

Aging Well

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Cognitive Camouflage — How Alzheimer’s Can Mask Mental Illness

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It’s not unusual for mental illness, particularly depression, to occur in the early stages of Alzheimer’s disease. But accurate diagnosis and treatment can improve cognitive function.

When he was in his early 70s, Frank, a successful and active lawyer, began to notice a significant deterioration in his memory and ability to think clearly. It wasn’t just that he forgot names—that had been occurring for years. He couldn’t recall legal precedents that had been at the center of his work for nearly 50 years. He forgot appointments. He got lost on his way to a meeting at a place he had been to many times before. He wasn’t surprised when his doctor said he might have Alzheimer’s disease (AD), but the diagnosis put him into a funk. He felt his life was now hopeless because he would become increasingly disabled and dependent. Death would be a blessing, he thought. He was consumed by such thoughts, unable to concentrate on his work, and distracted when he was with his wife, children, grandchildren, or friends. He slept less and less.

Fortunately, his physician recognized that Frank was depressed and persuaded him to go into therapy. He found a therapist who understood how to treat an individual with a combination of AD and depression. He involved Frank’s wife in the process and offered suggestions on ways to be helpful to her husband. With the combination of cognitive-behavioral therapy and psychoeducation, Frank’s depression lifted a bit. He was able to retire gracefully with his reputation intact. He rediscovered an old interest in music, and he was able to respond to care and affection from his family long after his capacity to speak had passed. For him, as for most older adults with AD, love was the last memory to die.

AD took its inevitable toll, but overcoming his depression gave Frank some additional time to live as he wanted and helped him prepare emotionally for the gradual decline into a life that he had previously dreaded. It wasn’t easy for Frank or his wife or their daughter, who also helped out. It never is. But their emotional bond carried them through the difficult times.

Frank and his family were fortunate to have a physician who could distinguish between the effects of AD and the effects of depression. Frequently, that’s not the case. It was also fortuitous to locate a therapist who had expertise in the mental disorders of older adults. Most do not. As the population of older adults explodes over the next 25 years, more elders will have similar problems, but very few will receive the skilled treatment they need.

An Alzheimer’s disease (AD) diagnosis is usually greeted as a death sentence—and with good reason. The disease grows progressively worse and currently cannot be reversed or even stopped, although it can be slowed in some cases. In 2006, it was the sixth leading cause of death, according to the Centers for Disease Control and Prevention (CDC).

But awareness of the ultimate outcome of AD often blinds people to the fact that, before reaching the end stage, elders with AD can engage in activities they find meaningful and maintain caring and pleasurable relationships. In addition, an AD diagnosis frequently results in the failure to recognize that cognitive problems may have other often treatable causes. Among these are other mental illnesses—especially depression—that are quite common among older adults in the early and midstages of AD. With accurate diagnosis and appropriate treatment, cognitive functioning often improves. The course of AD cannot be reversed, but life can be better—at least for a time.

Frightening Facts

AD is the most common, but not the only form, of dementia and occurs in 6% to 7% of the U.S. population aged 55 and older. The prevalence increases with age to more than 40% by the age of 85. As the population of older adults doubles over the next quarter century, so will the number of older adults with dementia.

AD is a progressive disorder. Although it can't be reversed or arrested, medications are available to slow its progress. It disrupts memory, thought, perception of reality, and behavior to such a degree that eventually it impairs the ability to work, engage in normal adult relationships, participate in ordinary social and leisure activities, carry out basic tasks such as shopping or paying bills, and ultimately manage basic activities of daily living, such as eating, toileting, and dressing.

The early signs—forgetting a recent event, neglecting to pay a bill, not recalling a friend's name—are often indistinguishable from typical "senior moments." To the older adults experiencing them, their families and friends, and their healthcare providers, they may seem like minor problems and a normal part of aging. As time passes, however, the cognitive dysfunction worsens, and the disease becomes more obvious and problematic, both for the individuals and those who care about and, increasingly, for them.

The caregiver burden can become tremendous, with mental, physical, and financial consequences. Families and friends who care for older adults with AD are at increased risk for depression, anxiety disorders, and physical illness. Many family caregivers manage to persevere despite the stress, but many burn out and, understandably, place family members in institutions to relieve themselves of the burden.

Mental Illness With AD

The inherent difficulty of living with AD is exacerbated when it co-occurs with other mental disorders such as depression, anxiety disorders, and psychotic conditions.

Serious symptoms of depression occur in up to 50% of older adults with AD, and major depression occurs in roughly 25% of cases, according to the CDC. Depression is often thought to be an older adult's reaction due to awareness of progressive decline, and this is probably the case. However, some research suggests that there may be a biological connection between AD and depression.

