Differentiating dementia, delirium and depression

Dementia, delirium and depression are all serious conditions that are particularly common in older people. Their similar symptoms mean the conditions can go undetected and untreated. However, although they may present in similar ways, there are differences in the treatment and support approaches used for each. It is vital that health and care professionals can identify key risks, signs and symptoms associated with all three conditions so that appropriate support, treatment and management can be given.

**Dementia**

There are approximately 850,000 people in the UK with dementia and this figure is predicted to rise to more than a million by 2025 (Alzheimer’s Society, 2015). The risk of developing dementia rises with age, and approximately one in three people over the age of 90 will have dementia.

Dementia is a term for a group of conditions that cause a decline in brain function and difficulties with skills such as:

- Memory and attention;
- Orientation to time, place or person;
- Language, reasoning and judgement;
- Regulating emotions;
- Processing information.

**Diagnosis**

Since many illnesses can affect cognitive function, initial screening aims to exclude other causes through routine haematology, biochemistry tests, thyroid function tests, and serum vitamin B12 and folate levels. A full assessment, physical examination and medications review should also be undertaken. Diagnosis often involves referral to specialist services such as a memory clinic, psychiatric services or older people’s mental health services after the GP has undertaken a screening test. Community psychiatric nurses, psychologists and occupational therapists may also be involved in the diagnostic process.

**Caring for people with dementia**

While drug treatments may slow the rate of decline in certain types of dementia, non-pharmacological treatment, including therapeutic relationships, is the key intervention. This should focus on promoting and maintaining independence.

A focus on the lived experience of dementia and understanding why a person with dementia may be experiencing stress or displaying distress is important in delivering person-centred care. This care should be responsive to changing circumstances and reviews should be carried out accordingly. People with dementia who have capacity should have choice and control in decisions that affect them.

**Delirium**

Delirium is a syndrome involving the “sudden deterioration of mental functioning, which is triggered by acute illness of the body or brain, acute injury or drug intoxication” (Manning et al, 2013). It is common, serious and a medical emergency (NICE, 2010). The condition causes significant distress and is associated with poor outcomes including increased risk of dementia, death, long-term care admission and length of hospital stay.

Although one in eight of all hospitalised patients (MacLullich et al, 2013) and 20-30% of those on medical wards have delirium (NICE, 2010), it is often not detected or diagnosed (MacLullich et al, 2013).

People admitted to hospital or a care home who are at risk of delirium should be assessed and given support and treatment to reduce their risk. The care and treatment of patients with delirium needs a multidisciplinary and person-centred approach. Key is identifying those most at risk. Risk factors are: age over 65 years; cognitive impairment or dementia; hip fracture; and severe illness (Holt et al, 2013).

**Preventing delirium**

Measures to prevent delirium include:

- Involving family members in care;
- Providing frequent orientation;
- Ensuring adequate hydration and nutrition;
- Detecting and treating pain, constipation and infection;
- Avoiding urinary catheterisation;
- Reviewing medication and avoiding delirogenic drugs;
- Providing activity that stimulates cognition;
- Reducing noise and avoiding interventions during sleep periods (MacLullich et al, 2013).

**What causes delirium?**

Delirium has a number of possible causes and in many cases two or more factors...
There is a higher risk of risk factor for depression in this group. Sleep disturbance is also common, and is a symptom of anxiety or agitation (Rodda et al, 2011). More physical symptoms and increased ones typical for younger adults. For example, older people may experience hallucinations, illusions, delusions), and emotional disturbance (Manning et al, 2013).

**Detecting delirium**

Delirium can sometimes be the only symptom of a serious underlying disease (Manning et al, 2013). Its serious nature means it is vital that professionals working with older people or those with long-term conditions know the main features of delirium to ensure further assessment and treatment can be organised promptly. This is particularly the case for people with dementia, who are at increased risk of delirium (MacLullich et al, 2013).

Signs and symptoms of delirium include impaired attention, memory disturbance, disorientation and disorganised thinking, altered perceptions, and emotional disturbance (Manning et al, 2013).

**Treatment**

Delirium requires a holistic, person-centred approach – prevention and treatment may overlap and may not be distinct (MacLullich et al, 2013). Needs such as pain, hunger, thirst, and sensory aids should be identified and addressed, while staff should adopt a reassuring approach, incorporating effective communication and reorientation. Environmental interventions for addressing the cognitive impairments and disorientation associated with delirium are similar to those for dementia.

**Depression**

Depression is common in older people and is under-detected and under-diagnosed (Rodda et al, 2011). In older people its symptoms can be slightly different to those typical for younger adults. For example, older people may experience physical symptoms and increased anxiety or agitation (Rodda et al, 2011). Sleep disturbance is also common, and is a risk factor for depression in this group (Fiske et al, 2009). There is a higher risk of suicide among older people with depression (Rodda et al, 2011).

Depression is a broad diagnosis in which low mood and/or loss of interest or pleasure in most activities are key features. Other symptoms include: irritability; anxiety; social withdrawal; pain; fatigue; reduced or altered sleep and appetite; feelings of guilt and worthlessness; reduced self-esteem and confidence.

**Depression assessment**

Various assessment tools are available, and staff should select one that is appropriate and validated. Assessment should be person-centred, and should not focus solely on symptoms but also on the degree of difficulty with daily living the person is experiencing, and the impact of the suspected depression. A variety of physical investigations should be completed to eliminate other causes.

**Treating depression**

Pharmacological and non-pharmacological treatments (alone or in combination) can be effective in treating depression. Non-pharmacological treatments include cognitive behavioural therapy, interpersonal therapy, behavioural activation, and counselling. Mindfulness based on cognitive therapy may prevent relapse, while sleep hygiene advice can be important for people experiencing changes in their sleep pattern (Downing et al, 2013).

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**References**


National Institute for Health and Care Excellence

