DEMENTIA: A SURVIVAL GUIDE
FOR FAMILY CAREGIVERS

Prepared by:

Susan V. Murray, CMSW, LMHP
Section of Geriatrics & Gerontology
Department of Internal Medicine
University of Nebraska Medical Center
DEMENTIA: CAUSES AND TREATMENTS

Dementia is not a specific disease. It is a term which describes a group of symptoms that causes a significant decline in intellectual functioning, impairing normal activities and relationships. While memory loss is a common symptom of dementia, by itself it does not mean that a person has dementia. Doctors diagnose dementia only if two or more brain functions - such as memory, learning or language skills, reasoning or judgment - are significantly impaired. Such impairments eventually lessen one’s ability to perform everyday activities like driving, paying bills, household chores and even personal care skills like bathing, dressing and eating. A person with dementia also may exhibit personality changes, loss of emotional control and behavioral problems such as agitation, paranoia and hallucinations.

Dementia is most common in older adults, but is not a normal part of aging. It is caused by a number of medical conditions. In come cases, dementia can be reversed or stopped from getting worse. In others, it is permanent and usually gets worse over time. As with any other medical condition, it is essential that a proper evaluation be made when the symptoms of dementia first appear, so that appropriate treatments can be offered. Common forms and causes of dementia include:

ALZHEIMER’S DISEASE is the most common cause of dementia in older persons. It is marked by the abnormally rapid death of brain cells. The precise cause of Alzheimer's Disease is unknown, but this is being aggressively studied worldwide by researchers. Alzheimer’s is characterized by a progressive loss of intellectual and functional abilities. On average, persons with Alzheimer’s Disease live for 8-10 years after they are diagnosed, with death often being caused by pneumonia and other infections that arise late in the disease. Current treatments focus on medications to prolong the functioning of still-living brain cells. These slow, but do not halt the progression of Alzheimer’s Disease.

VASCULAR DEMENTIA is caused either by a severe narrowing or blockage of arteries that carry blood to the brain, or from strokes caused by an interruption of blood flow to the brain. The first symptoms of vascular dementia usually start suddenly, and progression is often marked by abrupt “step downs” of cognitive abilities. But vascular dementia may also slowly and progressively worsen over time. Treatment involves preventing additional strokes by treating underlying diseases, such as high blood pressure and high cholesterol, and by use of blood-thinning medications. There is some evidence that use of medications commonly prescribed to treat Alzheimer’s Disease may slow the progression of vascular dementia.

PARKINSON’S DEMENTIA. Persons with late-stage Parkinson’s Disease or “Parkinson’s Plus” Diseases (such as Progressive Supranuclear Palsy) may develop a dementia with symptoms and a progressive course similar to those of Alzheimer’s Disease.

LEWY BODY DEMENTIA is marked by small protein deposits found in deteriorating nerve cells in the brain. These often appear in areas of the brain that are associated with the tremor and rigidity of Parkinson’s Disease. When these lewy bodies are spread through out the brain, they may produce symptoms similar to those of Alzheimer’s Disease as well as hallucinations and major fluctuations in alertness.

FRONTO-TEMPORAL DEMENTIA is marked by a deterioration of nerve cells in the frontal and temporal lobes of the brain. Initial symptoms include behavioral and personality changes, such as poor judgment and impulsiveness. It then progresses to impairments of language and cognitive skills. Fronto-Temporal Dementia is not curable, and usually does not respond to the medications used to treat Alzheimer’s Disease. Mood and behavioral problems can be treated using standard anti-psychotic and anti-depressant medications.
HEAD TRAUMA  Dementia may result from a single, significant head injury, or from a series of head blows, such as those suffered by professional boxers. A single traumatic brain injury may produce an immediate dementia, but symptoms vary depending on which part of the brain was damaged. Dementia from repeated head blows may appear many years after the trauma ends, and is often marked by symptoms of Parkinsonism.

Doctors have identified other conditions that can cause dementia or dementia-like symptoms. In the following conditions, cognitive problems may sometimes be reversed with appropriate treatment.

HYPOXIA occurs when there has been a significant disruption in the flow of oxygen to the brain. This can cause serious impairments of physical, cognitive and psychological skills. The rate and extent of recovery are unpredictable and largely depend on which parts of the brain have been affected, and how severe the injury is.

BRAIN TUMOR  A tumor may press on and damage brain cells, and other structures in the brain. Medical or surgical treatment of the tumor can sometimes reverse the symptoms of dementia however, depending upon the degree of brain injury sustained because of pressure on brain cells and structures, a person may be left with some degree of permanent cognitive disability.

