INVITED ARTICLE

PSYCHIATRY IN DEMENTIA

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ABSTRACT

Dementia is a significant cause of psychiatric morbidity in the elderly. The burden of care on families is tremendous and there is an urgent need to develop dementia-related services in Singapore. The role of the psychiatrist in assessment is to diagnose dementia accurately, to exclude treatable causes, and to organise an individualised plan of management, which includes referring the patient to the appropriate agencies in order to minimise the disability and help the family cope. Support and education of the caregivers is of paramount importance and attending support groups provides the opportunity for caregivers to share their experiences and learn from one another.

Keywords: *dementia, caregiver, social support, psychogeriatrics*

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Introduction

With the ageing of the Singapore population, dementia is becoming a significant source of psychiatric morbidity. It has been called the "Silent Epidemic" but it is no longer silent as there is a growing awareness of the impact this devastating disease has on a person, his family and society. It not only robs a person of his mental faculties but also causes tremendous suffering to the family. The economic cost in any country is enormous.

The burden of care has always been on the family and over the years much has been done in organising community services and treatment programmes which are specially designed to help families cope. In Singapore such services are being developed by both health and social authorities as well as voluntary welfare organisations.

Site of the problem

The prevalence of dementia increases with age and approximately 5% of the elderly above 65 years suffer from dementia. However, above the age of 80 years, as many as 20% are demented. In Singapore, a community study of elderly Chinese done by Kua EH[1] found that the prevalence of dementia was 1.8%. This means that in 1990 there were about 3,000 people with dementia but in the year 2030 this would increase dramatically to 12,000. The size of the problem is therefore alarming and there is an urgent need to develop dementia-related services to cope with this increase.

Diagnosis

Dementia is not part of normal ageing. It is an organic brain syndrome that is characterised by the presence of cognitive deficits. Often dementia is insidious in onset, progresses gradually and has diverse presenting symptoms, thus making diagnosis more difficult. At times the diagnosis only comes to light when a crisis occurs eg after a fall or when a key caregiver falls sick. Dementia has been overdiagnosed and as many as 15% of patients who were referred for assessment of dementia were in fact not demented and were usually suffering from depression[2].

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Dementia can present with anxiety, paranoid ideas or mood changes and may be misdiagnosed as another psychiatric disorder. Last but not least, dementia has been missed altogether and its symptoms erroneously labelled as "old age".

From the diagnostic criteria (Table I) memory deterioration is a prominent feature of dementia and is associated with other cognitive deficits. Of importance is that an acute confusional state (delirium) must be excluded as the cause for the confusion. Although it is known that delirium can occur in a patient with dementia, delirium must be excluded as the primary cause of confusion in an elderly person.

Table I – DSM III-R diagnostic criteria for dementia

A.	Impairment of short- and long-term memory
B.	One of the following:
	1. Impaired abstract thinking
	2. Impaired judgement
	3. Aphasia, apraxia, agnosia, constructional difficulties
	4. Personality change.
C.	Disturbance of work and/or relationships or activities
D.	Not occurring exclusively during the course of delirium
E.	Evidence for, or reasonable presumption of, an organic aetiologic factor

Dementia is also an acquired decline in intellect and therefore mental retardation is excluded. In dementia the cognition viz memory, orientation, learning and attention and the intellectual skills eg abstraction, judgement, comprehension, language, and calculation are affected, but at varying degrees. There often is an alteration in personality and behaviour and this leads to a disturbance of daily functioning in work and other activities eg self care, house chores, hobbies, etc.

Clinical features

The first presentation is usually that of a memory impairment but it can be very difficult to diagnose mild dementia as there is an overlap between the normal forgetfulness seen in the elderly and that of dementia. However, as the illness progresses the forgetfulness becomes more marked eg losing his belongings and accusing the family members for stealing them, getting lost, being unable to do his usual chores or having difficulty in finding the correct words. There may be an incessant repetition of

questions or aimless wandering.

The deficits become more apparent and he may get lost in familiar places or forget the names of close friends and relatives. The loss of memory usually affects recent events more than remote events and eventually he may not be able to perform complex tasks. Changes in the personality can occur. There may be odd behaviour, hallucinations or delusions or even outbursts of uncharacteristic temper.

Often the family members do not realise that the patient suffers from dementia and this can result in a great deal of conflict and misunderstandings. Even when the diagnosis is clear, and the family is aware that the change in behaviour is due to dementia, it can be extremely stressful for them to have to constantly deal with such behaviour.

