MENTAL HEALTH ISSUES IN THE ELDERLY

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CONTENTS

Growing old

Risk factors

Mental health conditions

- Depression
- Anxiety
- Adjustment disorder
- Grief
- Psychosis
- Bipolar disorder – first onset in old age is not common
- Dementia with BPSD
- Delirium

Biopsychosocial formulation and management

FOOD FOR THOUGHT

When I am 70,

- I see myself _____
- I wish for _____
- I hope for ____

Ageing backwards?

Never ageing?

Do we have a bucket list?

TRANSITION TO OLD AGE – IS AGE JUST A NUMBER?

How old is old? When would you call someone 'old'?

Geriatrics

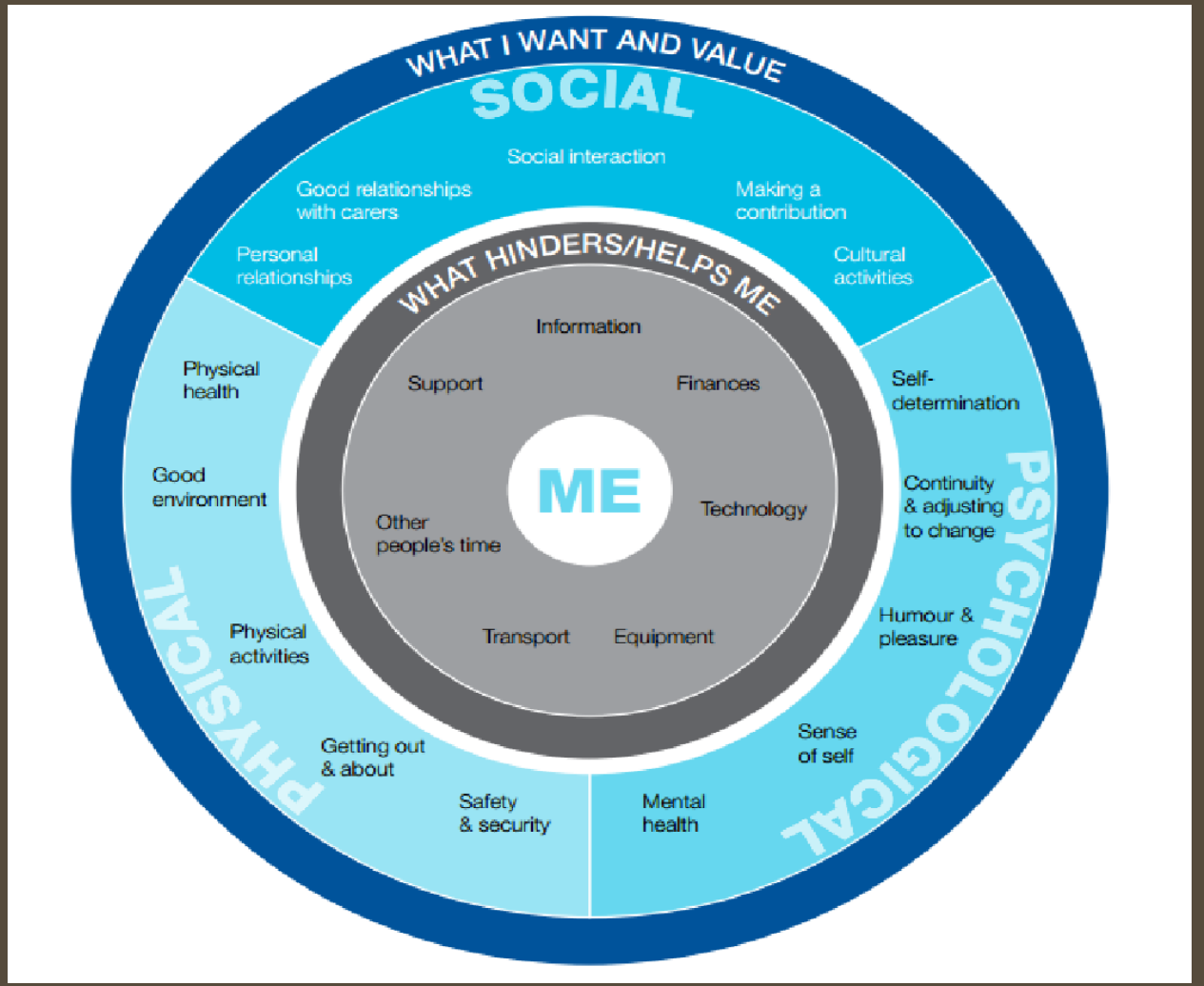
- from the Greek gēras, meaning "old age"
- suffix –iatric, which means "of or relating to a physician or medicine

Most countries accepted chronological age of 65 years old

Marker Events

- Menopause
- Empty Nest Syndrome
- Grandparenthood
- Retirement

WHAT ARE THE BIOPSYCHOSOCIAL NEEDS IN THE ELDERLY?



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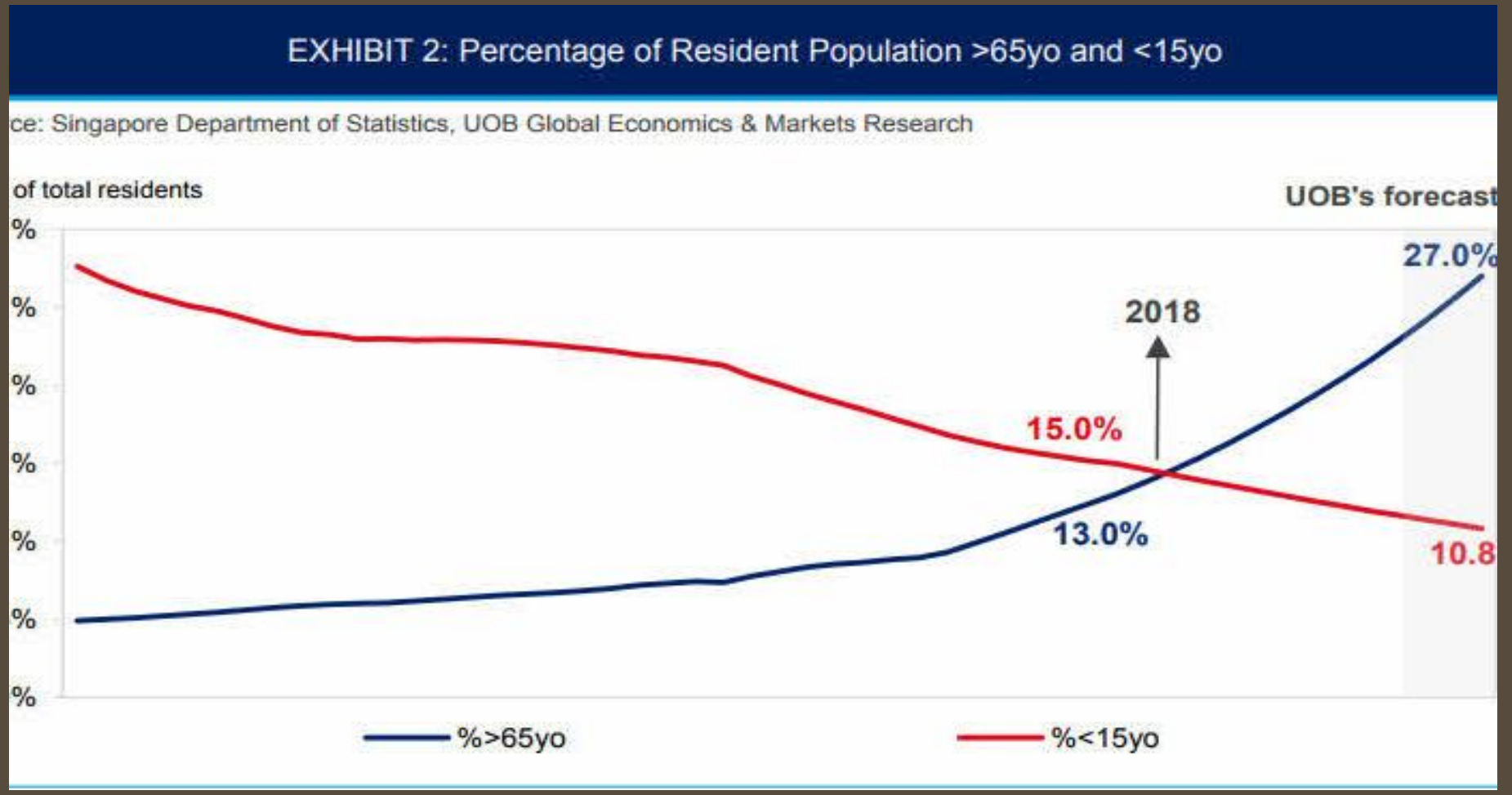
Erikson's Psychosocial Stages

