Dealing with Dementia: Part 2

In "Dealing with Dementia: Part 1 (June 2010 *Tenn. Bar Journal*)," we focused on Juanita Goggins, a dementia patient who died of exposure. Attorneys often counsel families who are dealing with a loved one who has dementia but like Ms. Goggins is resistant to care or intervention. For family attorneys, it is crucial to know something about dementia so that we may recognize it when interviewing a client or family and have strategies in our legal tool box to help the family, and above all, the dementia patient.

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Dementia is a general term for a group of brain disorders, of which Alzheimer's is the most common type. Dementia involves mental decline severe enough to interfere with usual activities of daily life. Health practitioners tell us that dementia affects more than one of the four core mental abilities:

Memory: the ability to learn and recall new information.

Language: the ability to write or speak and to understand written or spoken words.

Visual spatial functioning: the ability to understand and use symbols and maps, and the brain's ability to translate visual signals into a correct impression of where objects are in space.

Executive function: the ability to plan, reason, solve problems and focus on a task.

Dementia can be a primary illness or secondary to another condition. Primary dementias include Alzheimer's disease, vascular dementia, Lewy Body, Creutzfeldt Jakob's (Mad Cow) disease, Frontotemporal, Parkinson's and Huntington's chorea. The most common cause of dementia is Alzheimer's disease. The second most common type of dementia is vascular dementia.

Secondary dementia is caused by conditions including head trauma, metabolic problems (hypothyroid, B12 deficiency), toxins (e.g. alcohol, drugs and heavy metals), HIV, cancers, major depression and multiple sclerosis. In some cases, dementia symptoms may be treated. Dementing symptoms related to medication, depression and metabolic, endocrine and systemic disorders may be reversed. In fact, while pseudodementia associated with major depression can have a profound and disabling impact on functioning in the older adult, more than 85 percent of those treated with a combination of medications and counseling will recover.

Lawyers may counsel families on conservatorship for the patient suffering from frontotemporal dementia. Unlike the Alzheimer's patient who is having "memory trouble," the patient with frontotemporal dementia, "FTD," is characterized by marked changes in personal and social conduct. The individual may lack initiative and seem apathetic, or conversely, may become dangerously disinhibited or compulsive. Responsibilities in personal and work arenas may be neglected. This illness often manifests in terrible decisions about money and relationships. The patient is exceptionally vulnerable to all sorts of scams and financial exploitation. Consequences can be devastating for these individuals and their families.

Many FTD patients perform well on

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such screenings as the Folstein Mini Mental Status Exam (MMSE) and therefore may fly "under the 'dementia' radar," or be misdiagnosed with a mental illness such as bipolar disorder or depression, making intervention especially challenging. They may also present pretty well before the judge in a conservatorship hearing.

The conviction with which the FTD patient denies impairment is compelling! Anosognosia, the absence of insight into one's own disability and associated limitations is common in FTD as well as in Alzheimer's disease. This is not just righteous, conscious, stubborn denial. The result of damage to the brain caused by the disease creates a sort of "blindness" to one's own symptoms.

Therefore, collateral history, provided by those knowledgeable about these patients at baseline, and as the illness progresses, is critical. While conservatorship is often necessary to intervene for the safety and well-being of the patient, this proceeding does not "solve" the behavioral challenges faced by petitioning loved ones or beleaguered Adult Protection workers!

Another dramatic condition among elderly is delirium. Most often caused by infection or medications, the elder with delirium may experience vivid hallucinations, agitation and marked confusion. The distinguishing characteristic of delirium is its rapid onset. While Alzheimer's has a slow, insidious onset over months and years, the onset for delirium is relatively brief: hours and days. Treatment of the underlying condition results in resolution of these symptoms and a just as dramatic return to baseline.

What about treatment of Alzheimer's and other dementias? The sad fact is that there is no cure for these neurological disorders involving progressive damage to the brain. We have medications that may slow the progression of Alzheimer's disease: Aricept, Exelon and Namenda. There are also psychotropic medications that help to manage agitation, depression, insomnia and other related symptoms.

The general practitioner faces unique challenges when representing older adults who may be suffering from dementia or mental illness. Holding hands with family and with health care practitioners having expertise in diagnosis and treatment of older adults is crucial to achieve a positive outcome for all involved.

In the third part of this series, our focus will be on mental illness in the elderly population including depression and bipolar disorder.

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When ruling on a summary judgment motion, Rule 56(a) provides that the federal judge "should" state reasons for granting or denying the motion. In contrast, Tennessee Rule of Civil Procedure 56.04 mandates that the judge "shall" state the legal grounds for granting or denying summary judgment.

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