Anxiety disorders, including generalized nervousness, fear of leaving home, agitation about changes of routine, and suspiciousness—sometimes to paranoia proportions—are also common, occurring in up to 30% of older adults with AD. Anxiety seems easily understandable in older adults who are aware of their diminishing abilities. But it is possible that, like depression, it may be physically, as well as psychologically, linked to AD.

AD can also co-occur with psychotic conditions. Older adults with schizophrenia, for example, are as likely to develop AD as those without severe mental illness. And individuals with schizophrenia in old age are at higher risk for depression, creating the possibility of all three co-occurring mental disorders. Symptoms of these disorders include the following:

- profound sadness;
- hopelessness;
- disinterest in people and activities that have previously been a source of pleasure;
- irritability;
- anxiety about change, strangers, going out, etc.;
- suspiciousness or even paranoid ideas;
- sleep disturbances;
- agitation;
- restlessness;
- aggression;
- pacing or immobility;
- delusions;
- hallucinations; and
- various behaviors that are dangerous or distressing to others, including hoarding, verbal or physical abusiveness, and refusal to cooperate.

Such symptoms often have negative consequences for elders with AD and those who care for them. These include the following:

- the subjective distress of the person experiencing such symptoms;
- inability to participate in satisfying activities and relationships;
- increased disability and mortality;
- heightened caregiver burden;
- heightened risk of depression, anxiety disorders, and physical illness in caregivers; and
- earlier placement in institutions despite the preference of both the older adults with AD and their families for them to remain in community settings.

While suicide does not appear to be more prevalent for older adults with AD than other elders, its risk should not be ignored.

Fortunately, treatment of these disorders often results in improved functioning and quality of life for both the older adults with the disorders and their family caregivers.

Differential Diagnosis

Signs of depression include not only sadness and loss of interest in life, but can also include

cognitive impairments such as memory loss, difficulty concentrating, slow information processing, inability to think clearly, and distorted views of reality. Because these depression symptoms are so similar to dementia symptoms, the two disorders are frequently confused, especially when an AD diagnosis has already been made.

Therefore, a good differential diagnosis is critical but not easy. Symptoms of AD that are not common in depression include forgetting recently learned information, trouble performing once-familiar tasks, problems with remembering words, and impaired judgment, such as not perceiving the need to dress warmly in severe winter weather.

Screening tools can be helpful in distinguishing depression from AD. The Mini-Mental State Examination and the clock test are useful for revealing dementia. Depression scales include Patient Health Questionnaires 2 and 9 and the Geriatric Depression Scale, all of which can be easily administered unless dementia is fairly advanced, in which case interviewing family members and caregivers is essential, though not totally reliable.

Effective Interventions

Because there has been little research on the treatment of depression or anxiety in older adults with AD, there are no formally established, evidence-based practices. However, widespread consensus among experts in geriatric mental health is that there are effective interventions for depression and anxiety, sleep disturbances, and behavior problems.

Depression and anxiety can be treated effectively in older adults with and without AD. However, in older adults with AD, it needs to be approached differently from those without. In particular, it is important to begin with nonpharmacological interventions directed both at the patient and the caregiver to avoid the risks associated with antidepressant and antipsychotic medication use in older adults with AD. Such risks include falls—the major cause of disability in old age—severe weight loss and malnutrition, and increased confusion. Except in cases of very severe depression, antidepressants should be prescribed only after sufficient time has elapsed for the nonpharmacological interventions to succeed. And for frail older adults, electroconvulsive therapy should be used only as a last resort.

Nonpharmacological interventions can be as simple as providing pleasant activities, a normal routine, and exercise. Behavioral interventions and environmental modifications can help reduce anxiety, agitation, and hopelessness. In addition, formal cognitive behavioral therapy can be effective. And providing psychoeducation for caregivers can help them better deal with the elder with AD, which may have a positive impact on the individual's mood and general frame of mind.

Sleep disturbances are quite common among older adults with AD, especially those with co-occurring depression. Treatment for depression often results in improved sleeping. But there are also specific psychosocial interventions such as sleep restriction, sleep compression, multicomponent cognitive-behavioral therapy, and stimulus control that are quite effective. Promising interventions include muscle relaxation and sleep hygiene education.

Very cautious use of sedative/hypnotics should be considered only when behavioral treatments are not effective.

