Understanding the Psychiatric Issues of Dementia

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Psychiatric Issues of Dementia

- Caregiving and Depression
- Depression
- “Anxiety-based” behaviors
- Behavioral and psychological or Neuropsychiatric symptoms of dementia
- Delirium
Caregiving and Depression
It is a myth that most the elderly in the United States are cared for in nursing homes and health care institutions. Family and friends provide 80% of the long-term care of older adults in the United States.

National Alliance for Caregiving, 2009
Incidence and Prevalence of Depression among Caregivers

• Family Caregiver Alliance 1997 – 58% of caregivers showed clinically significant depressive symptoms
Family Caregiving

- The majority (83%) are family caregivers—unpaid persons such as family members, friends, and neighbors of all ages who are providing care for a relative.

*Family Caregiver Alliance, 2005*
Family Caregiving

• Almost 15.2 million Americans provide unpaid care for a person with Alzheimer’s Disease (Family members, friends and neighbors).

• In 2011, they provided 17.4 billion hours of unpaid care – an economic value of $210.5 billion dollars. (Based on “care valued” at $12.12 per hour.)

Alzheimer’s Association (2012)
Alzheimer’s Disease Facts and Figures
Family Caregiving

• Since 2004, the proportion of caregivers of adults who mention Alzheimer's or dementia as the main problem has risen (from 6% to 12%), this may be due to the increase in the care recipients age 75 or older.

• The presence of Alzheimer's or mental confusion is associated with a higher burden of care.

“Caregiving in the US (2009)” - National Alliance for Caregiving in collaboration with AARP
Incidence and Prevalence of Depression among Caregivers

• 61 percent of family caregivers of individuals with Alzheimer’s and other dementias rated the emotional stress of caregiving as high or very high.

• 33 percent report symptoms of depression.

Alzheimer’s Association (2012) Alzheimer’s Disease Facts and Figures
Family Caregiving

• It is not surprising then that these Alzheimer's caregivers report a greater physical strain than do others (with an average rating of 2.3 on a 5-point scale vs. 2.0). They also perceive their caregiving situation to be more emotionally stressful (3.1 vs. 2.7).

• Caregivers whose recipient has emotional or mental health problems are more likely than others to report a decline in their own health as a result of caregiving (28% vs. 12%).

“Caregiving in the US (2009)” - National Alliance for Caregiving in collaboration with AARP
Incidence and Prevalence of Depression among Caregivers

- 1/3 family caregivers of individuals with dementia have symptoms of depression

*Alzheimer’s Association, 2008; Yaffe and Newcomer, 2002*
Incidence and Prevalence of Depression among Caregivers

✓ 40 – 70% of family caregivers have clinically significant symptoms of depression with 25% meeting the diagnostic criteria for major depression.

Caregiving and Depression

- Family caregivers face a range of health risks and serious illnesses themselves
- Family caregivers experience high rates of depression, stress and other mental health problems
- Elderly spousal caregivers experiencing mental or emotional strain have a 63% higher risk of dying than non-caregivers.

*Family Caregiver Alliance 2007
National Policy Statement
Incidence and Prevalence of Depression among Caregivers

- 20 – 50% of caregivers report depressive disorders or symptoms
- Higher rates of depression are attributed to those caring for individuals with dementia
  - 30 – 40% of dementia caregivers suffer from depression and emotional stress
- Caregivers use prescription and psychotropic medications more than non-caregivers

Family Caregiver Alliance 2003
Incidence and Prevalence of Depression among Caregivers

- Care recipients behavior is an overwhelming predictor of caregiver depression.

