Dementia, Delirium, Depression
What’s the Difference & What do we Do?

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Objectives
• Discuss common and atypical presentation and symptoms of dementia, delirium and depression
• Identify 3 critical management issues for each syndrome: early identification, communication, environment
• Demonstrate communication strategies to improve care of people with dementia, delirium and depression

What’s the same?
• Common in older people
• Presentation...especially if you look at the snapshot, not the video
• Under-recognized
• Under-managed
• Mismanaged

What’s Different?
Dementia
Classic presentation
• Slow onset
• Progressive
• Irreversible
• First symptoms
  – Memory
  – Executive function
  – Language
• Later symptoms
  – Functional
  – Physical changes
Atypical presentation
• Sudden awareness of symptoms (early)
• Stable (MCI)
• Reversible
• Alternative onset
  – Mobility/tremor: Lewy body
  – Impulsivity/Language: Frontal-temporal
  – Fluctuating: vascular

Delirium
Classic presentation
• Sudden onset of symptoms
• Fluctuating course
• Inattention
• Altered level of consciousness
• Disorganized thinking
• Reversible
Atypical presentation
Types
• Hyperactive
  – Psychomotor agitation
  – Hallucinations
• Hypoactive
  – Psychomotor retardation
  – Hard to rouse
• Mixed

What’s Different?
Depression
Risk factors & triggers

- Age
- Sensory impairment
- Functional impairment
- Dementia, neurological condition: CVA, Parkinson
- Multiple medical problems, treatments/medications
- Acute medical issue
- Exacerbation of chronic medical problem
- Surgery/anesthesia
- Pain
- Constipation/impaction
- Dehydration or fluid/electrolyte imbalance
- Medications
- Infections
- Change in environment, routine

What’s Different?

Depression

Classic presentation

- Slow onset
- Following loss or change
- Sad, apathetic, withdrawn mood
- Alteration in activity, appetite, sleep

Atypical presentation

- Agitated depression
- Angry, distressed mood
- Decline not related to loss or change
- Memory impairment

Comparison of Grief and Depression

Dr Sid Zisook


Grief

- Emptiness/loss, especially when thinking about loss
- Intensity: decreases over time, waves, associated with thoughts about loss
- Positive emotions: humor, relief, warmth, pleasure in time with others.

Depression

- Depressed mood, inability to anticipate happiness or pleasure, when not thinking about loss
- Persistent sadness, not associated with thoughts
- Unhappiness, misery, absence of + emotions

How to Help

- Early identification
- Adequate management
- Communication
- Environment

Pet of depressed/non-depressed brain


Comparison of Grief and Depression

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Grief

- Thoughts focused on loss
- Self esteem at baseline
- Others can support, console
- Suicide: joining a loved one

Depression

- Thoughts focused on self, as bad, undeserving, unworthy
- Worthless, self-loathing
- Less impact, not open
- Suicide: undeserving of life, end personal pain, others better off
Early Identification

- Know normal
  - For this person
  - For aging people
- Have a low threshold for suspicion...when the person is different...check it out!!!
- Know how to ask for what you want
  - When you label, you limit
  - Describe the symptoms
  - Watch your language

Screening Tools

- Consult GeriRN
- [http://hartfordign.org/resources/try_this_series/](http://hartfordign.org/resources/try_this_series/)
  - Geriatric depression scale
  - MOCA
  - Mini-cog
  - CAM
  - AD8
- [SLUMS](http://familymed.uthscsa.edu/geriatrics/tools/SLUMS.pdf)

Maintain Function

- Promote mobility
- Maintain continence
- Support nutrition/hydration needs
- Provide sensory support

Treatment/Management: Dementia

- Match expectations to level of ability
- Manage the day not the moment
  - Progressively lowered stress threshold
    - Normal, anxious, dysfunctional behaviors
    - Hardest at best
  - Balance self care, work, recreation, rest