SUBDURAL HEMATOMA is a collection of blood that forms on the surface of the brain. It often results from head injury but can occur spontaneously in older persons, especially those who take blood thinning medications. Symptoms may include numbness and weakness, slurred speech, drowsiness and mental confusion. Cognitive changes occur and progress quickly or slowly depending upon the size and location of the hematoma. This condition requires emergency treatment that may include medications and/or surgery to drill a small hole in the skull to allow the blood to drain and relieve pressure on the brain. Depending upon the degree of brain injury caused by pressure from the hematoma, a person may be left with some degree of permanent cognitive disability.

NORMAL PRESSURE HYDROCEPHALUS is a condition that arises when the flow of spinal fluid in and out of the brain is obstructed, causing it to backup into areas of the brain and creating increased pressure that can damage brain tissue. NPH often results from a prior brain injury or infection, and also produces symptoms of walking difficulties and loss of bladder control. NPH may often be corrected with surgery to install a small tube (a “shunt”) into the brain to drain off the excess fluid. The degree of cognitive improvement after such treatment, however, varies among patients.

ALCOHOL DEPENDENCE can lead to symptoms of dementia. Long term and/or heavy use of alcohol can damage brain cells, causing them to deteriorate and die off more rapidly than they otherwise would. Alcohol abuse also contributes to nutritional and vitamin deficiencies and liver diseases which can cause dementia symptoms. Abstaining from alcohol can often improve all of these problems.

INFECTIONS of the brain and central nervous system, from disorders such as meningitis, encephalitis Lyme Disease or late-stage syphilis, will cause inflammation that damages brain cells if not properly treated.

HORMONE DISORDERS involve body glands that secrete and/or regulate hormones. These include the thyroid, parathyroid, pituitary and adrenal glands. Severe and/or prolonged imbalances in such hormones can lead to dementia if not corrected.

METABOLIC DISORDERS such as kidney, liver and pancreas diseases, can cause symptoms of dementia, and may be progressive and irreversible if left untreated.
WHAT CONDITIONS ARE NOT DEMENTIA?

DEPRESSION can make an older person appear to be demented because it can cause inattention, apathy and impair one’s ability to learn and remember new things. Persons with a significant depression, but without any underlying dementia, should regain cognitive skills if their mood is successfully treated. However, depression can also be a symptom of dementia. In such cases, treating depression is still important but does not fully restore cognition.

DELIRIUM causes confusion and rapidly fluctuating mental states. The person may also be disoriented, drowsy or incoherent, and may have personality changes. Delirium is usually caused by a treatable physical illness, such as a poisoning or an infection, and persons will often, though not always, make a complete recovery after the underlying illness is treated.

MEDICATION EFFECTS Misuse or abuse of some prescription and over-the-counter medications can produce a delirium that mimics symptoms of dementia. Medications which can produce such side effects include sleeping pills, tranquilizers and anti-anxiety drugs, antihistamines and other cold medications. When such medications are stopped or decreased, the delirium and symptoms of dementia usually lessen or stop.

AGE-RELATED COGNITIVE DECLINE is marked by very mild memory impairment and a slowing in the rate in which the brain processes new information. These changes are considered normal and are not considered signs of dementia.

MILD COGNITIVE IMPAIRMENT is a condition in which cognitive and memory problems are more pronounced than the cognitive changes associated with normal aging, but are not severe enough to be diagnosed as dementia. Many persons with Mild Cognitive Impairment eventually go on to develop a dementia.

SOURCES:
“What is Alzheimer’s Disease?” The National Alzheimer’s Association
“Dementia Overview” www.eMedicine.com
“Dementia” The Merck Manual or www.merck.com
MEDICATIONS TO TREAT DEMENTIA

Approximately 75% of all cases of dementia are caused by Alzheimer’s Disease or vascular brain disease, or by a combination of both disorders. New medications are now available that have been effective in improving mental function in persons with Alzheimer’s Disease, vascular dementia, and with mixed Alzheimer’s and vascular dementia. These medications are also being used more frequently to treat a condition known as Mild Cognitive Impairment (MCI). None of these medications stop the progression of cognitive decline, but they appear to slow down the rate at which such decline occurs. This can help ease the burden of family caregivers and delay placement in a long term care facility.

WHAT MEDICATIONS ARE CURRENTLY BEING PRESCRIBED?

There are two classes of medications currently being prescribed to treat Alzheimer’s Dementia: “Cholinesterase Inhibitors” such as Aricept (Donepezil), Exelon (Rivastigmine), and Razidyne (Galantamine); and an “NMDA Receptor Antagonist”, Namenda (Memantine).

HOW DO THESE MEDICATIONS WORK?