Stage	Basic Conflict	Virtue	Description
Infancy 0–1 year	Trust vs. mistrust	Hope	Trust (or mistrust) that basic needs, such as nourishment and affection, will be met
Early childhood 1–3 years	Autonomy vs. shame/doubt	Will	Develop a sense of independence in many tasks
Play age 3–6 years	Initiative vs. guilt	Purpose	Take initiative on some activities—may develop guilt when unsuccessful or boundaries overstepped
School age 7–11 years	Industry vs. inferiority	Competence	Develop self-confidence in abilities when competent or sense of inferiority when not
Adolescence 12–18 years	Identity vs. confusion	Fidelity	Experiment with and develop identity and roles
Early adulthood 19–29 years	Intimacy vs. isolation	Love	Establish intimacy and relationships with others
Middle age 30–64 years	Generativity vs. stagnation	Care	Contribute to society and be part of a family
Old age 65 onward	Integrity vs. despair	Wisdom	Assess and make sense of life and meaning of contributions

2018 WAS A SIGNIFICANT YEAR FOR US



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SILVER TSUNAMI

According to the annual Population In Brief report, the proportion of Singaporeans aged 65 and above increased to 18.4 per cent in 2022. By 2030, around one in four citizens, or 23.8 per cent, will be aged 65 and above.

Singaporeans are living longer

In 2018, Singaporeans are expected to live until the age of 83.3

In 2015, there were 5.7 working adults supporting 1 senior

In 2020, this number will fall to 4.3

In 2050, there will just be 1.5 working adults supporting 1 senior

WHAT ARE THE RISK FACTORS FOR MENTAL DISORDERS IN THE ELDERLY?

WHAT ARE THE LOSSES EXPERIENCED IN OLDER PEOPLE?

Loss of significant people

Loss of external objects

- Possession, wealth

Health

- Physical, cognition

Loss of identity/ part of self

- Roles, status, body image, safety, pride, control, autonomy

LOSSES

Physical losses

- Loss of sometime tangible

Symbolic losses

- Loss of something that is mainly psychosocial in nature
- Getting a divorce, losing a job, losing a friendship, or retiring

Secondary losses

- The implications or consequences of a loss, either physical or symbolic
- E.g. Loss of income after loss of main breadwinner

Grief is the price we pay for love.

Queen Elizabeth II

WHAT ARE THE RISK FACTORS FOR MENTAL DISORDERS IN THE ELDERLY?

Loss of social roles

Loss of autonomy

Declining functional ability

Declining physical health, chronic illnesses (such as heart disease, cancer or stroke)

Death of family and friends

Loneliness, social isolation

Financial constraints

Decreased cognitive functioning

Organic causes

- *Important contributor- medication induced*

BIOPSYCHOSOCIAL FORMULATION

Biological	Psychological	Social
- Physical illness masquerading (e.g. thyroid, cortisol, tumour) - Medication side effects (e.g. steroid, ventolin, thyroid) - Harbinger of another condition (e.g. depression as a risk factor/ prodrome of dementia) - Comorbid to cognitive disorder (decreased reserves) - Family history of psychiatric illness - Psychotropic adherence - Substance use - Chronic physical illness, pain conditions, disability	- Personality factors, cognitive coping styles, thinking patterns - Significant earlier life experiences/childhood events, ways of interpersonal relating - Mental health literacy - Insight	- Life events, loss - Social support - Financial

Predisposing, Precipitating, Perpetuating, Protective

TREATMENT BARRIERS

According to the Ministry of Health's (MOH) National Population Health Survey 2022, **older adults aged 60 to 74 are least willing to seek help from healthcare professionals and informal networks**, compared to younger cohorts.

Older generations may **not be as familiar with mental health issues** as younger folks. They may **keep their emotional suffering to themselves**, thinking it is a normal part of ageing, **not wanting to feel like a burden** to their family or friends.

They may also be living alone, dealing with **chronic ailments** or **financial issues**, and may simply have **no one around them to open up to**.

TREATMENT BARRIERS

While there are community initiatives which engage older adults struggling with mental health challenges, it is sometimes the seniors themselves who are **reluctant** to try solutions to improve their mental health.

Stepping out of their comfort zone to partake in community activities might feel overwhelming, and **travelling to unfamiliar locations** could lead to disorientation and stress.

Seniors may refuse medication out of a fear of costs or side effects and can feel self-conscious about discussing their preoccupations with a therapist or a peer support group. These solutions may look alien to seniors who have coped well with the hardships of life in their younger years.