Caregiver Burden

• Assessment for caregiver burden – The Zarit Burden Interview

• Alzheimer’s Association Stress Check - http://www.alz.org/stresscheck/
Symptoms of Caregiver Stress

- Denial
- Anger
- Social withdrawal
- Anxiety
- Depression
- Exhaustion
- Sleeplessness
- Irritability
- Lack of concentration
- Problems with physical health

2011 Alzheimer’s Association
Evidence-Based Practices for Older Adults with Behavioral Health Issues

✓ Interventions for Family Caregivers – (Mittelman) – combination of counseling sessions, support group, education and ongoing support
  ▪ Assists in delaying nursing home placement
  ▪ Improved caregiver depression and health outcomes
Depression
Psychiatric Issues in Dementia – Depression

- Causes of depression may be physical, social, or psychological in origin, including:
  - Specific events in a person's life, such as the death of a spouse, a change in circumstances, or a health problem that limits activities and mobility
  - Medical conditions - Parkinson's disease, dementia, hormonal disorders, heart disease, or thyroid problems
Psychiatric Issues in Dementia – Depression

✓ Causes may be physical, social, or psychological in origin (cont.), including:
  - Chronic pain
  - Nutritional deficiencies
  - Genetic predisposition to the condition
  - Chemical imbalance in the brain
Psychiatric Issues in Dementia – Depression

✓ Depression:

Behavioral symptoms of depression includes: appetite changes, sleep disturbance, irritability/agitation, refusal of “care”, inability to make a decision, social isolation, withdrawal, tearfulness, and sad mood.
Depression

✓ Major Depressive Episode
  - Depressed mood
  - Loss of interest or pleasure
  - Appetite disturbance
  - Insomnia or hypersomnia
  - Psychomotor agitation or retardation
Depression

✓ Major Depressive Episode
  ▪ Fatigue or loss of energy
  ▪ Feelings of worthlessness or guilt
  ▪ Decreased concentration indecisiveness
  ▪ Thoughts of death or suicide
  ▪ Impaired level of functioning
Depression and the Older Adult

- Affects more older adults in medical settings, up to 37% older patients in primary care – approximately 30% of these patients have major depression the remainder have a variety of depressive syndromes that could also benefit from medical attention (Alexopoulos, Koenig)
Older Adults at Risk for Depression

- Those with co-morbid disorders
- Frail elderly
- Older adults residing in care facilities
- Caregivers of older adults
- Isolated older adults
Depression and the Older Adult

• Medical illness is the most common stressor associated with major depression and it is the most powerful predictor of poor outcome

• Individuals who get depressed for the first time in later life have a depression that is related to medical illness

• Relationship between physical illness and depression
Late Onset Depression

• Depression occurring for the first time in late life – onset later than age 60
• Usually brought on by another “medical illness”
• When someone is already physically ill, depression is both difficult to recognize and treat
• Greater apathy/ anhedonia
• Less lifetime personality dysfunction
• Cognitive deficits more pronounced
• In some individuals may be a precursor to dementia
Depression and Dementia

- Depressive symptoms of various intensity occur in approximately 50% of demented patients

✔ Symptoms can include:
  - Abrupt loss of interest, increased irritability, refusal to eat, crying, and sudden deterioration in skills (Rovner)
Depression and Alzheimer’s Disease

- Depression that can occur with AD may be different than other depressive disorders in that the neuropathology of AD plays a role in the development of depression

Depression, Suicide and Older Adults

- **NIMH** - Older adults with depression are at risk for suicide. In fact, white men age 85 and older have the highest suicide rate in the United States.

- **American Association of Suicidology** - Suicide rates for elderly males are the highest risk at a rate of 29.0 per 100,000 (2010).

- White men over 85 (the old-old) were at the greatest risk of all age-gender-race groups. In 2010, the rates for these men was 47.33 per 100,000 - 2.37 times the current rate for men of all ages (19.94 per 100,000).  
  
  American Association of Suicidology

- Rates of suicide in Older Adults has declined as of 2016.  
  
  CDC Morbidity and Mortality Report; March 2016
Suicide in Older Adults

- APA – 20% of Older Adults who committed suicide saw their physician within the prior 24 hours, 41% in the past week and 75% within the past month

- The risk of depression in the elderly increases with other illnesses and when ability to function becomes limited.

