



Preliminary communication

Suicidal ideation and related factors among dementia patients



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ABSTRACT

Background: It is generally thought that people with dementia are not able to attempt suicide because of impaired executive function. Little research is available about suicidal ideation among dementia patients. The present study examines 1) the sociodemographic and clinical features of dementia patients with suicidal ideation and 2) the effect of suicidal ideation on caregiver burden.

Methods: A total of 634 dementia outpatients and their family caregivers participated in this study. Comparisons of variables were made among three groups: patients with suicidal ideation, patients with depression without suicidal ideation, and patients with neither suicidal ideation nor depression. Data were collected between April 2007 and July 2013.

Results: Suicidal ideation was seen in 64 patients (10.1%). Patients with suicidal ideation had a significantly higher rate of behavioural and psychological symptoms of dementia (BPSD) ($P < 0.001$). Caregivers of patients with suicidal ideation felt a higher caregiver burden, even after adjusting for BPSD score ($P < 0.01$).

Limitations: Suicidal ideation was assessed by interview with caregivers, so we may have overlooked people who had suicidal ideation but did not express it to their caregivers.

Conclusions: Suicidal ideation among dementia patients should receive greater attention. Adequate assessment of suicidal ideation and psychological support for both patients with suicidal ideation and their caregivers are needed.

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1. Introduction

Dementia is a worldwide problem affecting 44.4 million people. (International Alzheimer's Disease, 2013) Among dementia patients, depression is one of the major neuropsychiatric symptoms. (Pellegrino et al., 2013) Considering that depression sometimes leads to suicidal ideation, it is possible that some dementia patients have suicidal ideation or actually attempt suicide. However, it is generally thought that people with dementia are not able to attempt suicide because of impaired executive function. Haw et al. (Haw et al., 2009) reviewed the relation between dementia and suicidal behaviour and concluded that the relation is unclear. Therefore, suicidality among patients with dementia has received little attention. To date, some researchers have reported a higher rate of suicide among dementia patients, especially for patients with newly diagnosed dementia (Draper et al., 2010; Erlangsen et al., 2008; Lim et al., 2005; Mizukami et al., 2009; Seyfried et al., 2011) or those with specific types of dementia, such as semantic

dementia. (Hsiao et al., 2013; Sabodash et al., 2013) Rubio et al. (Rubio et al., 2001) also reported increased Alzheimer pathology in a population of elderly people committing suicide compared with subjects who died of natural causes. Considering that elderly people generally have a higher risk of suicide (Draper, 2014) and that dementia is frequently associated with depression, (Bennett and Thomas, 2014) the issue of suicidality among dementia patients should not be thought of lightly. Most previous studies about suicidality among dementia patients focused on suicidal behaviour, and suicidal ideation was rarely discussed. Having suicidal ideation, which is one of the most important risk factors for suicidal behaviour, (Almeida et al., 2012) would not only decrease patients' quality of life (QOL) but also affect caregivers. Based on the findings that caregivers of dementia patients with depression felt burdened more than those of dementia patients without depression, (Kang et al., 2014; Mohamed et al., 2010) we hypothesised that caring for dementia patients with suicidal ideation would be more stressful for caregivers.

This paper clarifies 1) the sociodemographic and clinical features of dementia patients with suicidal ideation and 2) the effect of suicidal ideation on caregiver burden.

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2. Methods

2.1. Participants

This study was approved by the Human Ethics Review Committee of Kumamoto University. After a complete description of all procedures of the study was provided, written informed consent was obtained from patients and their family caregivers.

Participants in this study were outpatients of the Dementia Clinic of the Department of Neuropsychiatry, Kumamoto University Hospital, from April 2007 to July 2013. Inclusion criteria was 1) provision of written informed consent; 2) diagnosed with Alzheimer's disease (AD), vascular dementia (VaD), dementia with Lewy bodies (DLB), or frontotemporal lobar degeneration (FTLD); 3) living at home, that is, not in a nursing home; and 4) both the patient and his/her main caregiver could participate in our survey. Patients who fulfilled the above criteria ($n=634$) were examined by senior neuropsychiatrists with adequate experience with patients with dementia. All patients had undergone routine laboratory tests, neuroimaging studies such as magnetic resonance imaging and single-photon emission computed tomography, and standard neuropsychological examinations. Dementia was diagnosed according to the Diagnostic and Statistical Manual of Mental Disorders, 3rd edition-revised (APA, 1987). Patients were divided into those with probable AD, defined according to the National Institute for Neurological and Communicative Disorders and Stroke-Alzheimer's disease and Related Disorders Association (McKhann et al., 1984); probable VaD, defined according to the National Institute for Neurological Disorders and Stroke-Association Internationale pour la Recherche et l'Enseignement en Neurosciences criteria (Román et al., 1993); probable DLB, defined according to the Consensus Criteria for the clinical diagnosis of DLB, 2005 (McKeith et al., 2005); or probable FTLD, defined according to the Consensus Criteria for the clinical diagnosis of FTLD (Neary et al., 1998).