MENTAL HEALTH ISSUES IN THE ELDERLY

14%[1] OF THOSE AGED 60 AND OVER HAVE A MENTAL DISORDER

Most common:

Depression

Anxiety disorders

Others:

Adjustment disorder

Schizophrenia and psychotic disorders

Bipolar disorder

Dementia

Delirium

[1]http://www.who.int/mediacentre/factsheets/fs381/en/

MR BLUE

MR BLUE

80yo Chinese Gentleman, retired school principal

Living alone in his HDB flat, wife passed away 5 years, children all living abroad

Premorbidly ADL independent, manages everything on his own, enjoys taking long walks on his own

Gradually struggling with failing eyesight and worsening osteoarthritis

Eventually had a fall and sustained hip fracture

Family hired a helper upon discharge, currently wheelchair bound

Noted to be more quiet and withdrawn, increasingly complained of abdominal and leg pain

What risk factors can you identify?

- Social isolation
- Death of spouse
- Physical decline
- Sensory impairment
- Somatic complaints
- Loss of independence

DEPRESSION

DEPRESSION IN THE ELDERLY

Incidence: 7% of the elderly

Second Well-Being of the Singapore Elderly (WiSE) study:

- Prevalence of depression increased from 3.7% (1 in 27) in 2013 to **4.4%** (1 in 23) in 2023; not statistically significant
- Older adults who were divorced/separated (compared to those who were married) and those who had below-primary education (compared to those with tertiary education) had a higher likelihood of depression (3.6 and 4.2 times, respectively)

CLINICAL FEATURES

- Similar to adults
- Possible differences:
  - More prominent **somatic complaints**
  - When cognitive impairment is present-will need to decide if this is 'pseudodementia' or part of an actual dementia
  - Apathy and poor motivation
  - Marked anxiety, 'MDD with anxious distress'
  - **High risk of completed suicide** in older adults who are depressed (26% increase in completed suicide in >60yo 2021)

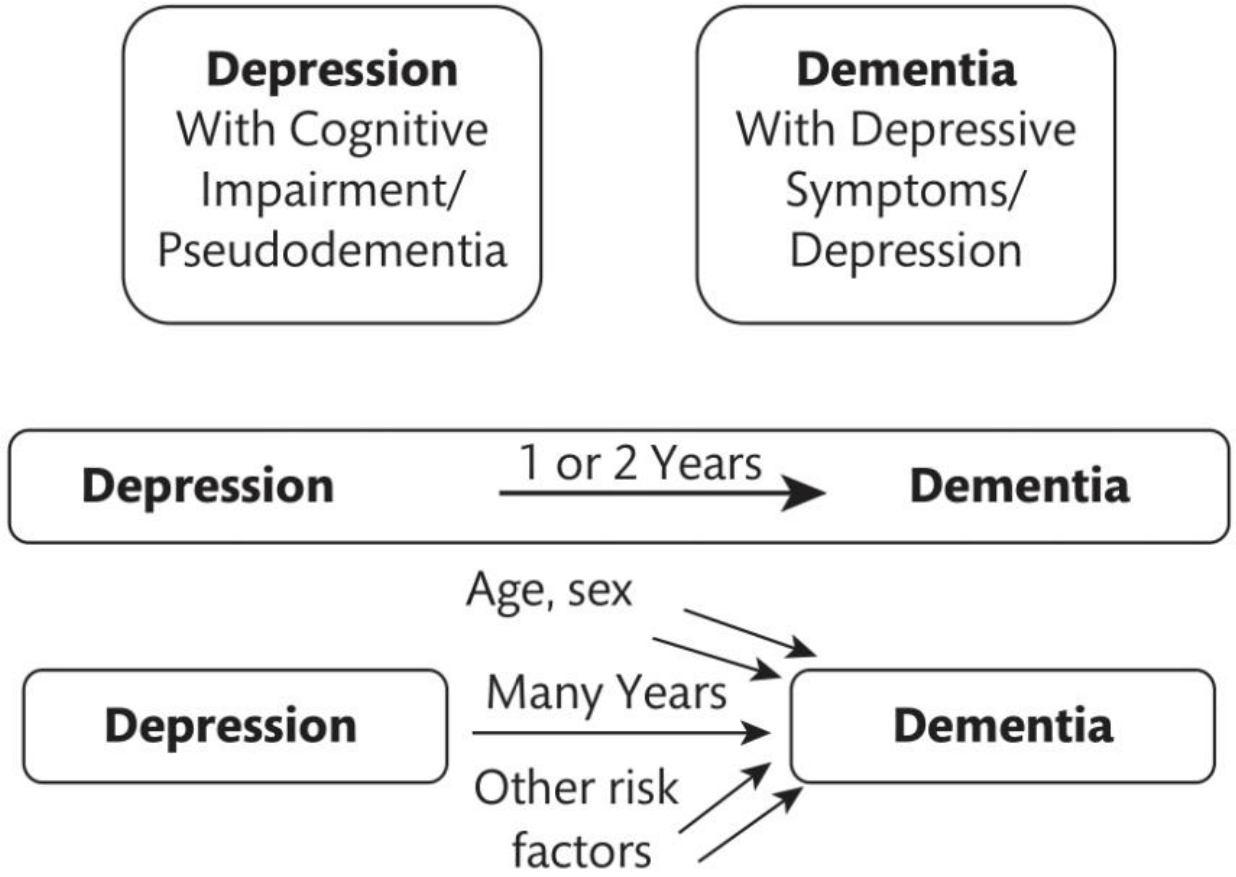


Fig. 39.1 Four types of relationship of between depression and dementia.

DEMENTIA VS PSEUDODEMENTIA

Dementia	Pseudodementia
Progressive onset	Rapid onset
Long term symptomatology	Short term symptomatology
Mood variations	Consistently depressed mood
Patient tries to answer to questions	Short answers like 'I don't know' , negativism
Concealing amnesia , making an effort on cognitive tasks	Highlighting amnesia – less effort when attempting cognitive tasks
Constant cognitive decline	Fluctuating cognitive impairment – attention and concentration deficits are variable

ELDERLY SUICIDE RATE IN SINGAPORE

Mean suicide rate (1985 to 1991) in Singapore

- 15.3 per 100,000

Mean annual suicide rate for elderly

- 52 per 100,000
- Males > females

Possible sociocultural factors account for differences

Ethnicity and elderly suicide in Singapore
Ko & Kua 1995

DEPRESSION - MANAGEMENT

Risk assessment

- Self-harm
- Suicide
- Neglect
- Substance misuse
- Abuse

Corroborative history

DEPRESSION - MANAGEMENT

Biological	• Exclude common organic causes • 'Start Low, Go Slow' • SSRIs are first line (monitor sodium – SIADH) • Mirtazapine useful if poor appetite and insomnia are prominent, monitor for transaminitis • Avoid TCAs • Electroconvulsive Therapy may be considered for severe cases
Psychosocial	• Similar principles to managing depression in adults • Consider psychological mindedness • In the elderly, there is an increased need to ensure they have adequate support in the community: • To meet basic needs for meaningful activity, socialisation, physical functioning

COMMUNITY RESOURCES

- Eldercare services: home-based, day/senior activity centre, day care, rehabilitation, respite, residential care
- Senior Activity Centres: AWWA, Care Corner, Fei Yue, Lions, NTUC, Sunlove, TOUCH, THK
- Befriending services: AIC, Brahm Centre, Health Hub, Lion, REACH, TOUCH
- COMIT, CREST

ANXIETY DISORDERS

ANXIETY DISORDERS

Age of onset-usually in early or middle adulthood, can present for the first time above age 60

1st episodes of panic after age 60 – rare

Aetiology:

- Difficulties in coping with increasing physical illness and functional decline, fear of falling can be especially prominent, coming to terms with the prospect of death
- More fragile autonomic nervous system

Table 42.2 Twelve-month prevalence rates for DSM-V and ICD-10 anxiety disorders.