Behavior Problems

In addressing problem behaviors, it is important for informal and formal caregivers and for healthcare and mental health providers to understand that problematic behavior is not

inherent in the patient, but rather is a problem in the interaction between the older adult with AD and the caregiver. Caregivers who develop insight into the experience of the elder for whom they're caring, who cultivate tolerance and patience, and who retain a sense of the humanity and dignity of the elder are likely to fare better than those who do not have these qualities.

Although not all experts agree, it may be particularly important for caregivers to be aware that not all mental functions decline as cognitive functions diminish. It may be that some people become more emotionally open and caring and that some develop more interest in creative activities such as music, art, and poetry. Affectionate, often nonverbal interactions may occur, and engagement in the arts may become more satisfying.

In addition, individually tailored behavioral management techniques such as antecedent-behavior-consequence interventions, where caregivers recognize the behavior, identify antecedents, and modify their reaction, the physical environment, and/or the older adult's routine, can be very effective at reducing problem behaviors when practiced with consistency.

Environmental modifications such as changing the visual environment, using mirrors, posting signs, and unlocking doors for a period of time on closed wards can also be effective.

There is also emerging evidence of the effectiveness of aromatherapy and bright light therapy for reducing agitation.

When behaviors are more severe or fail to respond to such nonpharmacological approaches, atypical antipsychotics may be considered. However, due to risks of enervation, clouded thinking and perception, falls, and premature mortality, they should be prescribed with great caution and monitored carefully.

Addressing the Needs of Family Caregivers

Family members are the most common caregivers for older adults with disabilities, including AD. They provide about 80% of all care at great cost to themselves and great savings to society. The financial value of the care they provided was about \$375 billion in 2007—the equivalent of nearly 20% of all healthcare costs in the United States, according to the CDC.

The stress borne by caregivers makes them highly vulnerable to depression, anxiety disorders, and physical illness. Many become overburdened, and some burn out. While not all need support, many can benefit from interventions such as psychoeducation, counseling, support groups, and respite. Mary Mittelman, DPH, a research professor at New York University's School of Medicine, has conducted research indicating that a combination of individual and family therapy, support groups, and ad hoc counseling for spousal caregivers reduces depression, anxiety, and physical illness in caregivers of older adults with AD and can delay nursing home placement by up to 18 months.

Caregivers' mental health also may benefit from behavioral management therapy for the elder with AD, as well as from learned coping strategies.

Care and Treatment Settings

Most older adults with AD receive treatment on an outpatient basis either in treatment settings or their homes. Some, however, live in residential care settings such as assisted living facilities, life care communities, and nursing homes.

For many, paid caregivers who come to the home, such as personal care attendants, home health aides, and case managers, make remaining at home possible. Unfortunately, many of these workers, despite their caring and skill in attending to physical needs, are not skilled in managing behaviors that can be troublesome or in identifying and responding to other mental disorders.

Some elders with AD receive care and have opportunities for activity and social interaction in day programs, including senior centers, social adult day care, and adult medical day care. These programs also function as a kind of respite service for family caregivers who work during the day. Unfortunately, it's not common in such programs to have staff with expertise in mental conditions such as depression, which, as previously noted, can make life far worse for older adults with AD.

Over the past several decades, there has been an increase in numbers of older adults moving to assisted living facilities, many of which have special programs or units for people with advanced dementia. Unfortunately, there is rarely much expertise in co-occurring mental disorders at such facilities.

Finally, of course, a significant number of older adults with AD go to nursing homes. While some of these facilities provide good care for people with co-occurring mental and behavioral disorders, many do not. There are grave concerns about inadequate attention to mental conditions and the overuse of antipsychotic medications, which can induce stupor and hasten death.

Future Directions

Although much has been learned about AD over the past few decades and treatment and other interventions have become more effective, the sad facts include the following:

- We do not know how to reverse, stop, or even substantially slow AD's progressive decline.
- AD takes a terrible toll, not only on the older adults who develop the disease, but also on their families and friends.
- There are also enormous costs to society, not only for care and treatment, but also in lost productivity of both elders with AD and their families.

Unfortunately, health, mental health, and aging services policies in the United States are not adequately responsive to these facts. Fundamental policy changes are needed, including enhanced research to develop and document effective interventions and enhanced translation of research findings into practice. Also critical are enhancing the quality of care in outpatient, home, community, and residential settings, as well as increasing training and education to build a health, mental health, and aging services workforce competent to meet the needs of older adults with co-occurring mental illnesses and their families.

Additional focus needs to be directed toward enhanced family support, expansion of affordable services, expansion of affordable residential alternatives to institutions, and enhanced integration of mental health and long-term care services.

Ultimately, bringing about the kinds of policy changes necessary to meet the needs of older adults with AD will depend on building political will. Unfortunately, we have a long way to go in that direction.

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