Alzheimer's Disease Management

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The psychiatrist can play several important roles in the care of persons with Alzheimer's disease and other dementing illnesses. Diagnostic issues for which psychiatrists have specific skills include identifying early cases, performing a differential diagnosis, and distinguishing reversible depression from depression associated with irreversible dementia and irreversible dementia without depression. Treatment should include management of behavioral, noncognitive, and cognitive symptoms. Environmental and pharmacologic therapies have proven efficacious in treating noncognitive behavioral symptoms. Neuroleptic antipsychotic drugs are effective in treating aggressive behaviors and delusions. The treatment of cognitive symptoms currently rests on cholinergic enhancement. Finally, the psychiatrist can play important roles in educating the public and supporting the distressed caregiver.

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This article focuses on how the practitioner can use the current knowledge base about dementia to help patients and caregivers function more efficiently. Three themes will run throughout. First, a significant body of knowledge is available that addresses the diagnosis, treatment, and basic biology of Alzheimer's disease. Second, clinical decisions should derive from this database, i.e., a knowledge of phenomenology, associated morbidity, and effective treatments forms the basis of care. Third, to have an effective clinical practice, a physician's clinical expertise must be recognized.

While the idea that dementia is an aspect of normal aging is much less prevalent than it used to be, the incorrect idea that Alzheimer's disease cannot be treated persists. The clinician's effectiveness in addressing the needs of patients with dementia can be enhanced by working at sites where patients with Alzheimer's disease receive care and by establishing his or her expertise with practicing clinicians and consumer groups.

SPECIFIC SKILLS

The psychiatrist has several specific skills relevant to care of persons with dementia. The first is establishing a diagnosis that utilizes the physician's knowledge and provides the data on which interventions are based; the second is treating noncognitive and cognitive symptoms; the third is helping caregivers manage better.

Making a Diagnosis

It is a mistake to underestimate the importance of making a specific diagnosis. While labels can have undesirable consequences, they also provide a number of benefits. Having a diagnosis helps people approach problems as issues to be solved rather than as behaviors or feelings that are unexplainable. A specific diagnosis helps the person plan for future needs (legal, financial, emotional, physical). Diagnoses also guide the choice of living environment and decision to use ongoing therapy such as day care.

The most common diagnostic error is overdiagnosing vascular dementia, often due to an overreliance on magnetic resonance imaging scans. Ironically, clinicians frequently underestimate the validity of the clinical diagnosis of Alzheimer's disease. Most case series suggest that the clinical diagnosis and neuropathologic diagnosis agree 85% to 90% of the time, a very high rate of concordance.[1,2] Few clinicians and most lay people are unaware that there is considerable disagreement among neuropathologists in making a diagnosis if autopsy material is the only data source. Thus, the clinical diagnosis of Alzheimer's disease has high validity.

Treating Noncognitive Behavioral Symptoms

The management of noncognitive behavioral symptoms requires a unique set of clinical skills. As reviewed by Cummings and Masterman in this supplement,[3] noncognitive behavioral symptoms are common. They are also a source of distress for caregivers. In one study of outpatients, families reported that physical aggression was the most distressing symptom when it occurred.[4] Neuro-

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leptics have demonstrated efficacy for this symptom,[5] but a variety of nonpharmacologic interventions are also available.

The first step in assessing problem behaviors is to consider each symptom separately and perform a differential diagnosis. For example, aggressive behavior may be due to misinterpretations secondary to the language disorder of Alzheimer's disease, disinhibition due to frontal injury, or fear resulting from paranoid delusions. It is important to determine, therefore, whether there is an underlying psychiatric syndrome such as major depression or delirium. If no specific syndromic diagnosis can be made, then the focus should be on the management of the particular symptoms such as hallucinations and delusions. It is important to distinguish between apathy versus depression and illusions versus hallucinations. These distinctions have clinical relevance because even if symptoms such as hallucinations or delusions are identified, the range of treatment for them is broad. Sometimes no specific therapy is needed, but if the symptom places someone in danger or causes a significant level of distress, then intervention is appropriate.