**Cholinesterase Inhibitors**: Acetylcholine is a substance manufactured by nerve cells in the brain. It helps transmit “messages” between cells, allowing a person to think and perform tasks. Alzheimer’s Disease and vascular brain disease both destroy some of the brain cells that make acetylcholine. Cholinesterase inhibitors temporarily boost the levels of acetylcholine in the brain, thereby preserving memory and cognitive function.

**NMDA Receptor Antagonists** regulate the activity of glutamate, another “messenger” chemical in the brain. Glutamate triggers NMDA receptors in the brain to allow a controlled amount of calcium to flow into nerve cells to help the brain process, store and retrieve information. Excess amounts of glutamate cause NMDA receptors to allow too much calcium into nerve cells, leading to disruption and death of cells. Namenda may protect cells against excess glutamate by partially blocking the NMDA receptors.

WHAT CAN I EXPECT THESE MEDICATIONS TO DO FOR MY LOVED ONE?

**Cholinesterase Inhibitors**: From 30%-50% of those taking cholinesterase inhibitors experience a mild but noticeable improvement in attention, concentration and in the ability to perform daily activities. The average improvement was comparable to “rolling back” the disease symptoms anywhere from 6-12 months. Cholinesterase Inhibitors appear to be most effective in the early to middle stages of dementia.

**NMDA Receptor Antagonists**: In US clinical studies, Memantine has proven modestly effective in improving functional performance in persons with moderate to late-stage dementia. It may be most effective when used along with a cholinesterase inhibitor.

WHAT SHOULD BE CONSIDERED WHEN USING THESE MEDICATIONS?

Dementia medications differ in two main areas: the number of daily doses required and the types of potential side effects. Aricept is taken once daily. Exelon, Razidyne and Namenda are taken twice daily.
The most common side effects of Aricept, Exelon and Razidyne are nausea, vomiting, loss of appetite and diarrhea. The most common side effects of Namenda are dizziness, headache and constipation. When they occur, these symptoms tend to be mild and transient in nature. Side effects may be prevented by starting out with the smallest possible dose of medication, then gradually increasing it to the highest dose. When side effects do appear, they may be able to be overcome by reducing the dose for a week or so, and then increasing it again. These medications may not be appropriate for persons with certain medical conditions. Your physician can determine whether a person has any medical conditions or potential risk factors that would preclude them using these medications.

As a rule of thumb, if a person is taking one of these medications - and is doing well - they should not switch to another. If they are not doing well on a particular medication (ie. having side effects, or showing no benefit after 6 months of use), it would be reasonable to stop that drug and to then start another, either in the same or a different class. If a person cannot take, or does not benefit from, any of these currently prescribed medications, it would be reasonable to consider enrolling them in a clinical research trial for medications that are still being tested.

WHAT DO THESE MEDICATIONS COST?

The current cost for a one-month’s supply of Aricept, Exelon, Razidyne or Namenda is approximately $130. These medications are covered by many of the Medicare-approved prescription drug plans. The pharmaceutical companies that produce these medications may also offer them free or at a discount to persons of limited means, and without insurance coverage for medications. Speak to your physician or pharmacist about these Patient Assistance Programs, or go online to the following sites:

Benefits Checkup Rx: www.benefitscheckup.org or Helping Patients.org www.helpingpatients.org

HOW DO I OBTAIN A PRESCRIPTION FOR THESE MEDICATIONS?

Any medical doctor may prescribe them. However, it is essential that an accurate diagnosis for the cause of cognitive problems be made first. To do this, the physician must perform a thorough physical examination, blood tests and a brain scan. The physician should also administer basic cognitive tests, and should review all the medication the person currently takes to look for possible side effects. Finally, the physician should gather from the family a detailed history of the type of onset and progression of the cognitive and functional decline, and the type of symptoms being exhibited. Such a thorough evaluation will help the physician identify and treat other medical conditions that may be mistaken for Alzheimer’s or vascular brain disease.

WHAT ABOUT MEDICATIONS THAT ARE CURRENTLY BEING TESTED?

Clinical research studies are part of a careful, scientific process to see whether new treatment approaches are safe and effective. After first being tested in the laboratory, and then with animals, treatments that appear promising are then tested on humans in carefully designed clinical trials. Interested persons are first screened to see if they are candidates to participate in a clinical trial. Those selected for a trial will be divided into two groups: one group will receive the trial medication and another will receive a “placebo”, a pill with no active medication in it. Patients agree to a series of follow-up appointments and phone calls to track their progress – or any side effects - over time. The medications, physical and cognitive examinations and lab tests are provided free of charge. For information about clinical trials in the Omaha area, contact the UNMC Psychopharmacology Consortium at (402)552-6005.
TIPS FOR CARING FOR A MEMORY-IMPAIRED PERSON

Memory aids (clocks, calendars and written notes) help a person stay oriented.