	DSM-V 12-Month Prevalence (95% CI)		ICD-10 12-Month Prevalence (95% CI)	
	65–85 Years	16–64 Years	65–85 Years	16–64 Years
Generalized Anxiety Disorder	1.4 (0.8–1.9)	4.3 (3.8–4.7)	1.5 (1.0–2.1)	3.7 (3.3–4.1)
Panic disorder	0.5 (0.2-0.9)	2.2 (1.9–2.6)	0.9 (0.5–1.4)	3.1 (2.7–3.5)
Agoraphobia (+/– panic disorder)	0.3 (0.1–0.6)	1.6 (1.3–1.9)	1.0 (0.6–1.5)	3.4 (3.0–3.9)
Social phobia	1.2 (0.7–1.7)	5.4 (4.8–5.9)	1.3 (0.8–1.8)	5.8 (5.3–6.4)
Post-traumatic stress disorder	1.6 (1.1–2.2)	5.3 (4.8–5.8)	2.5 (1.8–3.2)	7.9 (7.3–8.6)
Obsessive-compulsive disorder	0.7 (0.4–1.1)	3.1 (2.7–3.5)	0.7 (0.4–1.1)	2.4 (2.0–2.7)
Any anxiety disorder	4.3 (3.3–5.2)	14.2 (13.4–15.0)	6.0 (4.9–7.1)	17.1 (16.1–17.9)

These population-weighted estimates were calculated from the confidentialized unit record file of the National Survey of Mental Health and Wellbeing, Australian Bureau of Statistics (2007). All diagnoses are non-hierarchical.

Source: data from *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition, DSM-5, 2013, American Psychiatric Association; data from *International statistical classification of diseases and related health problems*, 10th Revision, 2010, World Health Organization.

Estimated prevalence of late-life anxiety disorder ranges from 1.5% to 15%
GAD, Panic, Specific phobias (esp related to falls, with an agoraphobic component), agoraphobia

GENERALISED ANXIETY DISORDER

Excessive anxiety and worry (apprehensive expectation) about multiple events/activities

3 or more of: Restlessness/keyed up/on edge, Fatigue, Difficulty concentrating/mind blank, Irritability, Muscle tension, Sleep disturbance

6 months or longer

GAD appears to precede MDD more often than MDD precedes GAD

PANIC DISORDER

Recurrent unexpected panic attacks

(sudden surge of intense fear/discomfort that peaks within minutes)

4 or more of: Palpitations, Sweating, Trembling, SOB, Feeling of choking, Chest discomfort, Nausea/abdo distress, Dizziness, Chills/heat sensations, Numbness/tingling sensations, Derealisation/depersonalisation, Fear of losing control/going 'crazy', Fear of dying

Persistent worry about additional panic attacks or their consequences, and/or Maladaptive change in behaviour related to the attacks

1 month or longer

Panic attacks may occur in other mental disorders e.g. MDD, GAD, alcohol withdrawal

AGORAPHOBIA

Fear and avoidance of situations from which escape might be difficult or help might not be available if panic-like symptoms or other incapacitating/embarrassing symptoms occur (e.g. fall, incontinence)

2 or more of such situations: Using public transport, Being in open spaces (e.g. parking lots, marketplaces, bridges), Being in enclosed places (e.g. shops, theatres), Standing in line or being in a crowd, Being outside of home alone

Often easier when accompanied by trusted family member/friend

SPECIFIC PHOBIA

Avoidance of feared objects/ situations

Generally associated with little distress or disability apart from when actually confronted by the phobic stimulus

Fear of falling is a relatively distinct syndrome in later life, with features of both specific phobia and agoraphobia

- Considerable disability for many older people
- 30% or more of people aged 65 years and older fall each year, and one-fifth of these falls require medical attention
- About 25% of those who fall develop fear of falling

SOCIAL ANXIETY DISORDER

Fear and avoidance of social situations in which the person is exposed to possible scrutiny by others

Fear of being negatively evaluated/judged, embarrassed, humiliated

6 months or more

Older people with this condition rarely present for treatment – perhaps due to reduced social and occupational demands in later life, hence not being particularly disabled by the condition?

POST-TRAUMATIC STRESS DISORDER

- Classically, the development of PTSD follows life-threatening trauma e.g. RTA, violent assault, rape, natural disaster
- Intrusive re-experiencing of traumatic event (e.g. flashbacks, nightmares)
- Hyperarousal (e.g. easily startled, hypervigilance, irritability, impaired concentration, insomnia)
- Avoidance of scene of the traumatic exposure or reminders of the trauma
- Negative changes in cognitions and mood (e.g. emotional numbing, negative beliefs about oneself/others/the world)
- 1 month or more

OBSESSIVE COMPULSIVE DISORDER

Obsessions: Recurrent intrusive and unwanted thoughts, images or urges that the person experiences as being the product of his/her own mind and causes distress

Compulsions: Repetitive behaviours (e.g. handwashing, checking) or mental acts (e.g. praying, repeating words silently) that the person feels driven to perform in response to an obsession (e.g. to undo the obsessional thought, prevent harm or reduce anxiety) or according to rigid rules

Time consuming (e.g. takes >1h daily) or causes significant functional impairment

TREATMENT

Psychological

Social

Biological – antidepressants e.g. SSRIs, SNRIs, NaSSAs

- Avoid benzodiazepines – risk of falls and confusion
- Propranolol – cautiously, low doses, risk of hypotension

ADJUSTMENT DISORDER

GRIEF

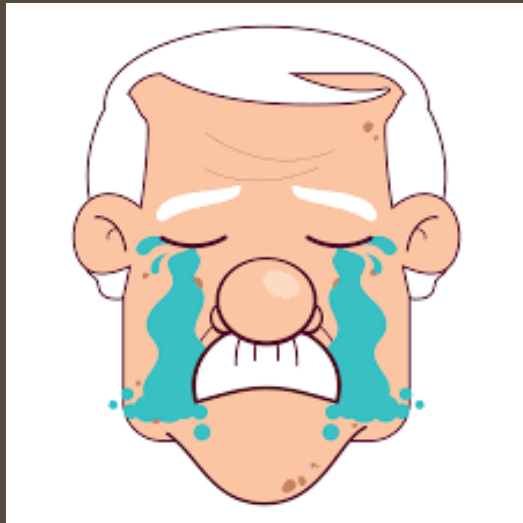
MR HONG

Mr Hong is a 75yo male who lives with his wife in a 2 room flat. He has no children and has been married for 45 years.