Depression and the Older Adult

- Untreated depression can lead to disability, worsening of other illnesses, institutionalization, premature death and suicide (GMHF)
- Community surveys have found that depressive disorders and symptoms account for more disability than medical illness
- With proper diagnosis and treated more than 80% of individuals with depression recover and return to normal lives (GMHF)
Depression and the “Nursing Home”

- Occurrence 10 times higher than those elderly residing in the community (Rovner)
- NIMH – up to 50% of nursing home residents are affected by significant depressive symptoms
- Associated with distress, disability and poor adjustment to the facility (Rovner)
- Most common cause of weight loss in long term care (Katz)
Depression and the “Nursing Home”

• Behavioral Symptoms include:
  • Low mood /hopelessness
  • Preoccupations with pain and somatic functions
  • Poor sleep
  • Lack of energy/low motivation
Depression and the “Nursing Home”

• Behavioral Symptoms include:
  • Loss of appetite and subsequent weight loss
  • Withdrawal and isolation
  • Uncooperativeness/ refusal of care
  • Screaming
Behavioral Interventions for Depression

• Structured activities
• Maintain social contacts
• Exercise
• Sleep hygiene
• Relaxation techniques
• Consistent staff
• Issues of autonomy and choice
Behavioral Interventions

- Life review/ reminiscing
- Religious/ Spiritual needs
- Support groups
Behavioral Interventions for Depression

- **Get outside** - Exposure to bright light for 30 minutes a day through artificial light, or perhaps even sunlight, can help with your circadian rhythm. This ensures a good night’s sleep, and in turn, helps your physical and mental health.

- **Exercise** - 20 - 30 minutes of walking or other “aerobic” exercise at least 3 times a week means healthy “endorphins” being released regularly. It’s also a great way to withstand and/or release stress. Remember to talk to your doctor first!
Behavioral Interventions for Depression

• **Structured activities** – Be sure to schedule activities consistently during the week whether it be volunteering, visits to museums, fishing or religious activities, etc.

• **Maintain social contacts** - Involving yourself with family and friends will help eliminate the feeling of isolation.

• **Sleep hygiene** - Go to bed at the same time every night. Before bed try and maintain a calm and quiet environment -- do activities such as reading or taking a warm bath (and make sure to avoid caffeine and alcohol!).
Behavioral Interventions for Depression

• **Negative Thoughts** – Be aware of ruminations of negative thoughts and redirect them to positive ones. This takes dedication and perseverance!

• **Relaxation Techniques** – Yoga, music, and visualization are important tools when trying to release stress and create positive energy.
Behavioral Interventions for Depression

• For “Care Facilities”:
  ▪ Know your resident!
  ▪ Utilize consistent staff, which assists in building relationships and trust.
  ▪ Administer “touch” and positive interactions.
  ▪ Remember issues of autonomy and choice. We all need to feel we “have control” over our environment.
Therapy and the Older Adult

- Life review/reminiscing
- Psychotherapy
  - Cognitive Behavioral Therapy
  - Problem Solving Therapy
  - Insight Oriented Therapy
  - Family Therapy
  - Psycho-educational Approaches
- Religious/Spiritual needs
- Support groups
Therapy and the Older Adult

- For older adults, especially those who are in good physical health, combining psychotherapy with antidepressant medication appears to provide the most benefit.

- One study showed that about 80 percent of older adults with depression recovered with this kind of combined treatment and had lower recurrence rates than with psychotherapy or medication alone.