Medications

Cholinesterase inhibitors

- Donepezel (Aricept), Rivastigmine (Exelon), Galantamine (Razadyne)
- FDA approved for use in early to middle stages (donepezel approved to late stage)
- Improve/stabilize cognition (thinking), language, behaviors, reduce caregiver stress

Medications

NMDA receptor antagonists

- Memantine (Namenda)
- FDA approved for use in middle to late stages
- Works on a different neurotransmitter
- Improve/stabilize cognition, function
Treatment/Management: Delirium

- Prevention is easier than management
- Simple Interventions = Significant Impact
  - Ensure use of hearing aides and eyeglasses
  - Discontinue “tethers” (IVF, catheters) ASAP, increase mobility
  - Maintain normal sleep, mobility patterns, function
  - Utilize family to avoid/reduce restraints

Medications: Delirium

- While medications may be part of the answer...they are never THE answer.
- When medications are started, the initial response is related to adverse reactions/side effects, not the therapeutic action
- Remember to discontinue when not needed
- Remember...low and slow!!!
- Medications: avoid discontinuing “Alzheimer’s” medications (Aricept, Exelon, Razadyne, Namenda)

Treatment/Management: Depression

- More than medications!!!
- Therapy
  - Individual
  - Group
- Movement & exercise
- Light
- Routine

Medications: Depression

- While medications may be part of the answer...they are never THE answer.
- When medications are started, the initial response is related to adverse reactions/side effects, not the therapeutic action
  - First function, energy, sleep appetite
  - Then mood
- Match the type of depression with the type of antidepressant

Verbal communication

**Instead of...**
- Explaining (logic/arguing)
- Telling the truth
- Talking down/patronizing
- Trying to prove yourself (Using authority credentials, asking for “trust”, I know best)
- Lying/deceiving/misleading
- Asking yes/no questions
- Ignoring responses
- Taking over/backing into corner

**Try...**
- Establishing relationship (casual, connecting comments & conversation)
- Speaking low & slow
- Simplifying (not baby-fy)
- Saying not now
- Wait for the response
- Will you help? Try?
- “I’m sorry, so sorry, so very sorry”

Empathetic Communication

Meet them where they are

- Start with the feelings
  - “Looks like”, “sounds like”
  - “Seems like”, “feels like”
  - Don’t be afraid to talk about feelings
- Get more information
  - “Tell me about...”
  - Repeat words and phrases
  - Move to remembering
- Move from talking to doing
  - “Could you help me?”
  - “Would you try?”
  - Related to topic
  - Familiar and positive
CONNECT with the Positive Physical Approach

CONNECT
C  Come from the front
O  Open palm
N  Not too fast
N  Not in front
E  Establish hand contact
C  Change to hand under hand
T  Take a seat/squat/kneel

Communication: Delirium
- Start by CONNECTing with the Positive Physical Approach
- Slow down
- Be positive
- Look for underlying meanings/perspectives
- Go with the flow
- Deal with the emotions
- Offer true reassurance

Communication: Depression
- Listen
- Use emotional words
- Give one step at a time
- Offer simple choices but avoid yes/no questions
- Would you help me?
- Could you try?

Environment
- Think about the environment from the perspective of the older person
- Look & listen through their eyes for misinterpretations
- Homework
  - Go to a place of care
  - Take pictures/video and LOOK
  - Close your eyes and listen

Environment
- Visual
  - Focus on what you want them to see
  - Lighting
  - Open doors
- Auditory
  - Limit background/extraneous
  - Offer positive
- Familiar
  - "Home-like"
  - Arrangement
- Equipment
  - Only what’s necessary and helpful
  - Stable surfaces

Special Challenges
- Knowing baseline
- Delirium superimposed on dementia
- Depression presenting as dementia

C D Depression
Delirium
Dementia
Final words

- Investigate
- Think about it
- Trust your instincts
- Advocate when you think something is different
- Really know what the baseline is