Is this depression?

A month ago , his wife suddenly passed away in a car accident after sustaining traumatic head injury. He has been crying daily, and has not been able to enjoy his usual activities which include golfing. Since his wife passed on , he described feelings of emptiness, and occasionally verbalized thoughts of wanting to 'join her'.

When surrounded by family members, he is able to respond to reassurance from others, and still remains connected with his friends. There are no thoughts of worthlessness.



SYMPTOMS OF GRIEF

Emotional

- Sadness
- Shock
- Guilt
- Anxiety
- Anger
- loneliness,
- Yearning, longing and relief

Physical

- Sleep disturbances
- Shortness of breath
- Tightness in throat
- Weight changes

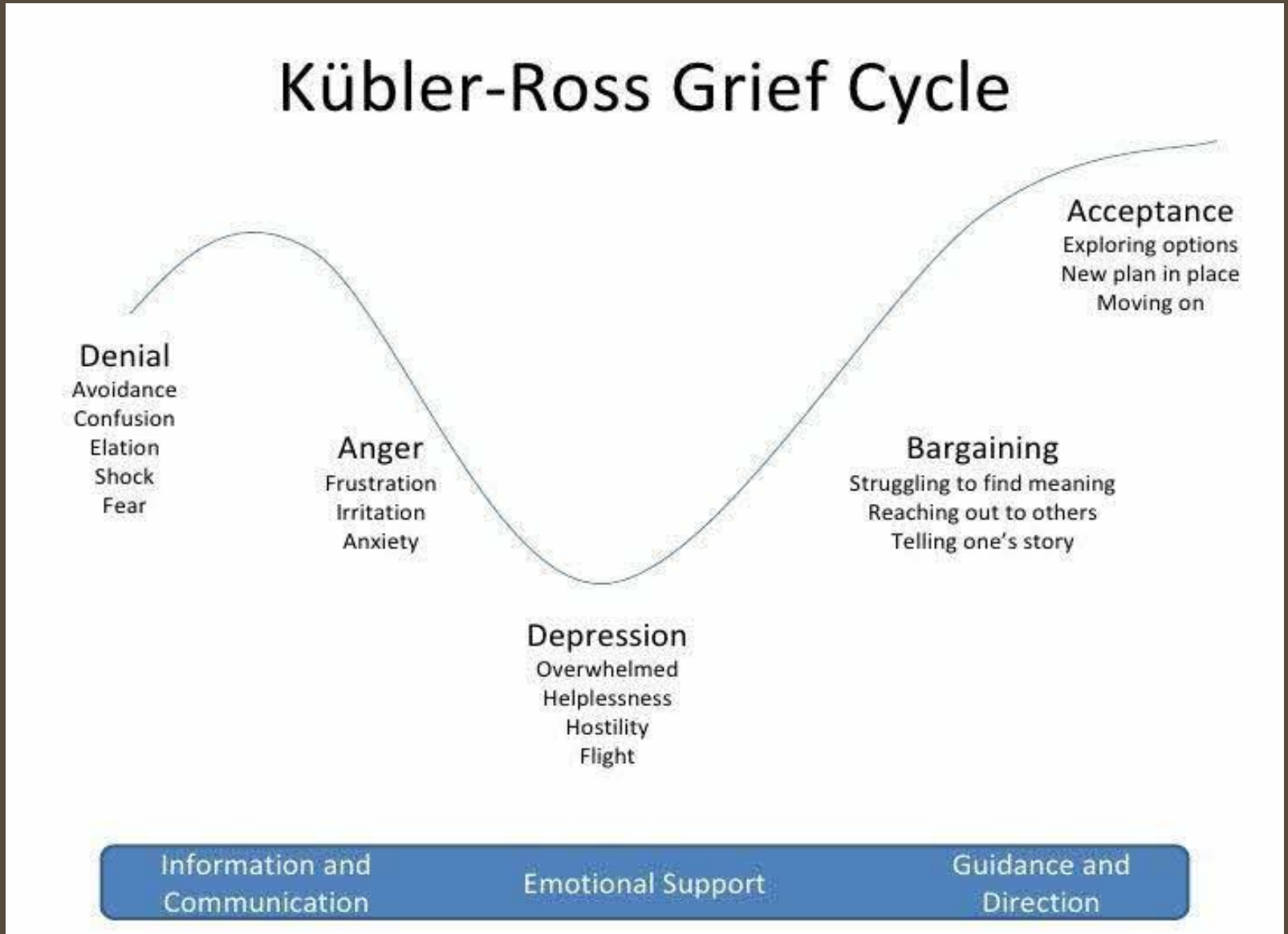
Behavioral

- Crying
- Social withdrawal
- Restlessness,
- Avoiding reminders of deceased, dreams
- Searching or pining for deceased
- Visiting places or carrying objects that remind of deceased

Cognitive

- Disbelief,
- Denial
- Forgetfulness
- Preoccupation with deceased
- Intrusive thoughts or images of deceased/death
- Sense of presence of deceased
- Pseudo-hallucinations

STAGES OF GRIEF



IDENTIFYING GRIEF AND DEPRESSION

Grief	Depression
• **Waxes and wanes** • Predominant feelings **emptiness and loss**	• Pervasive low mood and sadness
• Preoccupied with **loss** • Memories and reminders of deceased	• Preoccupied with negative distorted self-view
• No sense of worthlessness	• Sense of helplessness and worthlessness
• **Yearning longing** for deceased, pleasurable reveries	• Loss of interest and pleasure
• Guilt revolving around deceased	• Persistent , overwhelming guilt
• Thoughts of death about joining deceased	• Thoughts of death due to feelings of worthlessness
• Able to maintain closeness to others	• Tends to isolate from others

PSYCHOTIC DISORDERS

LATE ONSET SCHIZOPHRENIA

Onset of schizophrenia after age 45

First episodes after age 65 are rare, always make sure you screen for an organic cause of late onset symptoms

More common in women, sensory impairment

More likely to have paranoid delusions

Usually respond well to antipsychotics

- *Remember: Start with low doses and increase slowly!*

Table 43.1 Characteristics of various types of late-life psychosis.

