reason.
- Enhance verbal requests or instructions with physical guidance and demonstration.
- Use distraction techniques instead of verbal explanations when the person is upset.
- Avoid contests of wills.
- Develop a predictable daily routine, including pleasant activities and exercise.
- Keep explanations short—be willing to repeat.
- Focus on use of over-learned skills such as shoe tying and hair brushing that may be retained and brought out by demonstration long after the words for these tasks are forgotten.
- Avoid unfamiliar activities, situations and

For Agitation, Intervene With Medications After You:

- Evaluate for a possible delirium, pain, or undiagnosed medical condition.
- Consider the possibility of medication interaction or adverse medication effect.
- Identify the source of agitation (e.g. medical problems: dehydration, infection; or an inability to express needs, articulate pain, dental problems, etc.)

Medical Treatment:

For agitation with anxiety and restlessness, low-dose, trazodone in divided doses may be beneficial.

For acute treatment of delusions and agitation, low-dose haloperidol or risperidone may be helpful.

For patients with Parkinsonism, olanzapine may be better tolerated.

Notes for Families:

- Too much stimuli during family visits can increase distress. Sometimes brief, small group visits on-site are the best. Trips outside the nursing home can become frightening and distressful as dementia progresses.
- Often when an individual is losing the ability to identify family members it can increase distress to keep checking "You remember me, don't you?"
- Minimize discomfort / unfamiliarity by providing reassuring statements that re-orient the individual without being challenging. (i.e. "Isn't your granddaughter, Sally, wonderful. It's so nice she's visiting today.")
- When suspicious beliefs arise, they often involve family members stealing or mismanaging the individual's resources. Recognize these beliefs as symptoms of dementia; do not react with defensive/hurt behaviors.

For additional information about **Alzheimer's** and other related dementias check the following websites:

Alzheimers.com
<http://www.alzheimers.com>

Elderweb
<http://www.elderweb.com/body/alzheim.htm>

Alzwell—Caregiver Page
<http://www.alzwell.com>

MEDICATION CHART FOR DEPRESSION & DEMENTIA

For Depression			
Medication	Brand Name	Recommended Dosage	Comments
bupropion	Wellbutrin	75 – 100 mg po bid	Stimulant-like qualities may increase energy. May also infrequently cause anxiety, insomnia and psychosis.
citalopram	Celexa	10 – 20 mg po q am	Well tolerated first-line treatment. May interact with protein-bound drugs or those metabolized by hepatic cytochrome p450 2D6 isoenzyme, similar to all SSRIs below.
fluoxetine	Prozac	10 – 20 mg po q am	Longest half-life of SSRIs. May increase likelihood of insomnia. May have liver enzyme inhibition as noted above with Celexa.
mirtazapine	Remeron	7.5 – 30 mg po q hs	May be beneficial for depression with insomnia due to sleep-enhancing properties.
nortriptyline	Pamelor	50 – 150 mg po q hs	Improves sleep and appetite but anticholinergic side effects may include urinary retention, dry mouth, constipation and orthostatic hypotension. Imipramine and amitriptyline are not recommended due to greater anticholinergic effects.
paroxetine	Paxil	10 – 20 mg po q am	Well tolerated first-line treatment. May interact with protein-bound drugs or those metabolized by hepatic cytochrome p450 2D6 isoenzyme.
sertraline	Zoloft	25 – 100 mg po q am	Well tolerated first-line treatment. As with all SSRIs, may interact with protein-bound drugs or those metabolized by hepatic cytochrome p450 2D6 isoenzyme.
trazodone	Desyrel	25 – 200 mg q day	Beneficial for sleep, side effects may include sedation, and occasionally hypotension. Divided doses in daytime may help with agitation.
For Dementia			
busipirone	Buspar	5 – 30 mg TID	Non-sedating drug often perceived as less rapidly effective than benzodiazepines. May be beneficial for agitation with anxiety.
divalproex sodium	Depakote	125 - 500 mg po TID	May stabilize agitated behaviors, but sedation and gastrointestinal side effects may occur. Serum drug levels may be followed.
haloperidol	Haldol	0.5 – 2.0 mg per day	May cause more parkinsonian side effects such as muscle rigidity, tremors, drooling. Low dosages minimize these effects.
lorazepam	Ativan	0.5 – 1 mg bid	Useful for psychomotor agitation and anxiety. May cause sedation and gait instability. Lack of active metabolites is a benefit for use in elderly.
olanzapine	Zyprexa	2.5 – 7.5 mg per day	Does not have parkinsonian side effects, but may cause sedation, other anticholinergic effects.
risperidone	Risperdal	0.25 – 2.0 mg po q hs or bid	May cause more parkinsonian side effects such as muscle rigidity, tremors, drooling. Low dosages minimize side effects.