Anxiety
Anxiety in Older Adults

- Affects as many as 10 – 20% older adults, though it is often under diagnosed.
- Some argue that anxiety disorders in older adults are “different”.
- Most common behavioral health problem for women, second most common behavioral health problem for men (after substance abuse).
- Co-morbidity with physical problems makes diagnosis difficult.
Anxiety in Older Adults

- Causes of Anxiety Disorders:
  - Stress or trauma, complicated grief, medications, medical or psychiatric illness, a family history of anxiety disorders, a neurodegenerative disorder.
  - Geriatric Mental Health Foundation (GMHF)

- 24% of medically ill older adults have an anxiety disorder (Tolin et al, 2005).
  - Those homebound and in facilities have higher rates (Juninger et al., 1993).
Anxiety and Older Adults

✓ High level of co-morbidity of anxiety and depression
  ▪ 50% of clinically depressed older adults suffer from co-morbid anxiety.
  ▪ 25% of those with anxiety suffer from major depression.
  
  Beekman et al, 2000
Anxiety

- Universal human experience
- Catastrophic reaction?
- Emotionally based physical symptoms
- Question the cause of anxiety!
  - Organic Anxiety Disorders
  - Anxiety Disorders
  - Environmental issues
Anxiety

✓ Symptoms

- **Cognitive** – nervousness, worry, apprehension, fearfulness, irritability
- **Behavioral** – hyperkineses, pressured speech, exaggerated startle response
- **Physical** – muscle tension, chest tightness, palpitations, hyperventilation, paraesthesias, sweating, urinary frequency
Anxiety

✓ Common Medical Disorders that can produce anxiety symptoms –
  ▪ Endocrine disorders – hyper- and hypo-thyroidism, hypoglycemia, menopause
  ▪ Cardiovascular disorders – Congestive Heart Failure (CHF) Pulmonary Embolism, Angina, Arrhythmias
  ▪ Pulmonary conditions – Chronic Obstructive Pulmonary Disease (COPD), Pneumonia
  ▪ Neurological disorders – Parkinson’s disease
Anxiety

✓ Common medications/substances that can produce anxiety symptoms –
  - Stimulants – caffeine, Theophylline, ephedrine or pseudoephedrine
  - Steroids
  - Thyroid preparation
  - Anticholinergic medications
  - Antidepressants (first 1-3 weeks of treatment)
  - Alcohol
Anxiety Association with Dementia

✓ Anxiety occurs commonly with Dementia
  ▪ Depression and anxiety early to middle stages
  ▪ Anxiety/ agitation in moderate to late stages
    • Frequently with motor restlessness and inappropriate behavior

✓ Need to identify “triggers” – Examples
  ▪ Environmental stimuli
  ▪ Medications
  ▪ Inability to communicate
Behavioral Interventions for Anxiety

- Consistency
- Structured routines
- Relaxation techniques
- Exercise
- Life review/Reminiscing
- Psychotherapy
- Medications
Dementia
“Dementia”

- Irreversible chronic brain failure.
- Loss of mental abilities.
- Can involve memory, reasoning, learning and judgment.
- All patients with dementia have deficits, but how they are experienced depends on their personality, style of coping and their reaction to the environment.
Psychiatric Symptoms of Dementia

✓ Dementia is the greatest risk factor for the development of psychotic symptoms in the older adult population.

- Dementia process itself and;
- An increased vulnerability to delirium

Behavioral and Psychological or Neuropsychiatric Symptoms of Dementia

• Affects up to 90% of all individuals with dementia over the course of their illness
• Causes: psychological, social and biological factors?
• Recent research have emphasized the role of neuropathological and genetic factors underlying the clinical manifestation.
Psychiatric Symptoms of Dementia

• More than half of individuals with dementia experience psychotic symptoms during the course of their illness.

  ➢ Delusions are the most common (up to 70%)
    • House is not their house
    • Spouse not their spouse (Capgras syndrome)
    • Infidelity

  ➢ Hallucinations (up to 50%) – usually visual
    • Lewy Body Dementia up to 80% experienced visual hallucinations, usually early on in the disease.

Psychiatric Symptoms of Dementia

• Hallucinations and delusions are commonly associated with aggression, agitation and disruptive behaviors.

• Psychotic symptoms are associated with more caregiver distress.

• Associated with institutionalization.