	EOS	LOS	VLOSLP	PoD
Family history of schizophrenia	+	+	–	–
Female preponderance	–	+	++	–
Minor physical anomalies	+	+	–	–
Specific brain abnormalities (MRI)	–	–	+	+/–
Dementia-like cognitive decline	–	–	+	++
Magnitude of cognitive impairment	+	+	++	+++
Paranoid subtype	+	++	++?	N/A
Visual vs auditory hallucinations	+/–	+	+?	++
Complex vs simple delusions	++	+	+?	+/–
Thought disorder	+/++	+	–	–
Negative symptoms	++	+	–	–
Required neuroleptic dose	++	+	+	+/–

EOS, early-onset schizophrenia; LOS, late-onset schizophrenia; MRI, magnetic resonance imaging; N/A, not applicable; PoD, psychosis of dementia; VLOSLP, very-late-onset schizophrenia-like psychosis; +, moderately present; ++, strongly present; +++ very strongly present; –, not likely to be present; ?, only partially supported by the literature.

Adapted with permission from Iglewicz et al., 2011.

Adapted with permission from Iglewicz, A., et al. New Wine in Old Bottle: Late-life Psychosis. *Psychiatric Clinics of North America*, 34(2): 295–318.

DELUSIONAL DISORDER

Age of onset – usually 40 to 55

Common types:

- Persecutory
- Somatic

Risk factors: Sensory impairment, loss of spouse, social isolation

Risk needs to be closely monitored

- Aggression toward suspected persecutors
- Self-isolation

Treatment: Antipsychotics, supportive counselling, community support

MADAM DEDE

MADAM DEDE

76yo Chinese Lady, lives with her husband, retired dentist

Over the past year, has been preoccupied with being scammed by her bank. This happened when she forgot her ATM number and was hence convinced that the bank had tampered with this intentionally with the purpose of taking her money

Had made multiple calls to the police and written many letters to MP

Family noticed that she had also been misplacing her belongings and would then rationalize that the bankers had been sending people to spy on her

She had lost her way on numerous occasions during her attempts to go to the bank to look for their CEO

What are the potential risks identified?

- Financial exploitation
- Getting lost
- Potential aggression
- 'Public nuisance'

DEMENTIA (MAJOR NEUROCOGNITIVE DISORDER)

EPIDEMIOLOGY

- 8.8% of those age 60 and above in Singapore have dementia (2023) ← 10% in 2013
- Treatment gap improved, with a significant decrease in the rate of undiagnosed dementia to 51.5% in 2023 ← 70.6% in 2013
- No. of older adults with dementia rose from 51,934 in 2013 to 73,918 in 2023, largely due to the increase in the local older adult population

(Second Well-being of the Singapore Elderly (WiSE) Study)

- In 2020 there will be 53,000 people living with dementia. This will rise to 187,000 in 2050.

(Alzheimers Dementia Association Singapore)

- 46.8 million people world-wide live with dementia. This number is estimated to surge to 131.5 million in 2050.

(Ferri et al 2005; Prince and Wimo August 2015)

DEMENTIA

Risk factors:

- Older age (75 years and above)
- No formal education, or completed primary education (versus higher education)
- Homemaker and retired status (versus employed)
- History of stroke

DSM-5 DIAGNOSIS

Evidence of significant cognitive decline from a *previous level of performance* in one or more cognitive domains based on

- Concern of the individual, a knowledgeable informant, or the clinician AND
- Substantial impairment in cognitive performance, preferably documented by standardized neuropsychological testing or, in its absence, another quantified clinical assessment

Cognitive deficits **interfere with independence** in everyday activities activities (ie. At a minimum, require assistance with complex instrumental activities of daily living such as paying bills or managing medications)

Cognitive deficits do not occur exclusively in the context of a delirium

Cognitive deficits are not better explained by another mental disorder eg major depressive disorder, schizophrenia

Cognitive Domain	What it includes	Functional Assessment
Memory and Learning	Immediate memory Recent memory Very-long-term memory [semantic; autobiographical] implicit learning	•Repeats self in conversation •cannot keep track of shopping list/bills or plans •Requires frequent reminders
Complex Attention	Sustained attention Divided attention Selective attention Processing speed	•Easily distracted by competing events in the environment •Unable to perform mental calculations •Thinking takes longer than usual
Perceptual Motor	Visual perception, Visuo constructional Perceptual-motor Praxis	•Difficulties in using tools, driving •Difficulties navigating in familiar environment •Sundowning
Language	Expressive language [including naming, word finding, fluency, and grammar, and syntax] Receptive language	•Often uses general-use phrases such as “that thing” and “you know what I mean,” •Word finding difficulties •Idiosyncratic wordusage, grammatical errors •Stereotypy of speech
Executive Function	Planning Decision making Working memory Responding to feedback/error correction Overriding habits/inhibition mental flexibility	•Abandon complex projects •Needs to rely onothers to plan instrumental activities of daily living or make decisions.
Social Cognition	Recognition of emotions Theory of mind	•Inappropriate behaviour •Makes decisions without regard to safety

DEMENTIA - AETIOLOGY

Specify whether dementia is due to:

- Alzheimer's disease
- Vascular disease
- Frontotemporal neurocognitive disorder
- Lewy Body disease
- Parkinson's disease
- Traumatic Brain Injury
- Substance/Medication use
- HIV infection
- Multiple aetiologies

BEHAVIOURAL AND PSYCHOLOGICAL SYMPTOMS OF DEMENTIA (BPSD)

One or more of these symptoms are observed in 60 to 90 percent of patients with dementia; the prevalence increases with disease severity

Over a period of 5 years, more than 90% of people with dementia develop BPSD

COMMON BPSD CLUSTERS

Mood: Depression, Anxiety, Irritability, Emotionality/ lability, Euphoria

Thought content: Ideas of persecution, jealousy, misidentification etc (delusional intensity?)

Perception: Visual, auditory etc modalities (illusion vs hallucination?)

Hyperactivity: Agitation/ aggression, Wandering/ aberrant motor behaviour, Disinhibition/ impulsivity

Sleep: Insomnia, Hypersomnia, Fragmented sleep, Sleep-wake reversal, REM sleep disorder

Feeding: Poor oral intake, Hyperphagia, Particular food preferences

Others: Apathy, Resistiveness to care, Catastrophic reaction, Sundowning, Hoarding