Much of what you say to the person may soon be forgotten. Be prepared to repeat yourself sometimes often.

Speak in a calm voice. Make brief, simple statements. Try using touch and direct eye contact when responding to emphasize what you say.

Avoid presenting the person with more than one thought at a time, and limit choices (“Either/or”, rather than “multiple choice”).

Distract the person from an irritating or repetitive topic by using a word from the conversation to change the subject. Try such pleasurable distractions as taking a walk or drive, looking at family photos, playing music or giving the person a simple, repetitive task to perform, such as folding towels.

If distractions fail, try to ignore repeated questions. This may initially anger or agitate the person, but the questions may stop if they are not reinforced by your behavior. Ignoring is an especially good tactic when you are irritated. It may prevent the person from picking up on your irritation.

Most memory-impaired persons function best when following a familiar routine in familiar surroundings. Avoid abrupt or frequent changes of routine, activities and location. Avoid discussing plans for non-routine activities/appointments with the person until just prior to the event to avoid agitation and repeated questions days in advance.

Positive reinforcement and praise helps a person maintain social and self-care skills. When correcting or directing them, avoid negative commands ("Don't do that"). Use the positive focus ("Let's do this").

If the person's cognitive skills continue to worsen, closely monitor their ability to perform tasks and be prepared to lower your expectations for their performance. Allow the person to do as much for themselves as they possibly can, even if they are slower and less efficient. Take over a task completely only when they cannot perform it even with step-by-step instructions or help. Complex or risky tasks (such as driving, using appliances or managing financial affairs) may have to be assumed by others sooner.

To include the person in social conversations, refer to positive memories of the past. Encourage reminiscence, as the person is able to remember past events better than present.

Suggest a word or name the person is searching for in conversation, but avoid correcting mistakes already made. Contradicting or arguing with the person may only cause upset and humiliation.

Prevention is the most effective approach to reduce behavior problems. Anticipate and avoid activities and discussions that will provoke anger or agitation.

Look for a reason behind a troublesome behavior. Is the person frightened, in pain, hungry or needing to toilet? Respond to the need or emotion you feel the person is trying to express.

If the person becomes extremely agitated or verbally/physically threatening, remove them from the stressful situation or place. Avoid quick gestures and try to calm the person with a soothing and reassuring voice and gentle touch. Do not try to reason with the person, as their ability to understand
logic and reason is impaired. If you feel threatened, remove sharp or dangerous objects from the area and stay out of reach. Leave and seek help if needed.

Make note of when a catastrophic reaction occurs. Is there a pattern - ie. time of day, type of activity, specific person that can be identified? **Simplify the environment** by reducing extra people, clutter, noise and activity. Soft music, or holding a doll or a stuffed animal may ease agitation and calm fears in a severely impaired person.

While use of medication to control behavior should be a last resort, **medications may be necessary** to control depression, hallucinations, paranoia, sleeplessness and extreme agitation. Discuss this with your doctor.

Honestly **acknowledge to the person that they have a memory problem**, but confronting them with their loss of ability may lessen their sense of dignity and self esteem. Try to remind the person how much they can still do for themselves. Reassure them that they are still loved and valued. Try to discuss openly the person's memory and behavior problems with family, friends, neighbors and others who will have regular contact with him/her. People tend to respond more appropriately and offer assistance when they understand the situation.

Emotional support and **respite from care giving duties** are essential to helping you cope. Arrange for someone else to assume your care giving duties for several hours at a time on a regular basis so you can get out and "recharge your batteries". You cannot provide good care for your loved one if you neglect your own needs.

Consider joining a self-help or **support group**. These offer an excellent setting in which to express your feelings and learn creative approaches to solve the challenges you face in providing care. Your local Area Agency on Aging or regional chapter of the Alzheimer's Disease Association can direct you to such groups.

**Be patient with yourself**. Recognize that you will make mistakes and will become angry and impatient at times. Know your own limits and try not to feel guilty when you have to say "no" to others. Remember, you are only human!
BIBLIOGRAPHY: ALZHEIMER’S DISEASE AND DEMENTIA

CAREGIVING GUIDES


ALZHEIMER’S: CARING FOR YOUR LOVED ONE, CARING FOR YOURSELF. Sharon Fish. Waterbrook Press. (1996)


CARING FOR AN ALZHEIMER’S PATIENT AT HOME. Kay Lovette. Practice Management Information Corp. (1999).

