Objectives
At the end of this presentation participants will have an increased understanding of:
• How depression presents in people with dementia
• Diagnostic criteria & potential causes of depression in people with dementia
• Strategies & considerations to assist in the care of people with depression in dementia

What does depression look like in dementia?
• Unhappiness
• Withdrawal
• Inactivity
• Tearfulness
• Loss of interest
• Fatigue

Importantly, depression is NOT...
• part of normal ageing
• associated with emotional or character ‘weakness’
Potential causes of depression
• Changes in brain pathology
• Insight into their dementia & prognosis
• Family history of major depressive disorder
• Genetic factors may contribute

NB: Depression may present prior to a diagnosis or in the early stages of dementia

Pathology of depression in dementia
Dementia is associated with brain changes that can lead to depression

The interaction between the individual & the environment

Depression is associated with:
• family carer depression
• burden on family & RACF carers
• transition to RACFs
• likelihood of suicide
• mortality
• disability in ADLs
• medical comorbidity
• social withdrawal
• cognitive deficits
• quality of life

Depression in dementia causes stress &/or distress for:
• Care Staff
• Family
• Visitors
&… the person with dementia!

The three D’s
Depression may be:
• a presenting feature of dementia
• complicated by delirium
• & difficult to distinguish from symptoms of dementia when they present together

Diagnosing depression in dementia
• Eliminate reversible causes of delirium
• Differentiate from apathy, hypoactive delirium &/or symptoms of underlying dementia
• Depressive symptoms can overlap with dementia e.g. disturbed sleep, anxiety, agitation
• Treatment for depression may help identify if symptoms are due to dementia or depression
• Treat underlying causes
Suicide - not uncommon in older people

- Review any current or past suicidal behaviour
- Check for presence of:
  - suicidal ideation
  - suicidal intent/ plan
  - suicidal behaviour
- Older men at ↑ risk

Diagnostic Considerations
Using a person centred approach, gather ALL potentially important information:

- Could this be a delirium from pain/ discomfort, or other physical/ medical causes?
- Could the symptoms be due to apathy or the underlying dementia?

**IF YES, respond & treat accordingly FIRST**

If NO, consider management options

- Develop & trial psychosocial strategies & interventions
- Where necessary - individually targeted medication in combination with psychosocial interventions
- Review!

Measuring depression in dementia

Instruments to assist:
- The Cornell Scale for Depression in Dementia (CSDD)
- Hamilton Depression Rating Scale (HAM-D)
- The Geriatric Depression (GSD)
- Neuropsychiatric Inventory (NPI)

Prevalence of depression in dementia

- One of most commonly occurring BPSD
- Prevalence rates range from 9% - 96%, most typically around 30%
- ↑ prevalence in VaD, PDD & DLB when compared to AD
- Rates vary according to definition used, difficulty in diagnosis, carer stress influencing reporting & setting e.g. RACF vs at home

What might depression feel like?

“I don’t want to see anyone. I lie in the bedroom with curtains drawn & nothingness washing over me like a sluggish wave. Whatever is happening to me is my own fault. I have done something wrong, something so huge I can’t even see it, something that’s drowning me. I am inadequate & stupid, without worth. I might as well be dead.”

Margaret Atwood, Cat’s Eye
What might depression feel like?

"Depression is the most unpleasant thing I have ever experienced... it is that absence of being able to envisage that you will ever be cheerful again. The absence of hope. That very deadened feeling, which is so very different from feeling sad. Sad hurts but it’s a healthy feeling. It is a necessary thing to feel. Depression is very different."

J.K. Rowling

Before you move on have you:

• ensured that the person is not at risk?
• provided a full person-centred assessment of the presenting symptoms?
• excluded &/or treated any potentially contributing factors?

Psychotic depression & suicidal depression require URGENT psychogeriatric review

Your approach...

• Calm
• Gentle
• Thoughtful
• Work with the feeling
• Ensure comfort
• Take time
• Look behind the symptoms
• Don’t expect too much of them

Caring approaches & interventions

First line response:
Psychosocial &/or environmental e.g.
• ↑ opportunities for pleasurable events
• Light therapy – mixed results
• Life review/ storybook
• Cognitive Behavioural Therapy (CBT) where carer is also involved

Caring approaches & interventions

First line response:
Psychosocial &/or environmental e.g.
exercise & behavioural approaches provide best evidence

Principles of psychosocial responses
Caring approaches & interventions

Biological/ pharma approach

Non-psychotic depression-
- Limited evidence for use of antidepressants
- Adding ChEIs to treatment recommended as 2nd line option

Psychotic depression-
- 1st line treatment - antidepressant with antipsychotic
- 2nd line ECT - more severe/ urgent cases

2nd line approach – biological cont.

Where pharma is prescribed:
- Use with caution - short term only
- Use in combination with psychosocial interventions
- Be aware of risks
- Reduce, discontinue when indicated
- Monitor closely & REVIEW!

A clinical scenario - Mr L

Mr L - presentation

- Born in Poland, raised his family in Australia
- Lives with wife in retirement village & has family support
- Reluctant to attend family events or day centre
- Can become aggressive with staff
- ↑ sadness & tearfulness

Mr L - presentation cont.

- Increasing burden for wife
- GP advised no treatment, monitor only at this time
- Symptoms may indicate progression of Mr L’s dementia

Mr L

What are some of the potentially contributing factors for Mr L’s depression?
Mr L - potentially contributing factors

- Unreported pain/discomfort/acute illness/infection
- Medication interactions, dosage, adverse effects
  - Overstimulation (noise, people, activities)
  - Not attending to his culturally specific needs

Potentially contributing factors cont.

- Altered routines, new staff, particular staff &/or family members
- Others expecting too much of him
- Reduced threshold to cope with stress due to progress of dementia

Mr L

With the potentially contributing factors in mind, what aspects of Mr L's situation could be important in your assessment?

Mr L - assessing the situation

- Encourage Mr L to express his needs as far as he is able
- Directly observe what may increase his symptoms
- Consult close family members to identify potentially contributing factors
- Consult Mr L's life history

Mr L - assessing the situation cont.

- Consult day centre staff who know Mr L well for possible reasons for his mood changes
- Assess immediate environment for possible factors contributing to his symptoms

Mr L – some outcomes
Depression in dementia - conclusions

- May be mistaken for apathy, delirium or the underlying dementia
- Seek to understand underlying causes & target these for action
- Individualised psychosocial interventions recommended as initial approach
- Exercise & behavioural approaches provide best evidence
- Medication treatments vary for psychotic & non-psychotic depression

‘Success’

- Typically not about eliminating BPSD
- Has BPSD↓?
- Has person with dementia’s distress↓?
- Has carers’ understanding of potential causes↑?
- Has carers’ skills/coping↑?
- Do carers feel supported?
- Be realistic about goals/outcomes
- BPSD are SYMPTOMS of dementia!

Reflection & review

How can you use this information to make a difference in the lives of people with dementia who present with depression?

Resources

Alzheimer’s Australia Help Sheets

Depression & Dementia Q & A

Translating what we know about pain recognition & management in people with dementia

Dementia Outcomes Measurement Suite

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