VARIATION WITH TYPE/STAGE OF DEMENTIA

Certain BPSD are more commonly associated with certain types of dementia

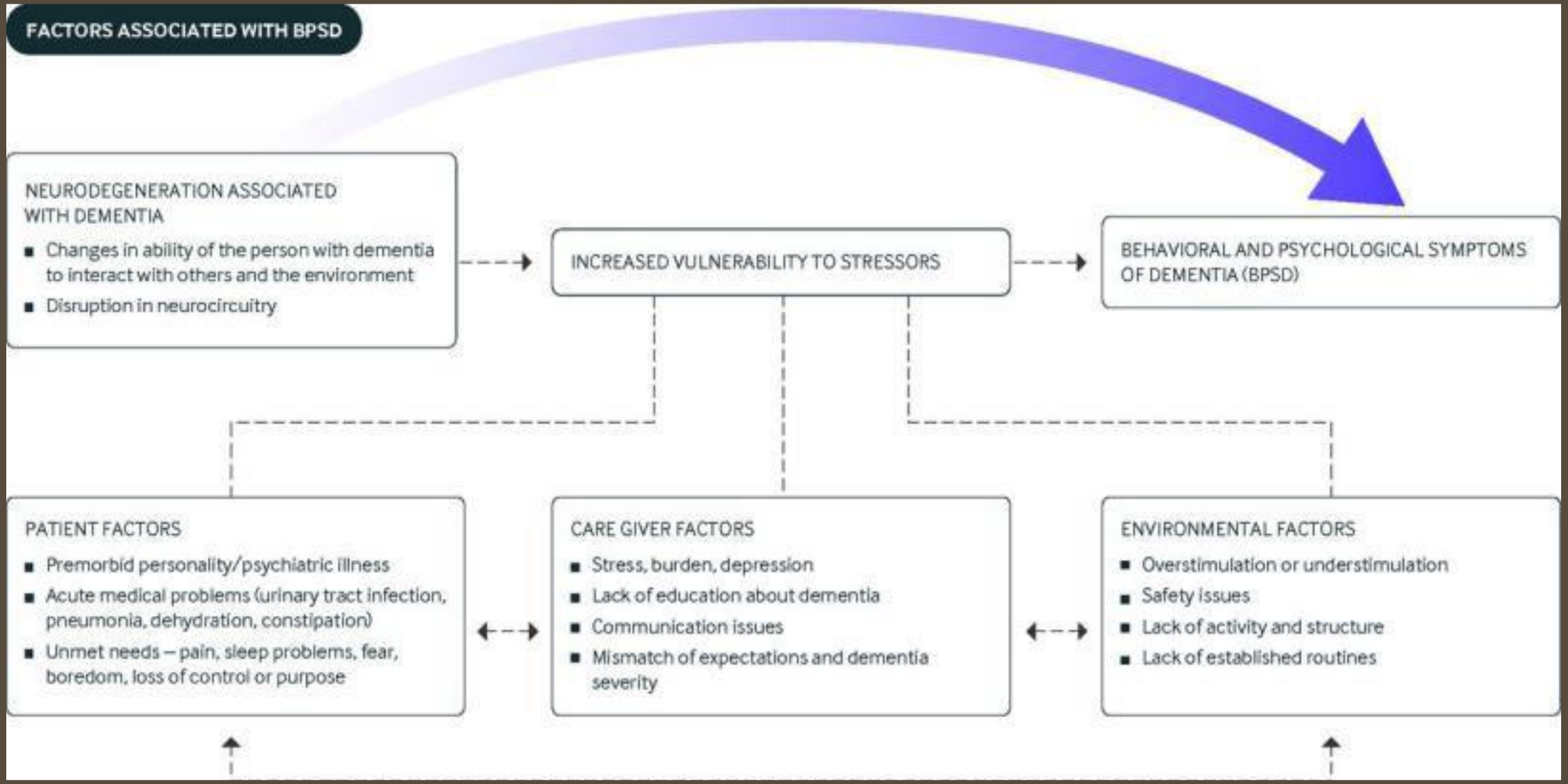
E.g. depression is more frequent in vascular dementia

Visual hallucinations are common in Lewy Body dementia

Disinhibition and apathy are more often exhibited in frontotemporal dementia

BPSD can present across all stages of dementia, though their type and prominence depend on the stage

E.g. anxiety and depression are more commonly seen in the early stage of Alzheimer's disease and may worsen with illness progression. Agitation is common, persistent, and may increase with disease severity. Apathy is commonly reported by family members across all stages of dementia and may worsen over time. Delusions, hallucinations, and aggression are more episodic and more common in the moderate to severe stages of disease



https://doi.org/10.1136/bmj.h369

ASSESSMENT OF BPSD – SYSTEMATIC APPROACH

History – direct patient + informant interviews

- Patient history can be subjective, tinted by cognitive impairment or limited insight
- Caregivers can be more objective but may be coloured by relationship with patient; they should have good knowledge of patient's daily life

Review of medical records

- Past medical history
- Medication list

Focused physical, neurological and mental status examinations

- Physical health issues
- Sensory impairments
- Functional disability
- Affected cognitive domains
- Mood, psychotic symptoms

DESCRIBE BPSD

What behaviour? (objective description, not subjective)

When? How often? How severe? Safety concerns?

What effect on patient vs those around?

Which context? Which trigger factors? Family dynamics?

ABC FRAMEWORK

ANTECEDENT/ UNMET NEED

What was the unmet need?

(Physical, medical, psychiatric, psychological/emotional, environmental)

BEHAVIOUR

What specific behaviour was displayed?

CONSEQUENCES

What were the consequences of the behaviour for the person as well as those around?

What kinds of reactions were observed from others?

BPSD MANAGEMENT – GENERAL GUIDELINES

Behavior has purpose – disruptive behavior can be an indication of underlying distress or an unmet need

Certain factors can increase stress and may contribute to BPSD

- Visual/hearing impairment
- Limited mobility
- Pain/physical discomfort
- Incontinence
- Inability to communicate (can be due to language)

Address the multifactorial aetiology of BPSD

Treat any potential medical causes first

- Could the behavioural disturbance be a manifestation of delirium/ acute medical illness?
- Could the person be in pain? (may consider empiric trial of analgesia)

GENERAL GUIDELINES

BPSD need treatment when:

- They are distressing to the patient
- They impair self care, social interaction or participation in activities
- They are a source of danger to the patient or to others
- They have an impact on placement
- They affect quality of life

There is no “one size fits all” solution

- Symptoms may change along the course of a person’s dementia
- Every patient and caregiver’s journey is distinct, with unique challenges and needs
- What appears challenging to one person may not be to another

NON-PHARMACOLOGICAL INTERVENTIONS

First line of treatment to manage milder BPSD

- For moderate to severe BPSD, medications can be used as an adjunct to non-pharmacological interventions

Address the cause of the symptom – ABC framework

Continued modification or adaptation may be needed

~~How do we manage 'challenging' behaviours?~~

> How can we help persons with dementia meet their unmet needs?