THE COMPLETE GUIDE TO ALZHEIMER’S-PROOFING YOUR HOME. (Revised Ed.) Mark L. Warner. Purdue University Press. (2000)


KEEPING BUSY: A HANDBOOK OF ACTIVITIES FOR PERSONS WITH DEMENTIA. 


LOSS OF SELF: A FAMILY RESOURCE FOR CARE OF ALZHEIMER’S DISEASE AND RELATED DISORDERS. (Revised Ed.) Donna Cohen & Carol Eis dorfer. W.W. Norton & Co. (2001)


UNDERSTANDING DIFFICULT BEHAVIORS: SOME PRACTICAL SUGGESTIONS FOR COPING WITH ALZHEIMER’S DISEASE AND RELATED ILLNESSES. Anne Robinson, Beth Spencer and Laurie White. Geriatric Education Center of Michigan, Eastern Michigan University, Ypsilanti, MI. (1989).


THE DIGNITY WITHIN: A HANDBOOK FOR CAREGIVERS, FAMILY MEMBERS AND FRIENDS OF THOSE WITH ALZHEIMER’S DISEASE OR RELATED DEMENTIA. Roger Brumbach, Pat Callone, Connie Kudlacek and Barb Vaseloff. Caring Concepts, P.O. Box 540885, Omaha, NE 68154-0885. (2004)
BOOKS BY FAMILY CAREGIVERS & PATIENTS


COPING WITH ALZHEIMER’S DISEASE: A CAREGIVER’S EMOTIONAL SURVIVAL GUIDE. Rose Oliver & Frances Bock. (1989).


LIFE WITH CHARLIE: COPING WITH AN ALZHEIMER’S SPOUSE OR OTHER DEMENTIA PATIENT, AND KEEPING YOUR SANITY. Carol Hickman-Owen. Pathfinder Publishing Co. (1992)


WHERE DID MARY GO?: A LOVING HUSBAND’S STRUGGLE WITH ALZHEIMER’S. Frank A Wall. Prometheus Books. (1996)


RELIGIOUS/INSPIRATIONAL


HOW TO FIND BOOKS:
To locate copies of these books, try public libraries and book stores (books not in stock may be special-ordered). The following internet book sellers will mail books to you, or direct you to out-of-print book finding services: www.amazon.com and www.bn.com. These web sites offer detailed descriptions of the focus and content of most books.

INTERNET WEBSITES FOR CAREGIVERS

National Alzheimer’s Disease and Related Disorders Association www.alz.org
Alzheimer’s Disease Education and Referral Center (ADEAR) www.alzheimers.org
Alzwell Caregiver Support www.alzwell.com
Alzheimer’s Research Foundation www.Alzinfo.org
Hydrocephalus Association www.hydroassoc.org
Lewy Body Dementia www.lewybodydementia.org
Children of Aging Parents www.caps4caregivers.org
Family Caregiver Alliance www.caregiver.org
National Alliance for Caregiving www.caregiving.org
National Family Caregiver Association www.nfcacares.org
The Well Spouse Foundation www.wellspouse.org
ALZHEIMER’S DISEASE & RELATED DISORDERS ASSOCIATIONS

National Alzheimer's Association
225 N. Michigan Ave. Floor #17
Chicago, IL 60601
(800) 272-3900  (24 Hour “Help Line”)  www.alz.org

Local Chapters/Satellite Offices:  All reachable toll free at (800) 272-3900

Midlands Chapter
The Center Mall #205 Southwestern Iowa Office
1941 S. 42nd St. 300 W. Broadway #233
Omaha, NE  68105 Council Bluffs, IA  51503
(402) 502-4300  (712) 322-8840
http://www.alz.org/midlands

Great Plains Chapter Kearney Office Scottsbluff Office
5601 S. 27 St. #201   (308) 440-7773  (308) 635-5230
Lincoln, NE 68512
(402) 420-2540
http://www.alz.org/greatplains

Big Sioux Chapter East Central Iowa Chapter
420 Chambers St. 1570  42 St. N.E.
Sioux City, IA 51101 Cedar Rapids, IA 52402
(712) 279-5802  (319) 294-9699

Satellite Offices:  Denison, Sheldon, Spencer

Greater Iowa Chapter
1730 28th St.
West Des Moines, IA 50266
(515) 440-2722
http://www.alz.org/greateriowa/

Satellite Offices: Burlington, Davenport, Dubuque, Fort Dodge

Eastern South Dakota Office Northwestern Missouri Regional Office
1000 N. West Avenue #250 10th & Faraon Sts.
Sioux Falls, SD 57104 St. Joseph, MO  64502
(605) 339-4543  (816) 364-4467