In the late stages of dementia the personality becomes unrecognisable and help may be needed for personal care. Disorientation is marked and even familiar people and their past personal memories are forgotten. Emotional changes and neurological signs eg gait disturbances, incontinence, spasticity may be present. Finally, even verbal ability is lost and the sufferer is totally dependent for all his needs.

Assessment

A detailed history is crucial, and should be collaborated by a key caregiver. A mental state examination and physical examination is necessary not only to diagnose dementia but also to exclude any treatable causes of dementia and any other physical disabilities that may complicate management. It is essential to exclude disorders that mimic dementia like depression or delirium. Individualised relevant investigations[3] should be done. (Table II).

Table II – Investigation for dementia

1. Full blood count
2. Urea/electrolytes
3. Thyroid function tests
4. Vitamin B_{12} and folate levels
5. Tests for syphilis
6. Urinalysis
7. ECG
8. Chest X-ray
9. CT scan (appropriate in the presence of a history suggestive of a mass, or focal neurological signs, or in dementia of brief duration).
10. EEG (appropriate for patients with altered consciousness, or suspected seizures)
11. Neuropsychological evaluation (appropriate to obtain baseline, when diagnosis is in doubt, in exceptionally bright individuals suspected of early dementia).

Types of dementia

Dementia is a syndrome that can occur secondary to another disorder eg due to strokes. head injury, hypothyroidism, or as a primary disorder like Alzheimer's disease or Pick's disease. The most common type of dementia is Alzheimer's disease followed by that due to strokes viz multi-infarct dementia. (Table III)

Table III – Some common causes of dementia

Degenerative	Alzheimer's disease, Huntington's chorea, Parkinson's disease, Pick's disease, normal pressure hydrocephalus
Vascular	Multi-infarct dementia
Deficiencies	Hypothyroidism, sustained lack of B_{12}, thiamine, folic acid
Metabolic	Uraemia, liver failure
Trauma	Head injuries
Intra-cranial lesions	Tumour, subdural haematoma
Infections	Encephalitis, neurosyphilis
Anoxia	Anaemia, cardiac arrest post-anaesthesia, chronic respiratory failure
Toxic	Drugs, alcohol, heavy metal poisoning

Management

In dealing with patients with dementia, **management** is the key rather than treatment. Despite research there is still no drug treatment that conclusively improves the cognitive deficits of dementia. Although nothing can be done for the illness itself, much can be done to improve the quality of life for the afflicted person and his family.

After the dementia syndrome has been identified and any treatable causes excluded, an assessment of the level of functioning of the patient as well as the psycho-social needs of his family is necessary. Any associated physical conditions should also be treated appropriately to minimise the disability and behavioural problems should be identified.

The role of the psychiatrist goes beyond making an early and accurate diagnosis. He is called upon to support and educate the family about dementia and organise a care plan for the patient with appropriate referrals to relevant services. The aim of management is to maintain whatever function that is present for as long as possible, to prevent premature institutionalisation and to help the family cope with the burden of care. Practical advice and regular reviews of the physical, mental and social situation are all part of a comprehensive management plan.

Financial and legal matters must also be considered and should be settled while the patient is still able to make the necessary decisions.

Drug Treatment

As far as possible drug use in the elderly should be kept to a minimum as intoxication and side-effects of drugs, especially psychotropics, are notorious in causing confusion in the elderly. Depressive symptoms occur commonly in patients with dementia but the depressive syndrome is much less common[4]. Co-existing depression can aggravate the disability and add to the distress of the family and, if present, should be adequately treated.

21-49% of demented patients have hallucinations (visual or auditory) and 30-38% have delusions[5] and treatment should be instituted only if the symptoms are distressing to the patient or his family, or interfere with management. Anti-psychotic drugs are the treatment of choice but must be used cautiously because of the side-effects.

Behavioural difficulties add a huge amount of strain on the caregivers and are associated with the more severe disease[6]. Wandering, incontinence, aggression and binge eating occur in a significant proportion of patients. As far as possible medication should be avoided, but if the agitation or aggression is severe enough to interfere with management, low doses of anti-psychotics eg thioridazine can be used judiciously.

Supporting the caregivers

Caregivers are under a great deal of physical, psychological and emotional stress and have been reported to have higher rates of psychological disorders such as depression and anxiety[7,9]. They are also likely to be socially isolated and this adds to the burden of care.

Doctors are often asked for advice on how to deal with patients with dementia, or abnormal or difficult behaviour. Books like "The 36-hour day"[10] provides an exceptional account of dementia and practical information on how to care for the confused elderly.