ENRICHED MODEL – THOMAS KITWOOD

NI Neurological impairment	H Health	B Biography	P Personality	SP Social psychology	PE Physical environment
- Dementia dx: type, stage - Biological changes, neurodegeneration, disruption in neurocircuitry - Cognitive, functional and psychological domains affected (and preserved)	- Co-existing health conditions (mental, physical) - Sensory impairment - Pain - Medications - Nutrition, hydration - Bladder, bowel - Delirium/ superimposed acute illness?	- Life history - Milestones - Significant events incl. trauma, abuse - Living arrangement - Family background - Marital status, relationship history - Occupation - Education - Interests, hobbies - Habits, routines - Cultural b/g - Spirituality, religion - Values, beliefs	- Personality traits e.g. introverted, sociable, anxious, perfectionistic, temperamental, suspicious, easy going, etc - Coping styles - Attachment styles	- Social environment & relationships Basic psychological needs:  	- Safety - Space, lighting, noise, temperature - Daily routines, structure - Appropriate level of activity stimulation

PERSON-CENTRED CARE (PCC)

Founded on the ethics that all human beings are of absolute value and worthy of respect, regardless of their disability (Kitwood, 1997)

Seeks to maintain the personhood of the person with dementia (see beyond the disease)

Utilises remaining abilities, emotions and cognitive abilities (not centred on disability/ losses)

Focuses on life experiences, personality and relationships

V = **Value** the person with dementia

I = treat them as unique **Individuals**; provide **Individualised** care plan

P = understand the **Perspective** of the person with dementia

S = supportive **Social** environment in which the person with dementia can experience relative well-being

INTERVENTIONS TARGETING THE PERSON WITH DEMENTIA

Reality orientation therapy

- Reminding them of the facts about themselves or their surroundings
- Use of signposts, notices, memory aids

Cognitive training and rehabilitation

- Bringing new structure to daily life
- Acquaintance with activities appropriate for remaining cognitive capacity

Psychotherapy

- Acknowledging fear of cognitive losses
- Managing anxiety in social situations
- Adjustment to reduction to social life

INTERVENTIONS TARGETING THE PERSON WITH DEMENTIA

Various interventions to increase wellbeing, providing pleasure, sensory and cognitive stimulation

Emotion oriented therapies

- Reminiscence therapy
- Validation therapy
- Simulated presence therapy

Sensory stimulation therapies

- Music therapy
- Aromatherapy
- Light therapy
- Pet therapy
- Doll therapy
- Acupuncture
- Massage/ touch therapy
- Sensory apron and felt props
- Snoezelen multisensory stimulation

INTERVENTIONS FOR CAREGIVERS

Psychoeducation

Main goal is to problem solve and identify precipitating and modifiable causes of BPSD

- ABC (Antecedent, behavior, consequence) approach

Caregiver training

Behavioural management techniques

Support groups

Family therapy

Community services – elder sitters, day care, respite care, financial assistance, etc

Psychotherapy – grief, depression

INTERVENTIONS TO IMPROVE THE ENVIRONMENT

Ideal environment: non-stressful, constant, familiar

- Avoid over-or under-stimulation
- Promote meaningful activity and social engagement

Encouraging independence whilst preserving safety

- Within the home
- In the community

Regular routine

Good sleep hygiene

PHARMACOLOGICAL INTERVENTIONS

Only to be considered as the last resort

- No identifiable physical cause
- Inadequate/non-response to non-pharmacological treatment
- BPSD cause significant distress or risk to the person with dementia

Cautions

- Medical co-morbidities, drug-drug interactions
- Sensitivity to side effects

Always start low, go slow

Regular reassessment, down-titration or discontinuation at earliest possible interval

TOP TEN BEHAVIOURS USUALLY NOT RESPONSIVE TO MEDICATION

Aimless wandering

Inappropriate urination/defecation

Inappropriate dressing/undressing

Perseverative activities

Vocally repetitious behaviour

Hiding/hoarding

Pushing other wheelchair bound seniors

Eating in-edibles

Inappropriate isolation

Tugging at/removal of restraints

TOP TEN BEHAVIOURS PERHAPS MORE AMENABLE TO MEDICATION

Physical aggression

Verbal aggression

Anxious, restless

Sadness, crying, anorexia

Withdrawn, apathetic

Sleep disturbance

Wandering with agitation/aggression

Vocally repetitious behaviour due to depression/pain

Delusions and hallucinations

Sexually inappropriate behaviour with agitation

PHARMACOLOGICAL INTERVENTIONS

MOH Clinical Practice Guidelines on Dementia

Antidepressants

- Treatment of depression and anxiety symptoms
- SSRIs (e.g. fluvoxamine, escitalopram), NaSSA (mirtazapine)
- Monitor serum sodium

Atypical antipsychotics

- Treatment of severe psychosis and aggression
- Risperidone, olanzapine, quetiapine, aripiprazole
- SE: EPSE, sedation, postural hypotension, anticholinergic, increased risk of falls, metabolic syndrome
- Note increased risk of mortality

PHARMACOLOGICAL INTERVENTIONS

Cognitive enhancers

- Slow progression of dementia (cognition)
- AChEIs (donepezil, rivastigmine), NMDA antagonist (memantine)
- Conflicting evidence for management of BPSD

Cautious with Hypnotics

- Treatment of insomnia
- Benzodiazepines, Z-drugs
- SE: confusion, sedation, risk of falls, dependence

MEDICOLEGAL

Lasting Power of Attorney vs Court Appointed Deputy

A Lasting Power of Attorney (LPA) is a legal document that allows a person who is 21 years of age or older to plan the management of his affairs in the event of a loss of mental capacity.

In the LPA, the person making the LPA (known as the donor) appoints one or more persons (known as the donee) to act and make decisions on his behalf.

A donee should be someone you trust who is reliable and competent to act on your behalf. The use of an LPA is especially important if one is a sole breadwinner for the family, or is frequently beset with health problems.

MEDICOLEGAL

Vulnerable Adults Act

DELIRIUM

CONNECTING...

To really connect with older parents or grandparents as their relatives, friends, or caregivers, we need to **meet them where they are**. This could mean **dedicating time to listen, chit-chat and create new shared experiences** with the seniors in our lives.

Rather than quick reassurance or trivialisation, **showing curiosity** about their preoccupations and reacting with **empathy** may help nurture trust and a sense of security in older relatives, encouraging them to open up and identify ways the family could help them.

Involving seniors in the family's life by **listening to their opinion**, inviting them to join everyday activities, and **asking for their help** can further strengthen ties and mutual feelings of being **valued and appreciated**.

In a soon-to-be-published study conducted by the Division of Family Medicine at the National University of Singapore on general practitioners' (GPs) perspective on late-life depression, GPs named **trust and rapport** between doctor and patient as the cornerstone to detect and address mental suffering in older individuals.

CONCLUSION

Remember biopsychosocial needs of the elderly

Pharmacological treatment – Start Low, Go Slow, mindful of medical comorbidities, side effects

Risk assessment

Good management is biopsychosocial, person-centred, multidisciplinary and involves caregivers

THANK YOU

Do Not Ask Me to Remember

Do not ask me to remember,
Don't try to make me understand,
Let me rest and know you're with me,
Kiss my cheek and hold my hand.
I'm confused beyond your concept,
I am sad and sick and lost.
All I know is that I need you
To be with me at all cost.
Do not lose your patience with me,
Do not scold or curse or cry.
I can't help the way I'm acting,
Can't be different though I try.
Just remember that I need you,
That the best of me is gone,
Please don't fail to stand beside me,
Love me 'til my life is done.

- Owen Darnell