• Psychotic symptoms disappear in the more advanced stages of the disease.
Behavioral and Psychological or Neuropsychiatric Symptoms of Dementia

- Symptoms of *disturbed perception, thought content, mood* or *behavior* that frequently occur in persons with Dementia
- BPSD are treatable!
- BPSD can result in:
  - Suffering
  - Premature Institutionalization
  - Increased Costs of Care
  - Loss of quality of life for the person and caregivers

Finkel et al 1996
Behavioral and Psychological or Neuropsychiatric Symptoms of Dementia

✓ Hallucinations (Usually visual)
✓ Delusions
  • People are stealing things
  • Abandonment
  • This is not my house
  • You are not my spouse
  • Infidelity
Behavioral and Psychological or Neuropsychiatric Symptoms of Dementia

✓ Misidentifications
  • People are in the house
  • People are not who they are
  • Talk to self in the mirror as if another person
  • Events on television
Behavioral and Psychological or Neuropsychiatric Symptoms of Dementia

- Depressed Mood
- Anxiety
- Apathy
  - Decreased social Interaction
  - Decreased facial expression
  - Decreased initiative
  - Decreased emotional responsiveness
Behavioral and Psychological or Neuropsychiatric Symptoms of Dementia

✓ Wandering
  • Checking
  • Attempts to leave
  • Aimless walking
  • Night-time walking
  • Trailing
  • Excessive activity
Behavioral and Psychological or Neuropsychiatric Symptoms of Dementia

- Verbal Agitation
  - Negativism
  - Constant requests for attention
  - Verbal bossiness
  - Complaining
  - Relevant interruptions
  - Irrelevant interruptions
  - Repetitive sentences
Behavioral and Psychological or Neuropsychiatric Symptoms of Dementia

✓ Verbal Aggression
  • Screaming
  • Cursing
  • Temper Outbursts
Behavioral and Psychological or Neuropsychiatric Symptoms of Dementia

✓ Physical Agitation
  • General Restlessness
  • Repetitive Mannerisms
  • Pacing
  • Trying to Get to a Different Place
  • Handling Things Inappropriately
  • Hiding Things
  • Inappropriate Dressing or Undressing
Behavioral and Psychological or Neuropsychiatric Symptoms of Dementia

 ✓ Physical Aggression
   • Hitting
   • Pushing
   • Scratching
   • Grabbing Things
   • Grabbing People
   • Kicking and Biting
Behavioral and Psychological or Neuropsychiatric Symptoms of Dementia

- Disinhibition
  - Poor Insight and Judgment
  - Emotionally Labile
  - Euphoria
  - Impulsive
  - Intrusiveness
  - Sexual Disinhibition
Delirium
Delirium

• Delirium refers to a constellation of clinical phenomena not to an underlying cause.
Delirium

• Delirium is a sudden, severe confusional state with rapid changes in brain function that occur with physical or mental illness

• Fluctuating level of consciousness

• Reversible/treatable
Delirium  DSM 5

1. Disturbance in **attention** (reduced ability to direct, focus, sustain and shift attention) and orientation to the environment.

2. Disturbance develops over a short period of time (hours to few days) and represents an acute change from baseline; not attributable to another neurocognitive disorder and tends to fluctuate in severity throughout the day.
3. A change in an additional cognitive domain such as memory deficit, disorientation or language disturbance, or perceptual disturbance that is not better accounted for by a pre-existing, established or evolving other neurocognitive disorder; and

4. Disturbance in #1 and #3 must not occur in the context of a severely reduced level of arousal, such as a coma.
Delirium

☑ Symptoms:

- Changes in alertness
- Changes in feeling (sensation) and perception
- Changes in level of consciousness or awareness
- Changes in movement
- Changes in sleep patterns, drowsiness
- Confusion (disorientation)
Delirium

✓ Symptoms:
  • Decrease in short-term memory and recall
  • **Disrupted or wandering attention**
  • Disorganized thinking
  • Emotional or personality changes
  • Incontinence
  • Psychomotor restlessness
Delirium