Some useful hints to help the family cope are as follows:

a) *Be informed* – It is of paramount importance that the family members understand what dementia is and what it is not. Accepting and understanding that a particular behaviour is due to an illness and is not done on purpose can be a great help. Families should know what services are available to help them cope.

b) *Have a regular routine* – Patients with dementia do not adapt easily to change in the environment. Having a regular schedule for meals, baths, walks, etc is useful. If he can tolerate an occasional change in the routine eg visiting relatives, do so. If not, caregivers should not insist on it. Often it is only by trial and error that families discover the right balance of activity.

c) *Use common sense* – Instead of arguing and struggling with the patient over every little thing, harmless compromises may be required eg if he doesn't want to bathe in the morning, find a time when he is more agreeable to having a bath instead. There is a need to be flexible.

d) *Solve problems one at a time* – Trying to feed, bathe and dress an uncooperative patient is a formidable task, but if each task can be broken down into simple steps, then families may not be overwhelmed by the problem.

e) *Keep the patient as active and as independent as possible.* A regular exercise programme or activity is helpful. Although it may be faster to do a task for him than to let him do it on his own, try to maintain as much function and independence as possible. Reality orientation[11], a form of treatment to rehabilitate elderly with moderate to severe disorientation, can be done at home. Most elderly enjoy talking of the past and reminiscence can be mentally stimulating for the patient[12].

f) *Advise caregivers to get enough rest as the burden of care is tremendous.* Caregivers need to make time for their own activities. Try to maintain a sense of humour and learn to share their frustrations with others who understand.

g) *Managing behavioural difficulties.*

(i) Memory aids – Clocks and calendars in obvious positions can help the disorientation and written instructions or a diary can help him keep track of time, events and instructions. If there are problems finding the toilet, conspicuous signs or a night light can be tried.

(ii) Temper outbursts – Stay calm. Try to understand what caused the reaction and do not confront the person directly. Occasionally, distracting the person can be effective eg offering the person a drink.

(iii) Incontinence – Try to keep a diary of the times that he is wet or soiled and when a pattern emerges then bring him to the toilet at a particular time eg 10 minutes after a drink, before he dirties himself. If the continence is because he cannot get to the toilet or take off his pants in time, then having a commode nearby or a change in clothing can be effective.

(iv) Wandering – At times camouflaging the doorway with a curtain or some plants can decrease wandering. Locks which are placed in inconspicuous places eg high up on the door will make it more difficult for the person to escape. However, if despite precautions there is a chance that he may wander and get lost, having him wear an identity bracelet or name tag with the contact phone number may be necessary. A regular exercise programme in the day-time can tire the person and may reduce night-time wandering.

(v) Communication problems – Often the demented person is unable to convey what he means and this can be frustrating for him as well as for the carer. Alternative methods eg pointing to objects or using touch to communicate may be required.

Dementia-related services

Strengthening healthcare for the elderly and improving mental healthcare have been identified as two of the Priority Health Programmes for the 1990s[13] in Singapore.

As part of the programme, there are plans to develop a Psychogeriatric Department in the new Woodbridge Hospital. This will involve a multidisciplinary team consisting of psychiatrists, psychologists, social workers, physiotherapists, occupational therapists and nurses. A memory clinic and general psychogeriatric clinics will be organised for outpatient care, and inpatient care will consist of wards for assessment of dementia and respite admissions. Day care programmes and community services involving the Community Psychiatric Nurses will also have to be developed as part of a comprehensive service.

Voluntary welfare organisations like the Alzheimer's Disease Association (ADA) have been formed and provide an invaluable source of information and service. The New Horizon Centre, which is the first day centre for sufferers of dementia in Singapore provides activities such as physical exercise, Reality Orientation, newspaper discussions, singing and games such as chess, cards and bingo are conducted with staff supervision. Patients attend from one to five days a week and this enables the family to have a break while keeping the patient active.

Support groups for caregivers of patients with dementia are held every six weeks at the New Horizon Centre. At meetings, caregivers talk about the difficulties faced, how they have coped and learn coping strategies from one another. Members are able to openly express their emotions and ventilate their frustrations because they realise that other caregivers can understand what they experience. The support and encouragement given and received at such meetings is tremendous.

Conclusion

The problems of dementia are often unrecognised and unacknowledged. The role of the psychiatrist in dementia is to improve diagnostic accuracy and to co-ordinate a comprehensive assessment and holistic management plan. The needs of both the patient and his family must be taken into consideration. It is important to remember that the burden of care is tremendous and that caregivers will need all the help, understanding and support

available.

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