2.2. Measures

2.2.1. Suicidal ideation and depression

We used a domain of the Japanese version of the Neuropsychiatric Inventory (NPI) to assess suicidal ideation and objective depression (Cummings et al., 1994; Hirono et al., 1997). The NPI, which is a semi-structured interview with a caregiver of patients, consists of ten behavioural domains including Depression/Dysphoria. For each domain, several subquestions are explored. For suicidal ideation, we regarded an answer of "yes" to the subquestion of the domain of Depression/Dysphoria, "Does the patient express a wish for death or talk about killing himself/herself?" as "having suicidal ideation".

2.2.2. Behavioural and Psychological Symptoms of Dementia (BPSD)

NPI was used to assess BPSD (Cummings et al., 1994; Hirono et al., 1997). Besides Depression/Dysphoria above, we evaluated the domains of Hallucinations, Delusions, Agitation/aggression, Anxiety, Euphoria, Apathy, Disinhibition, Irritability/lability, and Aberrant motor behaviour. The score of each domain was calculated by frequency (1 = less than once a week, 2 = once a week, 3 = a few times a week, 4 = once a day or more) \times severity (1 = mild, 2 = moderate, 3 = severe), and we regarded the sum of all scores of each domain excluding Depression/Dysphoria as the NPI total score (range, 0–108). Higher scores indicate worse conditions.

2.2.3. Caregiver burden

The Japanese version of the Zarit Caregiver Burden Interview (J-ZBI) (Arai et al., 1997), (Zarit et al., 1980) was used. ZBI consists of 22 questions about the impact of the patient's disabilities on the lifestyle of the caregiver. The questions were aimed at eliciting

information regarding areas most frequently mentioned by caregivers as problematic, including caregiver health, psychological well-being, finances, social life, and the relationship between the caregiver and recipient of care. For each item, caregivers indicate how often they feel that way (never=0, rarely=1, sometimes=2, quite frequently=3, nearly always=4). The sum of scores ranges from 0 to 88, and higher scores indicate higher burden.

2.2.4. Severity of dementia and cognitive function

The severity of dementia was assessed using the Clinical Dementia Rating (CDR) scale (Morris, 1993). It is a 5-point scale used to characterise six domains of cognitive and functional performance: Memory, Orientation, Judgment and Problem Solving, Community Affairs, Home and Hobbies, and Personal Care. Based on these domains, an overall CDR score is calculated. The overall CDR assigns cognitive function to five levels: no dementia, CDR 0; questionable dementia, CDR 0.5; mild dementia, CDR 1; moderate dementia, CDR 2; or severe dementia, CDR 3. The Mini-Mental State Examination (MMSE) was used to assess cognitive function (Folstein et al., 1975). MMSE is one of the most widely used cognitive screening tests that quantitatively assesses the severity of cognitive function. Scores range from 0 to 30, with higher scores indicating better cognitive functioning.

2.2.5. Other variables

Sociodemographic and clinical variables included age, gender, way of living (living alone, living with family), age of dementia onset (younger than 65 years, aged 65 years and older), and duration of illness.

2.3. Statistical analysis

Participants were divided into three groups: the suicidal ideation group (SI+), the no suicidal ideation with depression group (SI-/Dep+), and the neither suicidal ideation nor depression group (SI-/Dep-). Demographic and clinical factors were compared among groups using one-way analysis of variance and Bonferroni's post-hoc test. To compare caregiver burden among the three groups, we conducted one-way analysis of covariance adjusting for NPI total score (except for the Depression/Dysphoria score), which is strongly related to caregiver burden (Ornstein and Gaugler, 2012). All tests were two-tailed and the significance levels were set at $P < 0.05$. All statistical analyses were performed with SPSS 21.0 J for Windows (IBM SPSS Japan, Tokyo, Japan).

3. Results

Of 634 subjects, suicidal ideation was seen in 64 (10.1%). Of 570 subjects who did not have suicidal ideation, 133 (21.0%) had depression (SI-/Dep+ group), and 437 (68.9%) did not (SI-/Dep- group). Table 1 shows demographic and clinical characteristics of groups. The percentage of females was significantly higher in the SI+ and SI-/Dep+ groups than the SI-/Dep- group. Early-onset participants (younger than 65 years) had a significantly higher rate of SI-/Dep+ than late-onset participants and a significantly lower rate of SI-/Dep-. NPI total score except for the Depression/Dysphoria score was significantly lower in the SI-/Dep- group than in the SI+ and SI-/Dep- groups. There were no significant differences among groups in age, duration of illness, diagnoses, severity of dementia, way of living, and cognitive function.

Table 2 shows BPSD symptoms. Symptoms that were significantly more severe in the SI+ group than in the SI-/Dep+ and SI-/Dep- groups were delusions, agitation/aggression, and anxiety. Apathy and irritability/lability were significantly worse in the SI+ group than in the SI-/Dep- group, but were not worse than in the

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