- Most common complication of hospital admission of older individuals.
  - Occurs in 11 – 42% of medical inpatients
- Medications may be the sole precipitant for 12 – 39% of delirium.
  - Medications most commonly associated with delirium are benzodiazepines, narcotic analgesics, psychoactive drugs, and medications with anticholinergic effects.
Risk Factors for Delirium

- Pre-existing cognitive problems
- Advanced age
- Hospitalization
- Multiple medical conditions
- Depression
- Use of multiple medications, especially those with anticholinergic properties
- General anesthesia
- Visual problems
- Male gender
- Abnormal serum sodium
Delirium

✓ Causes:
  • Medications
  • Infections
  • Metabolic/ endocrine
  • Vitamin Deficiency
  • Anesthesia
  • Trauma
  • Alcohol or sedative drug withdrawal
Psychiatric Symptoms and Behavioral Problems in Older Adults

Psychiatric symptoms are common among individuals who live in nursing homes and other “care facilities”, with prevalence rates ranging from 51 percent to 94 percent.
Behaviors are a form of communication!

Understanding, flexibility and creativity are the keys to effective behavior management!

Building relationships with staff and families are one of the hallmarks in care!
Non-Pharmaceutical treatments

Collaborative care
• Can improve quality of care and improve behavioral and psychological symptoms of patients and caregivers.\(^1\)

Exercise plus caregiver training
• Can improve physical health and depression in patients with AD.\(^2\)

Cognitive training and memory rehabilitation
• Can improve cognition function\(^4\)

Enhanced counseling and support for caregivers
• Can reduce nursing home placement\(^5\)

Communication

• Good communication is essential!
• Assists in preventing stressful situations.
• Use all communication strategies.
• Observe and listen!
• Discuss most effective means of communicating with the resident and with the family.
• Remember though the individual may be unable to communicate, they may be able to communicate on an emotional level.
Emotional Contagion

• Refers to the way we sense the emotions of others through emotional expressions, body language and then we reflect their feelings.

• New research documents that emotional contagion is heightened in individuals with MCI (Mild Cognitive Impairment) and dementia.

• The greater the impairment the more pronounced the “emotional mirroring”.

Progressively Lowered Stress Threshold Model (PLST)

• Proactive approach!
• Focuses on assisting nursing staff to identify and relieve stressors in the patients/residents environment that may cause maladaptive behavior.
• Identifies 6 main groups of “stressors” that negatively affect individuals with dementia and can cause anxiety hence disruptive behaviors.

Progressively Lowered Stress Threshold Model (PLST)

- 6 Groups of Stressors include:
  - Fatigue
  - Changes in routine, environment or caregiver
  - Demands that exceed their understanding or capabilities
  - Multiple or completing stimuli
  - Affective responses to perceptions of loss, including anger
  - Physical stressors such as pain, constipation, medication side effects.

Principles of Progressively Lowered Stress Threshold Model (PLST)

- Maximize safety by modifying environment to compensate for cognitive losses
- Control for factors that increase stress – physical, medications, etc
- Plan and maintain a consistent routine (Discuss with family or caregiver)
- Implement regular rest periods
- Provide unconditional “positive regard”

Principles of Progressively Lowered Stress Threshold Model (PLST)

- Remain nonjudgmental about the appropriateness of all behaviors except those that pose safety risks
- Recognize individual expressions of fatigue, anxiety and increasing stress (discuss with family or caregiver) and intervene.
- Modify reality orientation and other therapeutic interventions
- Use reassuring forms of therapy such as music and reminiscence

Remember Behaviors may be related to:

- Physical discomfort – illness or medication (Delirium)
- Overstimulation – loud noises or a “busy” environment
- Unfamiliar surroundings – new places or the inability to recognize home
- Complicated tasks – difficulty with activities or chores or even simple requests
- Frustrating interactions – inability to communicate effectively

Alzheimer’s Association – “How to respond when dementia causes unpredictable behaviors.”
Handling Troubling Behaviors

☐ Check with the doctor first!
☐ We cannot change the person
  • Try to accommodate the behavior, not control the behavior.
  • Remember that we can change our behavior or the physical environment.