Psychiatrists have unique expertise in the design and implementation of nonpharmacologic environmental interventions in persons with cognitive impairments. One of the formidable challenges in caring for individuals with dementia is conforming the environment to the patients' needs because psychological flexibility is almost universally lost in individuals with Alzheimer's disease. Many individuals with Alzheimer's disease can no longer modify their behavior or adapt to changing environments. This presents a particular challenge to family members since their experience (almost universal) is that individuals need to adapt to the environment, not vice versa. Helping the family understand and emotionally accept this often allows the clinician to help the family modify the environment.

The issue of driving is another difficult challenge for people with Alzheimer's disease and their families. In the recent American Psychiatric Association (APA) *Practice Guideline for the Treatment of Persons With Alzheimer's Disease and Other Dementias of Late Life*,[6] driving was the most controversial of all treatment areas reviewed. While there was consensus that individuals with moderate and severe Alzheimer's disease should not drive, there was no consensus among expert clinicians regarding whether individuals with mild dementia have the capacity to drive. To date, no test or method has been developed that has high sensitivity and specificity for predicting who is likely to have an accident. What is clear is that even individuals with Mini-Mental State Examination (MMSE) scores in the normal range can have impaired driving.[7] Fitten and coworkers [7] demonstrated that persons with mild Alzheimer's disease (mean MMSE scores of 25.2) performed more poorly on actual driving performance and did worse than individuals who were diagnosed clinically as having vascular dementia (mean MMSE scores of 25.5) or those diagnosed with diabetes mellitus who had normal cognition (mean MMSE scores of 25.6). Thus, individuals with Alzheimer's disease are at increased risk of having driving accidents. It is unclear whether any person with Alzheimer's disease should drive, or whether the increased risk (which appears to be in the range of that for male teenagers) requires a global proscription against driving. Clinicians should be aware of the legal obligations in their state as some states require notification of diagnosis, while others do not allow such notification because of confidentiality restrictions.

Treating Cognitive Symptoms

The most exciting advance in Alzheimer's disease treatment in the past several years is the development of effective cognitive enhancers. While there is no cure for Alzheimer's disease, the cognitive deficits that define dementia do respond to these symptomatic therapies. As new agents and new strategies for cognitive enhancement are developed, it will be exciting to see whether these benefits are additive.

Educating the Caregiver and the Public

Another important role of the clinician is educational, both for the caregiver and the public. The clinician can provide education to the community by giving talks. These talks can serve as a forum for increasing knowledge about Alzheimer's disease and for establishing the clinician as an expert. The information gained in the history-taking process can guide discussions about prognosis since most patients with Alzheimer's disease decline at a steady rate.[8]

The physician does not need to know all the resources in the community, but it is helpful to link with some of the important ones such as the Alzheimer's Association. The local chapters often keep lists of physicians caring for persons with Alzheimer's disease and can also be a source of referral.

Supporting the Caregiver

Another important target of intervention is the emotional state of the family caregiver. Many studies demonstrate that emotional distress is 3 times higher in caregivers of persons with dementia than in noncaregivers, matched on other variables.[9] Nevertheless, the majority of caregivers are not emotionally distressed. Furthermore, over a 2-year period, levels of anger, depression, and guilt decline in caregivers in spite of the progression of the family member's dementia.[10]

There have been 11 randomized, controlled trials of interventions with family caregivers, 9 of which demonstrate that active treatment is better than placebo in improving caregiver emotional state.[11] Interventions that combine emotional support and education are more effec-

tive than either intervention alone. Recent work from New York University also suggests that time-limited support groups provide information and emotional support and can delay nursing home placement.[12]

SUMMARY

The treatment armamentarium for Alzheimer's disease is broad. It begins with the assessment and diagnosis. It should focus on both cognitive and noncognitive symptoms and utilize the range of pharmacologic and nonpharmacologic treatments. The psychiatric practitioner has a unique set of skills that addresses many of the needs of persons with dementia and their caregivers. Organizing a practice around these skills can benefit the large number of patients and their caregivers.

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