

Self-harm And Dementia: A Case Report

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Abstract

The association between dementia and self-harm behavior remains

controversial. Some authors report that the diagnosis of dementia is rarely found in those who commit suicide, yet others have reported Alzheimer pathology to be overrepresented in this same group.

We report the case of a man with a dementia superimposed on a longstanding mood disorder who recently started to express self-harm ideation. This case highlights several aspects of management including the importance of differentiating self-harm ideation and behavior as a symptom of psychosis in dementia vs a symptom of affective illness.

INTRODUCTION

The literature on self-harm behaviour and dementia highlights the need for further research in this area. Results of studies have often been conflicting with a lack of systematic investigation. Studies have reported suicide attempts in less than 1% of all patients with dementia and that a diagnosis of dementia is rarely found in suicide victims (1). A study in Australia found 0.9% of outpatients in a memory clinic with a diagnosis of dementia had suicidal ideation or gestures and none had made a suicide attempt (2). In contrast, a study of suicide and Alzheimer pathology in the elderly found severe Alzheimer pathology on autopsy was over-represented in the patients who completed suicide (3).

The case of an elderly man with a dementia superimposed on a longstanding mood disorder who started to express self-harm ideation highlights some of the complex diagnostic and management issues.

CASE REPORT

A 72-year-old single man residing in a nursing home presented with a 3-4 year history of decline in memory, self-care ability and disorientation for time and place. Mini-Mental State Examination scores had declined during that time from 26-27/30 to 18-19/30 and over the past year to 8-9/30. CT scan of the brain revealed generalized atrophy.

The patient had a 40-year history of a bipolar I disorder. A diagnosis was made of a superimposed dementia likely of the Alzheimer type.

The patient continued to receive lithium carbonate 450 mg daily and olanzapine 15 mg qhs with therapeutic serum lithium levels.

Staff at the nursing home were concerned that the patient had on several occasions reported receiving a 'phone call' from a man who told him to "jump off a bridge". These auditory command hallucinations occurred in the absence of other psychotic, affective or vegetative symptoms. The patient denied depression, hopelessness or any self-harm plan or intent to act on these commands. Hamilton Depression Rating Scale score was 8.

The patient had no insight into his memory deficits or the diagnosis of dementia. Past psychiatric history included no self-harm behavior or prominent self-harm ideation during major depressive or manic episodes.

There was no family involvement and the nursing home staff was the primary caregivers and referred the patient for urgent psychiatric consultation.

Differential diagnoses included a major depressive disorder with psychotic features in the context of bipolar illness, schizoaffective disorder of the bipolar type or a dementia with depression. Since there was no evidence of a major depressive episode, a diagnosis was made of psychotic symptoms associated with the dementia.

Olanzapine was increased to 17.5 mg daily and a supportive approach with reassurance and nursing home staff monitoring for depressive symptoms resulted in the resolution of these distressing symptoms within a week.

The nursing home staff were educated about self-harm and psychosis and depression in dementia and suggestions were made to enhance patient safety including moving his room closer to the nursing station for closer observation and removal of any potential safety hazards (eg. sharp objects, belts etc).

DISCUSSION

This case is an example of the complexity of patients with dementia who present with self-harm ideation or behavior.

Depression is a common risk factor of suicide and dementia (1). It is often described in patients with Alzheimer's disease and vascular dementia. Major depression has been found to be more common and more severe in those with a vascular dementia (4,5).

Suicidal ideation and /or the 'wish to die' has been found on self-report in 4% of dementia clinic patients with an association with co-morbid depressive symptoms particularly in Alzheimer's disease (2). Thoughts of hopelessness were found in 10% of a probable Alzheimer disease cohort (6). Yet, studies of hopelessness and suicidal ideation in the elderly have found that in contrast to younger adults, suicidal ideation in the elderly is not better predicted by hopelessness than depressive symptoms and both must be considered in assessment (7). In our case, there was denial of hopelessness and this was not a useful measure of self-harm symptoms.

Although the patient did not meet the criteria for a current major depressive episode, his past history of a mood disorder required careful assessment to exclude this diagnosis.

In our patient, the self-harm thoughts emerged in the context of auditory command hallucinations. These psychotic symptoms were not consistent with an affective illness. A study of nursing home residents with behavioral and psychological symptoms of dementia in nursing home residents found 60% had psychosis (8). Distinguishing self-harm ideation as a symptom of psychosis related to dementia vs as a symptom of underlying depressive illness is important in the study of self-harm and its links to depression and dementia. This was highlighted in the management with the use of an atypical antipsychotic.

Treatment to address self-harm in dementia patients includes pharmacotherapy and supportive approaches.

Pharmacotherapeutic options include antidepressant medication particularly the selective serotonin reuptake

inhibitors for depressive symptoms, antipsychotics for psychosis and the role of cognitive enhancers in the management of behavioral and psychological symptoms of dementia particularly of the Alzheimer type (9,10).

These medications were considered in the case presented. Since the psychotic symptoms were felt to be linked to the self-harm ideation, the antipsychotic was increased. The rapid response to a slight increase in atypical antipsychotic was an effective approach with no adverse effects and consistent with our clinical impression.

Olanzapine has been reported to be effective for psychotic symptoms in dementia (11). A recent study suggests citalopram, an SSRI is beneficial for the acute treatment of psychosis in dementia patients (12). This finding supports the concept that there may be several different pharmacotherapeutic options for self-harm ideation in dementia.

A key factor in the management of this behavior is support and education for family and caregivers. The goal is to address anxiety related to the risk of self-harm behavior. A review of the indications for psychiatric hospitalization may alleviate some of the family/caregiver stress and be vital for the patient's safety. A discussion of techniques to increase supervision and the safety of the environment is essential. Our patient benefited from these approaches which permitted him to remain in the more familiar environment of the nursing home rather than be hospitalized as initially requested by the nursing home staff.

Further study of the most effective techniques to permit caregivers to deal with self-harm ideation and behavior in dementia patients is important. Many of the interventions to support caregivers of people with dementia have been found to be inconclusive as to effectiveness (13). Nonetheless, the needs of the caregiver must be addressed in order to permit optimal management of the dementia patient with self-harm ideation and behavior. This was seen in our case where caregiver support permitted an optimal outcome.

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