Fact Sheet: Caregiver’s Guide to Understanding Dementia Behaviors, Family Caregiver Alliance
Handling Troubling Behaviors (Cont.)

- Behavior has purpose.
- Behavior is triggered.
- What works today may not work tomorrow!!
- Get support from others!

Fact Sheet: Caregiver’s Guide to Understanding Dementia Behaviors, Family Caregiver Alliance
Three Steps in Identifying Causes of Behaviors

1. Identify and examine the behavior:
   • Could it be related to medication or illness?
   • What was the behavior? Could it be considered harmful?
   • What happened before the behavior?
   • What was the trigger?
   • What happened immediately after the behavior occurred? How did individuals react?

Alzheimer’s Association – “How to respond when dementia causes unpredictable behaviors.”
Three Steps in Identifying Causes of Behaviors (Cont.)

2. Explore potential solutions:
   • What are the individual’s needs? Are they being met?
   • Can adapting the surroundings comfort the person?
   • How can you change your reaction or your approach to the behavior? Are you responding in a calm and supportive way?

Alzheimer’s Association – “How to respond when dementia causes unpredictable behaviors.”
Three Steps in Identifying Causes of Behaviors (Cont.)

3. Explore different responses:
   - Did your new response help?
   - Do you need to re-evaluate for other potential causes and solutions?
   - What could you do differently?

Alzheimer’s Association – “How to respond when dementia causes unpredictable behaviors.”
The Case for Individualized Care
Older adults with mental illness are at increased risk, compared with younger adults, for receiving inadequate and inappropriate care.
Multidisciplinary Needs

• Social needs for both caregivers and residents.
• Cognitive difficulties and behavioral manifestations
• Psychiatric symptoms
• Complicated medical needs
• Changing communication and ADL needs
• Normal age related changes may cause potential iatrogenic illness
Depression Assessment Scales

- Geriatric Depression Scale (Short and Long Version) - (Yesavage)
- Patient Health Questionnaire PHQ-9 for Depression
- Center for Epidemiologic Studies Depression Scale
- Beck Depression Protocol
- Cornell Scale for Depression in Dementia
Assessment Scales

- Montreal Cognitive Assessment - MOCA
- St. Louis University Mental Status Examination - SLUMS
- Mini-Mental Status Examination MMSE-(Folstein - Copyrighted)
- Clock Drawing
- Blessed Dementia Scale
Assessment Scales


Resources

• American Geriatrics Society 2012 BEERS Criteria -

• BEERS Criteria Pocket Card -
Resources: Depression and Caregiving

• Family Caregiver Alliance - https://caregiver.org/depression-and-caregiving


• Mayo Clinic - http://www.mayoclinic.org/healthy-living/caregivers/in-depth/caregiver-depression/art-20047051

Resources

• Alzheimer’s Association – www.alz.org

• ADEAR – aedar@alzheimers.org

• Family Caregiver Alliance – www.caregiver.org

• CDC Caregiving: A Public Health Priority - http://www.cdc.gov/aging/caregiving/

• Geriatric Mental Health Foundation – www.gmhfonline.org
Resources for Families


• **Still Alice**, Lisa Genova. (2009)

• **Contented Dementia**, Oliver James. (2008)

• **Dementia Reconsidered: the Person Comes First**, Thomas Kitwood. (1997)


• Kyomen, H, Whitfield, T., “Psychosis due to Alzheimer’s Type dementia,” Am J Psychiatry 2009; 166:146-150.


Citations


What makes the engine go?
Desire, desire, desire.
The longing for the dance
Stirs in the buried life.
One season only,
and it’s done.

Stanley Kunitz